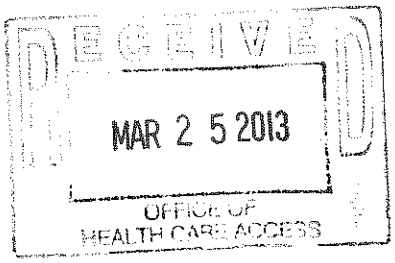
Retreat
at South Connecticut



March 25, 2013

Ms. Lisa A Davis
Deputy Commissioner
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS # 13HCA
Hartford, CT 06134

RE: Retreat at South Connecticut - Certificate of Need Application

Dear Ms. Davis:

On behalf of Retreat at South Connecticut, I am pleased to submit a Certificate of Need Application for 105 beds in order to provide residential detoxification and evaluation as well as rehabilitation and recovery-oriented care services

As requested, I have included an original and four hard copies in three-ring binders, along with electronic files in Adobe, Microsoft Word, and Microsoft Excel. Additionally attached top this submission is a check for the CON application filing fee in the amount of $500.00.

Please do not hesitate to contact me at (860) 767-8632, should you have questions, or I may be of further assistance. I look forward to working with you on this matter.

Sincerely yours,

William P. Beccaro

William P. Beccaro
on behalf of Retreat at South Connecticut

WPB/jv
Attachments
cc:
Ms. Kimberly R. Martone, Director of Operations – Office of Health Care Access
Mr. Steven W. Lazarus – Associate Health Care Analyst – Office of Health Care Access
Mr. Peter Schorr, *et. al.* - Retreat at South Connecticut

Retreat
at South Connecticut

NR CONNECTICUT, LLC
D/B/A RETREAT AT SOUTH CONNECTICUT

Certificate of Need Application for 105 beds in order to provide residential detoxification and evaluation as well as rehabilitation and recovery-oriented care services

March 25, 2013

Retreat
at South Connecticut

Certificate of Need Application for 105 beds in order to provide residential detoxification and evaluation as well as rehabilitation and recovery-oriented care services

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Retreat
at South Connecticut

EXHIBIT 1

APPLICATION CHECKLIST

Application Checklist

Instructions:

1. **Please check each box below, as appropriate; and**
2. **The completed checklist *must* be submitted as the first page of the CON application.**

X **Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.**

For OHCA Use Only:

Docket No.: 13 31828 CON **Check No.:** 2506
OHCA Verified by: SZ **Date:** 3/25/13

X **Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 428-7053, at the time of the publication)***

X **Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.**

X **Attached are completed Financial Attachments I and II.**

X **Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.**

Note: **A CON application may be filed with OHCA electronically through email, if the total number of pages submitted is 50 pages or less. In this case, the CON Application must be emailed to ohca@ct.gov.**

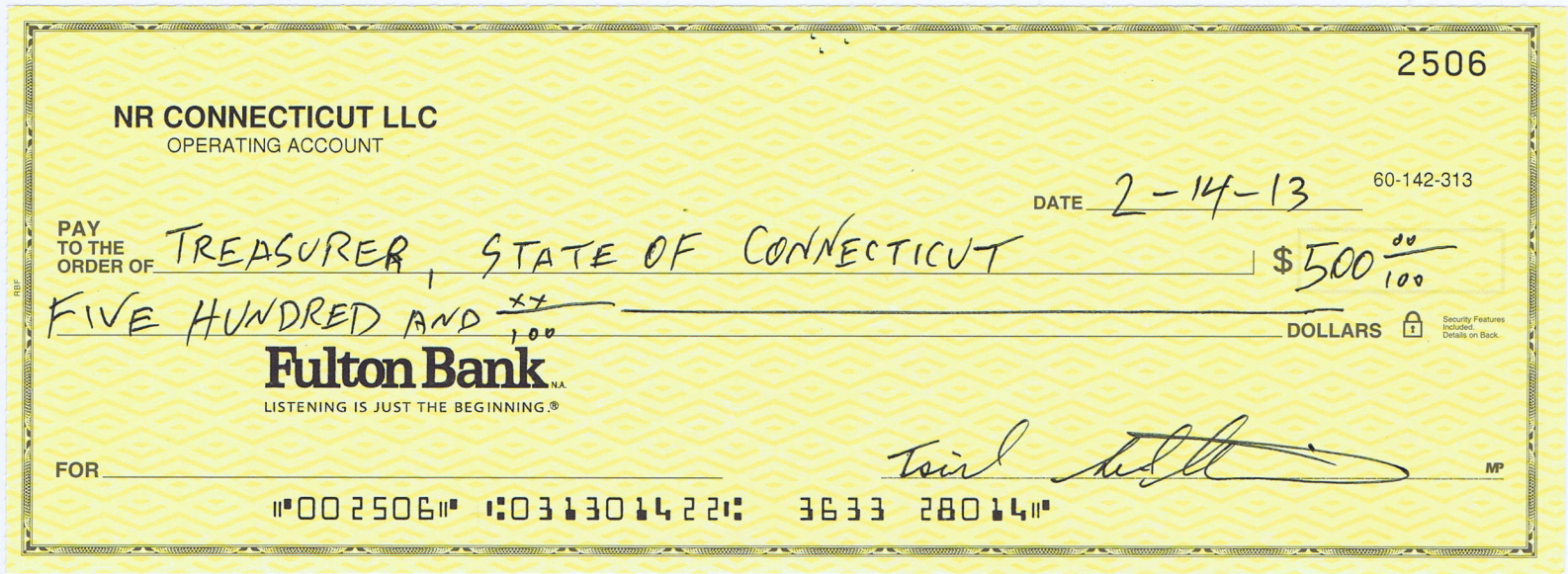
Important: **For CON applications(less than 50 pages) filed electronically through email, the singed affidavit and the check in the amount of $500 must be delivered to OHCA in hardcopy.**

X **The following have been submitted on a CD**

1. **A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.**
2. **An electronic copy of the documents in MS Word and MS Excel as appropriate.**

EXHIBIT 2

CERTIFICATE OF NEED APPLICATION FILING FEE



2506

NR CONNECTICUT LLC
OPERATING ACCOUNT

60-142-313

DATE 2-14-13

PAY TO THE ORDER OF TREASURER, STATE OF CONNECTICUT $500 00/100

FIVE HUNDRED AND XX/100 DOLLARS

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FOR

MP

⑈002506⑈ ⑆031301422⑆ 3633 28014⑈

EXHIBIT 3

Evidence demonstrating that public notice has been published

AFFIDAVIT OF PUBLICATION

New Haven Register

STATE OF CONNECTICUT

County of New Haven

I ***Barbara Colello*** of New Haven, Connecticut, being duly sworn, do depose and say that I am a ***Sales Representative*** of the New Haven Register, and that on

the following date ....3/2/13, 3/1/13 & 2/28/13....to wit.....

there was published in the regular daily edition of the said newspaper an

advertisement,

PUBLIC NOTICE

Pursuant to Section 19a-638 of the Connecticut General Statutes, NR Connecticut , I.L.C. d/b/a Retreat at South Connecticut, located at 915 Ella Grasso Boulevard, New Haven, will submit a certificate of need application to the Office of Health Care Access for the establishment of 105 residential detoxification and evaluation beds at an estimated total capital expenditure of $8.5 million dollars.

Barbara Colello 3/4/13

And that the newspaper extracts hereto annexed were clipped from each of the

above-named issues of said newspaper.

Subscribed and sworn to this 5th day of March 20.13.Before me.

Mary Faderico

My Commission Expires 10/31/2017

PUBLIC NOTICE

Pursuant to Section 19a-638 of the Connecticut General Statutes, NR Connecticut, LLC, d/b/a Retreat at South Connecticut, located at 915 Ella Grasso Boulevard, New Haven, will submit a certificate of need application to the Office of Health Care Access for the establishment of 105 residential detoxification and evaluation beds at an estimated total capital expenditure of $8.5 million dollars

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STATE LIC #0761

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203-468-5402 Office

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Office 203-888-5932

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INSURANCE
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LEGALS

LEGAL NOTICE

THE FOLLOWING INDIVIDUALS HAVE PERSONAL ITEMS BEING STORED BY THE TOWN OF HAMDEN AFTER A LAWFUL EVICTION ACCORDING TO THE GENERAL STATUTES OF THE STATE OF CONNECTICUT 47A-42-C:

NAME (S)
Dennis Williams
ADDRESS
411 Mill Rock Road
EVICTION DATE
2/6/13

Anyone wishing to reclaim their belongings must do so by 4:00 p.m., Thursday, March 14, 2013. Call Ace Van & Storage at 203-271-1555.

Items not claimed by that time will be sold at auction on Friday, March 15, 2013 at 9:00 a.m. at Ace Van & Storage, 210 Realty Dr., Cheshire, CT.

Auction will be by lot only, with a minimum bid of $25.00. Bids must be paid in full by cash at the conclusion of the bidding process. Successful bidder must have items cleared by 4:30 p.m. on Friday, March 15, 2013.

Items not sold will be disposed of immediately after the auction. Anyone owing fees to the Town of Hamden are prohibited from bidding in this auction. Anyone purchasing orders must have appropriate transportation for immediate removal.
2534109

NOTICE TO CREDITORS

ESTATE OF
James P. DiCaprio, AKA
James Pasquale DiCaprio,
AKA James DiCaprio, AKA
Jim DiCaprio

The Hon. Michael R. Brandt, Judge of the Court of Probate, East Haven - North Haven Probate District, by decree dated January 29, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Mary-Beth Cronk
Chief Clerk

The fiduciary is:

James R. DiCaprio,
Executor, c/o Simon J. Lebo, Esquire, c/o Brown, Paindiris & Scott, LLP,
2252 Main Street,
Glastonbury, CT 06033
2532161

LEGALS

NOTICE TO CREDITORS

ESTATE OF:
Margaret Planz

The Hon. Michael R. Brandt, Judge of the Court of Probate, East Haven - North Haven Probate District, by decree dated February 1, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Barbara Kieslich,
Assistaent Clerk

The fiduciary is:

Jennifer Planz
c/o Joseph E. DePaola,Esq.
97 Washington Avenue
PO Box 351
North Haven, CT 06473
2532173

NOTICE TO CREDITORS

ESTATE OF
Maria A. Cesarek

The Hon. Clifford D. Hoyle, Judge of the Court of Probate, Derby Probate District, by decree dated January 30, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Kay Jeanette, Clerk

The fiduciary is:

Melanie Caldwell
819 Grassy Hill Road
Orange, CT 06477

LEGAL NOTICE

A public sale of the contents of the storage units listed below will take place on **March 14th, 2013** at 10:00am. This sale will take place at **CubeSmart**, **873 Main Street**, Monroe, CT 06468. Each space will be sold as one lot. All items in storage units contain household items unless otherwise mentioned.

191: Eammon M. Donnelly
203: Cynthia O. Akinsanya-Lundkurst
219: Michael Stramandinoli
483: Linda L. Karolczuk
485: Linda L. Karolczuk
496: Brian C. Cooper

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LEGALS

STATE OF CONNECTICUT

RETURN DATE: MARCH 26, 2013 : SUPERIOR COURT
DEUTSCHE BANK NATIONAL, TRUST COMPANY, AS TRUSTEE FOR LONG BEACH MORTGAGE LOAN TRUST 2006-3 : JUDICIAL DISTRICT : OF NEW HAVEN
V. : AT NEW HAVEN
CARLOS MARCANO, ET AL : FEBRUARY 7, 2013

NOTICE TO CARLOS MARCANO AND DAMARIS RODRIGUEZ AND ALL UNKNOWN PERSONS, CLAIMING OR WHO MAY CLAIM, ANY RIGHTS, TITLE, INTEREST OR ESTATE IN OR LIEN OR ENCUMBRANCE UPON THE PROPERTY DESCRIBED IN THIS COMPLAINT, ADVERSE TO THE PLAINTIFF, WHETHER SUCH CLAIM OR POSSIBLE CLAIM BE VESTED OR CONTINGENT.

The Plaintiff has named as a Defendant, CARLOS MARCANO and DAMARIS RODRIGUEZ, and all unknown persons, claiming or who may claim, any rights, title, interest or estate in or lien or encumbrance upon the property described in this Complaint, adverse to the Plaintiff, whether such claim or possible claim can be vested or contingent, if not living, as a party defendant(s) in the complaint which it is bringing to the above-named Court seeking a foreclosure of its mortgage upon premises known as 278-280 LOMBARD STREET, NEW HAVEN, CT 06513.

The Plaintiff has represented to the said Court, by means of an affidavit annexed to the Complaint, that, despite all reasonable efforts to ascertain such information, it has been unable to determine the whereabouts of CARLOS MARCANO and DAMARIS RODRIGUEZ, and all unknown persons, claiming or who may claim, any rights, title, interest or estate in or lien or encumbrance upon the property described in this Complaint, adverse to the Plaintiff, whether such claim or possible claim can be vested or contingent, if not living.

Now, Therefore, it is hereby ORDERED that notice of the institution of this action be given to said CARLOS MARCANO and DAMARIS RODRIGUEZ, and all unknown persons, claiming or who may claim, any rights, title, interest or estate in or lien or encumbrance upon the property described in this Complaint, adverse to the Plaintiff, whether such claim or possible claim can be vested or contingent, by some proper officer causing a true and attested copy of this Order of Notice to be published in the NEW HAVEN REGISTER, once a week for two successive weeks, commencing on or before March 6, 2013, and that return of such service be made to this Court.

BY THE COURT
By: M. Maronich, Judge
February 19, 2013

A TRUE COPY ATTEST: Edward DiLieto
STATE MARSHAL, NEW HAVEN COUNTY

LEGALS

NOTICE TO CREDITORS

ESTATE OF:
William v. Palluotto

The Hon. Salvatore L. Diglio, Judge of the Court of Probate, Hamden - Bethany Probate District, by decree dated December 20, 2012, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Valerie A. Dondi, Clerk

The fiduciary is:

Dorothy I. Palluotto, c/o Marshal D. Gibson, Esq., One Century Tower, 265 Church Street, Suite 504, New Haven, CT 06510
2527466

NOTICE TO CREDITORS

ESTATE OF
Isabel J. Herb,
AKA Isabel Herb

The Hon. Beverly Streit-Kefalas, Judge of the Court of Probate, Milford - Orange Probate District, by decree dated January 30, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Karen Adams, Asst Clerk

The fiduciary is:

Isabel H. Kearns,
c/o Franklin A. Drazen, Esq.
Drazen Law Group, LLC,
245 Cherry Street,
Milford, CT 06460
2532166

PUBLIC NOTICE

Pursuant to Section 19a-638 of the Connecticut General Statutes, NR Connecticut , LLC, d/b/a Retreat at South Connecticut, located at 915 Ella Grasso Boulevard, New Haven, will submit a certificate of need application to the Office of Health Care Access for the establishment of 105 residential detoxification and evaluation beds at an estimated total capital expenditure of $8.5 million dollars.

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In person: 40 Sargent Drive, New Haven
(M-F 8:30AM–5:00PM)
New Haven Register
NewHavenRegister.com

NEW HAVEN

CITY NOTICE
BOARD OF ZONING APPEALS
CITY OF NEW HAVEN

Notice is hereby given of a Public Hearing held by the Board of Zoning Appeals in the Public Hearing Room (G-2), 200 Orange St, New Haven, CT, 6:30 p.m. Tuesday, March 12, 2013. At that time & place, opportunity will be given to those who wish to be heard relative to the appeals & applications of the following:

1. **13-17-13. 100 Farren Avenue**. Variance to allow side yard of 6ft where 8ft is required for a building addition. Zone:BA. Owner: Raul Valle; Applicant: Clara Suares
2. **13-18-13. 113 Cedar Street**. Variance to allow side yard of 1ft where 8ft is required for building addition. Zone:RM-2. Owner: Church of God of Prophecy; Applicant Jose Champagne
3. **13-19-V. 129 Putnam Street**. Variance to allow front yards of 7.5ft and 2ft where 17ft and 12 ft are required for new residential structure. Zone: RM-2. Owner: City of New Haven (LCI); Applicant :Cathy Schroeter
4. **13-20-V. 134 Putnam Street**. Variances to allow lot area of 4,625sf where 5,400sf is required, average lot width of 40.4ft where 50ft is required, side yard of 5.2ft where 8ft is required, front yard of 15ft where 17ft is required and building height of 20ft where a maximum of 11ft is permitted, all for a new residential structure. Zone: RM-2. Owner: City of New Haven (LCI); Applicant :Cathy Schroeter
5. **13-21-V. 193 Putnam Street**. Variances to allow lot area of 4,816sf where 5,400sf is required, average lot width of 44.5ft where 50ft is required, side yard of 5.2ft where 8ft is required, front yards of 11ft and 8ft where 17ft and 12ft are required and building height of 20ft where a maximum of 10.5 ft is permitted, all for a new residential structure. Zone: RM-2. Owner: City of New Haven (LCI); Applicant: Cathy Schroeter
6. **13-12-V. 201 Putnam Street**. Variance to allow front yards of 10.4ft , 11.6ft and 8.6ft where 17ft and 12 ft are required for new residential structure. Zone: RM-2. Owner: City of New Haven (LCI); Applicant :Cathy Schroeter

The appeals & applications w/reports of other City depts. are on file & may be seen at the City Plan Department, 5th Floor, City Hall, 165 Church Street, New Haven, CT

Gaylord Bourne, Secretary

HAMDEN

THE ZONING BOARD OF APPEALS,

Town of Hamden, held a Public Hearing & Regular Meeting on Thursday, February 21, 2013 with the following results:
1) **13-6487** 24 Thornton St., ***Granted*** a variance: Section 220, Table 2.1 to permit 37.3% impervious surface where only 30% is allowed for an addition, R-4 zone, Sara Borden, Applicant
2) **13-6488** 2761 Dixwell Ave., ***Granted*** a variance: Section 380.3.2, Table 3.7 to permit a 0 ft side yard where 50 ft are required for an all abilities playground, TG Zone, Town of Hamden, Applicant
3) **13-6489** 51 Worth Ave., ***Granted*** a variance: Table 3.4 & Figure 3.6, to permit a 0 ft side yard where 3 ft are required for an all abilities playground, T-4 zone, Town of Hamden, Applicant
4) **13-6490** 32 Barrett St., ***Granted*** a variance: Section 220, Table 2.5 to permit a garage with a front yard setback of 29 ft where 37 ft is required. R-4 zone, Gail Mase, Applicant
5) **13-6491** 29 Veranda St., ***Granted*** variances: Section 220, Table 2.5 to permit a garage with a front yard setback of 22 ft where 37 ft is required. Section 220, Table 2.3 to permit a sideyard of 10 ft where 12 ft is required. Section 220, Table 2.3 to permit a sideyard of 4 ft where 12 ft is required. Section 220, Table 2.1 to permit 35% impervious surface where only 30% is allowed, T-4 zone, Kevin Sweeney, Applicant
Submitted: Stacy Shellard, Commission Clerk
2534538



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NEW HAVEN

MILFORD

Legal Notice

CITY OF MILFORD
70 West River Street
Milford, CT 06460
Tel. (203) 783-3225
Fax (203) 876-1960

INVITATION TO BID

Notice is hereby given that sealed bids for the

Citywide installation /replacement of concrete sidewalks, curbs, aprons and related work, as needed

annual contract
will be received in the Purchasing Agent's Office until

3:00 p.m., Wednesday, March 20, 2013

when they will be publicly opened and read aloud.

Specifications may be obtained from the Purchasing Agent or may be downloaded at **www.ci.milford.ct.us** . Click on "City Departments", select "Purchasing Dept" then "Current Bids".

If you download bid packages it is *your responsibility* to insure that you have current information. Click on the "Changes in Bids" icon for any applicable addenda prior to submitting a bid. The City is not responsible for data or transmission errors.

A $20,000 Bid Bond must accompany each bid.

The successful bidder must post a $100,000 Performance Bond, a $100,000 Labor & Materials Bond, and a Certificate of Insurance on notice of contract award.

The Purchasing Agent reserves the right to reject any and all bids, waive defects, or to accept any proposal deemed to be in the City's best interests.

Fred Bialka
Purchasing Agent
2535025

NEW HAVEN

803 PETS & SUPPLIES

AKC Bernese Mt Pup, avail aft 3/2. $1100. 203-219-8886.

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203-795-9931 / ORANGE

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MALETESE PUPPIES 6wks old, vet ch, ACA 203-640-8519

812 TAG SALES

HAMDEN ESTATE SALE
Something for everyone! Hardware, records,furnishings.Saturday, March 2; 9:30-1, no early-birds, cash only & carry. Thornton St, Spring Glen. Look for signs

NORTH HAVEN - Estate Sale, Fr. Prov. LR, Dr, BR, 50's Bar, Brunswick Pool Table, Bric-a-Brac, Books & HH. RAIN OR SHINE ALL MUST GO! Fri. & Sat., Mar. 1 & 2, 9-1. Dixwell or Skiff - Ridge to 30 Windsor Rd.

881 WANTED TO BUY



1 BUY RADIOS, HAM, CB, VINTAGE ELECTRONICS, TUBE AUDIO,GUITARS,AMPS, MUSICAL INSTRUMENTS
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NEW HAVEN

ALDERMANIC NOTICE - NEW HAVEN

The Legislation Committee will meet on Thursday, March 14, 2013 at 6:30 P.M. in the Aldermanic Chamber of City Hall, 165 Church Street, to hear:

Zoning Ordinance Map Admendment to change the RM-1 designation of the properties at 137 Exchange Street (MBLU 163/0742/01500), 141 Exchange Street (MBLU 163/0742/01600), and a portion of 184 Grand Avenue (MBLU 163/0742/02200) from RM-1 (Low Middle Density Residential) to BA-1 (Neighborhood Center Mixed Use). (Submitted 12-17-12)

Zoning Ordinance Amendment to change the zoning from RM-1 to BA for properties on 137 Exchange Street (MBLU 163/0742/01500) and 141 Exchange Street (MBLU 163/0742/01600). (Submitted 9-18-12)

These items are filed with the City Clerk, Room 202, 200 Orange Street, where they are available for public inspection. Per order Hon. Jessica Holmes, Chair; Attest: Hon. Ron Smith, City Clerk.

If you need disability related accommodation, please call five business days in advance of the meeting: 946-8122 (Voice) or 946-8582 (TTY).

WOODBRIDGE

Notice of Public Hearing Woodbridge Town Plan and Zoning Commission

Notice is hereby given that the Woodbridge Town Plan and Zoning Commission will hold Public Hearings on Monday, March 4, 2013 in the Central Meeting Room of the Woodbridge Town Hall, 11 Meetinghouse Lane, beginning at 7:30 p.m. regarding:

1. **Savannah Stables LLC: 883 Baldwin Road**
   Application for a special permit for business sign for stables located at 883 Baldwin Road.
2. **ABC Sign Company, Inc: 176 Amity Road**
   Application for a special permit for an additional wall sign for the UPS Store located at 176 Amity Road.
3. **Ezra Academy: 360 Amity Road**
   Application for a special permit to relocate the education facility known as Ezra Academy to the Jewish Community Center at 360 Amity Road

The files on the applications are available for review in the Office of the Woodbridge Land Use Agencies in the lower level of the Woodbridge Town Hall, 11 Meetinghouse Lane, Woodbridge, CT.
Jeff Kaufman, Chairman for the Commission
2533074

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648 SALES & MARKETING

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Madison Chrysler, Inc.
203 Boston Post Road
Madison, CT - 203-245-0451

LEGALS

Notice of Permit Application Town: West Haven CT

Notice is hereby given that Enthone, Inc. (the "applicant") of 350 Frontage Road, West Haven, Connecticut has submitted to the Department of Energy and Environmental Protection an application under section 22a-430 of the Connecticut General Statutes for a permit to initiate, create, originate or maintain a discharge of water, substance or material to the waters of the state.

Specifically, the applicant proposes to continue discharging treated wastewaters from its research and development and quality control operations to the City of West Haven sanitary sewer. The proposed activity will take place at 350 Frontage Road, West Haven, Connecticut 06516. The proposed activity will potentially affect the City of West Haven Sewage Treatment Facility in West Haven, Connecticut.

Interested persons may obtain copies of the application from Fenton Macomber of Enthone, Inc., 350 Frontage Road, West Haven, Connecticut 06516, (203) 932-8680.

The application is available for inspection at the Department of Energy and Environmental Protection, Bureau of Materials Management and Compliance Assurance, Permitting and Enforcement, 79 Elm Street, Hartford, Connecticut 06106-5127 (860) 424-3018 from 8:30 to 4:30, Monday through Friday.

NOTICE TO CREDITORS

ESTATE OF:
Selma L. MacAdams,
AKA Sally L. MacAdams

The Hon. Michael R. Brandt, Judge of the Court of Probate, East Haven - North Haven Probate District, by decree dated February 15, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Barbara Kieslich, Asst Clerk

The fiduciary is:

Eileen M. Frame, c/o
Norman F. Fishbein, Esq.,
100 South Main Street
P.O. Box 363,
Wallingford, CT 06492
2534011

650 HEALTH CARE OPPORTUNITIES

LEGALS

NOTICE OF PUBLIC MEETING DISADVANTAGED BUSINESS ENTERPRISE (DBE) GOALS FFY 2011-2013

The Greater New Haven Transit District (GNHTD) is required by the Federal Transit Administration to establish an overall goal percentage for Disadvantaged Business Enterprise (DBE) participation during FFY 2011-2013. Vendors are invited to GNHTD for a public meeting to receive comments on establishing their goal for Disadvantaged Business Enterprises (DBE).

Date: Wednesday, March 6, 2013

Time: 2:00 P.M.

Location: Greater New Haven Transit District, 840 Sherman Avenue, Hamden, CT 06514

If you have any questions prior to the meeting, please contact Lori Richards at 203-288-6282 ext. 2519 or: lrichards@gnhtd.org.

NOTICE TO CREDITORS

ESTATE OF
Cornelia B. Trickett,
AKA Nelia Trickett

The Hon. Michael R. Brandt, Judge of the Court of Probate, East Haven - North Haven Probate District, by decree dated February 19, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Eileen Sweeney, Clerk

The fiduciary is:

Beverly Trickett, c/o Gerald E. Farrell, Jr., Esq., Farrell, Leslie & Grochowski, 375 Center Street, P.O. Box 369, Wallingford, CT 06492
2534172

STATE OF CONN

Superior Court
Juvenile Matters
ORDER OF NOTICE
NOTICE TO:
KENDALL THREATT,
FATHER OF MALE CHILD
BORN ON 10/31/2004,
TO MELISSA B.
IN THE CITY OF
NEW HAVEN, CT
of parts unknown

A petition has been filed seeking: Hearing on an Order of Temporary Custody will be heard on: 03/12/2013 at 10:00 A.M. at Superior Court for Juvenile Matters, 239 Wahlley Avenue, New Haven, CT 06511. Therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice, once, immediately upon receipt, on March 1, 2013, in the: New Haven Register, 40 Sargeant Drive, New Haven, CT 0651, a newspaper having a circulation in the town/city of: New Haven, CT.
Hon. Peter Brown,
Judge
Donna Nevins,
Cerk
2//28/13
Right to Counsel: Upon proof of inability to pay for a lawyer, the court will make sure that an attorney is provided to you by the Chief Public Defender. Request for an attorney should be made immediately in person, by mail, or by fax at the court office where your hearing is to be held.
2535214

650 HEALTH CARE OPPORTUNITIES

TotalCare

A Visiting Nurse Agency

Are you ready to join "Team TotalCare"?

- **RN/Clinical Nurse Supervisor**
  RN, 1 yr home care experience, strong management skills preferred. Supervise a team of field nurses in the community.
- **HHA Supervisor**
  Candidate must be an RN with home care experience. The supervisor will oversee HHA orientations, field visits and overall functions of the HHA department.
- **RN/Psychiatric Nurse**
  For on call after hours and weekends/Per diem. Home care experience required.
- **RN Psychiatric Case Manager**
  Full Time; Psych experience required Home Care experience preferred
- **Home Health Aides**
  Part time, full time, per diem



Excellent salary & benefits

Call **203.777.4900**
Fax **203.777.4916**
Send resumes to rachel@totalcarenursing.net

TotalCare
370 James St., Suite 303
New Haven, CT 06510
E.O.E.

LEGALS

STATE OF CONN

Superior Court
Juvenile Matters
ORDER OF NOTICE
NOTICE TO:
JOHN DOE,
FATHER OF MALE CHILD
BORN ON 7/9/03,
TO JESSICA T.
IN THE TOWN OF
NEW HAVEN,
WHERE THE CHILD
WAS BORN.
of parts unknown

A petition has been filed seeking: The petition whereby the court's decision can affect your parental rights, if any, regarding minor child(ren) will be heard on: 3/13/13 at 10:00 A.M. at Superior Court for Juvenile Matters, 7 Kendrick Avenue, Waterbury, CT 06702. Therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice, once, immediately upon receipt, on March 1, 2013, in the: New Haven Register, 40 Sargeant Drive, New Haven, CT 0651, a newspaper having a circulation in the town/city of: New Haven, CT.
Hon. Constance Epstein,
Judge
Joseph Inman,
Clerk
2//28/13
Right to Counsel: Upon proof of inability to pay for a lawyer, the court will make sure that an attorney is provided to you by the Chief Public Defender. Request for an attorney should be made immediately in person, by mail, or by fax at the court office where your hearing is to be held.
2535207

STATE OF CONN

Superior Court
Juvenile Matters
NOTICE TO
BROOKE BUTLER
(DOB 4/4/79)
of parts unknown

A petition has been filed seeking: Commitment of minor child(ren) of the above named or vesting of custody and care of said child(ren) of the above named in a lawful, private or public agency or a suitable and worthy person. Hearing on an order of Temporary Custody will be heard on: 03/08/13 at 12:00 P.M. at Superior Court for Juvenile Matters, 239 Whalley Avenue, New Haven, CT. 06511 Therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice once, immediately upon receipt, on March 1, 2013 in the: New Haven Register, a newspaper having a circulation in the town/city of: New Haven.
Hon. Peter L. Brown,
Judge
Mara Castro-Mesa,
Clerk
02/28/13
Right to Counsel: Upon proof of inability to pay for a lawyer, the court will make sure that an attorney is provided to you by the Chief Public Defender. Request for an attorney should be made immediately in person, by mail, or by fax at the court office where your hearing is to be held.
2535244

NOTICE TO CREDITORS

ESTATE OF:
William J. Dietz, Jr.

The Hon. Beverly Streit-Kefalas, Judge of the Court of Probate, Milford - Orange Probate District, by decree dated February 12, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Karen Adams, Asst Clerk

The fiduciary is:

Anna S. Dietz, c/o John E. Donegan, Esq., Gibson & Donegan, 420 East Main St. Unit 7, P.O. Box 808, Branford, CT 06405

NOTICE OF PUBLIC HEARING WEST HAVEN WATER POLLUTION CONTROL COMMISSION

To whom it may concern:

The West Haven Water Pollution Control Commission will hold a public hearing on Wednesday March 13, 2013 at 6:30pm in the City Council chambers located on the third floor of West Haven City Hall on the following agenda:

Submission of the Water Pollution Control Commission proposed operating budget for the fiscal year 2013-2014 in the amount of $11,326,589.00 and a proposed sewer use fee rate of $408.00 per unit

Peter O'Neill, Chairman
Water Pollution
Control Commission

ANSONIA

CITY OF ANSONIA NOTICE OF MEETING BOARD OF APPORTIONMENT AND TAXATION

DATE:
Monday: March 4, 2013
Monday: March 11, 2013
Monday: March 25, 2013
Monday: April 1, 2013
Monday: April 8, 2013
Monday: April 22, 2013
Monday: April 29, 2013
Monday: May 6, 2013
Thursday: May 16, 2013

TIME: 6:00 P.M.

PLACE: Ansonia City Hall,
Second Floor
253 Main Street

PURPOSE:
1. To meet and discuss 2013-2014 budget revisions with departments.

2. To take any action as needed.

James T. Della Volpe, Mayor
2535085

NEW HAVEN

NOTICE OF INTENT TO REQUEST RELEASE OF FUNDS

March 1, 2013
Housing Authority of the City of New Haven
360 Orange Street
New Haven CT, 06509
203-498-8800

On or about March 18, 2013 the Housing Authority of the City of New Haven (HANH) will submit a request to the Department of Housing and Urban Development (HUD), Hartford Field Office, located at One Corporate Center, 20 Church Street, 19th Floor, Hartford, CT 06103 for the release of funds for 84 units out of 175 units, under its Project Based Voucher Program for the new Farnam Courts Redevelopment located at 210 Hamilton Street, New Haven, CT.

The activities proposed comprise a project for which a Finding of No Significant Impact on the environment was published on March 1, 2013. An Environmental Review Record (ERR) that documents the environmental determinations for this project is on file at the HANH located at 360 Orange Street, New Haven, CT 06509 and may be examined or copied weekdays 9 A.M. to 4 P.M.

PUBLIC COMMENTS

Any individual, group, or agency may submit written comments on the ERR to the HANH located at 360 Orange Street, New Haven, CT 06511. All comments received by March 18, 2013 will be considered by the HANH prior to authorizing submission of a request for release of funds.

RELEASE OF FUNDS

The HANH certifies to HUD that John DeStefano Jr. in his capacity as Mayor consents to accept the jurisdiction of the Federal Courts if an action is brought to enforce responsibilities in relation to the environmental review process and that these responsibilities have been satisfied. HUD's approval of the certification satisfies its responsibilities under NEPA and related laws and authorities, and allows the HANH to use Program funds.

OBJECTIONS TO RELEASE OF FUNDS

HUD will accept objections to its release of funds and the HANH's certification for a period of fifteen days following the anticipated submission date or its actual receipt of the request (whichever is later) only if they are on one of the following bases: (a) the certification was not executed by the Mayor, John DeStefano Jr. of the HANH; (b) the HANH has omitted a step or failed to make a decision or finding required by HUD regulations at 24 CFR Part 58; (c) the grant recipient has committed funds or incurred costs not authorized by 24 CFR Part 58 before approval of a release of funds by HUD; or (d) another Federal agency acting pursuant to 40 CFR Part 1504 has submitted a written finding that the project is unsatisfactory from the standpoint of environmental quality. Objections must be prepared and submitted in accordance with the required procedures (24 CFR Part 58) and shall be addressed to HUD grant administration office at One Corporate Center, 20 Church Street, 19th Floor, Hartford, CT 06103. Potential objectors should contact HUD to verify the actual last day of the objection period.

John DeStefano, Jr., Mayor

LEGALS

PUBLIC NOTICE

Pursuant to Section 19a-638 of the Connecticut General Statutes, NR Connecticut , LLC, d/b/a Retreat at South Connecticut, located at 915 Ella Grasso Boulevard, New Haven, will submit a certificate of need application to the Office of Health Care Access for the establishment of 105 residential detoxification and evaluation beds at an estimated total capital expenditure of $8.5 million dollars.

The University of Connecticut

REQUEST FOR STATEMENT OF QUALIFICATIONS

ON-CALL PROFESSIONAL SERVICES FOR: Athletic, Recreation and Field Sports

Issue Date: March 1, 2013

Submission Due Date: March 22, 2013

THE UNIVERSITY OF CONNECTICUT IS SOLICITING THE SERVICES OF QUALIFIED FIRMS TO PERFORM ON-CALL PROFESSIONAL SERVICES FOR ATHLETIC, RECREATION AND FIELD SPORTS. TO FIND OUT MORE ABOUT THIS PROJECT, INTERESTED FIRMS SHOULD VISIT OUR WEBSITE AT:

http://cpca.uconn.edu/profserv/profserv_currentops.html

ANSONIA

NOTICE IS HEREBY GIVEN that the City of Ansonia will conduct a public hearing by the Office of the Mayor on Tuesday, March 12, 2013 at 6:00 p.m. in the Erlinghauser Room, City Hall, 253 Main Street, Ansonia, CT 06401, to discuss the Fiscal Year 2013 Community Development Block Grant program and to solicit citizen input. (The snow date will be Tuesday, March 19th at 6:00 in the Erlinghauser Room.)

Maximum award limits are $700,000 for Public Facilities; $700,000 for Public Housing Modernization of 25 units or less, or $800,000 for 26 units and over; $500,000 for Infrastructure; $400,000 for Housing Rehabilitation Program for single towns, $500,000 for two-town consortium, and $600,000 for three or more Towns; $25,000 for Planning Only Grants; $500,000 for Economic Development Activities, and $500,000 for Urgent Need.

Major activity categories are: Acquisition, Housing Rehabilitation, Public Housing Modernization, Community Facilities, Public Services, and Economic Development. Projects funded with CDBG allocations must carry out at least one of three National Objectives: benefit to low- and moderate-income persons, elimination of slums and blight, or meeting urgent community development needs.

The purpose of the public hearing is to obtain citizen's views on the City's community development and housing needs and review and discuss specific project activities in the areas of housing, economic development or community facilities which could be part of the City's application for funding.

Also, the public hearing will be to give citizens an opportunity to make their comments known on the program and for approval of the Program Income Reuse Plan. If you are unable to attend the public hearing, you may direct written comments to the City of Ansonia's Economic Development Office, 253 Main Street, Ansonia, CT 06401 or you may telephone Carol Forcier, 203-736-5927. In addition, information may be obtained at the above address between the hours of 8:30 a.m. and 4:30 p.m. on Monday through Thursday and 8:30 a.m. and 1 p.m. on Friday. Individuals with disabilities who wish to attend are encouraged to contact the Town's ADA Coordinator, Tara Kolakowski at (203) 736-5900.

The Office of the Mayor on behalf of the City of Ansonia anticipates applying for the maximum grant amount of $400,000 under the Housing Rehabilitation category. In addition, the City of Ansonia will create a revolving loan fund with program income (principal and interest) generated from the grant, if any, for further housing rehabilitation activities.

The City of Ansonia promotes fair housing and makes all programs available to low - and moderate-income families regardless of age, race, color, religion, sex, national origin, sexual preference, marital status, or handicap.

The City of Ansonia is an Equal Opportunity/Affirmative Action employer and fair housing advocate. Minority, disadvantaged, and section 3 businesses are encouraged to apply.
2533655

LEGALS

NOTICE TO CREDITORS

ESTATE OF:
Constance A. Viglione

The Hon. Michael R. Brandt, Judge of the Court of Probate, East Haven - North Haven Probate District, by decree dated February 19, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Eileen Sweeney, Clerk

The fiduciary is:

Stephen J. Viglione, Sr., c/o Stephen L. Saltzman, Esq., 271 Whitney Ave.
New Haven, CT 06511
2534316

HAMDEN

TOWN OF HAMDEN INVITATION TO BID BID #2709 REPLACE LOWER ROOF AT PUBLIC WORKS 1125 SHEPARD AVENUE, HAMDEN, CT

The Town of Hamden is publicly seeking competitive bids from qualified firms for the replacement of the lower roof on the Public Works building located at 1125 Shepard Avenue, Hamden, CT 06514.

Sealed proposals (1 original and 1 copy) will be received at the Finance Office to be held in the Purchasing Lock box until **11:00 A.M.** on **March 28, 2013** at which time they will be publicly opened and read aloud. Bids received after the time set will be considered informal and will be rejected.

It is the sole responsibility of the bidder to see that the bid is in the hands of the proper authority prior to the bid opening time.

Specifications and the form of proposal on which bids must be submitted may be obtained at the Purchasing Office, Hamden Government Center, 2750 Dixwell Avenue, Hamden, CT, between the hours of 8:30 A.M. and 4:30 P.M., Telephone (203) 287-7110. A PDF version may be obtained by e-mailing a request to purchasing@hamden.com.

The Town of Hamden reserves the right to accept or reject any or all options, bids, or proposals; to waive any technicality in a bid or part thereof submitted, and to accept the bid deemed to be in the best interest of the Town of Hamden.

Patti Riccitelli
Acting Purchasing Agent
2535082

TOWN OF HAMDEN INVITATION TO BID BID #2708 BUS TRIPS FOR YOUTH SERVICES

The Town of Hamden is publicly seeking sealed competitive bids from qualified companies to provide bus trips for the Youth Services Department.

Sealed proposals (1 original and 1 copy) will be received at the Finance Office to be held in the Purchasing Lock box until **11:00 A.M.** on **March 28, 2013** at which time they will be publicly opened and read aloud. Bids received after the time set will be considered informal and will be rejected.

It is the sole responsibility of the bidder to see that the bid is in the hands of the proper authority prior to the bid opening time.

Specifications and the form of proposal on which bids must be submitted may be obtained at the Purchasing Office, Hamden Government Center, 2750 Dixwell Avenue, Hamden, CT, between the hours of 8:30 A.M. and 4:30 P.M., Telephone (203) 287-7110. A PDF version may be obtained by e-mailing a request to purchasing@hamden.com.

The Town of Hamden reserves the right to accept or reject any or all options, bids, or proposals; to waive any technicality in a bid or part thereof submitted, and to accept the bid deemed to be in the best interest of the Town of Hamden.

Patti Riccitelli
Acting Purchasing Agent
2535077

GENERAL HELP WANTED

645 GENERAL HELP WANTED

Delivery Drivers/ Independent Contractors
Need reliable vehicles for same day deliveries. Call 1-800-818-7958.

Drivers Wanted!

Publishers Circulation Fulfillment Inc.
is seeking
Delivery Service Providers (DSPs)
for newspaper
home delivery routes.
DSP's are independently contracted. 7 days a week
2-3 hours daily,
starting around 3AM.
$350-500/bi-weekly

Routes available in:
East Haven, West Haven, Madison, Shelton, Clinton, N. Branford, Branford, Woodbridge, and Bethany

No $$ collections.
Must be 18+ yrs. old

Call: 1-800-515-8000

PCF

648 SALES & MARKETING

Sales Positions

Fantastic Opportunity!
Join a great team selling Detroit's hottest new vehicles. Sell the all new Chrysler, Jeep, Dodge and Ram Truck lines. Our business is coming back strong, and we need Salespeople. If you are well spoken, and present a good appearance, we can teach you everything else. Salary plus unlimited commissions. Paid vacations and retirement plan.

Assistant Sales Manager

If you are a top producer and ready to move to the next level this opportunity is for you.

Call or come in today.
Madison Chrysler, Inc.
203 Boston Post Road
Madison, CT - 203-245-0451

645 GENERAL HELP WANTED

LEGALS

LIQUOR PERMIT

Notice of Application
This is to give notice that I,
JACK I SMITH
12 DEERFIELD LN
BETHANY, CT 06524-3084
Have filed an application placarded 01/26/2013 with the Department of
Consumer Protection for a
RESTAURANT LIQUOR PERMIT for the sale of
alcoholic liquor on the
premises at
2151 STATE ST
HAMDEN, CT 06517-3834
The business will be owned by:
JIS & JAS LLC
Entertainment will consist of:
None
Objections must be filed by:
03/09/2013
JACK I SMITH

PUBLIC NOTICE

Pursuant to Section 19a-638 of the Connecticut General Statutes, NR Connecticut , LLC, d/b/a Retreat at South Connecticut, located at 915 Ella Grasso Boulevard, New Haven, will submit a certificate of need application to the Office of Health Care Access for the establishment of 105 residential detoxification and evaluation beds at an estimated total capital expenditure of $8.5 million dollars.



FIND IT

IN CLASSIFIED
It's the key source for information you're seeking -- about job opportunities homes for sale, lost pets and more.
777-FAST
1-877-872-FAST

CALL 203-777-3278 or
(TOLL FREE) 1-877-872-3278
TO PLACE
YOUR
CLASSIFIED AD

645 GENERAL HELP WANTED

ANNOUNCEMENT

Help wanted advertisements in these columns have been accepted on the premise that jobs offered will be filled on the basis of merit. It is a violation of the Connecticut Fair Employment Practice Law to present or publish or cause to be published any notice or advertisement for employment which indicates preference or limitation based on sex, color, race, national ancestry or origin, religion, age, or physical disability. An exception exists if there is a bonafide occupational qualification for employment. All inquiries should be made to the Connecticut Commision on Human Rights and Opportunities, 50 Linden Street, Waterbury, Ct. 06702
Telephone (203)805-653**0**

UNITED STATES POSTAL SERVICE

NOW HIRING IN THE NORTHEAST

- **Letter Carrier - City and Rural**
- **Clerks & Sales & Service Associates**
  (Postal Support Employee)
- **Custodians**
  (Postal Support Employee) (Many Locations)
- **Tractor Trailer Operator –**
  (Class A CDL Required)
- **Postmaster Relief**
  (Part Time – Many Locations)

New job vacancies being added to the website every day
Explore job openings and apply at:
www.usps.com/employment
Hurry before the Post Office job you've always wanted is taken
Applicants must have an e-mail address
The USPS is an Equal Opportunity Employer

Plant Operators

SYNAGRO

Synagro, the nation's leading provider of residual management services is currently seeking Plant Operators in New Haven area.

ESSENTIAL FUNCTIONS:
- Inspect, maintain, and control process equipment and perform mechanical maintenance within the plant.
- Monitor and control plant operations in accordance with company policies.
- Maintain records of plant operations (hourly operating data, plant violations, and abnormal operating conditions).
- Enforce and maintain standard safety procedures within compliance and maintain a clean work area.

KNOWLEDGE, SKILL AND ABILITY REQUIREMENTS:
- High School diploma or GED equivalent
- Mechanical & electrical aptitude required.

Qualified applicants should provide a resume to
Careers@synagro.com
for further consideration

Landscaping

PERCO
The Landscape Management People™

Landscape Maintenance FOREMAN

New Haven, 3+ yrs commercial landscape maintenance exp & valid CT DL required. 1+ yrs supervisory exp preferred.

Landscape Maintenance LABORER

New Haven, MUST HAVE 1+ yrs landscape maintenance exp. Exp using commercial equipment and proof of eligibility to work in the US are required.

PERCO, Inc.
203-777-3421 x201

803 PETS & SUPPLIES

AKC Bernese Mt Pup, avail aft 3/2. $1100. 203-219-8886.

ALL BREEDS PUPPIES
Statewidepets.com
203-795-9931 / ORANGE

BABY SCARLET MACAW and Sun Conures. **203-824-1717**

DOBERMAN pup for adoption. 8 mo.old. blk/tan. **203-231-7177**

MALETESE PUPPIES 6wks old, vet ch, ACA 203-640-8519

812 TAG SALES

CHESHIRE - ESTATE SALE
1 DAY ONLY-LAST CHANCE!
All **Reasonable** Offers **Considered**. Remaining Contents from previous sale. Contents include: **Exceptional** Dining Room Table, Chairs, Leafs, Pads, **Oriental Rugs**, Occas. Furniture, Artwork, Lighting, Men's Left-handed **Golf Clubs & Bags**, **Fine Men's Apparel**, **HH, etc**. **Please** go to **Craig's List** for a more complete listing. **Sat. March 2**, 10am-2pm, 145 Mountain Brook Dr., Whitney Ave. (Rt 10) to So. Brooksvale Rd to Mountain Brook Dr. to #145 **"Just Come!"**

HAMDEN ESTATE SALE
Something for everyone! Hardware, records,furnishings.Saturday, March 2; 9:30-1, no early-birds, cash only & carry. Thornton St, Spring Glen. Look for signs

645P PROFESSIONAL MARKETPLACE

812 TAG SALES

NORTH HAVEN - Estate Sale, Fr. Prov. LR, Dr, BR, 50's Bar, Brunswick Pool Table, Bric-a-Brac, Books & HH. RAIN OR SHINE ALL MUST GO! Fri. & Sat., Mar. 1 & 2, 9-1. Dixwell or Skiff - Ridge to 30 Windsor Rd.

WALLINGFORD Huge! Moving Lge variety of HH items & some furniture 7 Lily Lane ,1 block fr Oakdale Sat Mar 2nd & Sun Mar 3rd 8-3 Rain or Shine

881 WANTED TO BUY



1 BUY RADIOS, HAM, CB, VINTAGE ELECTRONICS, TUBE AUDIO,GUITARS,AMPS, MUSICAL INSTRUMENTS
860-707-9350

★

NICHOLS Salvage - Will buy your scrap steel, cars, trucks, alum., trailers, copper, batteries, heavy equip. 46 Meadow Rd. Clinton CT. 860-669-2808

975 VEHICLES WANTED

JUNK CARS WANTED
And late model wrecks.
HIGHEST PRICES PAID.
7 day & evening pickup.
ATLAS 203-865-JUNK (5865)

645P PROFESSIONAL MARKETPLACE

Education

WETHERSFIELD PUBLIC SCHOOLS
Wethersfield, Connecticut
February 2013

Elementary Principals (2)

Samuel B. Webb Elementary
Emerson-Williams Elementary

Wethersfield is a suburban community with a rich historical heritage located south of Hartford, Connecticut. Placing a high value on education, the district serves approximately 3,800 students in grades Pre-K – 12.

The Board of Education is seeking two (2) dedicated leaders with superior academic qualifications and communication skills for the position of Elementary Principal at the Samuel Webb and Emerson-Williams Elementary Schools.

Qualifications and Strengths:
- Strong collaborative and interpersonal skills to lead teachers, parents, and members of the school community
- Demonstrated success in the development, evaluation and implementation of curriculum and instruction and implementing Common Core State Standards.
- Excellent written and oral communication skills.
- Ability to use technology for data analysis and understand its application to student learning.
- At least five years successful teaching experience.
- Connecticut Administrative Certification (092).
- Working knowledge of and training in the use of a model comparable to Connecticut's Teacher Evaluation Model (SEED)
- The ability to ensure high standards for student achievement grounded in twenty-first century skills

Start Date: July 1, 2013

Salary Range: $113,621 - $130,536

All candidates must apply online, through the job posting on the district website at **www.wethersfield.k12.ct.us** by March 22, 2013 in order to be considered.

MERCHANDISE marketplace

Articles For Sale

Hot Tub 6 per. 50 jets with all options, never used. Cost $7,600 Sell $3,600. **203-988-9915.**

Hoveround w/controls, cup holder,nvr used, like new, buyer picks up. $3000. 203-937-7698.

QUEEN pillowtop mattress set w/boxspring, new,still in plastic, Cost $699. Sell $279.203-988-9915

STAIRLIFT CHAIR, used, like new. $700. Call 203-393-3497.

A HOME OF YOUR OWN
The Job of Your Dreams
A Pet for the Children
A Second Car for Commuting
A Tag Sale"Buried Treasure"
Find these and more in the ***New Haven Register Classifieds.***

Household Goods

AFFORDABLE
Washers, Dryers, Stoves, Refrigs. & Service
Delivery Available
203 - 284 - 8986

SNOWBLOWER 21" wide, gas engine almost new used 3x $175. Dining room set glass table, 4 chairs, mint cond $550 Call 203-407-8357

Outdoor Power Equipment

24" SNOWBLOWER
Husqvarna, used one season, was $800 new, now $500.
203-458-0338.

Four ways to place your ad in the Marketplace:
- Call: **203.777.3278** or **1.877.872.3278**
- Fax: **203.865.8360**
- On the web: **www.newhavenregister.com**
- Email: **classifiedads@nhregister.com**

Please be sure to include your name, address and telephone number when submitting your ad.

AFTERSCHOOL PROGRAMS.
IGNORE THEM AND THEY'LL GO AWAY.

CHARLES STEWART MOTT FOUNDATION
Ad Council

WWW.AFTERSCHOOLNOW.ORG

1-866-KIDS-TODAY

Afterschool Alliance

812 TAG SALES

812 TAG SALES

OPEN SUNDAY! 9AM - 4PM

Indoor Heated Flea Market

Grass Island Market Antiques and Collectibles
(Open Everyday Except Tuesday and Wednesday)
301 Boston Post Rd. • Guiford • Exit 59 off I-95
(Former Mannix Chevrolet Building)

WE'RE INSIDE!
Rain & Snow is never a problem

203-689-5072
Handicap Accessible
~ New Vendors Welcome ~



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203-468-6966

A BUY FUEL OIL
203-481-2289
$3.39
HOD708 - Will beat any price!

ALL SEASONS ENERGY
Guaranteed Lowest Price
203-208-3256

ASHLEY'S ENERGY
Call for Price
203-468-9444

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OPEN SATURDAYS
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www.centsableoil.com

FORBES PREMIUM FUEL
Is now selling home heating oil. **203-468-2777** for pricing

GINNETTI ENERGY
203-469-7249
203-421-4310

JUST OIL
MAKE US YOUR LAST CALL.
203-208-2012

KMS OIL CO., LLC
CALL FOR COMPETITIVE PRICING
HOD 1039
203-627-1058

Libretti & Son Fuel
466- 4328
Senior Discount
HOD#570

$ ONLY OIL$
$3.65
467-2220
$Accept Credit cards$
HOD #477

PHILLIPS OIL, LLC
Accepting Energy Assistance
203-758-6778 / HOD #983

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Or Order Online!
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cut, split & delivered.
$200/CORD. 203-799-2766

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to your financial puzzles
Personal Business Trust Investments
EssexSavingsBank
Service & Trust Since 1851
Member FDIC
essexsavings.com 877-377-3922

SUDOKU!

TODAY'S PUZZLE

Medium-56

					2			
			1	7			2	
6		5					1	4
2					8	9		
		7		1		2		
		1	9					6
5	4					8		2
	1			4	6			
			3					

Directions: Fill the grid so that every row, column, and 3x3 box contains the digits 1 through 9

For solutions, check 'JRC Publications' on the solutions page of www.sudoku.com.

su|do|ku
© Puzzles by Pappocom

YESTERDAY'S ANSWER

Easy-56

2	5	3	6	1	8	7	9	4
6	8	1	4	9	7	5	2	3
4	9	7	2	5	3	8	1	6
3	7	9	5	4	1	6	8	2
1	6	5	8	7	2	4	3	9
8	4	2	3	6	9	1	5	7
9	3	4	1	8	6	2	7	5
7	1	6	9	2	5	3	4	8
5	2	8	7	3	4	9	6	1

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EXHIBIT 4

Affidavit

AFFIDAVIT

Applicant: **NR Connecticut, LLC – d/b/a Retreat at South Connecticut**

Project Title: **Certificate of Need application for 105 beds in order to provide residential detoxification and evaluation as well as rehabilitation and recovery-oriented care services**

I, **Peter Schorr** (Individual's Name), **CEO** (Position Title – CEO or CFO),

of **Retreat at South Connecticut** (Hospital or Facility Name) being duly sworn, depose and state that

Retreat at South Connecticut 's (Hospital or Facility Name) information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Signature

11/2/12
Date

Subscribed and sworn to before me on November 2, 2012

Joann M. Michalski
Notary Public/Commissioner of Superior Court

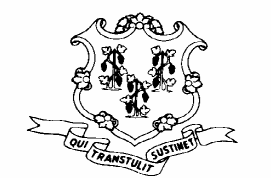
COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
JOANN M. MICHALSKI, Notary Public
Ephrata Boro., Chester County
My Commission Expires April 2, 2016

My commission expires:



EXHIBIT 5

CERTIFICATE OF NEED APPLICATION



State of Connecticut
Office of Health Care Access
Certificate of Need Application

Instructions: Please complete all sections of the Certificate of Need ("CON") application. If any section or question is not relevant to your project, a response of "Not Applicable" may be deemed an acceptable answer. If there is more than one applicant, identify the name and all contact information for each applicant. OHCA will assign a Docket Number to the CON application once the application is received by OHCA.

Docket Number:	***to be assigned by OCHA***
Applicant:	**NR Connecticut, LLC - d/b/a Retreat at South Connecticut**
Contact Person:	**Peter Schorr (c/o the Law Offices of William P. Beccaro)**
Contact Person's Title:	**President/CEO**
Contact Person's Address:	**12 New City Street, Essex, CT 06426**
Contact Person's Phone Number:	**(860) 767-8632**
Contact Person's Fax Number:	**(860) 767-0456**
Contact Person's Email Address:	**wbeccaro@snet.net**
Project Town:	**New Haven**
Project Name:	**Certificate of Need application for 105 beds in order to provide residential detoxification and evaluation as well as rehabilitation and recovery-oriented care services**
Statute Reference:	**Section 19a-638, C.G.S.**

Estimated Total Capital Expenditure: $ 7.5 million dollars

1. **Project Description: New Service (Behavioral Health/Substance Abuse)**

a. Please provide a narrative detailing the proposal.

To meet a growing need for addiction treatment services in Connecticut, this project (Retreat at South Connecticut) seeks to add to the State's existing system a 105 bed luxury residential substance abuse treatment facility to be located in New Haven, Connecticut.

It is well established that addiction is a primary, chronic disease with genetic, psychosocial and environmental factors influencing its manifestation and development. The disease is progressive, and frequently fatal if left untreated. We know from experience that the chemically dependent can and will recover if they are willing and able to enter into a process of change, and we have the expertise and the facility to assist in that journey. This project will improve the availability and delivery of these services for Connecticut's citizens, while providing numerous ancillary benefits to the State of Connecticut as well.

Once renovations to the existing 60,000 square foot two-story building located on Ella Grasso Boulevard in New Haven are complete, Retreat at South Connecticut will offer an ideal, self-contained setting, designed to provide the highest level of comprehensive multi-dimensional drug and alcohol rehabilitation services to its clients. The layout of this facility provides for efficient staff to patient ratios, and ample centralized common, group, and office spaces.

~ Please also see Attachment H for more detailed information

All patient rooms, corridors, dining, meeting, group areas, and office space will be upgraded to the same high quality standards of its sister facility - Retreat at Lancaster County, Ephrata, Pennsylvania. Further information on this remarkable facility can be found by visiting its website: http://www.retreat-lc.com.

~ Please also see Attachment A for more detailed information

Retreat at South Connecticut will offer a 3.7 level of residential treatment care as defined by the American Society of Addiction Medicine's five levels of detoxification care. This level of care includes providing around the clock evaluation and withdrawal management, a permanent facility with inpatient treatment services delivered under a set of physician approved policies, and the availability of continuous observation, monitoring, and treatment. It will be open for admission and treatment 7 days a week, 24 hours a day. Staff nurses

will be physically present and on duty around the clock, and physicians will either be on premises or on-call 7 days a week, 24 hours a day.

Retreat at South Connecticut's staff will be comprised of a dedicated team of professionals, consisting of a licensed medical staff of physicians and nurses as well as certified social workers, counselors and addiction professionals - all of whom are highly trained and experienced in treating individuals suffering from substance abuse of all types. They will utilize the most comprehensive and advanced techniques to treat those suffering from the disease of addiction. Retreat at South Connecticut will offer person-centered residential treatment services, partial hospitalization, intensive outpatient treatment, continuing recovery oriented care, and community education.

Retreat at South Connecticut's residential program will feature two main components: residential detoxification, and rehabilitation and recovery services. Upon admission, each patient receives a medical evaluation, followed by appropriate treatment and detoxification from the substance they are abusing. The rehabilitation and recovery-oriented care is tailored to meet the individual's needs. This program is designed in a manner which utilizes a variety of services and disciplines coordinated to assist a patient's personal recovery journey. By combining these key services (residential detoxification and rehabilitation and recovery) in one location, the success rate for the person seeking care increases significantly because they will not need to be discharged and transferred to another facility to begin the longer rehabilitation and recovery process. Continuity of care is a hallmark of the services we will offer. The program at Retreat at South Connecticut is designed to provide a seamless transition for clients through the levels of care and treatment offered, which will greatly strengthen their chance for achieving recovery.

~ Please also see Attachment B for more detailed information.

We know that addiction affects the person physically, psychologically, emotionally, and spiritually - resulting in negative effects to all facets of their lives, Retreat at South Connecticut utilizes a holistic approach in its treatment methodology. Person-centered and recovery oriented care is a core value of the Retreat's mission. This highly individualized approach has resulted in great success in treating clients at our Lancaster, Pennsylvania facility. We intend to replicate that documented successful approach in Connecticut.

~ Please also see Attachments A and B for more detailed information.

In addition to the comprehensive continuum of care treatment model, Retreat at South Connecticut will also offer specialized treatment plans to individuals with unique needs. These groups include but are not limited to: healthcare workers, first responders, veterans, labor union members, and professionals. Retreat at South Connecticut will offer a series of specialized

services to these populations, with additional programming focusing on their distinctive needs. Our mental health counselors and other trained professionals will utilize specialized training along with these programs to address these populations' particular requirements, which include, but are not limited to: physical, emotional, and psychological stress, access to 12-step networks, reintegration, and pain management programs.

Retreat has also developed a unique Youth Connection Program. Teenagers and adults, under the age of 25, who are dependent on drugs or alcohol, often find themselves dealing with additional pressures. They may have trouble with their workload at school, associate with delinquent peers, lack parental supervision, or just generally exhibit feelings of inadequacy, poor self-image, and depression. Often they have not learned the necessary skills that would otherwise enable them to cope with everyday life situations. Experience has shown us that we should expect the Retreat at South Connecticut's patient mix to be consistently 50% or more individuals under the age of 25.

Please also see Attachment B for more detailed information **which describes the Professional Services and Treatment Philosophy of the Retreat, as well a proposed program schedule and specialized program snapshots.**

The addition of Retreat at South Connecticut is a significant step towards improving vital access to residential detoxification and rehabilitation and recovery services to help Connecticut meet its treatment needs - now and into the future.

2. Clear Public Need

a. Explain why there is a clear public need for the proposal and provide evidence that demonstrates this need. Include statistical information from the Center for Behavioral Health Statistics and Quality (formerly Office of Applied Studies) of the federal Substance Abuse and Mental Health Administration ("SAMSHA") relating to the need for the proposal (i.e. the number of patients needing but not receiving treatment, the percentage of population in Connecticut needing treatment)

A CLEAR PUBLIC NEED EXISTS FOR ADDITIONAL SUBSTANCE ABUSE TREATMENT IN THE STATE OF CONNECTICUT.

- **Connecticut has a limited number of residential detoxification and rehabilitation and recovery beds, which cannot keep pace with the increasing need. Access to these beds is problematic, and there are often significant waiting lists at the facilities that presently offer the**

service. The result is that many individuals wishing to seek care are either unable to obtain it, or are often forced to do so outside of Connecticut.

- **Addiction, along with drug and alcohol abuse, continues to be a significant and growing health and societal issue. Effective treatment frequently begins with residential detoxification and rehabilitation. As a result, fewer individuals will require repeat addiction treatment and will incur fewer complex medical issues related to their addiction/abuse that may have to be treated in an expensive and overstressed Emergency Department setting. In addition to the obvious cost savings, and positive impact on the state's healthcare system, this results in general societal benefits as well.**

- **According to National Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA), the state of Connecticut is among the top 10 states in the nation in 2 key categories: *"Past Month Illicit Drug Use"* and *"Past Month Alcohol Use."***

(Attachment D - SAMSHA: Connecticut State in Brief - at page 1, and SAMSHA: Connecticut State Profile and Underage Drinking Facts)

- **Connecticut also places above the national average in most quantifiable categories, including *"Past Year Alcohol Dependence or Abuse"* and *"Past Year Dependence on or Abuse of Illicit Drugs."***

(Attachment D - SAMSHA: Connecticut State in Brief - at page 1, and SAMSHA: Connecticut State Profile and Underage Drinking Facts)

<u>Connecticut has a Limited Number of Residential Detoxification and Rehabilitation and Recovery Beds, with an increasing demand</u>

The limited number of available beds in cannot keep pace with the increasing need. Of the 44 licensed facilities reported by the Department of Public Health- only 10 of those facilities offer 3.7 level of residential detoxification services.

~ Please also see Attachment C, which provides additional details regarding these facilities.

Furthermore, in September of 2011, State budget cuts forced Connecticut Valley Hospital in Middletown to eliminate 20 detoxification beds, creating additional pressure on an already overburdened system and further escalating unmet need and demand.

~ Please also see Attachment D for articles from the Hartford Courant and the Middletown Press regarding the closure of these beds.

Recent phone surveys - conducted at two separate time periods – drive this point home as they revealed that facilities at a 3.7 level of care are operating at or close to 100% capacity and many of them had a long waiting list for a bed.

~ Please also see Attachment C, which provides a list of facilities surveyed and the results of the surveys.

Residential Detoxification services are a critical component of the recovery journey for most if not all individuals. This vital first phase generally requires 5 to 7 days to complete before the person is ready to begin substance abuse recovery and rehabilitation treatment which typically continues for up to 28 days.

The Connecticut Department of Mental Health and Addiction Services reports that it is estimated that for every one person that seeks treatment and or receives behavioral healthcare for addiction, there are six individuals with similar addictions who will neither gain access to nor receive such care.

(Attachment F, DMHAS guidelines, at page 8)

The need for immediate availability of a bed on the day an individual makes a decision to seek care and treatment is critical and cannot be overemphasized. Unavailability of a bed places the person at high risk for continued use/abuse and possible overdose which can frequently prove fatal. The statistics clearly show the urgent need for more residential services to provide the continuum of treatment in Connecticut. While Connecticut hospitals provide the first line of intervention and treatment in extreme circumstances, their capacities are overstressed, and they offer a higher level of detoxification services (at a 4.0 level) which is not required for most individuals in need of treatment. As the greatest need is for a 3.7 level of services, placing these patients in hospital care not only further overburdens the system, it results in unnecessary levels of treatment that are cost ineffective.

Addiction along with drug and alcohol abuse continues to be a significant and growing health and societal issue:

The state of Connecticut faces significant substance abuse issues, due in no small part to its geographic location. Statistical data shows that New York City and Boston, Massachusetts (and to a lesser degree Providence, Rhode Island) are major centers of drug importation and distribution, and drugs readily travel thru Connecticut between these cities. Treatment admissions for heroin and prescription opioid pain relievers in the region are the highest in the nation and the demand for services continues to outstrip availability.

~ Please also see Attachment D – U.S. Department of Justice: New England High Intensity Drug Trafficking Area, Drug Market Analysis, at page 1

Connecticut has seen a growing problem with binge drinking and general alcohol abuse among college students, increasing admissions due to heroin addiction in young adults, and an across the age spectrum increase in non-medical abuse of prescription opiates. Despite this, SAMHSA statistics indicate that the problem is not being adequately addressed - as only 11.2% of the people who needed treatment in a specialized facility for alcohol abuse or illicit drug use/abuse in the past year actually received treatment. Expanded and prompt access to all levels of addiction services located within the state of Connecticut is critical for the state to be able to addresses its citizens substance abuse issues. This project (Retreat at South Connecticut) is an important step in addressing that need.

~ Please also see Attachment G, pages 18-24, and Attachment D - U.S. Department of Justice: New England High Intensity Drug Trafficking Area, Drug Market Analysis, at pages 1 and 9, the NSDUH Report - Tables 23-24, SAMSHA: Connecticut State Profile and Underage Drinking Facts, as well as testimony before the Program Review and Investigations Committee

The State of Connecticut is among the top 10 states in the nation in 2 key categories and Connecticut also places above the national average in most quantifiable categories:

According to the most recent data from the Center for Behavioral Health Statistics and Quality (formerly Office of Applied Studies of the Federal Substance Abuse and Mental Health Administration- SAMSHA) more than 257,000 individuals in the State of Connecticut suffer from various forms of substance abuse addiction, but less than 45,000 have received treatment from any rehabilitation facility. The Retreat at South Connecticut will be in a strategic position to serve as a resource to alleviate this unmet need.

~ Please also see Attachment G, pages 18-24, and Attachment D – NSDUH Report: Connecticut States Estimates of Substance Dependence or Abuse,

Needing but not Receiving Treatment, tables 23 and 24, N-SSATS: Connecticut State Profiles, and SAMSHA: Connecticut TEDS

The State of Connecticut is identified in SAMSHA data as among the top 10 states in the nation in the following key areas:

- **Past Month Illicit Drug Use: ages 18-25**
- **Past Month Marijuana Use: ages 18-25**
- **Past Year Marijuana Use: ages 18-25**
- **Past Month Alcohol Use: ages 12+, 18-25, 26+**
- **Past Year Dependence on or Abuse of Illicit Drugs**
-

~ Please also see Attachment G, pages 18-24, and Attachment D – SAMSHA: Connecticut States in Brief, SAMSHA: Connecticut State Profile and Underage Drinking Facts, as well as articles from the Rocky Hill Patch and the Danbury News-Times

Of note, on the measures of drug use listed above, the rates of use for all age groups have been above the national averages for all survey years.

~ Please also see Attachment G, pages 18-24, and Attachment D – SAMSHA: Connecticut States in Brief, SAMSHA: Connecticut State Profile and Underage Drinking Facts

Additionally, the Connecticut Department of Mental Health and Addiction Services reports in the most recent Biennial Report that while the incidence of treatment admissions due to heroin use has begun to decrease overall, it has increased 18% since 2006 for those aged 18-24.

(Attachment D – Connecticut DMHAS: Collection and Evaluation of Data Related to Substance Use, Abuse and Addiction Programs at pages 5 and 19)

Today, Connecticut's rate of non-medical use of pain relievers is estimated to be 3.8% of the adult population. For young adults ages 18-25 the rate continues to be about 2.5 times the general adult population at 10.5%, continuing a 7 year increase. There is further evidence that many persons who become addicted to prescription pain relievers move to heroin as a cheaper and more readily available alternative.

(Attachment D – Connecticut DMHAS: Collection and Evaluation of Data Related to Substance Use, Abuse and Addiction Programs at page 5, and U.S. Department of Justice: New England High Intensity Drug Trafficking Area, Drug Market Analysis)

Treatment admissions due to "other" narcotics such as oxycodone or hydrocodone have continued to increase dramatically among young adults.

(Attachment D – Connecticut DMHAS: Collection and Evaluation of Data Related to Substance Use, Abuse and Addiction Programs at page 14)

Additionally, the Connecticut Treatment Episode Data Set reports that adolescents are .9 percent of admissions, while those aged 18-20 and 21-25 accounted for 5.8% and 16.1% respectively. Heroin and other opiate use accounts for 28% and 41% respectively for treatment admissions for 18-20 and 21-25 year olds in 2009-2011, much higher than those groups at national level.

(Attachment D - SAMSHA: Connecticut TEDS – 2010, 2011)

Furthermore, deaths from prescription painkillers have reached epidemic levels in the past decade. The number of these overdose deaths are now greater than those from heroin and cocaine combined. A significant portion of the problem can be traced to non-medical use of prescription painkillers. According to the latest data, approximately 12 million Americans ages 12 and over reported non-medical use of prescription painkillers in the past year. Moreover, anecdotal evidence from practitioners and the media suggest abuse of opiate and stimulant prescription drugs among mainly middle class and upper class youth may be increasing - both nationally and in Connecticut.

(Attachment D – CDC VitalSigns: Prescription Painkiller Overdoses in the US, and SAMSHA: Results from the 2011 National Survey on Drug Use and Health)

A comparison of SAMSHA reports between the 2002 and the 2007-2008 report shows the percentage of individuals needing but not receiving treatment for alcohol use in past year in ages 18-25 increased from 18.6% to 18.46% while the national average decreased from 16.89% to 16.41% in the same time period. Additionally, persons aged 26+ increased from 4.8% to 6.32%, as opposed to the national average which fell from of 5.73% in 2002 to 5.72% in 2008.

~ Please also see Attachment G, pages 18-24, and Attachment D – SAMSHA: Connecticut States in Brief, SAMSHA: Connecticut State Profile and Underage Drinking Facts, and NSDUH Report: Connecticut State Estimates of Substance Dependence or Abuse, Needing but not Receiving Treatment

While admissions to in-state substance abuse treatment facilities held stable between 2003-2009, Connecticut saw a 35% increase from 2009 to 2011. Simultaneously, the total number of beds at these facilities has shrunk between 2002 and 2010 by 37%. As most of these facilities are privately run, this has increased the burden on already overstressed state-operated facilities. From a fiscal perspective, spending on substance abuse treatment alone (i.e. not including prevention or deterrence) increased from $136.8 million to $248.69 million from 1999 – 2009 or 81.8%, while prevention spending decreased from $53.7 million to $25.45 million or 52.6% during the same period.

~ Please also see Attachment D – articles from the Connecticut Mirror, SAMSHA: Connecticut States in Brief, and Connecticut DMHAS: Collection and Evaluation of Data Related to Substance Use, Abuse and Addiction Programs at page 28

According to the SAMHSA data, Connecticut remains, or has increased, above the national averages for those *"Dependent on or Abuse of Illicit Drugs or Alcohol in the Past Year."* From 2002 to 2008, the percentage of those aged 18-25 and those 26+ has continued to increase in Connecticut, while national averages have decreased:

	18-25 (2002)	18-25 (2008)	26+ (2002)	26+ (2008)
National Average	21.37%	20.73%	7.15%	7.10%
Connecticut	22.74%	23.02%	6.76%	7.42%

Additionally, Connecticut remains above, or has increased above the national average in another key SAMHSA statistic, *"Needing But Not Receiving Treatment for Alcohol Use in the Past Year"*

	18-25 (2002)	18-25 (2008)	26+ (2002)	26+ (2008)
National Average	16.89%	16.41%	5.73%	5.72%
Connecticut	18.16%	18.46%	4.9%	6.32%

Provide the following regarding the proposal's location:

i. The rationale for choosing the proposed service location;

New Haven is the second largest city in Connecticut and the 6th largest in the Region. In spite of this fact, there is only 1 residential detoxification and rehabilitation and recovery facility care in New Haven with 29 beds.

~ Please also see Attachments C and G for more detailed information

The proposed facility, located at Ella Grasso Boulevard in New Haven, will offer an ideal, self-contained setting, designed to provide the highest level of comprehensive multi-dimensional drug and alcohol rehabilitation services. The layout of this facility provides for efficient staff to patient ratios and ample centralized common, group, and office spaces. Its four distinct wing design will be conducive to a therapeutic separation of demographics by gender and age, as well as unique areas for distinct patient groupings such as; healthcare workers, first responders, veterans, labor union members, and professionals. Furthermore, this site was chosen because it provides a centralized location with easy statewide access via two major interstate highways, which will provide Connecticut residents in need a viable in-state option centrally located for care. Currently, many individuals are forced to seek treatment out of state placing an additional burden on the individual and their family already under great stress. A New Haven facility will help to meet the unmet needs not just of New Haven County, but the rest of the state.

~ Please also see Attachments G and H for more detailed information

ii. The service area towns and the basis for their selection;

Given the tremendous unmet need for the services to be offered, the Retreat at South Connecticut will serve individuals from throughout the State of Connecticut as well as the surrounding states. The facilities geographic proximity to two major interstate highways, and its central location in Connecticut, means that in addition to the local area, the Retreat at South Connecticut's service area would be the entire state. It is also important to note that the nature of inpatient substance abuse treatment is such that prospective clients are often interested in seeking care outside their local area for privacy reasons.

~ Please also see Attachment G, pages 5-17 for more detailed information

iii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

The population to be served would be primarily Connecticut residents, aged 18 and older, in need of residential detoxification and rehabilitation and recovery. 2010 census data indicates there are approximately 2,757,082 individuals who reside in Connecticut who are aged 18 or older, comprising approximately 77% of the total population. As noted previously above, the incidence of substance abuse in the state is significantly greater than the national average for the ages 18-25, and increasing. Additionally, as was also noted, this population is increasingly underserved in this state.

~ Please also see Attachment G, pages 5-24, and Attachment D – SAMSHA: Connecticut States in Brief, and NSDUH Report: Connecticut State Estimates of Substance Dependence or Abuse, Needing but not Receiving Treatment

According to SAMHSA's States in Brief Report, 2011 Connecticut has been among the 10 States with the highest rates on the following measures:

- **Past Month Illicit Drug Use: ages 18 – 25**
- **Past Month Marijuana Use: ages 18-25**
- **Past Year Marijuana Use: ages 18-25**
- **Past Month Alcohol Use: ages 12+, 18-25, 26+**
- **Non-medical use of Prescription Narcotic Pain Relievers: ages 18 – 25**

~ Please also see Attachment G, pages 18-24, and Attachment D – SAMSHA: Connecticut States in Brief, SAMSHA: Connecticut State Profile and Underage Drinking Facts

It is worth noting that on the above measures, the rates of use for all age groups have been above the national averages for all survey years, and this has been a steady trend in survey data collected in Connecticut from 2002 forward.

(Attachment D – Connecticut DMHAS: Collection and Evaluation of Data Related to Substance Use, Abuse and Addiction Programs, at page 14)

SAMSHA's annual survey of drug and alcohol use reveals the following specific to Connecticut:

Substance Abuse Rates in Connecticut

	18-26 Year Olds	26+	**Total**
Population	350,601	2,277,969	2,628,570
Alcohol %*	18.46%	6.32%	24.78%
Illicit Drugs**	8.16%	1.42%	+13
Alcohol Dependent by population	64,721	143,968	208,689
Illicit Drug Use by population	28,609	32,347	60,956

Needing but not receiving treatment for Alcohol Dependence
****Needing but not receiving treatment for Illicit Drug Dependence***

iv. How and where the proposed patient population is currently being served;

- **Some are being served in existing Connecticut facilities**
- **Some are accessing treatment facilities out of state**

- **And, as was previously discussed above, the statistical data demonstrates a number of these individuals are not receiving treatment due to the difficulty of obtaining an in-state residential detoxification and rehabilitation and recovery bed in a timely manner, and the myriad of difficulties regarding accessing out of state treatment facilities**

  ~ Please also see Attachments C and G for more detailed information

v. All existing providers (name, address, services provided, capacity and actual population) of the proposed service in the towns listed above and in nearby towns; and

~ PLEASE SEE ATTACHMENT C

Note: The Department of Mental Health and Addiction Services ("DMHAS" collects capacity and actual population statistics on **most** existing **licensed** and **state operated providers** by town/city, and service/program.

vi. The effect of the proposal on existing providers, explaining how current referral patterns will be affected by the proposal.

The proposed project should have little or no impact on existing providers. As noted above, the statistical data demonstrates a number of Connecticut citizens are unable to receive treatment due to the difficulty of accessing an in-state residential detoxification and rehabilitation and recovery bed in a timely manner, and the limited number of these beds. Given the minimal same-day detoxification and rehabilitation and recovery bed availability in-state, combined with the data showing a number of individuals who therefore are forced to seek treatment at out of state facilities, it is clear that the existing providers of detoxification and rehabilitation and recovery services are often not able to meet the demand for these services (a demand which continues to increase every year).

What this project will impact is the delivery of state of the art detoxification and rehabilitation and recovery services in-state in a positive manner that will benefit Connecticut's citizens, while providing a number of ancillary benefits to the State of Connecticut as well.

3. Projected Volume

a. Complete the following table for the first three fiscal years ("FY") of the proposed service.

Table 1: Projected Volume

	Projected Volume (First 3 Full Operational FYs)**			
	FY2013	FY2014	FY2015	FY2016
Service type***				
Detoxification	5280	7260	7920	7920
Rehabilitation	15,840	21,780	23,760	23,760
Partial Hospitalization	2203	4563	4875	4875
Intensive Outpatient	1322	2738	2925	2925
Outpatient	1763	3650	3900	3900
Total	**26,408**	**39,991**	**43,380**	**43,380**

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.
*** Identify each service/procedure type and add lines as necessary.
**** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

b. Provide a detailed description of all assumptions used in the derivation/calculation of the projected volumes.

Admission and demographic data are derived from extensive experience and data from previously run facilities, which was then matched to Connecticut statistics regarding location and number of facilities, available beds, and SAMSHA data to obtain projected volumes. Furthermore, our experience indicates that typically 25% of inpatient service days are spent in detoxification and the remainder in a rehabilitation setting. Additionally, approximately 25% of inpatients continue through to partial hospitalization (PHP) and/or intensive outpatient (IOP). We will offer PHP 5 days a week and IOP 3 days a week. Again, based on past experience, 50% of those in IOP/POP will continue to general outpatient services.

c. If the Applicant(s) currently offers mental health or substance abuse services/programs, please address the following:

i. The units of service (i.e. group/individual counseling sessions, bed days, etc. clinic visits??) for last three completed Fiscal Years ("FYs") by patient town of origin for each service.
ii. The units of service (i.e. # of admissions) for last three completed FYs by patient town of origin for each service.
iii. The available capacity of each program, and

iv. For most recent completed FY, please provide any backlogs and waiting lists for each program.

NEW FACILITY – THEREFORE NOT APPLICABLE

d. Please provide by month, for the most recent completed FY, the following: average daily census; number of clients on the last day of the month; the number of clients admitted during the month; and the number of clients discharged during the month for each existing service/program in the proposed service area.

Note: DMHAS also collects statistical information related to the admission and discharge status of clients at existing behavioral health facilities.

NEW FACILITY – THEREFORE NOT APPLICABLE

e. Provide a copy of any articles, studies, or reports that support the statements made in this application justifying need for the proposal, along with a brief explanation regarding the relevance of the selected articles.

~ PLEASE SEE ATTACHMENT D

4. Quality Measures

a. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

The Key Staff *(identified in Attachment E, which also includes their Curriculum Vitae and additional information)* will be our Executive Management Team.

We anticipate hiring 70 people initially, with an increase to over 100 within the first year. These positions will cover a broad range of disciplines, education, and skill-set levels, including: physicians and nurses, master prepared therapists, other certified specialty practitioners, certified nurse aides, kitchen and dietary personnel, as well as administrative and maintenance staff. Retreat at South Connecticut personnel will receive regular, extensive, and continuing training in their respective fields of specialty as well the requirements of state licensing, national accreditation, and agency standards. Additionally, our staff training runs the gamut, from understanding federal guidelines such as HIPAA compliance, and confidentiality requirements, to admission criteria and use of electronic medical records. Retreat at South Connecticut will utilize a state of the art paperless practice

management system throughout the facility which will contribute to overall efficiency.

A local job fair will be held to hire needed personnel including: nursing and clinical aides, utilization management specialists, other certified specialty practitioners, admission staff, facility and operations personnel, admission, human resource and billing staff, kitchen and dietary staff, as well as maintenance and transportation personnel.

b. Explain how the proposal contributes to the quality of health care delivery in the region.

Connecticut continues to lead the nation in substance abuse rates in several key areas that have yet to be addressed. This 105 bed facility will positively influence the quality of health care delivery in the region by increasing access to a variety of individualized substance abuse services that will benefit Connecticut's citizens, while providing a number of ancillary benefits to the State of Connecticut as well. Our ability to provide this full continuum – individualized medically supervised residential detoxification, rehabilitation, and recovery services within one facility - significantly increases the chances the individual seeking treatment will successfully complete their treatment journey. All too often, an addicted individual will develop a false impression that they have completed their treatment once detoxification is over simply because they are feeling better. This false impression leads them to avoid the critical process of rehabilitation and recovery services - a primary cause of the almost certain relapse, with its attendant costs to the health care delivery system and society as a whole.

Furthermore, significant economic and social benefits result from successful treatment of substance abuse. Crime rates drop, and substance abuse related accidents go down. In the area of health care delivery, there are fewer emergency room visits, medical intervention associated with DCF child neglect declines, and most importantly as the state's addiction rates decline. The result - the costs and stresses on the overburdened and underfunded health care delivery system are lessened.

c. Identify the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet each of the guidelines.

~ PLEASE SEE ATTACHMENT F

5. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

LLC

b. Does the Applicant have non-profit status?

No

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.

All appropriate and necessary licenses will be sought in order to operate a facility for the care or treatment of substance abusive or dependant persons

d. Financial Statements

i. If the Applicant is a Connecticut hospital: Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

ii. If the Applicant is not a Connecticut hospital (other health care facilities): Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

e. Submit a final version of all capital expenditures/costs as follows:

Table 2: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$ 6,000.00
Imaging Equipment Purchase	~
Non-Medical Equipment Purchase	$ 460,000.00
Land/Building Purchase *	$ 3,200,000.00
Construction/Renovation **	$ 1,600,000.00
Other Non-Construction (Specify) - Startup Costs: - Working Capital:	 $ 650,000.00 $ 1,300,000.00
Total Capital Expenditure (TCE)	**$ 7,216,000.00**
Medical Equipment Lease (Fair Market Value) ***	~
Imaging Equipment Lease (Fair Market Value) ***	~
Non-Medical Equipment Lease (Fair Market Value) ***	$ 150,000.00
Fair Market Value of Space ***	~
Total Capital Cost (TCC)	**$ 150,000.00**
Total Project Cost (TCE + TCC)	**$ 7,366,000.00**
Capitalized Financing Costs (Informational Purpose Only)	$ 200,000.00
Total Capital Expenditure with Cap. Fin. Costs	$ 7,566,000.00

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.

~ PLEASE SEE ATTACHMENT G

** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.

~ PLEASE SEE ATTACHMENT H

*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

~ PLEASE SEE ATTACHMENT I

f. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

~ PLEASE SEE ATTACHMENTS I and J

6. Patient Population Mix: Current and Projected

a. Provide the current and projected patient population mix (based on the number of patients, not based on revenue) with the CON proposal for the proposed program.

Table 3a: Patient Population Mix

Detox	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Medicare*	0	0	0	0
Medicaid*	0	0	0	0
CHAMPUS & TriCare	0	0	0	0
Total Government	**0**	**0**	**0**	**0**
Commercial Insurers*	4,488	6,171	6,732	6,732
Uninsured	792	1,089	1,188	1,188
Workers Compensation	0	0	0	0
Total Non-Government	**5,280**	**7,260**	**7,920**	**7,920**
Total Payer Mix	**5,280**	**7,260**	**7,920**	**7,920**

* Includes managed care activity.
** New programs may leave the "current" column blank.
*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

Table 3b: Patient Population Mix

Rehab	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Medicare*	0	0	0	0
Medicaid*	0	0	0	0
CHAMPUS & TriCare	0	0	0	0
Total Government	**0**	**0**	**0**	**0**
Commercial Insurers*	13,464	18,513	20,196	20,196
Uninsured	2,376	3,267	3,564	3,564
Workers Compensation	0	0	0	0
Total Non-Government	**15,840**	**21,780**	**23,760**	**23,760**
Total Payer Mix	**15,840**	**21,780**	**23,760**	**23,760**

* Includes managed care activity.
** New programs may leave the "current" column blank.
*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

Table 3c: Patient Population Mix

PHP	FY 2013	FY 2014	FY 2015	FY 2016
Medicare*	0	0	0	0
Medicaid*	0	0	0	0
CHAMPUS & TriCare	0	0	0	0
Total Government	**0**	**0**	**0**	**0**
Commercial Insurers*	1,873	3,879	4,144	4,144
Uninsured	330	684	731	731
Workers Compensation	0	0	0	0
Total Non-Government	**2,203**	**4,563**	**4,875**	**4,875**
Total Payer Mix	**2,203**	**4,563**	**4,875**	**4,875**

* Includes managed care activity.
** New programs may leave the "current" column blank.
*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

Table 3d: Patient Population Mix

IOP	FY 2013	FY 2014	FY 2015	FY 2016
Medicare*	0	0	0	0
Medicaid*	0	0	0	0
CHAMPUS & TriCare	0	0	0	0
Total Government	**0**	**0**	**0**	**0**
Commercial Insurers*	1,124	2,327	2,486	2,486
Uninsured	198	411	439	439
Workers Compensation	0	0	0	0
Total Non-Government	**1,322**	**2,738**	**2,925**	**2,925**
Total Payer Mix	**1,322**	**2,738**	**2,925**	**2,925**

* Includes managed care activity.
** New programs may leave the "current" column blank.
*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

Table 3e: Patient Population Mix

OP	FY 2013	FY 2014	FY 2015	FY 2016
Medicare*	0	0	0	0
Medicaid*	0	0	0	0
CHAMPUS & TriCare	0	0	0	0
Total Government	**0**	**0**	**0**	**0**
Commercial Insurers*	1,499	3,103	3,315	3,315
Uninsured	264	548	585	585
Workers Compensation	0	0	0	0
Total Non-Government	**1,763**	**3,650**	**3,900**	**3,900**
Total Payer Mix	**1,763**	**3,650**	**3,900**	**3,900**

b. Provide the basis for/assumptions used to project the patient population mix.

The above population mix is derived from SAMHSA's annual survey of drug and alcohol use. Regarding Connecticut, the latest survey provides the following data:

State of Connecticut	**Residents Age 18 – 26**	**Residents Age 26 +**	**Total**
Population:	**350,601**	**2,277,969**	**2,628,570**
Population needing, but not receiving treatment for alcohol dependence:	**64,721 or 18.46%**	**143,968 or 6.32%**	**208,689 or 7.94%**
Population needing, but not receiving treatment for illicit drug dependence:	**28,609 or 8.16%**	**32,347 or 1.42%**	**60,956 or 2.32%**

Assuming a 100 percent overlap between the above 2 categories (i.e. all those needing, but not receiving treatment for illicit drug dependence are also dependent on alcohol), a total of 208,689 Connecticut residents need, but have not received treatment for some form of substance abuse dependence. To meet its first year projections, Retreat at South Connecticut would need to admit less than 0.5 percent of this population. The latest Kaiser Foundation survey (2010) revealed that 65 percent of Connecticut residents carry commercial health insurance. Retreat at South Connecticut would need to attract less than 1 percent of commercially insured residents classified as needing, but not receiving treatment to meet its goals.

7. Financial Attachments I & II

a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

~ PLEASE SEE ATTACHMENT K

b. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

~ PLEASE SEE ATTACHMENT K

c. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

~ PLEASE SEE ATTACHMENT K

d. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

~ PLEASE SEE ATTACHMENT K

e. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

~ PLEASE SEE ATTACHMENT K

f. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

~ PLEASE SEE ATTACHMENT K

g. Describe how this proposal is cost effective.

This proposal is cost effective for a number of reasons:

- **A new 105 bed facility will increase access to vital detoxification and recovery services, reducing the number of individuals who are currently going without care when they need it. Left untreated, substance abuse will continue unchecked - placing the individual at risk of overdosing, and causing harm to self and/or others (thru automobile accidents, family and workplace violence, violent crime, etc). Drug and alcohol abuse contribute significantly to healthcare costs: ER visits, personal illness, and exacerbation of existing health conditions brought about as a result of the ongoing substance abuse. Additionally, drug and alcohol abuse have tremendous societal costs: crime, violence, job loss, child abuse and neglect, high rate of workplace and school absences - to name just a few.**

- **Retreat at South Connecticut will provide residential detoxification, rehabilitation, and recovery services within one facility. This seamless transition significantly enhances successful treatment completion rates, leading to the savings innumerated above. Presently, many families are forced to seek treatment services out of state or forgo treatment because a bed is simply not available when**

needed. The addition of 105 new beds in Connecticut will reduce this need for travel and attendant costs. It also gives the addicted individual's family the important opportunity for active participation in the recovery process as they do not have to travel great distances in order to stay involved. Family involvement therapy is often a key component to achieving successful completion of the rehabilitation process.

h. Describe how the proposal will affect the financial strength of the health care system in Connecticut.

The addition of this new facility will positively affect the financial strength of the health care system in Connecticut in numerous ways. When in-state access to treatment for substance abuse is increased and existing obstacles to care are reduced, a result is that all of the incumbent health system costs are also reduced. Additionally, this has the effect of strengthening the existing health care system in Connecticut across the continuum. Substance abuse takes a serious toll on the abuser. It exacerbates existing heath issues and creates a host of new ones. The result - greater stress is placed on the state's healthcare resources: from ER visits, and ambulance calls, to doctor and clinic visits, as well as diagnostic testing to address existing health conditions. When access to treatment is more readily available, the demand on those resources is reduced. Furthermore, if treatment is completed successfully, this extra demand will often be eliminated.

This project will improve the availability and delivery of comprehensive multi-dimensional drug and alcohol rehabilitation services, and help meet a growing need for substance abuse treatment services in Connecticut for its citizens. Reducing substance abuse rates in any category (and preferably all categories), directly and positively affects the financial strength of the health care system in Connecticut by reducing demand on a myriad of healthcare services.



Attachment A

In response to CON application item 1 a:

Information about Retreat at Lancaster County


www.retreatlc.com
Retreat
at Lancaster County

OUR FOUNDER

Peter Schorr, Founder and CEO of Retreat at Lancaster County has realized his vision of creating the highest quality substance abuse treatment center on the East Coast. Over his 25 years as both a clinician and manager of health care facilities, he has developed innovative programs to treat those suffering the disease of addiction. Retreat will provide the most serene and peaceful setting for patients to heal, learn and prepare for lifelong sobriety.

MISSION STATEMENT

To provide a compassionate and spiritual environment where those suffering from the disease of addiction can begin the journey to recovery by providing enlightenment and education to the individual and their families.









Our Executive Chef and his staff prepare wholesome and nutritious meals to patients of the Retreat. Kosher and special dietary meals are also available upon request.



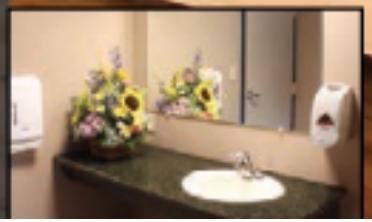


FACILITY OVERVIEW

Retreat, a 120-bed inpatient Substance Abuse facility located in Ephrata, PA provides the full continuum of care to its patients on a picturesque and secluded 24 acre campus. Retreat is licensed by the Pennsylvania Department of Drug and Alcohol Programs for 30 detox and 90 rehabilitation beds and accredited by CARF.

ACCOMMODATIONS

Patient rooms have been designed with uncompromising attention to detail. With expansive views and warm relaxing colors, spacious accommodations feature full size beds, granite vanities, tile showers and locally handmade Amish furniture.



OUR TREATMENT PHILOSOPHY

Retreat offers a complete continuum of care, including Detox, Rehabilitation, Partial Hospitalization, Intensive Outpatient and Outpatient programs. Once a patient's residential stay is complete, the tools acquired in treatment will be further utilized in the various step-down and support programs. Continued counseling and participation in the recovery community is essential to a comprehensive treatment and aftercare plan.

Types of Treatment Available:

- Addiction Neuroscience
- Psychopharmacoloy
- Holistic Therapy, including:

  - Massage Therapy
  - Drumming Therapy
  - Nutrition Counseling
  - Fitness Counseling
  - Yoga & Meditation
  - Equine Therapy





CLINICAL PROGRAMS

Retreat has a Clinical Team of credentialed therapists that work under the guidance of our Medical team and full-time Psychiatrist to engage patients into treatment and to provide an individualized treatment plan for each patient. Each treatment plan is customized and tailored to each patients' needs and is reviewed daily by a multi-disciplinary clinical and medical team. Additionally, Masters Level Clinical Specialists are available to patients that need additional clinical support and one-on-one therapy.

Retreat offers two curriculums. The Core Curriculum is designed for patients 26 years of age and older, consisting of track groups that focus on Relapse Prevention, Coping Strategies, and Social Relations. The Youth Connection program is created for patients 25 years of age and younger and is designed to treat their unique issues and includes focus on Building Sober Support, Family Relations and Peer Influences.


CLINICAL PROGRAMS - Comprehensive Curriculum
Retreat has developed the most comprehensive curriculum and delivery of drug and alcohol services to its patients. Retreat will further expand the quality and enhance the delivery of the most effective services through continued review of our programs, incorporating the latest innovations and practices in the industry. By having the best service products, Retreat will continually have the ability to provide to its patients the most innovative Detox, Rehabilitation, Partial Hospitalization, Intensive Outpatient and Outpatient services in the region.



Intervention Services

Many times families lose the ability to effectively communicate their fears and concerns to the alcoholic or addict. Trained professional help is available for intervention services. An intervention can help your family member or loved one recognize their addiction before it's too late. Retreat can help schedule an appointment with a professional interventionist.

Family Program

Addiction not only affects the patient but also those who love them. Retreat's family program is designed to educate loved ones about the disease of addiction and the dynamics it creates. The goal is to facilitate and promote healthy communication skills and repair lost trust. With guidance and time, relationships are able to be healed.

Retreat's Clinical Staff understands the dynamics of addiction and the associated destructive behaviors. Didactic programming, group and individual therapy sessions will focus on core issues including:

- **Pain Management**
- **Impulse Control**
- **Anger Management**
- **Denial**
- **Grief and Loss**
- **Resistance**
- **Minimization**
- **Relationships**
- **Peer Influence**
- **Relapse Prevention**
- **Development of a sober network**
- **12-Step assimilation**
- **Aftercare Planning**



Located in the heart of Pennsylvania Dutch Country, Retreat's 24-acre campus provides expansive living and treatment space. The natural landscape creates an idyllic setting for serenity, **focus and reflection.**



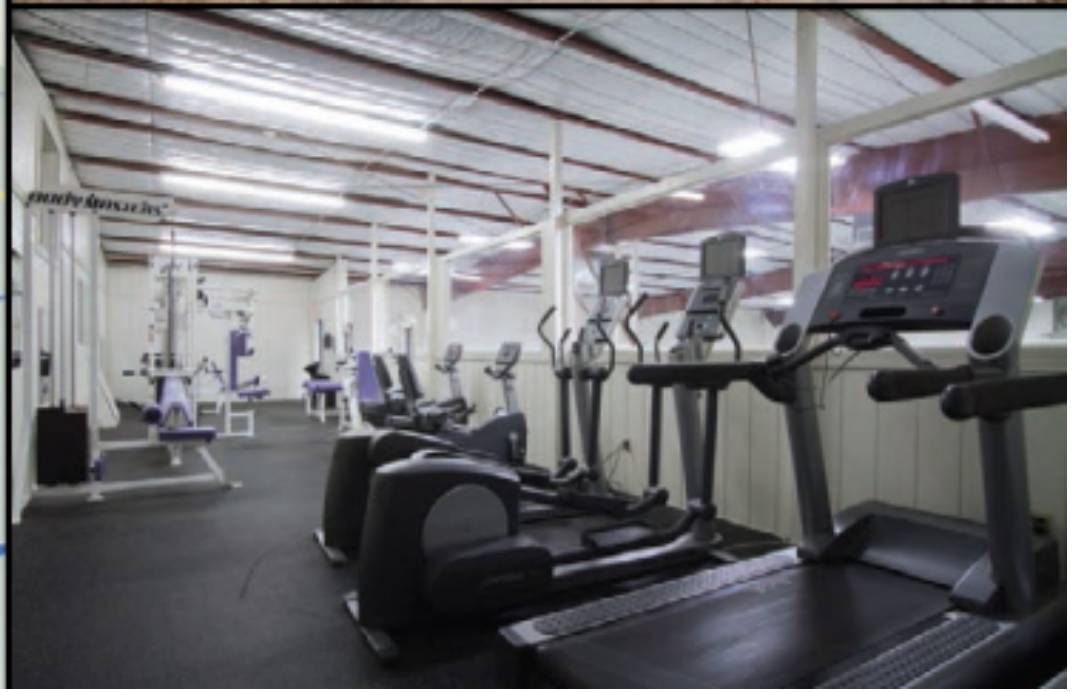




Recreation is an essential component to a healthy lifestyle. **Retreat offers a full gymnasium and fitness center to help** patients reduce stress, relieve anxiety and eliminate toxins from the body.









Chance



Mickey



By integrating the most advanced and proven clinical approaches with alternative therapies including Tai Chi, yoga and meditation, massage therapy and equine therapy, **Retreat offers a holistic** approach to treatment, providing an ideal setting for spiritual healing.



Chrissy Gariano, MA
Executive Director

FINAL WORDS

I would like to extend my warmest regards and thanks for considering Retreat at Lancaster County. Addiction is a complex and complicated **disease. We believe in offering treatment with** utmost compassion and integrity. Every patient that enters the facility is treated as an individual. **Here at Retreat, you will receive a specific treat-**ment plan and a curriculum that is designed just for you.

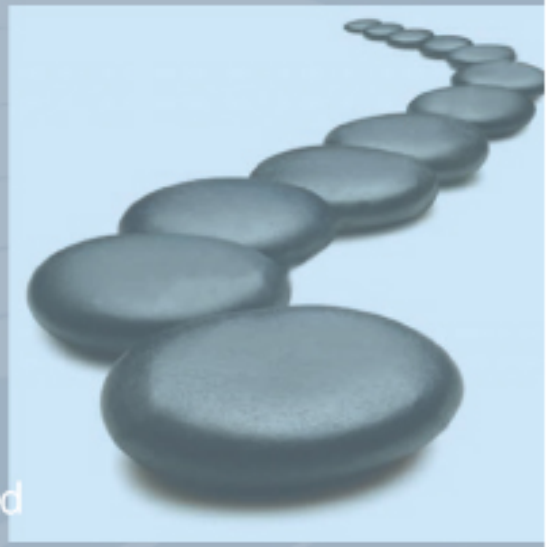

Retreat strives to provide the highest quality drug and alcohol services in a luxury setting, while remaining affordable. We accept most major insurance plans and offer payment options. Our admissions department is open 24 hours a day, 7 days a week. For your convenience, courtesy transportation may be available.
Retreat
at Lancaster County
1170 South State Street
Ephrata, PA 17522
717.859.8000
Toll Free: 855.859.8808
Fx: 717.859.6330
www.retreatlc.com


For Immediate Assistance
717.859.8000 or Toll Free: 855.859.8808
1170 South State Street, Ephrata, PA 17522, www.retreatlc.com
"Go In Peace"
Retreat
at Lancaster County

Youth Connection

CLINICAL PROGRAM

YOUTH CONNECTION



Youth Connection is an intensive track program designed for those individuals in the young community who suffer from the disease of addiction. This program focuses on related issues, such as peer influences, social structure and sober support. The program is designed for patients that are 25 years of age or younger. Highlights of the program include daily track groups, individual sessions with Clinical Specialists, assisting patients in building sober peer groups and improving family relationships. The program works to unify the young community and reinforce adult responsibilities in every day living. It helps patients target specific stressors that contribute to their addiction and help establish relapse prevention strategies and healthy coping skills.

Health Care Workers

CLINICAL PROGRAM

SPECIALIZED TREATMENT PLANS



Health Care Workers face a unique challenge of a highly stressful occupation that has a great deal of access to potentially addictive pharmaceuticals. Specialized programs are necessary to address these issues during treatment and have the ability to further address these issues as part of their long-term recovery. Specialized treatment plans are designed to educate and expand their knowledge of dealing with these "triggers" and further enhance the chanc of long-term recovery.

First Responders

CLINICAL PROGRAM

SPECIALIZED TREATMENT PLANS



Retreat understands the unique needs of Uniformed Professionals who experience high levels of physical, emotional and psychological stress on a daily basis.

This Program is designed to address the immediate and long-term chalenges of First Responders and the daily dangers of their careers, including Post Traumatic Stress Disorder and Critical Incidents.

Family Education Program

CLINICAL PROGRAM

SPECIALIZED TREATMENT PLANS



Addiction not only affects the patient but also those who love them. Our complimentary family program is designed to educate loved ones about the disease of addiction and the dynamics that it creates. The goal is to facilitate and promote healthy communication skills that will lead to regaining trust and healing relationships through the process of treatment and recovery.

Retreat
at South Connecticut

Attachment B

In response to CON application item 1 a:

A description of the professional services and treatment philosophy, program snapshots, and a proposed program schedule

PROFESSIONAL SERVICES

TREATMENT PHILOSOPHY

Addiction is a primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. The disease is progressive and potentially fatal. It is characterized by continuous or periodic impaired control over drinking/chemical use, preoccupation with the drug, use of alcohol/drugs despite adverse consequences, and distortions in thinking. Because addiction affects the person physically, psychologically, emotionally, and spiritually and negatively affects all facets of one's life, most notably relationships, we take a holistic approach in our treatment methodology.

People come to Retreat in various stages of crisis reflective of their progressive stage of chemical dependence. Alcohol and/or drugs have become the controlling force in their lives, and as such, have severely limited their ability to make good, reasoned choices for themselves. The self-destructive nature of addiction has left them broken and lost, and has either impeded the development of healthy coping skills or has deteriorated existing coping skills necessary to live a happy and successful life. Many participants, especially the chronic relapser, have little faith or hope that they can successfully abstain from mood altering chemicals and unwittingly live out a self-fulfilling prophecy whereby their feelings of hopelessness overwhelm their desire for a better life, and they continue to stay entrenched in the destructive cycle of addiction.

The staff of Retreat strongly believes that there is hope for the addicted person. We know from experience that the chemically dependent can recover and will recover if they are willing to enter into a process of change. For the people who come to us for help, this concept is easy to grasp but very difficult to actualize.

The chemically dependent enter treatment for a variety of reasons and with varying levels of motivation. We expect this and know that the reason why a person enters treatment is less important than what occurs while she/he is here. Change is the key. Participants who want to stop drinking and using drugs have to change some or all of the following areas of their lives: counterproductive attitudes; distorted thinking; maladaptive behaviors; unhealthy lifestyles. Through the use of motivational techniques, change theory, and cognitive-behavioral therapy. We assist the participant in making these necessary changes.

Many treatment professionals believe that a participant's denial of addiction is the main obstacle to successful recovery, and that it is their job to break through this denial. Although we acknowledge that denial, the inability to accept something as true even in the face of compelling evidence, is problematic for many addicts, we believe that the major impediments to successful treatment and recovery are ambivalence and resistance to change.

Ambivalence manifests itself in the addicted person when he or she has as strong desire for recovery and at the same time a desire to continue to use. The addicted person often feels caught in the middle of these opposing feelings, not knowing how to dislodge himself from the conundrum. It is our job to assist the participant to accept ambivalent feelings regarding their addiction and to help identify and build upon the patient's motivation and desire for recovery.

Program Descriptions

Individual

Each patient receives individual counseling and, if appropriate, may receive individual therapy. Tasks of the individual therapist or therapist are:

- Data base collection and assessment
- Provide an environment conducive to learning;
- Develop, revise, and update individual treatment plans designed to educate, relate learning to experience, and bring about behavioral change;
- Confront denial didactically only;
- Teach patient about defense mechanisms and how they are used to justify drinking and drugging and to avoid treatment;
- Provide opportunities for patients to witness defense mechanisms in use and to identify them;
- Provide patients with all the data you learn about him or her-no secrets are to be kept;
- Self-disclose only when appropriate;
- Motivate for continuing care;
- Teach patient how to use AA.

Community Meeting

Community Meeting is held every morning. Its major task is to solve community problems. As part of community meeting the community rules and boundaries are read every day. The Community Meeting is facilitated by clinical staff and the major goal is for the community to solve its own problems. Therapists may intercede to facilitate the community meeting and give direction in the solution of the problems. Occasionally staff will solve the community problems but reliance is on the group and individual responsibility. The underlying goals of the community meeting are to promote cohesiveness in the patient community in order to help patients' focus, their thinking, help increase their problem solving skills, and to prepare them for group self-help.

Small Group Therapy

Small groups occur every day at Retreat. The job of the therapist in these small groups is only to facilitate it and make observations on the mode of the group and to help them become a working group. Individual and interpersonal therapy is not done in these small groups. Groups include but are not limited to:

- **Defense Mechanisms**. The task of the defense mechanisms group is to study defense mechanisms with the emphasis on how they are used to avoid self-diagnosis, avoid treatment, and return to drinking and drugging which would lead to relapse. The role of the facilitator is to see that the environment is conducive to work. Facilitators are to be familiar with the defense mechanisms, make interventions only after assessing the mode of the group, make interventions designed to enhance work or move the group toward work and not create more confusion. Refer to group intervention model to see sample interventions. If the group is functioning well, the therapist will be quiet; if the group worked well, the therapist should compliment
- **Step Groups**. These groups go sequentially through the first three steps so that a patient will get all 3 of the major steps. The task is to discuss each step as it relates to the patient's experience. The emphasis in the Step 1 group is the disease process leading to powerlessness, tolerance, withdrawal, loss of control, pathologic organ change. The secondary emphasis is on unmanageability as a secondary symptom of the disease and problems resulting from the disease such as legal, family, job, financial, etc. Treatment for powerlessness is abstinence. Treatment for unmanageable life is working the steps. In Step 2 the emphasis is on a power greater than ourselves; it need not be God. The statement "restore us to sanity" implies that sanity once existed. It is necessary for the therapist to stress that insanity is a direct result of the disease, toxicity, pathologic organ change and augmentation. Step 2 stresses the importance of group, A.A., and reality testing. It is important to link Step 1 with Step 2. If one is powerless one needs a power to survive. The power can work through the group. Step 3 discusses what will is, where the will is, why will power does not work, how getting one's way relates to will, how to turn will over by using the group to follow directions and to live in the present. It helps the group to see how they are already working Step 3.
- **Self diagnosis**. This group should allow patient education to understand the nature of addiction, the disease model and how it applies to self. The patients need to relate learning to their experience. If they can't relate it to themselves it does not count. They also need to identify educationally weak areas in the group. The goal is to have the patients' self diagnose as chemically dependent based on the primary symptoms of the disease.
- **Relapse Prevention**. The task of Relapse Prevention Group is for patients, who have relapsed, to identify triggers, patterns and emotions that led to their relapse and for patients who are in treatment for the first time to identify the triggers, patterns and emotions, which could lead to relapse. All patients will discuss and get feedback on the changes they will need to make in order to minimize the potential for relapse.

Special Tracks

- **Early Recovery –** Designed for patients early in treatment to orient to the program and begin learning about the disease of addiction and treatment protocols.
- **Co-Dependency** – Designed for patients to understand the link between addiction and co-dependency and strategies for coping and making changes with self and family/friends.
- **Relapse Prevention –** Designed for patients to learn about triggers and coping mechanisms for prevention. Education focuses on how relapse can begin prior to actually using again.
- **Relationships –** Designed for patients to understand the impact of how addiction can affect relationships, how to create health relationships, improve existing relationships and how effective communication is important.
- **Anger Management –** Designed for patients that have difficulty expressing anger and emotions in a healthy manner that is productive to social and interpersonal relationships.
- **Emotional Health -** Designed for patients to learn about identifying emotions, how it affects mood, interpersonal and social relationships and how to express and manage appropriately.
- **Coping Mechanisms –** Designed to educate on what coping skills are, how they are important in dealing with daily life issues and how to develop health coping skills.

SERVICES OFFERED AT RETREAT

Services

In order to meet our program goals, Retreat offers residential treatment, partial hospitalization, intensive outpatient treatment, continuing care, and community education.

The residential phase of our program consists of a program of varying length with 2 main components:

- **Detoxification -** Upon admission to Retreat, each patient receives medical evaluation, treatment and detoxification from the substance they are abusing.
- **Rehabilitation -** The majority of our program is designed to provide a variety of services via a variety of disciplines, coordinated to assist the beginning of the patient's personal rehabilitation.
- **Partial Hospitalization** - provides intensive treatment up to 5 days a week. It is the belief that a step down from residential to IOP is too great a gap between levels of care. PHP is offered 5 days a week, 4 hours each day. This provides a step down of 20 hours weekly of treatment coming out of residential rather 9 hours weekly for IOP.
- **Intensive outpatient and outpatient program -** provides a method of treating patients who for whatever reason are unable to enter or complete inpatient treatment or where less restrictive treatment is appropriate.

- **Continuing care phase of treatment** - provides for on-going individual, group, and/or family/marital therapy for patients who have re-entered the community following the residential or intensive outpatient phase of treatment, but are in need of on-going therapy and support services in order to assist their continued abstinence from substance abuse, and program of personal rehabilitation.
- **Community education** – provides for information about substance abuse, including education about primary prevention, individual case identification, and referral, and consultation and treatment resources available. These are provided on an on-going basis to health care providers, industry, social service organizations, schools, churches, and other individuals and groups seeking information and education. Community Education Services are provided either at Retreat, or in the community, through the outreach department primarily or by other staff as requested.

Hours and Days of Operation

Retreat is open for admission and treatment 7 days a week, 24 hours a day. Staff nurses are on duty around the clock and physicians are either on the premises or on-call 7 days a week, 24 hours a day.

Admission to Retreat's intensive outpatient program can be arranged at any time. Both day and evening intensive outpatient services are provided. PHP, IOP and GOP are offered both day and evening hours. Individual therapy, family therapy and psychiatric sessions are scheduled on an individual basis.

Routine services provided to meet clinical needs of patients

At Retreat a variety of services are available to help treat the identified clinical needs of the patient. These services include:

- Thorough medical evaluation with a physical exam, lab tests when ordered, and other related studies done by a physician.
- Medical treatment of either known or newly recognized illness, as well detoxification under controlled conditions from the substances the patient was abusing prior to admission. These services are provided by an on-site full-time Medical Director.
- Nursing care under the direction of a registered nurse is available on a 24-hour a day basis at Retreat to help implement the patient's treatment plan and monitor them during the acute phases of detoxification as well as to provide medication and on-going nursing care for other illnesses the patient may have.
- Psychiatric evaluation shall be done when indicated on any patient upon admission. In-depth evaluations are available as required.
- A thorough bio-psycho-social evaluation is performed by a primary therapist or other designated staff member on each patient.
- Psychiatric treatment is available for those patients who are diagnosed as having an underlying psychiatric disorder either in conjunction with or as a consequence

of their substance dependence. Psychiatric treatment is provided by board certified psychiatrists at the facility.

- Substance abuse treatment is provided by the patient's substance abuse therapist. Substance abuse education is provided by the staff in the form of lectures, workshops, videotapes, and reading materials including A.A. literature.
- Lectures and workshops concentrating on living skills are provided to the patients by staff trained in those areas.
- Marital and family education and counseling are available through the patient's attending physician, the substance abuse therapist, staff nurse, and the family program.
- Social case-work is available including assistance in helping the patient locate appropriate housing, public medical assistance or financial assistance and related services by a therapist on the staff of the facility.
- The patient is exposed to the A.A./N.A. program of recovery including A.A. Step program, and A.A./N.A. meetings are held at the facility.
- Organized activities are provided to help the patient develop an awareness of constructive use of leisure time, to provide recreation and to supplement the treatment done in other group activities.
- Discharge planning and continuing care services are provided for every patient.
- When needed, outpatient placement is made to Retreat's intensive outpatient program or outpatient program or to an appropriate addictive disease center, psychiatric outpatient center, or related facility. A. A. /N.A. is always included, and outpatient group therapy at Retreat can be included.
- Other continuing care service may involve a half-way house, referral to the company E.A.P. program or medical department or to the patient's private physician or counseling service.
- Patients who present needing special services, which cannot be provided at Retreat will have referral arrangements that are appropriate:
    - Community area hospitals
    - Licensed ambulance services
    - IMS laboratory facilities.

    These facilities and a number of consultants are available at the request of the patient's attending physician.

PROVISION OF SERVICE VIA MULTIDISCIPLINARY TREATMENT TEAM

Composition of Treatment Team

Services are provided to patients of Retreat by a multidisciplinary treatment team including:

- Primary Physician or Nurse Practitioner
- Psychiatrist or Clinical Nurse Specialist, if applicable
- Substance Abuse Therapist/Social Worker
- Aftercare Coordinator
- Registered Nurse
- Licensed Practical Nurse, if applicable
- Dietician, if required
- Aides

Roles and Responsibilities of Treatment Team Members

- Primary Physician or Nurse Practitioner
- Psychiatrist, or Clinical Nurse Specialist
  The duties include:
    - Responsibility for all medical and psychiatric matters.
    - Responsibility for the observance of all Codes of Ethics
    - The physician provides:
        - ❖ Evaluation of medical and addictive problems.
        - ❖ Treatment of medical and addictive problems.
        - ❖ Prescription of medications.
        - ❖ Individual, marital, and family counseling/psychiatric treatment as needed.
        - ❖ Consultation for all treatment team members in the performance of their clinical duties.
        - ❖ Psychiatric evaluation and treatment as necessary.

- Therapist
  The substance abuse therapist facilitates task groups for the patients.
  In addition, duties include:
    - Completes the bio-psycho-social evaluation and integrated summary of assigned patients.
    - Helps develop the comprehensive treatment plan.
    - Assists in the education program about substance abuse for the patients including the delivery of educational lectures about addictive diseases and the recovery process.
    - Exposes the patient to the A.A./N.A. program of recovery
    - Provides education for the patient's family.
    - Coordinates his/her efforts with those of the employer, other clinics, and other interested individuals in assisting the patient's recovery.
    - Formulates a continuing care plan with each assigned patient.
- Registered Nurse
  The nurse at Retreat is a registered nurse with additional training and experience either with psychiatric patients or in provision of services to patients with addictive diseases. The nurse at Retreat is responsible for:
    - Patient intake and orientation to the treatment program.
    - Administration of medical care during and after the detoxification process itself.
    - Dispensing prescribed medications.
    - The management of the therapeutic milieu at the facility.
- Licensed Practical Nurse
  The licensed practical nurse is licensed by the State with additional training and experience either with psychiatric patients or in the provision of services to patients with addictive diseases. Additionally, they are also licensed to dispense medication and is C.P.R. certified. The LPN assists with:
    - Patient intake and orientation to the treatment program.
    - The administration of medical care during and after the detoxification process itself.
    - Dispensing prescribed medications.
    - The management of the therapeutic milieu at the facility.
- Executive Chef

Consults with the physician as well as with the dietary staff in order to:
    - Provide special diets for patients with identified illnesses.
    - Provide a wholesome menu for the patients in general.
- Aides
  The aides assist with the intake and discharge procedures and with other assigned tasks.

Treatment Planning Process

The initial data base is completed within the first 72 hours and includes, but is not limited to:

- Physical examination including appropriate laboratory studies.
- A thorough bio-psycho-social history.
- Where indicated, a psychiatric evaluation (psychiatric evaluation or re-evaluation at any time in the course of treatment as needed).

This data provides the basis for the development of the integrated summary leading to the development of the treatment plan under the supervision of the physician. The plan will then be updated as necessary in response to continued observation of the patient.

The treatment program is focused on the:

- Development of the patient's self-identity as alcoholic and/or addict
- The understanding of the disease concept of alcoholism/addiction and
- The commitment to abstinence after discharge.
- Problems which require on-going treatment are addressed in continuing care plan

Case Management and Treatment Team Meetings

Case Management Conferences for the inpatient program are held with the entire treatment team five days a week. The focus of these meetings is to review therapy, review diagnoses, and to assist in the management of "tough cases." Depending on the findings of the meetings, additional services such as consultation with the dietician, family therapy, or other related services may be added to the revised treatment plan. Utilization Management Coordinators attend the Case Management/Treatment Team Meetings.

Continuing Care

A continuing care plan is developed with each patient and may include either continuing care services at Retreat including intensive outpatient program, individual, group, marital, or family therapy, as well as A.A. meetings, or may call for provision of similar care at facilities in the patient's home area. On occasion patients are placed in halfway facilities or in long term treatment centers with the assistance of Retreat staff. In some instances a patient may need/want to be re-admitted to Retreat.

Core Curriculum

130-230p Track Groups

Recovery Planning

- Focus on developing sober structure and support
- Learning to make changes in daily living to support recovery

Relapse Prevention

- Learning to identify triggers for relapse and developing an action plan
- Learning how to identify stages of relapse

Relapse Chronicles – Special Track

- Designed for patients with chronic relapse issues
- Focus on identifying underlying issues that contribute to relapse

Coping Skills

- Focusing on developing healthy coping skills in dealing with life stressors
- Learn to identify stressors and change ways of coping with them

Social Relations

- Focus on how to communicate with others in a healthy manner
- Process how to re-build trust in relationships and managing emotions

PROGRAM SNAPSHOT
600 – 700p Track Groups

Integral Services

- Provides deeper insight into addiction and its roots
- Development of alternate coping skills with stressors
- Creating connections with others in support for recovery
- Treatment engagement process

Emotional Losses

- Learning to cope with losses due to addiction
- Focus on other types of losses and the grieving process
- How to utilize support from others when experiencing loss
- Learn to deal with feelings of guilt, loss, shame, hopelessness

Next Chapter

- Life After Rehab – what to expect
- Education on utilizing 12-Step program and sponsorship
- Learn how to deal with daily life functions
- How to begin developing sober structure and support

YOUTH CONNECTION

130-230p – Youth Connection
600–700p – Track Groups Below

Parallel Perceptions

- Focus on specific stressors faced by those in young adult community
- Common issues that face this population are examined
    - Peer influences
    - Impulsivity
    - Difficulty engaging in treatment
    - Family stress and losses
    - Relationships

Mind Games

- Learning to walk your way into a new way of thinking
- Focus on how to change behaviors that support recovery
- Discuss how to change your thinking to match your actions
- Provides tools in how to live in the moment

Family Matters

- Focuses on struggles with family relationships
- Provides hope for reconciliations with family members
- Have identified family members as obstacles toward recovery process
- Learning how to re-build trust after it has been lost

Retreat at South Connecticut

PROPOSED PROGRAM SCHEDULE

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
	Disease of Addiction	Emotional Health	Physical Health	Coping Skills	Relapse Prevention
7:45a	BREAKFAST	BREAKFAST	BREAKFAST	BREAKFAST	BREAKFAST
8:30a	COMMUNITY MTG	COMMUNITY MTG	COMMUNITY MTG	COMMUNITY MTG	COMMUNITY MTG
9:30 - 10:30a	GROUP THERAPY	GROUP THERAPY	GROUP THERAPY	GROUP THERAPY	GROUP THERAPY
	PRIMARY THERAPIST	*PRIMARY THERAPIST*	*PRIMARY THERAPIST*	*PRIMARY THERAPIST*	*PRIMARY THERAPIST*
10:45 - 11:30a	WORKSHOP	WORKSHOP	WORKSHOP	WORKSHOP	WORKSHOP
	TOPIC OF DAY	TOPIC OF DAY	TOPIC OF DAY	OPEN DISCUSSION	MEDICAL ASPECT
12n	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
1:30 - 2:30p	SPECIAL TRACK	SPECIAL TRACK	SPECIAL TRACK	SPECIAL TRACK	SPECIAL TRACK
	REFER TO	REFER TO	REFER TO	REFER TO	REFER TO
	SPECIAL TRACK	SPECIAL TRACK	SPECIAL TRACK	SPECIAL TRACK	SPECIAL TRACK
	SCHEDULE	SCHEDULE	SCHEDULE	SCHEDULE	SCHEDULE
3:30 - 4:30p	WORKSHOP	WORKSHOP	WORKSHOP	WORKSHOP	MEN'S GROUP
	DRUMMING SESSION	YOGA	DRUMMING SESSION	YOGA	
	Community Room	Community Room	Community Room	Community Room	
	HOPE FOR HEALING	GRIEF and LOSS	HOPE FOR HEALING	GRIEF and LOSS	HOPE FOR HEALING
	4ht Fl Office	4ht Fl Office	4ht Fl Office	4ht Fl Office	4ht Fl Office
		EMOTIONAL HEALING		EMOTIONAL HEALING	WOMEN'S GROUP
					Community Room
	PAIN MANAGEMENT		PAIN MANAGEMENT		
	Schoolhouse		Schoolhouse		
	"INTEGRAL SERVICES"	"INTEGRAL SERVICES"	"INTEGRAL SERVICES"	"INTEGRAL SERVICES"	"INTEGRAL SERVICES"
	Schoolhouse	Schoolhouse	Schoolhouse	Schoolhouse	Schoolhouse
5p	DINNER	DINNER	DINNER	DINNER	DINNER
6:00 - 7:00p	WORKSHOP - ADDICTION	WORKSHOP - ADDICTION	WORKSHOP - ADDICTION	WORKSHOP - ADDICTION	WORKSHOP - ADDICTION
	COMMUNITY	COMMUNITY	COMMUNITY	COMMUNITY	COMMUNITY
			PAIN MANAGEMENT	PAIN MANAGEMENT	PAIN MANAGEMENT
			Schoolhouse	Schoolhouse	Schoolhouse
	PAIN MANAGEMENT	PAIN MANAGEMENT	PAIN MANAGEMENT	PAIN MANAGEMENT	PAIN MANAGEMENT
	Schoolhouse	Schoolhouse	Schoolhouse	Schoolhouse	Schoolhouse
7:30p	12-STEP MEETING	12-STEP MEETING	12-STEP MEETING	12-STEP MEETING	12-STEP MEETING
	AA	AA	AA	AA	AA
830p	REFLECTIONS	REFLECTIONS	REFLECTIONS	REFLECTIONS	REFLECTIONS
	GYM	GYM	GYM	GYM	GYM
9:30p	SNACK	SNACK	SNACK	SNACK	SNACK
11:00p	LIGHTS OUT	LIGHTS OUT	LIGHTS OUT	LIGHTS OUT	LIGHTS OUT

Retreat
at South Connecticut

PROPOSED SCHEDULE - YOUTH CONNECTION

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
7:45a	BREAKFAST	BREAKFAST	BREAKFAST	BREAKFAST	BREAKFAST
8:30	COMMUNITY MTG	COMMUNITY MTG	COMMUNITY MTG	COMMUNITY MTG	COMMUNITY MTG
9:30 - 10:30a	GROUP THERAPY	GROUP THERAPY	GROUP THERAPY	GROUP THERAPY	GROUP THERAPY
	PRIMARY THERAPIST	*PRIMARY THERAPIST*	*PRIMARY THERAPIST*	*PRIMARY THERAPIST*	*PRIMARY THERAPIST*
10:45 - 11:30a	WORKSHOP	WORKSHOP	WORKSHOP	WORKSHOP	WORKSHOP
	TOPIC OF DAY	TOPIC OF DAY	TOPIC OF DAY	OPEN DISCUSSION	MEDICAL -NURSING
12n	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
1:30 - 2:30p	TRACK GROUP	TRACK GROUP	TRACK GROUP	TRACK GROUP	TRACK GROUP
	GYM	GYM	GYM	GYM	GYM
	"YC ORIENTATION"	GROUP WILL SPLIT	GROUP WILL SPLIT	GROUP WILL SPLIT	GROUP WILL SPLIT
3:30 - 4:30p	WOMEN'S GROUP	RECREATION	WOMEN'S GROUP	RECREATION	YOUTH CONNECTION
	YC THERAPIST	YC THERAPIST	YC THERAPIST	YC THERAPIST	ALL PARTICIPANTS
	PHP ROOM 1	GYM	PHP ROOM 1	GYM	WORKSHOP
	MEN'S GROUP		MEN'S GROUP		GYM
	YC THERAPIST		YC THERAPIST		
	PHP ROOM 2		PHP ROOM 2		
5p	DINNER	DINNER	DINNER	DINNER	DINNER
6:00 - 7:00p	REFER TO	REFER TO	REFER TO	REFER TO	REFER TO
	YOUTH CONNECTION	YOUTH CONNECTION	YOUTH CONNECTION	YOUTH CONNECTION	YOUTH CONNECTION
	TRACK PROGRAM	TRACK PROGRAM	TRACK PROGRAM	TRACK PROGRAM	TRACK PROGRAM
7:30p	12-STEP MEETING	12-STEP MEETING	12-STEP MEETING	12-STEP MEETING	12-STEP MEETING
	AA or NA	AA or NA	AA or NA	AA or NA	AA or NA
830p	REFLECTIONS	REFLECTIONS	REFLECTIONS	REFLECTIONS	REFLECTIONS
	GYM	GYM	GYM	GYM	GYM
915p	SNACK	SNACK	SNACK	SNACK	SNACK
11:00p	LIGHTS OUT	LIGHTS OUT	LIGHTS OUT	LIGHTS OUT	LIGHTS OUT



Attachment C

In response to CON application item 2 a, i, iv, v:

List of existing providers, and results of multiple surveys regarding bed availability

List of substance abuse facilities in Connecticut currently providing level 3.7 residential detoxification and rehabilitation and recovery services

Name of Facility	Address	Town	County	Telephone	Facility total beds	Available beds ~ 1st Survey	Available beds ~ 2nd Survey
South Central Rehabilitation Center [SCRC]	232 Cedar Street	New Haven	New Haven	203-503-3300	29	0	3
Silver Hill Hospital	208 Valley Road	New Cannan	Fairfield	203-966-3561	129	0	"few" beds available
Midwestern Connecticut Council of Alcoholism [MCCA]	30 Old Ridgeberry Road	Danbury	Fairfield	203-792-4515	33	"few" beds available	0
First Step	425 Grant Street	Bridgeport	Fairfield	203-416-1915	19	0	0
Detoxification Center [Blue Hills and ADRC]	500 Blue Hills Avenue	Hartford	Hartford	860-714-3700	73	"few" beds available	"few" beds available
Mountainside Treatment Center	187 South Cannan Road	Cannan	Litchfield	800-762-5433	78	available for rehab only	0
Connecticut Valley Hospital [Merritt Hall]	Tynan Circle	Middletown	Middlesex	860-262-6333	110	0	0
Rushford Center	1250 Silver Street	Middletown	Middlesex	860-346-0300	58	"few" beds available	0
Stonington Institute	75 Swantown Hill Road	North Stonington	New London	800-832-1022	63	0	0
Southeastern Council on Alcohol and Drug Dependence [SCADD]	37 Camp Mooween Road	Lebanon	New London	860-447-1717	20	0	0
Community Health Resources [CHR - formely CAPS]	391 Pomfrest Street	Putnam	Windham	860-928-1860	36	0	0

Retreat
at South Connecticut

Attachment D

In response to CON application item 2a, and in response to CON application item 3e:

SAMSHA statistics relating to the need for the proposal, and other statistics, studies, articles, or reports that support the statements made in this application justifying the need for the proposal

- *Connecticut DMHAS: Collection and Evaluation of Data Related to Substance Use, Abuse, and Addiction Programs*
- *SAMHSA: Connecticut States in Brief*
- *SAMSHA: Connecticut State Profile and Underage Drinking Facts*
- *U.S. Department of Justice: New England High Intensity Drug Trafficking Area, Drug Market Analysis 2011*
- *SAMSHA: Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings*
- *N-SSATS: Connecticut State Profiles for 2009, 2010*
- *SAMSHA: Connecticut TEDS: 2010, 2011*
- *NSDUH Report: State Estimates of Drunk and Drugged Driving*
- *CDC VitalSigns: Prescription Painkiller Overdoses in the US*
- *NSDUH Report: Connecticut State Estimates of Substance Dependence or Abuse, Needing but not Receiving Treatment*
- *Hartford Courant: State seeks to divert veterans from jail to treatment*
- *Rocky Hill Patch: Blumenthal holds forum on prescription drug abuse*
- *Connecticut Mirror: Budget cuts eliminating beds for substance abuse treatment*
- *Middletown Press: CVH employees rally to save detox facility*
- *Danbury News-Times: Prescription drug abuse in Danbury area is stealing lives*
- *Connecticut General Assembly: Testimony of Mary Marcuccio before the Program Review and Investigations Committee*

Collection and Evaluation of Data Related to Substance Use, Abuse, and Addiction Programs

2010 Biennial Report

For Submittal to

Members of the
Connecticut General Assembly,
Office of Policy and Management, and the
Connecticut Alcohol and Drug Policy Council

Prepared by the
Department of Mental Health
and Addiction Services

Patricia A. Rehmer
Commissioner

June 2011

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Department of Public Health	Jewel Mullen Commissioner	Meg A. Hooper
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I. Background

Enacted in 1999, Connecticut General Statutes (CGS) Section 17a-451(o) requires the Department of Mental Health and Addiction Services (DMHAS) to establish uniform policies and procedures for collecting, standardizing, managing, and evaluating data related to substance use, abuse, and addiction programs administered by state agencies, state-funded community-based programs, and the Judicial Branch.

Furthermore, it is DMHAS' responsibility to establish and maintain a central data repository of substance abuse services and submit a report to the General Assembly, the Office of Policy and Management (OPM), and the Connecticut Alcohol and Drug Policy Council (ADPC). This report shall include: a) client and patient demographic information; b) trends and risk factors associated with alcohol and drug use, abuse, and addiction; c) effectiveness of services based on outcome measures; and d) a statewide cost analysis. In 2002, CGS Section 17a-451(o) was amended, changing the submission of the report from annual to biennial.

Since the enactment of CGS 17a-451(o), the number of collaborating state agencies and scope of data sharing has grown immensely. Today eleven state departments, the Office of Policy and Management, and the Judicial Branch work together to share data and report the findings presented in the ***2010 Biennial Report on the Collection and Evaluation of Data Related to Substance Use, Abuse, and Addiction Programs*** (2010 Biennial Report). This broad-based interagency collaboration has resulted in the submission of seven previous reports (February 2000, July 2001, February 2002, December 2003, May 2004, June 2007 and December 2009).

Progress made over the past eleven years towards achieving the legislative directive has included:

- continued assessment of uniform procedures and the data interoperability of substance abuse treatment and prevention information systems across state agencies;
- sharing data across state agencies to determine the interrelated service needs of those receiving substance abuse treatment; and
- enhancing the level of interagency collaboration leading to more effective and efficient use of scarce resources.

In 2004, the first of a series of treatment outcome and effectiveness studies was initiated. Collaborating with the Department of Labor, DMHAS' Research Division and Yale University, conducted a study of earnings two years before and after receiving treatment. The ***Treatment Effects on Wages Study*** was the first in Connecticut to directly link employment wage data with substance abuse treatment records. This study of treatment effectiveness was followed by a study of treatment and its effects on recidivism as measured by re-arrest and re-incarceration. Findings from the joint DMHAS and Department of Correction (DOC) ***Treatment Effects on Criminal Justice Involvement Study*** were presented in the 2006 Biennial Report. In the 2008 Biennial Report, the most ambitious yet data linkage study was completed—***Young Adults Receiving Substance Abuse Treatment with Prior Child Welfare or Judicial Court Involvement*** - an analysis linking child welfare, juvenile justice, adult substance abuse treatment, adult arrests and mortality records. For the 2010 Biennial Report, DMHAS collaborated with the Department of Consumer Protection to link patients in Connecticut's Prescription Monitoring Program with substance abuse data. The ***Nonmedical Use of Narcotic Prescriptions and Its Affect on Connecticut's Substance Abuse Treatment System*** focuses on those abusing opiate prescription drugs, particularly young adults, the rate of transitioning to heroin, the rate of treatment access, and the use of Medication Assisted Therapies (e.g., Suboxone).

In 2010, work continued on population overlaps as part of the **Data Sharing Project.** The Probabilistic Population Estimation or PPE model used in previous years was replaced with **a direct linking model**. As criminal justice data (i.e., arrests, incarcerations and probationers) has been routinely linked with behavioral health (substance abuse and mental health) records, this was thought to be a good starting point to pilot the new method of analysis. More comprehensive analyses may soon be performed to better understand the characteristics of those who are criminally involved and receiving care for their behavioral health needs. As confidentiality requirements are addressed, other state agency populations will be included in the population overlap model. This would include child welfare neglect and abuse cases, social services recipients (e.g. Medicaid, Temporary Family Assistance, etc.) and others.

The cross-agency data repository initiative begun in September 2002, known as the ***Interagency Substance Abuse Treatment Information System*** (I-SATIS), met with challenges over the years due to confidentiality concerns brought about by the Health Insurance Portability and Accountability Act (HIPAA). Even more stringent HIPAA security and privacy regulations were recently enacted. Also, technological changes in data transfer and sharing require reexamination of how a data repository is conceptualized. Due to these and other factors, work continues as how best to bring together the various state-funded and -operated addiction service data systems.

Another area of data sharing is the *State Epidemiological Outcomes Workgroup* (SEOW), first convened in 2005 as part of DMHAS' Strategic Prevention Framework State Incentive Grant funded by the federal Center for Substance Abuse Prevention (CSAP). The primary mission of the SEOW is to contribute to the collection, analysis, and interpretation of state- and community-level epidemiological data, track data trends over time, and produce information to prioritize, focus, and strengthen prevention efforts. For DMHAS, the SEOW provides a broader perspective of trends in substance use and consequences, taps into other state agency areas of expertise and knowledge, works towards more universally accessible information for all stakeholders, and offers the possibility to collaborate on studies of common concern. In 2007, the SEOW was expanded to incorporate some of the reporting objectives under the Biennial Report.

The SEOW has collected and reviewed state level consumption and consequence data from a variety of state and federal sources. These data were used to develop a state epidemiological profile which identified the top six problem substances in the state based on their impact, burden and susceptibility to change. This profile formed the basis of the Comprehensive Strategic Prevention Plan available at http://www.ct.gov/dmhas/lib/dmhas/prevention/ctspf/SEWprofiles09.pdf. Through the SEOW, data is reviewed and updated biennially, and secondary data sources are made available to regions and municipalities to develop community profiles which are used to plan effective prevention strategies.

The SEOW, managed by the DMHAS Prevention and Health Promotion Unit, is working with the Connecticut Data Quality and Access Consortium to pilot a web-based interactive social indicator data repository. The website will contain approximately 50 indicators, as well as census data and student survey data collected locally. It will allow users to create tables, charts, and maps, displaying data values (numbers, percentages, or rates) for towns, Uniform Service Regions (USR), or statewide, and by population group. The site is expected to be up and running by summer 2011.

Another important stakeholder body is the state Child Poverty and Prevention Council (CPPC). The Council continues to meet to formulate strategies for action on its priority recommendations. To advance its efforts in reducing poverty among children in Connecticut by 50% over ten years, the Council's work has focused on a process that: selected target populations; built consensus around priority recommendations using national experts, documented research and proven practices; utilized a Results Based Accountability approach to focus resources and strategies; created an economic model to assess which policies will likely reduce child poverty by 50%; developed a community model where selected municipalities will work to decrease child poverty; and promoted interagency collaborations among state agencies to meet the child poverty and prevention goals.

Additionally, the Council will examine strategies to lessen the impact of the recession on Connecticut's children. The Council will work with other agencies to develop and promote policies, practices and procedures, to mitigate the long-term impact of economic recessions on children; provide appropriate assistance and resources to families to minimize the number of children who enter poverty as a result of the recession; and reduce the human and fiscal costs of recessions, including foreclosures, child hunger, family violence, school failure, youth runaways, homelessness, and child abuse and neglect. Child Poverty and Prevention Council Plans and Reports are available at the Office of Policy and Management web site at http://www.ct.gov/opm/cwp/view.asp?a=2997&q=383356 .

II. Executive Summary

The 2010 Biennial Report, as in previous reports, looks across the spectrum of state agency services for the prevention, intervention, and treatment of substance use, misuse, and abuse. A range of information is reported using various methods (trend analyses, data sharing and linkage, etc.) to provide the best overview of the current situation. Barriers to implementing a consolidated substance abuse services information system persist but advances in data sharing technology afford an opportunity for expanded collaborations.

The 2010 Biennial Report contains the culmination of years of work on some very important cross-agency projects. Among them are:

1. Adolescent Treatment Service Data

In the last decade, the Department of Children and Families (DCF) has focused on integrating services for substance use and mental health disorders, including co-occurring disorders. At the same time, the department has led the country in implementing evidence-based approaches to treating adolescent substance use. This has included funding services with proven success such as MultiSystemic Therapy (MST) and Multi-Dimensional Family Therapy (MDFT). In order to assess the effectiveness of services DCF has implemented the Global Appraisal of Individual Needs (GAIN) standardized assessment tool. Also the department revamped its behavioral health services information system in 2009, now known as Programs and Services Data Collection Reporting System or PSDCRS.

Together, these data provide rich detail about those served by DCF's substance abuse treatment providers, and document the success of these services in improving the health and well-being of youth and families. DCF's entire report can be found at:

http://www.ct.gov/dcf/lib/dcf/substance_abuse_services_report_2011.pdf

Major findings include:

- Utilization of adolescent substance abuse treatment services has more than doubled since 2004. While the volume of clients served in outpatient and intensive in-home community-based programs has risen, residential treatment has remained unchanged.
- Ninety-eight percent of adolescents in residential treatment and 81% of adolescents in outpatient treatment report a 50% or greater reduction in problems related to substance use from intake to discharge.
- At discharge from Family Based Recovery , 75% of children were living at home with their biological parent(s).
- The MST-Building Stronger Families pilot study shows that children of families receiving these services were less likely to be placed out-of-home.
- Intensive, in-home services result in reduced marijuana and alcohol use; getting into trouble at home, school or with friends; or missed school days.

2. Adult Treatment Service Data

Using data collected through DMHAS' substance abuse treatment information systems a trend analysis was conducted for SFYs 2006, 2008, and 2010. This comprehensive data repository contains admission and discharge information from all community-based substance abuse treatment programs licensed by the Department of Public Health (DPH). Additionally, some non-licensed, state-operated programs report to DMHAS as well, including DMHAS operated hospitals and Department of Correction prison-based services. Client-level data are routinely submitted and contain information on each admitted or discharged client.

As in past reports, trends in admissions are analyzed for the primary drug reported at admission, age of first use, demographics, service utilization and other areas of interest.

Major findings in the SFY 2006 to 2010 analysis include:

- The percent of primary heroin admissions continued to drop after years of steady increases giving rise to alcohol to become, once again, the most frequently reported substance at admission.
- Treatment admissions due to other (prescription) opiates (e.g.,OxyContin®, Vicodin®) had the greatest percentage increase, continuing a seven-year trend.
- The average age at admission for those with a primary heroin problem decreased from SFY 2008 to 2010 by one year (34.8 to 33.1) and by 4.5 years for those reporting other opiates.

3. Caseload Overlaps

Since 2000, the Data Sharing Project has drawn upon data from seven state agencies and the Judicial Branch. This project has been highly successful in generating statistical information in the past including trends in measuring the overlap of state agency populations receiving treatment.

While PPE was useful to examine general rates of treatment access, it was very limited in its capacity to provide insight as to the sequencing of treatment services (e.g., before or after incarceration) or client outcomes. For this reason it was decided to move to linking individual records directly across systems. As DMHAS and the state's criminal justice agencies have established consistent and valid methods for linking large administrative databases, this seemed a logical starting point.

At the June 2010 meeting of the Criminal Justice Policy Advisory Commission, a recommendation was offered that would allow for the routine linking of behavioral health and criminal justice data. During SFY 2011, DMHAS and the criminal justice partners formed a steering committee responsible for:

- Determining the scope of data sharing.
- Overseeing the creation of essential data documentation.
- Recommending a linking method that meets state and federal confidentiality laws and regulations.
- Suggesting standard reports and developing criteria for ad hoc or special reports.
- Assisting in the interpretation of findings.
- Developing and facilitating the execution of confidentiality agreements and approvals across all participating parties.

It is anticipated that data documentation and the Memorandum of Understanding regarding governance, publication and other pertinent matters will be completed by late summer 2011. At that time, five years of criminal justice (arrests, incarceration and probation) and behavioral health data will be linked for the purpose of services research, evaluation, and outcomes analysis.

4. Nonmedical Use of Prescription Narcotic Pain Relievers and Treatment

Today, Connecticut's rate of non-medical use of pain relievers is estimated to be 3.8% of the adult population according to the most recent National Survey on Drug Use and Health findings. For young adults (18-25), the rate continues to be about two and a half times the general adult population at 10.5%. There is evidence that many persons who become addicted to prescription pain relievers move to heroin as a cheaper and more readily available alternative.

Recent analyses of DMHAS substance abuse treatment data indicate that the rate of primary heroin admissions is declining. On the other hand, persons entering treatment reporting a primary substance problem for "other synthetic opiates" (e.g., Vicodin®) continues to rise. Over the past decade, treatment options for opiate dependent persons have expanded, particularly with the introduction of buprenorphine (e.g., Subutex, Suboxone). Use of buprenorphine for both detoxification and long-term replacement therapy has been proven to be effective and DMHAS has encouraged the expansion of this treatment approach for opiate dependent persons.

For the purpose of this study, data from the Department of Consumer Protection's (DCP) Connecticut Prescription Monitoring Program (CPMP), a central database containing prescription drug data for Schedule II-V controlled medications, was linked to DMHAS substance abuse treatment service records. Other data included in the linked analytic database were adult arrests, incarceration, adult probation and deaths.

Preliminary analyses conducted include the following results:

- Many young adults (18-24) prescribed buprenorphine were found to have a history of criminal justice involvement (arrested – 48%) but at a rate lower than those the same age treated in licensed or operated programs (arrested - 72%).
- Access to buprenorphine treatment for young adults as been steadily increasing over the last two years (SFYs 2009 and 2010) providing an important alternative to Methadone Maintenance for the treatment of opiate addiction.
- Identifying cases in which questionable activity such as "doctor shopping" or abuse of prescription pain relievers requires more careful consideration due to "false positives".

As this study was exploratory in nature, analyses will continue in the coming year.

5. Prevention Services

Prevention Data

Over the recent past, the DMHAS Prevention and Health Unit, in collaboration with other state agencies, has leveraged federal funding to enhance its capacity for obtaining, using, and disseminating interagency data. Since 2005, through funding from the federal Center for Substance Abuse Prevention (CSAP), DMHAS has supported the efforts of the State Epidemiological Outcomes Workgroup (SEOW) to promote the use of substance abuse prevention and mental health promotion data to select effective programs and strategies. The SEOW provides a framework to expand interagency collaboration, promote sharing of state agency expertise to access, interpret, and analyze data, and explore opportunities to collaborate on issues of common concern.

Since 2006, the SEOW has been tracking epidemiological data on six substances (alcohol, tobacco, marijuana, heroin, prescription drugs, and cocaine). SEOW data were used to update profiles for each substance, as well as suicide and problem gambling. These profiles can be found at: http://www.ct.gov/dmhas/lib/dmhas/prevention/ctspf/SEWprofiles09.pdf

In SFY 2010, the SEOW began the process of replacing its web-based data repository with a state-of-the-art, interactive site which will enable any registered user to access substance abuse prevention and mental health promotion indicators, analyze the data, and produce high-quality visualizations (maps, graphs, etc.). These reports may be used to construct community profiles, assess service needs, prepare funding applications, and measure the impact and effectiveness of programs. The new site is expected to be up and running by summer 2011.

6. Statewide Cost Analysis

Overall funding for substance abuse services has grown from SFY 1999 to SFY 2009. Some of the growth, especially in SFYs 1999 to 2002, reflects improved expenditure reporting. Particularly, the increase in total expenditures between SFYs 2000 and 2001 is partially due to the identification and inclusion of additional state agencies not previously reporting (e.g., Department of Social Services–Medicaid).

Overall funding for substance abuse services has experienced a steady growth from SFY 1999 to SFY 2007 but saw a 1.2% decrease (not adjusted for inflation) from SFY 2007 to 2009. Looking at SFY 2009 expenditure categories, the greatest reduction (40.9%) from SFY 2007 was seen in prevention services. The major contributor to this reduction was a $13.6 million dollar loss in State Department of Education discretionary federal grants. Treatment expenditures saw a slight increase (6.7%) due primarily to DSS Medicaid expenditures while deterrence dropped by 19% in SFY 2009 when compared to SFY 2007.

III. Adolescent Substance Abuse Treatment

In the last decade, the Department of Children and Families (DCF) has focused on integrating services for substance use and mental health disorders, including co-occurring disorders. At the same time, DCF has led the country in implementing evidence-based approaches to treating adolescent substance use by focusing its funding on services with proven success including MultiSystemic Therapy (MST) and Multi-Dimensional Family Therapy (MDFT), and implementing data collection systems to evaluate the effectiveness of these treatment services. In addition, DCF is leading the nation with approaches to caregiver substance abuse treatment and child maltreatment, including participating in a National Institute of Drug Abuse (NIDA) clinical trial for MST-Building Stronger Families.

The data that follow are excerpts from a comprehensive service system report prepared by DCF. The comprehensive report includes data from many of the sources the agency uses to monitor and evaluate its services including the Global Appraisal of Individual Needs (GAIN) standardized assessment tool, the Programs and Services Data Collection Reporting System (PSDCRS), and model-specific quality assurance data. Together, these data provide rich details about those served by DCF's substance abuse treatment providers, and document the success of these services in improving the health and well-being of youth and families. DCF's entire report can be found at: http://www.ct.gov/dcf/lib/dcf/substance_abuse_services_report_2011.pdf

Outcomes from DCF's substance abuse programs include:

- All of DCF's substance abuse programs average lengths of stay that meet or exceed NIDA's recommendation of 90 days or more to obtain a therapeutic effect from treatment. (Table 1)

- Ninety-eight percent of adolescents in residential treatment and 81% of adolescents in outpatient treatment report a 50% or greater reduction in problems related to substance use from intake to discharge from treatment. (Graph 2)

- At discharge, adolescents receiving intensive in-home services (MDFT and MST) report reductions in: marijuana and alcohol use; getting into trouble at home, school or with friends; missed school days; and days bothered by mental health problems. (Graph 3)

- Among the 278 caregivers discharged from Family Based Recovery (FBR), there were statistically significant improvements in parental depression, stress and postpartum bonding with their child(ren) (Table 2). At discharge from FBR, 75% of children were living at home with their biological parent(s). (Table 3)

- The MST-Building Stronger Families pilot study shows that children of families receiving these services were less likely to be placed out-of-home and had significantly fewer reports of child maltreatment when compared to services as usual. (Graph 4)

- Project SAFE, a DCF and DMHAS interagency program, provides screening and treatment referrals to families involved in child protective services. The rate at which those referred to treatment actually enter treatment has increased dramatically in recent years. (Graph 5)

Table 1. Adolescent Substance Abuse Outpatient & Residential Treatment Individuals Served: SFY 2010

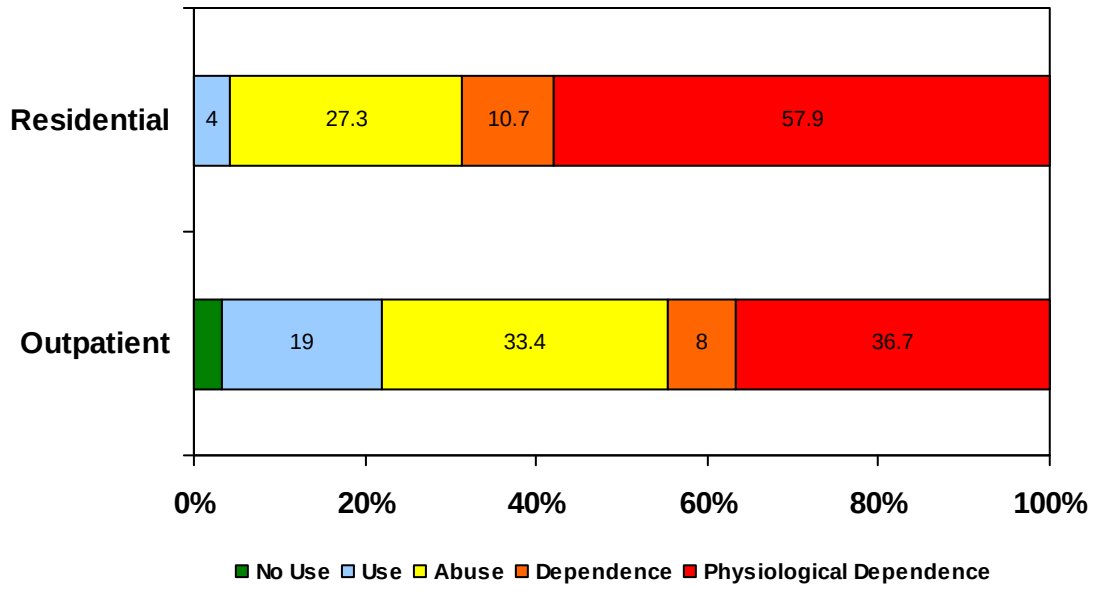
OUTPATIENT		RESIDENTIAL	
Total Served	804	Total Served	102
Male	71.4 %	Male	71.2 %
Age of Youth Served		Age of Youth Served	
11-12	0.7 %	11-12	0.0 %
13-14	13.3 %	13-14	15.3 %
15-16	50.6 %	15-16	67.8 %
17-18	34.9 %	17-18	16.9 %
>18	0.5 %	>18	0.0 %
Average Length of Treatment	94 Days	Average Length of Treatment	191 Days

Adequate Length of Treatment = Good Outcomes

NIDA recommends <u>at least 90</u> days for positive outcomes.

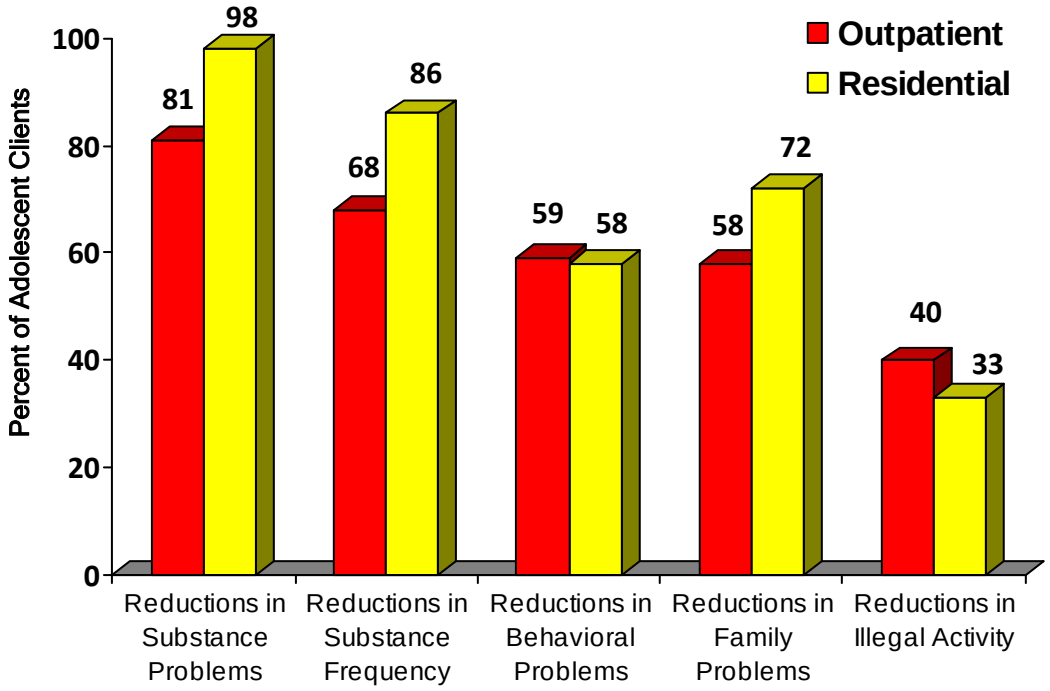
Source: Intake Data for SFY 2010 from PSDCRS, the Behavioral Health Partnership and the GAIN

Graph 1. Lifetime Substance Use Severity Reported by Adolescents at Intake



Ninety-six percent of adolescents in residential treatment and nearly 80% of adolescents in outpatient treatment self report having problems that indicate a substance use diagnosis.

Graph 2. Percent of Adolescent Treatment Clients With Reduced Problems* at Discharge



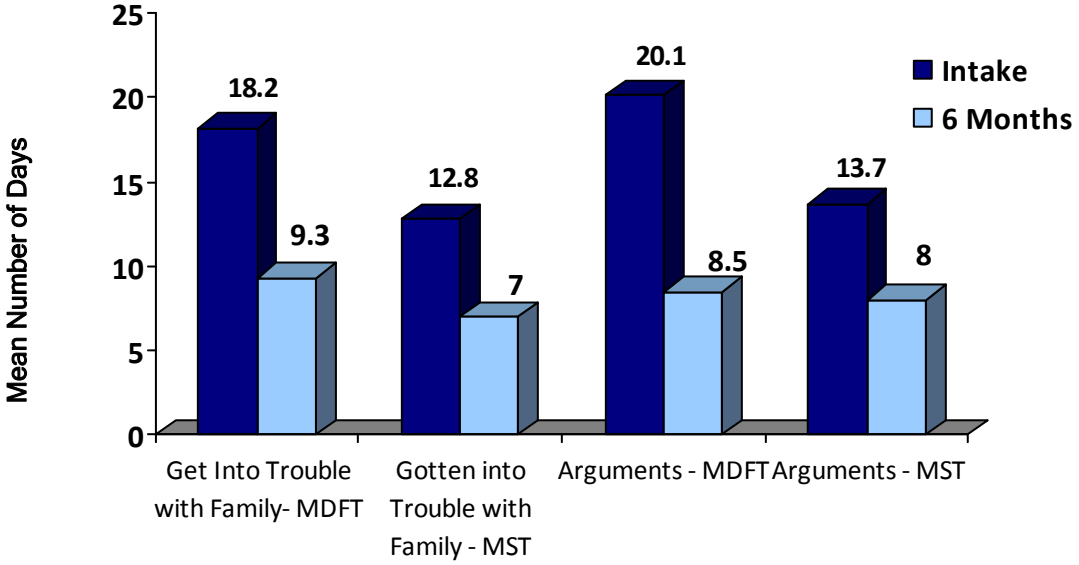
Treatment works:

At discharge, adolescents report significant reductions in problems related to substance use, frequency of use and associated problems.

* Having a **50% or better reduction** in substance related problems from intake to discharge.

In-Home Adolescent Treatment

Graph 3. Mean Days of Family or Peer Problems Reported



Over time, adolescents in MDFT and MST report fewer days of getting into trouble with family and having fewer arguments.

Family Based Recovery (FBR) Programs

Using an evidenced-based and preferred practice model, Family Based Recovery (FBR) Programs provide intensive home-based services that integrate parental substance abuse treatment with family treatment designed to enhance parenting and parent-child attachment. The target population is infants (birth to 24 months) who have been exposed to parental substance abuse in-utero and/or environmentally from their parent(s) and their siblings; who are involved with DCF for child abuse / neglect issues; and who are at risk of removal from their homes.

Table 2. Changes Over Time in Parental Depression, Stress and Postpartum Bonding in FBR

Measures	Baseline	Discharge	T-Value and Significance
Edinburgh Depression Scale (N= 174)			
Total Score	7.24	5.01	5.20 **
Parenting Stress Index-Short Form (N=163)			
Total Score	68.03	61.55	5.42 **
Postpartum Bonding Questionnaire (N=149)			
Total Score	5.79	4.37	3.35**
Note: *p<05 **p<01			

Significant improvement in depression, parental stress and bonding were seen in Family Based Program participants from baseline to discharge.

Table 3. Family Based Recovery - Child Placement at Discharge

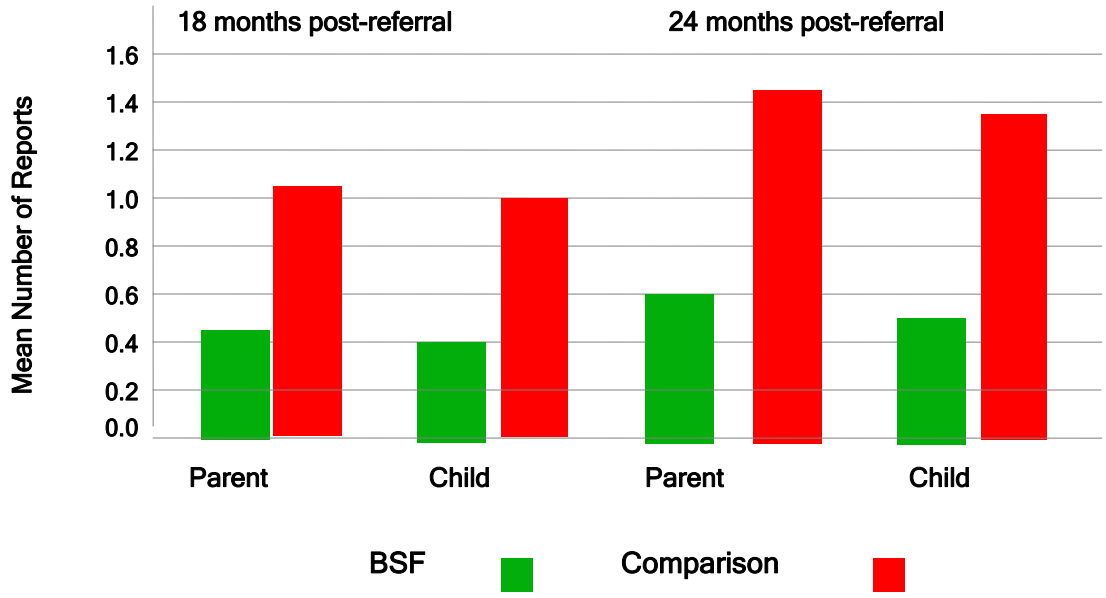
Total Served in SFY10	164
Child Placement at Discharge	
Home with Biological Parent	**75%**
Relative's Home	13%
Foster Care	10%
Other	2%
Mean Length of Stay	8.7 Months

Three out of four children receiving family-based services were placed in the home with their biological parent at time of discharge.

MultiSystemic Therapy - Building Stronger Families (MST-BSF)

MST-BSF provides intensive in-home and community-based treatment for DCF families with physical abuse and/or neglect of a child due to parental substance abuse. The target population is children, age 6 - 17 years, who have had maltreatment reports within the past 180 days and are at risk of removal from the home.

Graph 4. Maltreatment Reports After Initial Referral To MST-BSF Therapy



MST-BSF shows statistically significant improvements in child maltreatment when compared to services as usual.

Recovery Services Voluntary Program (RSVP)

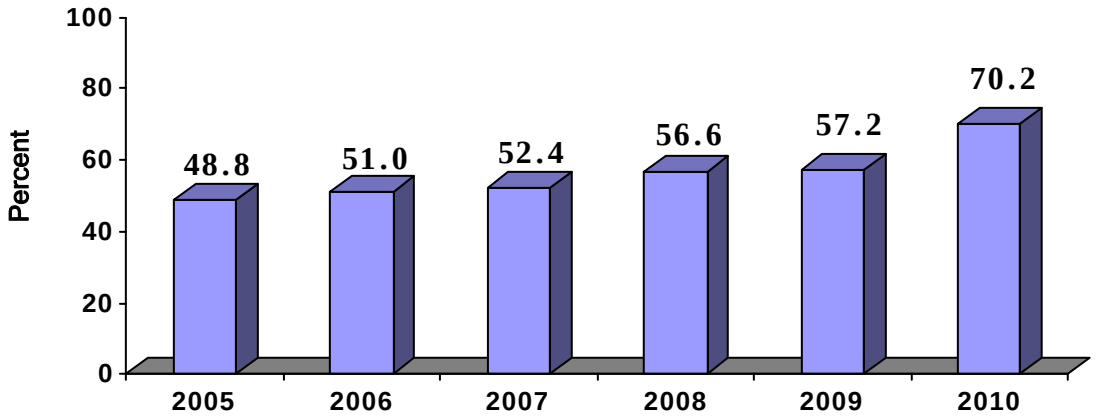
RSVP is a voluntary program within Project SAFE (Substance Abuse Family Evaluation) for parents/ caregivers who have had a child removed by an Order of Temporary Custody (OTC) and need support for recovery from problematic use of alcohol and/or drugs. The program is the result of a joint collaboration between DCF, the Judicial Branch, and DMHAS in three pilot sites: Bridgeport/ Norwalk, New Britain, and Willimantic DCF Area Offices. RSVP helps the parent/caregiver engage in substance abuse treatment, conducts random alcohol/drug screens, supports parents in increasing their recovery capital (e.g. housing, employment), and provides timely documentation to the courts and DCF on the parents' efforts and progress. As of December 2010, RSVP has served 113 families in the three pilot locations.

When parents with substance use problems who are involved with the child welfare system have their children removed from their homes, the children tend to have significantly longer out-of-home placements than parents who do not have substance-related problems. The goal of RSVP is to improve permanency by quickly engaging and retaining parents in substance abuse treatment and support services. Early data from the court indicates more timely permanency plans for children of parents who agree to participate in RSVP.

Project SAFE

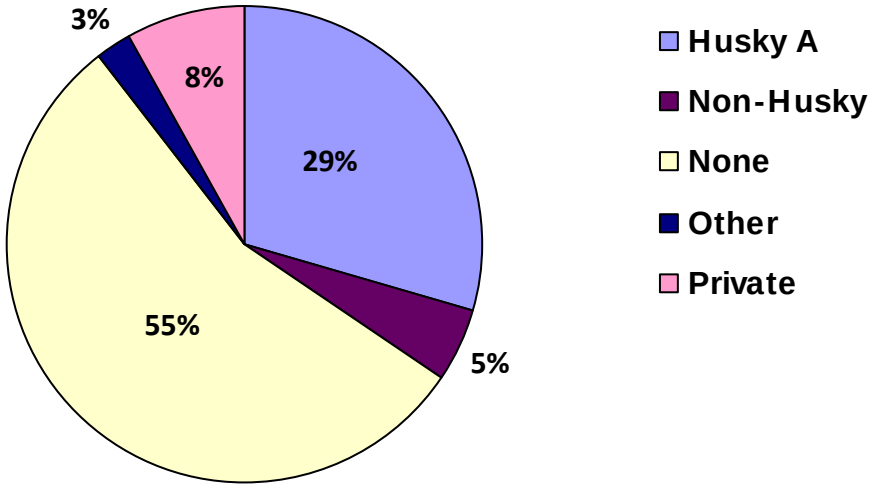
Project SAFE (Substance Abuse Family Evaluation) is an interagency collaboration between DMHAS and DCF that funds evaluations and direct care services for families identified with substance abuse treatment needs. Advanced Behavioral Health, the Administrative Services Organization, manages all referrals to Project SAFE, collects screening information, and manages utilization of treatment services. Over the past several years, DCF has implemented a standardized screening tool, the GAIN Short Screener (GAIN-SS), to improve identification of substance use among caregivers.

Graph 5. Project SAFE Referrals to Treatment Percent Receiving Services: SFY 2005 - 2010



The "show rate" of individuals evaluated and recommended for treatment through Project SAFE rose 18% between 2009 and 2010.

Graph 6. Health Insurance Status at Intake to Project SAFE: SFY 2010



Most Project SAFE clients have no insurance (55%) while the remainder have mostly public entitlement coverage.

IV. Adult Substance Abuse Treatment

Substance Abuse Treatment Information for Adults
Trend Analysis of Admissions for State Fiscal Years (SFY) 2006 - 2010

Most Connecticut substance abuse treatment programs report client information, for persons 18 and older, to DMHAS through its data collection system. Data are electronically submitted to DMHAS monthly and contain information on each admitted or discharged client. The range of client information collected at admission includes: demographics, employment status, education level, type of drug use, frequency of drug use, living arrangements, arrests, and other pertinent data.

All substance abuse treatment programs licensed by the Department of Public Health (DPH) are required, by state statute, to report to DMHAS. Additionally, some non-licensed, state-operated programs report as well, including DMHAS state hospitals and DOC prison-based services. This mandatory reporting system ensures that all publicly supported clients, i.e., those whose treatment is paid out of public entitlement programs such as Medicaid or have no insurance, are included in the department's database. Excluded from the DMHAS information system are those persons who receive services through the Veterans' Administration, general hospitals or private practitioners.

DMHAS routinely checks the data for quality, completeness and internal consistency. On-line reports are available to treatment providers and DMHAS monitoring, evaluation and planning staff. The department is in the process of finalizing "report cards" to evaluate individual service providers as well as overall system performance. Specific trends over the three-year period include:

Client Demographics

- Whites comprised about two-thirds of all admissions while blacks accounted for almost one in five admissions, and Hispanics about one in four.
- Males represented the vast majority of admissions (73%).
- The average age at admission dropped slightly between SFY 2008 and 2010 (36.7 vs. 35.9).
- Rates of admissions grew slightly for those age 25 to 34 and 45 to 64 while those age 25 to 34 dropped over the five-year period. (Graph 7)

Patterns and Trends of Primary Problem Substance

- The percent of primary heroin admissions dropped after years of steady increases giving rise to alcohol to become, once again, the most frequently reported substance at admission. (Graph 8).

- Treatment admissions due to other (prescription) opiates (e.g., OxyContin®, Vicodin®) continued to have the greatest percentage increase continuing a seven-year trend. (Graph 8)

- The average age at admission for those with a primary heroin problem decreased from SFY 2008 to SFY 2010 by 1.7 years (34.8 to 33.1) and by 4.5 years for those reporting other opiates. (Table 4)

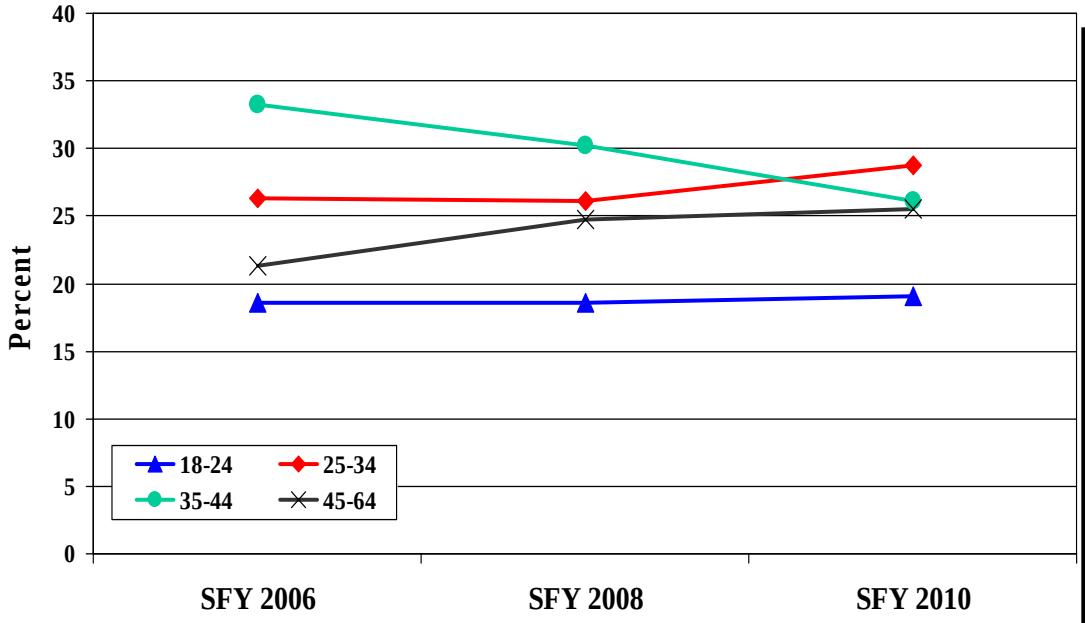
- The pattern of primary substances reported by race or ethnicity remained similar to those in past years. Whites most frequently present for treatment of other opiates and alcohol followed by cocaine and then heroin. Blacks reported primarily marijuana followed by cocaine. Latinos reported marijuana followed by heroin as their primary problem substance. (Table 4)

- Injection drug use in SFY 2010 remained similar to past years with about one out of every five persons admitted to treatment having injected drugs.

- Type of care received by primary problem substance followed past patterns with alcohol admissions using outpatient and detoxification; heroin - detoxification and methadone maintenance; cocaine - outpatient followed by residential care; and marijuana predominately outpatient. Overall, utilization of detoxification services dropped while and outpatient increased, and residential rehabilitation and methadone maintenance remained unchanged. (Table 5).

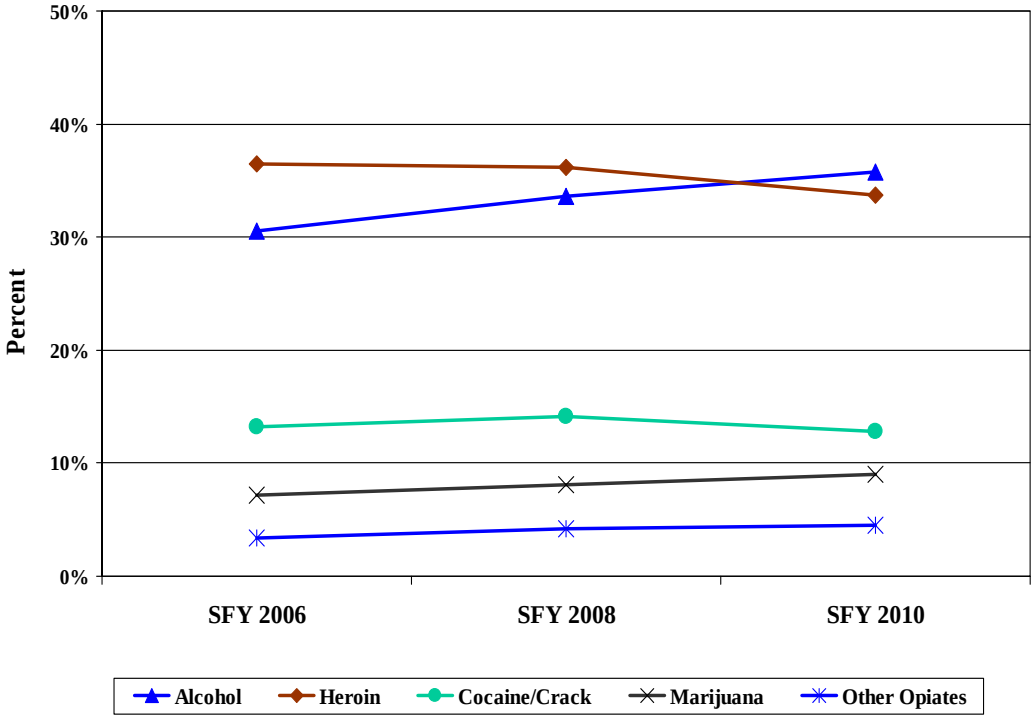
- Variation in age of first use for primary problem substances reported at admission showed little change and only minor differences between males and females. The greatest variance was seen with clients reporting age of first use for other opiates. In SFYs 2006 and 2008, the average age of first use was about 25.5 years old. In SFY 2010, the average age dropped to 23.5.

Graph 7. Admissions to Substance Abuse Treatment at Time of Admission: SFYs 2006 - 2010



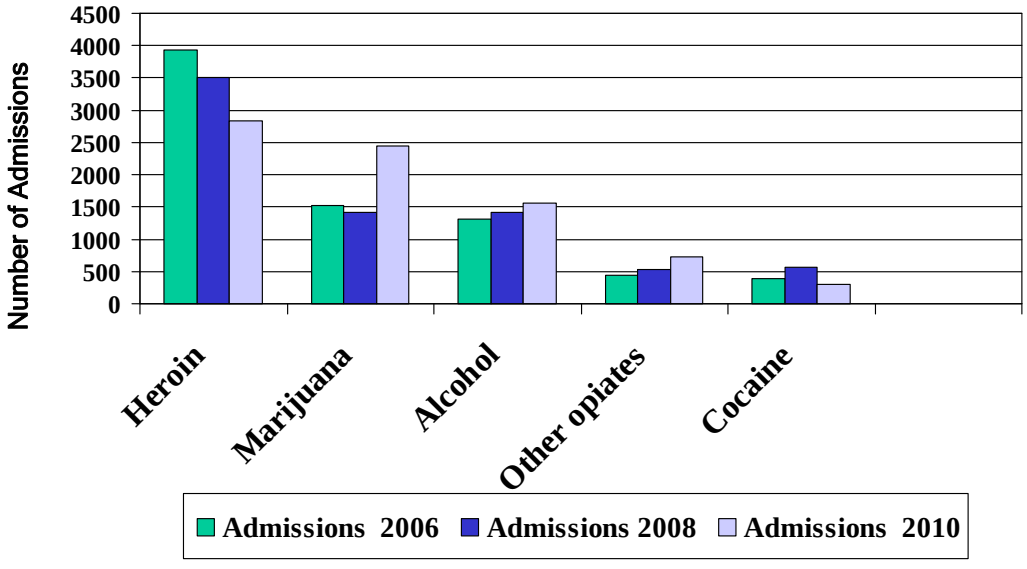
While the average age (35.9) at admission has stayed fairly constant, the percent of admissions by those 25 to 34 and 45 to 64 has increased. Admissions for persons age 35 to 44 experienced a drop over the five year period while young adult admissions (18-24) remained fairly constant.

Graph 8. Primary Problem Substance Reported at Time of Admission: SFYs 2006 - 2010



The percent of clients reporting heroin as their primary drug at admission began to drop in SFY 2006 and by SFY 2009 was replaced by alcohol admissions as the most reported abused substance. Cocaine continued a slow but steady decrease while marijuana had a noticeable increase from SFY 2008 to SFY 2010. Admissions for other opiates (e.g., Vicodin®) continued a steady upward climb.

Graph 9. Admissions of Young Adults (18 - 24) by Primary Drug Reported at Admission: SFY 2006 - SFY 2010



Admissions by young adults between SFYs 2006 and 2010 indicate that the spike in heroin admissions seen in SFY 2006 has declined steadily while marijuana had a rapid rise in SFY 2010. Those presenting for treatment with prescription opiate abuse increased by 60%. Alcohol admissions increased while cocaine admissions had a slight increase in SFY 2008 before dropping back in SFY 2010.

Table 4. Characteristics of Substance Abuse Treatment Clients by Primary Problem Substance at Admission - SFY 2010

	Alcohol	Heroin	Other Opiates	Cocaine	Marijuana
% Female	24.7	27.9	35.1	36.2	20.3
Mean age (years)	42.9	33.1	29.3	39.8	26.3
Race					
% White	71.5	68.1	90.7	50.4	37.9
% Black	17.8	9.7	2.3	33.2	38.7
% Other	10.0	21.4	6.3	15.5	22.2
Ethnicity					
% Hispanic	16.4	25.7	9.9	20.9	32.0
%Non-Hispanic	83.6	74.3	90.1	79.1	68.0

Types of primary substances reported at admission differ by gender, age, race, and ethnicity. Those who enter treatment for marijuana are generally younger and male. The rate of admission for a heroin problem continued to drop for Hispanics from a previous high of 4 out of 10 to 1 out of 4 in SFY 2010. On the other hand, almost all admissions for other opiates, like OxyContin® , continue to be white non-Hispanics. Of note, the median age at admission for heroin and other opiates dropped between SFYs 2008 and 2010 (34.8 to 33.1 and 33.8 to 29.3), respectively.

Table 5. Level of Service by Primary Substance Among Substance Abuse Treatment Admissions - SFY 2010

	Alcohol	Heroin & Other Opiates	Cocaine	Marijuana
% Hospital & Residential De-toxification	29.4	31.6	3.9	0.0
% Residential Rehabilitation	20.9	20.2	33.2	11.6
% Outpatient Services	49.7	14.1	62.8	88.4
% Methadone Services	0.0	30.9	0.0	0.0
% Ambulatory Detoxification	0.0	3.2	0.0	0.0

Treatment varies by type of substance and severity. Persons reporting heroin and other opiates as their primary problem substance mainly use detoxification services followed by methadone. In recent years emphasis has been placed on connecting opiate detox clients to residential and methadone services. This has resulted in a significant decrease in the use of costly detox services. Persons seeking treatment for cocaine addiction continued to use mostly outpatient services followed by residential rehabilitation. The vast majority of those reporting marijuana as their primary problem substance received outpatient services.

V. Substance Abuse Treatment and Caseload Overlaps

The Data Sharing Project, initiated in December 2000, originally drew upon data from seven state agencies and the Judicial Branch. The project had been highly successful in generating statistical information including trends over the years regarding shared caseloads. Analyses conducted using a statistical model called Probabilistic Population Estimation or PPE was instrumental in measuring the "population or caseload overlap" of Connecticut's substance abuse treatment system with criminal justice, and health and human service systems. Over that 10-year period, a series of reports were produced which included an unduplicated count of persons in each state agency population, the percent and number of overlap (i.e., those receiving treatment who were also arrested, incarcerated, on probation, receiving welfare benefits, involved in child protective services, etc.) and demographics such as age, race and gender.

While PPE was useful in examining general rates of treatment access, it was very limited in its capacity to provide insight as to the sequencing of treatment services (e.g., before or after incarceration) or client outcomes. For this reason it was decided to move to linking individual records directly across systems. As DMHAS and the state's criminal justice agencies had established consistent and valid methods for linking large administrative databases, this seemed a logical starting point. At the June 2010 meeting of the Criminal Justice Policy Advisory Commission, a recommendation was offered that would allow for the routine linking of behavioral health and criminal justice data. Essentially, the concept was to match individual records across separate databases using person identifiers such as first/last name, Social Security number, date of birth and gender. Once linked, all person identifiers would be removed although a random identifier for each person would be assigned so that analyses could be conducted at the person level. This random unique identifier would not be tied to any person identifiers and therefore would pose no risk for redisclosure. This linking method has been exhaustively scrutinized by a number of state agency review boards and academic human subject committees, and has been validated as complying with state and federal confidentiality laws and regulations.

During SFY 2011, DMHAS and the criminal justice partners (DOC, DPS and JB-CSSD) formed a steering committee responsible for the following components of the data linking project:

- Determining the scope of data sharing (i.e., which data elements to be included, frequency of updates, etc.).
- Overseeing the creation of data dictionaries and other essential documentation.
- Recommending a linking method that meets state and federal confidentiality laws and regulations.
- Suggesting standard reports and developing criteria for ad hoc or special reports.
- Assisting in the interpretation of findings.
- Developing and facilitating the execution of confidentiality agreements and approvals across all participating parties.

It is anticipated that data documentation and the Memorandum of Understanding regarding governance, publication and other pertinent matters will be completed by late summer 2011. At that time, five years of criminal justice (arrests, incarceration and probationer) and behavioral health data will be linked for the purpose of services research, evaluation and outcomes analysis.

VI. Data Linkage Study

Nonmedical Use of Narcotic Prescriptions and Its Affect on Connecticut's Substance Abuse Treatment System

Today, Connecticut's rate of non-medical use of pain relievers is estimated to be 3.8% of the adult population, according to the most recent National Survey on Drug Use and Health findings. For young adults (18-25), the rate continues to be about two and a half times the general adult population at 10.5%. There is evidence that many persons who become addicted to prescription pain relievers move to heroin as a cheaper and more readily available alternative. An analysis conducted by the Department of Mental Health and Addiction Services (DMHAS) for the 2006 Biennial Report highlighted this trend. Treatment admission data for SFY 2003 through SFY 2006 indicted that the number of young adults (18-24) entering treatment for a primary heroin and other opiate (e.g., Vicodin® , Oxycontin) addiction grew significantly. In fact, heroin admissions increased by 18% over the four-year period for young adults.

More recent analyses (see Graph 9) of DMHAS substance abuse treatment data indicate that the rate of primary heroin admissions is declining. On the other hand, persons entering treatment reporting a primary substance problem for "other synthetic opiates" (e.g., Vicodin®) continues to rise. Over the past decade, treatment options for opiate dependent persons have expanded particularly with the introduction of buprenorphine (e.g., Subutex, Suboxone). Use of buprenorphine for both detoxification and long-term replacement therapy has been proven to be effective and DMHAS has encouraged the expansion of this treatment approach for opiate dependent persons.

For the purpose of this study, data from the Department of Consumer Protection's (DCP) Connecticut Prescription Monitoring Program (CPMP), a central database containing prescription drug data for Schedule II-V controlled medications, was linked to DMHAS substance abuse treatment service records. Two years of prescription records (SFYs 2009 and 2010) and three years (SFYs 2008, 2009 and 2010) of DMHAS substance abuse treatment were included. Additionally data sets for SFYs 2008-2010 included:

- Department of Correction (DOC) inmate files,
- Department of Public Safety arrest records,
- Judicial Branch-Court Support Services Division adult probation data, and
- Department of Public Health death records.

Study objectives included:

- Understanding the scope of nonmedical use of opiate prescription drugs;
- Assessing the association between abuse of narcotic prescription drugs and initiation of heroin for those individuals seeking treatment;
- Determining whether there has been a change in Medication Assisted Therapies (e.g., methadone maintenance and/or buprenorphine) in response to opiate abuse; and
- Analyzing outcomes such as successful treatment completion, criminal justice involvement (i.e., arrest or incarceration) or death.

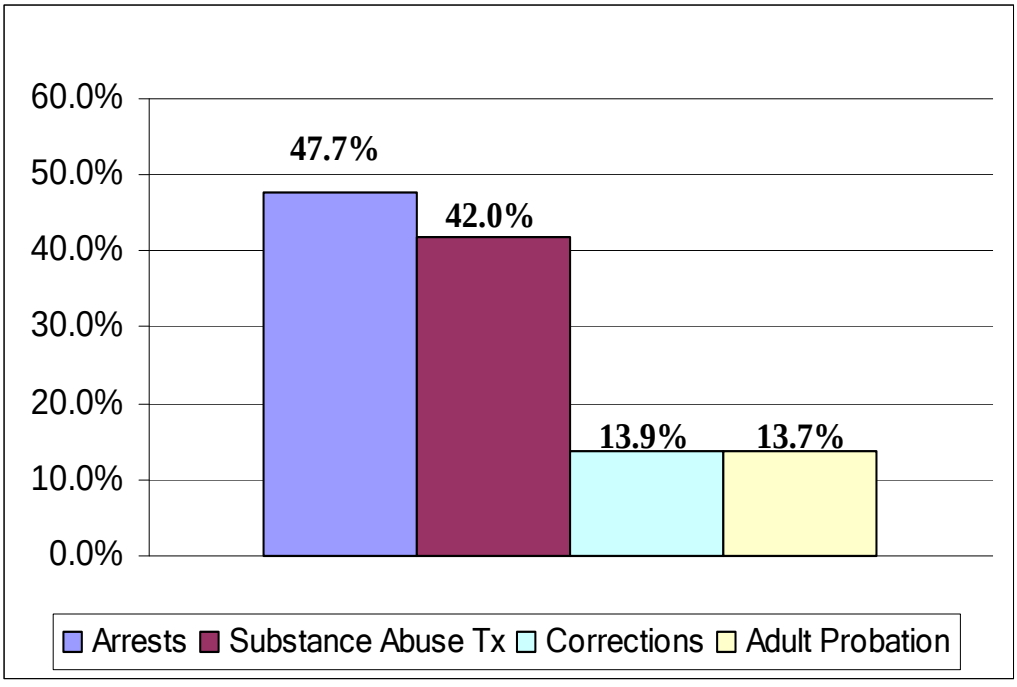
Access to Alternative Treatment for Opiate Addiction

National data, such as the Drug Abuse Warning Network or DAWN which captures emergency department (ED) visits, show that the nonmedical use of narcotic pain relievers to be a growing problem. In a June 2010 DAWN report, trends ED visits for 2004 to 2008 found the two most frequently mentioned prescription pain relievers to be oxycodone and hydrocodone. The rate of reported ED visits for these two narcotic pain relievers grew by 152% and 123%, respectively.

DMHAS has supported expanded access to buprenorphine as a way of addressing opiate dependence, whether from heroin or nonmedical use of prescription pain relievers. This has been especially important for increasing the likelihood of young adults to seek treatment. The CPMP linkage study affords an opportunity to examine how physician-based buprenorphine treatment has assisted in expanding access. There were limitations in the CPMP data set as there were fewer person identifiers upon which to link records. This in turn lowered the possible number of valid matches and as such the following analyses are more than likely an underreporting.

Graph 10 shows the overlap of young adults prescribed buprenorphine and their rate of involvement with the criminal justice system or treatment. Compared with all young adults treated for substance abuse in licensed facilities, those receiving buprenorphine were less likely to have been arrested (48% vs. 72%), on probation (14% vs. 40%) or incarcerated (14% vs. 42%).

Graph 10. Young Adults (18-24) Prescribed Buprenorphine Rate of Involved with the Criminal Justice System or Receiving Substance Abuse Treatment SFYs 2009 - 2010



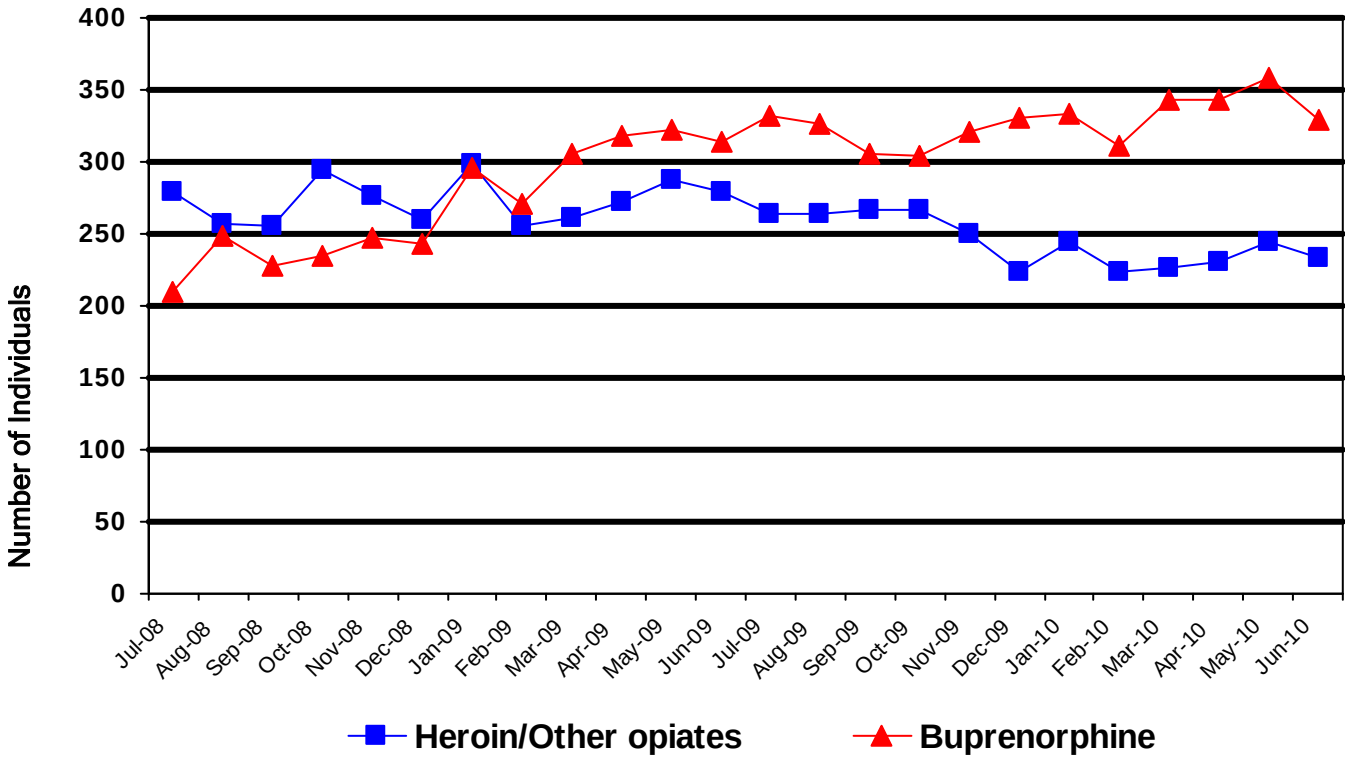
Many (44%) young adults, age 18-24 at the time of filling a prescription for buprenorphine, had a history of arrest. Close to fourteen percent had been incarcerated and/or were or had been on adult probation. Over 42% had received some form of substance abuse treatment in the past year or two.

Access to Alternative Treatment for Opiate Addiction

One of the aims of the prescription drug linkage study was to determine whether there has been a change in response to treating individuals with an opiate dependence. Graph 11 displays, by month, the rate of young adults prescribed buprenorphine (i.e., Suboxone or Subutex) compared to the rate of admission of young adults reporting a primary heroin or other opiate substance problem at time of admission to a licensed or state operated treatment facility. As can be seen from the graph, the number individuals admitted to all treatment facilities with a primary opiate addiction has declined slightly over the 24-month period while the rate of those prescribed buprenorphine has continued to increase.

This appears to be a promising sign that access to an alternative treatment approach (i.e., buprenorphine) to opiate addiction is growing in recognition and access.

Graph 11. Young Adults (18-24) Prescribed Buprenorphine[1] vs. Heroin and Other Opiate Admissions by Monthly Volume: SFY 2009 and 2010



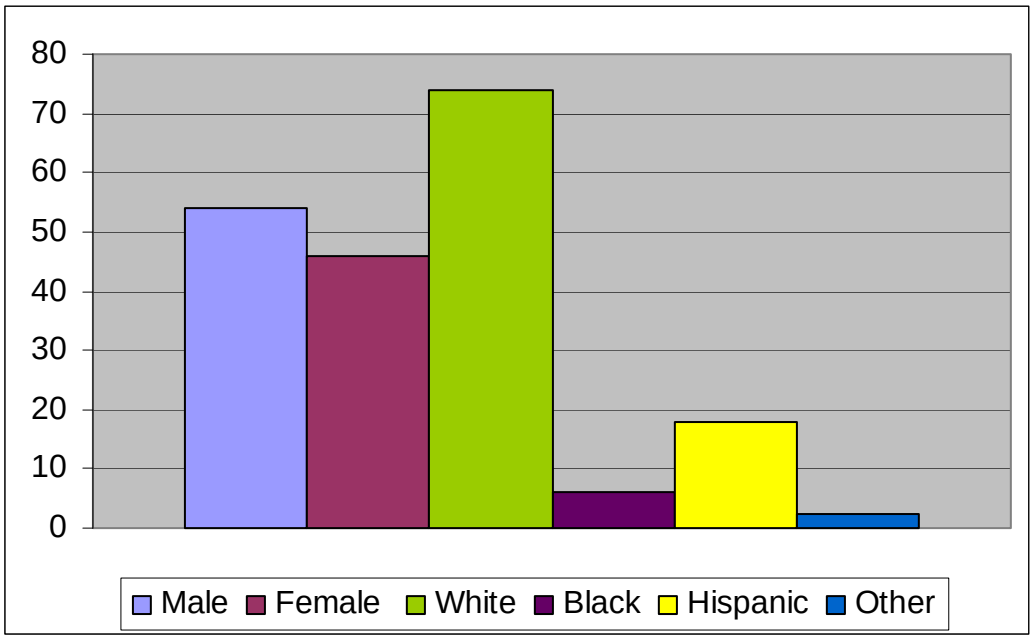
[1] The monthly number of persons prescribed buprenorphine adjusted based upon the one year prevalence rate (NSDUH) of persons age 18-24 estimated to be using narcotic pain relievers for nonmedical purposes.

Another objective of the prescription drug linkage study was to assess the association between the abuse of narcotic prescription drugs and initiation of heroin for those individual seeking treatment. There has been much anecdotal evidence that individuals who become addicted to narcotic pain relievers often seek out heroin as an inexpensive and readily available substitute.

As part of that analysis, it had been of interest to identify those cases in which there was questionable activity such as "doctor shopping" or abuse of prescription pain relievers. This type of analysis proved difficult as identifying multiple prescribers or pharmacies, overlapping prescriptions or increased dosage can produce "false positives". DMHAS and DCP will continue to explore other methods to identify those cases in the linked data set which might be recognized as nonmedical users of prescription drugs.

In an attempt to begun to understand the scope on this phenomenon, persons treated for an opiate addiction (either heroin or other opiate) in a state operated or licensed addictions treatment program in SFY 2010 and having been prescribed a narcotic pain reliever were analyzed. Of all (11,670) persons admitted to treatment in SFY 2010 who reported a primary opiate problem, 47.7% (5,565) had a history of narcotic prescription use prior to admission. About 35% (1,934) of the 5,565 might be identified as having questionable use of narcotic pain relievers. This is based upon criteria used in a 2009 study of Massachusetts' prescription drug monitoring system (Pharmacoepidemiology and Drug Safety: 2010: 19: 115-123) . In that study, a cut-point for identifying individuals having questionable nonmedical use of narcotic pain relievers was - having 4 or more prescribers and 4 or more pharmacies. Graph 12 shows the distribution by gender, race and ethnicity of those thought to have been engaged in questionable use of prescription pain relievers and admitted to treatment.

Graph 12. SFY 2010 Treatment Admissions Reporting Heroin Or Other Opiates as a Primary Substance Who Had a History of Prescribed Narcotic Pain Relievers and Identified as Having Questionable Nonmedical Use



Of those admitted to treatment for opiate abuse or dependence and having a "questionable" history of narcotic pain reliever use, there was little difference in gender. Regarding race and ethnicity most were white, with Hispanics the next highest.

VII. Prevention Data

Over the past two years, the DMHAS Prevention and Health Unit, in collaboration with other state agencies, has leveraged federal funding to enhance its capacity for obtaining, using, and disseminating interagency data. Since 2005, through funding from the federal Center for Substance Abuse Prevention (CSAP), DMHAS has supported the efforts of the State Epidemiological Outcomes Workgroup (SEOW) to promote the use of substance abuse prevention and mental health promotion data to select effective programs and strategies. The SEOW provides a framework to expand interagency collaboration, promote sharing of state agency expertise to access, interpret, and use data, and explore opportunities to collaborate on issues of common concern.

In SFY 2010, the SEOW began the process of replacing its web-based data repository with a state-of-the-art, interactive site which will enable any registered user to access substance abuse prevention and mental health promotion indicators, analyze the data, and produce high-quality visualizations (maps, graphs, etc.). These reports may be used to construct community profiles, assess service needs, prepare funding applications, and measure the impact and effectiveness of programs. The new site is expected to be up and running by summer 2011.

Partnerships for Success Initiative

In September 2009, DMHAS was awarded a Partnerships For Success grant from CSAP. The goal of this grant program is to achieve a quantifiable decline in statewide substance abuse rates, incorporating an incentive award to grantees that have reached or exceeded their prevention performance targets. The statewide prevention priority to be addressed is underage drinking. The performance target approved by CSAP was a reduction in the incidence of past month drinking among 12 to 20 years olds as measured by the 2006-2007 National Survey on Drug Use and Health, from 19.6% to 14.9% - a 4.7 percentage point reduction from the baseline rate.

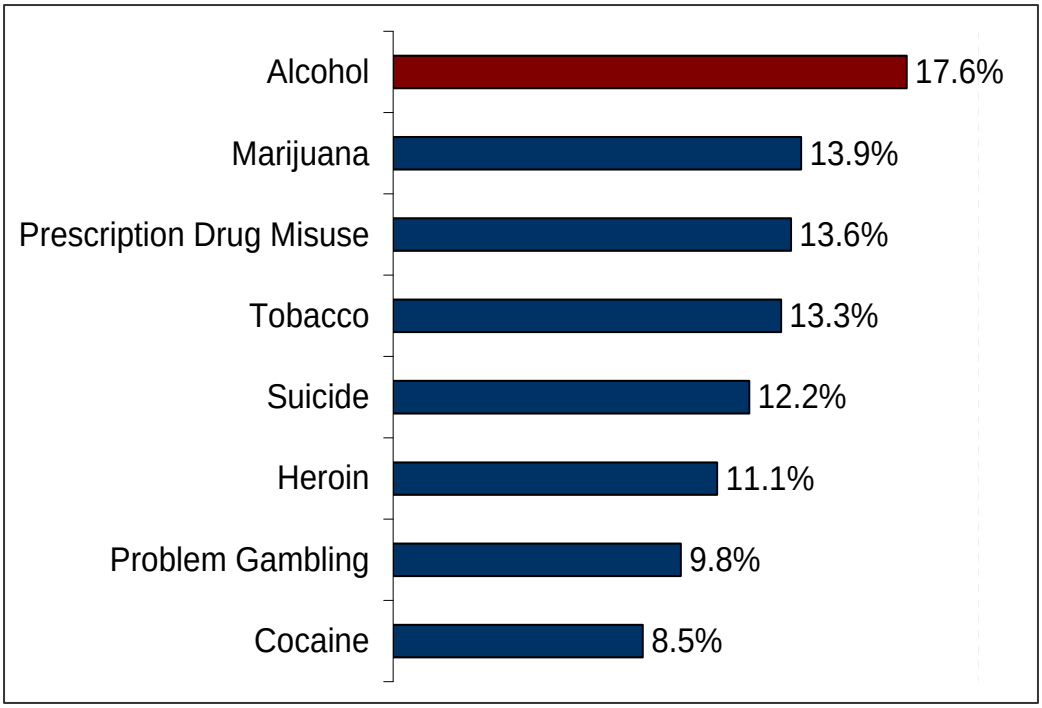
State Epidemiologic Profile

Since 2006, the SEOW has been tracking epidemiological data on six substances (alcohol, tobacco, marijuana, heroin, prescription drugs, and cocaine). SEOW data were used to update profiles for each substance, as well as suicide and problem gambling. These profiles can be found at: http://www.ct.gov/dmhas/lib/dmhas/prevention/ctspf/SEWprofiles09.pdf

Trends in Alcohol and Other Drug Use in Connecticut

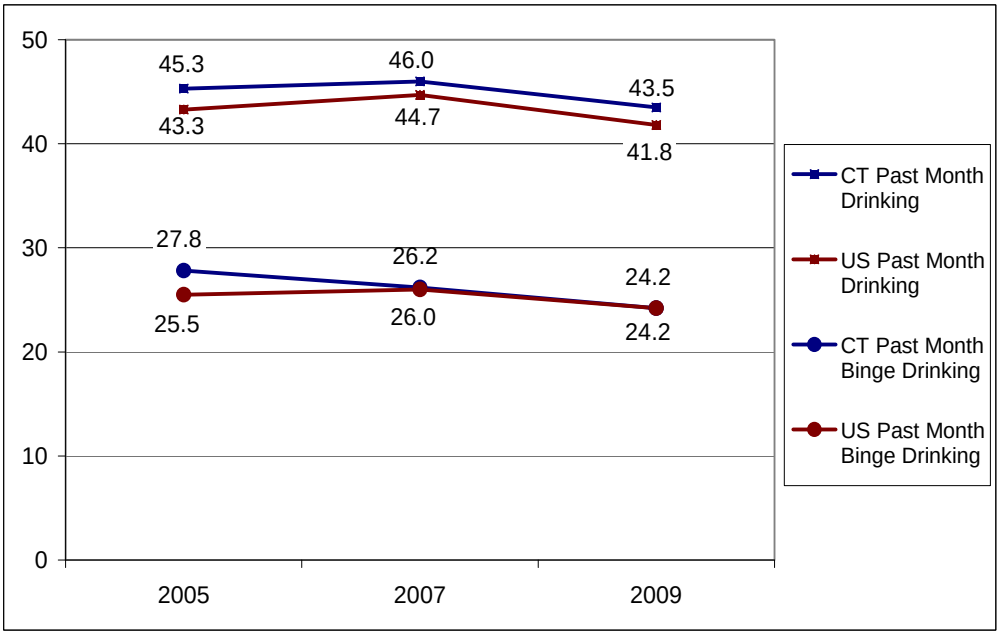
In 2010, Regional Action Councils reconvened subregional Community Needs Assessment Workgroups, for a third time since 2006, to assist in development of community profiles with regard to alcohol and other substances. The Community Workgroups were charged with examining the use and consequences of alcohol, tobacco, marijuana, nonmedical use of prescription drugs, heroin, and cocaine in their geographic areas. After analyzing the data, each substance was scored on a scale of one to five (low to high) for magnitude (burden/breadth of problem); impact (depth of problem across dimensions); and changeability (amenable to change through evidence-based strategies). Also suicide and problem gambling data were incorporated for the first time in SFY 2010. Overall, alcohol use especially underage drinking was ranked as the highest priority Nonmedical use of prescription drugs rose to be ranked third in SFY 2010. (Graph 13).

Graph 13. 2010 Community Needs Assessment Workgroups Priority Problem Ranking



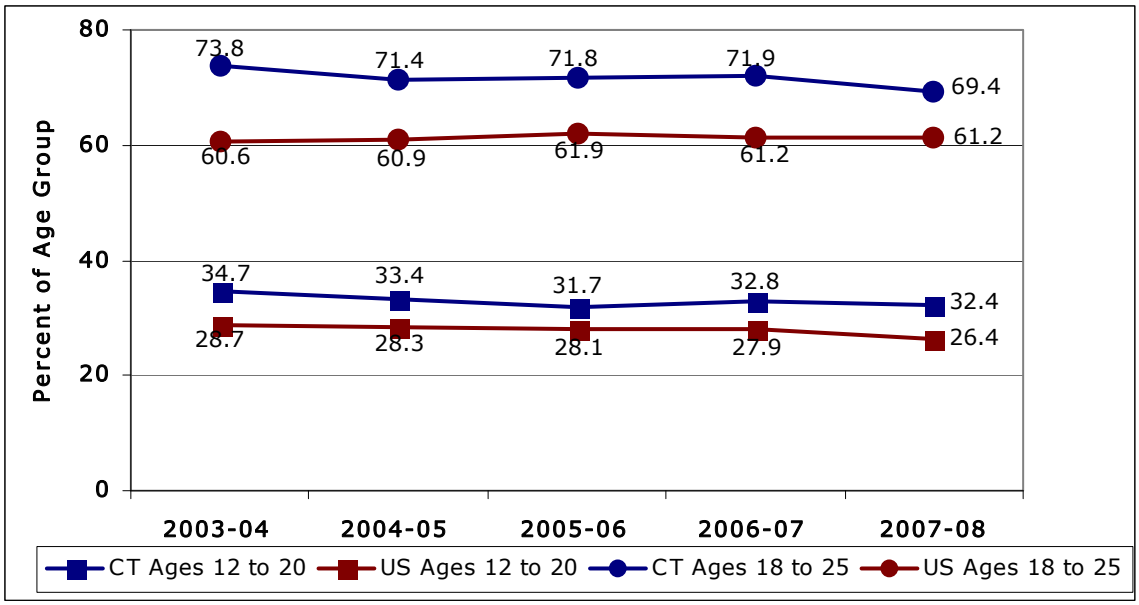
In the 2010 community assessment of alcohol and other drugs, alcohol and marijuana continued to be in the top ranking for use and consequences. Of particular notice is the ranking of prescription drug misuse in the top three substances. As was noted in earlier in this report, nonmedical use of prescription drugs is a growing concern requiring coordinated efforts at public awareness, prevention and treatment.

Graph 14. Trends in Past 30 Day Alcohol Use and Binge Drinking High School Students Connecticut vs. US



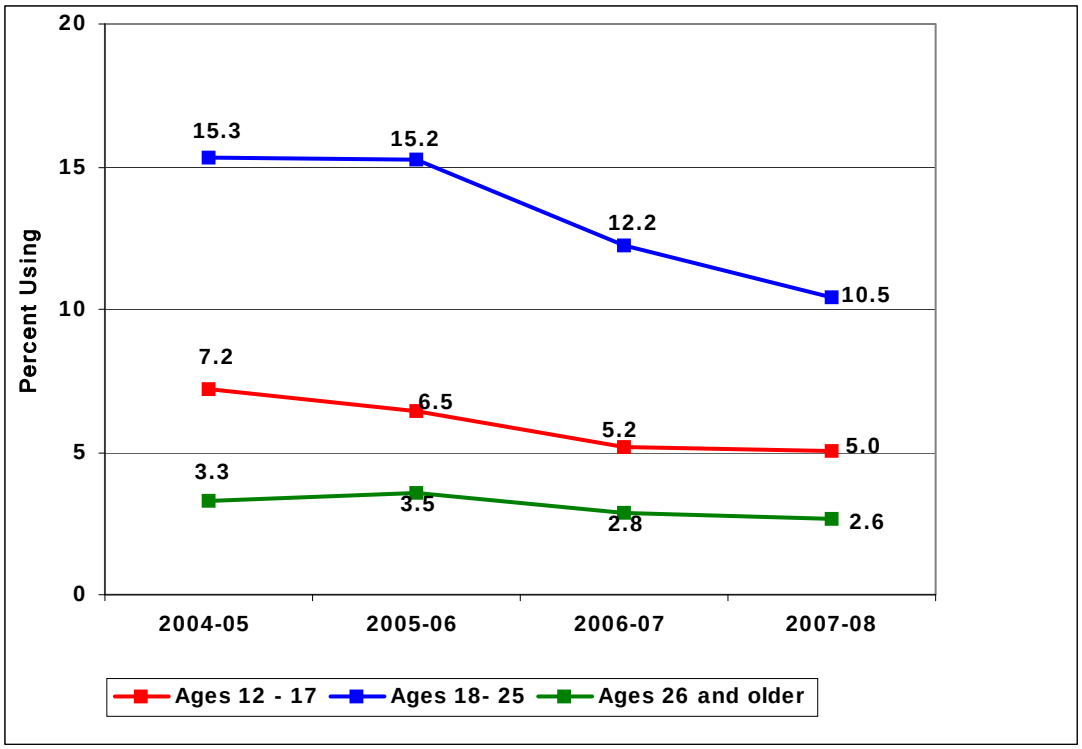
Findings from the Connecticut School Health Surveys show a decline in past month alcohol use and binge drinking among high school students. Although Connecticut's prevalence of binge drinking was above the national average in 2005, it declined in 2007 and now (2009) equals the national average.

Graph 15. Past 30 Day Alcohol Use Among Age Groups Connecticut vs. US: NSDUH 2003-2008



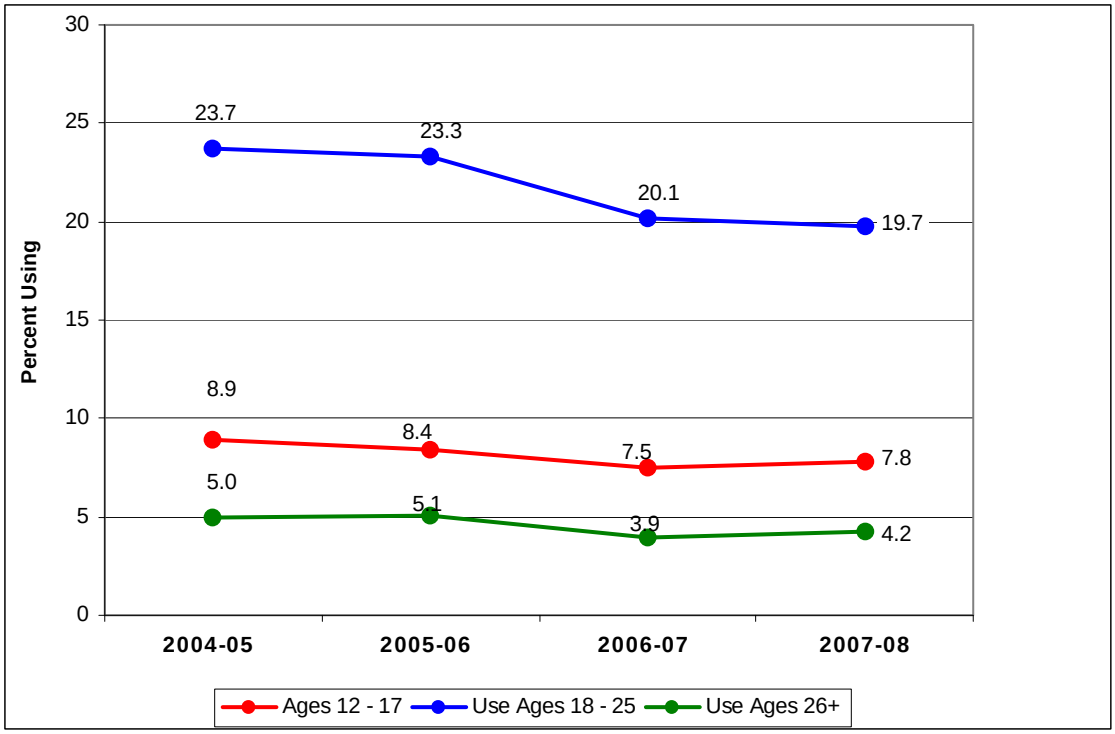
From 2003 to 2008, past month alcohol use in Connecticut has declined. This is especially true among 18 to 25 year olds. Underage (12-20) drinking declined, but only slightly, indicating that efforts are still needed to delay early use.

Graph 16. Past Year Non-Medical Use of Pain Relievers Among Age Groups - Connecticut vs. US: NSDUH 2004 - 2008



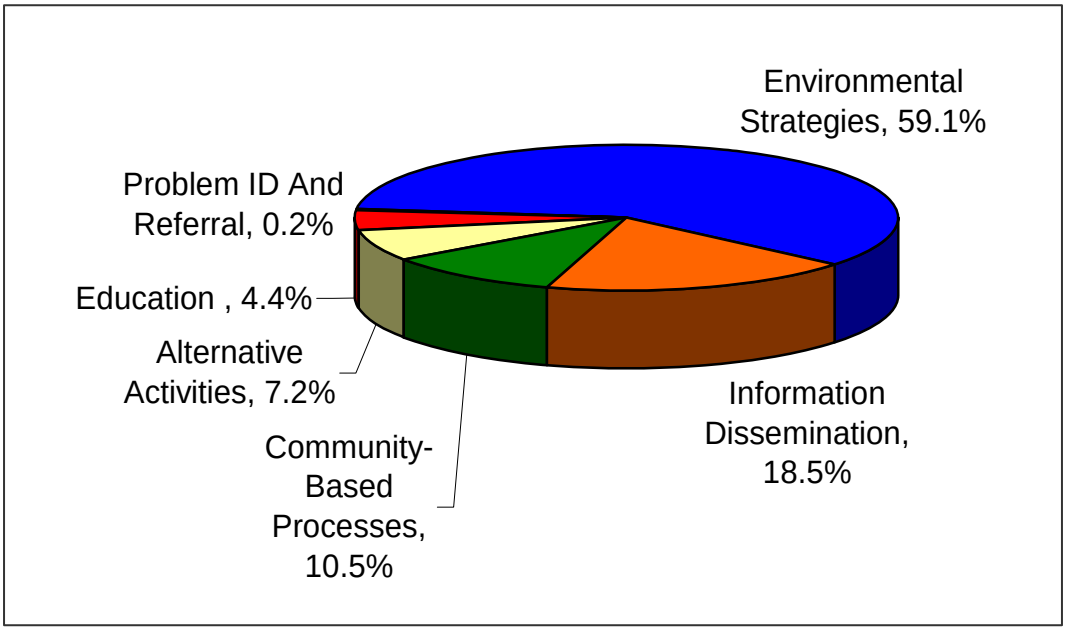
From 2004 to 2008, past year nonmedical use of narcotic pain relievers has decreased for all age groups. Most striking is the decline in use by young adults (18-25 years old) experiencing a 31% drop in the four year period. This is promising as nonmedical use of narcotic pain relievers has sometimes been associated with subsequent use of heroin.

Graph 17. Past 30-Day Use of Marijuana Among Age Groups - Connecticut vs. US NSDUH 2004 - 2008



Current (past 30 days) use of marijuana has declined since 2004/2005 but the decrease has varied by age group. Certainly the most impressive drop has been with young adults (18-25) having a 17% reduction. While those 26 and older showed a general decline, the rate in 2007/2008 has begun to reverse and is on the rise.

Graph 18. Programs and Strategies DMHAS Funded Prevention Programs SFYs 2008 - 2010



Reflecting a shift in federal priorities toward changing the community environment, DMHAS refocused its prevention services to information dissemination (public education/media campaigns) and environmental strategies (alcohol compliance checks, sobriety checkpoints, and enforcement of the social host liability law).

Community Readiness Assessment

For the third time in four years, a key informant survey was administered to a broad range of community key informants, including youth 18 or under, parents, business community, media, school, youth-serving organization, law enforcement agencies, religious or fraternal organizations, civic and volunteer groups, healthcare professionals, State, local, or tribal governmental agencies with expertise in the field of substance abuse (if applicable, the State authority with primary authority for substance abuse), and other organizations involved in substance abuse prevention and mental health promotion. Beyond identifying the drug that most concerned them, which across all age groups was alcohol, they provided their perspective on the importance of data in planning, budgeting, resource development and other critical functions.

Survey results indicated that key informants believed that data relevant for substance abuse prevention were most likely to be used for strategic planning and evaluation purposes. There was an overall spike in uses of data from 2006 to 2008 when community grantees had just completed their needs assessments and were implementing their strategic plans.

Overall, there were fewer barriers to data collection reported from 2006 to 2010 (Table 6). The greatest reductions in barriers to data collection were the following: community not seeing the need for data, people to collect data, and funds for a community needs assessment. Although not asked in 2006, uncertainty about what data to collect, lack of cooperation among stakeholders, and concerns about negative publicity were less likely to be reported between 2010 than in 2008.

Table 6. Barriers to Data Collection in the Community DMHAS Community Readiness Assessment 2006, 2008, and 2010

Barrier to Data Collection	2006 (%)	2008 (%)	2010 (%)
Community does not see need to collect data	29	26	21
Lack of understanding of how to collect data	17	26	18
Lack of understanding of how to use data	19	30	24
Lack of trained volunteers/personnel to facilitate data collection	41	39	31
Lack of trained volunteers/personnel to interpret data	31	34	30
Lack of community leadership support to collect data	29	34	25
Unable to gain permission to collect data from students, local government personnel	23	30	23
Lack of funds to facilitate a comprehensive community needs assessment process	58	57	48
Uncertainty about which data to collect	N/A	29	19
Lack of cooperation among stakeholders	N/A	24	19
Concerns about negative publicity	N/A	43	36

VIII. Statewide Cost Analysis

Information regarding the funding, directly or indirectly, of substance abuse services was gathered from ten state agencies and the Judicial Branch, the Office of Policy Management (OPM) and the Board of Pardons and Paroles. Expenditures reported include all funding sources – state, federal, or other. Clearly, the most easily defined service is substance abuse treatment. Treatment dollars, for the most part, are readily identified and reported. Less clearly defined are intervention activities, as the range of services in this category often overlap into prevention services. Therefore, intervention funds are included within prevention expenditures. While CGS Section 17a-451(o) speaks about prevention and education services separately, for purposes of expenditure reporting, these two activities have been combined, as education is one segment of the prevention continuum. The category "deterrence", also a component of prevention services, was added in the *2001 Annual Report* but is reported separately as law enforcement activities. A summary of statewide service expenditures by state fiscal years is shown in Table 7, while substance abuse service expenditures by agency for SFY 2009 are included in Table 8.

Overall funding for substance abuse services has experienced a steady growth from SFY 1999 to SFY 2007 but saw a 1.2% decrease (not adjusted for inflation) from SFY 2007 to 2009. Some of the growth over the decade, especially in SFYs 1999 to 2002, reflects improved expenditure reporting, for instance the inclusion of Medicaid expenditures. Also, improvements in reporting methodologies has made trend analysis of expenditures difficult. Looking at SFY 2009 expenditure categories, the greatest reduction (40.9%) from SFY 2007 was seen in prevention services. The major contributor to this reduction was a $13.6 million dollar loss in State Department of Education discretionary federal grants. Treatment expenditures saw a slight increase (6.7%) due primarily to DSS Medicaid expenditures while deterrence dropped by 18.7% in SFY 2009 when compared to SFY 2007.

Table 7. Substance Abuse Service Expenditures By State Fiscal Years (Dollars in Millions)

Services	Prevention*	Deterrence	Treatment	Total
SFY 1999**	$53.70	NA	$136.80	$190.50
SFY 2000***	$54.80	$6.80	$152.40	$214.00
SFY 2001	$55.90	$8.50	$153.20	$217.60
SFY 2002****	$53.60	$7.60	$175.00	$236.20
SFY 2003	$47.25	$8.93	$182.94	$239.12
SFY 2005	$59.21	$5.76	$202.04	$267.01
SFY 2007	$43.05	$7.49	$233.12	$283.66
SFY 2009	$25.45	6.09	$248.69	$280.23

* Includes substance abuse education, prevention, and intervention expenditures.
** Expenditures for SFY 1999 updated to include Board of Pardons and Paroles and Department of Veteran Affairs, but missing Department of Public Health.
*** Expenditures for SFY 2000 updated to include Department of Veteran Affairs' treatment expenditures.
**** Department of Social Services treatment expenditures, omitted in previous SFYs, reported for SFY 2002 forward.

Table 8. Substance Abuse Service Expenditures By Agency State - Fiscal Year 2009

Agency	Prevention	Deterrence	Treatment	Total
DMHAS[1]	$11,657,735	$0	$155,717,125	$167,374,860
JUDICIAL-CSSD[2]	$6,515,788	$0	$9,006,298	$15,522,086
DCF[3]	$1,587,518	$0	$19,068,456	$20,655,974
DMV[4]	$0	$0	$0	$0
DOC[5]	$0	$0	$13,363,604	$13,363,604
DOT[6]	$1,281,195	$2,602,950	$0	$3,884,145
DPH[7]	$1,589,305	$0	$0	$1,589,305
DPS	$80,932	$3,484,107	$0	$3,565,039
DSS[8]	$0	$0	$51,135,498	$51,135,498
DVA	$0	$0	$396,337	$396,337
OPM[9]	$419,260	$0	$0	$419,260
PAROLE[10]	$0	$0	$0	$0
SDE[11]	$2,322,177	$0	$0	$2,322,177
TOTAL	**$25,453,910**	**$6,087,057**	**$248,687,318**	**$280,228,285**

[1]Note that expenditures do not include administration dollars.
[2]Expenditures for SFY 2007 and later reflect improved reporting and includes only those services that are directly related to substance abuse prevention and treatment. Since 2005 accounting and data collection has improved and CSSD is now able to identify expenditures devoted to either treatment or prevention.
[3]Decreases in expenditures for SFY 2009 are due to a shift in funding priorities from residential to evidenced based and promising practices of In-home Family treatment.
[4]Clients pay directly for retraining, education and required substance abuse treatment programs.
[5]Department of Correction expenditures include Parole and Community Services outpatient and residential drug treatment expenditures.
[6]All figures are based upon a Federal Fiscal Year (i.e., October 1 through September 30). Prevention costs from the Transportation Safety Section include staff salaries, public information and education initiatives and media. Deterrence costs reflect law enforcement initiatives.
[7]SFY 2009 expenditures reflect adjustments in existing and new programs involved in tobacco cessation.
[8]Increase in SFY 2009 expenditures were due to enhanced Medicaid fee and caseload growth. Expenditures include claims paid for Inpatient and Outpatient substance abuse treatment. Excludes pharmacy, transportation and crossover claims.
[9]SFY 2009 expenditures are lower than in past reporting as several programs previously included no longer address substance abuse.
[10]Treatment expenditures include services provided to offenders in Parole and Community Services, see DOC expenditures.
[11]Decrease in FY 2009 expenditures due to the loss of federal competitive grant funding.

IX. Update on DMHAS Three-Year Strategic Substance Abuse Treatment Plan

Background

On June 29, 2009 the Connecticut state legislature passed, and the governor signed, Public Act 09-149 which required DMHAS, to address in its three-year strategic substance abuse treatment plan, a number of specific elements for consideration, such as data management, continuum of care and use of evidence based practices. This was offered as part of observations and recommendations provided by the Program Review and Investigation Committee's report entitled ***State Substance Abuse Treatment for Adults*** published in December 2008.

The DMHAS strategic report was issued in September 2010 based upon focus groups held with key stakeholders, consultation with advisory bodies such as the Alcohol and Drug Policy Council and the Criminal Justice Policy Advisory Commission, and the department's biennial priority setting process. Below is an update on the status of strategies and activities as developed in the DMHAS three-year substance abuse treatment plan.

Strategy #1

Assure the availability of adequate residential and case management supports to eligible individuals in the network of Supported Recovery Housing Services.

Supported Recovery Housing Services provide safe, sober housing and case management to support residents in securing treatment and other community based recovery supports. There are currently 11 providers in 21 locations providing 158 beds with supports. This includes a recent acquisition in March 2010 of two new providers and 18 additional beds. DMHAS is currently assessing gaps in need for a potential re-procurement, pending resource availability.

Strategy #2

Analyze the impact, opportunities, and potential challenges of the Patient Protection and Affordable Care Act (i.e., health reform).

DMHAS, in partnership with Department of Social Services (DSS), converted the State Administered General Assistance program to the Medicaid Low Income Adult population, taking advantage of provisions within the health reform act that afford broader coverage. An Alternative Benefit Package, an option under the act, is being explored to both assure quality and manage costs.

The DMHAS Commissioner was an active participant on the Health Reform Cabinet chaired by the Department of Public Health's Deputy Commissioner.

Health reform is a standing agenda item in the Commissioner's Executive Group where a number of demonstration projects were considered. As a result, a workgroup which includes Department of Social Services staff is exploring the advantages of the Medicaid state plan option – 1915(i) Home and Community Based Services - that was significantly modified under the Affordable Care Act.

Strategy #3

Examine the ability to expand provision of case management, life coaching, employment, education, community affiliation and wellness supports, including the provision of these services by peer providers (continuum of care), by capitalizing on opportunities created by federal reforms to address desires of the recovery community and service providers.

These services are available throughout the state funded by the federal Center on Substance Abuse Treatment grant program known as, Access to Recovery III. The ability to expand provision of these services will be addressed by the Commissioner's Executive Group described

in Strategy #2. Shifting resources in support of these efforts may be a consideration as greater numbers of the population obtain coverage for clinical services through the Patient Protection and Affordable Care Act.

Strategy #4

Promote the provision of comprehensive assessments.

DMHAS is in the process of completing the Assessment Guidance document and will complete that by July 2011, as scheduled. The plan is to disseminate this document to state-operated and DMHAS-funded agencies via their CEOs and to the various Learning Communities DMHAS regularly convenes; these learning communities or collaboratives include program managers and directors. Agencies will be asked to review their biopsychosocial assessment documents and compare them to the DMHAS Assessment Guidance document. Changes to assessment forms may be needed so that they are more consistent with DMHAS' assessment expectations.

Strategy #5

Promote the adoption of evidence based and best practices and models

DMHAS recently created an Evidence-Based and Best Practices Governance Committee, chaired by the DMHAS Commissioner. This committee met for the first time in January 2011 and continues to meet on a quarterly basis. The Governance Group consists of 17 members in addition to the Commissioner and includes other executive staff and Office of the Commissioner Division Directors. Over the past year DMHAS also designated a new position in the Office of the Commissioner's Community Services Division: Manager of Evidence-Based and Best Practices Implementation. This manager provides staff support to the Governance Group as described above along with other functions that promote the adoption of evidence based practices. A behavioral health specialist has been reassigned to work for this manager, further enhancing the infrastructure necessary to complete the multiple and varied goals involving evidence-based and best practices in the DMHAS system.

The first product from the Governance Committee is the DMHAS Catalog of Evidence-Based & Best Practices. This catalog includes twenty practices that are currently being implemented in various ways through the DMHAS system of care, across six Divisions. The catalog describes each practice, the number of programs involved, the implementation process being used, training and technical assistance currently available, a summary of fidelity measurement being used, and a summary of how client outcomes are being measured. A version of this catalog will be disseminated to providers in 2011. A project plan for next steps to more fully implement several of these practices is being developed with completion anticipated by June 30, 2011.

Strategy #6

Improve access to treatment for young adults, criminal justice populations, and other adults

6.1 Young Adults

DMHAS is exploring expansion of buprenorphine (i.e., Suboxone or Subutex) services through its recently awarded federal grant – **Access to Recovery (ATR) III**. The goals of the federal grant include: 1) facilitating individual choice and promoting multiple pathways to recovery; 2) expanding access to a comprehensive array of clinical substance use treatment and recovery support services; and (3) ensuring each client receives an assessment for the appropriate level of services. All services are designed to assist recipients remain engaged in their recovery while promoting independence, employment, self-sufficiency, and stability.

When fully operational, ATR III will support the administration or prescription of buprenorphine for persons having an opioid

addiction. Clinical supports will include an assessment of needs, recovery planning, individual and group therapy, and relapse prevention strategies.

Suboxone has been suggested as an alternative to methadone for individuals uncomfortable with or unable to attend a licensed Chemical Maintenance Treatment Facility (i.e., a methadone clinic) for daily dispensing and receipt of the methadone. In order to allow for great access to Suboxone, DMHAS collaborated with the Department of Public Health (DPH) to enact changes in Connecticut's licensing regulations. Currently, DPH regulations prohibit dispensing of Suboxone in substance abuse outpatient clinics not licensed as Chemical Maintenance Treatment Facilities. DPH has submitted a bill which would allow for the prescribing of Suboxone in licensed substance abuse outpatient clinics (other than Chemical Maintenance Treatment Facilities) while final licensing regulations are codified. This change would greatly increase access to Suboxone providing an alternative treatment option to methadone. Individuals having an opiate dependence, whether to heroin or narcotic painkillers, would be able to receive treatment within their own communities. This is especially true of young adults who are struggling with a short-term addiction to heroin or painkillers who would be able to access care through an outpatient program instead of a methadone clinic.

6.2 Criminal Justice Populations

By July 1, 2011, a preliminary pilot implementation report will be drafted that will: 1) determine the scope of the pilot; 2) roles of each party in the pilot program; 3) costs associated with the pilot; and a recommendation as to the number and location of pilot sites situated in Geographical Area Courts.

The first Proposed Outcome for Goal 6.2 indicates that "DMHAS, CSSD, and the Office of the Public Defender will meet to discuss the possibility of developing a pilot program modeled after DMHAS' Jail Diversion Program" for "unsentenced inmates who have an unplanned release from custody by the courts." Such a pilot program would include an increase in services and service capacity, requiring additional resources. Due to uncertainty of the State Fiscal Year 2012 state budget, DMHAS is delaying plan development for this pilot until available resources are determined. Until then, existing collaborations to address Goal 6.2 will continue as follows:

- The DMHAS Jail Diversion program, in collaboration with CSSD and the Office of the Public Defender, is present in every arraignment court and currently serves a significant number of individuals with substance use disorders.
- A significant portion of individuals currently served by DMHAS have open cases in criminal court.
- As described in the 2011 Criminal Justice Policy Advisory Commission (CJPAC) Reentry and Risk Assessment Strategy, DMHAS and CSSD will continue to operate programs that connect unsentenced inmates to community treatment upon planned release from custody by the court.

Criminal Justice and Behavioral Health Data Linkage Initiative

At the June 6, 2010 meeting of the CJPAC, members endorsed a proposal to link individual records across the criminal justice (arrests, incarcerations, adult probation and parole) and behavioral health populations. In December 2011 a Steering Committee with representation from the Judicial Branch (CSSD), Department of Correction, Department of Public Safety, Department of Mental Health and Addiction Services, Board of Pardons and Paroles, and Office of Policy

and Management was formed. The University of Connecticut Health Center's Correctional Managed Health Care division was later added.

The current plan is for each party to contribute five years of data (e.g., SFY 2006 – SFY 2010) which will be linked and de-identified. Currently, work continues on drafting a Memorandum of Understanding that will include the data sharing protocol, confidentiality and governance, and documentation of data sets (e.g. data dictionaries). Intensive work is underway on data documentation and conventions (e.g., race/ethnicity values). It is anticipated that all work will be concluded by summer 2011 at which time the data linkage will be completed.

6.3 Treatment Availability for Public Information

Upon further review of the Connecticut Clearinghouse's Behavioral Health Service Directory, DMHAS decided that improvements could be implemented on the department's website that would result in a more consumer- and public- friendly application for locating treatment resources.

As a result of some of these changes already being implemented, a consumer or member of the public can now be linked directly to a specific provider website, once the geographic preference has been indicated. By accessing the provider's web site through a hyperlink, an interested individual will be able to develop his/her own impression of the treatment provider and perhaps be motivated to make that first contact to enter treatment. DMHAS website users are given the opportunity to offer feedback about the use of the website though the "Contact Us" link:
"Do you have questions, inquiries or feedback regarding the DMHAS Website?"
Please contact: DMHAS Webmaster@po.state.ct.us"

Some individuals may be interested in more than just provider website information and seek out actual "performance" information. As previously described, DMHAS has been developing provider performance reports intended for use by consumers, providers and other interested parties for assessing treatment effectiveness as well as customer satisfaction. Although customer satisfaction reports are currently available, provider performance reports are still under development. DMHAS will make performance reports available on its provider locator website once available.

Finally, DMHAS is in the process of developing a "Facebook" page for users of this form of social media. The intent is not to replicate what already exists on the DMHAS website but rather to help individuals know when and how to access the website for treatment service resources, as well as other relevant information pertaining to behavioral health.

6.4 Demand for Services

DMHAS will track individuals admitted to treatment regarding the wait time between first contact and first treatment service. Also, DMHAS will continue to monitor its annual client satisfaction survey as to access to services to evaluate the responsiveness of the treatment system to admit persons demanding treatment.

See Strategy 8.1

Strategy #7

Implement provisions of the Criminal Justice Policy Advisory Committee Community Re-entry Strategy

The Preliminary Action Steps of Goal 7 indicates that "DMHAS will convene an interagency workgroup to develop a detailed Action Plan to establish a comprehensive substance abuse service system for reentry." Such an Action Plan would include an increase in services and service

capacity, and would require additional resources. Due to uncertainty of the State Fiscal Year 2012 state budget, DMHAS is delaying development of an Action Plan until available resources are determined. Until then, existing collaborations to address Goal 7 will continue as follows.

- DMHAS, DOC, CSSD, and BOPP have constant formal and informal communications to manage referral of discharging inmates to the community service system.
- DMHAS, DOC, and CSSD will continue to operate reentry programs as discussed earlier.
- State agencies and the Judicial Branch will continue to develop and implement the reentry strategy as discussed in the 2011 CJPAC Reentry and Risk Assessment Strategy.

Strategy #8

Address data management and policy provisions of P.A. 09-149

DMHAS implemented two new data systems in SFY 2010. The Avatar system collects client level data from state-operated facilities. This system was implemented in mid-May 2010. The DMHAS Data Performance system (DDaP) captures client level data from private not-for-profit providers. DDaP was implemented in mid-July 2010. Since these systems were implemented, DMHAS has been designing and developing a data warehouse that standardizes and stores the data form both of information systems. The data warehouse became fully operational in March 2011 and the department is now aggressively working to enhance its reporting capacities. These new data systems have greatly enhanced the department's ability to collect and report on client outcomes. Providers have been required to report outcome data on an episodic basis (every 6 months) and early efforts post-implementation have focused on reporting compliance and data quality. The sections that follow highlight the status of certain measures.

8.1 Access to services prior to and following admission.

Establish baseline data of actual system performance reflecting time from request to service to service initiation, January 1, 2012.

DMHAS' new data systems now capture the date a person requested service from a substance abuse agency. DMHAS is using this data element to track how long it takes before a client receives their first service at that agency. Providers are now entering this data on all new admissions. Providers are required to report the services they provide so DMHAS is able to determine the time it takes to receive treatment. Now that all data has been consolidated in the data warehouse, a report is being developed that will measure the "time to treatment". DMHAS will be able to report a full year's data in the next (2012) Biennial Report.

Determine correlation between performance measures and National Outcome Measure System (NOMS) on a sample of individuals served.

DMHAS issued provider Quality Reports throughout SFY 2010 to all DMHAS providers. These "report cards" compared how providers were performing in relation to DMHAS benchmarks and statewide averages for key indicators such as abstinence, arrests, stable living, employment, use of 12 step programs, and treatment completions. The reports also show utilization rates and the degree to which consumers are satisfied with their services. Report cards were issued on a quarterly basis during SFY 2010.

Currently these Quality Reports are being redesigned to be more consumer-friendly. DMHAS expects to pilot a new version of the report cards in summer 2011 and to begin posting report cards to the web in fall 2011. Since the report cards were implemented, data quality has significantly improved as

providers have focused more attention on data reporting and data quality. The report cards will be available to consumers and will help inform them as they make decisions regarding where to access treatment. These reports are also being used to target monitoring and corrective actions by identifying providers with poor performance.

8.2 Percentage of clients who should receive a treatment episode of ninety days or greater

Establish a baseline for the percentage of clients exposed to ninety-day (or greater) care episodes from July 1, 2010 to July 1, 2011.

The data warehouse now provides DMHAS with the ability to monitor the length of time that a consumer is exposed to substance abuse treatment. Substance abuse literature suggests that patients with treatment exposures in excess of 90 days have improved outcomes. DMHAS is now developing a report that shows the number and percentage of DMHAS clients that have continuous treatment episodes of 90 days or more. The report definitions and specifications are being developed and DMHAS will be able to report on a full year's worth of data in the next Biennial Report.

8.3 Department policies and guidelines concerning recovery oriented treatment

Substance Use Monitoring

It is in the best interest of DMHAS to wait for a decision from DPH regarding their position on oral swabs for drug testing before the department proceeds with a policy or position. This issue will be covered under DPH's licensing of substance abuse treatment agencies. It will be addressed as an adjustment to DPH's technical bill authorizing this testing and then in DPH proposed regulation revisions that are being developed. DMHAS will revisit this issue in a timeframe that will ensure consistency between the state agencies.

CONNECTICUT

States In Brief



Substance Abuse and Mental Health Issues At-A-Glance

A Short Report from the Office of Applied Studies



Prevalence of Illicit Substance[1] and Alcohol Use

The National Survey on Drug Use and Health (NSDUH) generates state-level estimates for 23 measures of substance use and mental health problems for four age groups: the entire state population over the age of 12 (12+); individuals age 12 to 17; individuals age 18 to 25; and individuals age 26 and older (26+). Since state estimates of substance use and abuse were first generated using the combined 2002–2003 NSDUHs and continuing until the most recent state estimates based on the combined 2005–2006 surveys, Connecticut has been among the 10 States with the *highest*[2] rates on the following measures (Table 1).

Table 1: Connecticut is among those States with the highest rates of the following:

Measure	Age Groups
Past Month Illicit Drug Use	18-25
Past Month Marijuana Use	18-25
Past Year Marijuana Use	18-25
Past Month Alcohol Use	12+, 18-25, 26+

It is worth noting that on the three measures of drug use in Table 1, the rates of use for all age groups have been above the national averages for all survey years.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

This is one in a series of brief state-based reports intended to give the reader a quick overview of substance abuse and mental health issues within a single state. The data derive principally from national surveys conducted by the Office of Applied Studies, a component of the Substance Abuse and Mental Health Services Administration (SAMHSA). Sources for all data used in this report appear at the end.

Abuse and Dependence

Questions in NSDUH are used to classify persons as being dependent on or abusing specific substances based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)* (American Psychiatric Association, 1994).

On the global measure of any abuse of or dependence on illicit drugs or alcohol, Connecticut's rates have generally been at or above the national rates. In 2004–2005 and again in 2005–2006, the rates for those individuals age 18 to 25 were among the highest in the country. It is also worth noting that over the same time period, the rates of alcohol dependence or abuse and illicit drug dependence or abuse were among the highest in the country for this age group (Charts 1 and 2).

Chart 1

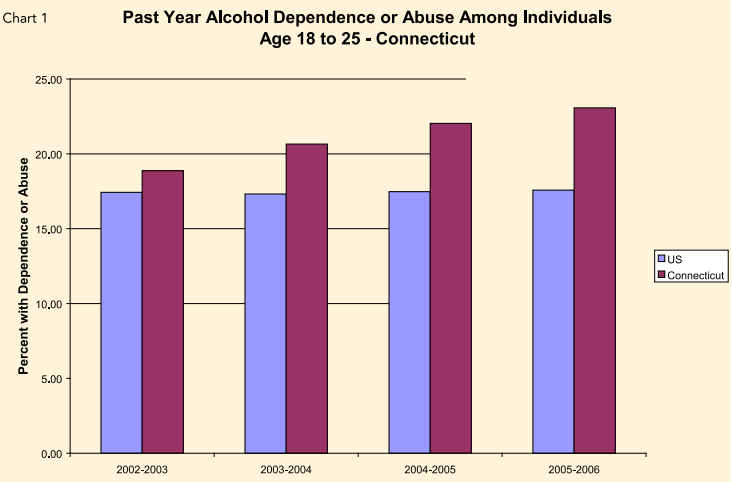
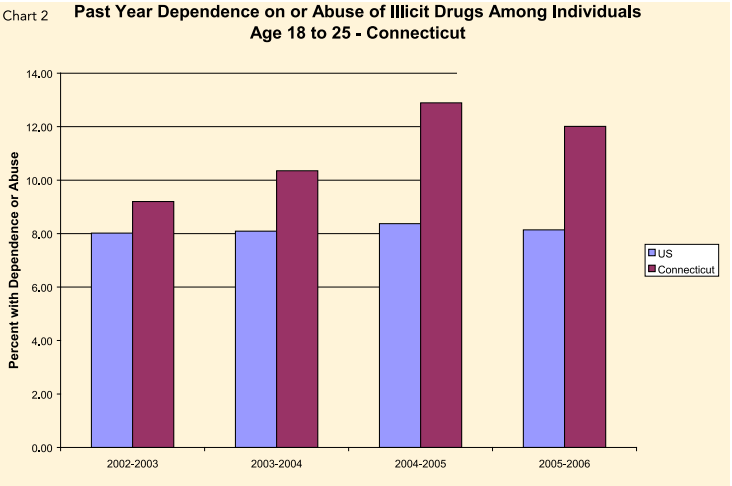


Chart 2



Substance Abuse Treatment Facilities

According to the National Survey of Substance Abuse Treatment Services (N-SSATS)[3] annual surveys, the number of treatment facilities in Connecticut has declined from 247 in 2002, to 209 facilities in 2006. In 2006, the majority of facilities (179 of 209, or 86%) were private nonprofit. An additional 12 facilities were private for-profit. One facility in Connecticut is owned/operated by a Tribal government. The decrease in facilities between 2002 and 2006 is primarily accounted for by the loss of 32 private for-profit facilities and 10 private nonprofit facilities.

Although facilities may offer more than one modality of care, 152 facilities (73%) offer some form of outpatient care. An additional 66 facilities offer some form of residential care, and 41 facilities offer an opioid treatment program. In addition, 171 physicians and 46 treatment programs are certified to provide buprenorphine treatment.

In 2006, 73 percent of all facilities (153) received some form of Federal, State, county, or local government funds, and 142 facilities had agreements or contracts with managed care organizations for the provision of substance abuse treatment services.

Treatment

State treatment data for substance use disorders are derived from two primary sources—an annual one-day census in N-SSATS and annual treatment admissions from the Treatment Episode Data Set (TEDS).[4] In the 2006 N-SSATS survey, Connecticut showed a one-day total of 22,809 clients in treatment, the majority of whom (20,896 or 92 %) were in outpatient treatment. Of the total number of clients in treatment on this date, 645 (3%) were under the age of 18.

Since 1992, there has been a steady increase in the annual number of admissions to treatment; from 39,000 in 1992, to 46,000 in 2006 (the most recent year for which data are available). Chart 3 shows the percent of admissions mentioning particular drugs or alcohol at the time of admission.[5] Across the last 15 years, there has been a steady decline in the number of admissions mentioning alcohol as a substance of abuse; from 78 percent of all admissions in 1992, to 50 percent in 2006. At the same time, the number of admissions mentioning heroin has nearly doubled; from 22 percent in 1992, to 41 percent in 2006.

Across the years for which TEDS data are available, Connecticut has seen a substantial shift in the constellation of problems present at treatment admission. Alcohol-only admissions have declined from over 36 percent of all admissions in 1992, to just over 16 percent in 2006. Concomitantly, drug-only admissions have increased from 22 percent in 1992, to 45 percent in 2006 (Chart 4).

Chart 3

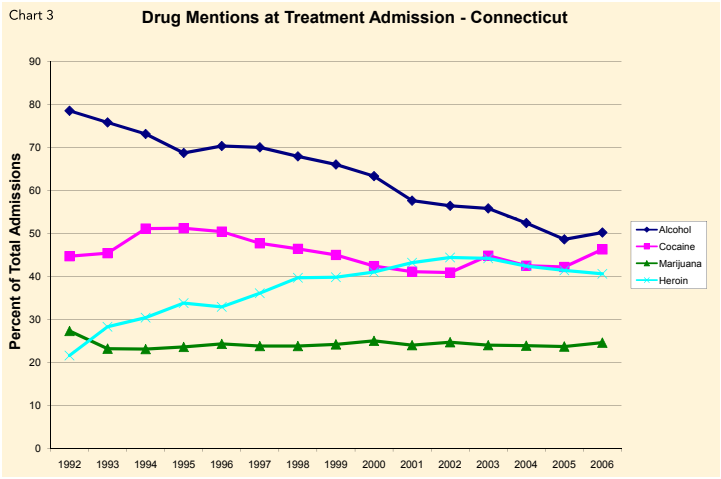
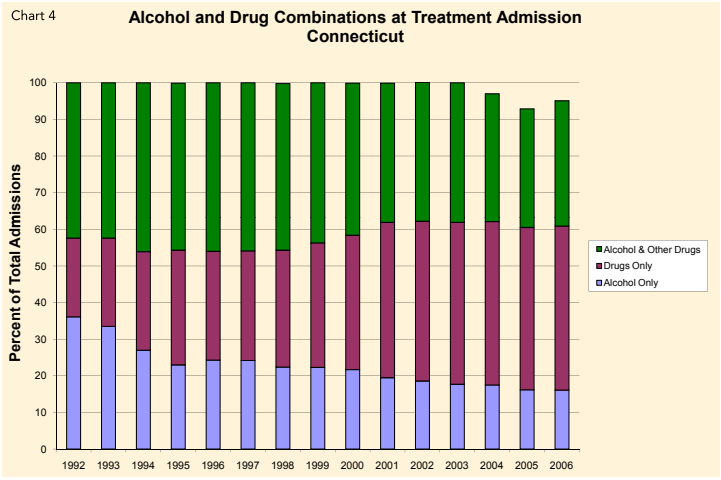


Chart 4



Unmet Need for Treatment

NSDUH defines unmet treatment as an individual who meets the criteria for abuse of or dependence on illicit drugs or alcohol according to the *DSM-IV,* but who has not received specialty treatment for that problem in the past year. Connecticut's rates of unmet need for drug treatment have generally remained at or above the national average. In 2005–2006, the rates of this unmet need for individuals age 12 to 17 and for those age 18 to 25 were among the highest in the Nation (Chart 5).

Similarly, rates of unmet treatment need for alcohol use have generally remained at or above the national rates for all age groups, but especially for those individuals age 18 to 25 (Chart 6).

Chart 5 **Needing and Not Receiving Treatment for Drug Use 2005-2006 Connecticut**

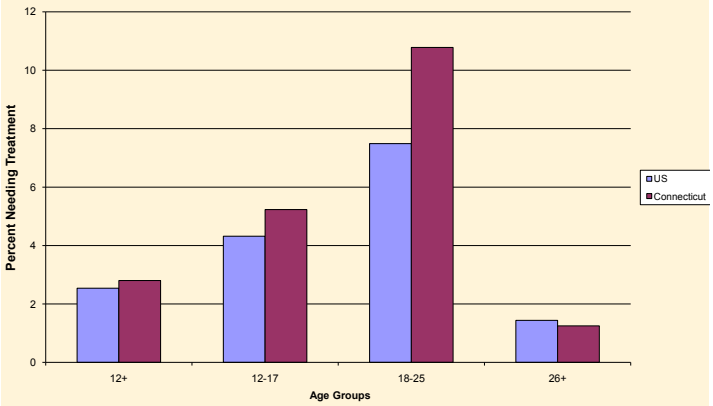
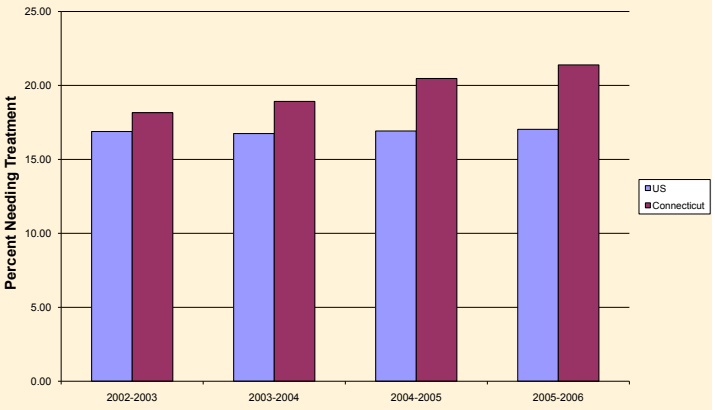


Chart 6 **Needing and Not Receiving Treatment for Alcohol Use Among Individuals Age 18 to 25 - Connecticut**

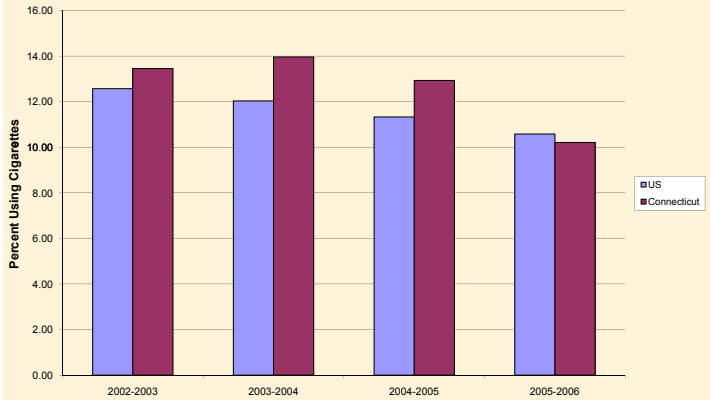


Tobacco Use and Synar Compliance

Connecticut's rates for past month cigarette use and tobacco products use for the State population age 12 and older for all survey years have been among the lowest in the country. However, the rates for underage smokers have generally been at or above the national rate (Chart 7).

SAMHSA monitors the rate of retailer violation of tobacco sales through the Agency's responsibilities under the Synar Amendment. Retailer violation rates represent the percentage of inspected retail outlets that sold tobacco products to a customer under the age of 18. Connecticut's rates of noncompliance with the Synar Amendment have been consistently below the target rate since 1998 (Chart 8).

Chart 7 **Past Month Cigarette Use Among Individuals Age 12 to 17 Connecticut**



Mental Health Indicators

For individuals age 18 and older, the National Survey on Drug Use and Health measures past year serious psychological distress (SPD), an overall indicator of nonspecific psychological distress. Since 2004–2005, the survey also measures past year major depressive episodes (MDE) for the same age group and for individuals age 12 to 17. MDE is defined as a period of 2 weeks or longer during which there is either depressed mood or loss of interest or pleasure, and at least four other symptoms that reflect a change in functioning such as problems with sleep, eating, energy, concentration, and self-image.

In the 2005–2006 analyses, Connecticut's rates on both of these measures for the State population age 18 and older were among the lowest in the country (Charts 9 and 10).

Chart 8

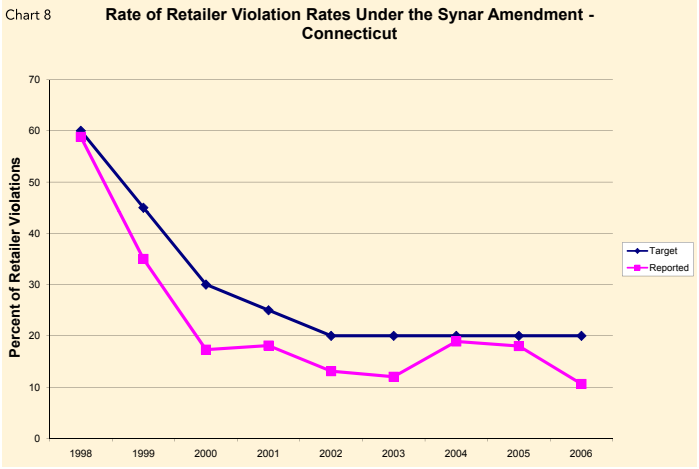


Chart 9

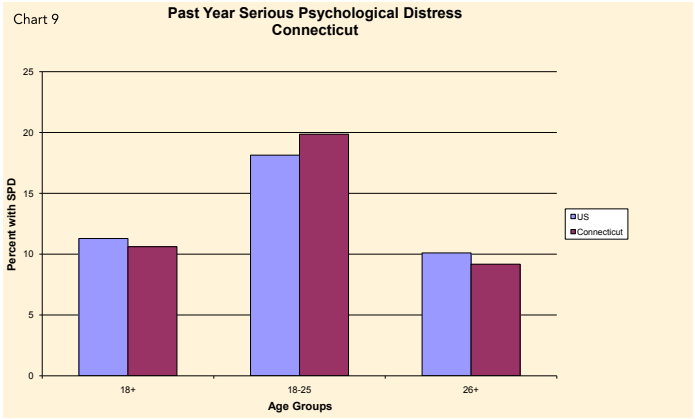
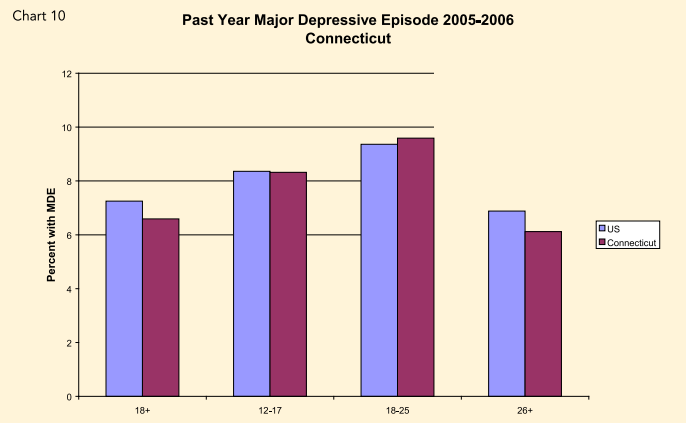


Chart 10



SAMHSA Funding

SAMHSA funds two basic types of grants—block and formula grants allocated to states and territories by formula, and discretionary grants which are awarded competitively (Chart 11). Each of the three SAMHSA Centers (Center for Substance Abuse Treatment [CSAT], the Center for Substance Abuse Prevention [CSAP] and the Center for Mental Health Services [CMHS]) has a unique discretionary portfolio.

2004–2005:	
$16.9 million	Substance Abuse Prevention and Treatment Block Grant
$5.5 million	Mental Health Block and Formula Grants
$22.8 million	SAMHSA Discretionary Program Funds
$45.2 million	Total SAMHSA Funding

CMHS: State Mental health Data Infrastructure Grant; Children's Services; Youth Violence Prevention; Jail Diversion; Emergency Response (mental health); Statewide Family Networks; AIDS Targeted Capacity Expansion—Service Capacity Building in Minority Communities; Past-Traumatic Stress Disorder in Children.

CSAP: Drug-Free Communities (20 grants); Drug-Free Communities—Mentoring; HIV/AIDS Services; Strategic Prevention Framework State Incentive Grant; State Incentive Cooperative Agreement; Ecstasy and Other Club Drug Prevention.

CSAT: Targeted Capacity Expansion—HIV/AIDS; Targeted Capacity Expansion—Innovative Treatment; Strengthening Communities—Youth; Access to Recovery; Recovery Community Support—Recovery; State Data Infrastructure; Effective Adolescent Treatment; and SAMHSA Dissertation Grants.

2005–2006:	
$16.7 million	Substance Abuse Prevention and Treatment Block Grant
$5.5 million	Mental Health Block and Formula Grants
$28.8 million	SAMHSA Discretionary Program Funds
$51.0 million	Total SAMHSA Funding

CMHS: Children's Services; Child Mental Health Initiative; Mental Health Transformation State Incentive Grant; Co-Occurring State Incentive Grant; State Mental health Data Infrastructure Grant; Jail Diversion; Statewide Family Networks; AIDS Targeted Capacity Expansion—Service Capacity Building in Minority Communities; Community Treatment and Service Centers of the National Child Traumatic Stress Initiative; National Child Traumatic Stress Initiative—Treatment and Service Adaptation Centers.

CSAP: Drug-Free Communities (18 grants); Drug-Free Communities—Mentoring; Strategic Prevention Framework State Incentive Grant; State Incentive Cooperative Agreement; HIV Strategic Prevention Framework; Ecstasy and Other Club Drug Prevention.

CSAT: Targeted Capacity Expansion—HIV/AIDS; Targeted Capacity Expansion—Innovative Treatment; Strengthening Communities—Youth; Access to Recovery; SAMHSA Conference Grant; State Adolescent Substance Abuse Treatment; Targeted Capacity Expansion—Campus Screening/ Colleges and Universities; Recovery Community Support—Recovery; Homeless Addictions Treatment; and Effective Adolescent Treatment.

2006–2007:	
$16.7 million	Substance Abuse Prevention and Treatment Block Grant
$5.5 million	Mental Health Block and Formula Grants
$28.8 million	SAMHSA Discretionary Program Funds
$51.0 million	Total SAMHSA Funding

CMHS: Child Mental Health Initiative; Mental Health Transformation State Incentive Grant; Co-Occurring State Incentive Grant; State Mental health Data Infrastructure Grant; Youth Suicide Prevention and Early Intervention; Children's Services; Jail Diversion; Statewide Family Network; Campus Suicide; Community Treatment and Service Centers of the National Child Traumatic Stress Initiative; National Child Traumatic Stress Initiative—Treatment and Service Adaptation Centers.

CSAP: Drug-Free Communities (15 grants); Drug-Free Communities—Mentoring; Strategic Prevention Framework State Incentive Grant; State Incentive Cooperative Agreement; HIV Strategic Prevention Framework.

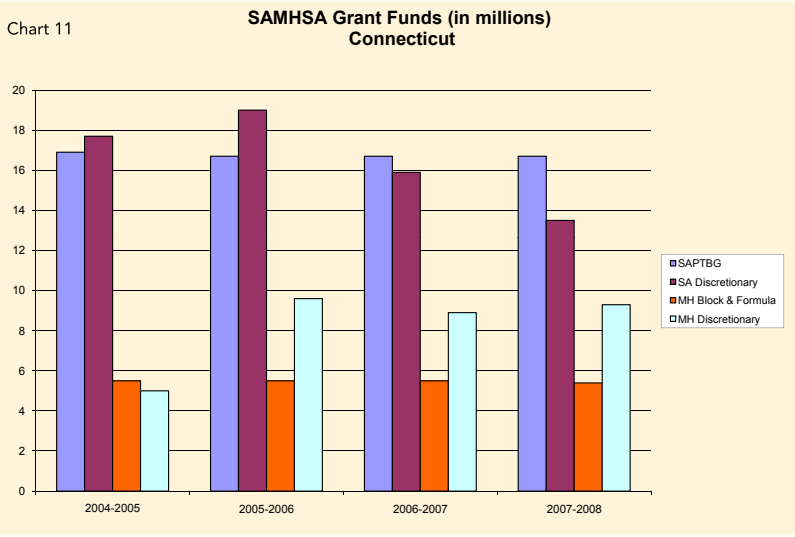
CSAT: Targeted Capacity Expansion—HIV/AIDS; Targeted Capacity Expansion—Innovative Treatment; Strengthening Communities—Youth; Access to Recovery; SAMHSA Conference Grant; State Adolescent Substance Abuse Treatment; Targeted Capacity Expansion—Campus Screening/ Colleges and Universities; Recovery Community Support—Recovery; Homeless Addictions Treatment; and Effective Adolescent Treatment.

2007–2008:	
$16.7 million	Substance Abuse Prevention and Treatment Block Grant
$5.5 million	Mental Health Block and Formula Grants
$28.8 million	SAMHSA Discretionary Program Funds
$51.0 million	Total SAMHSA Funding

CMHS: Child Mental Health Initiative; State Mental health Data Infrastructure Grant; Seclusion and Restraint; Mental Health Transformation State Incentive Grant; Statewide Consumer Network; Co-Occurring State Incentive Grant; Youth Suicide Prevention and Early Intervention; Jail Diversion; Statewide Family Networks; Community Treatment and Service Centers of the National Child Traumatic Stress Initiative; National Child Traumatic Stress Initiative—Treatment and Service Adaptation Centers.

CSAP: Drug-Free Communities (17 grants); Drug-Free Communities—Mentoring; Strategic Prevention Framework State Incentive Grant.

CSAT: State Adolescent Substance Abuse Treatment; Access to Recovery; Targeted Capacity Expansion—HIV/AIDS; Targeted Capacity Expansion—Campus Screening/ Colleges and Universities; and Homeless Addictions Treatment.





For Further Information

A comprehensive listing of all NSDUH measures for every state is available at: **http://oas.samhsa.gov/statesList.cfm**.

Also, information about variations in incidence and prevalence of the NSDUH substance abuse and mental health measures within each state is available at: **http://oas.samhsa.gov/metro.htm**.

Data Sources

Grant Awards: **http://www.samhsa.gov/statesummaries/index.aspx**.

Facility Data: National Survey of Substance Abuse Treatment Services (N-SSATS)—2006 available at: **http://www.dasis.samhsa.gov**.

Treatment Data: Treatment Episode Data Set—Concatenated File—available from the Substance Abuse and Mental Health Data Archive: **http://www.icpsr.umich.edu/SDA/SAMHDA**.

[1] NSDUH defines *illicit drugs* to include marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, or prescription-type drugs used nonmedically. Nonmedical use is defined as use not prescribed for the respondent by a physician or used only for the experience or feeling the drug(s) caused. Nonmedical use of any prescription-type pain reliever, sedative, stimulant, or tranquilizer does not include over-the-counter drugs. Nonmedical use of stimulants includes methamphetamine use.

[2] States are assigned to one of five groups according to their ranking (quintiles). Because there are 51 areas to be ranked for each measure, the middle quintile was assigned 11 areas and the remaining groups 10 each. Throughout this document "highest" refers to the 10 states in the first quintile and "lowest" to those in the fifth quintile.

[3] N-SSATS is designed to collect information from all facilities in the United States, both public and private, that provide substance abuse treatment. N-SSATS does not collect information from the following three types of facilities: non-treatment halfway houses; jails, prisons, or other organizations that treat incarcerated clients exclusively; and solo practitioners.

[4] TEDS is an admissions-based system, and TEDS admissions do not represent individuals. For example, an individual admitted to treatment twice within a calendar year would be counted as two admissions.

[5] TEDS collects information on up to three substances of abuse that lead to the treatment episode. These are not necessarily a complete enumeration of all drugs used at the time of admission.

Prevalence Data

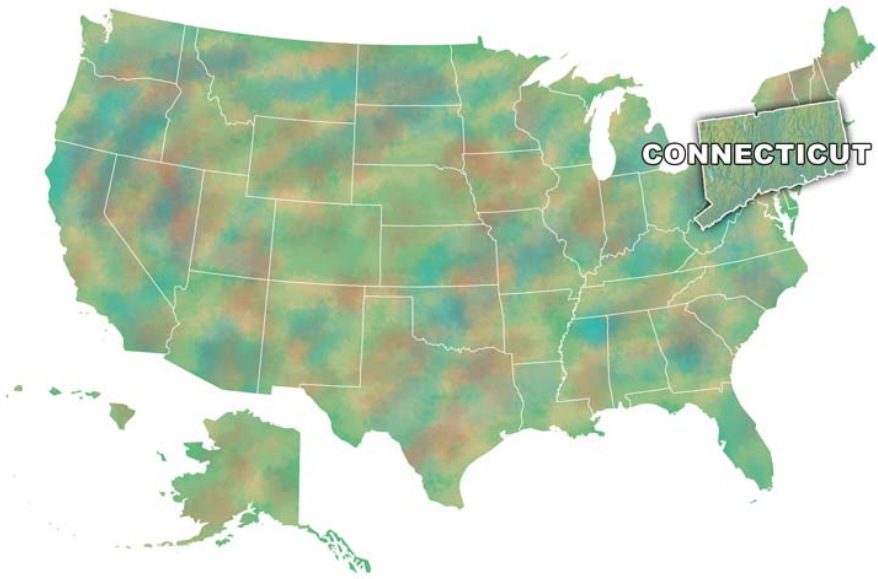
Wright, D. & Sathe, N. (2005) *State Estimates of Substance Use from the 2002-2003 National Surveys* on Drug Use and Health (DHHS Publication No. SMA-05-3989, NSDUH Series H-26) Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Wright, D. & Sathe, N. (2006) *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health* (DHHS Publication No. SMA-06-4142, NSDUH Series H-29) Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Wright, D., Sathe, N. & Spagnola, K. (2007) *State Estimates of Substance Use from the 2004-2005 National Surveys on Drug Use and Health* (DHHS Publication No. SMA-07-4235, NSDUH Series H-31) Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Hughes, A. & Sathe, N. (2008) *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health* (DHHS Publication No. SMA-08-4311, NSDUH Series H-33) Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services



CONNECTICUT

State Profile and Underage Drinking Facts[39]

State Population	3,501,252	
Population-Ages 12-20	425,000	
	Percentage	**Number**
Ages 12-20		
Past-Month Alcohol Use	32.3	137,000
Past-Month Binge Alcohol Use	23.5	100,000
Ages 12-14		
Past-Month Alcohol Use	5.9	8,000
Past-Month Binge Alcohol Use	2.8	4,000
Ages 15-17		
Past-Month Alcohol Use	32.3	51,000
Past-Month Binge Alcohol Use	22.5	35,000
Ages 18-20		
Past-Month Alcohol Use	60.7	78,000
Past-Month Binge Alcohol Use	47.1	61,000

[39] Overall population information is taken from 2008 population estimates based on 2000 Census data. Data about the portion of each State's population comprised of 12- to 20-year-olds is averaged from 2005, 2006, 2007, and 2008 NSDUHs (SAMHSA, CBHSQ, NSDUH, special data analysis, 2009), as are facts about past-month alcohol use and binge use. Additional references for data in this section can be found in Appendix C.

Alcohol-Attributable Deaths (under 21)		34
Years of Potential Life Lost (under 21)		1,976
Traffic Fatalities, 15- to 20-Year-Old Drivers With BAC >.01	22.0	8

Laws Addressing Minors in Possession of Alcohol

Underage Possession of Alcohol

Possession is prohibited WITH THE FOLLOWING EXCEPTION(S):

- Private location OR
- Parent/guardian presence and consent OR
- Spouse

Underage Consumption of Alcohol

Consumption is not explicitly prohibited.

Internal Possession by Minors

Internal possession is not explicitly prohibited.

Underage Purchase of Alcohol

Purchase is prohibited, but youth may purchase for law enforcement purposes.

False Identification for Obtaining Alcohol

Provision(s) targeting minors

- Use of a false ID to obtain alcohol is a criminal offense
- Penalty may include driver's license suspension through a judicial procedure

Provisions targeting retailers

- State provides incentives to retailers who use electronic scanners that read birth dates and other information digitally encoded on valid identification cards
- Licenses for drivers under age 21 are easily distinguishable from those for drivers age 21 and older
- Specific affirmative defense: the retailer inspected the false ID and came to a reasonable conclusion based on its appearance that it was valid

Laws Targeting Underage Drinking and Driving

BAC Limits: Youth (Underage Operators of Noncommercial Motor Vehicles)

- BAC limit: 0.02
  - BAC at or above the limit is *per se* (conclusive) evidence of a violation
  - Applies to drivers under age 21

Loss of Driving Privileges for Alcohol Violations by Minors ("Use/Lose Laws")

Use/lose penalties apply to minors under age 21.

Type(s) of violation leading to driver's license suspension, revocation, or denial:

- Underage possession

Authority to impose driver's license sanction:

- Mandatory

Length of suspension/revocation:

- 30 days

Graduated Driver's License

Learner stage

- Minimum entry age: 16
- Minimum learner stage period:
  - 4 months —with driver education
  - 6 months—without driver education
- Minimum supervised driving requirement: 40 hours

Intermediate stage

- Minimum age: 16 years, 4 months
- Unsupervised night driving:
  - Prohibited after 11 p.m.
  - Primary enforcement of the night driving rule
- Passenger restrictions exist:
  - First 6 months—limited to one parent, instructor, or licensed adult who is at least 20 years old
  - Second 6 months—expands to include immediate family
  - Primary enforcement of the passenger restriction rule

License stage

- Minimum age to lift restrictions: 18
- Passenger restrictions expire 12 months after issuance of intermediate license
- Unsupervised night driving restrictions remain until age 18

Notes: A parent or guardian of any applicant less than 18 to whom a learner's permit is issued on or after August 1, 2008 shall attend two hours of safe driving instruction with such applicant.

Laws Targeting Alcohol Suppliers

Furnishing of Alcohol to Minors

Furnishing is prohibited WITH THE FOLLOWING EXCEPTION(S):

- Parent/guardian OR
- Spouse

Responsible Beverage Service

No beverage service training requirement.

Minimum Ages for Off-Premises Sellers

- Beer 15
- Wine 18
- Spirits 18

Minimum Ages for On-Premises Sellers

- Beer 18 for both servers and bartenders
- Wine 18 for both servers and bartenders
- Spirits 18 for both servers and bartenders

Dram Shop Liability

Statutory liability exists subject to the following conditions:

- Limitations on damages: $250,000.
- Limitations on elements/standards of proof: Minor must be intoxicated at time of service.
- The courts recognize common law dram shop liability

Notes: A common law cause of action is not precluded by the dram shop statute. Under common law, the limitations on damages may be avoided.

Social Host Liability

There is no statutory liability. The courts recognize common law social host liability.

Host Party Laws

Social host law is not specifically limited to underage drinking parties:

- Action by underage guest that triggers violation: possession
- Property type(s) covered by liability law: residence, outdoor, other
- Standard for hosts' knowledge or action regarding the party: KNOWLEDGE—host must have actual knowledge of the occurrence
- Preventive action by the host negates the violation (see note)
- Exception(s): family

Notes: The "preventive action" provision in Connecticut requires the prosecution to prove that the host failed to take preventive action.

Direct Sales/Shipments From Producers to Consumers

Direct sales/shipments from producers to consumers are permitted for wine with the following restrictions:

Age verification requirements

- Producer must verify age of purchaser: ID check is required at some point prior to delivery.
- Common carrier must verify age of recipient: ID check required at some point prior to delivery.

State approval/permit requirements

- Producer/shipper must obtain State permit
- State must approve common carrier

Reporting requirements

- Producer must record/report purchaser's name
- Common carrier must record/report purchaser's name

Shipping label statement

- Contains alcohol
- Recipient must be 21

Keg Registration

Keg definition: 6 gallons or more.

Prohibited

- Possessing an unregistered, unlabeled keg—max. fine/jail: $500 or 3 months

Purchaser information collected

- Purchaser's name and address: verified by a government-issued ID
- Warning information to purchaser: passive—no purchaser action required
- Deposit: not required
- Provisions do not specifically address disposable kegs

U.S. Department of Justice
National Drug Intelligence Center

New England
High Intensity Drug Trafficking Area

Drug Market Analysis 2011

Source Summary Statement

The National Drug Intelligence Center (NDIC) has high confidence in this drug market analysis as it is based on multiple sources of information that have proved highly reliable in prior NDIC, law enforcement, and intelligence community reporting. Quantitative data, including seizure, eradication, and arrest statistics, were drawn from data sets maintained by federal, state, or local government agencies. Discussions of the prevalence and consequences of drug abuse are based on published reports from U.S. Government agencies and interviews with public health officials deemed reliable because of their expertise in the diagnosis and treatment of drug abuse. Trends and patterns related to drug production, trafficking, and abuse were identified through detailed analysis of coordinated counterdrug agency reporting and information. NDIC intelligence analysts and field intelligence officers obtained this information through numerous interviews with law enforcement and public health officials (federal, state, and local) in whom NDIC has a high level of confidence based on previous contact and reporting, their recognized expertise, and their professional standing and reputation within the U.S. counterdrug community. This report was reviewed and corroborated by law enforcement officials who have jurisdiction in the New England High Intensity Drug Trafficking Area and possess an expert knowledge of its drug situation.

U.S. Department of Justice
National Drug Intelligence Center

2011-R0813-018

September 2011

New England
High Intensity Drug Trafficking Area

Drug Market Analysis 2011

This assessment is an outgrowth of a partnership between the NDIC and HIDTA Program for preparation of annual assessments depicting drug trafficking trends and developments in HIDTA Program areas. The report has been coordinated with the HIDTA, is limited in scope to HIDTA jurisdictional boundaries, and draws upon a wide variety of sources within those boundaries.

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Executive Summary

The overall drug threat to the New England (NE) High Intensity Drug Trafficking Area (HIDTA) region remained fairly consistent during the past year. Opioid abuse—primarily of South American heroin and controlled prescription opioids—remains the most significant drug threat to the NE HIDTA region, according to federal, state, and local law enforcement agencies and public health officials, and there are no signs that this problem will abate in the near term. Treatment admission rates for heroin and prescription opioid pain relievers in the region are among the highest in the nation, and the demand for these services continues to outstrip availability. Moreover, controlled prescription opioid abusers are fueling the heroin abuse problem in the NE HIDTA region as a rising number of them switch to heroin because of its wide availability, higher potency, and greater affordability.

Cocaine distribution and abuse had a negative impact on the region in 2010, contributing to high levels of crime and straining healthcare systems The threat posed to the region by marijuana rose during 2010, with cultivation of the drug increasing substantially. Many cannabis growers are exploiting state medical marijuana laws to cultivate illicit crops under the guise of the laws. Violent street gangs, which are active in each state in the region, are interwoven through the entire spectrum of illicit drug trafficking. Law enforcement reporting indicates that gang members increasingly obtain and use firearms to protect themselves and their drug distribution territories.

Key issues identified in the New England HIDTA region include the following:

- Opioid abuse—primarily of heroin and controlled prescription opioids—poses the most significant drug threat to the NE HIDTA region and places a significant burden on law enforcement and public health resources.

- The trafficking and abuse of cocaine pose significant threats to the NE HIDTA region by contributing to high levels of associated criminal activity and threatening the public welfare.

- Marijuana availability is high and increasing in the region. Criminals are exploiting state medical marijuana laws to increase cannabis cultivation.

- Street gangs in the region derive most of their income from drug distribution. They are prone to violence and have been linked to increasing reports of weapons possession.

Key Issues[a]

Opioid abuse—primarily of heroin and controlled prescription opioids—poses the most significant drug threat to the NE HIDTA region and places a significant burden on law enforcement and public health resources in the region.

Law enforcement agencies and public health officials report that opioid abuse is widespread throughout the NE HIDTA region, resulting in significant negative societal impacts. According to National Drug Intelligence Center (NDIC) National Drug Threat Survey (NDTS) 2011[b] data, 174 of the 263 state and local law enforcement agency respondents in the NE HIDTA region identify opioids—controlled prescription drugs (CPDs) (97) and heroin (77)—as the greatest drug threat in their jurisdictions. A significant number of NDTS respondents also identify opioids as the category of drugs that most contributes to both violent and property crime in the region. (See Table 1 on page 3.) Crime associated with opioid abuse is increasing in the region as indicated by Drug Enforcement Administration (DEA) arrest data. To illustrate, the total number of cocaine-related arrests in the region from 2006 through 2010 exceeded those for any other drug types during that period. However, 2010 was markedly different as law enforcement made 509 opioid-related arrests—310 for heroin and 199 for prescription opioids—exceeding those for cocaine (497).[1] Prescription opioid-related arrests are a particular concern in Maine, where they accounted for 40 percent of the state-reported drug arrests in 2009 (the latest available data), the most for any drug category.[2] Much of the crime associated with prescription opioids results from the illegal methods and means that abusers use to obtain them.[3] Controlled prescription opioid abusers illicitly obtain their drug supplies through doctor-shopping, Internet pharmacies, prescription fraud, and theft; they also acquire them through publicly funded health programs.[4] (See textbox.)

Pharmacy Robberies Increase in Maine

The number of pharmacy robberies in Maine increased fivefold from 2009 (4) to 2010 (21).[5] To address the increasing number of CPD thefts from pharmacies, the United States Attorney for the District of Maine established a protocol in January 2011 that provides federal resources to assist in investigating and prosecuting these crimes.[6]

a. For a general overview of the drug threat in the New England HIDTA region, see Appendix A.

b. The NDTS is conducted annually by NDIC to solicit information from a representative sample of state and local law enforcement agencies. NDIC uses this information to produce national, regional, and state estimates of various aspects of drug trafficking activities. NDTS data reflect agencies' perceptions based on their analysis of criminal activities that occurred within their jurisdictions during the past year. NDTS 2011 data cited in this report are raw, unweighted responses from federal, state, and local law enforcement agencies solicited through either NDIC or the Office of National Drug Control Policy (ONDCP) HIDTA program as of March 1, 2011.

Table 1. Greatest Drug Threat and Drug Most Contributing to Violent or Property Crime in the NE HIDTA Region, by NDTS 2011 Respondents

Drug	Greatest Drug Threat	Most Contributes to Violent Crime	Most Contributes to Property Crime
Crack Cocaine	41	67	32
Powder Cocaine	11	21	9
Heroin	77	56	97
CPDs	97	65	97
Marijuana	26	21	18
Powder Methamphetamine	8	4	1
Ice Methamphetamine	0	1	0
Other Dangerous Drugs	1	1	1
No Response or Not Applicable	2	17	3
Don't Know	0	10	5

Source: National Drug Threat Survey 2011.

Opioid abuse also has a tremendous impact on public health and places a significant burden on state and local drug treatment services.[7] For example, opioids were mentioned in the majority of drug-related deaths reported in the five New England states for which such data are available[c] (see Table B1 in Appendix B). A significant number of drug-related deaths in New England have also been attributed to the abuse of opioid addiction treatment drugs, such as methadone and buprenorphine, often in conjunction with benzodiazepines.[8] Treatment data further reflect the magnitude of the opioid abuse problem in New England.[d] Treatment Episode Data Set reporting indicates that the number of heroin-related treatment admissions to publicly funded facilities in New England exceeded admissions related to all other illicit substances combined from 2003 through 2009, the latest complete year for which such data are available.[9] Heroin and other opioid-related treatment admissions trended upward during that period, and in 2009, they accounted for approximately 74 percent of all illicit drug-related treatment admissions in the region (see Figure 1 on page 4). Preliminary data for the first three quarters of 2010 indicate that opioid-related treatment admissions in the region remained at levels comparable to those of the previous year.[10]

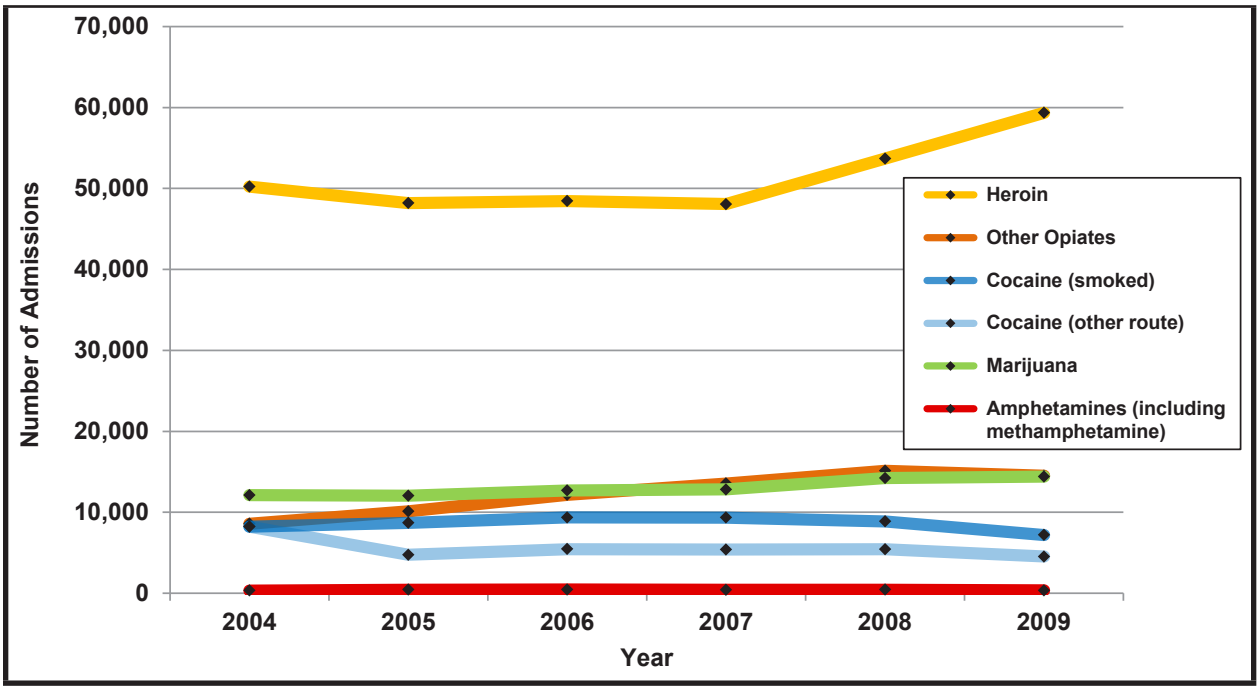
High levels of opioid abuse place a substantial burden on treatment services in the region. The number of individuals in New England who are in need of treatment services currently exceeds available resources, and waiting lists exist for those seeking treatment.[11] For example, the rates of unmet drug treatment need for all age groups in Massachusetts ranged from 6.8 percent to 8.8 percent from 2006 through 2009. Additionally, the rates for unmet drug treatment need for those aged 18 to 25 in the state have consistently been among the highest in the nation at 9 percent, versus the national average of 7 percent.[12] Additionally, opioid-related inquiries accounted for the highest percentage of all substance abuse-related nonemergency information calls to the Northern New England Poison Center hotline from 2005 through 2010[13] (see Figure B1 in Appendix B). During

c. State Medical Examiner data, Connecticut, Maine, Massachusetts, New Hampshire, and Vermont.

d. Substance abuse treatment data included in this section represent services provided through publicly funded programs in New England; additional data for comparable services provided through private insurers are unavailable.

this period, the majority of opioid-related calls to the hotline, which serves Maine, New Hampshire, and Vermont, were for incidents involving oxycodone products—hydrocodone products and morphine products, respectively, accounted for the second- and third-highest number of calls.[14]

Figure 1. Drug-Related Treatment Admissions to Publicly Funded Facilities in New England, 2004–2009



Source: Treatment Episode Data Set.

The Impact of Reformulated OxyContin on Abuse Levels in New England

OxyContin abuse in New England continues to evolve following the reformulation of domestic supplies of the drug in 2010. Reformulated OxyContin includes additional inactive ingredients to deter abusers from snorting or injecting the drug. The new tablets are difficult to cut, break, chew, crush, or dissolve, thereby deterring abuse of the drug. Recent indicators suggest, however, that some OxyContin abusers are using methods that circumvent the physical properties of the new formulation, others obtain supplies from foreign countries where the drug has not been reformulated, and a significant number of abusers appear to be switching to other types of prescription opioids (such as immediate-release oxycodone products and immediate- or extended-release oxymorphone products) or heroin.[15]

Controlled prescription opioid abusers are fueling the heroin abuse problem in the NE HIDTA region as an increasing number of them switch to heroin because of its wide availability and greater affordability.[16] Abusers typically begin their opioid addiction by abusing Percocet and Vicodin and, after developing a tolerance, often progress to OxyContin or other immediate-release oxycodone products and immediate- or extended-release oxymorphone products before ultimately switching to heroin when they can no longer locate a supply or afford the high cost of controlled prescription

opioids.[17] Some opioid addicts continue to abuse both prescription opioids and heroin, obtaining each based upon availability or affordability of the drug to the user at the time.[18] When compared with controlled prescription opioids, street level heroin prices remain relatively low in the region depending on the distributor and market location.[19] For example, oxycodone abusers with a high tolerance may typically ingest 400 milligrams of the drug daily (five 80-mg tablets) at a cost of $400 when purchased at the street level. These abusers could maintain their addictions with 2 grams of heroin daily, at a cost of one-third to one-half that of prescription opioids, depending on the price and purity of the heroin.[20]

The trafficking and abuse of cocaine pose significant threats to the NE HIDTA region by contributing to high levels of associated criminal activity and threatening the public welfare.

Cocaine in both powder and crack form poses significant challenges to law enforcement and health providers throughout the region. According to NDTS 2011 data, 52 of the 263 state and local law enforcement agency respondents in the NE HIDTA region identify cocaine as the greatest drug threat in their jurisdictions. Further, 88 of the respondents identify cocaine as the drug that most contributes to violent crime, while 41 identify cocaine as contributing most to property crime. Law enforcement officers report that the abuse and distribution of crack cocaine spark much of the drug-related violence among rival inner-city street gangs within the region and that nearly half of all DEA drug-related arrests in the NE HIDTA region from 2006 through 2010 were associated with cocaine.[21] During 2010, the number of cocaine-related arrests in the region (497) was exceeded only by the number of opioid-related arrests (509). Crack availability has expanded in many northern New England cities, such as Burlington, Manchester, and Portland, largely because African American and Hispanic criminal groups and street gangs from southern New England states and New York City have increased distribution in those areas.[22] Approximately 218 kilograms of powder cocaine and 16 kilograms of crack cocaine were seized through HIDTA initiatives during 2010[23] (see Table B2 in Appendix B). The number of cocaine-related treatment admissions in New England remained fairly constant from 2004 through 2008, with a slight drop during 2009[24] (see Figure 1 on page 4). While exact figures are difficult to quantify because of differing reporting requirements across the New England states, medical examiner reporting generally indicates that cocaine contributed to numerous drug-related deaths in the region during 2010.[25] Samples of cocaine tested in New England have been found to contain the harmful adulterant levamisole, which can cause serious health consequences for cocaine abusers.[26]

Marijuana availability is high and increasing in the region. Criminals are exploiting state medical marijuana laws to increase cannabis cultivation.

Marijuana trafficking and abuse are pervasive throughout the NE HIDTA region, where sales of the drug can generate large profits for traffickers.[27] According to NDTS 2011 data, 244 of the 263 state and local law enforcement agency respondents in the NE HIDTA region characterize marijuana availability as high in their jurisdictions. Supplies of commercial-grade Mexican marijuana and high-potency marijuana from domestic and Canadian suppliers are readily available and increasing.[28] Law enforcement officials seized approximately 12,000 kilograms of marijuana in conjunction with NE HIDTA initiatives during 2010 (see Table B2 in Appendix B), compared with 8,800 kilograms in 2009 and 6,700 kilograms in 2008.[29]

Law enforcement officials believe that medical marijuana programs in Maine, Rhode Island, and Vermont are contributing to increased cannabis cultivation and the prevalence of marijuana

in the region.[30] Some of the marijuana purportedly produced for medical marijuana patients is being diverted for nonmedical use.[31] Additionally, some trafficking groups are expanding their illicit cannabis cultivation operations under the umbrella of these medical programs.[32] As such, the total number of cannabis plants eradicated at cultivation sites in New England during 2010 increased to the second-highest level in the region since 2005.[33] (See Table 2.)

Table 2. Cannabis Plants Eradicated at Indoor and Outdoor Cultivation Sites in the New England HIDTA Region, 2005–2010

	2005	2006	2007	2008	2009	2010
Indoor cultivation sites	2,712	15,337	5,277	5,671	10,047	12,761
Outdoor cultivation sites	11,054	13,622	14,486	7,430	10,636	13,466
Total	**13,766**	**28,959**	**19,763**	**13,101**	**20,683**	**26,227**

Source: Domestic Cannabis Eradication/Suppression Program.

Street gangs in the region derive most of their income from drug distribution. They are prone to violence and have been linked to increasing reports of weapons possession.

African American, Asian, and Hispanic neighborhood gangs are major mid- and retail-level polydrug distributors in the NE HIDTA region.[34] The majority of street gangs in the region are small, poorly organized neighborhood gangs; however, some nationally recognized gangs such as 18th Street, Almighty Latin King/Queen Nation (ALKQN), Asian Boyz, Bloods, Crips, La Familia, Latin Gangster Disciples, Los Solidos, Mara Salvatrucha (MS 13), Ñetas, Sureños (SUR 13), and Tiny Rascal Gangsters (TRG) are also active in drug distribution in the region.[35] Street gangs derive most of their income from the distribution of powder cocaine, crack cocaine, CPDs, heroin, marijuana, and other dangerous drugs (ODDs), as well as limited amounts of PCP (phencyclidine). Law enforcement reporting indicates that street gangs are currently operating in every New England state.[36]

Law enforcement officers report that street gangs in New England are linked to a considerable percentage of the violent and property crime in the region.[37] Street gangs often commit crimes such as robbery, assault, and homicide in order to defend or expand territories, gain financially, or establish and maintain their reputation.[38] Law enforcement officers further report that firearm seizures from street gang members are increasing as traffickers arm themselves to reduce the threat of being robbed of their drugs or illicit proceeds by other gangs, a situation that poses a significant threat to law enforcement, first responders, and the public in general.[39]

National Initiative Targets Members of Violent Gangs in New England

In March 2010, U.S. Immigration and Customs Enforcement officials announced the results of Project Southern Tempest, a nationwide enforcement effort that targeted violent gangs whose members were affiliated with transnational drug trafficking organizations (DTOs). The 168-city operation targeted a total of 133 different gangs and resulted in the arrest of 678 gang members or associates. Of those arrested, 447 were charged with criminal offenses, 231 were charged administratively, 322 had violent criminal histories, and 421 were foreign nationals. During the operation, 21 of the 25 individuals arrested in Massachusetts, Maine, and New Hampshire were gang members, 9 of whom were charged with criminal offenses and 16 with immigration offenses. Law enforcement officials in the region also seized numerous weapons, including five handguns and two assault weapons, as well as approximately 36 grams of crack cocaine and a small quantity of heroin.

Source: U.S. Immigration and Customs Enforcement, Boston Field Office.

Outlook

NDIC assesses with high confidence[e] that the abuse of opioids (heroin and controlled prescription opioids) will remain the primary drug threat to the New England HIDTA region over the next year, continuing to place a significant burden on already strained law enforcement and public health resources. NDIC assesses with medium confidence that the number of heroin overdose incidents will increase if OxyContin abusers are driven to abandon the drug (as a result of its domestic antiabuse reformulation) and transition to more affordable, more potent, and more readily available heroin.

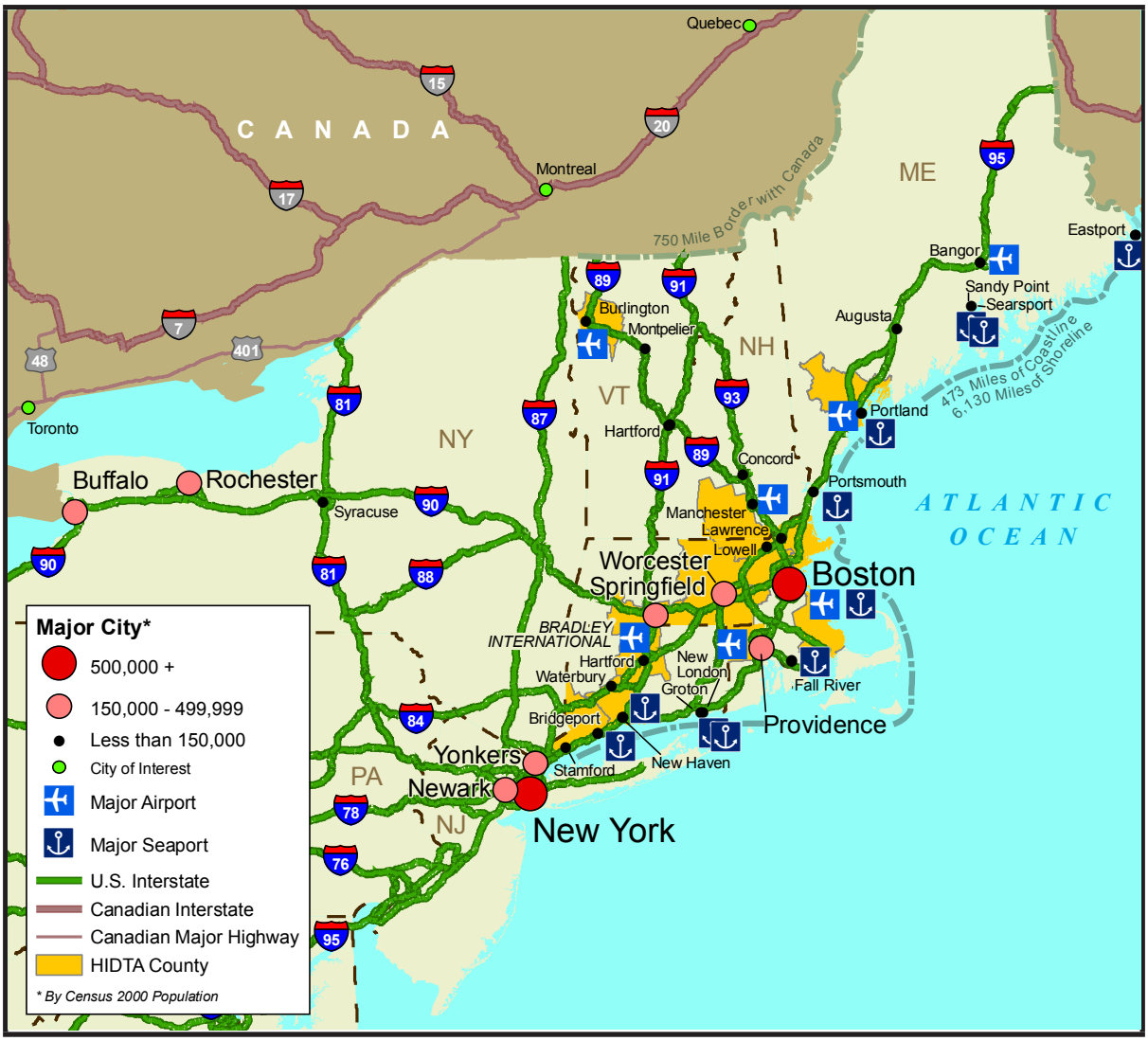
NDIC assesses with high confidence that cannabis cultivation and marijuana availability in the region will remain at high levels as traffickers and growers take advantage of the various state medical marijuana laws. Producers and distributors of high-potency marijuana have ample incentive to traffic the drug, since the profit margin for marijuana is high in the region.

NDIC assesses with high confidence that violence and drug distribution involving street gangs in New England will continue to increase as these gangs compete for illicit drug markets in the region. Law enforcement reports of increasing weapon seizures from gang members indicate that levels of gang-related violence will increase.

e. **High Confidence** generally indicates that the judgments are based on high-quality information or that the nature of the issue makes it possible to render a solid judgment. **Medium Confidence** generally means that the information is credibly sourced and plausible but can be interpreted in various ways, or is not of sufficient quality or corroborated sufficiently to warrant a higher level of confidence. **Low Confidence** generally means that the information is too fragmented or poorly corroborated to make a solid analytic inference, or that there are significant concerns or problems with the sources.

Appendix A. New England HIDTA Overview

Map A1. New England High Intensity Drug Trafficking Area



The NE HIDTA region comprises 13 counties in six states, including six counties in Massachusetts, three in Connecticut, and one each in Maine, New Hampshire, Rhode Island, and Vermont.[40] Bridgeport, Hartford, and New Haven (CT); Boston, Brockton, Cambridge, Lynn, Springfield, and Worcester (MA); Portland (ME); Manchester (NH); Providence (RI); and Burlington (VT) are the largest cities in the HIDTA counties.[41] Approximately 8.9 million residents, 61.4 percent of the New England population, reside in the HIDTA region.[42] Drug distribution within the NE HIDTA region is centered in two primary hubs located in the Hartford (CT)/Springfield (MA) and Lowell/Lawrence (MA) areas.[43] The Providence (RI)/Fall River (MA) area is a secondary distribution center that supplies Cape Cod.[44] Boston is New England's largest city and is predominantly a consumer drug market supplied primarily by distributors operating from Lawrence, Lowell, and the New York City metropolitan area.[45] In 2010, NE HIDTA initiatives reported seizing drugs, currency, and other assets valued at approximately $80.7 million.[46]

Opioids—including heroin (primarily South American heroin) and CPDs—pose the greatest drug threat to the NE HIDTA region. Limited amounts of Asian and Mexican heroin are available in some markets. Controlled prescription opioid abusers are fueling the heroin abuse problem in the region as they increasingly switch to heroin because of its higher potency and greater affordability; heroin prices at the street level remain low in some primary drug distribution centers. For example, a bag of heroin sold for less than $10 in Boston and Hartford in late 2010. Heroin abuse now encompasses a broad cross-section of society in the region, including chronic abusers in urban areas, residents of suburban and rural communities, and young adults and teenagers who switched to heroin after initially abusing CPDs.

Cocaine, particularly crack, is commonly abused in some parts of the region, mainly inner-city neighborhoods such as Boston and Springfield (MA), Providence (RI), and Bridgeport, Hartford, and New Haven (CT). Crack availability has also expanded in many northern New England cities, such as Burlington, Manchester, and Portland, largely because African American and Hispanic criminal groups and street gangs from southern New England states and New York City have increased distribution in those areas.

Marijuana abuse is pervasive throughout the NE HIDTA region. Commercial-grade Mexican marijuana and high-potency marijuana from domestic and Canadian suppliers operating in the area are readily available. Criminal exploitation of medical marijuana laws and a law decriminalizing possession of small amounts of marijuana in Massachusetts contribute to the problem.[47]

MDMA (3,4-methylenedioxymethamphetamine, also known as ecstasy) availability in the NE HIDTA region is moderate, and distribution and abuse levels are stable in most areas. Some synthetic drug tablets available in the region are represented by distributors as MDMA but actually contain methamphetamine—or methamphetamine and MDMA in combination—as well as other drug combinations. Public health officials report that MDMA and methamphetamine combinations may produce greater adverse neurochemical and behavioral effects than either drug alone, thus placing abusers at greater risk.[48] The overall threat posed by PCP in the region remains low; however, law enforcement reporting indicates that abuse is increasing in some parts of Connecticut.[49]

Major DTOs currently operating in the NE HIDTA area are increasingly working in concert to facilitate their drug trafficking activities. New York City-based Colombian DTOs, primary suppliers of heroin and cocaine to New England, often work in conjunction with Mexican and Dominican DTOs to maintain a constant flow of drug supplies to the region.[50] Central American- and Caribbean-based groups smuggle kilogram quantities of heroin to the region on behalf of Colombian DTOs directly from Latin America and Caribbean countries and through Florida, New York, Georgia, and Puerto Rico.[51] Increased law enforcement pressure along the Southwest Border has led some of these smuggling groups to favor routes through the Atlantic corridor.[52]

Mexican DTOs are strengthening their foothold in the region and control an increasing portion of the flow of cocaine, heroin, marijuana, and methamphetamine to New England, as well as the flow of illicit drug proceeds from the region.[53] They also serve as primary suppliers of cocaine for Dominican organizations and recently have been linked to some of the largest cocaine seizures reported in the region.[54] Numerous DTOs operating in the Northeast have been linked to prominent Mexican drug cartels, including the Sinaloa, Juárez, La Familia Michoacana, and Gulf Cartels.[55]

Dominican DTOs are expanding their drug distribution operations and are the predominant distributors of cocaine and South American heroin throughout New England.[56] These groups are primarily involved in the distribution of heroin, cocaine, and marijuana, as well as limited amounts of CPDs and MDMA.[57]

Asian polydrug trafficking organizations operating in Canada are major producers, transporters, and wholesale distributors of high-potency marijuana, MDMA, and tablets/capsules/powder that contain multiple synthetic drugs that are sold in New England.[58] They use well-established networks to supply illicit drugs to the region and to transport cocaine, drug proceeds, and weapons to Canada.[59] The St. Regis Mohawk Reservation, which straddles the Canada–New York border, is a key smuggling route for drugs supplied from Canada to New England.[60]

Drug traffickers generate tens of millions of dollars in illicit drug proceeds in the NE HIDTA region each year.[61] New England HIDTA initiatives seized drugs valued at more than $56.3 million and more than $24.3 million in cash and other assets in 2010.[62] Illicit drug proceeds generated in the NE HIDTA region are typically transported by traffickers through bulk cash (U.S. and foreign currency) and monetary instrument smuggling to New York City, Canada, the Dominican Republic, Mexico, and other source areas for eventual repatriation.[63] Drug proceeds are also laundered through various methods such as casinos, depository institutions, front companies, money services businesses, retail businesses, securities and futures instruments, and the purchase of real property and expensive consumer goods.[64] In addition, drug traffickers use prepaid cards—often referred to as stored value cards—to anonymously move illicit proceeds.[65]

Appendix B. Tables and Figures

Table B1. Drug-Related Deaths in New England HIDTA States

State	Year(s) (Most Current)	Total Number of Drug-Related Deaths	Total Number of Opioid Mentions (Heroin and/or Controlled Prescription Opioids)	Top Illicit Drug Mentions and Number (Excludes Alcohol)
Connecticut	2009	515	192	Heroin (98), multiple drugs (88), cocaine (48), methadone (31), opiates (25), oxycodone (21), fentanyl (11)
	2010	488	197	Heroin (72), multiple drugs (55), cocaine (47), opiates (39), methadone (35), oxycodone (33), benzodiazepines (18), fentanyl (10), hydrocodone (8)
Maine	2008	168	Not available	Not available
	2009	179	Not available	Not available
Massachusetts	2007	965	637	Not available
	2008	844	622	Not available
New Hampshire	2009	164	124	Methadone (41), oxycodone (29), cocaine (25), heroin (22), citalopram (11), fentanyl (16), morphine (15), alprazolam (14), diazepam (13), clonazepam (11), opiates (9)
	2010	174	Not available	Other opiates (82), benzodiazepines (49), methadone (39), oxycodone (38), cocaine (24)
Rhode Island	2009	537*	Not available	Not available
Vermont	2009	93	52	Methadone (18), oxycodone (13), hydrocodone (10), morphine (10)

Source: State Medical Examiner Offices.

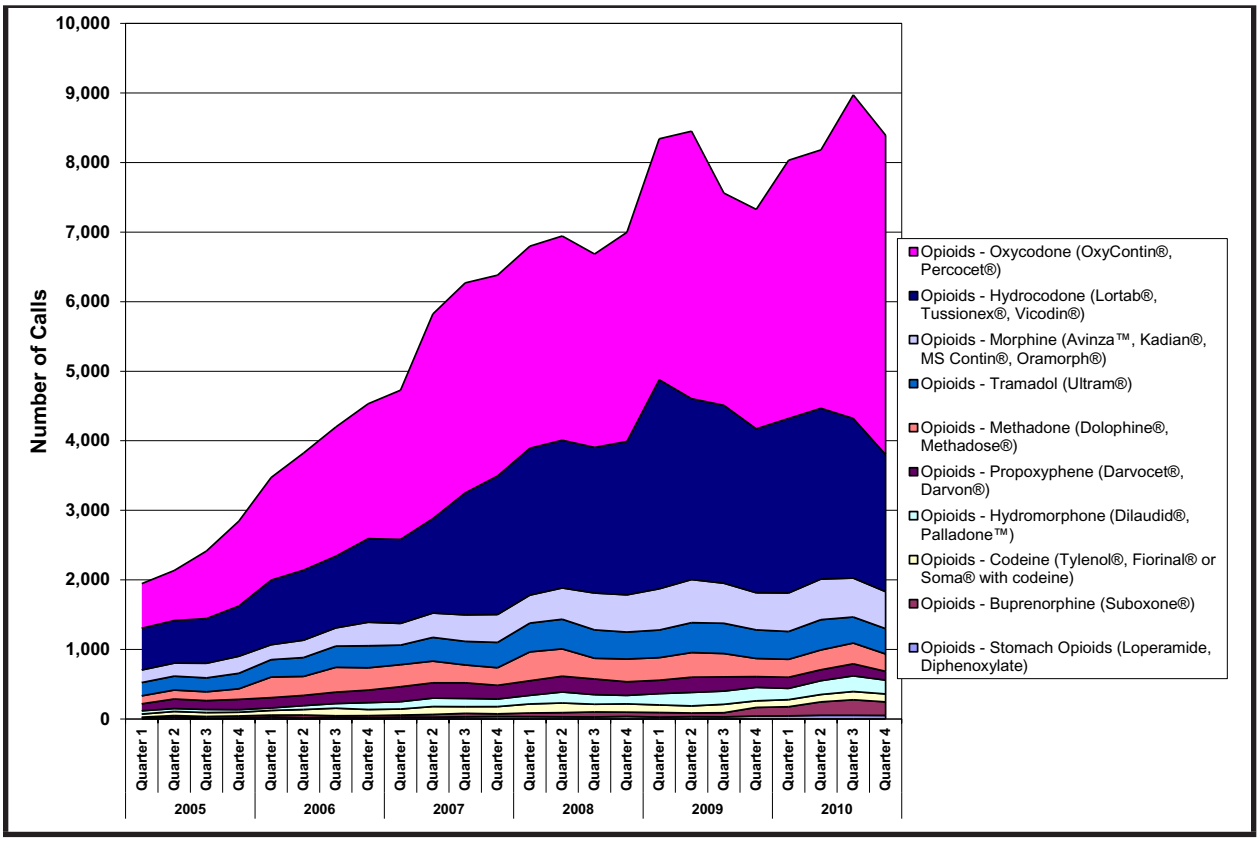
*Medical Examiner data provided by DAWN *Live!*.

Table B2. Drug Seizures Attributed to New England HIDTA Initiatives, 2010

Drug	Amount Seized	Wholesale Value
Adderall (in dosage units)	32	$320
Alprazolam (in dosage units)	116	$1,240
Anabolic steroids (in dosage units)	3,395	$68,618
Clonazepam (in dosage units)	385	$2,130
Cocaine HCL (in kilograms)	218.1	$7,971,189
Crack Cocaine (in kilograms)	15.6	$655,320
Diazepam (in dosage units)	108	$1,080
DMT (in kilograms)	0.005	$200
GHB (in dosage units)	4	$40
Hashish (in kilograms)	0.02	$49
Heroin (in kilograms)	34.6	$3,432,074
Hydrocodone (in dosage units)	461	$12,600
Hydromorphone (in dosage units)	9	$108
Klonopin (in dosage units)	10	$100
LSD (in dosage units)	2,013	$10,065
Marijuana (in kilograms)	11,948	$40,899,432
MDMA (in dosage units)	12,121	$345,800
Meloxicam (in dosage units)	20	$200
Methadone (in dosage units)	226	$5,060
Methamphetamine (in kilograms)	0.5	$17,101
Opium poppy capsules (in dosage units)	5,188	$103,760
Other drugs not identified (in dosage units)	240	$1,200
Oxycodone (in dosage units)	14,057	$637,407
OxyContin (in dosage units)	39,958	$2,076,756
PCP (in kilograms)	0.001	$10
Percocet (in dosage units)	3,247	$67,905
Psilocybin (in kilograms)	0.1	$262
Suboxone (in dosage units)	216	$3,942
Valium (in dosage units)	224	$1,930
Viagra (in dosage units)	1	$10
Vicodin (in dosage units)	390	$3,306
Xanax (in dosage units)	2,463	$25,110
Total Wholesale Value		**$56,344,324**

Source: New England High Intensity Drug Trafficking Area.

Figure B1. Substance Abuse-Related Nonemergency Calls to the Northern New England Poison Center, 2005–2010



Source: Northern New England Poison Center, Substance Abuse Surveillance and Reporting System.

Endnotes

1. Drug Enforcement Administration (DEA), *DEA Arrests by State of Arrest 2006-2010*, February 7, 2011.
2. Maine Drug Enforcement Agency, *Percent of MDEA Arrests for Pharmaceuticals Compared to Cocaine/Crack and Heroin*, 2011.
3. New England High Intensity Drug Trafficking Area (HIDTA) Drug Task Forces, interviews by National Dug Intelligence Center (NDIC) intelligence analyst (IA), February 2011.
4. New England Drug Task Forces, interviews by NDIC IA, February 2011; Maine Benzodiazepine Conference, interviews by NDIC field intelligence officer (FIO), October 2010.
5. *New York Times*, "Pharmacies Besieged by Addicted Thieves," February 6, 2011.
6. U.S. Attorney, District of Maine, Thomas E. Delahanty II, News Conference Remarks, Portland (ME), January 26, 2011.
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Bristol Police Department
Connecticut Intelligence Center
East Haven Police Department
Hartford Police Department
Meriden Police Department
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U.S. Department of State
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  Financial Crimes Enforcement Network
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Other

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Center for Behavioral Health Statistics and Quality

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Highlights

This report presents the first information from the 2011 National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The survey is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the civilian, noninstitutionalized population of the United States aged 12 years old or older. Approximately 67,500 persons are interviewed in NSDUH each year. Unless otherwise noted, all comparisons in this report described using terms such as "increased," "decreased," or "more than" are statistically significant at the .05 level.

Illicit Drug Use

- In 2011, an estimated 22.5 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 8.7 percent of the population aged 12 or older. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics (pain relievers, tranquilizers, stimulants, and sedatives) used nonmedically.
- The rate of current illicit drug use among persons aged 12 or older in 2011 (8.7 percent) was similar to the rate in 2010 (8.9 percent).
- Marijuana was the most commonly used illicit drug. In 2011, there were 18.1 million past month users. Between 2007 and 2011, the rate of use increased from 5.8 to 7.0 percent, and the number of users increased from 14.5 million to 18.1 million.
- In 2011, there were 1.4 million current cocaine users aged 12 or older, comprising 0.5 percent of the population. These estimates were similar to the number and rate in 2010 (1.5 million or 0.6 percent), but were lower than the estimates in 2006 (2.4 million or 1.0 percent).
- The number of persons who were past year heroin users in 2011 (620,000) was higher than the number in 2007 (373,000).
- Hallucinogens were used in the past month by 972,000 persons (0.4 percent) aged 12 or older in 2011. These estimates were lower than the estimates in 2010 (1.2 million or 0.5 percent).
- In 2011, there were 6.1 million persons (2.4 percent) aged 12 or older who used prescription-type psychotherapeutic drugs nonmedically in the past month. These estimates were lower than the estimates in 2010 (7.0 million or 2.7 percent).
- The number of past month methamphetamine users decreased between 2006 and 2011, from 731,000 (0.3 percent) to 439,000 (0.2 percent).
- Among youths aged 12 to 17, the current illicit drug use rate was similar in 2010 (10.1 percent) and 2011 (10.1 percent), but was higher than the rate in 2008 (9.3 percent). Between 2002 and 2008, the rate declined from 11.6 to 9.3 percent.

- The rate of current marijuana use among youths aged 12 to 17 decreased from 8.2 percent in 2002 to 6.7 percent in 2006, remained unchanged at 6.7 percent in 2007 and 2008, then increased to 7.4 percent in 2009. Rates in 2010 (7.4 percent) and 2011 (7.9 percent) were similar to the rate in 2009.
- Among youths aged 12 to 17, the rate of current nonmedical use of prescription-type drugs declined from 4.0 percent in 2002 to 2.8 percent in 2011. The rate of nonmedical pain reliever use declined during this period from 3.2 to 2.3 percent among youths.
- The rate of current use of illicit drugs among young adults aged 18 to 25 increased from 19.7 percent in 2008 to 21.4 percent in 2011, driven largely by an increase in marijuana use (from 16.6 percent in 2008 to 19.0 percent in 2011).
- Among young adults aged 18 to 25, the rate of current nonmedical use of prescription-type drugs in 2011 was 5.0 percent, which was lower than the rate in the years from 2003 to 2010. There was a decrease from 2005 to 2011 in the use of cocaine among young adults, from 2.6 to 1.4 percent.
- Among those aged 50 to 59, the rate of past month illicit drug use increased from 2.7 percent in 2002 to 6.3 percent in 2011. This trend partially reflects the aging into this age group of the baby boom cohort (i.e., persons born between 1946 and 1964), whose lifetime rate of illicit drug use has been higher than those of older cohorts.
- Among unemployed adults aged 18 or older in 2011, 17.2 percent were current illicit drug users, which was higher than the 8.0 percent of those employed full time and 11.6 percent of those employed part time. However, most illicit drug users were employed. Of the 19.9 million current illicit drug users aged 18 or older in 2011, 13.1 million (65.7 percent) were employed either full or part time.
- In 2011, 9.4 million persons aged 12 or older reported driving under the influence of illicit drugs during the past year. This corresponds to 3.7 percent of the population aged 12 or older, which was lower than the rate in 2010 (4.2 percent) and was lower than the rate in 2002 (4.7 percent). In 2011, the rate was highest among young adults aged 18 to 25 (11.6 percent).
- Among persons aged 12 or older in 2010-2011 who used pain relievers nonmedically in the past 12 months, 54.2 percent got the drug they most recently used from a friend or relative for free. Another 18.1 percent reported they got the drug from one doctor. Only 3.9 percent got pain relievers from a drug dealer or other stranger, and 0.3 percent bought them on the Internet. Among those who reported getting the pain relievers from a friend or relative for free, 81.6 percent reported in a follow-up question that the friend or relative had obtained the drugs from just one doctor.

Alcohol Use

- Slightly more than half (51.8 percent) of Americans aged 12 or older reported being current drinkers of alcohol in the 2011 survey, similar to the rate in 2010 (51.8 percent). This translates to an estimated 133.4 million current drinkers in 2011.
- In 2011, nearly one quarter (22.6 percent) of persons aged 12 or older participated in binge drinking. This translates to about 58.3 million people. The rate in 2011 was similar to the estimate in 2010 (23.1 percent). Binge drinking is defined as having five or more drinks on the same occasion on at least 1 day in the 30 days prior to the survey.
- In 2011, heavy drinking was reported by 6.2 percent of the population aged 12 or older, or 15.9 million people. This rate was lower than the rate of heavy drinking in 2010 (6.7 percent). Heavy drinking is defined as binge drinking on at least 5 days in the past 30 days.
- Among young adults aged 18 to 25 in 2011, the rate of binge drinking was 39.8 percent. The rate of heavy drinking was 12.1 percent, which was lower than the rate in 2010 (13.5 percent).
- The rate of current alcohol use among youths aged 12 to 17 was 13.3 percent in 2011. Youth binge and heavy drinking rates in 2011 were 7.4 and 1.5 percent, respectively. These rates were all similar to those reported in 2010 (13.6, 7.9, and 1.7 percent, respectively).
- In 2011, an estimated 11.1 percent of persons aged 12 or older drove under the influence of alcohol at least once in the past year. This percentage was lower than in 2002, when it was 14.2 percent. The rate of driving under the influence of alcohol was highest among persons aged 21 to 25 (21.9 percent).
- There were an estimated 9.7 million underage (aged 12 to 20) drinkers in 2011, including 6.1 million binge drinkers and 1.7 million heavy drinkers.
- Past month, binge, and heavy drinking rates among underage persons declined between 2002 and 2011. Past month alcohol use declined from 28.8 to 25.1 percent, while binge drinking declined from 19.3 to 15.8 percent, and heavy drinking declined from 6.2 to 4.4 percent.
- In 2011, 57.0 percent of current underage drinkers reported that their last use of alcohol occurred in someone else's home, and 28.2 percent reported that it had occurred in their own home. About one third (30.3 percent) paid for the alcohol the last time they drank, including 7.7 percent who purchased the alcohol themselves and 22.4 percent who gave money to someone else to purchase it. Among those who did not pay for the alcohol they last drank, 38.2 percent got it from an unrelated person aged 21 or older, 19.1 percent from another person younger than 21 years old, and 21.4 percent from a parent, guardian, or other adult family member.

Tobacco Use

- In 2011, an estimated 68.2 million Americans aged 12 or older were current (past month) users of a tobacco product. This represents 26.5 percent of the population in that age range. Also, 56.8 million persons (22.1 percent of the population) were current cigarette smokers; 12.9 million (5.0 percent) smoked cigars; 8.2 million (3.2 percent) used smokeless tobacco; and 2.1 million (0.8 percent) smoked tobacco in pipes.
- Between 2002 and 2011, past month use of any tobacco product decreased from 30.4 to 26.5 percent, past month cigarette use declined from 26.0 to 22.1 percent, and past month cigar use declined from 5.4 to 5.0 percent. Rates of past month use of smokeless tobacco and pipe tobacco in 2011 were similar to corresponding rates in 2002.
- The rate of past month tobacco use among 12 to 17 year olds declined from 15.2 percent in 2002 to 10.0 percent in 2011, including a decline from 2010 (10.7 percent) to 2011. The rate of past month cigarette use among 12 to 17 year olds also declined between 2002 and 2011, from 13.0 to 7.8 percent, including a decline between 2009 (9.0 percent) and 2011.
- One in six pregnant women aged 15 to 44 smoked cigarettes in the past month during 2010-2011. The rate of current smoking among pregnant women did not change between 2002-2003 (18.0 percent) and 2010-2011 (17.6 percent), while among women aged 15 to 44 who were not pregnant, the rate declined from 30.7 to 25.4 percent.

Initiation of Substance Use (Incidence, or First-Time Use) within the Past 12 Months

- In 2011, an estimated 3.1 million persons aged 12 or older used an illicit drug for the first time within the past 12 months. This averages to about 8,400 initiates per day and was similar to the estimate for 2010 (3.0 million). A majority of these past year illicit drug initiates reported that their first drug was marijuana (67.5 percent). More than one in five initiated with psychotherapeutics (22.0 percent, including 14.0 percent with pain relievers, 4.2 percent with tranquilizers, 2.6 percent with stimulants, and 1.2 percent with sedatives). In 2011, 7.5 percent of initiates reported inhalants as their first illicit drug, and 2.8 percent used hallucinogens as their first drug.
- In 2011, the illicit drug categories with the largest number of past year initiates among persons aged 12 or older were marijuana use (2.6 million) and nonmedical use of pain relievers (1.9 million). These estimates were not significantly different from the numbers in 2010. However, the number of marijuana initiates increased between 2008 (2.2 million) and 2011 (2.6 million).
- In 2011, the average age of marijuana initiates among persons aged 12 to 49 was 17.5 years, which was higher than the average age of marijuana initiates in 2002 (17.0 years).
- The number of past year initiates of methamphetamine among persons aged 12 or older was 133,000 in 2011. This estimate was lower than the estimates in 2002 to 2006, which ranged from 192,000 to 318,000.
- The number of past year initiates of Ecstasy aged 12 or older was similar in 2011 (922,000) and 2010 (949,000), but the number in 2011 increased from 2005 (615,000).

- The number of past year cocaine initiates aged 12 or older declined from 1.0 million in 2002 to 670,000 in 2011. The number of initiates of crack cocaine declined during this period from 337,000 to 76,000.
- In 2011, there were 178,000 persons aged 12 or older who used heroin for the first time within the past year, not significantly different from the estimates from 2009 and 2010. However, this was an increase from the annual numbers of initiates during 2005 to 2007 (between 90,000 and 108,000).
- Most (82.9 percent) of the 4.7 million past year alcohol initiates in 2011 were younger than 21 at the time of initiation.
- The number of persons aged 12 or older who smoked cigarettes for the first time within the past 12 months was 2.4 million in 2011, which was the same as the estimate in 2010 (2.4 million), but higher than the estimate for 2002 (1.9 million). Most new smokers in 2011 were younger than 18 when they first smoked cigarettes (55.7 percent or 1.3 million). The number of new smokers who began smoking at age 18 or older increased from 623,000 in 2002 to 1.1 million in 2011.
- The number of persons aged 12 or older who used smokeless tobacco for the first time within the past year was 1.3 million, similar to the estimates in 2005 to 2010.

Youth Prevention-Related Measures

- The percentage of youths aged 12 to 17 perceiving great risk in smoking marijuana once or twice a week decreased from 54.6 percent in 2007 to 44.8 percent in 2011.
- Between 2002 and 2008, the percentage of youths who reported great risk in smoking one or more packs of cigarettes per day increased from 63.1 to 69.5 percent, but the percentage dropped to 65.5 percent in 2009 and remained steady at 65.3 percent in 2010 and 66.2 percent in 2011.
- Almost half (47.7 percent) of youths aged 12 to 17 reported in 2011 that it would be "fairly easy" or "very easy" for them to obtain marijuana if they wanted some. More than one in six reported it would be easy to get cocaine (17.5 percent). About one in eight (12.2 percent) indicated that LSD would be easily available, and 10.7 percent reported easy availability for heroin. Between 2002 and 2011, there were declines in the perceived availability for all four drugs.
- A majority of youths aged 12 to 17 (89.3 percent) in 2011 reported that their parents would strongly disapprove of their trying marijuana once or twice. Current marijuana use was much less prevalent among youths who perceived strong parental disapproval for trying marijuana once or twice than for those who did not (5.0 vs. 31.5 percent).
- In 2011, 75.1 percent of youths aged 12 to 17 reported having seen or heard drug or alcohol prevention messages from sources outside of school, which was lower than in 2002 (83.2 percent). The percentage of school-enrolled youths reporting that they had seen or heard prevention messages at school also declined during this period, from 78.8 to 74.6 percent.

Substance Dependence, Abuse, and Treatment

- In 2011, an estimated 20.6 million persons (8.0 percent of the population aged 12 or older) were classified with substance dependence or abuse in the past year based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV). Of these, 2.6 million were classified with dependence or abuse of both alcohol and illicit drugs, 3.9 million had dependence or abuse of illicit drugs but not alcohol, and 14.1 million had dependence or abuse of alcohol but not illicit drugs.
- Between 2002 and 2010, the number of persons with substance dependence or abuse was stable, ranging from 21.6 million to 22.7 million. However, the number in 2011 (20.6 million) was lower than the number in 2010 (22.2 million).
- The specific illicit drugs that had the highest levels of past year dependence or abuse in 2011 were marijuana (4.2 million), pain relievers (1.8 million), and cocaine (0.8 million). The number of persons with marijuana dependence or abuse did not change between 2002 and 2011. Between 2004 and 2011, the number with pain reliever dependence or abuse increased from 1.4 million to 1.8 million, and between 2006 and 2011, the number with cocaine dependence or abuse declined from 1.7 million to 0.8 million.
- The number of persons with heroin dependence or abuse increased from 214,000 in 2007 to 426,000 in 2011.
- In 2011, adults aged 21 or older who had first used alcohol at age 14 or younger were more than 7 times as likely to be classified with alcohol dependence or abuse than adults who had their first drink at age 21 or older (13.8 vs. 1.8 percent).
- Between 2002 and 2011, the percentage of youths aged 12 to 17 with substance dependence or abuse declined from 8.9 to 6.9 percent.
- Treatment need is defined as having substance dependence or abuse or receiving treatment at a specialty facility (hospital inpatient, drug or alcohol rehabilitation, or mental health centers) within the past 12 months. In 2011, 21.6 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem (8.4 percent of persons aged 12 or older). Of these, 2.3 million (0.9 percent of persons aged 12 or older and 10.8 percent of those who needed treatment) received treatment at a specialty facility. Thus, 19.3 million persons (7.5 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty facility in the past year.
- Of the 19.3 million persons aged 12 or older in 2011 who were classified as needing substance use treatment but did not receive treatment at a specialty facility in the past year, 912,000 persons (4.7 percent) reported that they felt they needed treatment for their illicit drug or alcohol use problem. Of these 912,000 persons who felt they needed treatment, 281,000 (30.8 percent) reported that they made an effort to get treatment, and 631,000 (69.2 percent) reported making no effort to get treatment.
- The number of people receiving specialty substance abuse treatment in the past year in 2011 (2.3 million) was similar to the number in 2002 (2.3 million). However, the number receiving specialty treatment for a problem with nonmedical pain reliever use increased during this period, from 199,000 to 438,000.

1. Introduction

This report presents a first look at results from the 2011 National Survey on Drug Use and Health (NSDUH), an annual survey of the civilian, noninstitutionalized population of the United States aged 12 years old or older. The report presents national estimates of rates of use, numbers of users, and other measures related to illicit drugs, alcohol, and tobacco products. The report focuses on trends between 2010 and 2011 and from 2002 to 2011, as well as differences across population subgroups in 2011. NSDUH estimates related to mental health, which were included in national findings reports prior to 2009, are not included in this 2011 report.

Summary of NSDUH

NSDUH is the primary source of statistical information on the use of illegal drugs, alcohol, and tobacco by the U.S. civilian, noninstitutionalized population aged 12 or older. Conducted by the Federal Government since 1971, the survey collects data through face-to-face interviews with a representative sample of the population at the respondent's place of residence. The survey is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, and is planned and managed by SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ). Data collection and analysis are conducted under contract with RTI International.[1] This section briefly describes the survey methodology; a more complete description is provided in Appendix A.

NSDUH collects information from residents of households and noninstitutional group quarters (e.g., shelters, rooming houses, dormitories) and from civilians living on military bases. The survey excludes homeless persons who do not use shelters, military personnel on active duty, and residents of institutional group quarters, such as jails and hospitals. Appendix C describes substance use surveys that cover populations outside the NSDUH target population.

From 1971 through 1998, the survey employed paper and pencil data collection. Since 1999, the NSDUH interview has been carried out using computer-assisted interviewing (CAI). Most of the questions are administered with audio computer-assisted self-interviewing (ACASI). ACASI is designed to provide the respondent with a highly private and confidential mode for responding to questions in order to increase the level of honest reporting of illicit drug use and other sensitive behaviors. Less sensitive items are administered by interviewers using computer-assisted personal interviewing.

The 2011 NSDUH continued to employ a State-based design with an independent, multistage area probability sample within each State and the District of Columbia. The eight States with the largest population (which together account for about half of the total U.S. population aged 12 or older) are designated as large sample States (California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas) and have a sample size of about 3,600 each. For the remaining 42 States and the District of Columbia, the sample size is about 900 per State. In 2011, four States in the Gulf Coast (Alabama, Florida, Louisiana, and Mississippi) had a

[1] RTI International is a trade name of Research Triangle Institute.

1-year supplemental sample to facilitate a study of the impact of the April 2010 Deepwater Horizon oil spill on substance use and mental health. In all States and the District of Columbia, the design oversampled youths and young adults; each State's sample was approximately equally distributed among three age groups: 12 to 17 years, 18 to 25 years, and 26 years or older.

Nationally, screening was completed at 156,048 addresses, and 70,109 completed interviews were obtained, which reflect the oversample of about 2,000 cases in the Gulf Coast. The survey was conducted from January through December 2011. Weighted response rates for household screening and for interviewing were 87.0 and 74.4 percent, respectively. See Appendix B for more information on NSDUH response rates.

Limitations on Trend Measurement

Trend analysis using NSDUH data is limited to 2002 to 2011, even though the survey has been conducted since 1971. Because of the shift in interviewing method in 1999, the estimates from the pre-1999 surveys are not comparable with estimates from the current CAI-based surveys. Although the design of the 2002 through 2011 NSDUHs is similar to the design of the 1999 through 2001 surveys, methodological differences affect the comparability of the 2002 to 2011 estimates with estimates from prior surveys. The most important change was the addition of a $30 incentive payment in 2002. Also, the name of the survey was changed in 2002, from the National Household Survey on Drug Abuse (NHSDA) to the current name. Improved data collection quality control procedures were introduced in the survey starting in 2001, and updated population data from the 2000 decennial census were incorporated into the sample weights starting with the 2002 estimates. Analyses of the effects of these factors on NSDUH estimates have shown that 2002 and later data should not be compared with 2001 and earlier data from the survey series to assess changes over time. Appendix C of the 2004 NSDUH report on national findings discusses this in more detail (Office of Applied Studies, 2005).

Because of changes in the questionnaire, estimates for methamphetamine, stimulants, and psychotherapeutics in this report should not be compared with corresponding estimates presented in previous reports for data years prior to 2007. Estimates for 2002 to 2006 for these drug categories in this report, as well as in the 2007 and 2008 reports, incorporate statistical adjustments that enable year-to-year comparisons to be made over the period from 2002 to 2011.

The calculation of NSDUH person-level weights includes a calibration step that results in weights that are consistent with population control totals obtained from the U.S. Census Bureau (see Section A.3.3 in Appendix A). These control totals are based on the most recently available decennial census; the Census Bureau updates these control totals annually to account for population changes after the census. For the analysis weights in the 2002 through 2010 NSDUHs, the control totals were derived from the 2000 census data; for the 2011 NSDUH weights, the control totals were based on data from the 2010 census. This shift to the 2010 census data could affect comparisons between substance use estimates in 2011 and those from prior years. Analyses of the impact of this change in NSDUH weights show that estimates of the number of substance users for some demographic groups were substantially affected, but percentages of substance users within these groups (i.e., rates) were not. Section B.4.3 in Appendix B provides results of investigations of the change to use of 2010 census control totals for the 2011 NSDUH.

Format of Report and Data Presentation

This report has separate chapters that discuss findings on the use of illicit drugs; use of alcohol; use of tobacco products; initiation of substance use; prevention-related issues; and substance dependence, abuse, and treatment. A final chapter summarizes the results and discusses key findings on marijuana and heroin use and the nonmedical use of prescription drugs, including comparisons with other survey results. The data and findings described in this report are based on a comprehensive set of tables, referred to as "detailed tables," that include population estimates (e.g., numbers of drug users), rates (e.g., percentages of the population using drugs), and standard errors of estimates. These tables are available separately on the SAMHSA Web site (http://www.samhsa.gov/data/). In addition, the tables are accompanied by a glossary that covers key definitions used in this report and in the detailed tables. Appendices in this report describe the survey (Appendix A), technical details on the statistical methods and measurement (Appendix B), and other sources of related data (Appendix C). A list of references cited in the report (Appendix D) and contributors to this report (Appendix E) also are provided.

Text, figures, and detailed tables present prevalence measures for the population in terms of both the number of persons and the percentage of the population and by lifetime (i.e., ever used), past year, and past month use. Analyses focus primarily on past month use, also referred to as "current use." Where applicable, footnotes are included in tables and figures to indicate whether the 2011 estimates are significantly different from 2010 or earlier estimates. In addition, some estimates are presented based on data combined from two or more survey years to increase precision of the estimates; those estimates are annual averages based on multiple years of data.

During regular data collection and processing checks for the 2011 NSDUH, data errors were identified. These errors affected the data for Pennsylvania (2006 to 2010) and Maryland (2008 and 2009). Data and estimates for 2011 were not affected. The errors had minimal impact on the national estimates. The only estimates appreciably affected in the report and detailed tables are estimates for the mid-Atlantic division and the Northeast region. Cases with erroneous data were removed from data files, and the remaining cases were reweighted to provide representative estimates. Therefore, some estimates for 2010 and other prior years in the 2011 national findings report and the 2011 detailed tables will differ from corresponding estimates found in some previous reports and tables. Further information is available in Section B.3.5 in Appendix B of this report.

All estimates presented in the report have met the criteria for statistical reliability (see Section B.2.2 in Appendix B). Estimates that do not meet these criteria are suppressed and do not appear in tables, figures, or text. Statistical tests have been conducted for all statements appearing in the text of the report that compare estimates between years or subgroups of the population. Suppressed estimates are not included in statistical tests of comparisons. For example, a statement that "whites had the highest prevalence" means that the rate among whites was higher than the rate among all nonsuppressed racial/ethnic subgroups, but not necessarily higher than the rate among a subgroup for which the estimate was suppressed. Unless explicitly stated that a difference is not statistically significant, all statements that describe differences are significant at the .05 level. Statistically significant differences are described using terms such as "higher," "lower," "increased," and "decreased." Statements that use terms such as "similar," "no difference," "same," or "remained steady" to describe the relationship between estimates denote

that a difference is not statistically significant. When a set of estimates for survey years or population subgroups is presented without a statement of comparison, statistically significant differences among these estimates are not implied and testing may not have been conducted.

Data are presented for racial/ethnic groups based on guidelines for collecting and reporting race and ethnicity data (Office of Management and Budget [OMB], 1997). Because respondents could choose more than one racial group, a "two or more races" category is included for persons who reported more than one category (i.e., white, black or African American, American Indian or Alaska Native, Native Hawaiian, Other Pacific Islander, Asian, Other). Respondents choosing both Native Hawaiian and Other Pacific Islander but no other categories are classified as being in the "Native Hawaiian or Other Pacific Islander" category instead of the "two or more race" category. Except for the "Hispanic or Latino" group, the racial/ethnic groups include only non-Hispanics. The category "Hispanic or Latino" includes Hispanics of any race.

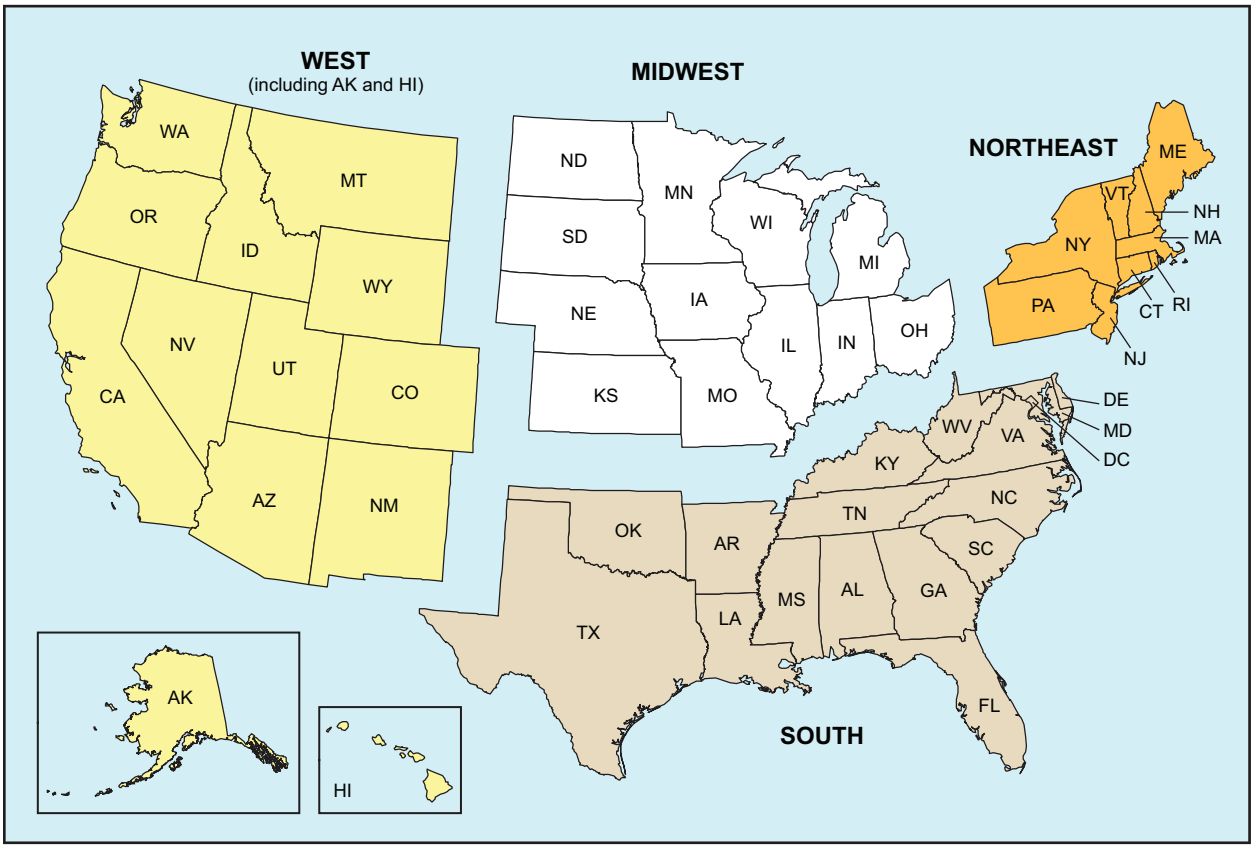
Data in this report also are presented for four U.S. geographic regions as defined by the U.S. Census Bureau (Figure 1.1). Other geographic comparisons also are made based on county type, a variable that reflects different levels of urbanicity and metropolitan area inclusion of counties. This county classification was originally developed and subsequently updated by the U.S. Department of Agriculture (Butler & Beale, 1994). Each county is either inside or outside a metropolitan statistical area (MSA), based on metropolitan area definitions issued by the OMB in June 2003 (OMB, 2003). Large metropolitan areas have a population of 1 million or more. Small metropolitan areas have a population of fewer than 1 million. Nonmetropolitan areas are outside of MSAs. Counties in nonmetropolitan areas are further classified based on the number of people in the county who live in an urbanized area, as defined by the Census Bureau at the subcounty level. "Urbanized" counties have a population of 20,000 or more in urbanized areas, "less urbanized" counties have at least 2,500 but fewer than 20,000 population in urbanized areas, and "completely rural" counties have populations of fewer than 2,500 in urbanized areas.

Other NSDUH Reports and Data

Other reports focusing on specific topics of interest will be produced using the 2011 NSDUH data and made available on SAMHSA's Web site. In particular, data on mental health will be discussed in a separate report to be released later this year: *Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings*. State-level estimates for substance use and mental health for 2010-2011 are scheduled to be released by early 2013.

The detailed tables, other descriptive reports and in-depth analytic reports focusing on specific issues or populations, and methodological information on NSDUH are all available at http://www.samhsa.gov/data/. In addition, CBHSQ makes public use data files available through the Substance Abuse and Mental Health Data Archive at http://www.datafiles.samhsa.gov. Currently, files are available from the 1979 to 2010 surveys. The 2011 NSDUH public use file will be available by the end of 2012.

Figure 1.1 U.S. Census Bureau Regions



2. Illicit Drug Use

The National Survey on Drug Use and Health (NSDUH) obtains information on nine categories of illicit drug use: use of marijuana, cocaine, heroin, hallucinogens, and inhalants, as well as the nonmedical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives. In these categories, hashish is included with marijuana, and crack is considered a form of cocaine. Several drugs are grouped under the hallucinogens category, including LSD, PCP, peyote, mescaline, psilocybin mushrooms, and "Ecstasy" (MDMA). Inhalants include a variety of substances, such as nitrous oxide, amyl nitrite, cleaning fluids, gasoline, spray paint, other aerosol sprays, and glue. Respondents are asked to report use of inhalants to get high but not to report times when they accidentally inhaled a substance.

The four categories of prescription-type drugs (pain relievers, tranquilizers, stimulants, and sedatives) cover numerous medications that currently are or have been available by prescription. They also include drugs within these groupings that originally were prescription medications but currently may be manufactured and distributed illegally, such as methamphetamine, which is included under stimulants. Respondents are asked to report only "nonmedical" use of these drugs, defined as use without a prescription of the individual's own or simply for the experience or feeling the drugs caused. Use of over-the-counter drugs and legitimate use of prescription drugs are not included. NSDUH reports combine the four prescription-type drug groups into a category referred to as "psychotherapeutics."

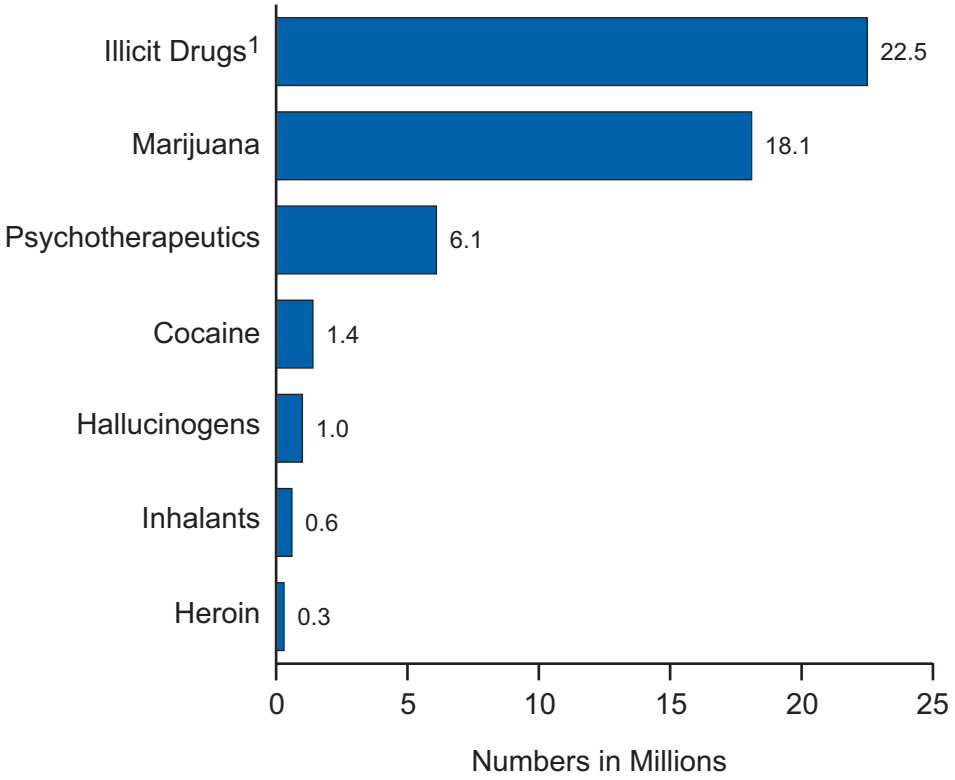
Estimates of "illicit drug use" reported from NSDUH reflect the use of any of the nine drug categories listed above. Use of alcohol and tobacco products, while illegal for youths, is not included in these estimates, but is discussed in Chapters 3 and 4.

- In 2011, an estimated 22.5 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview (Figure 2.1). This estimate represents 8.7 percent of the population aged 12 or older.

- The overall rate of current illicit drug use among persons aged 12 or older in 2011 (8.7 percent) was similar to the rates in 2010 (8.9 percent), 2009 (8.7 percent), and 2002 (8.3 percent), but it was higher than the rates in most years from 2003 through 2008 (Figure 2.2).

- In 2011, marijuana was the most commonly used illicit drug, with 18.1 million current users. It was used by 80.5 percent of current illicit drug users. About two thirds (64.3 percent) of illicit drug users used only marijuana in the past month. Also, in 2011, 8.0 million persons aged 12 or older were current users of illicit drugs other than marijuana (or 35.7 percent of illicit drug users aged 12 or older). Current use of other drugs but not marijuana was reported by 19.5 percent of illicit drug users, and 16.2 percent of illicit drug users reported using both marijuana and other drugs.

Figure 2.1 Past Month Illicit Drug Use among Persons Aged 12 or Older: 2011



[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

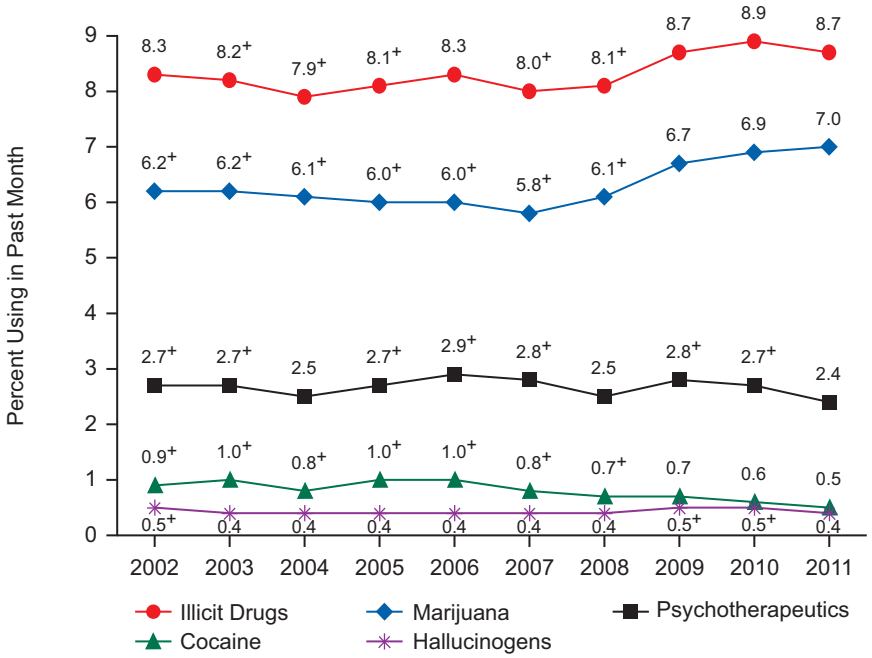
- The number and percentage of persons aged 12 or older who were current users of marijuana in 2011 (18.1 million or 7.0 percent) were similar to the estimates for 2010 (17.4 million or 6.9 percent). The 2011 rate of current marijuana use also was similar to the rate in 2009 (6.7 percent), but it was higher than those in 2002 through 2008. Between 2007 and 2011, for example, the rate of use increased from 5.8 to 7.0 percent, and the number of users increased from 14.5 million to 18.1 million.

- An estimated 8.0 million people aged 12 or older (3.1 percent) were current users of illicit drugs other than marijuana in 2011. The majority of these users (6.1 million persons or 2.4 percent of the population) were nonmedical users of psychotherapeutic drugs, including 4.5 million users of pain relievers, 1.8 million users of tranquilizers, 970,000 users of stimulants, and 231,000 users of sedatives.

- The number and percentage of persons aged 12 or older who were current nonmedical users of psychotherapeutic drugs in 2011 (6.1 million or 2.4 percent) were lower than those in 2010 (7.0 million or 2.7 percent) and 2009 (7.0 million or 2.8 percent) (Figure 2.2).

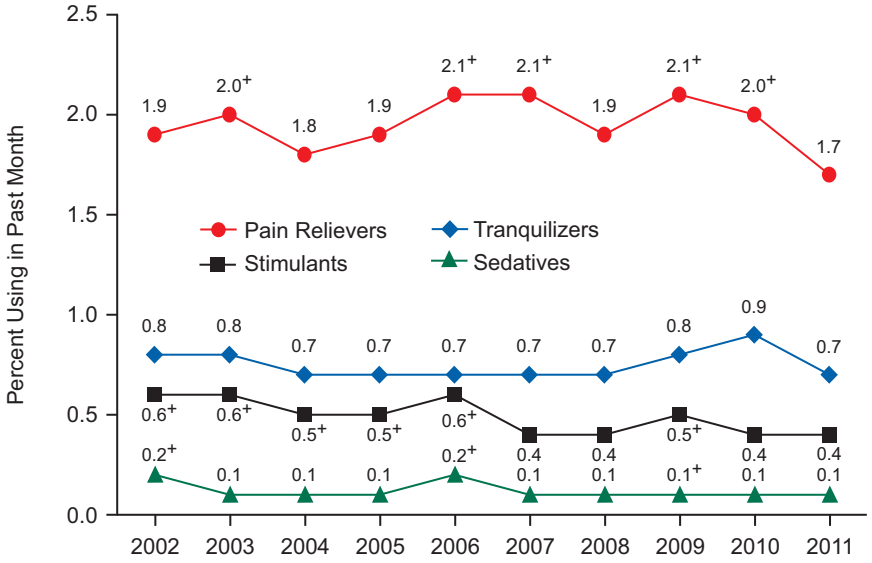
- The number and percentage of persons aged 12 or older who were current nonmedical users of pain relievers in 2011 (4.5 million or 1.7 percent) were lower than those in 2010 (5.1 million or 2.0 percent) and 2009 (5.3 million or 2.1 percent) (Figure 2.3).

Figure 2.2 Past Month Use of Selected Illicit Drugs among Persons Aged 12 or Older: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

Figure 2.3 Past Month Nonmedical Use of Types of Psychotherapeutic Drugs among Persons Aged 12 or Older: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

- The number and percentage of persons aged 12 or older who were current nonmedical users of stimulants in 2011 (970,000 or 0.4 percent) were similar to those in 2010 (1.1 million or 0.4 percent), but lower than those in 2009 (1.3 million or 0.5 percent).

- The number and percentage of persons aged 12 or older who were current users of methamphetamine in 2011 (439,000 or 0.2 percent) were similar to those from 2007 through 2010, but lower than those from 2002 through 2006. The previous numbers and percentages were 353,000 (0.1 percent) in 2010, 502,000 (0.2 percent) in 2009, 314,000 (0.1 percent) in 2008, 530,000 (0.2 percent) in 2007, 731,000 (0.3 percent) in 2006, 628,000 (0.3 percent) in 2005, 706,000 (0.3 percent) in 2004, 726,000 (0.3 percent) in 2003, and 683,000 (0.3 percent) in 2002.

- The number and percentage of persons aged 12 or older who were current users of cocaine in 2011 (1.4 million or 0.5 percent) were similar to those in 2010 (1.5 million or 0.6 percent) and 2009 (1.6 million or 0.7 percent), but lower than those from 2002 through 2008 (Figure 2.2). The previous numbers and percentages were 1.9 million (0.7 percent) in 2008, 2.1 million (0.8 percent) in 2007, 2.4 million (1.0 percent) in 2006, 2.4 million (1.0 percent) in 2005, 2.0 million (0.8 percent) in 2004, 2.3 million (1.0 percent) in 2003, and 2.0 million (0.9 percent) in 2002.

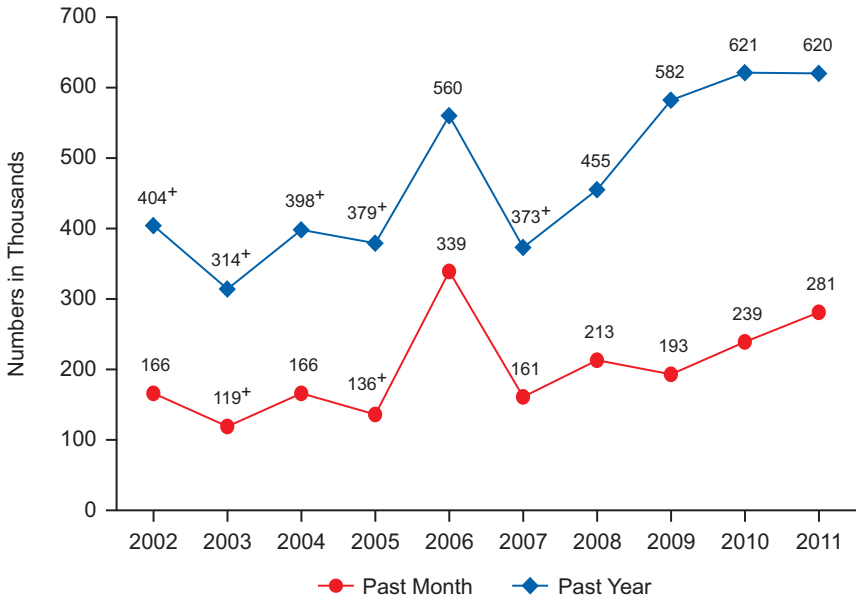
- The number and percentage of persons aged 12 or older who were current heroin users in 2011 (281,000 or 0.1 percent) were similar to those from 2006 through 2010 (239,000 or 0.1 percent in 2010; 193,000 or 0.1 percent in 2009; 213,000 or 0.1 percent in 2008; 161,000 or 0.1 percent in 2007; and 339,000 or 0.1 percent in 2006), but were higher than those in 2005 (136,000 or 0.1 percent) and 2003 (119,000 or 0.1 percent) (Figure 2.4). Additionally, the number and percentage of persons aged 12 or older who were past year heroin users in 2011 (620,000 or 0.2 percent) were similar to those in 2008 to 2010 (621,000 or 0.2 percent in 2010; 582,000 or 0.2 percent in 2009; and 455,000 or 0.2 percent in 2008) and in 2006 (560,000 or 0.2 percent), but were higher than those from 2003 through 2005 and in 2007.

- The number and percentage of persons aged 12 or older who were current users of hallucinogens in 2011 (972,000 or 0.4 percent) were lower than those in 2010 (1.2 million or 0.5 percent), 2009 (1.3 million or 0.5 percent), and 2002 (1.2 million or 0.5 percent) (Figure 2.2).

Age

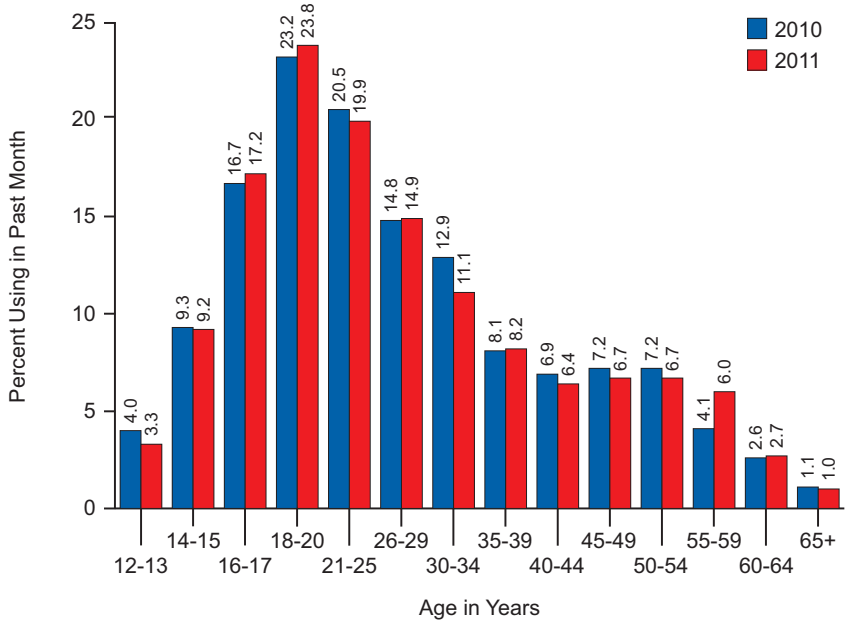
- The rate of current illicit drug use varied by age. Among youths aged 12 to 17 in 2011, the rate increased from 3.3 percent at ages 12 or 13 to 9.2 percent at ages 14 or 15 to 17.2 percent at ages 16 or 17 (Figure 2.5). The highest rate of current illicit drug use was among 18 to 20 year olds (23.8 percent), with the next highest rate among 21 to 25 year olds (19.9 percent). Thereafter, the rate generally declined with age, although not all declines were significant.

Figure 2.4 Past Month and Past Year Heroin Use among Persons Aged 12 or Older: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

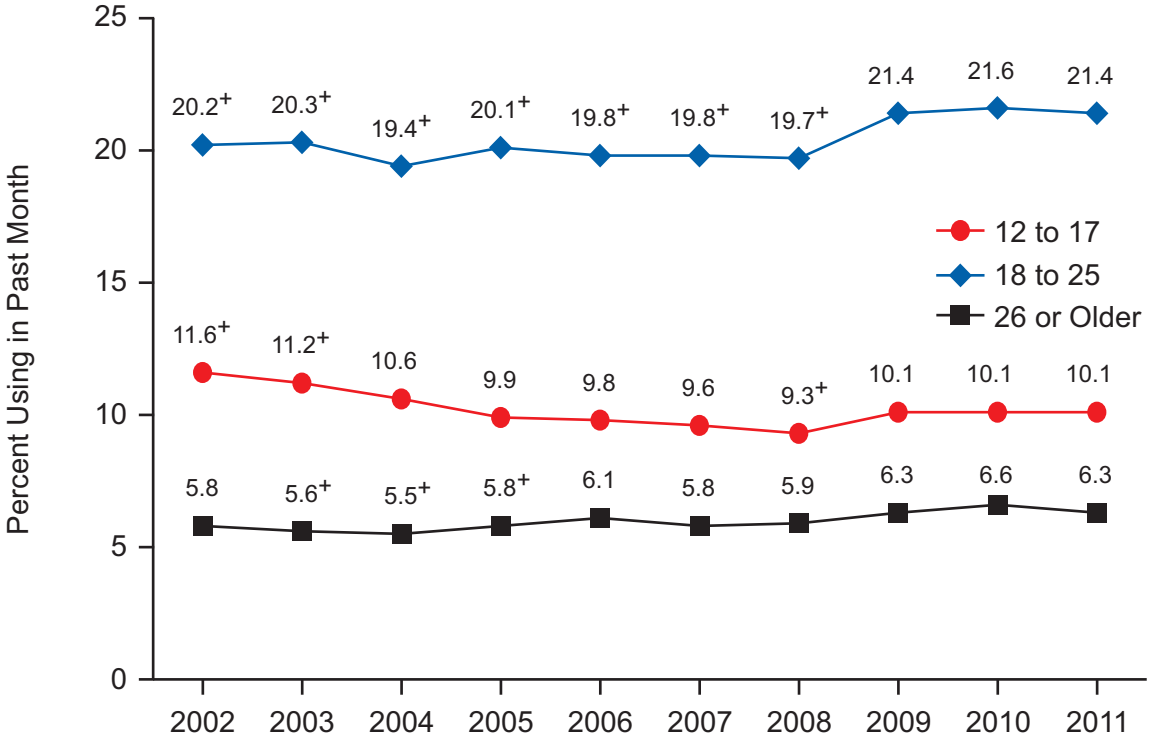
Figure 2.5 Past Month Illicit Drug Use among Persons Aged 12 or Older, by Age: 2010 and 2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

- In 2011, adults aged 26 or older were less likely to be current users of illicit drugs than youths aged 12 to 17 or young adults aged 18 to 25 (6.3 vs. 10.1 and 21.4 percent, respectively) (Figure 2.6). However, there were more current users of illicit drugs aged 26 or older (12.6 million) than users aged 12 to 17 (2.5 million) and users aged 18 to 25 (7.4 million) combined.

Figure 2.6 Past Month Illicit Drug Use among Persons Aged 12 or Older, by Age: 2002-2011



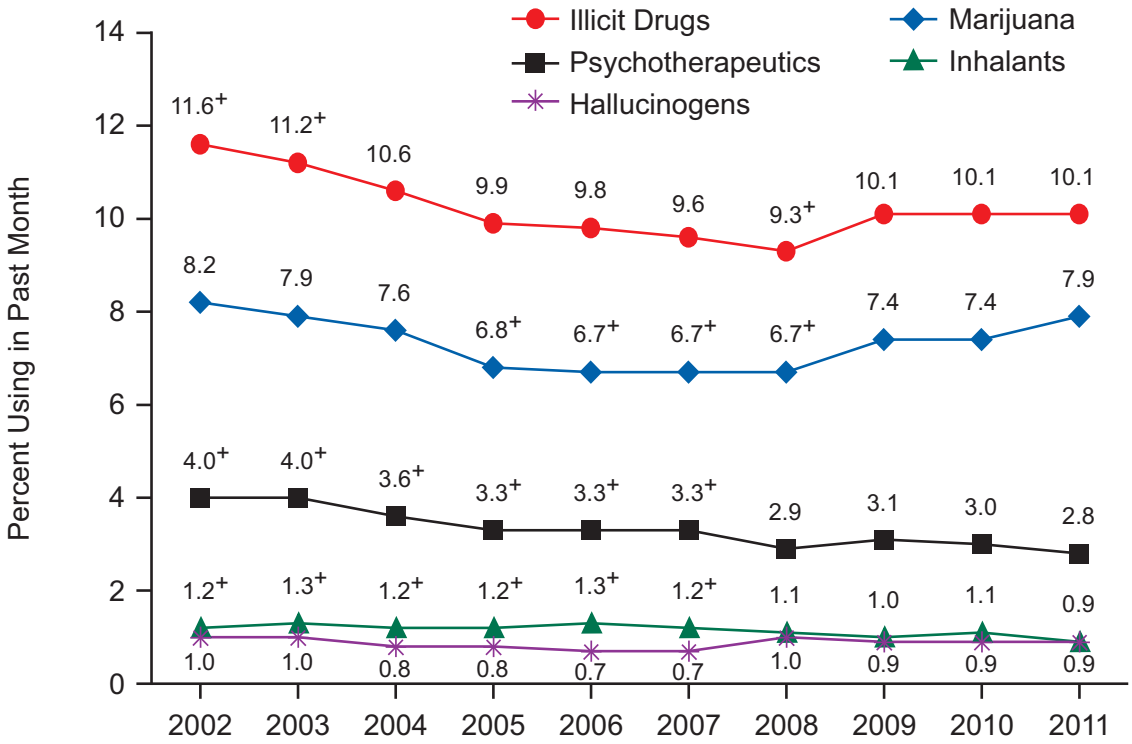
+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

Youths Aged 12 to 17

- The rate of current illicit drug use among youths aged 12 to 17 remained unchanged between 2009 and 2011 (10.1 percent in each year), but it was higher than the rate in 2008 (9.3 percent). Between 2002 and 2008, the rate declined from 11.6 to 9.3 percent (Figure 2.7).

- In 2011, 10.1 percent of youths aged 12 to 17 were current illicit drug users, with 7.9 percent current users of marijuana, 2.8 percent current nonmedical users of psychotherapeutic drugs, 0.9 percent current users of hallucinogens, 0.9 percent current users of inhalants, and 0.3 percent current users of cocaine.

Figure 2.7 Past Month Use of Selected Illicit Drugs among Youths Aged 12 to 17: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

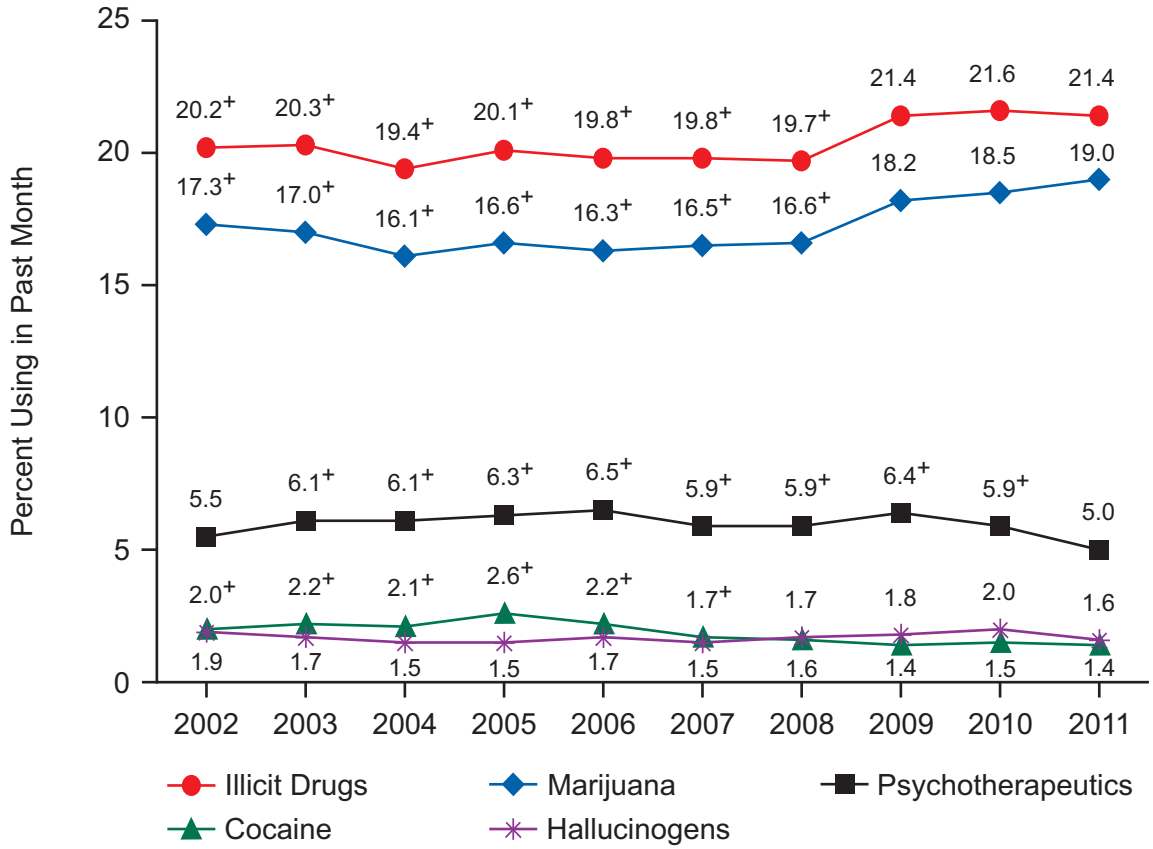
- Among youths aged 12 to 17, the specific illicit drugs used in the past month varied by age in 2011. Among 12 or 13 year olds, 1.3 percent used marijuana and 1.3 percent used psychotherapeutic drugs nonmedically (which was a decrease from 2.0 percent in 2010, with most of the decrease occurring in the nonmedical use of pain relievers from 1.8 percent in 2010 to 1.1 percent in 2011). Among 14 or 15 year olds, 6.7 percent used marijuana, 2.6 percent used psychotherapeutic drugs nonmedically, and 0.8 percent used hallucinogens. Among 16 or 17 year olds, 15.1 percent used marijuana, 4.2 percent used psychotherapeutic drugs nonmedically, 1.6 percent used hallucinogens, and 0.5 percent used cocaine. Rates of current use of inhalants were 1.0 percent for 12 or 13 year olds, 0.9 percent for 14 or 15 year olds, and 0.7 percent for 16 to 17 year olds.

- After gradually declining from 11.6 percent in 2002 to 9.3 percent in 2008, the rate of current illicit drug use among 12 to 17 year olds increased to 10.1 percent in 2009, 2010, and 2011 (Figure 2.7). Current marijuana use declined from 8.2 percent in 2002 to 6.7 percent in 2008 before increasing to 7.4 percent in 2009 and 2010; the prevalence of current marijuana use in 2011 (7.9 percent) also was greater than that in 2008, but it was similar to the rates in 2009 and 2010. Current nonmedical use of psychotherapeutic drugs declined from 4.0 percent in 2002 and 2003 to 2.8 percent in 2011. This includes the decrease in the current nonmedical use of pain relievers from 3.2 percent in 2002 to 2.3 percent in 2011.

Young Adults Aged 18 to 25

- In 2011, the rate of current illicit drug use was higher among young adults aged 18 to 25 (21.4 percent) than among youths aged 12 to 17 (10.1 percent) and adults aged 26 or older (6.3 percent). Among young adults, the 2011 rate was similar to the 2009 (21.4 percent) and 2010 (21.6 percent) rates, but it was higher than the 2008 rate (19.7 percent) (Figure 2.8).

Figure 2.8 Past Month Use of Selected Illicit Drugs among Young Adults Aged 18 to 25: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

- Among young adults, the 2011 rate of current marijuana use (19.0 percent) was similar to the 2009 (18.2 percent) and 2010 (18.5 percent) rates, but it was higher than the 2008 rate (16.6 percent).

- In 2011, the rate of current nonmedical use of psychotherapeutic drugs among young adults aged 18 to 25 was 5.0 percent, which was lower than the rates from 2003 through 2010. Similarly, in 2011, the rate of current nonmedical use of pain relievers was 3.6 percent, which was lower than the rates from 2002 through 2010. Rates of current nonmedical use of pain relievers among young adults for 2002 to 2010 ranged from 4.1 percent in 2002 to 5.0 percent in 2006; the rate in 2010 was 4.4 percent.

- In 2011, the rate of current use of cocaine among young adults aged 18 to 25 was 1.4 percent, which was similar to the rates from 2008 through 2010, but was lower than the rates from 2002 through 2007.

Adults Aged 26 or Older

- In 2011, the rate of current illicit drug use among adults aged 26 or older was 6.3 percent, with 4.8 percent current users of marijuana and 1.9 percent current nonmedical users of psychotherapeutic drugs. Less than 1 percent each were current users of cocaine (0.4 percent), heroin (0.1 percent), and inhalants (0.1 percent). These rates were similar to those in 2009 and 2010. For example, 6.3 percent of adults aged 26 or older in 2009 and 6.6 percent of those in 2010 were current illicit drug users.

- Among adults aged 50 to 59, the rate of current illicit drug use increased from 2.7 to 6.3 percent between 2002 and 2011 (Figure 2.9). For those aged 50 to 54, the rate increased from 3.4 percent in 2002 to 6.7 percent in 2011. Among those aged 55 to 59, current illicit drug use increased from 1.9 percent in 2002 to 6.0 percent in 2011. These patterns and trends partially reflect the aging into these age groups of members of the baby boom cohort, whose rates of illicit drug use have been higher than those of older cohorts. The baby boom cohort refers to persons born in the United States after World War II between 1946 and 1964 (Han, Gfroerer, & Colliver, 2009).

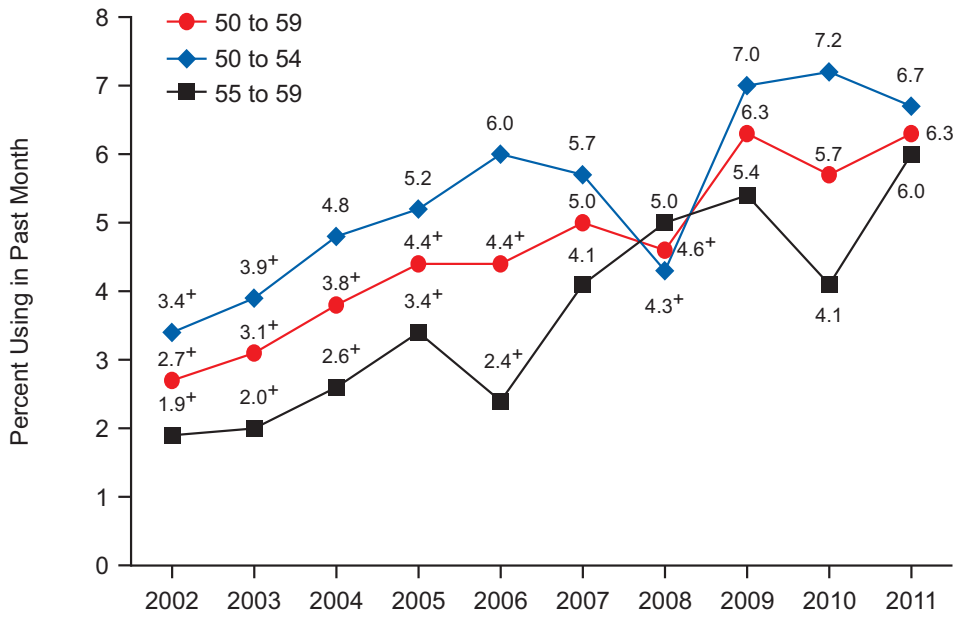
Gender

- In 2011, as in prior years, the rate of current illicit drug use among persons aged 12 or older was higher for males (11.1 percent) than for females (6.5 percent). Males were more likely than females to be current users of several different illicit drugs, including marijuana (9.3 vs. 4.9 percent), nonmedical use of prescription drugs (2.6 vs. 2.2 percent), cocaine (0.7 vs. 0.4 percent), and hallucinogens (0.5 vs. 0.3 percent). The 2011 rates for both males and females aged 12 or older were similar to those reported in 2010, with the exception of a decrease in the current nonmedical use of prescription drugs among females (down from 2.5 percent in 2010).

- In 2011, the rate of current illicit drug use was higher among males aged 12 to 17 than females aged 12 to 17 (10.8 vs. 9.3 percent), which represents a change from 2010, when current illicit drug use did not differ significantly between males and females (10.4 and 9.8 percent). Males aged 12 to 17 also were more likely than females to be current marijuana users (9.0 vs. 6.7 percent). However, females aged 12 to 17 were more likely than males to be current nonmedical users of psychotherapeutic drugs (3.2 vs. 2.4 percent) and current nonmedical users of pain relievers (2.6 vs. 1.9 percent).

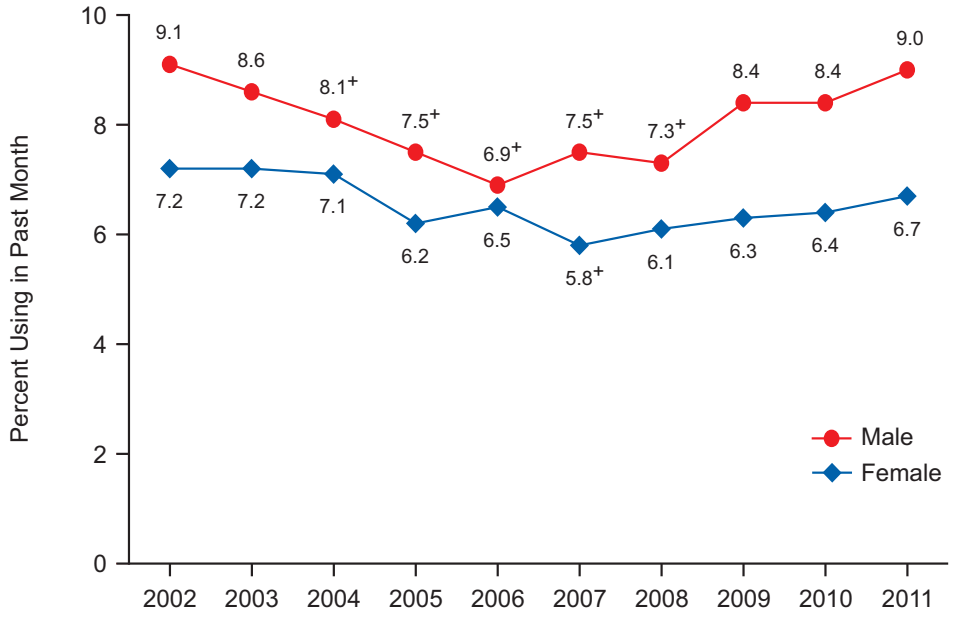
- The rate of current marijuana use among males aged 12 to 17 declined from 9.1 percent in 2002 to 6.9 percent in 2006, then increased between 2006 and 2009 (8.4 percent); rates remained stable after 2009 (8.4 percent in 2010 and 9.0 percent in 2011) (Figure 2.10). Among females aged 12 to 17, the rate of current marijuana use changed little between 2002 (7.2 percent) and 2004 (7.1 percent), then declined to 5.8 percent in 2007 before increasing in 2011 to 6.7 percent.

Figure 2.9 Past Month Illicit Drug Use among Adults Aged 50 to 59: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

Figure 2.10 Past Month Marijuana Use among Youths Aged 12 to 17, by Gender: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

Pregnant Women

- Among pregnant women aged 15 to 44, 5.0 percent were current illicit drug users based on data averaged across 2010 and 2011. This was lower than the rate among women in this age group who were not pregnant (10.8 percent). Among pregnant women aged 15 to 44, the average rate of current illicit drug use in 2010-2011 (5.0 percent) was not significantly different from the rate averaged across 2008-2009 (4.5 percent).

- The rate of current illicit drug use in the combined 2010-2011 data was 20.9 percent among pregnant women aged 15 to 17, 8.2 percent among pregnant women aged 18 to 25, and 2.2 percent among pregnant women aged 26 to 44. None of these rates were significantly different from those in the combined 2008-2009 data (15.8 percent among pregnant women aged 15 to 17, 7.1 percent among pregnant women aged 18 to 25, and 2.3 percent among pregnant women aged 26 to 44).

Race/Ethnicity

- In 2011, among persons aged 12 or older, the rate of current illicit drug use was lowest among Asians (3.8 percent) (Figure 2.11). The rates were 8.4 percent among Hispanics, 8.7 percent among whites, 10.0 percent among blacks, 11.0 percent among Native Hawaiians or Other Pacific Islanders, 13.4 percent among American Indians or Alaska Natives, and 13.5 percent among persons of two or more races.

- There were no statistically significant differences in the rates of current illicit drug use between 2010 and 2011 or between 2002 and 2011 for any of the racial/ethnic groups, except for Hispanics. The current illicit drug use rate for Hispanics increased between 2002 and 2011 (from 7.2 to 8.4 percent).

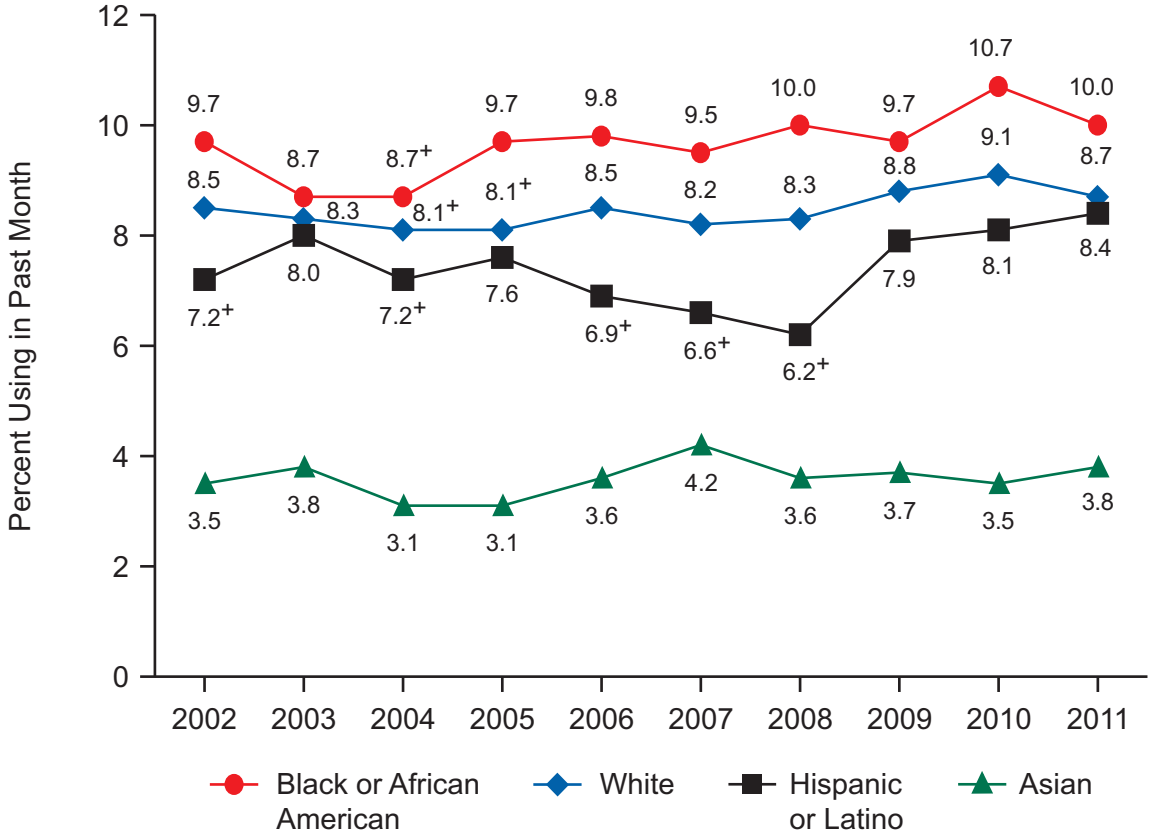
Education

- Illicit drug use in 2011 varied by the educational status of adults aged 18 or older, with the rate of current illicit drug use lower among college graduates (5.4 percent) than those with some college education (10.4 percent), high school graduates (8.9 percent), and those who had not graduated from high school (11.1 percent).

College Students

- In 2011, the rate of current use of illicit drugs was 22.0 percent among full-time college students aged 18 to 22. This was similar to the rate among other persons aged 18 to 22 (23.4 percent), which included part-time college students, students in other grades or types of institutions, and nonstudents.

Figure 2.11 Past Month Illicit Drug Use among Persons Aged 12 or Older, by Race/Ethnicity: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

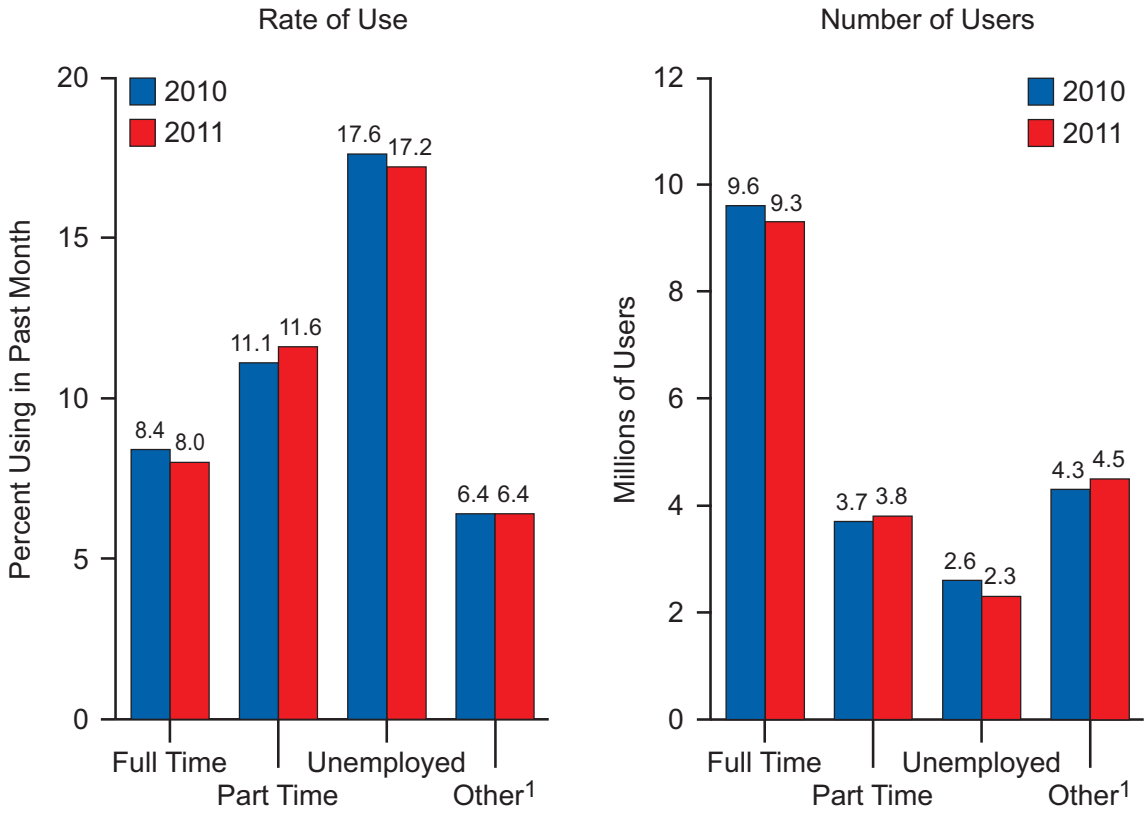
Note: Sample sizes for American Indians or Alaska Natives and for persons of two or more races were too small for reliable trend presentation for these groups. Due to low precision, estimates for Native Hawaiians or Other Pacific Islanders are not shown.

- In 2011, the rate of current illicit drug use was 25.8 percent among male full-time college students aged 18 to 22, which was higher than the rate among female full-time college students aged 18 to 22 (18.9 percent). Similarly, 23.7 percent of male full-time college students aged 18 to 22 were current marijuana users compared with 17.5 percent of female full-time college students aged 18 to 22.

Employment

- Current illicit drug use differed by employment status in 2011. Among adults aged 18 or older, the rate of current illicit drug use was higher for those who were unemployed (17.2 percent) than for those who were employed full time (8.0 percent), employed part time (11.6 percent), or "other" (6.4 percent) (which includes students, persons keeping house or caring for children full time, retired or disabled persons, or other persons not in the labor force) (Figure 2.12).

Figure 2.12 Past Month Illicit Drug Use among Persons Aged 18 or Older, by Employment Status: 2010 and 2011



+Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

[1] The Other Employment category includes students, persons keeping house or caring for children full time, retired or disabled persons, or other persons not in the labor force.

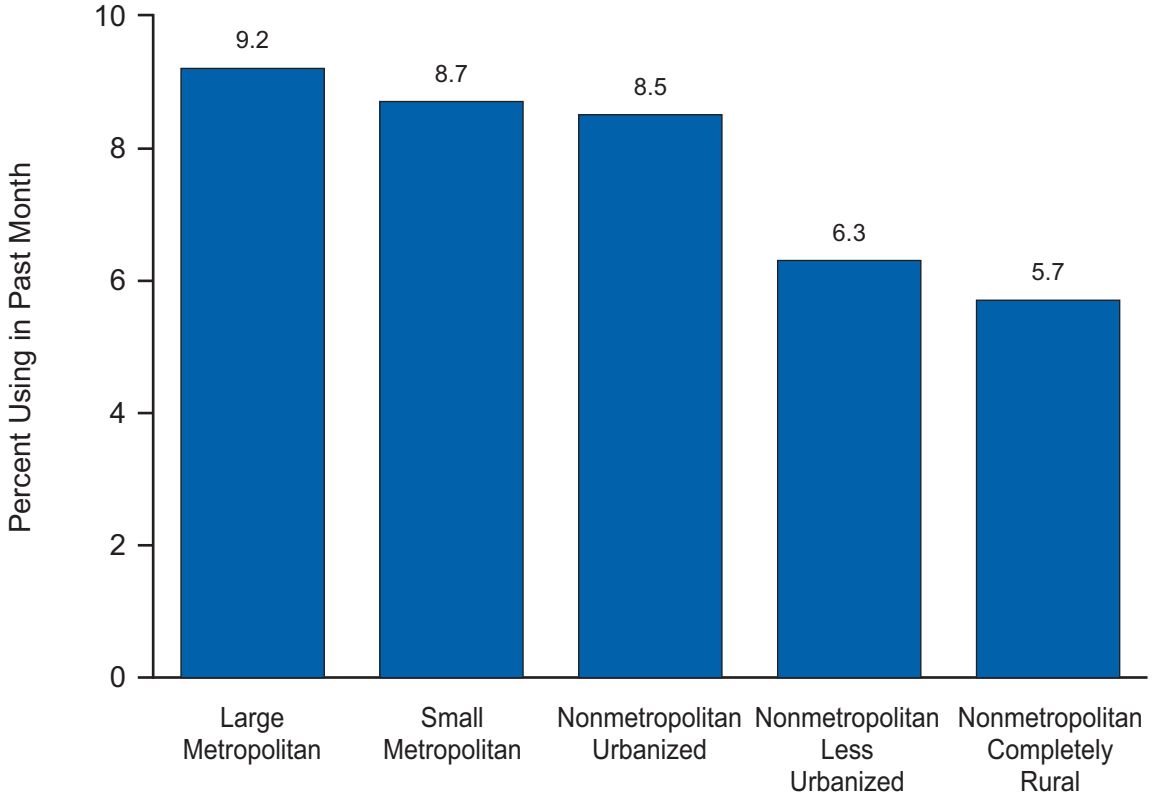
- Although the rate of current illicit drug use was higher among unemployed persons in 2011 compared with those who were either employed full time, employed part time, or "other," most of these users were employed. Of the 19.9 million current illicit drug users aged 18 or older in 2011, 13.1 million (65.7 percent) were employed either full or part time.

Geographic Area

- Among persons aged 12 or older, the rate of current illicit drug use in 2011 was 10.5 percent in the West, 9.2 percent in the Northeast, 8.5 percent in the Midwest, and 7.5 percent in the South.

- In 2011, the rate of current illicit drug use among persons aged 12 or older was 9.2 percent in large metropolitan counties, 8.7 percent in small metropolitan counties, and 7.2 percent in nonmetropolitan counties as a group (Figure 2.13). Within nonmetropolitan areas, the rate was 8.5 percent in urbanized counties, 6.3 percent in less urbanized counties, and 5.7 percent in completely rural counties.

Figure 2.13 Past Month Illicit Drug Use among Persons Aged 12 or Older, by County Type: 2011



Criminal Justice Populations

- In 2011, an estimated 1.7 million adults aged 18 or older were on parole or other supervised release from prison at some time during the past year. More than one quarter of these (26.5 percent) were current illicit drug users, with 20.4 percent reporting current use of marijuana and 9.1 percent reporting current nonmedical use of psychotherapeutic drugs. These rates were higher than those reported by adults aged 18 or older who were not on parole or supervised release during the past year (8.4 percent for illicit drug use, 6.8 percent for marijuana use, and 2.3 percent for nonmedical use of psychotherapeutic drugs).

- In 2011, an estimated 4.7 million adults aged 18 or older were on probation at some time during the past year. More than one quarter (28.5 percent) were current illicit drug users, with 23.6 percent reporting current use of marijuana and 10.1 percent reporting current nonmedical use of psychotherapeutic drugs. These rates were higher than those reported by adults who were not on probation during the past year (8.2 percent for illicit drug use, 6.6 percent for marijuana use, and 2.2 percent for nonmedical use of psychotherapeutic drugs).

Frequency of Marijuana Use

- In 2011, an estimated 16.7 percent of past year marijuana users aged 12 or older used marijuana on 300 or more days within the past 12 months. This translates into nearly 5.0 million persons using marijuana on a daily or almost daily basis over a 12-month period.

- In 2011, an estimated 39.1 percent (7.1 million) of current marijuana users aged 12 or older used marijuana on 20 or more days in the past month. This was similar to the 2010 estimate of 39.8 percent or 6.9 million users.

Association with Cigarette and Alcohol Use

- In 2011, the rate of current illicit drug use was approximately 9.5 times higher among youths aged 12 to 17 who smoked cigarettes in the past month (57.6 percent) than it was among those who did not smoke cigarettes in the past month (6.1 percent). Moreover, the 2011 rate of current illicit drug use among youths aged 12 to 17 who smoked cigarettes in the past month was an increase from the 2010 estimate of 52.7 percent.

- In 2011, the rate of current illicit drug use was associated with the level of past month alcohol use. Among youths aged 12 to 17 who were heavy drinkers (i.e., consumed five or more drinks on the same occasion on each of 5 or more days in the past 30 days), 70.4 percent were current illicit drug users, which was higher than the rate among those who were not current alcohol users (5.3 percent). Additionally, among youths aged 12 to 17 who were binge but not heavy drinkers (i.e., consumed five or more drinks on the same occasion on 1 to 4 days in the past 30 days), 44.7 percent were also current illicit drug users.

- In 2011, the rate of current illicit drug use was approximately 17 times higher among youths aged 12 to 17 who both smoked cigarettes and drank alcohol in the past month (68.7 percent) than it was among those who neither smoked cigarettes nor drank alcohol in the past month (4.0 percent).

Driving Under the Influence of Illicit Drugs

- In 2011, 9.4 million persons or 3.7 percent of the population aged 12 or older reported driving under the influence of illicit drugs during the past year. This was a decrease from the rate in 2010 (4.2 percent) and the rate in 2002 (4.7 percent). Across age groups, the rate of driving under the influence of illicit drugs in 2011 was highest among young adults aged 18 to 25 (11.6 percent); this rate for young adults in 2011 was lower than the rate in 2010 (12.7 percent). Additionally, the rate of driving under the influence of illicit drugs during the past year decreased among adults aged 26 or older (from 2.9 percent in 2010 to 2.4 percent in 2011).

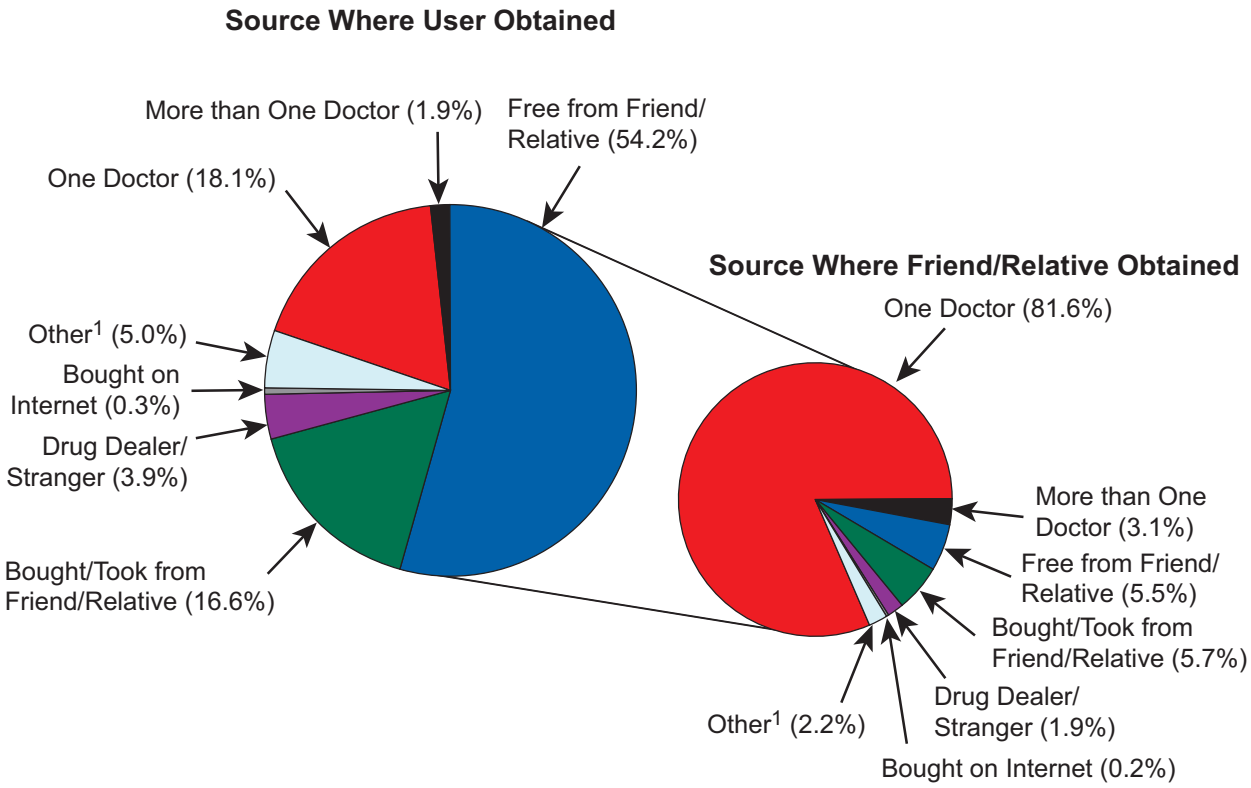
Source of Prescription Drugs

- Past year nonmedical users of psychotherapeutic drugs are asked how they obtained the drugs they most recently used nonmedically. Rates averaged across 2010 and 2011 show that over one half of the nonmedical users of pain relievers, tranquilizers, stimulants, and sedatives aged 12 or older got the prescription drugs they most recently used "from a friend of relative for free." About 4 in 5 of these nonmedical users who obtained prescription drugs from a friend or relative for free indicated that their friend or relative had obtained the drugs from one doctor.

- Among persons aged 12 or older in 2010-2011 who used pain relievers nonmedically in the past year, 54.2 percent got the pain relievers they most recently used from a friend or relative for free (Figure 2.14). Another 12.2 percent bought them from a friend of relative (which was higher than the 9.9 percent in 2008-2009). In addition, 4.4 percent of these nonmedical users in 2010-2011 took pain relievers from a friend or relative without asking. More than one in six (18.1 percent) indicated that they got the drugs they most recently used through a prescription from one doctor. Less than 1 in 20 users (3.9 percent) got pain relievers from a drug dealer or other stranger, 1.9 percent got pain relievers from more than one doctor, and 0.3 percent bought them on the Internet. These other percentages were similar to those reported in 2008-2009.

- Among persons aged 12 or older in 2010-2011 who used pain relievers nonmedically in the past year and indicated that they most recently obtained the drugs from a friend or relative for free in the past year, 81.6 percent of the friends or relatives obtained the drugs from just one doctor (Figure 2.14). About 1 in 20 of these past year nonmedical users of pain relievers (5.5 percent) reported that the friend or relative got the pain relievers from another friend or relative for free, 3.9 percent reported that the friend or relative bought the drugs from a friend or relative, 1.9 percent reported that the friend or relative bought the drugs from a drug dealer or other stranger, and 1.8 percent reported that the friend or relative took the drugs from another friend or relative without asking.

Figure 2.14 Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2010-2011



Note: The percentages do not add to 100 percent due to rounding.

[1] The Other category includes the sources "Wrote Fake Prescription," "Stole from Doctor's Office/Clinic/Hospital/Pharmacy," and "Some Other Way."

3. Alcohol Use

The National Survey on Drug Use and Health (NSDUH) includes questions about the recency and frequency of consumption of alcoholic beverages, such as beer, wine, whiskey, brandy, and mixed drinks. A "drink" is defined as a can or bottle of beer, a glass of wine or a wine cooler, a shot of liquor, or a mixed drink with liquor in it. Times when the respondent only had a sip or two from a drink are not considered to be consumption. For this report, estimates for the prevalence of alcohol use are reported primarily at three levels defined for both males and females and for all ages as follows:

Current (past month) use - At least one drink in the past 30 days.

Binge use - Five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

Heavy use - Five or more drinks on the same occasion on each of 5 or more days in the past 30 days.

These levels are not mutually exclusive categories of use; heavy use is included in estimates of binge and current use, and binge use is included in estimates of current use.

This chapter is divided into two main sections. Section 3.1 describes trends and patterns of alcohol use among the population aged 12 or older. Section 3.2 is concerned particularly with the use of alcohol by persons aged 12 to 20. These persons are under the legal drinking age in all 50 States and the District of Columbia.

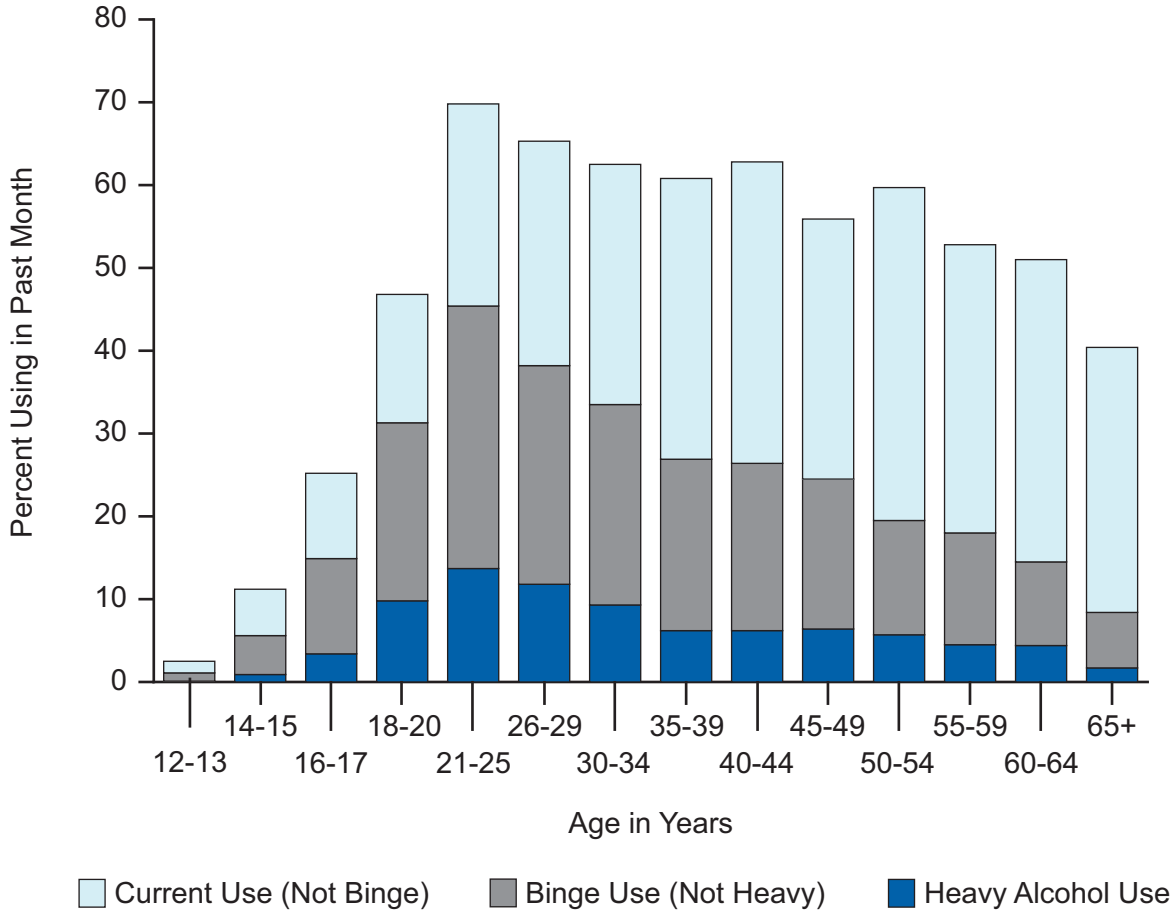
3.1. Alcohol Use among Persons Aged 12 or Older

- Slightly more than half (51.8 percent) of Americans aged 12 or older reported being current drinkers of alcohol in the 2011 survey, similar to the rate in 2010 (51.8 percent). This translates to an estimated 133.4 million current drinkers in 2011.
- Nearly one quarter (22.6 percent) of persons aged 12 or older participated in binge drinking at least once in the 30 days prior to the survey in 2011. This translates to about 58.3 million people. The rate in 2011 was similar to the rate in 2010 (23.1 percent).
- In 2011, heavy drinking was reported by 6.2 percent of the population aged 12 or older, or 15.9 million people. This percentage was lower than the rate of heavy drinking in 2010 (6.7 percent).

Age

- In 2011, rates of current alcohol use were 2.5 percent among persons aged 12 or 13, 11.3 percent of persons aged 14 or 15, 25.3 percent of 16 or 17 year olds, 46.8 percent of those aged 18 to 20, and 69.7 percent of 21 to 25 year olds (Figure 3.1). These estimates were similar to the rates reported in 2010.
- The prevalence of current alcohol use was lower among 60 to 64 year olds (50.9 percent) and adults aged 65 or older (40.3 percent) than among 26 to 29 year olds (65.3 percent).
- Rates of binge alcohol use in 2011 were 1.1 percent among 12 or 13 year olds, 5.7 percent among 14 or 15 year olds, 15.0 percent among 16 or 17 year olds, 31.2 percent among persons aged 18 to 20, and peaked among those aged 21 to 25 at 45.4 percent. The binge drinking rate for 14 or 15 year olds was lower in 2011 than in 2010 (5.7 and 6.7 percent, respectively).

Figure 3.1 Current, Binge, and Heavy Alcohol Use among Persons Aged 12 or Older, by Age: 2011



- The rate of binge drinking in 2011 was 39.8 percent for young adults aged 18 to 25. Heavy alcohol use was reported by 12.1 percent of persons aged 18 to 25, which was lower than the rate in 2010 (13.5 percent).

- The rate of binge drinking among persons aged 65 or older in 2011 was 8.3 percent, while the rate of heavy drinking was 1.7 percent. These rates were similar to the binge and heavy drinking rates in this age group in 2010 (7.6 and 1.6 percent, respectively).

- The rate of current alcohol use among youths aged 12 to 17 was 13.3 percent in 2011. Youth binge and heavy drinking rates were 7.4 and 1.5 percent, respectively. These rates were all similar to those reported in 2010 (13.6, 7.9, and 1.7 percent, respectively).

Gender

- In 2011, an estimated 56.8 percent of males aged 12 or older were current drinkers, which was higher than the rate for females (47.1 percent). However, among youths aged 12 to 17, the percentage of males who were current drinkers (13.3 percent) was similar to the rate for females (13.3 percent).

- Among young adults aged 18 to 25, an estimated 58.1 percent of females and 63.3 percent of males reported current drinking in 2011. The rate for males was lower in 2011 than in 2010 (65.7 percent).

Pregnant Women

- Among pregnant women aged 15 to 44, an estimated 9.4 percent reported current alcohol use, 2.6 percent reported binge drinking, and 0.4 percent reported heavy drinking. These rates were lower than the rates for nonpregnant women in the same age group (55.1, 24.5, and 5.3 percent, respectively). The rate of binge drinking among pregnant women in 2011 and 2010 combined was lower than it was in combined years 2010 and 2009 (2.6 vs. 4.4 percent). All of the estimates by pregnancy status are based on data averaged over 2 years.

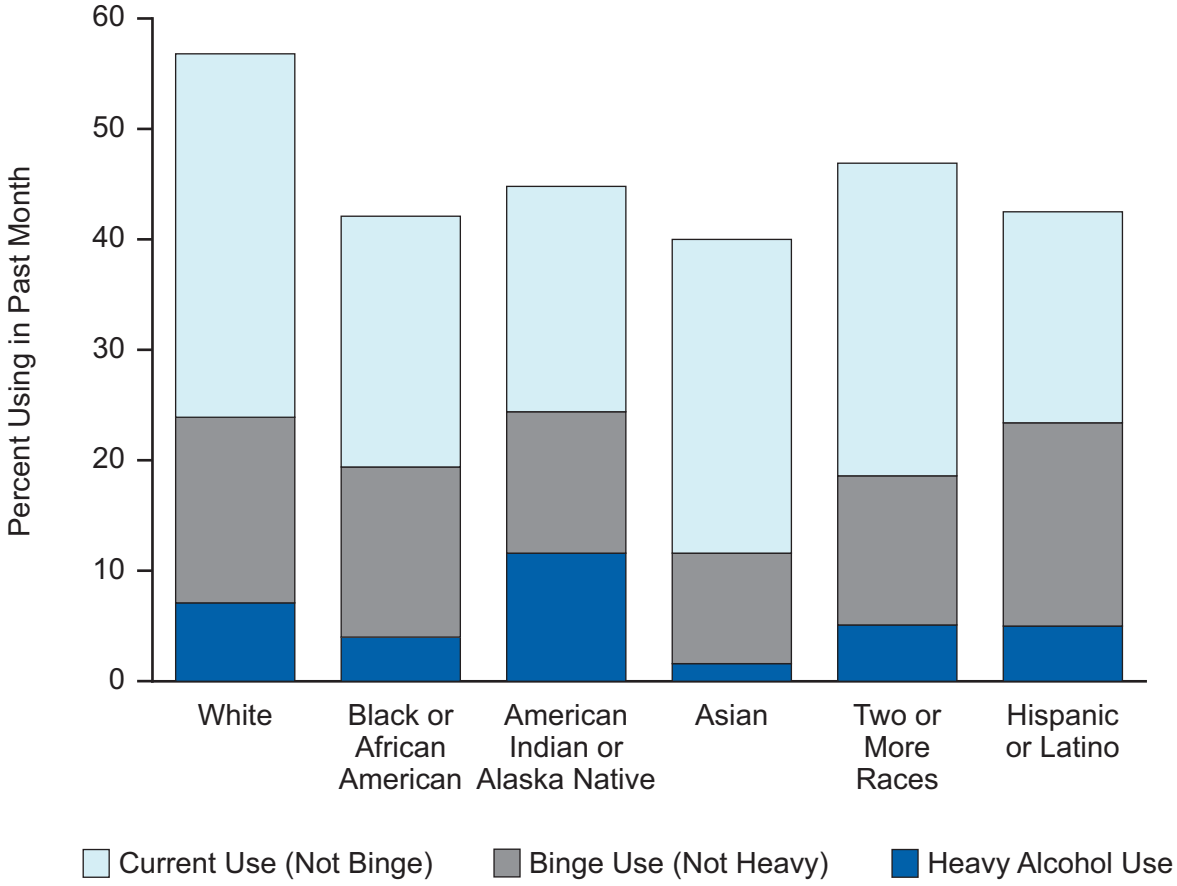
Race/Ethnicity

- Among persons aged 12 or older, whites in 2011 were more likely than other racial/ethnic groups to report current use of alcohol (56.8 percent) (Figure 3.2). The rates were 46.9 percent for persons reporting two or more races, 44.7 percent for American Indians or Alaska Natives, 42.5 percent for Hispanics, 42.1 percent for blacks, and 40.0 percent for Asians.

- The rate of binge alcohol use was lowest among Asians (11.6 percent). Rates for other racial/ethnic groups were 18.6 percent for persons reporting two or more races, 19.4 percent for blacks, 23.4 percent for Hispanics, 23.9 percent for whites, and 24.3 percent for American Indians or Alaska Natives.

- Among youths aged 12 to 17 in 2011, Asians had lower rates of current alcohol use than any other racial/ethnic group (7.4 percent), while 10.5 percent of black youths, 12.6 percent of Hispanic youths, 14.6 percent of white youths, 15.2 percent of American Indian or Alaska Native youths, and 17.5 percent of youths reporting two or more races were current drinkers.

Figure 3.2 Current, Binge, and Heavy Alcohol Use among Persons Aged 12 or Older, by Race/Ethnicity: 2011



Note: Due to low precision, estimates for Native Hawaiians or Other Pacific Islanders are not shown.

Education

- Among adults aged 18 or older, the rate of past month alcohol use increased with increasing levels of education. Among adults with less than a high school education, 35.1 percent were current drinkers in 2011, which was lower than the 68.2 percent of college graduates who were current drinkers.

- Among adults aged 18 or older, rates of binge and heavy alcohol use varied by level of education. Among those with some college education, 26.7 percent were binge drinkers, and 7.9 percent were heavy drinkers. Among those who had graduated from college, rates of binge and heavy drinking were 21.8 and 5.4 percent, respectively.

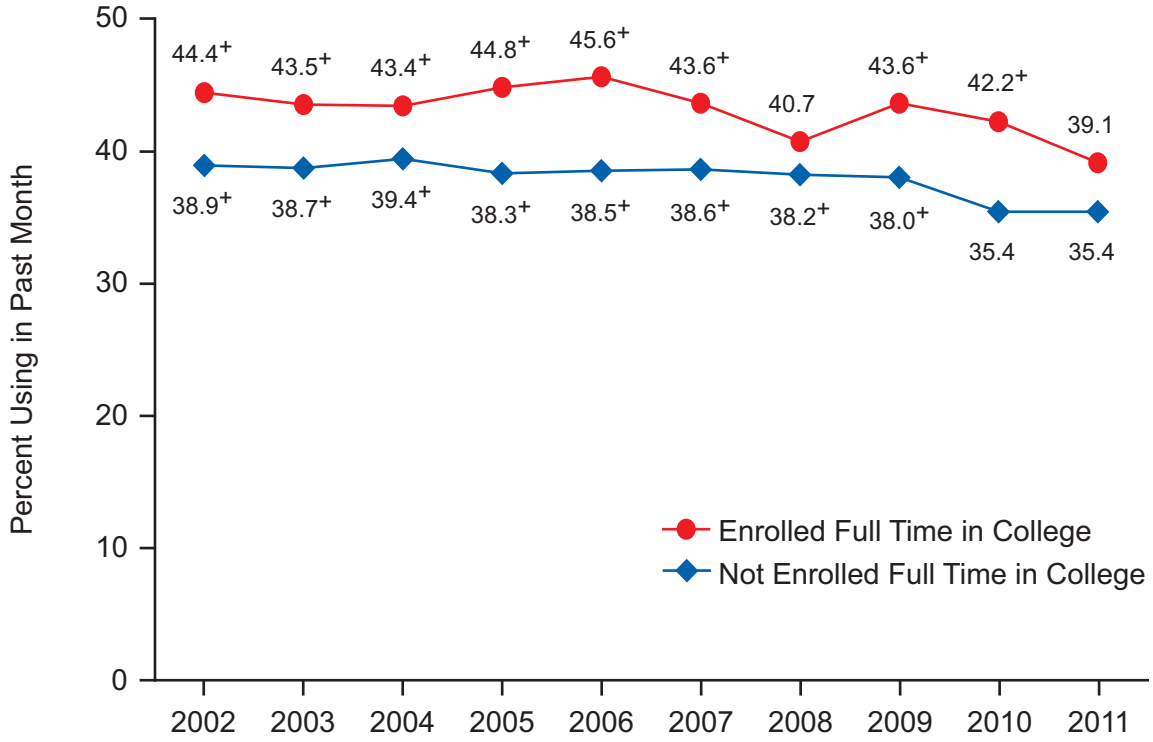
College Students

- Young adults aged 18 to 22 enrolled full time in college were more likely than their peers not enrolled full time (i.e., part-time college students and persons not currently enrolled in college) to use alcohol in the past month, binge drink, and drink heavily. Among full-time college students in 2011, 60.8 percent were current drinkers, 39.1 percent were binge drinkers, and 13.6 percent were heavy drinkers. Among those not enrolled full time in college, these rates were 52.0, 35.4, and 10.5 percent, respectively.

- The pattern of higher rates of current alcohol use, binge alcohol use, and heavy alcohol use among full-time college students compared with rates for others aged 18 to 22 has remained consistent since 2002 (Figure 3.3).

- Among young adults aged 18 to 22, the rate of binge drinking appears to be declining somewhat. In 2002, the binge drinking rate within this age group was 41.0 percent compared with 36.9 percent in 2011. Among full-time college students, the rate decreased from 44.4 to 39.1 percent. Among part-time college students and others not in college, the rate decreased from 38.9 to 35.4 percent during the same time period.

Figure 3.3 Binge Alcohol Use among Adults Aged 18 to 22, by College Enrollment: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

Employment

- The rate of current alcohol use was 64.3 percent for full-time employed adults aged 18 or older in 2011, which was higher than the rate for unemployed adults (54.1 percent). However, the rate of binge drinking among unemployed persons (33.2 percent) was higher than among full-time employed persons (29.5 percent).

- Most binge and heavy alcohol users were employed in 2011. Among 56.5 million adult binge drinkers, 42.1 million (74.4 percent) were employed either full or part time. Among 15.5 million heavy drinkers, 11.6 million (74.9 percent) were employed.

- The rate of heavy alcohol use among unemployed adults in 2011 was lower than the rate in 2010 (9.0 vs. 11.1 percent, respectively).

Geographic Area

- The rate of past month alcohol use for people aged 12 or older in 2011 was lower in the South (48.6 percent) and West (50.7 percent) than in the Northeast (57.1 percent) or Midwest (53.9 percent).

- Among people aged 12 or older, the rates of past month alcohol use in large and small metropolitan areas (54.3 and 51.5 percent, respectively) were higher than in nonmetropolitan areas (43.8 percent). Binge drinking was equally prevalent in large and small metropolitan areas (both 23.1 percent), but was less prevalent in nonmetropolitan areas (20.0 percent).

- The rates of binge alcohol use among youths aged 12 to 17 were 7.3 percent in large metropolitan areas, 7.5 percent in small metropolitan areas, and 7.7 percent in nonmetropolitan areas.

Association with Illicit Drug and Tobacco Use

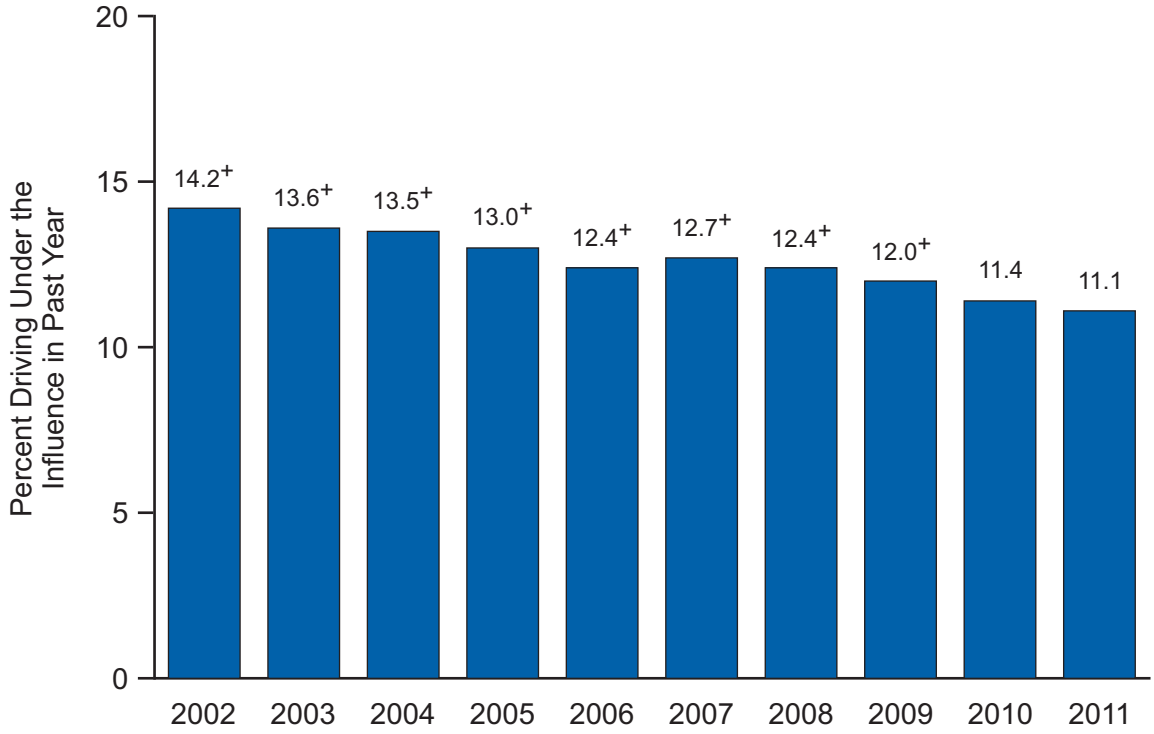
- As was the case in prior years, the level of alcohol use was associated with illicit drug use in 2011. Among the 15.9 million heavy drinkers aged 12 or older, 31.3 percent were current illicit drug users. Persons who were not current alcohol users were less likely to have used illicit drugs in the past month (4.2 percent) than those who reported (a) current use of alcohol but no binge or heavy use (6.7 percent), (b) binge use but no heavy use (17.2 percent), or (c) heavy use of alcohol (31.3 percent).

- Alcohol consumption levels also were associated with tobacco use. Among heavy alcohol users aged 12 or older, 54.9 percent smoked cigarettes in the past month, while only 18.1 percent of non-binge current drinkers and 15.3 percent of persons who did not drink alcohol in the past month were current smokers. Smokeless tobacco use and cigar use also were more prevalent among heavy drinkers (11.7 and 15.2 percent, respectively) than among non-binge drinkers (1.9 and 4.5 percent) and nondrinkers (1.9 and 2.2 percent).

Driving Under the Influence of Alcohol

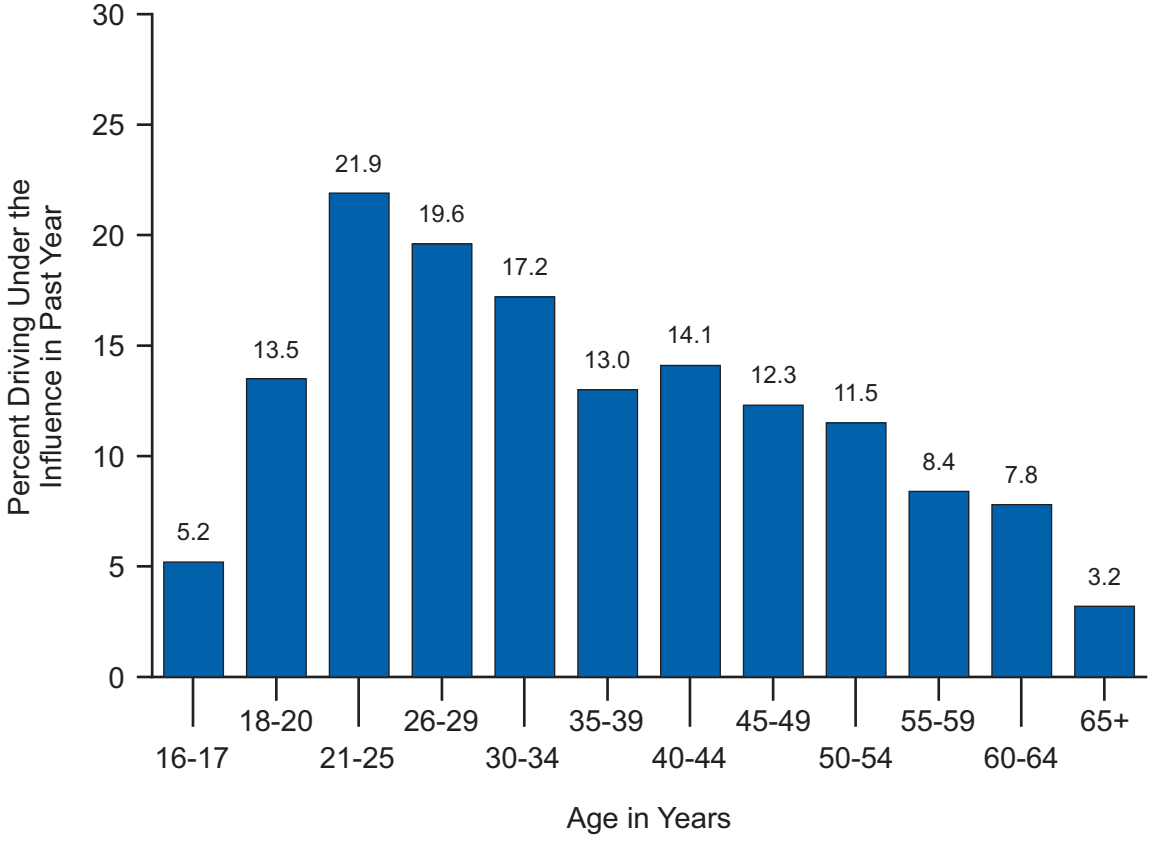
- In 2011, an estimated 11.1 percent of persons aged 12 or older drove under the influence of alcohol at least once in the past year (Figure 3.4). This percentage has dropped since 2002, when it was 14.2 percent. The 2011 estimate corresponds to 28.6 million persons.
- Driving under the influence of alcohol differed by age group in 2011. The rate was highest among persons aged 21 to 25 (21.9 percent) (Figure 3.5). An estimated 5.2 percent of 16 or 17 year olds and 13.5 percent of 18 to 20 year olds reported driving under the influence of alcohol in the past year. Beyond age 25, these rates showed a general decline with increasing age.
- Among persons aged 18 to 25, the rate of driving under the influence of alcohol decreased from the rate reported in 2010, from 20.0 to 18.6 percent.
- Among persons aged 12 or older, males were more likely than females (14.6 vs. 7.8 percent) to drive under the influence of alcohol in the past year.

Figure 3.4 Driving Under the Influence of Alcohol in the Past Year among Persons Aged 12 or Older: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

Figure 3.5 Driving Under the Influence of Alcohol in the Past Year among Persons Aged 16 or Older, by Age: 2011



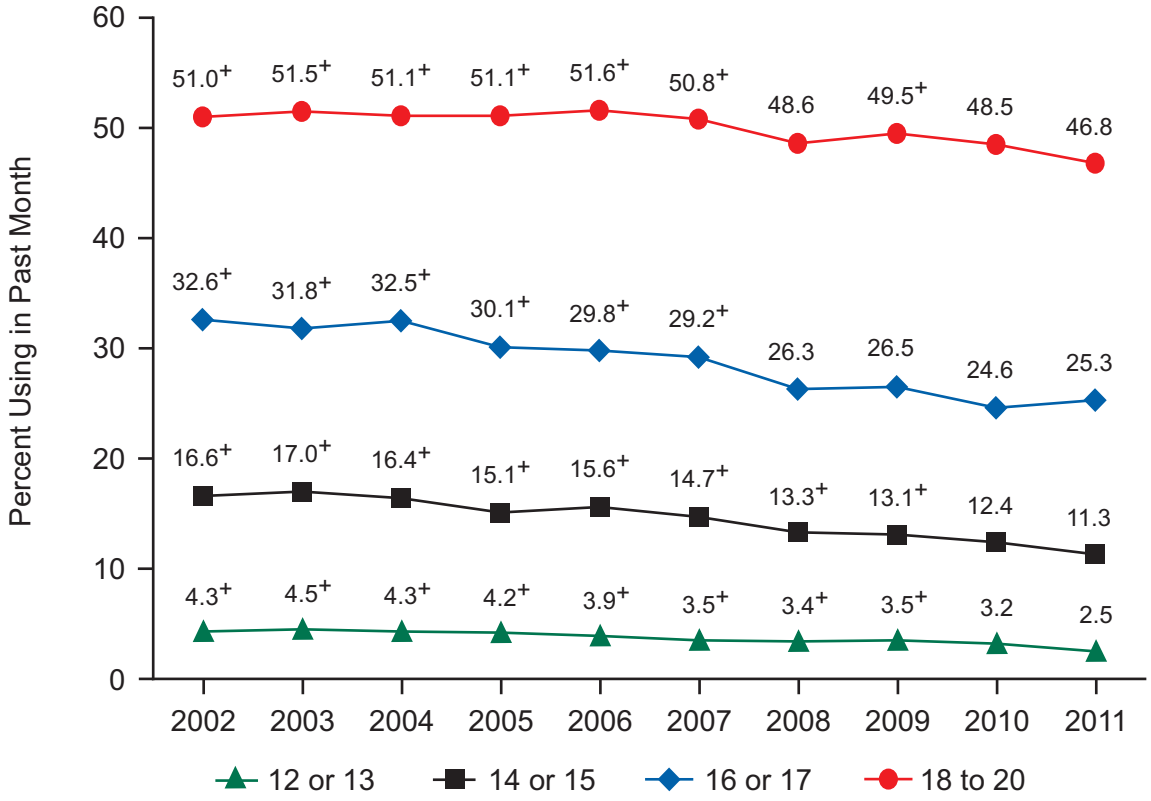
3.2. Underage Alcohol Use

- In 2011, about 9.7 million persons aged 12 to 20 (25.1 percent of this age group) reported drinking alcohol in the past month. Approximately 6.1 million (15.8 percent) were binge drinkers, and 1.7 million (4.4 percent) were heavy drinkers. The rates for binge and heavy drinking were lower than those in 2010 (16.9 and 5.1 percent, respectively).

- Rates of current, binge, and heavy alcohol use among underage persons declined between 2002 and 2011. The rate of current alcohol use among 12 to 20 year olds went from 28.8 percent in 2002 to 25.1 percent in 2011. The binge drinking rate declined from 19.3 to 15.8 percent, and the rate of heavy drinking declined from 6.2 to 4.4 percent.

- Rates of current alcohol use increased with age among underage persons. In 2011, 2.5 percent of persons aged 12 or 13, 11.3 percent of persons aged 14 or 15, 25.3 percent of 16 or 17 year olds, and 46.8 percent of 18 to 20 year olds drank alcohol during the 30 days before they were surveyed. This pattern by age has been observed since 2002 (Figure 3.6).

Figure 3.6 Current Alcohol Use among Persons Aged 12 to 20, by Age: 2002-2011



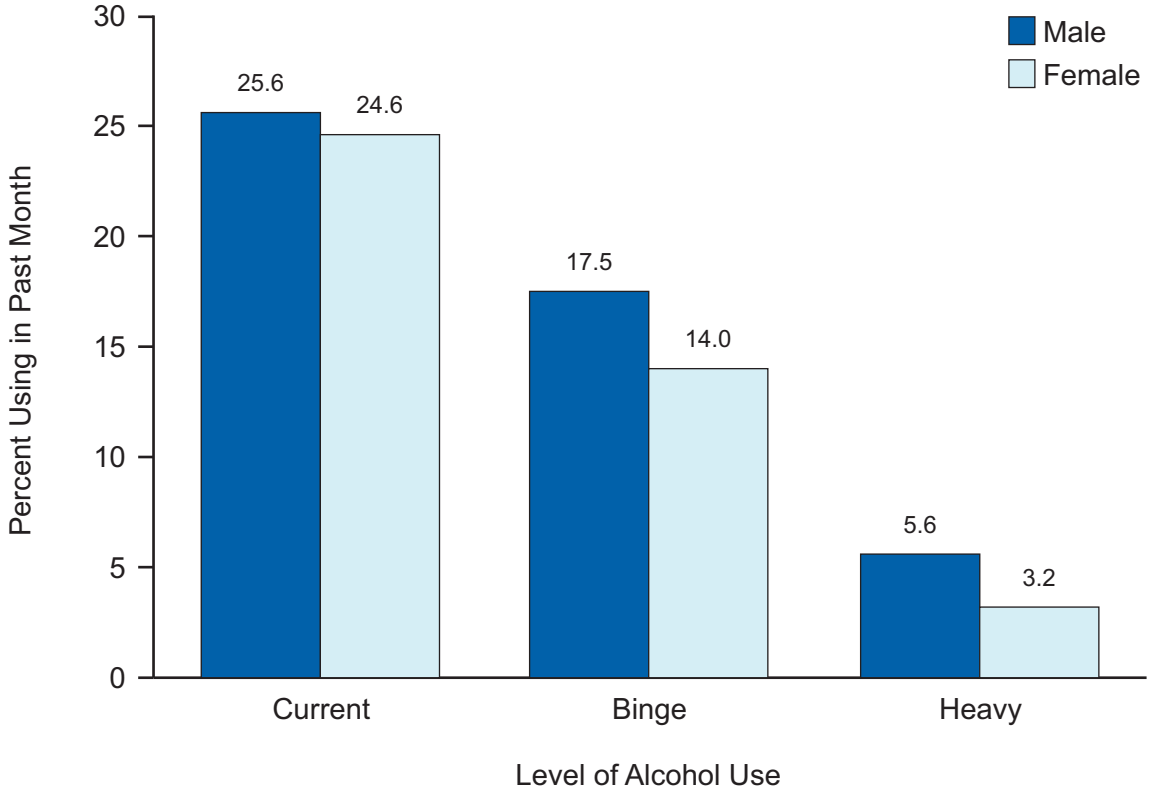
+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

- Males aged 12 to 20 in 2011 were more likely than underage females to be current alcohol users (25.6 vs. 24.6 percent), binge alcohol users (17.5 vs. 14.0 percent), or heavy alcohol users (5.6 vs. 3.2 percent) (Figure 3.7). Rates among underage males for current, binge, and heavy drinking were all lower in 2011 than they were in 2010 (28.1, 19.7, and 6.7 percent, respectively). However, the rates in 2011 among underage females did not differ from the rates in 2010 (24.0, 14.0, and 3.4 percent).

- Among persons aged 12 to 20, past month alcohol use rates in 2011 were 18.1 percent among blacks, 18.8 percent among Asians, 20.0 percent among American Indians or Alaska Natives, 22.5 percent among Hispanics, 27.5 percent among those reporting two or more races, and 28.2 percent among whites.

- In 2011, among persons aged 12 to 20, binge drinking was reported by 18.6 percent of whites, 15.9 percent of persons reporting two or more races, 14.0 percent of Hispanics, and 13.9 percent of American Indians or Alaska Natives. Blacks and Asians in this age group were less likely to report binge drinking (9.4 and 9.1 percent, respectively).

Figure 3.7 Current, Binge, and Heavy Alcohol Use among Persons Aged 12 to 20, by Gender: 2011



- Across geographic regions in 2011, the underage current alcohol use rate was higher in the Northeast (30.8 percent) than in the Midwest (25.4 percent), West (24.2 percent), and South (22.7 percent).
- In 2011, the underage current alcohol use rate was similar in large metropolitan areas (24.9 percent), small metropolitan areas (26.1 percent), and nonmetropolitan areas (23.5 percent).
- In 2011, 80.8 percent of current drinkers aged 12 to 20 were with two or more other people the last time they drank alcohol, 14.5 percent were with one other person the last time they drank, and 4.7 percent were alone.
- A majority of underage current drinkers in 2011 reported that their last use of alcohol in the past month occurred either in someone else's home (57.0 percent) or their own home (28.2 percent). Underage females were more likely than males to have been in a restaurant, bar, or club on their last drinking occasion (11.4 vs. 6.6 percent).
- Among underage current drinkers in 2011, 30.3 percent paid for the alcohol the last time they drank, including 7.7 percent who purchased the alcohol themselves and 22.4 percent who gave money to someone else to purchase it.

- In 2011, among underage drinkers who did not pay for the alcohol the last time they drank, the most common source was an unrelated person aged 21 or older (38.2 percent). Other underage persons provided the alcohol on the last occasion for 19.1 percent of underage drinkers. Parents, guardians, or other adult family members provided the last alcohol to 21.4 percent of underage drinkers. Other sources of alcohol for underage drinkers who did not pay included (a) took the alcohol from home (5.9 percent), (b) took it from someone else's home (3.9 percent), and (c) got it some other way (6.8 percent).

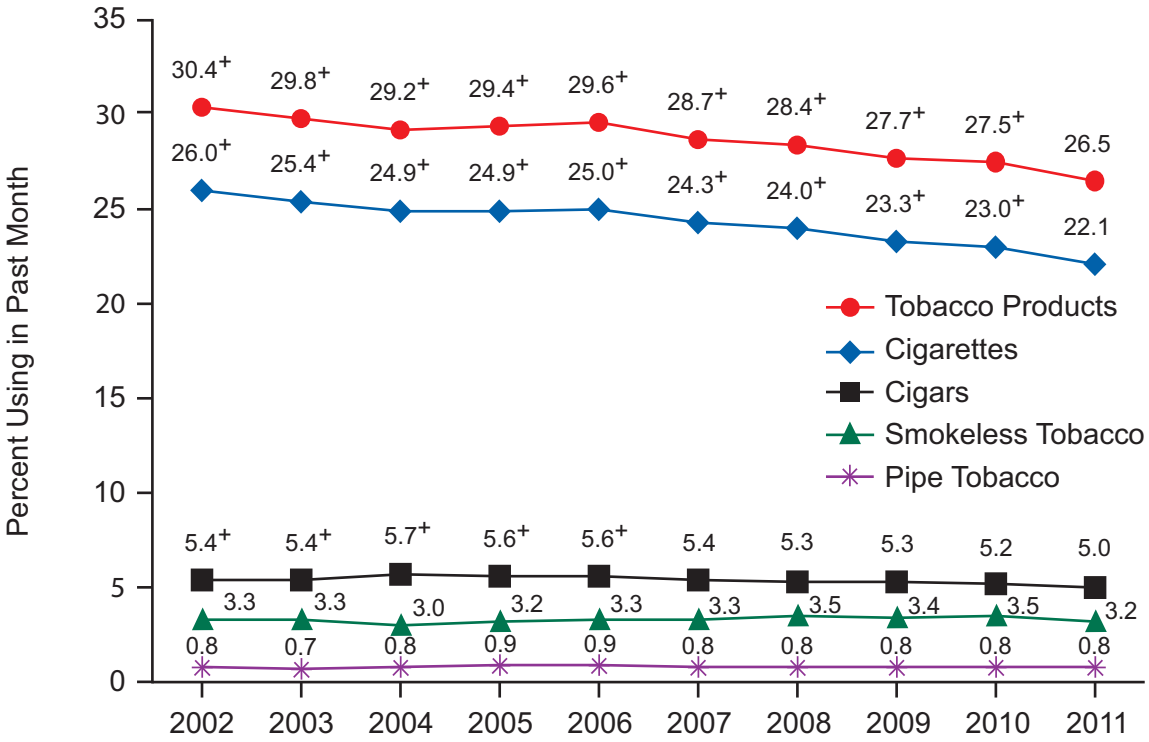
- In 2011, underage drinkers were more likely than current alcohol users aged 21 or older to use illicit drugs within 2 hours of alcohol use on their last reported drinking occasion (20.1 vs. 4.9 percent, respectively). The most commonly reported illicit drug used by underage drinkers in combination with alcohol was marijuana, which was used within 2 hours of alcohol use by 19.2 percent of current underage drinkers (1.8 million persons) on their last drinking occasion.

4. Tobacco Use

The National Survey on Drug Use and Health (NSDUH) includes a series of questions about the use of tobacco products, including cigarettes, chewing tobacco, snuff, cigars, and pipe tobacco. Cigarette use is defined as smoking "part or all of a cigarette." For analytic purposes, data for chewing tobacco and snuff are combined and termed "smokeless tobacco."

- In 2011, an estimated 68.2 million Americans aged 12 or older were current (past month) users of a tobacco product. This represents 26.5 percent of the population in that age range. Also, 56.8 million persons (22.1 percent of the population) were current cigarette smokers; 12.9 million (5.0 percent) smoked cigars; 8.2 million (3.2 percent) used smokeless tobacco; and 2.1 million (0.8 percent) smoked tobacco in pipes (Figure 4.1).

Figure 4.1 Past Month Tobacco Use among Persons Aged 12 or Older: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

- The rate of current use of any tobacco product among persons aged 12 or older decreased from 27.5 percent in 2010 to 26.5 percent in 2011. The rate of current use of cigarettes also declined during the same period (from 23.0 to 22.1 percent). Use of smokeless tobacco, cigars, and pipe tobacco did not change significantly over that period. Between 2002 and 2011, past month use of any tobacco product decreased from 30.4 to 26.5 percent, past month cigarette use declined from 26.0 to 22.1 percent, and past month cigar use declined from 5.4 to 5.0 percent. Rates of past month use of smokeless tobacco and pipe tobacco were similar in 2002 and 2011.

Age

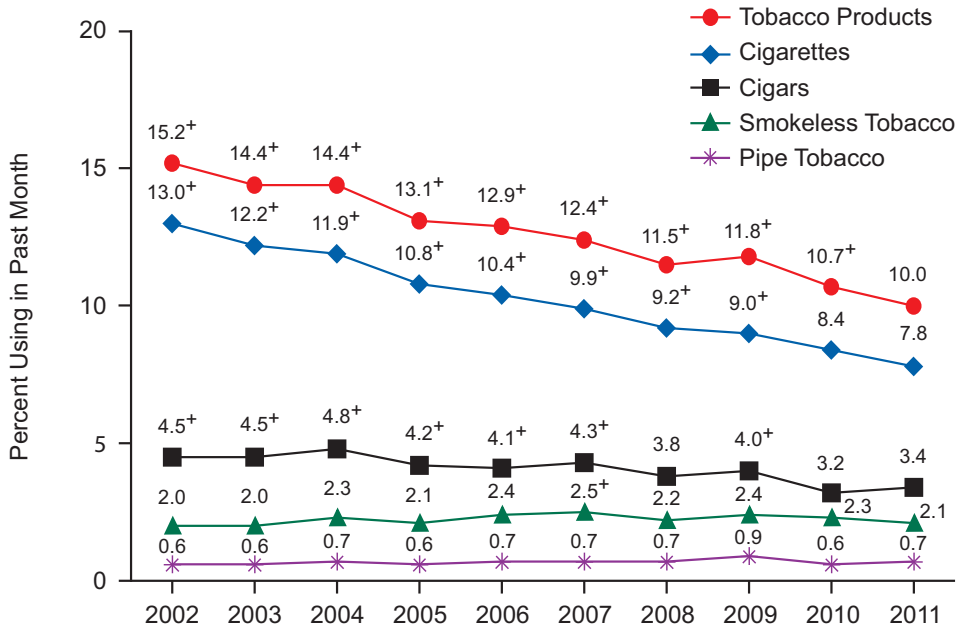
- In 2011, young adults aged 18 to 25 had the highest rate of current use of a tobacco product (39.5 percent) compared with youths aged 12 to 17 and adults aged 26 or older (10.0 and 26.3 percent, respectively). Young adults had the highest usage rates of each of the specific tobacco products as well. In 2011, the rates of past month use among young adults were 33.5 percent for cigarettes, 10.9 percent for cigars, 5.4 percent for smokeless tobacco, and 1.9 percent for pipe tobacco.

- The rate of current use of a tobacco product by young adults declined from 40.9 percent in 2010 to 39.5 percent in 2011. Between 2002 and 2011, there was a significant decrease in the rates for current use of tobacco products and cigarettes among young adults; in 2002, the rates were 45.3 and 40.8 percent, respectively. The rate of current use of pipe tobacco by young adults increased from 1.1 percent in 2002 to 1.9 percent in 2011.

- The rate of past month tobacco use among 12 to 17 year olds declined from 15.2 percent in 2002 to 10.0 percent in 2011, including a decline from 2010 (10.7 percent) to 2011 (Figure 4.2). The rate of past month cigarette use among 12 to 17 year olds declined from 13.0 percent in 2002 to 9.0 percent in 2009 and to 7.8 percent in 2011. The rate of past month smokeless tobacco use among 12 to 17 year olds remained steady between 2002 and 2011 (2.0 and 2.1 percent, respectively).

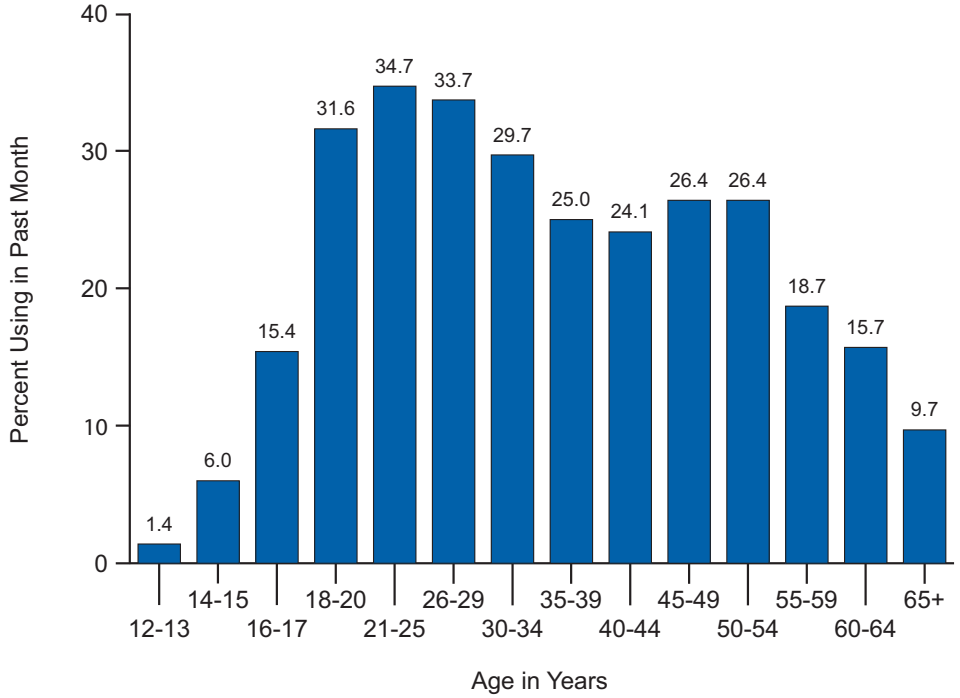
- Across age groups, current cigarette use was highest among persons aged 18 to 20 (31.6 percent), those aged 21 to 25 (34.7 percent), those aged 26 to 29 (33.7 percent), and those aged 30 to 34 (29.7 percent) (Figure 4.3). About one fifth (19.7 percent) of persons aged 35 or older in 2011 smoked cigarettes in the past month.

Figure 4.2 Past Month Tobacco Use among Youths Aged 12 to 17: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

Figure 4.3 Past Month Cigarette Use among Persons Aged 12 or Older, by Age: 2011



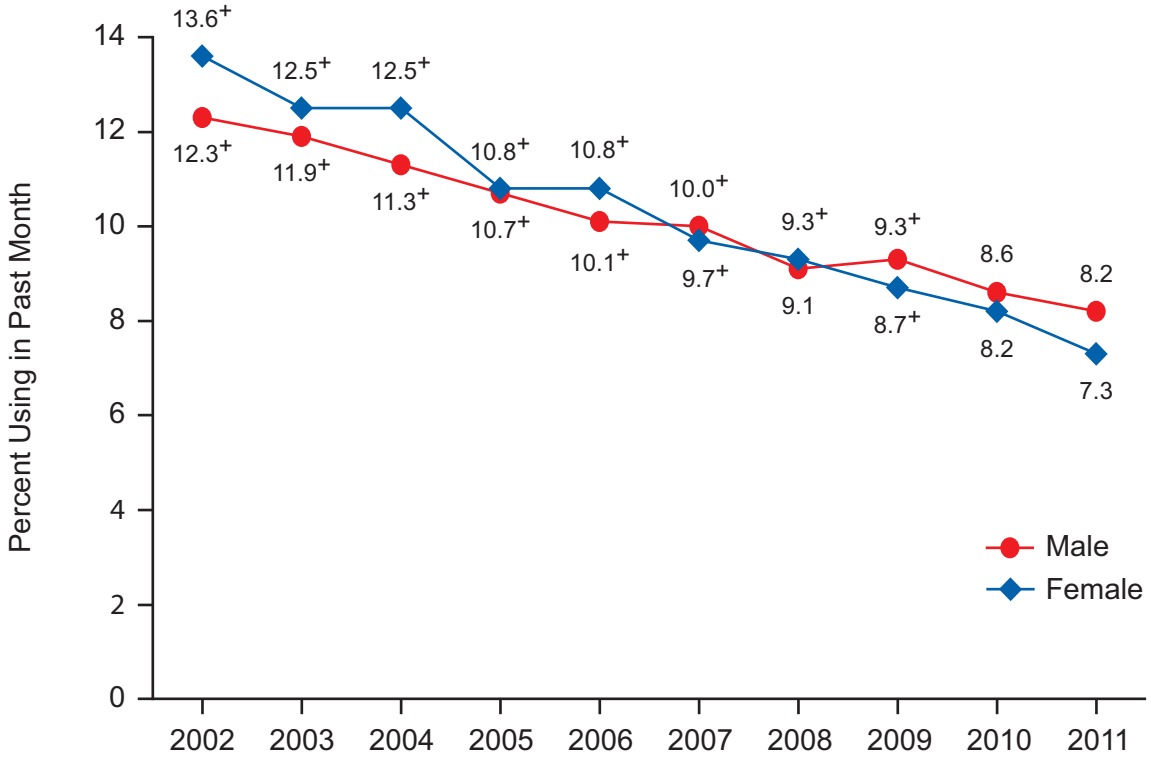
Gender

- In 2011, current use of a tobacco product among persons aged 12 or older was reported by a higher percentage of males (32.3 percent) than females (21.1 percent). Males also had higher rates of past month use than females of each specific tobacco product: cigarettes (24.3 percent of males vs. 19.9 percent of females), cigars (8.2 vs. 2.0 percent), smokeless tobacco (6.2 vs. 0.4 percent), and pipe tobacco (1.4 vs. 0.3 percent).

- The 2011 rate of any tobacco use by males (32.3 percent) was lower than the rate in 2010 (33.7 percent).

- Among youths aged 12 to 17, the rates of current cigarette smoking in 2011 were similar for males (8.2 percent) and females (7.3 percent) (Figure 4.4). The rates in 2011 for males and females did not differ from corresponding rates in 2010 (8.6 and 8.2 percent, respectively). The prevalence declined from 2009 to 2011 for both males and females. From 2002 to 2011, the rate of current cigarette smoking among youths decreased for both males (from 12.3 to 8.2 percent) and females (from 13.6 to 7.3 percent).

Figure 4.4 Past Month Cigarette Use among Youths Aged 12 to 17, by Gender: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

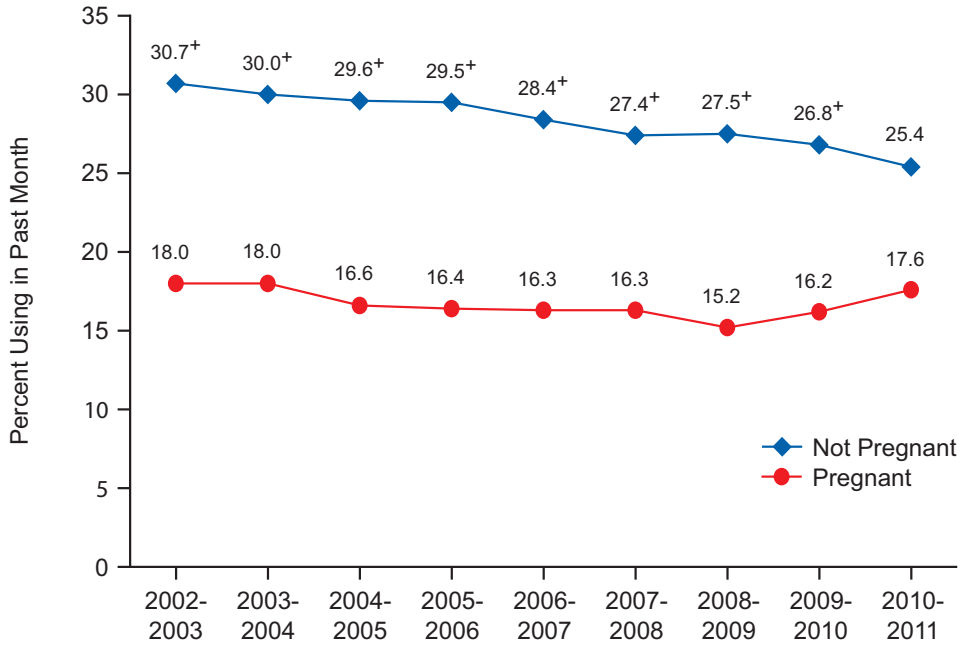
- After declining from 40.4 percent in 2009 to 38.1 percent in 2010, the rate of current cigarette smoking among male young adults aged 18 to 25 held steady in 2011 (38.3 percent). The rate of cigarette smoking declined for female young adults between 2010 and 2011 (from 30.5 to 28.7 percent). Between 2002 and 2011, the rate of cigarette use among young adults declined for both males (from 44.4 to 38.3 percent) and females (from 37.1 to 28.7 percent).

Pregnant Women

- About one in six pregnant women aged 15 to 44 had smoked cigarettes in the past month, based on combined data for 2010 and 2011. The rate of past month cigarette use was lower among women who were pregnant (17.6 percent) than it was among women who were not pregnant (25.4 percent) (Figure 4.5). This pattern was also evident among women aged 18 to 25 (22.4 vs. 29.9 percent for pregnant and nonpregnant women, respectively) and among women aged 26 to 44 (14.3 vs. 25.7 percent, respectively).

- Two-year moving average rates indicate that current cigarette use among women aged 15 to 44 decreased from 30.7 percent in 2002-2003 to 25.4 percent in 2010-2011 for those who were not pregnant (Figure 4.5). However, the prevalence of cigarette use among pregnant women in that age range was similar between 2002-2003 (18.0 percent) and 2010-2011 (17.6 percent).

Figure 4.5 Past Month Cigarette Use among Women Aged 15 to 44, by Pregnancy Status: Combined Years 2002-2003 to 2010-2011



+ Difference between this estimate and the 2010-2011 estimate is statistically significant at the .05 level.

Race/Ethnicity

- In 2011, the prevalence of current use of a tobacco product among persons aged 12 or older was 13.0 percent for Asians, 20.4 percent for Hispanics, 26.2 percent for blacks, 28.6 percent for whites, 36.1 percent for persons who reported two or more races, and 43.0 percent for American Indians or Alaska Natives. There were no statistically significant changes in past month use of a tobacco product between 2010 and 2011 for any of these racial/ethnic groups.

- In 2011, current cigarette smoking among youths aged 12 to 17 and young adults aged 18 to 25 was more prevalent among whites than blacks (9.3 vs. 4.9 percent for youths and 37.8 vs. 25.7 percent for young adults).

- Among Hispanics, the rate of current cigarette smoking decreased from 7.9 percent in 2010 to 6.1 percent in 2011 for youths aged 12 to 17. Rates of current cigarette smoking were 28.4 percent for young adults aged 18 to 25 and 18.4 percent among those aged 26 or older. Among Hispanics in these two adult age groups, rates of current cigarette use in 2011 were not significantly different from corresponding rates in 2010.

- Current cigarette smoking rates across age groups held steady for Asians between 2010 and 2011. The current cigarette smoking rate for Asian youths aged 12 to 17 was 3.6 percent in 2010 and 3.3 percent in 2011. The rates in 2010 and 2011 for Asian adults were 21.1 and 22.7 percent, respectively, for young adults aged 18 to 25 and were 10.1 and 10.6 percent for those aged 26 or older.

- The prevalence of current cigarette smoking for American Indian or Alaska Native youths aged 12 to 17 was 12.3 percent in 2011. This rate was not significantly different from the rate in 2010 (14.9 percent).

Education

- Since 2002, cigarette smoking in the past month has been less prevalent among adults who were college graduates compared with those with less education. Among adults aged 18 or older, current cigarette use in 2011 was reported by 33.7 percent of those who had not completed high school, 28.3 percent of high school graduates who did not attend college, 25.9 percent of persons with some college, and 11.7 percent of college graduates. These rates were similar to the 2010 rates by educational attainment.

College Students

- Among young adults 18 to 22 years old, full-time college students were less likely to be current cigarette smokers than their peers who were not enrolled full time in college. Cigarette use in the past month in 2011 was reported by 23.8 percent of full-time college students, which was less than the rate of 39.2 percent for those not enrolled full time. The same pattern was found among both males and females in this age range.

- Among males aged 18 to 22 who were full-time college students, the rate of cigarette use remained steady between 2010 and 2011 (27.3 and 26.6 percent, respectively). The rate of past month use of cigars decreased among male full-time college students aged 18 to 22 from 2010 to 2011 (from 18.5 to 14.9 percent).

Employment

- In 2011, current cigarette smoking was more common among unemployed adults aged 18 or older than among adults who were working full time or part time (40.7 vs. 23.3 and 22.9 percent, respectively). Cigar smoking followed a similar pattern, with 8.9 percent of unemployed adults reporting past month use compared with 5.6 percent of full-time workers and 5.8 percent of part-time workers.

- Current use of smokeless tobacco in 2011 was higher among adults aged 18 or older who were employed full time and those who were unemployed (4.3 and 3.5 percent, respectively) than among adults who were employed part time (2.5 percent) and those in the "other" employment category, which includes persons not in the labor force (2.1 percent). These rates were similar to the 2010 smokeless tobacco use rates for these employment categories.

Geographic Area

- In 2011, current cigarette smoking among persons aged 12 or older was lower in the West (18.1 percent) than in the Northeast (22.2 percent), the South (23.2 percent), and the Midwest (24.2 percent). Use of smokeless tobacco was highest in the Midwest (4.3 percent), followed by the South (3.7 percent), then the West (2.4 percent), then the Northeast (1.9 percent).

- As in previous years, the rates of tobacco use in 2011 were associated with county type among persons aged 12 or older. The rate of current cigarette use was 20.4 percent in large metropolitan areas, 22.8 percent in small metropolitan areas, and 26.4 percent in nonmetropolitan areas. Use of smokeless tobacco in the past month in 2011 among persons aged 12 or older was lowest in large metropolitan areas (2.0 percent). In small metropolitan areas, the current smokeless tobacco use rate was 4.0 percent; in nonmetropolitan areas, it was 5.7 percent.

Association with Illicit Drug and Alcohol Use

- Use of illicit drugs and alcohol was more common among current cigarette smokers than among nonsmokers in 2011, as in prior years since 2002. Among persons aged 12 or older, 22.1 percent of past month cigarette smokers reported current use of an illicit drug compared with 4.9 percent of persons who were not current cigarette smokers. Over half of youths aged 12 to 17 (57.6 percent, or 1.1 million youths) who smoked cigarettes in the past month also used an illicit drug compared with 6.1 percent of youths who did not smoke cigarettes.

- Past month alcohol use was reported by 66.5 percent of current cigarette smokers compared with 47.6 percent of those who did not use cigarettes in the past month. The association also was found with binge drinking (42.5 percent of current cigarette smokers vs. 17.0 percent of current nonsmokers) and heavy drinking (15.3 vs. 3.6 percent, respectively).

Frequency of Cigarette Use

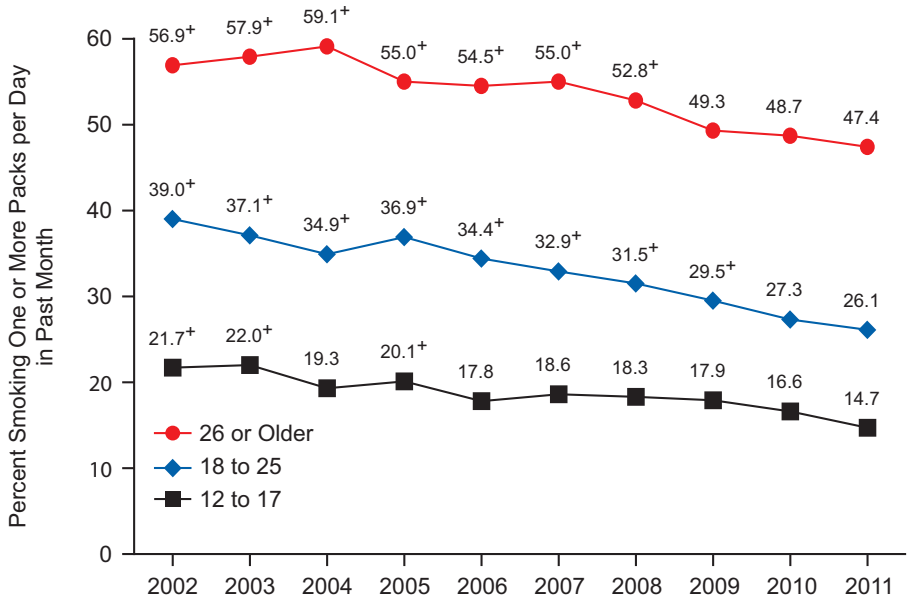
- Among the 56.8 million current cigarette smokers aged 12 or older in 2011, 34.5 million (60.7 percent) used cigarettes daily. The percentage of daily cigarette smokers among past month cigarette users increased with age (22.7 percent of past month cigarette users aged 12 to 17, 45.3 percent of those aged 18 to 25, and 66.5 percent of those aged 26 or older).

- The percentage of current smokers who used cigarettes daily decreased from 63.4 percent in 2002 to 60.7 percent in 2011. During the same time period, daily cigarette use among current smokers aged 12 to 17 decreased from 31.8 to 22.7 percent. Daily cigarette use among young adult smokers aged 18 to 25 also declined (from 51.8 to 45.3 percent). Percentages of adult current cigarette smokers aged 26 or older who used cigarettes daily were 68.8 percent in 2002 and 66.5 percent in 2011.

- Less than half (43.8 percent) of daily smokers aged 12 or older reported smoking 16 or more cigarettes per day (i.e., approximately one pack or more). The percentage of daily smokers who smoked at least one pack of cigarettes per day increased with age, from 14.7 percent among of daily smokers aged 12 to 17 to 26.1 percent of those aged 18 to 25, then to 47.4 percent of those aged 26 or older (Figure 4.6).

- The percentage of daily smokers aged 26 or older who smoked one or more packs of cigarettes per day was lower in 2011 (47.4 percent) than in 2002 to 2008. Declines also were seen from 2002 to 2011 for youths aged 12 to 17 (from 21.7 to 14.7 percent) and young adults (from 39.0 to 26.1 percent).

Figure 4.6 Past Month Smokers of One or More Packs of Cigarettes per Day among Daily Smokers, by Age Group: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

5. Initiation of Substance Use

Information on substance use initiation, also known as incidence or first-time use, is important for policymakers and researchers. Measures of initiation are often leading indicators of emerging patterns of substance use. They provide valuable information that can be used to assess the effectiveness of current prevention programs and to focus prevention efforts.

With its large sample size and oversampling of youths aged 12 to 17 and young adults aged 18 to 25, the National Survey on Drug Use and Health (NSDUH) provides estimates of recent or past year initiation of use of illicit drugs, tobacco, and alcohol based on reported age and on year and month at first use. Recent or past year initiates are defined as those who reported use of a particular substance for the first time within 12 months preceding the date of interview. There is a caveat to the past year initiation measure worth mentioning. Because the survey interviews persons aged 12 or older, the past year initiation estimates reflect only a portion of the initiation that occurred at age 11 and none of the initiation that occurred at age 10 or younger. This underestimation primarily affects estimates of initiation for cigarettes, alcohol, and inhalants because they tend to be initiated at a younger age than other substances. See Section B.4.1 in Appendix B for further discussion of the methods and bias in initiation estimates.

This chapter includes estimates of the number and rate of past year initiation of illicit drug, tobacco, and alcohol use among the total population aged 12 or older and by selected age and gender categories from the 2011 NSDUH, comparing with prior year(s). Also included are initiation estimates that pertain to persons at risk for initiation. Persons at risk for initiation of use of a particular substance are those who never used the substance in their lifetime plus those who used that substance for the first time in the 12 months prior to the interview. In other words, persons at risk are those who had never used as of 12 months prior to the interview date. Some analyses are based on the age at the time of interview, and others focus on the age at the time of first substance use. Readers need to be aware of these alternative estimation approaches when interpreting NSDUH incidence estimates and pay close attention to the approach used in each situation. Titles and notes on figures and associated detailed tables document which method applies.

For trend measurement, initiation estimates for each year (2002 to 2011) are produced independently based on the data from the survey conducted that year. Estimates of trends in incidence based on longer recall periods have not been considered because of concerns about their validity (Gfroerer, Hughes, Chromy, Heller, & Packer, 2004).

Regarding the age at first use estimates, means, as measures of central tendency, are heavily influenced by the presence of extreme values in the data for persons aged 12 or older. To reduce the effect of extreme values, the mean age at initiation was calculated for persons aged 12 to 49, leaving out those few respondents who were past year initiates at age 50 or older. Including data from initiates aged 26 to 49 in this broad age group also can cause instability of estimates of the mean age at initiation among persons aged 12 to 49, but this effect is less than that of including data from initiates aged 50 or older. Nevertheless, caution is needed in interpreting these trends for persons aged 12 to 49. Section B.4.1 in Appendix B also discusses this issue. Note, however, that this constraint affects only the estimates of mean age at initiation.

Other estimates in this chapter, including the numbers and percentages of past year initiates, are not affected by extreme ages at initiation and therefore are reported for all persons aged 12 or older.

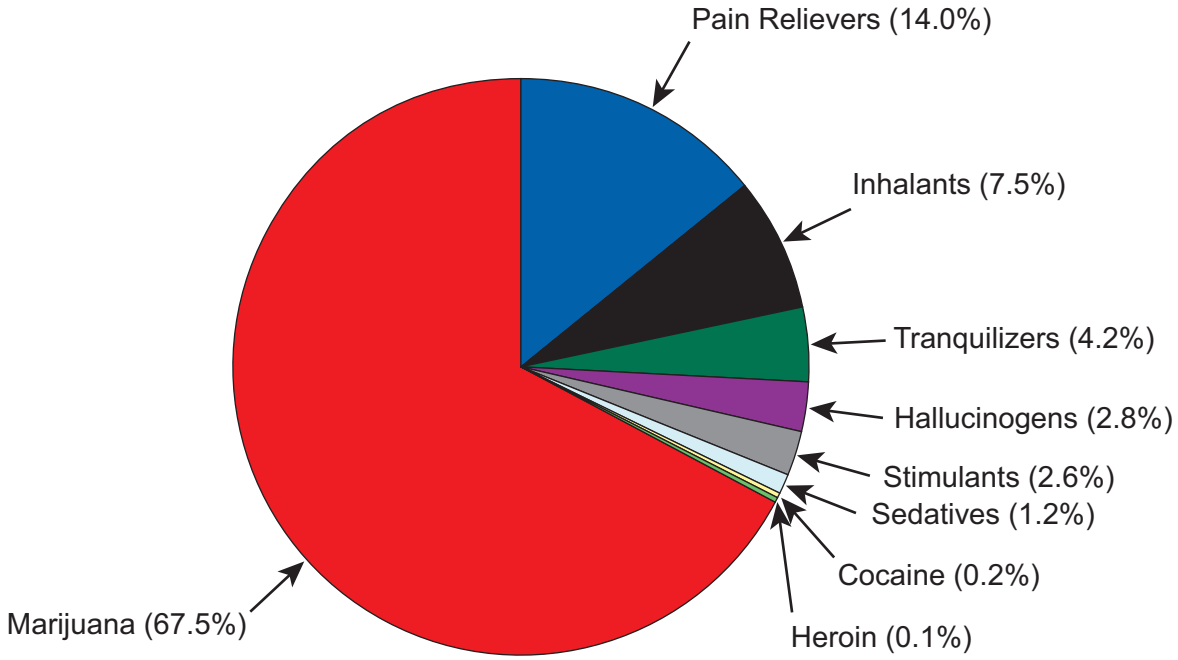
Another important consideration in examining incidence estimates across different drug categories is that substance users typically initiate use of different substances at different times in their lives. Thus, the estimates for past year initiation of each specific illicit drug cannot be added to obtain the total number of overall illicit drug initiates because some of the initiates previously had used other drugs. The initiation estimate for any illicit drug represents the past year initiation of use of a specific drug that was not preceded by use of other illicit drugs. For example, a respondent who reported initiating marijuana use in the past 12 months is counted as a marijuana initiate. The same respondent also can be counted as an illicit drug initiate with marijuana as the first drug only if his or her marijuana use initiation was not preceded by use of any other drug (cocaine, heroin, hallucinogens, inhalants, pain relievers, tranquilizers, stimulants, or sedatives). In addition, past year initiates of lysergic acid diethylamide (LSD), phencyclidine (PCP), or Ecstasy use are counted as past year initiates of any hallucinogen use only if they had not previously used other hallucinogens. Similarly, past year initiates of crack cocaine, OxyContin®, or methamphetamine use are counted as past year initiates for the broader category (i.e., any cocaine, nonmedical use of pain relievers, or nonmedical use of stimulants, respectively) only if they did not report previous use (or nonmedical use) for the broader category.

Initiation of Illicit Drug Use

- In 2011, about 3.1 million persons aged 12 or older used an illicit drug for the first time within the past 12 months; this averages to about 8,400 new users per day. This estimate was not significantly different from the number in 2010 (3.0 million). Over half of initiates (55.5 percent) were younger than age 18 when they first used, and 55.8 percent of new users were female. The 2011 average age at initiation among persons aged 12 to 49 was 18.1 years, which was similar to the 2010 estimate (19.1 years). See Section B.4.1 in Appendix B for a discussion of the effects of older adult initiates on estimates of mean age at first use.

- Of the estimated 3.1 million persons aged 12 or older in 2011 who used illicit drugs for the first time within the past 12 months, a majority reported that their first drug was marijuana (67.5 percent) (Figure 5.1). More than 1 in 5 initiated with nonmedical use of psychotherapeutics (22.0 percent, including 14.0 percent with pain relievers, 4.2 percent with tranquilizers, 2.6 percent with stimulants, and 1.2 percent with sedatives). A notable proportion reported inhalants (7.5 percent) as their first illicit drug, and a small proportion used hallucinogens (2.8 percent). Except for marijuana, all of the above percentages of first illicit drug use were similar to the corresponding percentages in 2010. The percentage whose first illicit drug was marijuana in 2011 was greater than the percentage in 2010 (62.0 percent).

Figure 5.1 First Specific Drug Associated with Initiation of Illicit Drug Use among Past Year Illicit Drug Initiates Aged 12 or Older: 2011



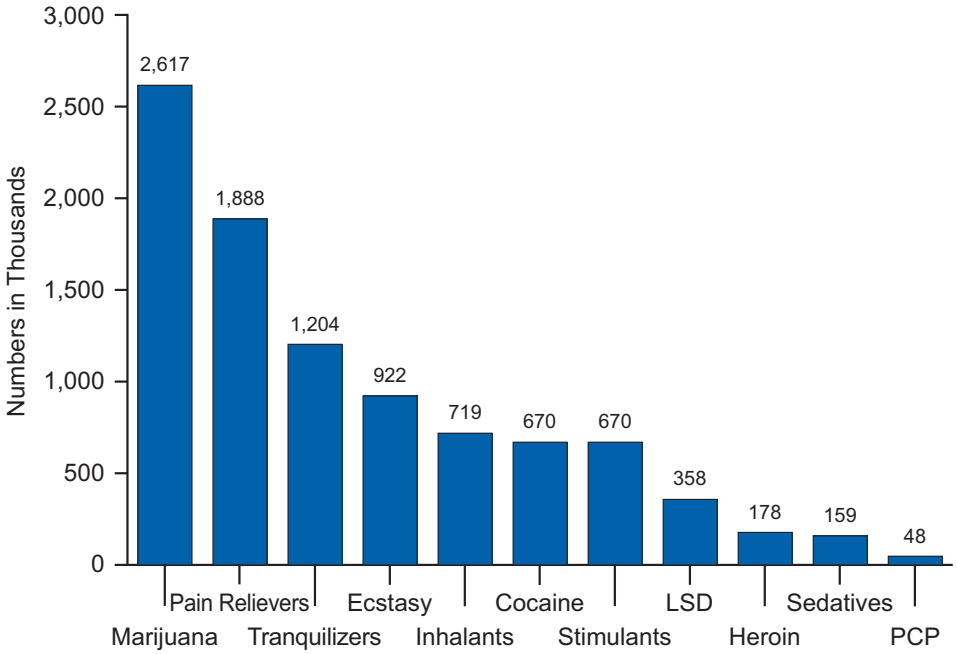
Note: The percentages do not add to 100 percent due to rounding or because a small number of respondents initiated multiple drugs on the same day. The first specific drug refers to the one that was used on the occasion of first-time use of any illicit drug.

Comparison, by Drug

- In 2011, the specific illicit drug category with the largest number of recent initiates among persons aged 12 or older was marijuana use (2.6 million), followed by nonmedical use of pain relievers (1.9 million), nonmedical use of tranquilizers (1.2 million), Ecstasy (0.9 million), and cocaine and stimulants (0.7 million each) (Figure 5.2).

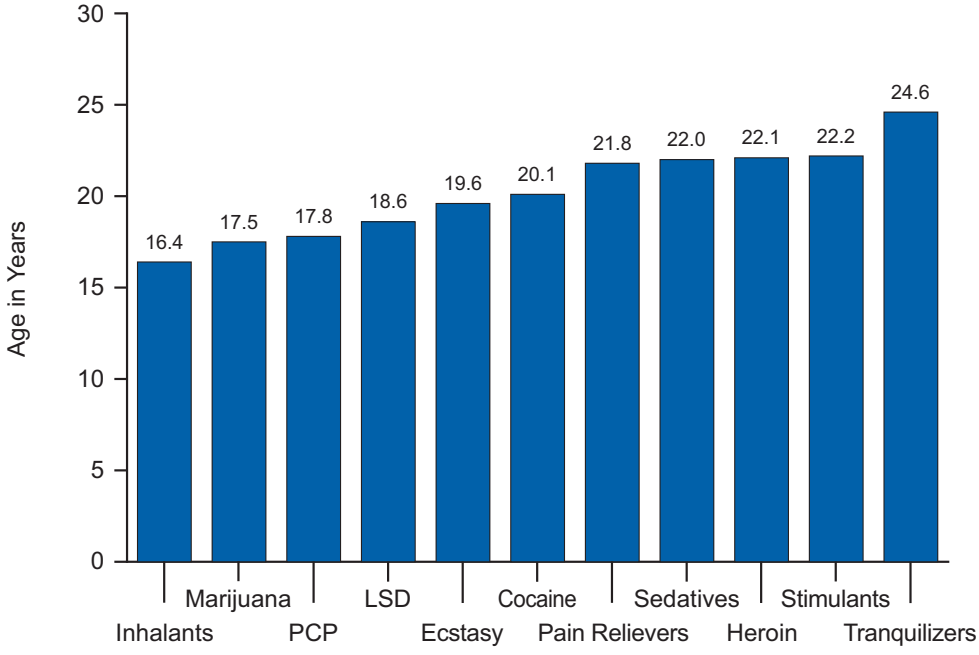
- Among persons aged 12 to 49 in 2011, the average age at first use was 16.4 years for inhalants, 17.5 years for marijuana, 19.6 years for Ecstasy, 20.1 years for cocaine, 21.8 years for pain relievers, 22.1 years for heroin, 22.2 years for stimulants, and 24.6 years for tranquilizers (Figure 5.3).

Figure 5.2 Past Year Initiates of Specific Illicit Drugs among Persons Aged 12 or Older: 2011



Note: Numbers refer to persons who used a specific drug for the first time in the past year, regardless of whether initiation of other drug use occurred prior to the past year.

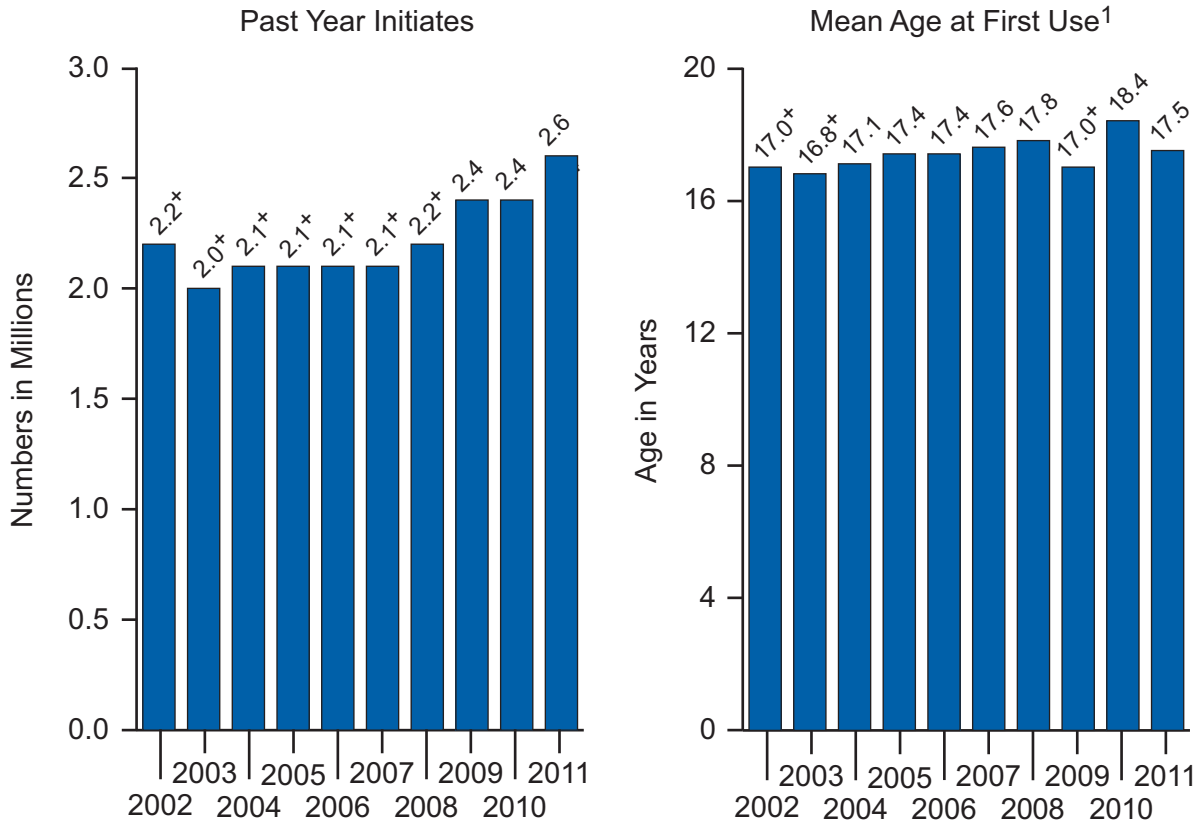
Figure 5.3 Mean Age at First Use for Specific Illicit Drugs among Past Year Initiates Aged 12 to 49: 2011



Marijuana

- In 2011, there were 2.6 million persons aged 12 or older who had used marijuana for the first time within the past 12 months; this averages to about 7,200 new users each day. The 2011 estimate was similar to the estimates in 2009 and 2010 (2.4 million each), but higher than the estimates in 2002 through 2008 (Figure 5.4). In 2011, the majority (57.7 percent) of the 2.6 million recent marijuana initiates were younger than age 18 when they first used. Among all youths aged 12 to 17, an estimated 5.5 percent had used marijuana for the first time within the past year, which was similar to the rate in 2010 (5.2 percent).

Figure 5.4 Past Year Marijuana Initiates among Persons Aged 12 or Older and Mean Age at First Use of Marijuana among Past Year Marijuana Initiates Aged 12 to 49: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

[1] Mean-age-at-first-use estimates are for recent initiates aged 12 to 49.

- In 2011, among persons aged 12 or older, an estimated 1.5 million first-time past year marijuana users initiated prior to the age of 18. This estimate was about the same as the corresponding estimates in 2010 (1.4 million) and 2009 (1.5 million).

- As a percentage of those aged 12 to 17 who had not used marijuana prior to the past year (i.e., those at risk for initiation), the youth marijuana initiation rate in 2011 (6.3 percent) was similar to the rate in 2010 (5.9 percent).

- In 2011, the average age at first marijuana use among recent initiates aged 12 to 49 was 17.5 years, which was similar to the average age in 2010 (18.4 years) and 2004 through 2008, but was higher than the average ages in 2002, 2003, and 2009 (Figure 5.4). Section B.4.1 in Appendix B discusses the potential instability of estimates of older adult initiation and the impact on estimates of mean age at first use.

- In 2011, among recent initiates aged 12 or older who initiated marijuana use prior to the age 21, the mean age at first use was 16.2 years, which was the same as the mean age in 2010.

Cocaine

- In 2011, there were 670,000 persons aged 12 or older who had used cocaine for the first time within the past 12 months; this averages to approximately 1,800 initiates per day. This estimate was similar to the number in 2010 (642,000), 2009 (623,000), and 2008 (724,000). The annual number of cocaine initiates declined from 1.0 million in 2002 to 670,000 in 2011. The number of initiates of crack cocaine declined during this period from 337,000 to 76,000.

- In 2011, most (74.7 percent) of the 0.7 million recent cocaine initiates were 18 or older when they first used. The average age at first use among recent initiates aged 12 to 49 was 20.1 years. The average age estimates have remained fairly stable since 2002.

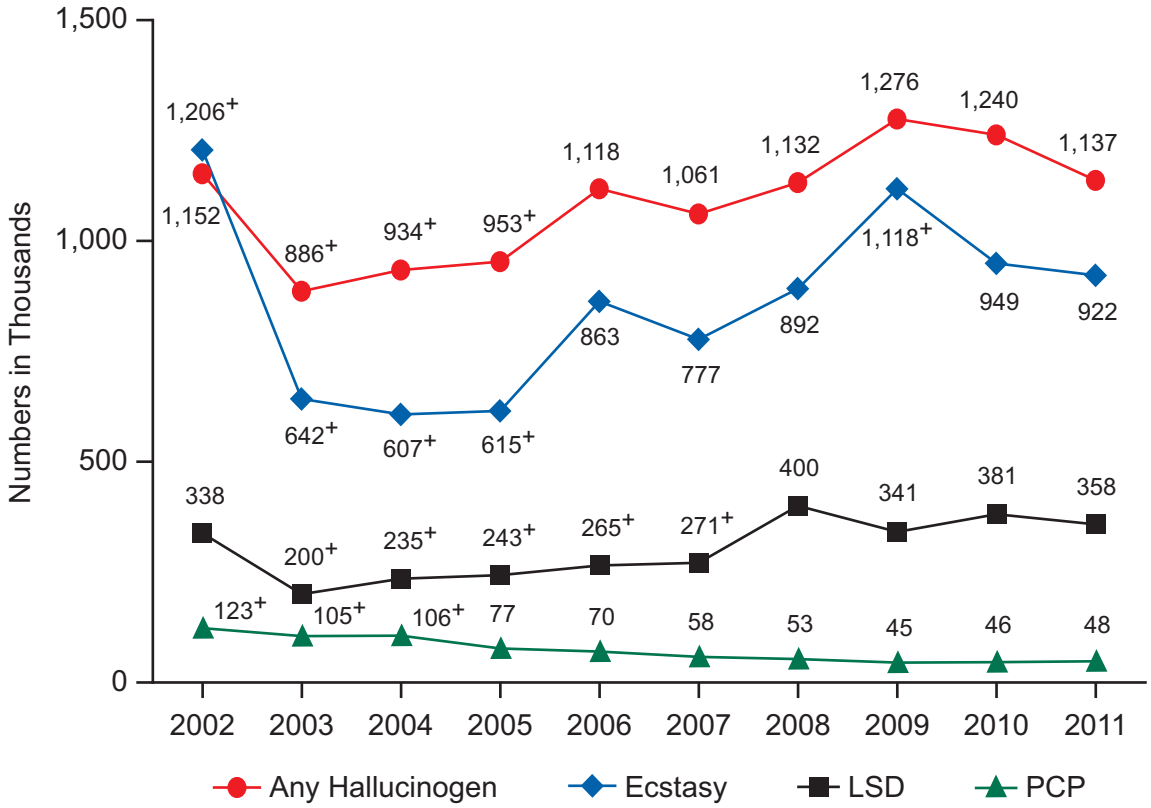
Heroin

- In 2011, there were 178,000 persons aged 12 or older who had used heroin for the first time within the past 12 months. Although this number was similar to the estimates in 2010 (142,000) and 2009 (187,000), the 2011 estimate was higher than the estimates during 2005 to 2007 (ranging from 90,000 to 108,000 per year). The average age at first use among recent initiates aged 12 to 49 was 22.1 years, which was similar to the 2010 estimate (21.4 years).

Hallucinogens

- In 2011, there were 1.1 million persons aged 12 or older who had used hallucinogens for the first time within the past 12 months (Figure 5.5). This estimate was similar to the estimates from 2006 to 2010 (ranging from 1.1 million to 1.3 million), but was higher than the estimates from 2003 to 2005 (ranging from 886,000 to 953,000).

Figure 5.5 Past Year Hallucinogen Initiates among Persons Aged 12 or Older: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

- The number of past year initiates of LSD aged 12 or older was 358,000 in 2011, which was similar to the number in 2010 (381,000), but higher than the estimates from 2003 to 2007 (ranging from 200,000 to 271,000) (Figure 5.5). Past year initiates of PCP decreased from 123,000 in 2002 to 48,000 in 2011.

- The number of past year initiates of Ecstasy was 922,000 in 2011, which was similar to the number in 2010 (949,000), but lower than the number in 2009 (1.1 million) (Figure 5.5). The estimate was 1.2 million in 2002, declined to 642,000 in 2003, and increased by about 50 percent between 2005 (615,000) and 2011 (922,000). Most (61.3 percent) of the recent Ecstasy initiates in 2011 were aged 18 or older at the time they first used Ecstasy. Among past year initiates aged 12 to 49, the average age at initiation of Ecstasy in 2011 was 19.6 years, which was similar to the average age in 2010 (19.4 years), but lower than the average age in 2002 (21.2 years).

- In 2011, among persons aged 12 or older, the number of first-time past year Ecstasy users who initiated use prior to the age of 18 was 357,000. This estimate was higher than the estimate in 2005 (209,000).

Inhalants

- In 2011, there were 719,000 persons aged 12 or older who had used inhalants for the first time within the past 12 months, which was lower than the numbers in prior years from 2002 to 2005 (ranging from 849,000 to 877,000). An estimated 67.1 percent of past year initiates of inhalants in 2011 were under age 18 when they first used. The average age at first use among recent initiates aged 12 to 49 was similar in 2010 and 2011 (16.3 and 16.4 years, respectively).

Psychotherapeutics

- Psychotherapeutics include the nonmedical use of any prescription-type pain relievers, tranquilizers, stimulants, or sedatives. Over-the-counter substances are not included. In 2011, there were 2.3 million persons aged 12 or older who used psychotherapeutics nonmedically for the first time within the past year, which averages to around 6,400 initiates per day. The number of new nonmedical users of psychotherapeutics in 2011 was similar to the 2010 estimate (2.4 million), but was lower than the 2004 estimate (2.8 million). The number of new nonmedical users of pain relievers in 2011 (1.9 million) was lower than the numbers in 2002 through 2005 and in 2008 and 2009 (ranging from 2.2 million to 2.5 million). In 2011, the number of initiates was 1.2 million for tranquilizers, 670,000 for stimulants, and 159,000 for sedatives.

- In 2011, the average age at first nonmedical use of any psychotherapeutics among recent initiates aged 12 to 49 was 22.4 years. More specifically, it was 21.8 years for pain relievers, 22.0 years for sedatives, 22.2 years for stimulants, and 24.6 years for tranquilizers. All of these estimates were similar to the corresponding estimates in 2010.

- In 2011, the number of new nonmedical users of OxyContin® aged 12 or older was 483,000, which was similar to the 2010 estimate of 600,000. The average age at first use of OxyContin® among past year initiates aged 12 to 49 was the same in 2010 and 2011 (22.8 years).

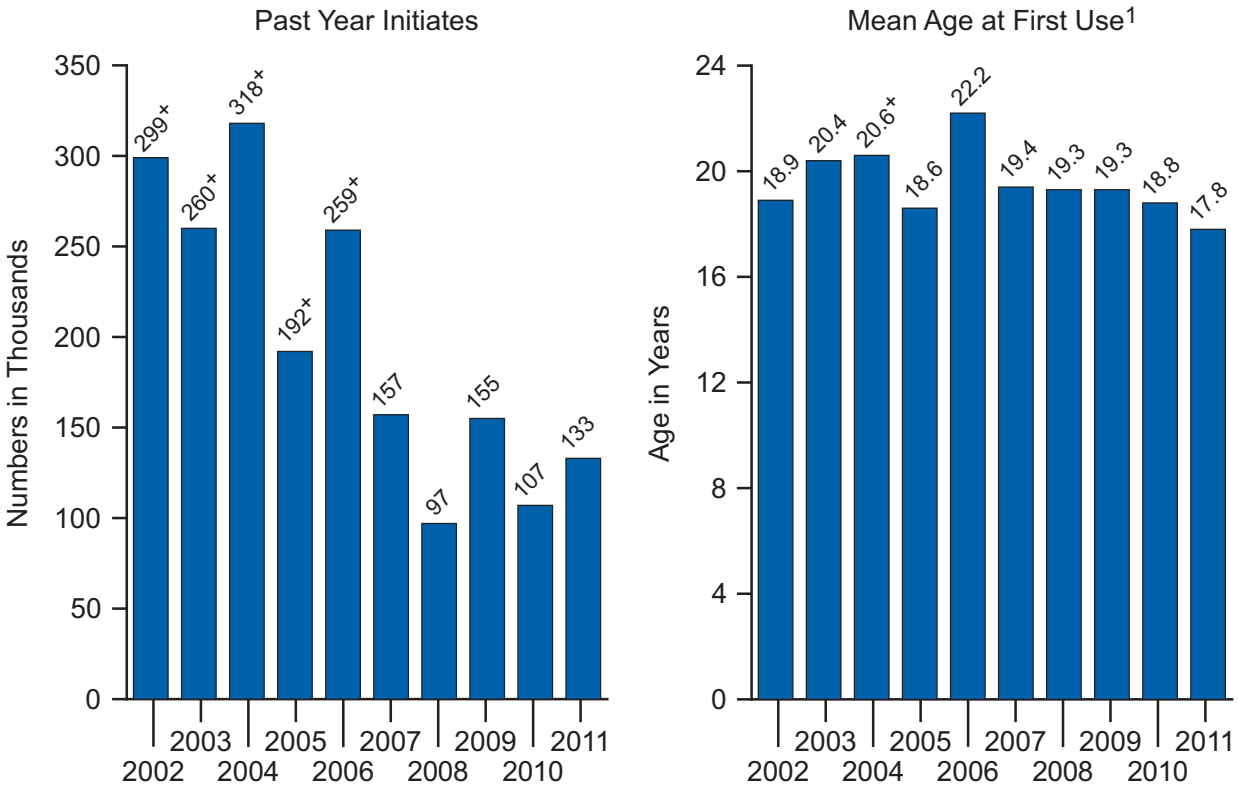
- The number of recent new users of methamphetamine among persons aged 12 or older was 133,000 in 2011 (Figure 5.6), which was similar to the 2010 estimate (107,000), but lower than the 2002 to 2006 estimates (ranging from 192,000 to 318,000). The average age of new methamphetamine users aged 12 to 49 in 2011 was 17.8 years, which was not significantly different from the corresponding estimates for 2002 and 2003 and from 2005 to 2010, but was lower than the 2004 estimate (20.6 years).

Alcohol

- In 2011, there were 4.7 million persons aged 12 or older who had used alcohol for the first time within the past 12 months; this averages to approximately 12,900 initiates per day.

- Most (82.9 percent) of the 4.7 million recent alcohol initiates were younger than age 21 at the time of initiation. Approximately 61.2 percent initiated prior to age 18.

Figure 5.6 Past Year Methamphetamine Initiates among Persons Aged 12 or Older and Mean Age at First Use of Methamphetamine among Past Year Methamphetamine Initiates Aged 12 to 49: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

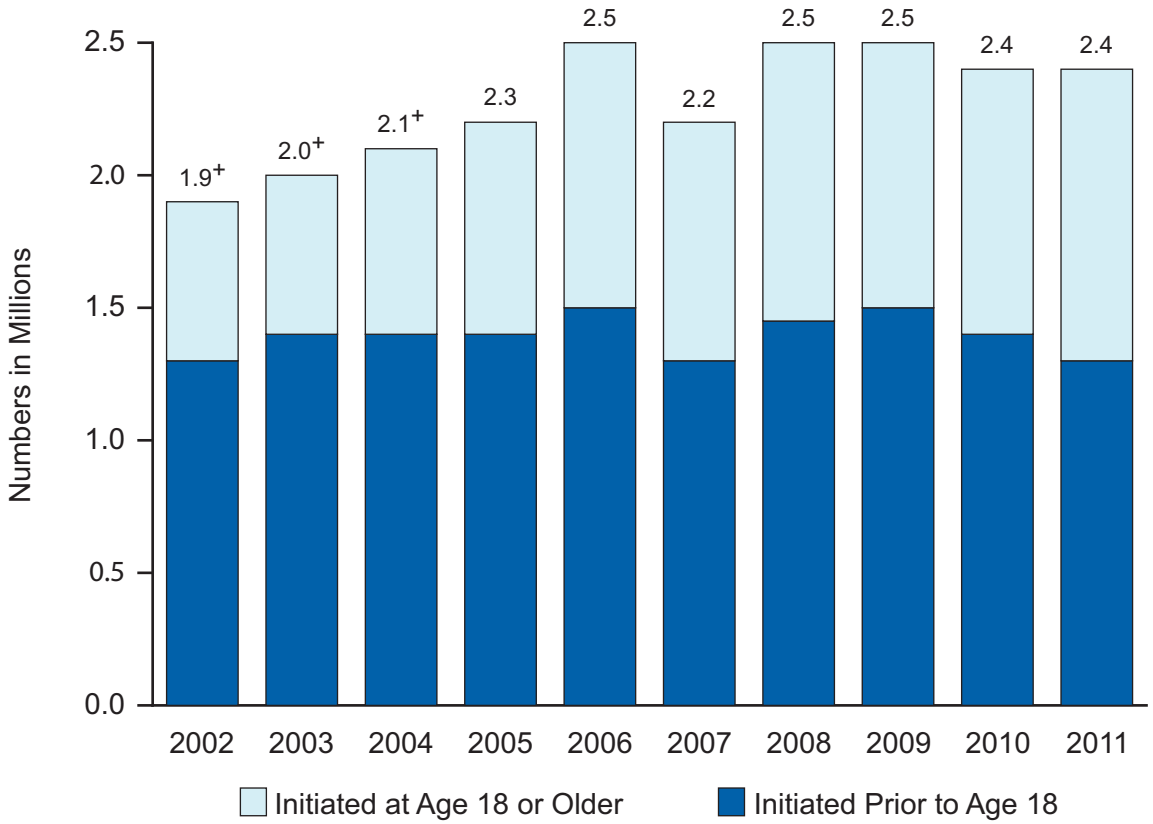
1 Mean-age-at-first-use estimates are for recent initiates aged 12 to 49.

- In 2011, the average age at first alcohol use among recent initiates aged 12 to 49 was 17.1 years, which was the same as the 2010 estimate, but higher than the 2002 to 2006 estimates (ranging from 16.4 to 16.6 years). The mean age at first use among recent initiates aged 12 or older who initiated use prior to the age of 21 was 15.9 years, which was similar to the 2010 estimate of 16.0 years.

Tobacco

- The number of persons aged 12 or older who smoked cigarettes for the first time within the past 12 months was 2.4 million in 2011, which was the same as the estimate in 2010, but was higher than the estimates for 2002 (1.9 million), 2003 (2.0 million), and 2004 (2.1 million) (Figure 5.7). The 2011 estimate averages out to approximately 6,600 new cigarette smokers every day. The majority of new cigarette smokers in 2011 initiated prior to age 18 (55.7 percent).

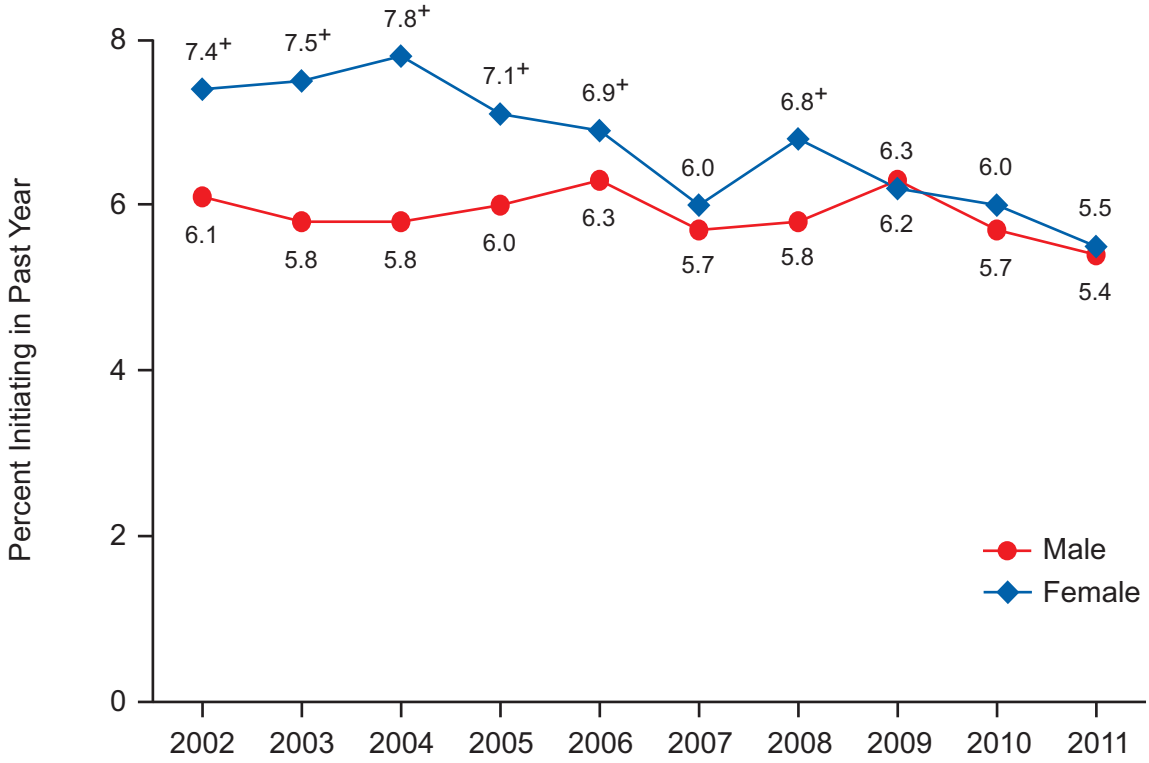
Figure 5.7 Past Year Cigarette Initiates among Persons Aged 12 or Older, by Age at First Use: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

- In 2002 and 2011, the numbers of cigarette initiates who were under age 18 when they first used were the same (1.3 million). However, the number of cigarette initiates who began smoking at age 18 or older increased from 623,000 in 2002 to 1.1 million in 2011.
- In 2011, among recent initiates aged 12 to 49, the average age of first cigarette use was 17.2 years, which was similar to the average in 2010 (17.3 years).
- Of those aged 12 or older who had not smoked cigarettes prior to the past year (i.e., those at risk for initiation), the past year initiation rate for cigarettes was 2.4 percent in 2011, which was similar to the rate in 2010 (2.6 percent). Among youths aged 12 to 17 who had not smoked cigarettes prior to the past year, the incidence rate in 2011 was 5.5 percent, which was similar to the 2010 rate (5.9 percent). Among males aged 12 to 17 who had never smoked prior to the past year, past year initiation rates in 2002 to 2010 were not significantly different from the rate in 2011 (Figure 5.8). However, the past year initiation rate among females aged 12 to 17 who were at risk for initiation was lower in 2011 (5.5 percent) than in 2002 to 2006 or in 2008.

Figure 5.8 Past Year Cigarette Initiation among Youths Aged 12 to 17 Who Had Never Smoked Prior to the Past Year, by Gender: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

- In 2011, the number of persons aged 12 or older who had started smoking cigarettes daily within the past 12 months was 878,000. This estimate was similar to the 2010 estimate (962,000), but was lower than the estimates in 2003, 2004, 2006, and 2009 (ranging from 1.0 million to 1.1 million). Of the new daily smokers in 2011, 38.0 percent, or 334,000 persons, were younger than age 18 when they started smoking daily. This figure averages to approximately 916 initiates of daily smoking under the age of 18 every day.

- The average age of first daily smoking among new daily smokers aged 12 or older was 19.1 years in 2010 and 2011. Among males and females, the average age at first use was similar in 2010 and 2011 (18.6 and 19.2 years for males, 19.8 and 19.0 years for females).

- In 2011, there were 2.8 million persons aged 12 or older who had used cigars for the first time in the past 12 months, which was similar to the 2010 estimate (3.0 million). However, the 2011 estimate was lower than the 2005 estimate (3.3 million). Among past year cigar initiates aged 12 to 49, the average age at first use was 19.6 years in 2011, which was similar to the estimate in 2010 (20.5 years).

- The number of persons aged 12 or older initiating use of smokeless tobacco in the past year was 1.3 million in 2011, which was similar to the estimates in 2005 to 2010 (ranging from 1.1 million to 1.5 million). In 2011, over three quarters (77.6 percent) of new initiates were male, and over two fifths (43.7 percent) were under age 18 when they first used.

- In 2011, the average age at first smokeless tobacco use among recent initiates aged 12 to 49 was 19.8 years, which was similar to the 2010 estimate (19.3 years). Among both males and females, the average ages at first use of smokeless tobacco were similar in 2010 and 2011 (19.1 and 20.1 years for males, 19.9 and 18.9 years for females).

6. Youth Prevention-Related Measures

Research has shown that substance use by adolescents can often be prevented through interventions involving risk and protective factors associated with the onset or escalation of use (Catalano, Hawkins, Berglund, Pollard, & Arthur, 2002). Risk and protective factors include variables that operate at different stages of development and reflect different domains of influence, including the individual, family, peer, school, community, and societal levels (Hawkins, Catalano, & Miller, 1992; Robertson, David, & Rao, 2003). Interventions to prevent substance use generally are designed to ameliorate the influence of risk factors and enhance the effectiveness of protective factors.

The National Survey on Drug Use and Health (NSDUH) includes questions for youths aged 12 to 17 to measure the risk and protective factors that may affect the likelihood that they will engage in substance use. This chapter presents findings on youth prevention-related measures, comparing the findings from 2002 to 2011. Included are measures of the perceived risk of substance use (cigarettes, alcohol, and illicit drugs), perceived availability of substances, being approached by someone selling drugs, perceived parental disapproval of youth substance use, parental involvement, feelings about peer substance use, involvement in fighting and delinquent behavior, participation in religious and other activities, and exposure to substance use prevention messages and programs. Also presented are findings on the associations between selected measures of risk and protective factors and substance use from NSDUH, although the cross-sectional nature of these data preclude making any causal connections between these risk and protective factors and substance use.

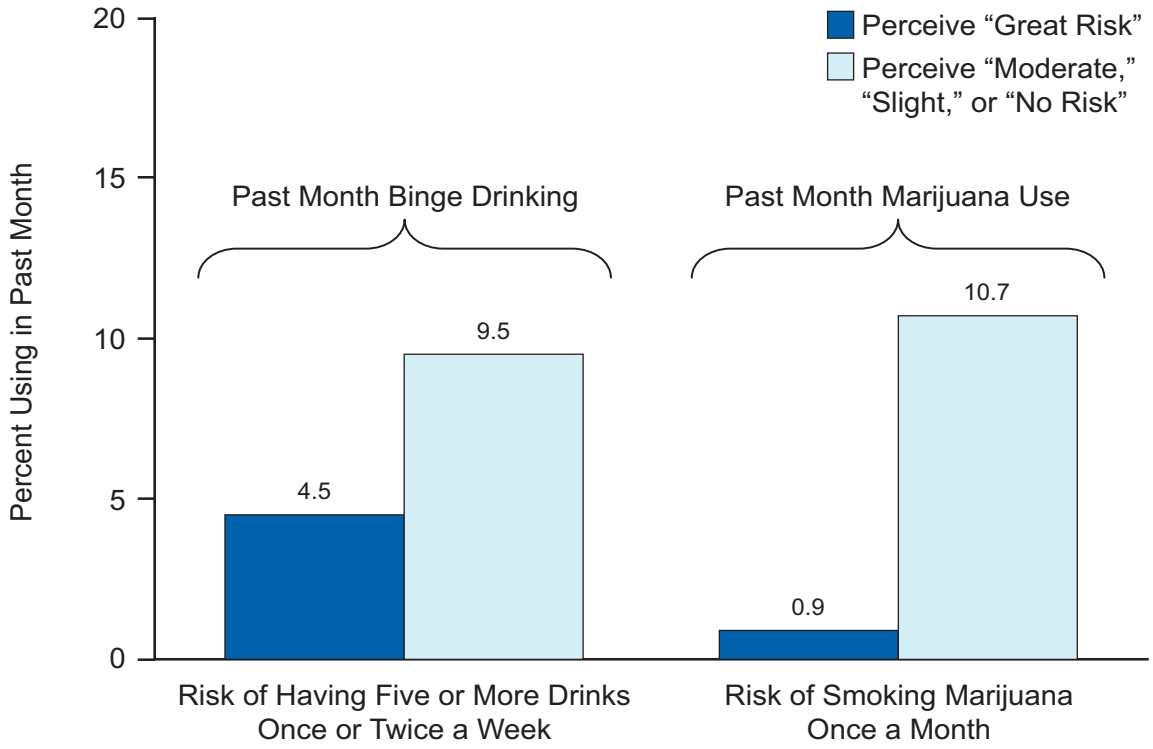
Perceived Risk of Substance Use

One factor that can influence whether youths will use tobacco, alcohol, or illicit drugs is the extent to which they believe these substances might cause them harm. NSDUH respondents were asked how much they thought people risk harming themselves physically and in other ways when they use various substances in certain amounts or frequencies. Response choices for these items were "great risk," "moderate risk," "slight risk," or "no risk."

- In 2011, 66.2 percent of youths aged 12 to 17 perceived great risk in smoking one or more packs of cigarettes per day, 64.8 percent perceived great risk in having four or five drinks of an alcoholic beverage nearly every day, and 40.7 percent perceived great risk in having four or five drinks once or twice a week. For marijuana, 44.8 percent of youths perceived great risk in smoking marijuana once or twice a week, and 27.6 percent perceived great risk in smoking marijuana once a month. The percentages of youths who perceived great risk in using other drugs once or twice a week were 79.7 percent for heroin, 78.1 percent for cocaine, and 70.4 percent for LSD.

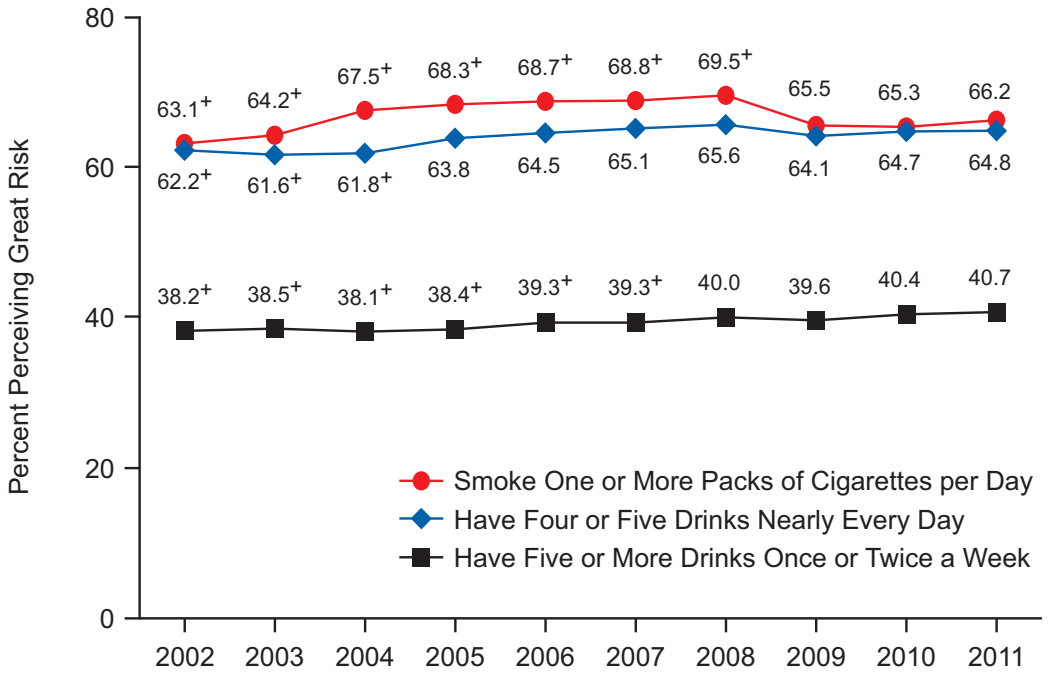
- The percentages of youths reporting binge alcohol use and the use of cigarettes and marijuana in the past month were lower among those who perceived great risk in using these substances than among those who did not perceive great risk. For instance, in 2011, past month binge drinking (consumption of five or more drinks of an alcoholic beverage on a single occasion on at least 1 day in the past 30 days) was reported by 4.5 percent of youths aged 12 to 17 who perceived great risk from "having five or more drinks of an alcoholic beverage once or twice a week," which was lower than the rate (9.5 percent) for youths who saw moderate, slight, or no risk from having five or more drinks of an alcoholic beverage once or twice a week (Figure 6.1). Past month marijuana use was reported by 0.9 percent of youths who saw great risk in smoking marijuana once a month compared with 10.7 percent of youths who saw moderate, slight, or no risk.

Figure 6.1 Past Month Binge Drinking and Marijuana Use among Youths Aged 12 to 17, by Perceptions of Risk: 2011



- Trends in substance use often coincide with trends in perceived risk. Increases in perceived risk typically precede or occur simultaneously with decreases in use, and vice versa. For example, the proportion of youths aged 12 to 17 who reported perceiving great risk from smoking one or more packs of cigarettes per day increased from 63.1 percent in 2002 to 69.5 percent in 2008, then declined to 65.5 percent in 2009; this rate remained unchanged between 2009 and 2011 (66.2 percent) (Figure 6.2). Consistent with increases in the perceived risk of cigarette smoking, the rate of past month adolescent cigarette smoking decreased from 13.0 percent in 2002 to 7.8 percent in 2011.

Figure 6.2 Perceived Great Risk of Cigarette and Alcohol Use among Youths Aged 12 to 17: 2002-2011



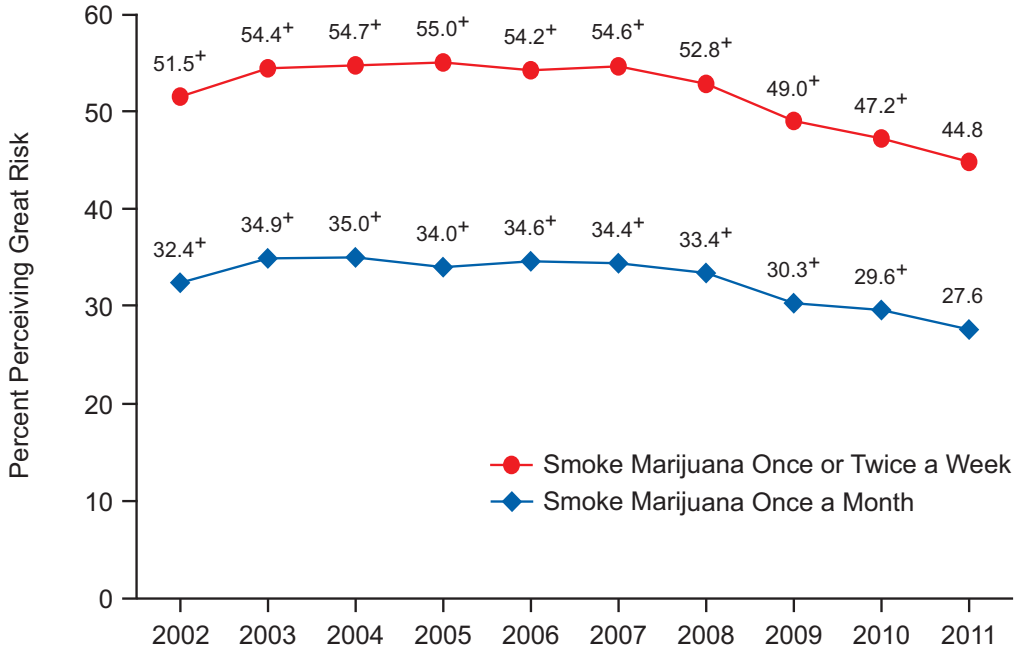
+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

- The percentage of youths aged 12 to 17 indicating great risk in having four or five drinks of an alcoholic beverage nearly every day increased from 62.2 percent in 2002 to 64.8 percent in 2011 (Figure 6.2). The percentage of youths perceiving great risk in having five or more drinks of an alcoholic beverage once or twice a week increased from 38.2 percent in 2002 to 40.7 percent in 2011. Consistent with these increases in perceived risk among youths aged 12 to 17, there were decreases between 2002 and 2011 in the rates of past month heavy alcohol use (from 2.5 to 1.5 percent) and binge alcohol use (from 10.7 to 7.4 percent).

- The percentage of youths aged 12 to 17 indicating great risk in smoking marijuana once a month decreased from 34.4 percent in 2007 to 27.6 percent in 2011, and the rate of youths perceiving great risk in smoking marijuana once or twice a week also decreased from 54.6 percent in 2007 to 44.8 percent in 2011 (Figure 6.3). Consistent with decreasing trends in the perceived risk of marijuana use, the prevalence of past month marijuana use among youths increased between 2007 (6.7 percent) and 2011 (7.9 percent).

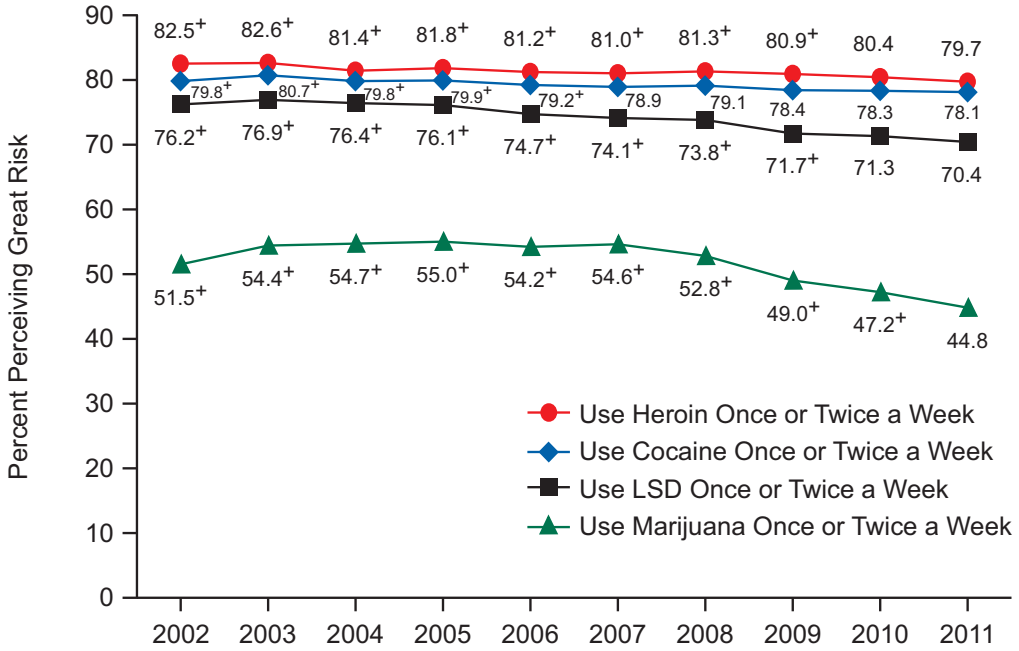
- Between 2002 and 2011, the percentage of youths aged 12 to 17 perceiving great risk from using a substance once or twice a week declined for the following substances: heroin (from 82.5 to 79.7 percent), cocaine (from 79.8 to 78.1 percent), LSD (from 76.2 to 70.4 percent), and marijuana (from 51.5 to 44.8 percent) (Figure 6.4). The rates remained unchanged between 2010 and 2011 for heroin, cocaine, and LSD, but declined for marijuana (from 47.2 to 44.8 percent). Youths were less likely to perceive great risk for smoking marijuana than for use of the other listed substances.

Figure 6.3 Perceived Great Risk of Marijuana Use among Youths Aged 12 to 17: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

Figure 6.4 Perceived Great Risk of Use of Selected Illicit Drugs Once or Twice a Week among Youths Aged 12 to 17: 2002-2011



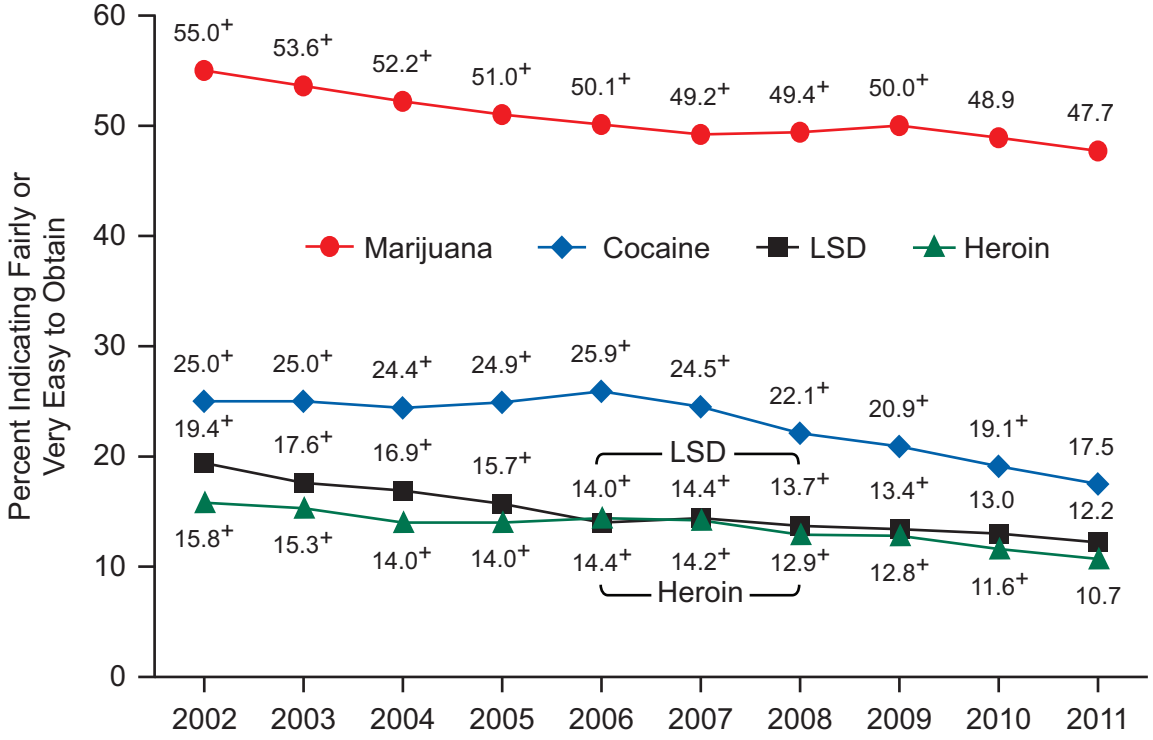
+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

Perceived Availability

- In 2011, about half (47.7 percent) of youths aged 12 to 17 reported that it would be "fairly easy" or "very easy" for them to obtain marijuana if they wanted some (Figure 6.5). About one in nine (10.7 percent) indicated that heroin would be fairly or very easily available, and 12.2 percent reported so for LSD. Between 2002 and 2011, there were decreases in the perceived easy availability of marijuana (from 55.0 to 47.7 percent), cocaine (from 25.0 to 17.5 percent), crack (from 26.5 to 18.2 percent), LSD (from 19.4 to 12.2 percent), and heroin (from 15.8 to 10.7 percent).

- Youths aged 12 to 17 in 2011 who perceived that it was easy to obtain specific illicit drugs were more likely to be past month users of illicit drugs or marijuana than were youths who perceived that obtaining specific illicit drugs would be fairly difficult, very difficult, or probably impossible. For example, 18.7 percent of youths who reported that marijuana would be easy to obtain were past month illicit drug users, but only 2.8 percent of those who thought marijuana would be more difficult to obtain were past month users. Similarly, 15.7 percent of youths who reported that marijuana would be easy to obtain were past month marijuana users, but only 1.2 percent of those who thought marijuana would be more difficult to obtain were past month users.

Figure 6.5 Perceived Availability of Selected Illicit Drugs among Youths Aged 12 to 17: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

- The percentage of youths who reported that marijuana, cocaine, crack, heroin, and LSD would be easy to obtain increased with age in 2011. For instance, 19.3 percent of those aged 12 or 13 said it would be fairly or very easy to obtain marijuana compared with 50.0 percent of those aged 14 or 15 and 70.7 percent of those aged 16 or 17.

- In 2011, 13.8 percent of youths aged 12 to 17 indicated that they had been approached by someone selling drugs in the past month. This rate was similar to the 2010 rate (14.3 percent), but was lower than the rate reported in 2002 (16.7 percent).

Perceived Parental Disapproval of Substance Use

- Most youths aged 12 to 17 believed their parents would "strongly disapprove" of their using substances. In 2011, 89.3 percent of youths reported that their parents would strongly disapprove of their trying marijuana or hashish once or twice; this was similar to the 89.1 percent reported in 2002. Most youths in 2011 (90.5 percent) reported that their parents would strongly disapprove of their having one or two drinks of an alcoholic beverage nearly every day, which was the same as the rate in 2010 and was higher than the rate in 2002 (89.0 percent). In 2011, 93.2 percent of youths reported that their parents would strongly disapprove of their smoking one or more packs of cigarettes per day, which was similar to the rate reported in 2010 (92.6 percent), but was higher than the 89.5 percent reported in 2002.

- Youths aged 12 to 17 who believed their parents would strongly disapprove of their using substances were less likely to use that substance than were youths who believed their parents would somewhat disapprove or neither approve nor disapprove. For instance, in 2011, past month cigarette use was reported by 5.5 percent of youths who perceived strong parental disapproval if they were to smoke one or more packs of cigarettes per day compared with 37.1 percent of youths who believed their parents would not strongly disapprove. Also, past month marijuana use was much less prevalent among youths who perceived strong parental disapproval for trying marijuana or hashish once or twice than among those who did not perceive this level of disapproval (5.0 vs. 31.5 percent, respectively).

Attitudes toward Peer Substance Use

- A majority of youths aged 12 to 17 reported that they disapprove of their peers using substances. In 2011, 91.0 percent of youths "strongly" or "somewhat" disapproved of their peers smoking one or more packs of cigarettes per day, which was similar to the rate of 90.5 percent in 2010, but was higher than the 87.1 percent in 2002. Also in 2011, 80.3 percent strongly or somewhat disapproved of peers using marijuana or hashish once a month or more, which was lower than the 81.5 percent reported in 2010, but was similar to the 80.4 percent reported in 2002. In addition, 88.1 percent of youths strongly or somewhat disapproved of peers having one or two drinks of an alcoholic beverage nearly every day in 2011, which was the same as the rate reported in 2010, but was higher than the 84.7 percent reported in 2002.

- In 2011, past month marijuana use was reported by 2.5 percent of youths aged 12 to 17 who strongly or somewhat disapproved of their peers using marijuana once a month or more, which was lower than the 29.9 percent among youths who reported that they neither approve nor disapprove of such behavior from their peers.

Fighting and Delinquent Behavior

- In 2011, 19.1 percent of youths aged 12 to 17 reported that, in the past year, they had gotten into a serious fight at school or at work; this was lower than the rates in 2010 (20.1 percent) and 2002 (20.6 percent). Approximately one in eight youths (12.2 percent) in 2011 had taken part in a group-against-group fight, which was similar to the rate in 2010 (12.8 percent) and was lower than the rate in 2002 (15.9 percent). About 1 in 30 (3.5 percent) had carried a handgun at least once in the past year in 2011, which was similar to the rates in 2010 (3.1 percent) and 2002 (3.3 percent). An estimated 5.9 percent had, in at least one instance, attacked others with the intent to harm or seriously hurt them in 2011, which was lower than the rates in 2010 (7.2 percent) and 2002 (7.8 percent). An estimated 3.0 percent had sold illegal drugs in 2011, which was similar to the rate of 3.1 percent in 2010, but was lower than the rate in 2002 (4.4 percent). In 2011, 3.8 percent had, at least once, stolen or tried to steal something worth more than $50; this was similar to the rate of 4.0 percent in 2010, but was lower than the rate of 4.9 percent in 2002.

- Youths aged 12 to 17 who had engaged in fighting or other delinquent behaviors were more likely than other youths to have used illicit drugs in the past month. For instance, in 2011, past month illicit drug use was reported by 18.5 percent of youths who had gotten into a serious fight at school or work in the past year compared with 8.0 percent of those who had not engaged in fighting at school or work, and by 45.1 percent of those who had stolen or tried to steal something worth over $50 in the past year compared with 8.7 percent of those who had not attempted or engaged in such theft.

Religious Beliefs and Participation in Activities

- In 2011, 30.7 percent of youths aged 12 to 17 reported that they had attended religious services 25 or more times in the past year, which was similar to the rate in 2010 (30.8 percent), but was lower than the rate in 2002 (33.0 percent). Also, 73.5 percent agreed or strongly agreed with the statement that religious beliefs are a very important part of their lives, which was similar to the rate in 2010 (74.6 percent), but was lower than the 78.2 percent reported in 2002. In 2011, 33.1 percent agreed or strongly agreed with the statement that it is important for their friends to share their religious beliefs, which was similar to the rate in 2010 (32.8 percent), but was lower than the rate in 2002 (35.8 percent).

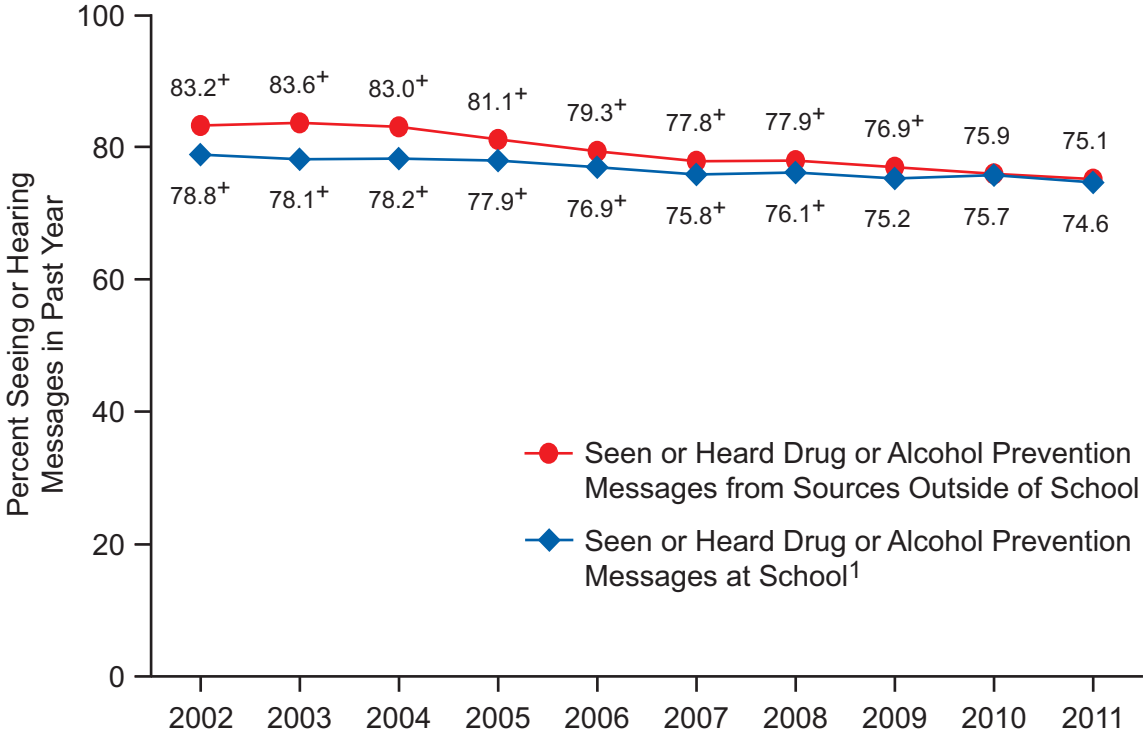
- The rates of past month use of illicit drugs and cigarettes and binge alcohol use were lower among youths aged 12 to 17 who agreed with these statements about religious beliefs than among those who disagreed. For instance, in 2011, past month illicit drug use was reported by 7.4 percent of those who agreed or strongly agreed that religious beliefs are a very important part of their lives compared with 17.5 percent of those who disagreed with that statement. Similar differences were found between those two subgroups for the past month use of cigarettes and binge alcohol use (5.3 vs. 14.3 percent, and 5.7 and 12.1 percent, respectively).

Exposure to Substance Use Prevention Messages and Programs

- In 2011, approximately one in eight youths aged 12 to 17 (11.7 percent) reported that they had participated in drug, tobacco, or alcohol prevention programs outside of school in the past year. This rate was similar to the 11.5 percent reported in 2010, but was lower than the rate reported in 2002 (12.7 percent). In 2011, the prevalence of past month use did not differ significantly between those who did or did not participate in these programs for illicit drugs (10.8 and 9.9 percent, respectively), marijuana (7.5 and 7.9 percent), cigarettes (6.8 and 7.8 percent), or binge alcohol use (6.9 and 7.5 percent).

- In 2011, 75.1 percent of youths aged 12 to 17 reported having seen or heard drug or alcohol prevention messages in the past year from sources outside of school, which was similar to the 75.9 percent reported in 2010, but was lower than the 83.2 percent reported in 2002 (Figure 6.6). In 2011, the prevalence of past month use of illicit drugs among those who reported having such exposure (10.0 percent) was not significantly different from the prevalence among those who reported having no such exposure (10.2 percent).

Figure 6.6 Exposure to Substance Use Prevention Messages and Programs among Youths Aged 12 to 17: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

1 Estimates are from youths aged 12 to 17 who were enrolled in school in the past year.

- In 2011, 74.6 percent of youths aged 12 to 17 enrolled in school in the past year reported having seen or heard drug or alcohol prevention messages at school, which was similar to the 75.7 percent reported in 2010, but was lower than the 78.8 percent reported in 2002 (Figure 6.6). In 2011, the prevalence of past month use of illicit drugs or marijuana was lower among those who reported having such exposure (9.2 and 7.2 percent for illicit drugs and marijuana, respectively) than among those who reported having no such exposure (13.2 and 10.8 percent).

Parental Involvement

- Youths aged 12 to 17 were asked several questions related to the extent of support, oversight, and control that they perceived their parents exercised over them in the year prior to the survey interview. In 2011, among youths aged 12 to 17 who were enrolled in school in the past year, 69.9 percent reported that their parents limited the amount of time that they spent out with friends on school nights. This was similar to the rate reported in 2010 and remained statistically unchanged from the rate reported in 2002. In 2011, 81.1 percent reported that in the past year their parents always or sometimes checked on whether or not they had completed their homework, and 80.4 percent reported that their parents always or sometimes provided help with their homework. Both of the rates reported in 2011 were similar to the rates in 2010. However, the rate for parents checking on completing homework was higher than in 2002 (78.4 percent), and the rate for parents providing help with homework was lower than the rate in 2002 (81.4 percent).

- In 2011, 88.4 percent of youths aged 12 to 17 reported that in the past year their parents always or sometimes made them do chores around the house, which was similar to the rate in 2010 (88.0 percent), but was slightly higher than the rate in 2002 (87.4 percent). In 2011, 85.9 percent of youths reported that their parents always or sometimes let them know that they had done a good job, and 85.8 percent reported that their parents always or sometimes let them know they were proud of something they had done. These percentages in 2011 were similar to those reported in 2010 and 2002. In 2011, 40.5 percent of youths reported that their parents limited the amount of time that they watched television, which was similar to the rate in 2010 (39.5 percent), but was higher than the 36.9 percent reported in 2002.

- In 2011, past month use of illicit drugs and cigarettes and binge alcohol use were lower among youths aged 12 to 17 who reported that their parents always or sometimes engaged in monitoring behaviors than among youths whose parents seldom or never engaged in such behaviors. For instance, the rate of past month use of any illicit drug was 8.2 percent for youths whose parents always or sometimes helped with homework compared with 18.7 percent among youths who indicated that their parents seldom or never helped. Rates of current cigarette smoking and past month binge alcohol use also were lower among youths whose parents always or sometimes helped with homework (6.3 and 6.1 percent, respectively) than among youths whose parents seldom or never helped (14.3 and 13.8 percent).

7. Substance Dependence, Abuse, and Treatment

The National Survey on Drug Use and Health (NSDUH) includes a series of questions to assess the prevalence of substance use disorders (substance dependence or abuse) in the past 12 months. Substances include alcohol and illicit drugs, such as marijuana, cocaine, heroin, hallucinogens, inhalants, and the nonmedical use of prescription-type psychotherapeutic drugs. These questions are used to classify persons as dependent on or abusing specific substances based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV) (American Psychiatric Association [APA], 1994).

The questions related to dependence ask about health and emotional problems associated with substance use, unsuccessful attempts to cut down on use, tolerance, withdrawal, reducing other activities to use substances, spending a lot of time engaging in activities related to substance use, or using the substance in greater quantities or for a longer time than intended. The questions on abuse ask about problems at work, home, and school; problems with family or friends; physical danger; and trouble with the law due to substance use. Dependence is considered to be a more severe substance use problem than abuse because it involves the psychological and physiological effects of tolerance and withdrawal.

This chapter provides estimates of the prevalence and patterns of substance use disorders occurring in the past year from the 2011 NSDUH and compares these estimates against the results from the 2002 through 2010 surveys. It also provides estimates of the prevalence and patterns of the receipt of treatment in the past year for problems related to substance use. This chapter concludes with a discussion of the need for and the receipt of treatment at specialty facilities for problems associated with substance use.

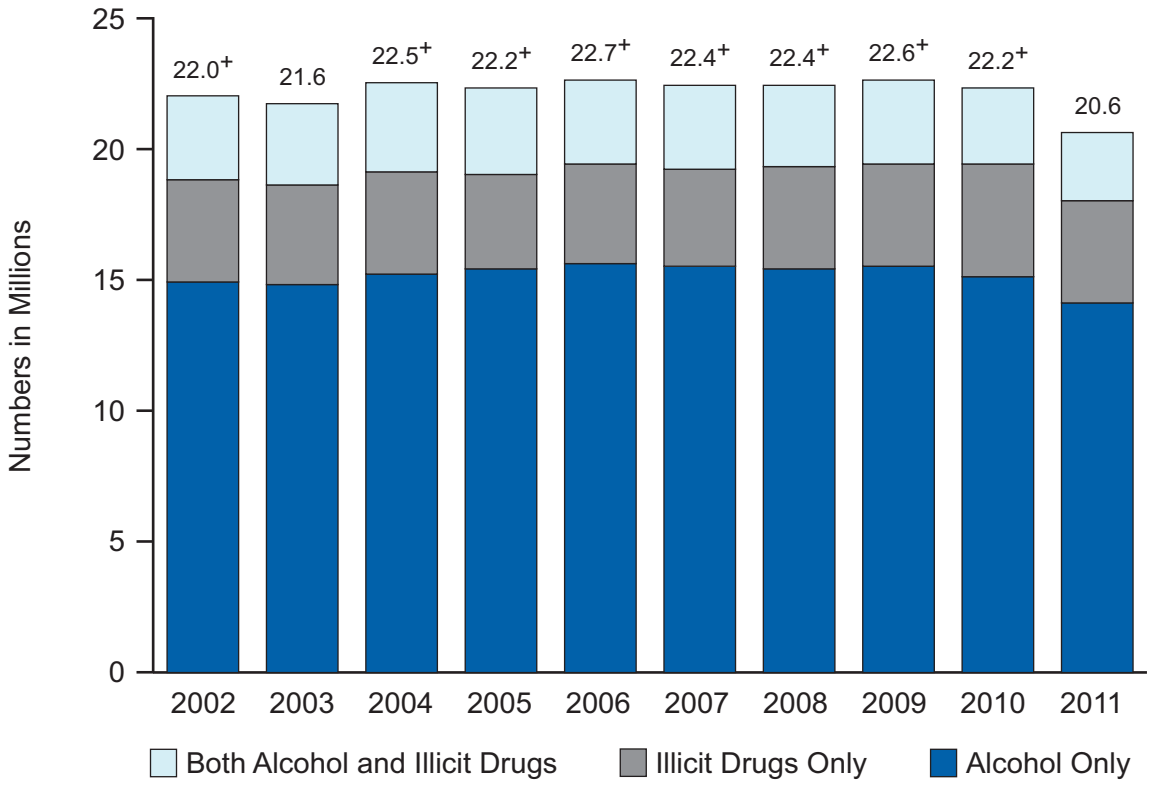
7.1. Substance Dependence or Abuse

- In 2011, an estimated 20.6 million persons aged 12 or older were classified with substance dependence or abuse in the past year (8.0 percent of the population aged 12 or older) (Figure 7.1). Of these, 2.6 million were classified with dependence or abuse of both alcohol and illicit drugs, 3.9 million had dependence or abuse of illicit drugs but not alcohol, and 14.1 million had dependence or abuse of alcohol but not illicit drugs.

- The annual number of persons with substance dependence or abuse remained stable between 2002 and 2010, ranging from 21.6 million to 22.7 million. However, the number in 2011 (20.6 million) was lower than the number in 2010 (22.2 million).

- In 2011, 16.7 million persons aged 12 or older were classified with alcohol dependence or abuse, which was lower than the number in 2010 (18.0 million) and in each year from 2002 to 2009 (18.1 million in 2002, 17.8 million in 2003, 18.7 million in 2004, 18.7 million in 2005, 18.9 million in 2006, 18.7 million in 2007, 18.5 million in 2008, and 18.8 million in 2009).

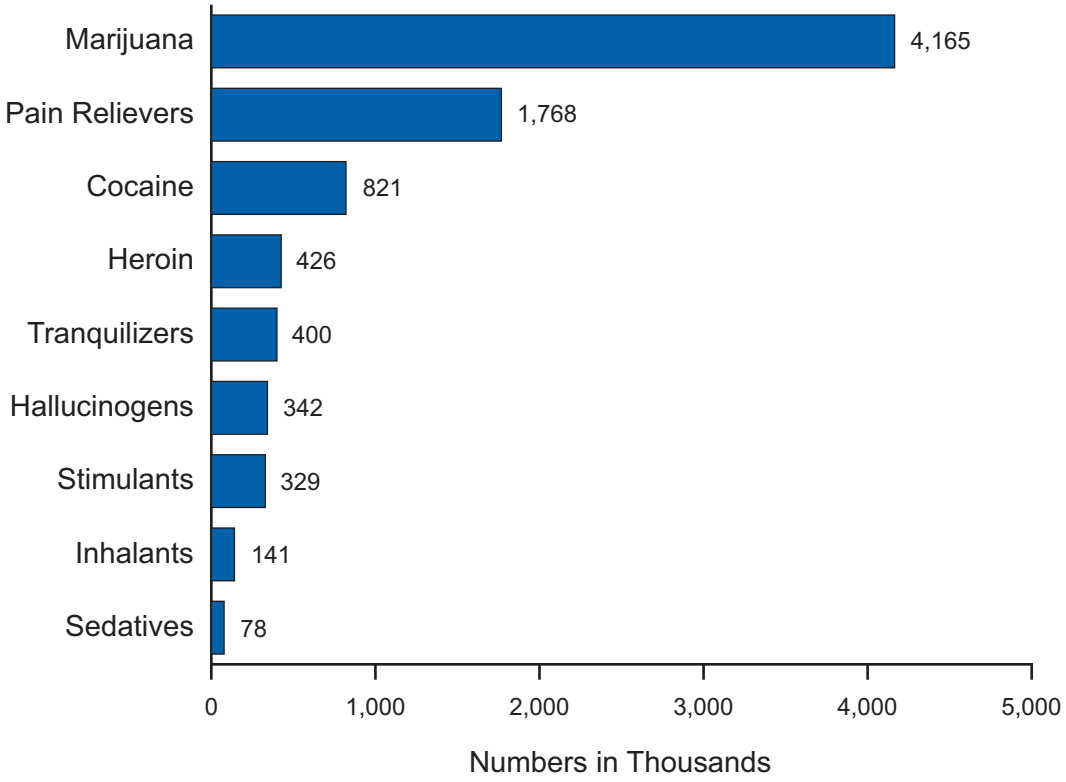
Figure 7.1 Substance Dependence or Abuse in the Past Year among Persons Aged 12 or Older: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

- In 2011, 6.5 percent of the population aged 12 or older had alcohol dependence or abuse, which was lower than the rate in each year since 2002 (7.7 percent in 2002, 7.5 percent in 2003, 7.8 percent in 2004, 7.7 percent in 2005, 7.7 percent in 2006, 7.5 percent in 2007, 7.4 percent in 2008, 7.5 percent in 2009, and 7.1 percent in 2010).
- The number of persons aged 12 or older who had illicit drug dependence or abuse was similar between 2010 (7.1 million) and 2011 (6.5 million) and between 2002 (7.1 million) and 2011. However, the rate of persons aged 12 or older who had illicit drug dependence or abuse in 2011 (2.5 percent) was lower than the rate in 2010 (2.8 percent) and in most years from 2002 to 2009. The rate of illicit drug dependence or abuse in 2002 to 2009 ranged from 2.8 to 3.0 percent.
- Marijuana was the illicit drug with the highest rate of past year dependence or abuse in 2011, followed by pain relievers and cocaine. Of the 6.5 million persons aged 12 or older classified with illicit drug dependence or abuse in 2011, 4.2 million had marijuana dependence or abuse (representing 1.6 percent of the total population aged 12 or older, and 63.8 percent of all those classified with illicit drug dependence or abuse), 1.8 million persons had pain reliever dependence or abuse, and 821,000 persons had cocaine dependence or abuse (Figure 7.2).

Figure 7.2 Specific Illicit Drug Dependence or Abuse in the Past Year among Persons Aged 12 or Older: 2011



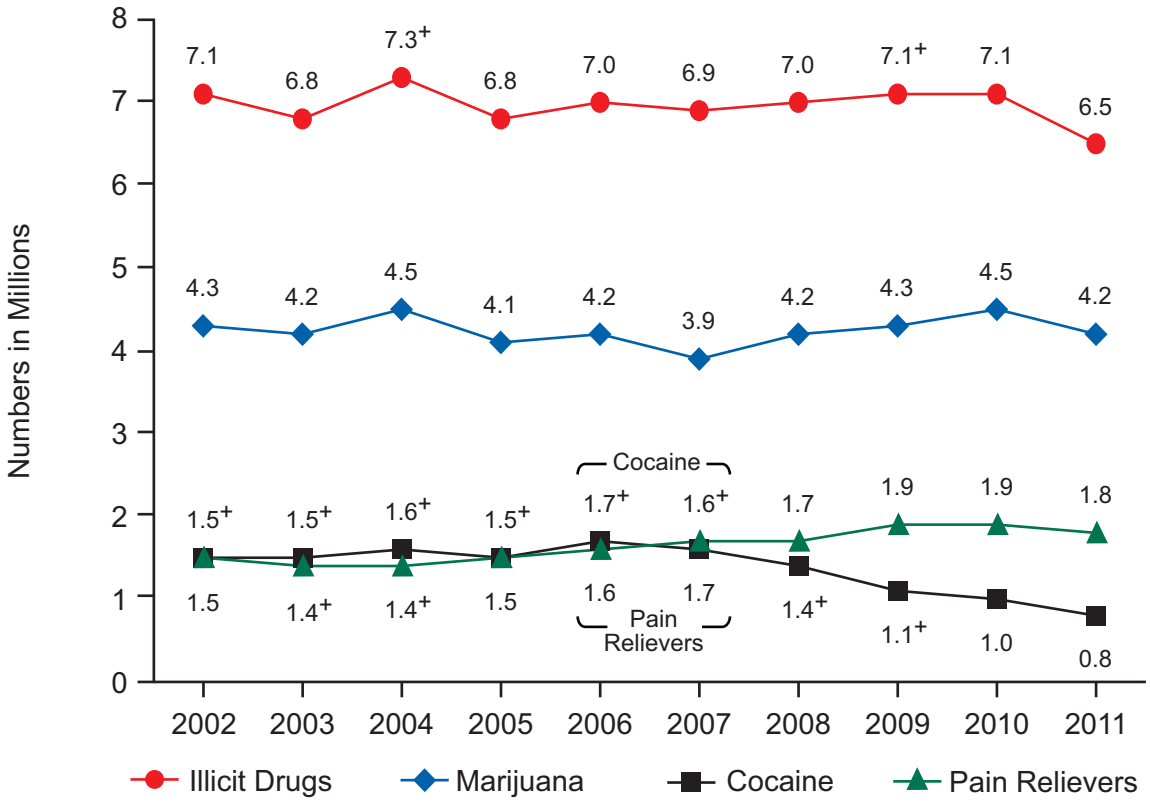
- The number of persons who had marijuana dependence or abuse did not change significantly between 2002 (4.3 million) and 2011 (4.2 million) or between 2010 (4.5 million) and 2011 (Figure 7.3). The rate of persons who had marijuana dependence or abuse in 2011 (1.6 percent) was lower than the rates in 2002 (1.8 percent) and 2004 (1.9 percent), but was similar to the rate in 2010 (1.8 percent).

- The rate and the number of persons who had pain reliever dependence or abuse remained unchanged between 2010 (0.8 percent and 1.9 million) and 2011 (0.7 percent and 1.8 million) and between 2002 (0.6 percent and 1.5 million) and 2011. However, the number with pain reliever dependence or abuse was higher in 2011 than in 2004 (1.4 million).

- The rate and the number of persons who had cocaine dependence or abuse were similar between 2010 (0.4 percent and 1.0 million) and 2011 (0.3 percent and 821,000). However, they decreased between 2006 (0.7 percent and 1.7 million) and 2011.

- The rate and the number of persons who had heroin dependence or abuse were stable between 2010 (0.1 percent and 361,000) and 2011 (0.2 percent and 426,000). However, they increased between 2007 (0.1 percent and 214,000) and 2011.

Figure 7.3 Illicit Drug Dependence or Abuse in the Past Year among Persons Aged 12 or Older: 2002-2011



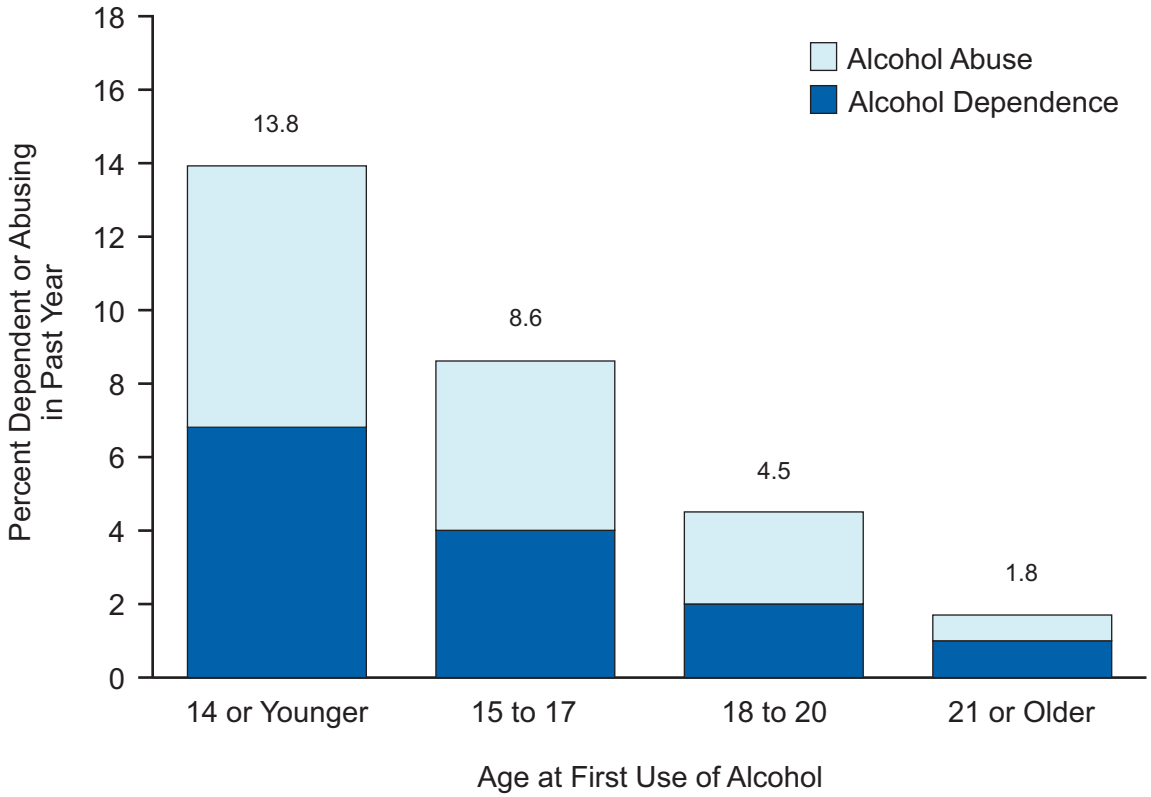
+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

Age at First Use

- In 2011, among adults aged 18 or older, age at first use of marijuana was associated with illicit drug dependence or abuse. Among those who first tried marijuana at age 14 or younger, 12.7 percent were classified with illicit drug dependence or abuse, which was higher than the 2.0 percent of adults who had first used marijuana at age 18 or older.

- Among adults, age at first use of alcohol was associated with alcohol dependence or abuse. In 2011, among adults aged 18 or older who first tried alcohol at age 14 or younger, 14.8 percent were classified with alcohol dependence or abuse, which was higher than the 3.5 percent of adults who had first used alcohol at age 18 or older. Adults aged 21 or older who had first used alcohol before age 21 were more likely than adults who had their first drink at age 21 or older to be classified with alcohol dependence or abuse (Figure 7.4). In particular, adults aged 21 or older who had first used alcohol at age 14 or younger were more than 7 times as likely to be classified with alcohol dependence or abuse than adults who had their first drink at age 21 or older (13.8 vs. 1.8 percent). The rate of adults aged 21 or older who first used alcohol at age 21 or older and were classified with alcohol dependence or abuse in 2011 was lower than the rate in 2010 (2.7 percent).

Figure 7.4 Alcohol Dependence or Abuse in the Past Year among Adults Aged 21 or Older, by Age at First Use of Alcohol: 2011

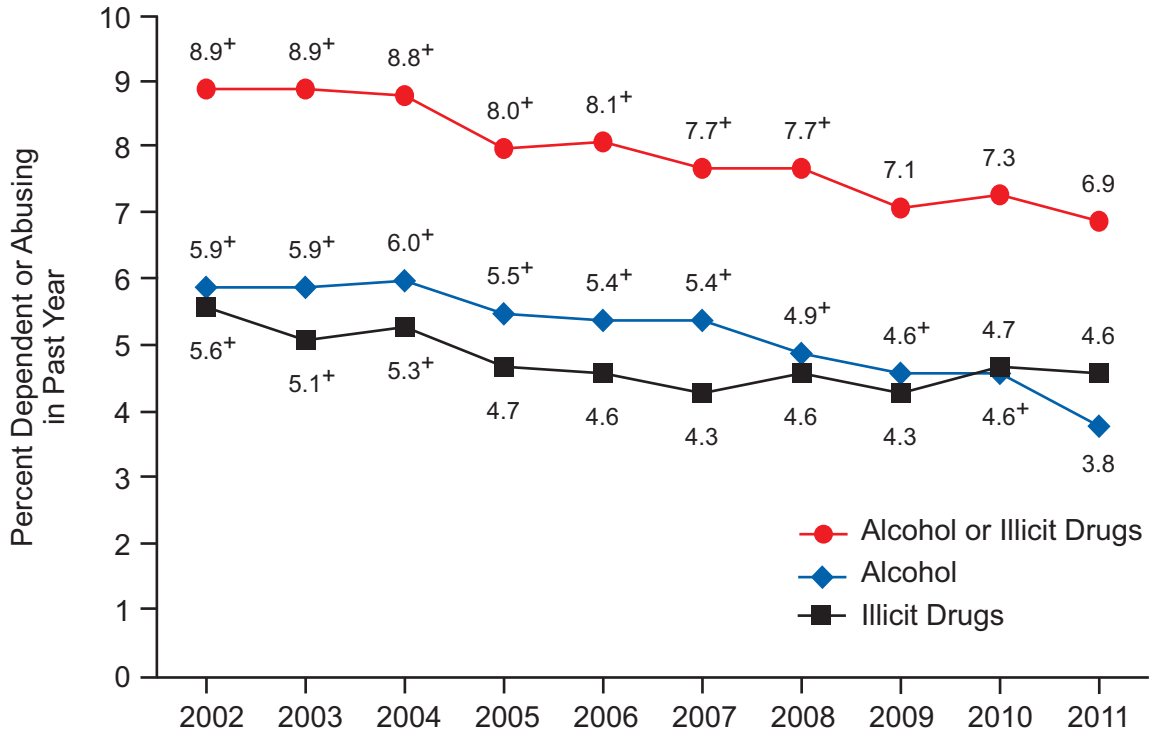


Age

- Rates of substance dependence or abuse were associated with age. In 2011, the rate of substance dependence or abuse among adults aged 18 to 25 (18.6 percent) was higher than that among youths aged 12 to 17 (6.9 percent) and among adults aged 26 or older (6.3 percent). Both the rate among adults aged 18 to 25 and the rate among adults aged 26 or older declined between 2010 (20.0 and 7.0 percent, respectively) and 2011. From 2002 to 2011, the rate decreased for youths aged 12 to 17 (from 8.9 to 6.9 percent), for young adults aged 18 to 25 (from 21.7 to 18.6 percent), and for adults aged 26 or older (from 7.3 to 6.3 percent).

- The rate of alcohol dependence or abuse among youths aged 12 to 17 was 3.8 percent in 2011, which declined from 4.6 percent in 2010 and from 5.9 percent in 2002 (Figure 7.5). Among young adults aged 18 to 25, the rate of alcohol dependence or abuse also decreased between 2010 (15.7 percent) and 2011 (14.4 percent) and between 2002 (17.7 percent) and 2011. Among adults aged 26 or older, the rate was stable between 2010 (5.9 percent) and 2011 (5.4 percent), but it decreased between 2002 (6.2 percent) and 2011.

Figure 7.5 Alcohol and Illicit Drug Dependence or Abuse among Youths Aged 12 to 17: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

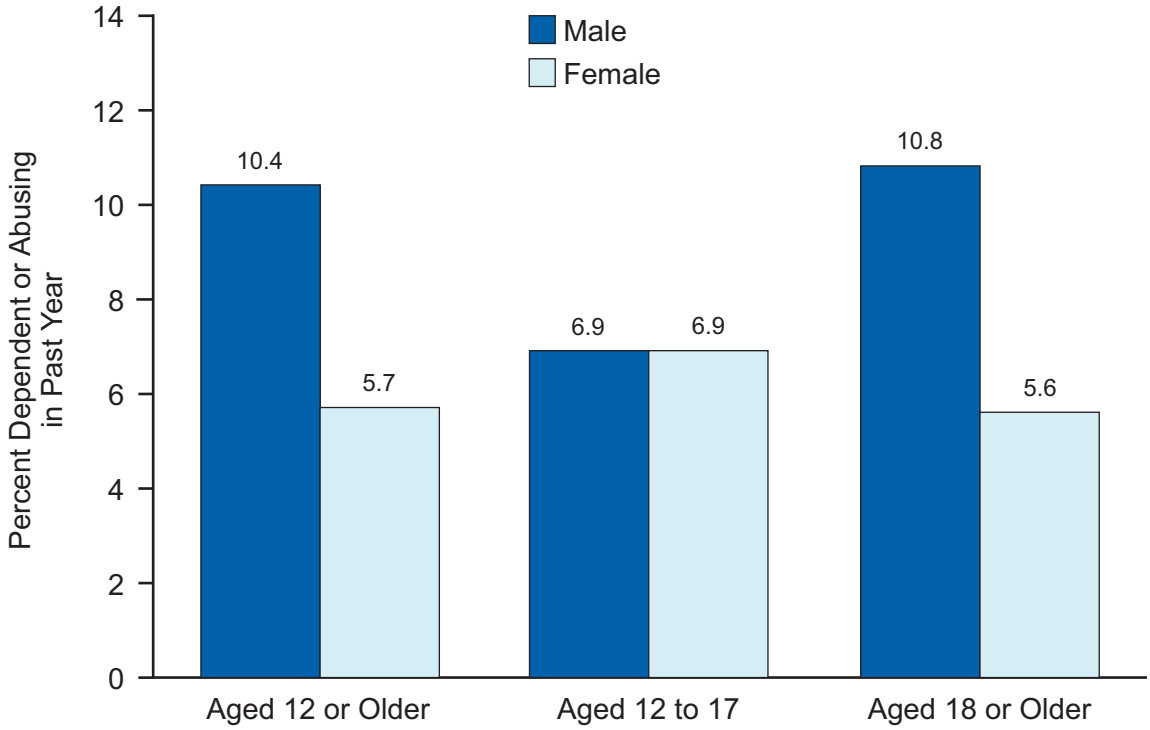
Gender

- As was the case from 2002 through 2010, the rate of substance dependence or abuse for males aged 12 or older in 2011 was about twice as high as the rate for females. For males in 2011, the rate was 10.4 percent, which decreased from 11.7 percent in 2010 (Figure 7.6). For females, it was 5.7 percent in 2011, which did not differ from the rate of 6.0 percent in 2010. Among youths aged 12 to 17, the rate of substance dependence or abuse among males was not different from the rate among females in 2011 (6.9 percent for each).

Race/Ethnicity

- In 2011, among persons aged 12 or older, the rate of substance dependence or abuse was lower among Asians (3.3 percent) than among other racial/ethnic groups. The rates for the other racial/ethnic groups were 16.8 percent for American Indians or Alaska Natives, 10.6 percent for Native Hawaiians or Other Pacific Islanders, 9.0 percent for persons reporting two or more races, 8.7 percent for Hispanics, 8.2 percent for whites, and 7.2 percent for blacks.

Figure 7.6 Substance Dependence or Abuse in the Past Year, by Age and Gender: 2011



Education

- Rates of substance dependence or abuse were associated with level of education in 2011. Among adults aged 18 or older, those who graduated from a college or university had a lower rate of substance dependence or abuse (6.4 percent) than those who graduated from high school (8.0 percent), those who did not graduate from high school (9.3 percent), and those with some college (9.5 percent).

Employment

- Rates of substance dependence or abuse were associated with current employment status in 2011. A higher percentage of unemployed adults aged 18 or older were classified with dependence or abuse (14.8 percent) than were full-time employed adults (8.4 percent) or part-time employed adults (9.8 percent).

- About half of the adults aged 18 or older with substance dependence or abuse were employed full time in 2011. Of the 18.9 million adults classified with dependence or abuse, 9.8 million (51.8 percent) were employed full time.

Criminal Justice Populations

- In 2011, adults aged 18 or older who were on parole or a supervised release from jail during the past year had higher rates of illicit drug or alcohol dependence or abuse (35.1 percent) than their counterparts who were not on parole or supervised release during the past year (7.9 percent).

- In 2011, probation status was associated with substance dependence or abuse. The rate of substance dependence or abuse was 33.7 percent among adults who were on probation during the past year, which was higher than the rate among adults who were not on probation during the past year (7.6 percent).

Geographic Area

- In 2011, rates of substance dependence or abuse for persons aged 12 or older were 8.9 percent in the West, 8.6 percent in the Northeast, 8.3 percent in the Midwest, and 7.0 percent in the South.

- Rates for substance dependence or abuse among persons aged 12 or older in 2011 were similar in large metropolitan counties (8.4 percent) and small metropolitan counties (8.2 percent), but were higher than in nonmetropolitan counties (6.3 percent).

7.2. Past Year Treatment for a Substance Use Problem

Estimates described in this section refer to treatment received for illicit drug or alcohol use, or for medical problems associated with the use of illicit drugs or alcohol. This includes treatment received in the past year at any location, such as a hospital (inpatient), rehabilitation facility (outpatient or inpatient), mental health center, emergency room, private doctor's office, prison or jail, or a self-help group, such as Alcoholics Anonymous or Narcotics Anonymous. Persons could report receiving treatment at more than one location. Note that the definition of treatment in this section is different from the definition of specialty treatment described in Section 7.3. Specialty treatment includes treatment only at a hospital (inpatient), a rehabilitation facility (inpatient or outpatient), or a mental health center.

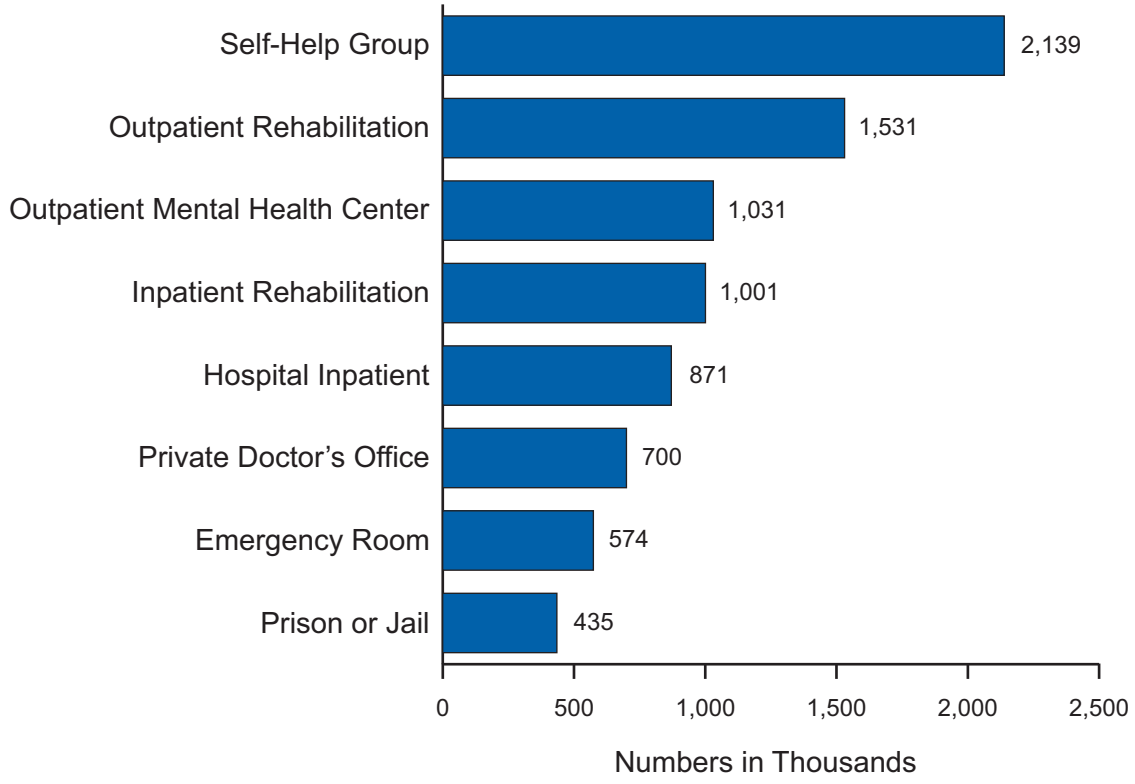
Individuals who reported receiving substance use treatment but were missing information on whether the treatment was specifically for alcohol use or illicit drug use were not counted in estimates of either illicit drug use treatment or alcohol use treatment; however, they were counted in estimates for "drug or alcohol use" treatment.

- In 2011, 3.8 million persons aged 12 or older (1.5 percent of the population) received treatment for a problem related to the use of alcohol or illicit drugs. Of these, 1.2 million received treatment for the use of both alcohol and illicit drugs, 0.8 million received treatment for the use of illicit drugs but not alcohol, and 1.4 million received treatment for the use of alcohol but not illicit drugs. (Note that estimates by substance do not sum to the total number of persons receiving treatment because the total includes persons who reported receiving treatment but did not report for which substance the treatment was received.)

- The rate and the number of persons in the population aged 12 or older receiving substance use treatment within the past year was stable between 2010 (1.6 percent and 4.2 million) and 2011 (1.5 percent and 3.8 million) and between 2002 (1.5 percent and 3.5 million) and 2011.

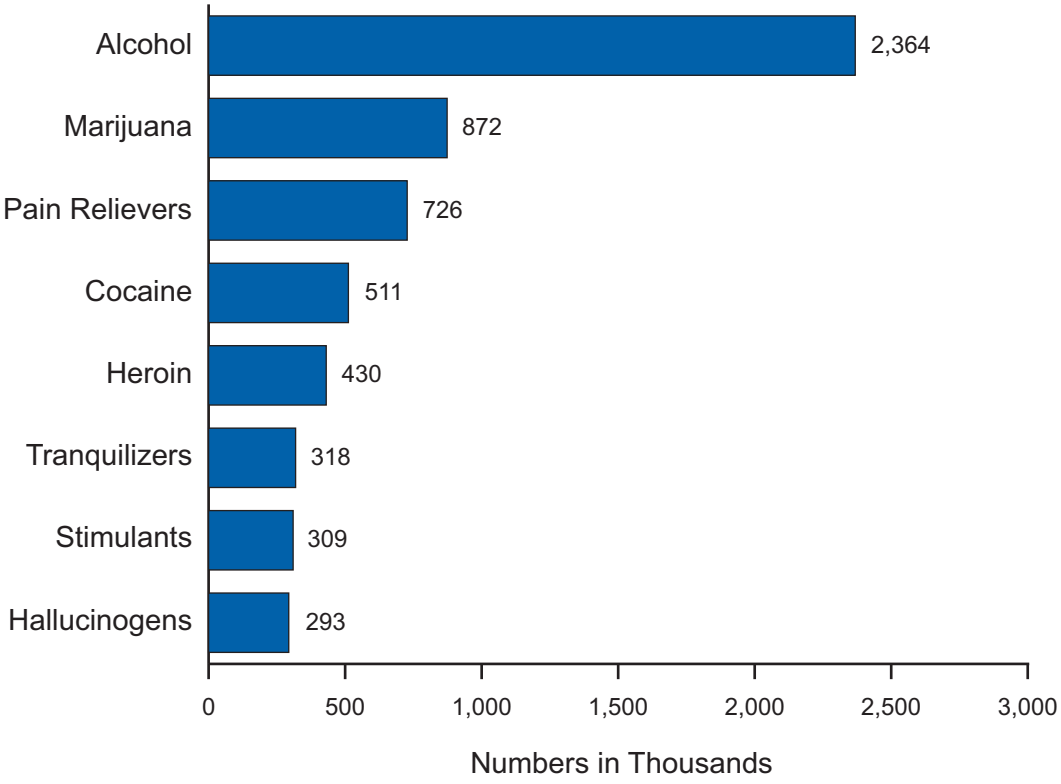
- In 2011, among the 3.8 million persons aged 12 or older who received treatment for alcohol or illicit drug use in the past year, 2.1 million persons received treatment at a self-help group, and 1.5 million received treatment at a rehabilitation facility as an outpatient (Figure 7.7). There were 1.0 million persons who received treatment at a mental health center as an outpatient, 1.0 million persons who received treatment at a rehabilitation facility as an inpatient, 871,000 at a hospital as an inpatient, 700,000 at a private doctor's office, 574,000 at an emergency room, and 435,000 at a prison or jail. None of these estimates changed significantly between 2010 and 2011. Except for persons who received treatment at a prison or jail, these estimates also did not change between 2002 and 2011; the number of persons who received treatment at a prison or jail increased from 259,000 in 2002 to 435,000 in 2011.

Figure 7.7 Locations Where Past Year Substance Use Treatment Was Received among Persons Aged 12 or Older: 2011



- In 2011, during their most recent treatment in the past year, 2.4 million persons aged 12 or older reported receiving treatment for alcohol use, and 872,000 persons reported receiving treatment for marijuana use (Figure 7.8). Estimates for receiving treatment for the use of other drugs were 726,000 persons for pain relievers, 511,000 for cocaine, 430,000 for heroin, 318,000 for tranquilizers, 309,000 for stimulants, and 293,000 for hallucinogens. None of these estimates changed significantly between 2010 and 2011.

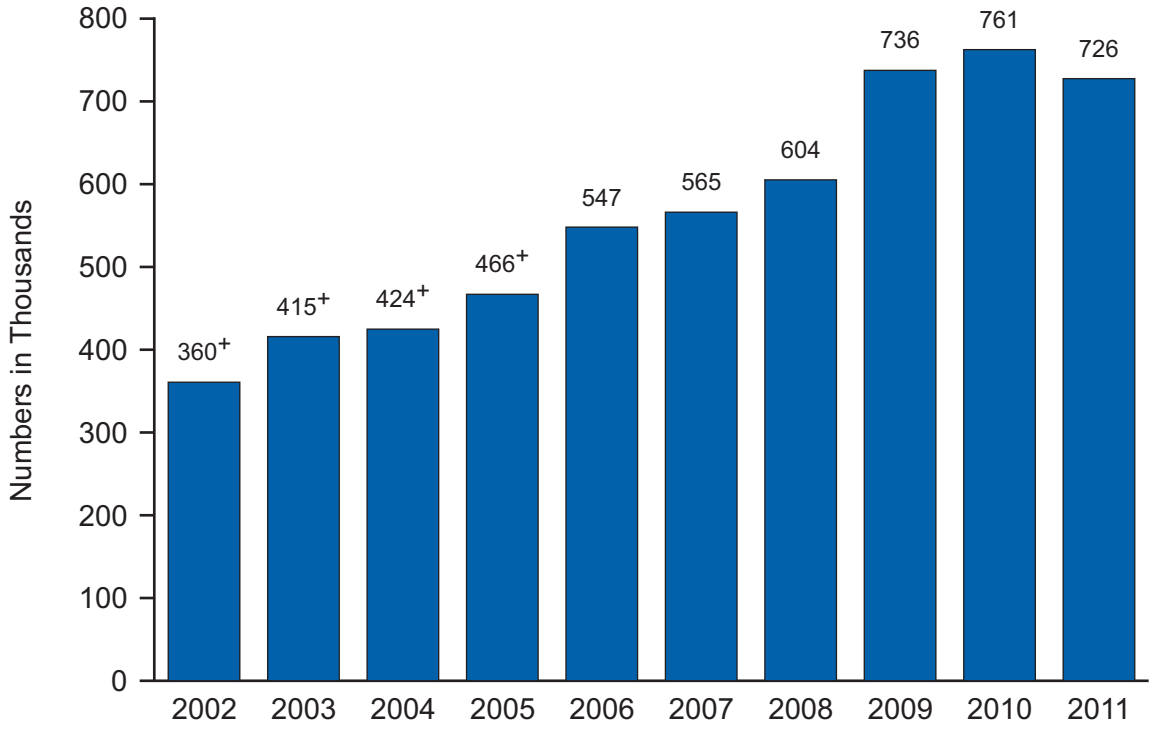
Figure 7.8 Substances for Which Most Recent Treatment Was Received in the Past Year among Persons Aged 12 or Older: 2011



- The numbers of persons aged 12 or older who received treatment for the use of pain relievers (see Figure 7.9) and tranquilizers increased between 2002 and 2011. Numbers who received treatment for pain relievers in 2009 to 2011 ranged from 726,000 to 761,000 persons and were greater than the numbers in 2002 to 2005.

- The numbers of persons aged 12 or older who received treatment for marijuana, hallucinogens, and stimulants were stable between 2002 and 2011. (Note that respondents could indicate that they received treatment for more than one substance during their most recent treatment.)

Figure 7.9 Received Most Recent Treatment in the Past Year for the Use of Pain Relievers among Persons Aged 12 or Older: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

7.3. Need for and Receipt of Specialty Treatment

This section discusses the need for and receipt of treatment for a substance use problem at a "specialty" treatment facility. Specialty treatment is defined as treatment received at any of the following types of facilities: hospitals (inpatient only), drug or alcohol rehabilitation facilities (inpatient or outpatient), or mental health centers. It does not include treatment at an emergency room, private doctor's office, self-help group, prison or jail, or hospital as an outpatient. An individual is defined as needing treatment for an alcohol or drug use problem if he or she met the DSM-IV (APA, 1994) diagnostic criteria for alcohol or illicit drug dependence or abuse in the past 12 months or if he or she received specialty treatment for alcohol use or illicit drug use in the past 12 months.

In this section, an individual needing treatment for an illicit drug use problem is defined as receiving treatment for his or her drug use problem only if he or she reported receiving specialty treatment for illicit drug use in the past year. Thus, an individual who needed treatment for illicit drug use but received specialty treatment only for alcohol use in the past year or who received treatment for illicit drug use only at a facility not classified as a specialty facility was not counted as receiving treatment for illicit drug use. Similarly, an individual who needed

treatment for an alcohol use problem was counted as receiving alcohol use treatment only if the treatment was received for alcohol use at a specialty treatment facility. Individuals who reported receiving specialty substance use treatment but were missing information on whether the treatment was specifically for alcohol use or drug use were not counted in estimates of specialty drug use treatment or in estimates of specialty alcohol use treatment; however, they were counted in estimates for "drug or alcohol use" treatment.

In addition to questions about symptoms of substance use problems that are used to classify respondents' need for treatment based on DSM-IV criteria, NSDUH includes questions asking respondents about their perceived need for treatment (i.e., whether they felt they needed treatment or counseling for illicit drug use or alcohol use). In this report, estimates for perceived need for treatment are discussed only for persons who were classified as needing treatment (based on DSM-IV criteria) but did not receive treatment at a specialty facility. Similarly, estimates for whether a person made an effort to get treatment are discussed only for persons who felt the need for treatment and did not receive it.

Illicit Drug or Alcohol Use Treatment and Treatment Need

- In 2011, 21.6 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem (8.4 percent of persons aged 12 or older). Both the rate and the number declined between 2010 (9.2 percent and 23.2 million) and 2011 and between 2002 (9.7 percent and 22.8 million) and 2011. In 2011, 2.3 million persons (0.9 percent of persons aged 12 or older and 10.8 percent of those who needed treatment) received treatment at a specialty facility, which did not differ from the rates and numbers in 2010 and 2002.

- In 2011, 19.3 million persons (7.5 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty facility in the past year. Both the rate and the number declined between 2010 (8.1 percent and 20.6 million) and 2011 and between 2002 (8.7 percent and 20.5 million) and 2011.

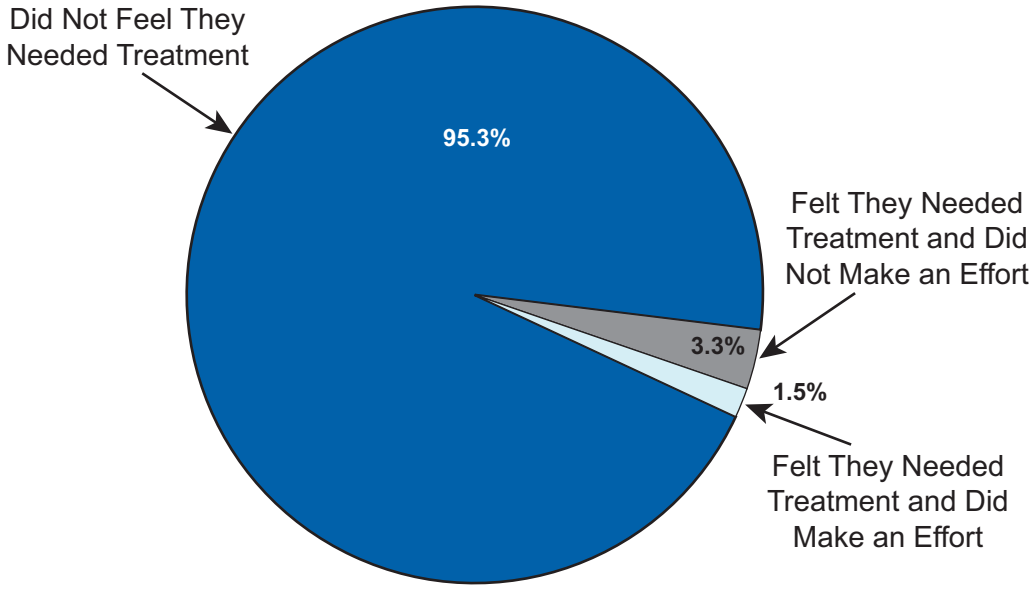
- Of the 2.3 million persons aged 12 or older who received specialty substance use treatment in 2011, 898,000 received treatment for alcohol use only, 780,000 received treatment for illicit drug use only, and 574,000 received treatment for both alcohol and illicit drug use. These estimates were similar to the estimates for 2010 and 2002.

- Among persons in 2011 who received their most recent substance use treatment at a specialty facility in the past year, 46.4 percent reported using their "own savings or earnings" as a source of payment for their most recent specialty treatment, 38.5 percent reported using private health insurance, 35.0 percent reported using Medicaid, 31.2 percent reported using Medicare, 31.0 percent reported using public assistance other than Medicaid, and 26.0 percent reported using funds from family members. None of these estimates changed significantly between 2010 and 2011. However, there were increases in persons reporting using Medicaid or using Medicare between 2002 (23.1 and 19.5 percent, respectively) and 2011.

- Of the 19.3 million persons aged 12 or older in 2011 who were classified as needing substance use treatment but not receiving treatment at a specialty facility in the past year, 912,000 persons (4.7 percent) reported that they perceived a need for treatment for their illicit drug or alcohol use problem (Figure 7.10). Of these 912,000 persons who felt they needed treatment but did not receive treatment in 2011, 281,000 (30.8 percent) reported that they made an effort to get treatment, and 631,000 (69.2 percent) reported making no effort to get treatment. These estimates were stable between 2010 and 2011.

- The rate and the number of youths aged 12 to 17 who needed treatment for an illicit drug or alcohol use problem in 2011 (7.0 percent and 1.7 million) were similar to those in 2010 (7.5 percent and 1.8 million), but they were lower than those in 2002 (9.1 percent and 2.3 million). Of the 1.7 million youths who needed treatment in 2011, 146,000 received treatment at a specialty facility (about 8.4 percent of the youths who needed treatment), leaving about 1.6 million who needed treatment for a substance use problem but did not receive it at a specialty facility.

Figure 7.10 Past Year Perceived Need for and Effort Made to Receive Specialty Treatment among Persons Aged 12 or Older Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use: 2011



Note: The percentages do not add to 100 percent due to rounding.

- Based on 2008-2011 combined data, the six most often reported reasons for not receiving illicit drug or alcohol use treatment among persons aged 12 or older who needed and perceived a need for treatment but did not receive treatment at a specialty facility were (a) not ready to stop using (39.2 percent), (b) no health coverage and could not afford cost (32.3 percent), (c) possible negative effect on job (13.9 percent), (d) concern that receiving treatment might cause neighbors/community to have negative opinion (12.3 percent), (e) not knowing where to go for treatment (9.9 percent), and (f) could handle the problem without treatment (8.8 percent).

- Based on 2008-2011 combined data, among persons aged 12 or older who needed but did not receive illicit drug or alcohol use treatment, felt a need for treatment, and made an effort to receive treatment, the most often reported reasons for not receiving treatment were (a) no health coverage and could not afford cost (37.3 percent), (b) not ready to stop using (25.5 percent), (c) might have negative effect on job (10.1 percent), (d) had health coverage but did not cover treatment or did not cover cost (10.1 percent), (e) no transportation or inconvenient (9.5 percent), (f) did not know where to go for treatment (7.3 percent), (g) might cause neighbors/community to have negative opinion (7.2 percent), and (h) did not have time for treatment (7.1 percent) (Figure 7.11).

Illicit Drug Use Treatment and Treatment Need

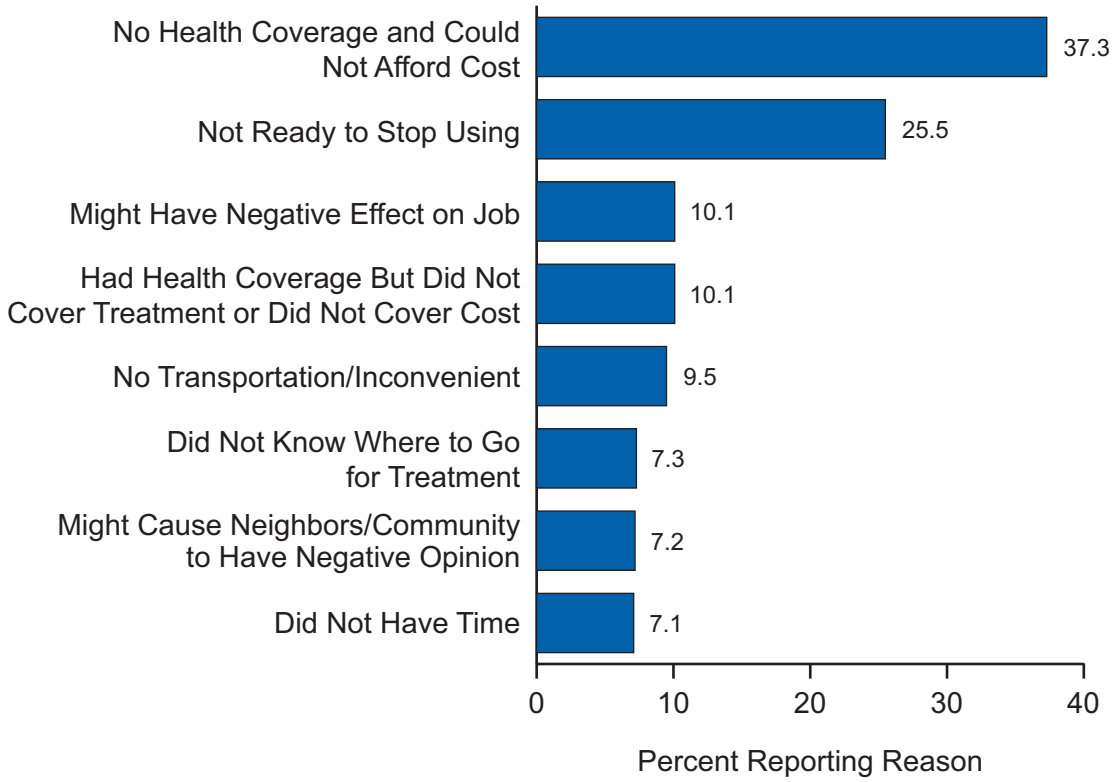
- In 2011, the number of persons aged 12 or older needing treatment for an illicit drug use problem was 7.2 million (2.8 percent of the total population). Both the rate and the number declined between 2010 (3.1 percent and 7.9 million) and 2011. Although the percentage of persons needing treatment for an illicit drug use problem declined between 2002 (3.3 percent) and 2011, the corresponding number of persons did not differ between 2002 (7.7 million) and 2011.

- Of the 7.2 million persons aged 12 or older who needed treatment for an illicit drug use problem in 2011, 1.4 million (0.5 percent of the total population and 18.8 percent of persons who needed treatment) received treatment at a specialty facility for an illicit drug use problem in the past year. The rate and the number were similar between 2010 and 2011 and between 2002 and 2011.

- There were 5.8 million persons (2.3 percent of the total population) who needed but did not receive treatment at a specialty facility for an illicit drug use problem in 2011, which declined between 2010 (6.4 million and 2.5 percent) and 2011. The rate declined between 2002 (2.7 percent) and 2011, but the numbers in 2002 (6.3 million) and 2011 were similar.

- Of the 5.8 million people aged 12 or older who needed but did not receive specialty treatment for illicit drug use in 2011, 488,000 (8.4 percent) reported that they perceived a need for treatment for their illicit drug use problem, and 5.3 million did not perceive a need for treatment. The number of persons who needed treatment for an illicit drug use problem but did not perceive the need declined between 2010 (6.0 million) and 2011 (5.3 million).

Figure 7.11 Reasons for Not Receiving Substance Use Treatment among Persons Aged 12 or Older Who Needed and Made an Effort to Get Treatment But Did Not Receive Treatment and Felt They Needed Treatment: 2008-2011 Combined



- Of the 488,000 persons who felt a need for treatment in 2011, 187,000 reported that they made an effort to get treatment, and 301,000 reported making no effort to get treatment. These estimates were similar to the estimates in 2010.
- Among youths aged 12 to 17, there were 1.2 million persons (4.7 percent) who needed treatment for an illicit drug use problem in 2011. Of this group, only 125,000 received treatment at a specialty facility (10.5 percent of youths aged 12 to 17 who needed treatment), leaving 1.1 million youths who needed treatment but did not receive it at a specialty facility.

- Among people aged 12 or older who needed but did not receive illicit drug use treatment and felt they needed treatment (based on 2008-2011 combined data), the most often reported reasons for not receiving treatment were (a) no health coverage and could not afford cost (43.6 percent), (b) not ready to stop using (29.0 percent), (c) concern that receiving treatment might cause neighbors/community to have negative opinion (14.6 percent), (d) possible negative effect on job (14.1 percent), (e) not knowing where to go for treatment (14.0 percent), and (f) having health coverage that did not cover treatment (10.6 percent).

Alcohol Use Treatment and Treatment Need

- In 2011, the number of persons aged 12 or older needing treatment for an alcohol use problem was 17.4 million (6.8 percent of the population aged 12 or older). Both the number and the rate declined between 2010 (18.6 million and 7.3 percent) and 2011 and between 2002 (18.6 million and 7.9 percent) and 2011.

- Among the 17.4 million persons aged 12 or older who needed treatment for an alcohol use problem in 2011, 1.5 million (0.6 percent of the total population and 8.5 percent of the people who needed treatment for an alcohol use problem) received alcohol use treatment at a specialty facility. These estimates of the need and receipt of treatment for an alcohol use problem did not change significantly between 2010 and 2011 or between 2002 and 2011. However, the number and the rate of persons aged 12 or older who needed but did not receive treatment at a specialty facility for an alcohol use problem declined between 2010 (17.0 million and 6.7 percent) and 2011 (16.0 million and 6.2 percent) and between 2002 (17.1 million and 7.3 percent) and 2011.

- Among the 16.0 million people aged 12 or older who needed but did not receive specialty treatment for an alcohol use problem in 2011, there were 505,000 persons (3.2 percent) who felt they needed treatment for their alcohol use problem. The number and the rate were similar to those reported in 2010 (706,000 persons and 4.1 percent), but were lower than those reported in 2002 (761,000 persons and 4.5 percent). Of the 505,000 persons in 2011 who perceived a need for treatment for an alcohol use problem but did not receive specialty treatment, 368,000 did not make an effort to get treatment, and 137,000 made an effort but were unable to get treatment in 2011.

- In 2011, there were 978,000 youths aged 12 to 17 (3.9 percent) who needed treatment for an alcohol use problem. Of this group, only 63,000 received treatment at a specialty facility (0.3 percent of all youths and 6.4 percent of youths who needed treatment), leaving about 915,000 youths (3.7 percent) who needed but did not receive treatment.

8. Discussion of Trends in Marijuana, Prescription Drug, Heroin, and Other Substance Use among Youths and Young Adults

Previous chapters in this report presented findings from the 2011 National Survey on Drug Use and Health (NSDUH) that describe trends and demographic differences for the incidence and prevalence of use for a variety of substances. This chapter expands upon previous chapters by discussing, in more depth, topics that have been of particular interest in recent years. That is, a comparison of NSDUH trend results with results from other surveys of youth and young adult substance use is presented. Recent trends in the misuse of prescription pain relievers and in the use of heroin, based on NSDUH and other data sources, are discussed.

Description of NSDUH and Other Data Sources

Conducted since 1971 and previously named the National Household Survey on Drug Abuse (NHSDA), the survey underwent several methodological improvements in 2002 that have affected prevalence estimates. As a result, the 2002 through 2011 estimates are not comparable with estimates from 2001 and earlier surveys. Therefore, the primary focus of this report is on comparisons of measures of substance use across subgroups of the U.S. population in 2011, changes between 2010 and 2011, and changes between 2002 and 2011. An important step in the analysis and interpretation of NSDUH or any other survey data is to compare the results with those from other data sources. This can be difficult because the other surveys typically have different purposes, definitions, and designs. Research has established that surveys of substance use and other sensitive topics often produce inconsistent results because of different methods used. Thus, it is important to understand that conflicting results often reflect differing methodologies, not incorrect results. Despite this limitation, comparisons can be very useful. Consistency across surveys can confirm or support conclusions about trends and patterns of use, and inconsistent results can point to areas for further study. Further discussion of this issue is included in Appendix C, along with descriptions of methods and results from other sources of substance use data.

Unfortunately, few additional data sources are available to compare with NSDUH results. One established source is Monitoring the Future (MTF), a study sponsored by the National Institute on Drug Abuse (NIDA). MTF surveys students in the 8th, 10th, and 12th grades in classrooms during the spring of each year, and it also collects data by mail from a subsample of adults who had participated earlier in the study as 12th graders (Johnston, O'Malley, Bachman, & Schulenberg, 2011, 2012). Historically, NSDUH rates of youth substance use have been lower than those of MTF. Occasionally, the two surveys have shown different trends in youth substance use over a short time period, although the two sources of youth behavior have shown very similar long-term trends in prevalence. NSDUH and MTF rates of substance use generally have been similar among young adults, and the two sources also have shown similar trends.

Another source of data on trends in the use of drugs among youths is the Youth Risk Behavior Survey (YRBS), sponsored by the Centers for Disease Control and Prevention (CDC). YRBS surveys students in the 9th through 12th grades in classrooms every other year during the spring (Eaton et al., 2012). The most recent survey was completed in 2011. Generally, the YRBS showed higher prevalence rates but similar trends when compared with NSDUH and MTF. However, comparisons between the YRBS and NSDUH or MTF were less straightforward because of the different periodicity (i.e., biennially instead of annually) and ages covered, the limited number of drug use questions, and smaller sample size in the YRBS.

For the pain reliever and heroin analyses, data from two other studies are discussed. The Treatment Episode Data Set (TEDS) is a SAMHSA study that compiles data on admissions to publicly funded substance abuse treatment centers in the United States. The Drug Abuse Warning Network (DAWN) is a SAMHSA public health surveillance system that, since 2004, has monitored a nationally representative sample of hospitals in the United States for patients' medical records of emergency department visits that are related to drug use, abuse, and misuse.

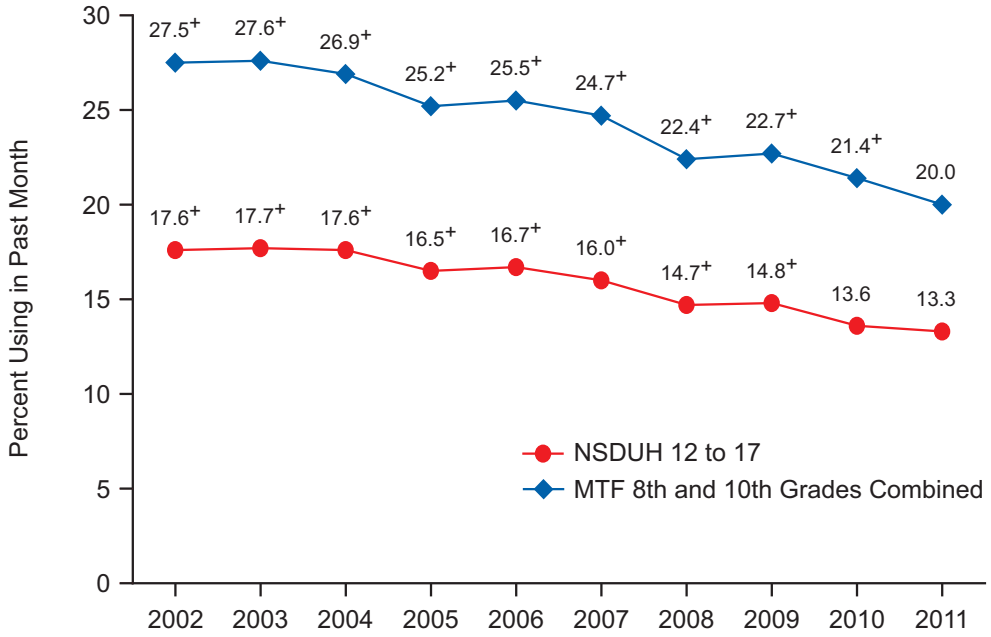
Comparison of NSDUH, MTF, and YRBS Trends

A comparison of NSDUH and MTF estimates for 2002 to 2011 is shown in Tables 8.1 through 8.6 at the end of this chapter for several substances that are defined similarly in the two surveys. For comparison purposes, MTF data on 8th and 10th graders are combined to give an age range close to 12 to 17 years, the standard youth age group for NSDUH. Appendix C provides comparisons according to MTF definitions. MTF follow-up data on persons aged 19 to 24 provide the closest match on age to estimates for NSDUH young adults aged 18 to 25. The NSDUH results are remarkably consistent with MTF trends for both youths and young adults, as discussed in the following paragraphs.

Both surveys showed decreases between 2002 and 2011 in the percentages of youths who used cocaine, inhalants, alcohol, and cigarettes in the past month (Table 8.3). For youth alcohol use, MTF showed a decrease between 2010 and 2011, while NSDUH indicated no significant change. Over the long term, however, the two surveys have shown remarkably consistent trends in alcohol use (Figure 8.1). There have been other instances where the two surveys show differing trends from 1 year to the next, but these discrepancies usually "correct" themselves with 1 or 2 more years of data, pointing to the need to use caution in the interpretation of 1-year shifts in prevalence levels.[2] For marijuana use, both surveys showed declines from 2002 to 2006 and increases from 2008 to 2011, with the 2011 estimates approaching the respective 2002 levels (Figure 8.3). NSDUH and MTF data showed generally consistent trends for past month use of Ecstasy, with decreases in use from 2002 to the middle of the decade, then increasing use from 2007 to 2010. However, MTF showed a decline in use in 2011, while NSDUH did not. Both surveys indicated little change in past month use of LSD.

[2] For example, 2010 MTF data indicated a leveling or possible increase in current cigarette use among youths, in contrast to the 2010 NSDUH data, which showed a continuing decline. The 2011 MTF estimate, however, was lower than the 2010 estimate, and over the long term, the two surveys showed consistent trends. From 2006 to 2011, NSDUH and MTF each showed a 2.6 percentage point decline in youth cigarette use (Figure 8.2).

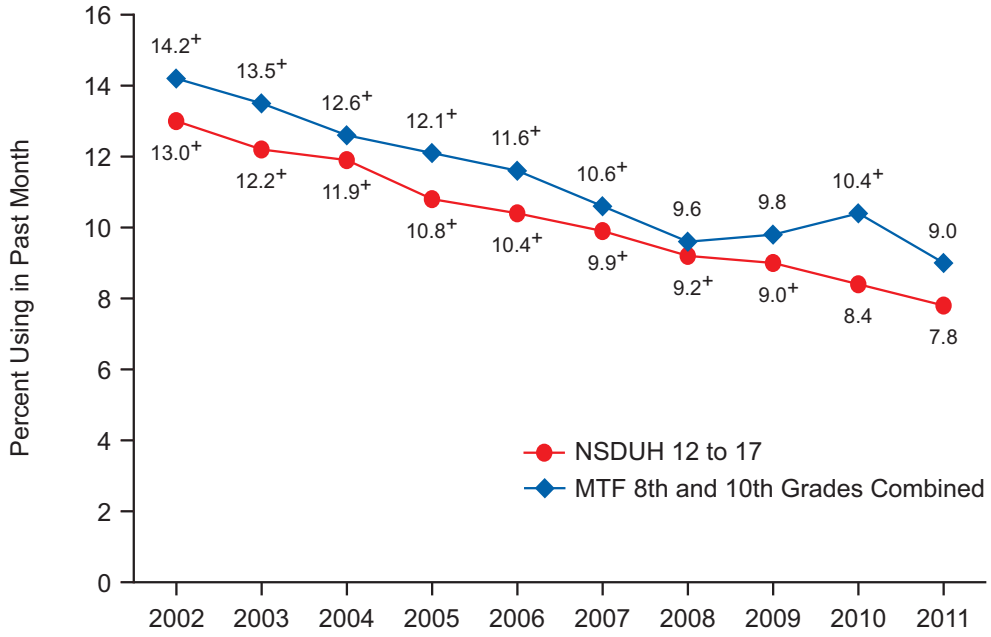
Figure 8.1 Past Month Alcohol Use among Youths in NSDUH and MTF: 2002-2011



MTF = Monitoring the Future; NSDUH = National Survey on Drug Use and Health.

+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

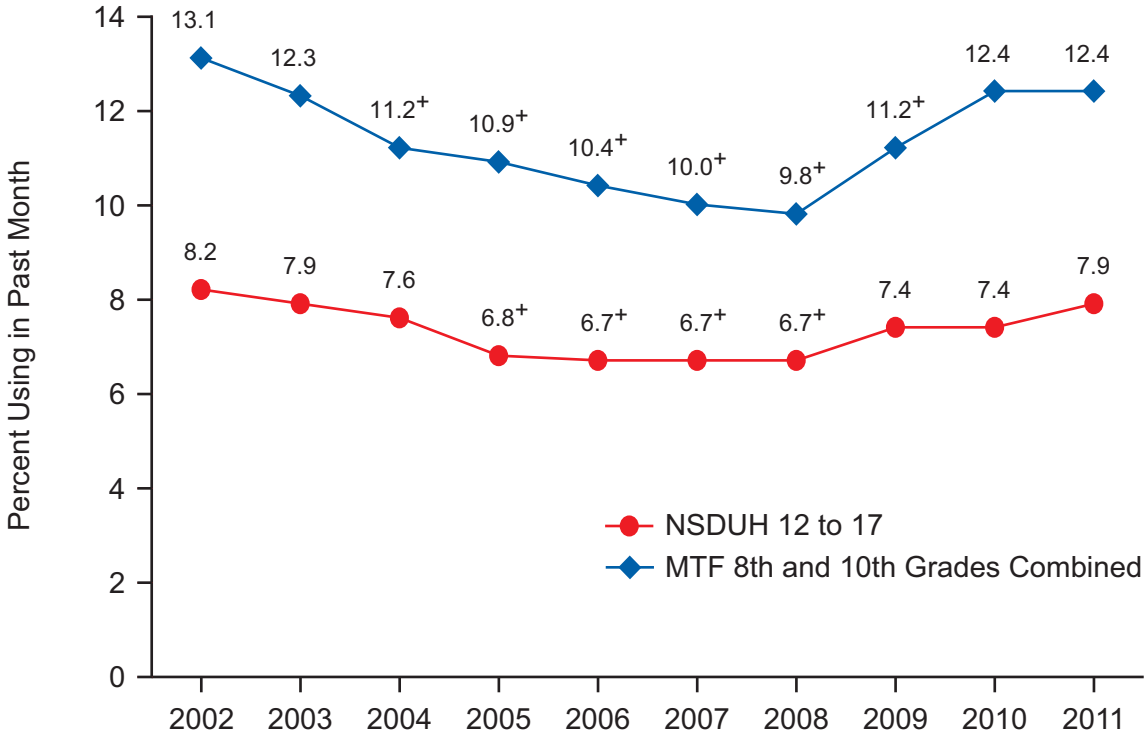
Figure 8.2 Past Month Cigarette Use among Youths in NSDUH and MTF: 2002-2011



MTF = Monitoring the Future; NSDUH = National Survey on Drug Use and Health.

+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

Figure 8.3 Past Month Marijuana Use among Youths in NSDUH and MTF: 2002-2011



MTF = Monitoring the Future; NSDUH = National Survey on Drug Use and Health.

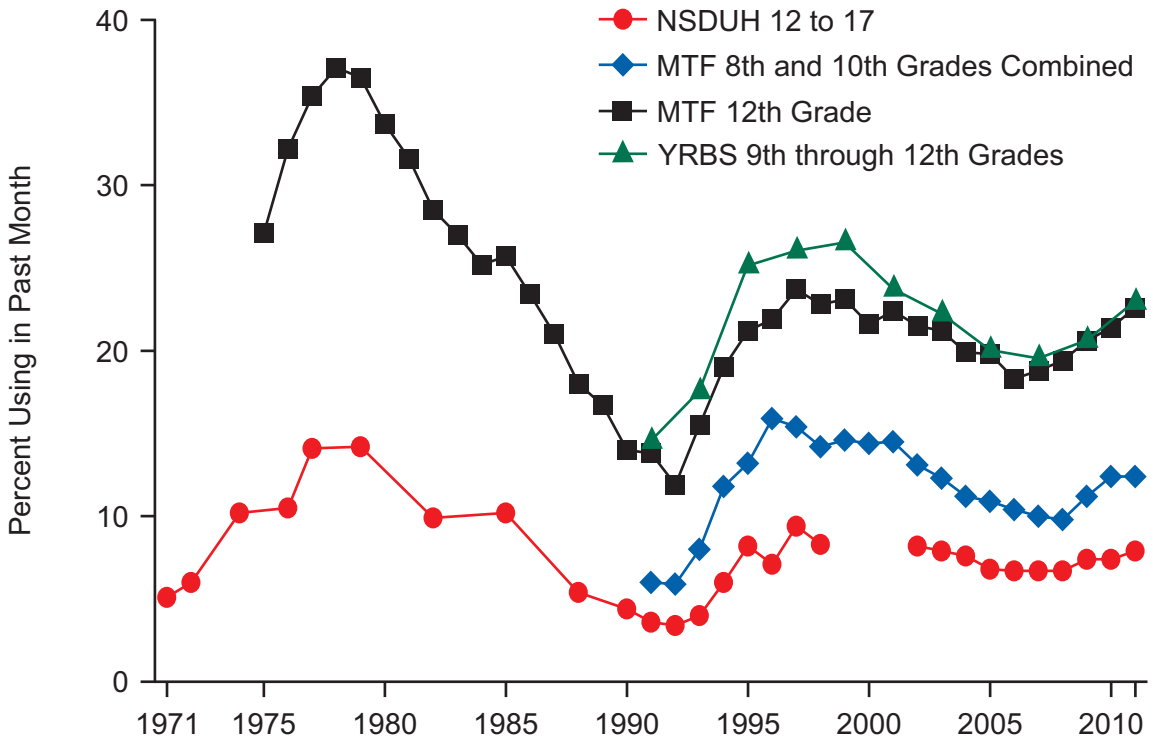
[+] Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

NSDUH and MTF also collect data on perceived risk of harm. The extent to which youths believe that substances might cause them harm is an important factor influencing whether or not they will use these substances. Declining levels of perceived risk among youths historically have been associated with subsequent increases in rates of use. Among youths aged 12 to 17, the percentage reporting in NSDUH that they thought there was a great risk of harm in smoking marijuana once or twice a week declined from 54.6 percent in 2007 to 44.8 percent in 2011. MTF data for combined 8th and 10th graders showed a similar decline in perceived great risk of harm of regular marijuana use over this time period, from 69.4 to 61.8 percent.

For the substances for which information on current use was collected in the YRBS, including alcohol, cigarettes, marijuana, and cocaine, the YRBS trend results between 2001 and 2011 were consistent with NSDUH and MTF (see http://www.cdc.gov/HealthyYouth/yrbs/; Grunbaum et al., 2002). YRBS data for the combined grades 9 through 12 showed decreases in past month alcohol use (47.1 percent in 2001 and 38.7 percent in 2011) and cigarette use (28.5 percent in 2001 and 18.1 percent in 2011). YRBS showed a decline in past month marijuana use between 2001 (23.9 percent) and 2007 (19.7 percent), and an increase between 2007 and 2011 (23.1 percent). This increase was consistent with the recent NSDUH and MTF increases since 2007.

Although changes in NSDUH survey methodology preclude direct comparisons of recent estimates with estimates from before 2002, it is important to put the recent trends in context by reviewing longer term trends in use. NSDUH data (prior to the design changes in 1999 and 2002) on youths aged 12 to 17 and MTF data on high school seniors showed substantial increases in youth illicit drug use during the 1970s, reaching a peak in the late 1970s. Both surveys then showed declines throughout the 1980s until about 1992, when rates reached a low point. These trends were driven by the trend in marijuana use. With the start of annual data collection in NSDUH in 1991, along with the biennial YRBS and the annual 8th and 10th grade samples in MTF, trends among youths are well documented since the low point that occurred in the early 1990s. Although they employ different survey designs and cover different age groups, the three surveys are consistent in showing increasing rates of marijuana use during the early to mid-1990s, reaching a peak in the late 1990s (but lower than in the late 1970s). This peak in the late 1990s was followed by declines in use after the turn of the 21st century and an increase in the most recent years (Figure 8.4).

Figure 8.4 Past Month Marijuana Use among Youths in NSDUH, MTF, and YRBS: 1971-2011



MTF = Monitoring the Future; NSDUH = National Survey on Drug Use and Health; YRBS = Youth Risk Behavior Survey.

Note: NSDUH data for youths aged 12 to 17 are not presented for 1999 to 2001 because of design changes in the survey. These design changes preclude direct comparisons of estimates from 2002 to 2011 with estimates prior to 1999.

Data on young adults also showed similar trends in NSDUH and MTF, although not as consistent as for the youth data (Tables 8.4 to 8.6). Potential reasons for differences from the data for youths are the relatively smaller MTF sample size for young adults and possible bias in the MTF sample due to noncoverage of school dropouts and a low overall response rate; the response rate is affected by nonresponse by schools, by students in the 12th grade survey, and by students in the follow-up mail survey.

Both surveys showed an increase in past month marijuana use among young adults from 2008 to 2011 (16.6 to 19.0 percent in NSDUH; 17.3 to 20.1 percent in MTF) (Table 8.6). Both surveys showed declines in cigarette use between 2002 and 2011, with NSDUH showing a decline from 40.8 to 33.5 percent and MTF showing a decline from 31.4 to 21.3 percent. There was no significant change between 2002 and 2011 in the rate of current alcohol use among young adults in either survey. Both surveys showed declines in past year and past month cocaine use from 2002 to 2011, with no changes in rates between 2010 and 2011 (Tables 8.5 and 8.6, respectively). Similarly, past year and past month Ecstasy use among young adults increased between 2007 and 2010 and remained steady in 2011, according to both NSDUH and MTF.

Nonmedical Use of Prescription Pain Relievers

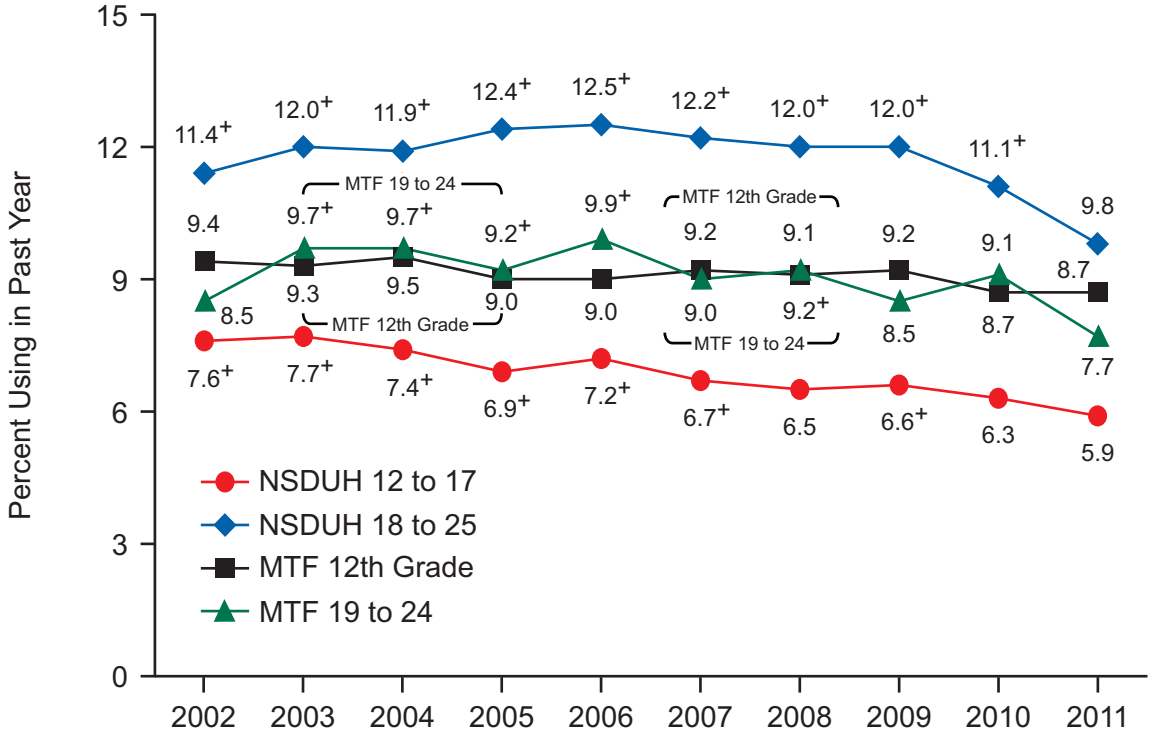
As noted in Chapter 2 of this report, NSDUH data indicated that nonmedical use of prescription drugs among youths aged 12 to 17 and young adults aged 18 to 25 in 2011 was the second most prevalent illicit drug use category, with marijuana being first. NSDUH data showed a decline in past month nonmedical prescription drug use among youths between 2002 (4.0 percent) and 2008 (2.9 percent), with no significant change between 2008 and 2011 (2.8 percent). Among young adults aged 18 to 25, past month prevalence of nonmedical prescription drug use was 5.0 percent in 2011. This prevalence in 2011 was lower than the rates in other years since 2003, which varied between 5.9 and 6.5 percent. The most prevalent category of misused prescription drugs is pain relievers. Nonmedical pain reliever use in the past month among youths declined from 3.2 percent in 2002 to 2.3 percent in 2011, while the rate among young adults was lower in 2011 (3.6 percent) than in 2010 (4.4 percent) as well as in years from 2002 to 2009 (between 4.1 and 5.0 percent).

NSDUH and MTF use different definitions and questioning strategies to track misuse of prescription drugs. For example, NSDUH defines misuse as use of prescription drugs that were not prescribed for the respondent or use of these drugs only for the experience or feeling they caused; MTF defines misuse as use not under a doctor's orders. MTF also does not estimate overall prescription drug misuse. However, MTF asks questions about "narcotics other than heroin," a category similar in coverage to the pain reliever category in NSDUH. These data are reported for 12th graders and for young adults. In addition, as is the case with NSDUH trends, methodological changes in MTF have sometimes resulted in discontinuities. For the data on use of narcotics other than heroin, there was a questionnaire change in the 2002 MTF that resulted in increased reporting of opiates, such that estimates prior to 2002 are not strictly comparable with estimates for 2002 and beyond.

Figure 8.5 shows NSDUH data for past year misuse of pain relievers from 2002 to 2011 for youths aged 12 to 17 and young adults aged 18 to 25 (comparable estimates for prior years are not available). MTF data for 12th graders and young adults (aged 19 to 24) are shown for

past year misuse of narcotics other than heroin since 2002. Except for 12th graders in MTF, both surveys showed declines from 2006 to 2011 in the prevalence of past year misuse of pain relievers/narcotics other than heroin. Among youths (NSDUH only), the rate of past year use declined from 7.2 to 5.9 percent. Among young adults, NSDUH showed a decline from 12.5 to 9.8 percent, while MTF showed a decline from 9.9 to 7.7 percent (Table 8.5). MTF estimates for 12th graders were similar between 2006 and 2011 (9.0 and 8.7 percent). However, the pattern of estimates for 12th graders in MTF between 2006 and 2011 was in the same direction as those for youths in NSDUH and young adults in both surveys.

Figure 8.5 Past Year Nonmedical Pain Reliever Use among Youths and Young Adults in NSDUH and MTF: 2002-2011



MTF = Monitoring the Future; NSDUH = National Survey on Drug Use and Health.

Note: Data for MTF are for "narcotics other than heroin."

+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

Although the focus of attention is primarily on drug use among young people, NSDUH data demonstrate that the majority (57 percent) of past year nonmedical pain reliever users were aged 26 or older in 2011. Among this age group, the percentage that had used pain relievers nonmedically in the past 12 months rose from 3.1 percent in 2002 to 3.6 percent in 2006 and 2007, then declined to 3.2 percent in 2011.

These data generally indicate a decline in nonmedical pain reliever use from 2002 to 2011. However, other trends indicate a growing problem. According to NSDUH, initiation rates for nonmedical pain reliever use, although declining, were second to initiation rates for

marijuana in 2010 and 2011 and were similar to or greater than marijuana initiation rates in 2002 to 2009. There have been 1.9 million or more new nonmedical pain reliever users each year since 2002. The sustained numbers of new and continuing users have contributed to increases in indicators of problems associated with use, especially among adults. The number of persons with nonmedical pain reliever dependence increased from 936,000 in 2002 to 1.4 million in 2011. An estimated 56.1 percent of these pain reliever-dependent persons in 2011 were aged 26 or older, but about one third (472,000) were aged 18 to 25. The number of persons receiving specialty substance abuse treatment within the past year for misuse of pain relievers increased during this period, from 199,000 to 438,000. In 2011, 63.7 percent of those receiving specialty substance abuse treatment for pain relievers were aged 26 or older, and 29.6 percent were aged 18 to 25. TEDS and DAWN data confirm these trends. Special analyses of TEDS admissions data indicate that admissions to publicly funded substance abuse treatment programs for a nonheroin opiate problem increased from 91,000 in 2002 to 259,000 in 2010; in 2010, 69 percent of such admissions were aged 25 or older, and 28 percent were aged 18 to 24. According to DAWN data, the number of emergency department visits involving nonmedical use of narcotic pain relievers increased from 145,000 in 2004 to 360,000 in 2010 (Center for Behavioral Health Statistics and Quality, 2012).

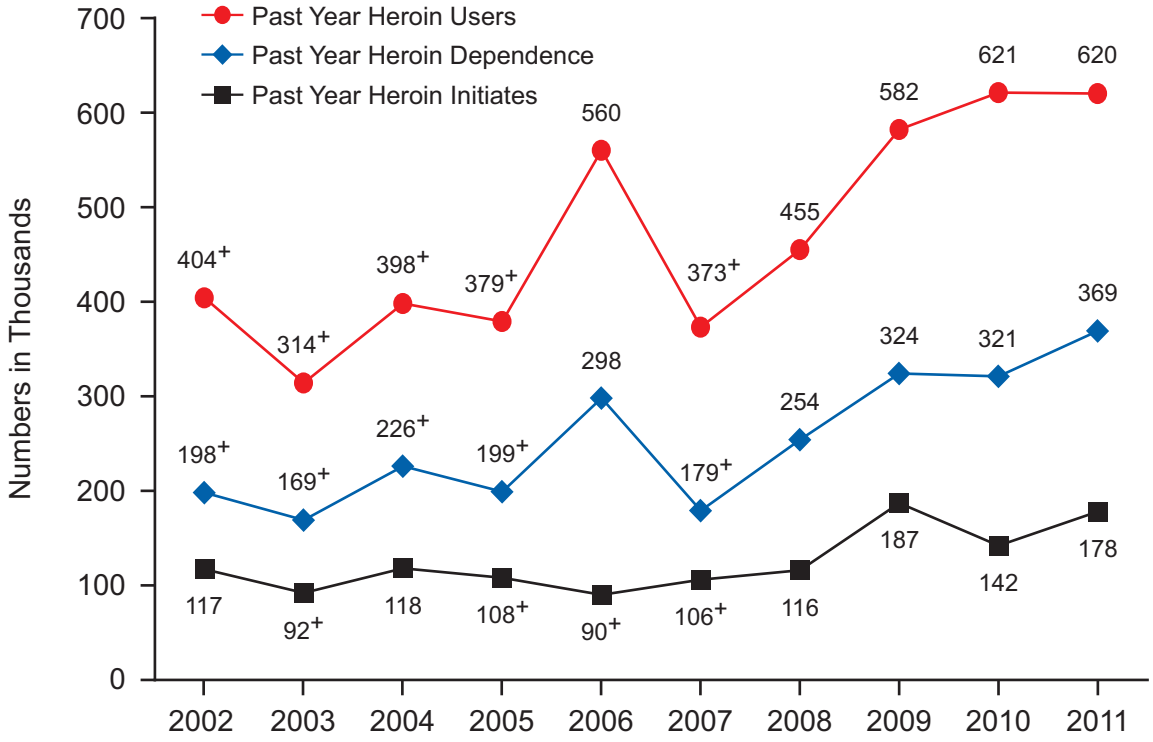
Heroin Use

Chapters 2 and 5 of this report note that the 2011 NSDUH data showed higher numbers of heroin users and initiates than in some prior years. These findings seem to support anecdotal reports that have suggested increasing use of heroin among young people. For example, news media reports have linked the increase in heroin use to nonmedical use of prescription pain relievers among young people, suggesting that some prescription pain reliever abusers have shifted to heroin. It is not possible in this summary report of the 2011 NSDUH findings to fully explore the potential association between pain reliever misuse and heroin use. In addition, a limitation of NSDUH and other household surveys is the difficulty in estimating heroin use prevalence because of the low prevalence of use in the general population, the likelihood of underreporting of use, and undercoverage of heroin users in a household sample. Nevertheless, despite the underestimation that is believed to be present, NSDUH's consistent methodology over time permits assessment of trends, providing an important baseline and descriptive background for studying the recent heroin problem. To provide stable estimates for assessing trends, a comparison of combined 2002-2005 estimates with 2009-2011 estimates is made.

Figure 8.6 shows the estimated annual numbers of past year heroin users, persons with past year heroin dependence, and first-time users (past year initiates) from 2002 to 2011. Numbers of past year heroin users and persons with heroin dependence increased from 2002 to 2011, and the number of past year initiates increased from 2003 to 2011. Estimates of the number of users for 2009, 2010, and 2011 yielded an annual average of 607,000 per year, compared with an annual average of 374,000 during 2002-2005. Similarly, the estimated number of new users increased from 109,000 per year during 2002-2005 to 169,000 per year during 2009-2011. The increase in initiation is evident among young adults aged 18 to 25 and adults aged 26 and older. There were 28,000 youth initiates per year in 2002-2005 and 27,000 in 2009-2011. Young adult initiates increased from 53,000 per year to 89,000 per year, and older adult initiates increased from 28,000 to 54,000 for these combined time periods. Past year use estimates for 2002-2005 and 2009-2011 showed the same pattern: for youths, estimates were

43,000 and 39,000; for young adults, the estimates were 124,000 and 208,000; and for older adults, the estimates were 207,000 and 361,000. MTF data indicated an increase for young adults aged 19 to 28 and a decrease for 10th graders in rates of past year heroin use between 2002 and 2011. MTF data did not indicate any changes among 8th and 12th graders between these 2 years.

Figure 8.6 Past Year Heroin Use, Heroin Dependence, and Heroin Initiates among Persons Aged 12 or Older: 2002-2011



+ Difference between this estimate and the 2011 estimate is statistically significant at the .05 level.

NSDUH has consistently found that about half or more of past year heroin users are dependent on heroin. Thus, it is not surprising that the number of persons with heroin dependence has risen along with the number of users. The average annual number of persons with heroin dependence increased from 198,000 per year during 2002-2005 to 338,000 during 2009-2011. The majority of these heroin-dependent persons were aged 26 or older. However, the annual average number of heroin-dependent young adults rose from 53,000 in 2002-2005 to 109,000 in 2009-2011. The annual average number of older adults who were dependent on heroin increased from 137,000 to 216,000 between these two periods. Youth heroin dependence estimates were 8,000 and 13,000, respectively.

Finally, the NSDUH estimated annual average number of persons receiving treatment in the past year for a heroin problem at a specialty substance abuse facility increased from 181,000 during 2002-2005 to 289,000 during 2009-2011. However, this increase in treatment for heroin is not evident in TEDS data from publicly funded treatment programs. Special analyses of TEDS admissions data indicated that there were 340,000 admissions for a heroin problem in 2002 and

314,000 in 2010. This decline could be associated with an increase in private-for-profit opioid treatment facilities during the past few years. Most of these private facilities are not included in TEDS data. There was also no increase in heroin-related emergency department visits according to DAWN results. DAWN estimated that there were 214,000 visits in 2004 and 225,000 in 2010 (CBHSQ, 2012). These apparently inconsistent findings based on data from service providers need further study.

Table 8.1 Comparison of NSDUH and MTF Lifetime Prevalence Estimates among Youths: Percentages, 2002-2011

Substance/ Survey	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Marijuana										
NSDUH	20.6[a]	19.6[a]	19.0[a]	17.4	17.3	16.2[a]	16.6	17.1	17.1	17.5
MTF	29.0[a]	27.0	25.7	25.3	23.8	22.6[a]	22.3[a]	24.0	25.4	25.5
Cocaine										
NSDUH	2.7[a]	2.6[a]	2.4[a]	2.3[a]	2.2[a]	2.2[a]	1.9[a]	1.6	1.5	1.3
MTF	4.9[a]	4.4[a]	4.4[a]	4.5[a]	4.1[a]	4.2[a]	3.8[a]	3.6[a]	3.2[a]	2.8
Ecstasy										
NSDUH	3.3[a]	2.4	2.1	1.6[a]	1.9[a]	1.8[a]	2.1	2.3	2.5	2.4
MTF	5.5[a]	4.3	3.6[a]	3.4[a]	3.5[a]	3.8[a]	3.4[a]	3.9	4.9	4.6
LSD										
NSDUH	2.7[a]	1.6[a]	1.2[a]	1.1	0.9	0.8	1.1	1.0	0.9	0.9
MTF	3.8[a]	2.8	2.3	2.2	2.2	2.3	2.3	2.4	2.4	2.3
Inhalants										
NSDUH	10.5[a]	10.7[a]	11.0[a]	10.5[a]	10.1[a]	9.6[a]	9.3[a]	9.3[a]	8.3[a]	7.5
MTF	14.4[a]	14.3[a]	14.9[a]	15.1[a]	14.7[a]	14.6[a]	14.3[a]	13.6[a]	13.3[a]	11.6
Alcohol										
NSDUH	43.4[a]	42.9[a]	42.0[a]	40.6[a]	40.4[a]	39.5[a]	38.6[a]	38.4[a]	35.4	34.5
MTF	57.0[a]	55.8[a]	54.1[a]	52.1[a]	51.0[a]	50.3[a]	48.6[a]	47.9[a]	47.0[a]	44.6
Cigarettes										
NSDUH	33.3[a]	31.0[a]	29.2[a]	26.7[a]	25.9[a]	23.7[a]	23.1[a]	22.3[a]	20.5[a]	19.1
MTF	39.4[a]	35.7[a]	34.3[a]	32.4[a]	30.4[a]	28.4[a]	26.1[a]	26.4[a]	26.5[a]	24.4

MTF = Monitoring the Future; NSDUH = National Survey on Drug Use and Health.

NOTE: NSDUH data are for youths aged 12 to 17. Some 2006 to 2010 NSDUH estimates may differ from previously published estimates due to updates (see Section B.3 in Appendix B of this report).

NOTE: MTF data are simple averages of estimates for 8th and 10th graders. MTF data for 8th and 10th graders are reported in Johnston, O'Malley, Bachman, and Schulenberg (2012), as are the MTF design effects used for variance estimation.

[a] Difference between this estimate and 2011 estimate is statistically significant at the .05 level.

Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2011. National Institute on Drug Abuse, Monitoring the Future Study, University of Michigan, 2002-2011.

Table 8.2 Comparison of NSDUH and MTF Past Year Prevalence Estimates among Youths: Percentages, 2002-2011

Substance/ Survey	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Marijuana										
NSDUH	15.8[a]	15.0	14.5	13.3[a]	13.2[a]	12.5[a]	13.1[a]	13.7	14.0	14.2
MTF	22.5[a]	20.5	19.7	19.4	18.5[a]	17.5[a]	17.4[a]	19.3	20.6	20.7
Cocaine										
NSDUH	2.1[a]	1.8[a]	1.6[a]	1.7[a]	1.6[a]	1.5[a]	1.2[a]	1.0	1.0	0.9
MTF	3.2[a]	2.8[a]	2.9[a]	2.9[a]	2.6[a]	2.7[a]	2.4[a]	2.2[a]	1.9	1.7
Ecstasy										
NSDUH	2.2[a]	1.3[a]	1.2[a]	1.0[a]	1.2[a]	1.3[a]	1.4	1.7	1.9	1.7
MTF	3.9[a]	2.6	2.1[a]	2.2[a]	2.1[a]	2.5[a]	2.3[a]	2.5[a]	3.6	3.1
LSD										
NSDUH	1.3[a]	0.6	0.6	0.6	0.4[a]	0.5	0.7	0.6	0.6	0.6
MTF	2.1[a]	1.5	1.4	1.4	1.3	1.5	1.6	1.5	1.6	1.5
Inhalants										
NSDUH	4.4[a]	4.5[a]	4.6[a]	4.5[a]	4.4[a]	3.9[a]	4.0[a]	3.9[a]	3.6	3.3
MTF	6.8[a]	7.1[a]	7.8[a]	7.8[a]	7.8[a]	7.5[a]	7.4[a]	7.1[a]	6.9[a]	5.8
Alcohol										
NSDUH	34.6[a]	34.3[a]	33.9[a]	33.3[a]	33.0[a]	31.9[a]	31.0[a]	30.5[a]	28.7	27.8
MTF	49.4[a]	48.3[a]	47.5[a]	45.3[a]	44.7[a]	44.1[a]	42.3[a]	41.6[a]	40.7[a]	38.4
Cigarettes										
NSDUH	20.3[a]	19.0[a]	18.4[a]	17.3[a]	17.0[a]	15.7[a]	15.1[a]	15.1[a]	14.2[a]	13.2
MTF	--	--	--	--	--	--	--	--	--	--

MTF = Monitoring the Future; NSDUH = National Survey on Drug Use and Health.

-- Not available.

NOTE: NSDUH data are for youths aged 12 to 17. Some 2006 to 2010 NSDUH estimates may differ from previously published estimates due to updates (see Section B.3 in Appendix B of this report).

NOTE: MTF data are simple averages of estimates for 8th and 10th graders. MTF data for 8th and 10th graders are reported in Johnston, O'Malley, Bachman, and Schulenberg (2012), as are the MTF design effects used for variance estimation.

[a] Difference between this estimate and 2011 estimate is statistically significant at the .05 level.

Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2011. National Institute on Drug Abuse, Monitoring the Future Study, University of Michigan, 2002-2011.

Table 8.3 Comparison of NSDUH and MTF Past Month Prevalence Estimates among Youths: Percentages, 2002-2011

Substance/ Survey	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Marijuana										
NSDUH	8.2	7.9	7.6	6.8[a]	6.7[a]	6.7[a]	6.7[a]	7.4	7.4	7.9
MTF	13.1	12.3	11.2[a]	10.9[a]	10.4[a]	10.0[a]	9.8[a]	11.2[a]	12.4	12.4
Cocaine										
NSDUH	0.6[a]	0.6[a]	0.5[a]	0.6[a]	0.4[a]	0.4[a]	0.4	0.3	0.2	0.3
MTF	1.4[a]	1.1[a]	1.3[a]	1.3[a]	1.3[a]	1.1[a]	1.0	0.9	0.8	0.8
Ecstasy										
NSDUH	0.5	0.4	0.3	0.3	0.3	0.3[a]	0.4	0.5	0.5	0.4
MTF	1.6[a]	0.9	0.8[a]	0.8[a]	1.0	0.9	1.0	1.0	1.5[a]	1.1
LSD										
NSDUH	0.2	0.2	0.2	0.1	0.1	0.1	0.2	0.1	0.2	0.1
MTF	0.7	0.6	0.6	0.6	0.6	0.6	0.6	0.5	0.7	0.6
Inhalants										
NSDUH	1.2[a]	1.3[a]	1.2[a]	1.2[a]	1.3[a]	1.2[a]	1.1	1.0	1.1	0.9
MTF	3.1[a]	3.2[a]	3.5[a]	3.2[a]	3.2[a]	3.2[a]	3.1[a]	3.0[a]	2.8	2.5
Alcohol										
NSDUH	17.6[a]	17.7[a]	17.6[a]	16.5[a]	16.7[a]	16.0[a]	14.7[a]	14.8[a]	13.6	13.3
MTF	27.5[a]	27.6[a]	26.9[a]	25.2[a]	25.5[a]	24.7[a]	22.4[a]	22.7[a]	21.4[a]	20.0
Cigarettes										
NSDUH	13.0[a]	12.2[a]	11.9[a]	10.8[a]	10.4[a]	9.9[a]	9.2[a]	9.0[a]	8.4	7.8
MTF	14.2[a]	13.5[a]	12.6[a]	12.1[a]	11.6[a]	10.6[a]	9.6	9.8	10.4[a]	9.0

MTF = Monitoring the Future; NSDUH = National Survey on Drug Use and Health.

NOTE: NSDUH data are for youths aged 12 to 17. Some 2006 to 2010 NSDUH estimates may differ from previously published estimates due to updates (see Section B.3 in Appendix B of this report).

NOTE: MTF data are simple averages of estimates for 8th and 10th graders. MTF data for 8th and 10th graders are reported in Johnston, O'Malley, Bachman, and Schulenberg (2012), as are the MTF design effects used for variance estimation.

[a] Difference between this estimate and 2011 estimate is statistically significant at the .05 level.

Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2011. National Institute on Drug Abuse, Monitoring the Future Study, University of Michigan, 2002-2011.

Table 8.4 Comparison of NSDUH and MTF Lifetime Prevalence Estimates among Young Adults: Percentages, 2002-2011

Substance/ Survey	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Marijuana										
NSDUH	53.8[a]	53.9[a]	52.8	52.4	52.5	50.9	50.8	52.6	51.4	51.9
MTF	56.1[a]	56.4[a]	55.6[a]	54.4	53.8	53.9	53.0	53.8	53.2	53.1
Cocaine										
NSDUH	15.4[a]	15.0[a]	15.2[a]	15.1[a]	15.7[a]	15.0[a]	14.5[a]	14.9[a]	13.4[a]	12.4
MTF	12.9[a]	14.5[a]	14.3[a]	12.6[a]	13.6[a]	12.4[a]	12.2[a]	12.2[a]	10.9	10.3
Ecstasy										
NSDUH	15.1[a]	14.8[a]	13.8[a]	13.7[a]	13.4[a]	12.8	12.2	12.5	12.4	12.3
MTF	16.0[a]	16.6[a]	14.9[a]	12.4[a]	11.5	9.5	10.1	9.3	10.2	9.9
LSD										
NSDUH	15.9[a]	14.0[a]	12.1[a]	10.5[a]	9.0[a]	7.3[a]	6.6	6.9[a]	6.4	6.0
MTF	13.9[a]	13.8[a]	10.4[a]	7.9[a]	6.7[a]	5.9	5.6	5.3	5.7	5.4
Inhalants										
NSDUH	15.7[a]	14.9[a]	14.0[a]	13.3[a]	12.5[a]	11.3[a]	10.5[a]	10.8[a]	10.0[a]	9.1
MTF	11.7[a]	11.4[a]	10.6[a]	9.3[a]	9.7[a]	7.5	8.4[a]	7.7	6.8	6.0
Alcohol										
NSDUH	86.7[a]	87.1[a]	86.2[a]	85.7[a]	86.5[a]	85.2	85.6[a]	85.8[a]	85.7[a]	84.3
MTF	88.4[a]	87.6[a]	87.2[a]	87.1[a]	87.0[a]	86.0	86.4[a]	85.7	84.9	84.4
Cigarettes										
NSDUH	71.2[a]	70.2[a]	68.7[a]	67.3[a]	66.6[a]	64.8[a]	64.4[a]	63.8[a]	62.3	61.0
MTF	--	--	--	--	--	--	--	--	--	--
Pain Relievers[1]										
NSDUH	22.1	23.7[a]	24.3[a]	25.5[a]	25.5[a]	24.9[a]	24.6[a]	24.5[a]	23.9[a]	22.2
MTF	--	17.3	17.7	16.9	17.9[a]	17.8	17.8	17.2	16.6	16.0

MTF = Monitoring the Future; NSDUH = National Survey on Drug Use and Health.

-- Not available.

NOTE: NSDUH data are for persons aged 18 to 25. Some 2006 to 2010 NSDUH estimates may differ from previously published estimates due to updates (see Section B.3 in Appendix B of this report).

NOTE: MTF data were calculated for persons aged 19 to 24 using simple averages of modal age groups 19-20, 21-22, and 23-24 (source data at http://www.monitoringthefuture.org/pubs.html). Estimates may differ from those published previously due to rounding. For the 19 to 24 age group in the MTF data, significance tests were performed assuming independent samples between years an odd number of years apart because two distinct cohorts a year apart were monitored longitudinally at 2-year intervals. Although appropriate for comparisons of 2002, 2004, 2006, 2008, and 2010 estimates with 2011 estimates, this assumption results in conservative tests for comparisons of 2003, 2005, 2007, and 2009 data with 2011 estimates because it does not take into account covariances that are associated with repeated observations from the longitudinal samples. Estimates of covariances were not available.

[a] Difference between this estimate and 2011 estimate is statistically significant at the .05 level.

[1] MTF data are for "narcotics other than heroin."

Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2011. National Institute on Drug Abuse, Monitoring the Future Study, University of Michigan, 2002-2011.

Table 8.5 Comparison of NSDUH and MTF Past Year Prevalence Estimates among Young Adults: Percentages, 2002-2011

Substance/ Survey	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Marijuana										
NSDUH	29.8	28.5[a]	27.8[a]	28.0[a]	28.1[a]	27.5[a]	27.8[a]	30.8	30.0	30.8
MTF	34.2	33.0	31.6	31.4	30.9[a]	31.0[a]	30.9[a]	32.2	31.7	33.7
Cocaine										
NSDUH	6.7[a]	6.6[a]	6.6[a]	6.9[a]	6.9[a]	6.4[a]	5.6[a]	5.3[a]	4.7	4.6
MTF	6.5[a]	7.3[a]	7.8[a]	6.9[a]	7.0[a]	6.3[a]	6.0[a]	5.7	4.7	4.8
Ecstasy										
NSDUH	5.8[a]	3.7	3.1[a]	3.1[a]	3.8	3.5[a]	3.9	4.3	4.4	4.1
MTF	8.0[a]	5.3	3.3	3.4	3.6	2.8[a]	3.8	3.5	4.7	4.4
LSD										
NSDUH	1.8	1.1[a]	1.0[a]	1.0[a]	1.2[a]	1.1[a]	1.5	1.6	1.6	1.7
MTF	2.4	1.5[a]	1.2[a]	1.1[a]	1.5	1.4[a]	1.9	2.1	1.8	2.2
Inhalants										
NSDUH	2.2[a]	2.1[a]	2.1[a]	2.1[a]	1.8	1.6	1.6	1.9[a]	1.8	1.5
MTF	2.2[a]	1.5	2.3[a]	1.6	1.8[a]	1.1	1.7	1.2	1.7	0.9
Alcohol										
NSDUH	77.9	78.1	78.0	77.9	78.8[a]	77.9	78.0	78.7[a]	78.6[a]	77.0
MTF	83.9[a]	82.3	83.1[a]	82.8[a]	83.2[a]	82.8[a]	82.5	82.0	80.5	80.6
Cigarettes										
NSDUH	49.0[a]	47.6[a]	47.5[a]	47.2[a]	47.0[a]	45.2[a]	45.1[a]	45.3[a]	43.2	42.3
MTF	41.8[a]	40.8[a]	41.4[a]	40.2[a]	37.1[a]	36.2[a]	35.4[a]	35.0[a]	33.0	32.6
Pain Relievers[1]										
NSDUH	11.4[a]	12.0[a]	11.9[a]	12.4[a]	12.5[a]	12.2[a]	12.0[a]	12.0[a]	11.1[a]	9.8
MTF	8.5	9.7[a]	9.7[a]	9.2[a]	9.9[a]	9.0	9.2[a]	8.5	9.1	7.7

MTF = Monitoring the Future; NSDUH = National Survey on Drug Use and Health.

NOTE: NSDUH data are for persons aged 18 to 25. Some 2006 to 2010 NSDUH estimates may differ from previously published estimates due to updates (see Section B.3 in Appendix B of this report).

NOTE: MTF data were calculated for persons aged 19 to 24 using simple averages of modal age groups 19-20, 21-22, and 23-24 (source data at http://www.monitoringthefuture.org/pubs.html). Estimates may differ from those published previously due to rounding. For the 19 to 24 age group in the MTF data, significance tests were performed assuming independent samples between years an odd number of years apart because two distinct cohorts a year apart were monitored longitudinally at 2-year intervals. Although appropriate for comparisons of 2002, 2004, 2006, 2008, and 2010 estimates with 2011 estimates, this assumption results in conservative tests for comparisons of 2003, 2005, 2007, and 2009 data with 2011 estimates because it does not take into account covariances that are associated with repeated observations from the longitudinal samples. Estimates of covariances were not available.

[a] Difference between this estimate and 2011 estimate is statistically significant at the .05 level.

[1] MTF data are for "narcotics other than heroin." In 2002, MTF question text was changed in half of the sample by updating the example list of narcotics other than heroin. To be consistent with MTF data for 2003 and later years, MTF data for 2002 past year use of narcotics other than heroin are based on the half sample that received the new question text.

Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2011. National Institute on Drug Abuse, Monitoring the Future Study, University of Michigan, 2002-2011.

Table 8.6 Comparison of NSDUH and MTF Past Month Prevalence Estimates among Young Adults: Percentages, 2002-2011

Substance/ Survey	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Marijuana										
NSDUH	17.3[a]	17.0[a]	16.1[a]	16.6[a]	16.3[a]	16.5[a]	16.6[a]	18.2	18.5	19.0
MTF	19.8	19.9	18.2[a]	17.0[a]	17.0[a]	17.5[a]	17.3[a]	18.5	17.8[a]	20.1
Cocaine										
NSDUH	2.0[a]	2.2[a]	2.1[a]	2.6[a]	2.2[a]	1.7[a]	1.6	1.4	1.5	1.4
MTF	2.5[a]	2.6[a]	2.4[a]	2.1	2.4[a]	1.9	1.9	1.8	1.5	1.5
Ecstasy										
NSDUH	1.1	0.7	0.7	0.8	1.0	0.7	0.9	1.1	1.2	0.9
MTF	1.6	1.0	0.8	0.6	0.9	0.3	0.9	0.7	1.2	0.9
LSD										
NSDUH	0.1[a]	0.2	0.3	0.2	0.2	0.2	0.3	0.3	0.3	0.3
MTF	0.4	0.2[a]	0.2[a]	0.2[a]	0.3	0.3	0.5	0.3	0.5	0.5
Inhalants										
NSDUH	0.5	0.4	0.4	0.5	0.4	0.4	0.3	0.4	0.4	0.4
MTF	0.8[a]	0.3	0.4	0.3	0.4	0.3	0.6	0.2	0.2	0.2
Alcohol										
NSDUH	60.5	61.4	60.5	60.9	62.0	61.3	61.1	61.8	61.4	60.7
MTF	67.7	66.3	67.3	66.8	67.0	67.4	67.4	68.1	65.8	65.8
Cigarettes										
NSDUH	40.8[a]	40.2[a]	39.5[a]	39.0[a]	38.5[a]	36.2[a]	35.7[a]	35.8[a]	34.3	33.5
MTF	31.4[a]	29.5[a]	30.2[a]	28.7[a]	26.7[a]	25.7[a]	24.3[a]	23.5[a]	21.8	21.3
Pain Relievers[1]										
NSDUH	4.1[a]	4.7[a]	4.7[a]	4.7[a]	5.0[a]	4.6[a]	4.5[a]	4.8[a]	4.4[a]	3.6
MTF	--	3.4	3.4	3.7	3.6	3.5	3.7	3.2	3.5	2.9

MTF = Monitoring the Future; NSDUH = National Survey on Drug Use and Health.

-- Not available.

NOTE: NSDUH data are for persons aged 18 to 25. Some 2006 to 2010 NSDUH estimates may differ from previously published estimates due to updates (see Section B.3 in Appendix B of this report).

NOTE: MTF data were calculated for persons aged 19 to 24 using simple averages of modal age groups 19-20, 21-22, and 23-24 (source data at http://www.monitoringthefuture.org/pubs.html). Estimates may differ from those published previously due to rounding. For the 19 to 24 age group in the MTF data, significance tests were performed assuming independent samples between years an odd number of years apart because two distinct cohorts a year apart were monitored longitudinally at 2-year intervals. Although appropriate for comparisons of 2002, 2004, 2006, 2008, and 2010 estimates with 2011 estimates, this assumption results in conservative tests for comparisons of 2003, 2005, 2007, and 2009 data with 2011 estimates because it does not take into account covariances that are associated with repeated observations from the longitudinal samples. Estimates of covariances were not available.

[a] Difference between this estimate and 2011 estimate is statistically significant at the .05 level.

[1] MTF data are for "narcotics other than heroin."

Sources: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2011. National Institute on Drug Abuse, Monitoring the Future Study, University of Michigan, 2002-2011.

Appendix A: Description of the Survey

A.1 Sample Design

The sample design for the 2011 National Survey on Drug Use and Health (NSDUH)[3] was an extension of a coordinated 5-year design providing estimates for all 50 States plus the District of Columbia initially for the years 2005 through 2009, then continuing through 2011. The respondent universe for NSDUH is the civilian, noninstitutionalized population aged 12 years old or older residing within the United States. The survey covers residents of households (persons living in houses/townhouses, apartments, condominiums; civilians living in housing on military bases, etc.) and persons in noninstitutional group quarters (e.g., shelters, rooming/boarding houses, college dormitories, migratory workers' camps, halfway houses). Excluded from the survey are persons with no fixed household address (e.g., homeless and/or transient persons not in shelters), active-duty military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental institutions, and long-term hospitals.

The coordinated design for 2005 through 2009 facilitated a 50 percent overlap in second-stage units (area segments) within each successive 2-year period from 2005 through 2009. The 2010 and 2011 NSDUHs continued the 50 percent overlap by retaining half of the second-stage units from the previous survey. Those segments not retained are considered "retired" from use. Because the coordinated design enabled estimates to be developed by State in all 50 States plus the District of Columbia, States may be viewed as the first level of stratification and as a reporting variable.

In 2011, an oversample was included to help in measuring and reporting on the impact that the April 2010 Deepwater Horizon oil spill had on substance use and mental health along the gulf coast. To that end, the target sample was expanded by 2,000 cases in four Gulf Coast States (Alabama, Florida, Louisiana, and Mississippi), resulting in a total targeted national sample size of 69,500. The 2011 Gulf Coast Oversample (GCO) was attained by supplementing the NSDUH sample with 89 segments in GCO-designated counties and parishes in these four States. These 89 segments were retired from use in the 2009 and 2010 surveys. For more details on the GCO and information about the general 2011 NSDUH sample design, see the 2011 NSDUH sample design report by Morton, Martin, Shook-Sa, Chromy, and Hirsch (2012).

For the 50-State design, 8 States were designated as large sample States (California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas) with pre-oversample target sample sizes of 3,600. In 2011, the actual sample sizes in these States ranged from 3,074 to 4,029.[4] For the remaining 42 States and the District of Columbia, the pre-oversample target

[3] Prior to 2002, the survey was known as the National Household Survey on Drug Abuse (NHSDA).

[4] One large sample State, Pennsylvania, had a lower final sample size (3,074) because of interviews that were dropped due to data quality issues. Florida received a portion of the GCO supplement and therefore had a higher sample size (4,029).

sample size was 900. Sample sizes in these States ranged from 865 to 1,746 in 2011.[5] This approach ensured there was sufficient sample in every State to support State estimation by either direct methods or small area estimation (SAE)[6] while at the same time maintaining efficiency for national estimates.

States were first stratified into a total of 900 State sampling regions (SSRs) (48 regions in each large sample State and 12 regions in each small sample State). These regions were contiguous geographic areas designed to yield approximately the same number of interviews.[7] Unlike the 1999 through 2001 NHSDAs and the 2002 through 2004 NSDUHs in which the first-stage sampling units were clusters of census blocks called area segments, the first stage of selection for the 2005 through 2011 NSDUHs was census tracts.[8] This stage was included to contain sample segments within a single census tract to the extent possible.[9]

Within each SSR, 48 census tracts were selected with probability proportional to population size. Within sampled census tracts, adjacent census blocks were combined to form the second-stage sampling units or area segments. One area segment was selected within each sampled census tract with probability proportional to population size. Although only 24 segments were needed to support the coordinated 5-year sample, an additional 24 segments were selected to support any supplemental studies that the Substance Abuse and Mental Health Services Administration (SAMHSA) may choose to field. These 24 segments constituted the reserve sample and were available for use in 2010 and 2011. Eight reserve sample segments per SSR were fielded during the 2011 survey year. Four of these segments were retained from the 2010 survey, and four were selected for use in the 2011 survey.

These sampled segments were allocated equally into four separate samples, one for each 3-month period (calendar quarter) during the year. That is, a sample of addresses was selected from two segments[10] in each calendar quarter so that the survey was relatively continuous in the field. In each of the area segments, a listing of all addresses was made from which a national sample of 216,521 addresses was selected. Of the selected addresses, 179,293 were determined to be eligible sample units. In these sample units (which can be either households or units within group quarters), sample persons were randomly selected using an automated screening procedure programmed in a handheld computer carried by the interviewers. The number of sample units completing the screening was 156,048. Youths aged 12 to 17 years and young adults aged 18 to

[5] The State at the top end of the range (Louisiana, with a sample size of 1,746) included a portion of the GCO supplement.

[6] SAE is a hierarchical Bayes modeling technique used to make State-level estimates for 25 measures related to substance use and mental health. For more details, see the *State Estimates of Substance Use and Mental Disorders from the 2009-2010 National Surveys on Drug Use and Health* (Hughes, Muhuri, Sathe, & Spagnola, 2012).

[7] Sampling areas were defined using 2000 census geography. Counts of dwelling units (DUs) and population totals were obtained from the 2000 decennial census data supplemented with revised population counts from Nielsen Claritas.

[8] Census tracts are relatively permanent statistical subdivisions of counties and parishes and provide a stable set of geographic units across decennial census periods.

[9] Some census tracts had to be aggregated in order to meet the minimum DU requirement of 150 DUs in urban areas and 100 DUs in rural areas.

[10] The sample was selected from up to four segments per calendar quarter in SSRs receiving the GCO supplement.

25 years were oversampled at this stage, with 12 to 17 year olds sampled at an actual rate of 87.2 percent and 18 to 25 year olds at a rate of 69.5 percent on average, when they were present in the sampled households or group quarters. Similarly, persons in age groups 26 or older were sampled at rates of 38.2 percent or less, with persons in the eldest age group (50 years or older) sampled at a rate of 8.9 percent on average. The overall population sampling rates were 0.09 percent for 12 to 17 year olds, 0.07 percent for 18 to 25 year olds, 0.02 percent for 26 to 34 year olds, 0.01 percent for 35 to 49 year olds, and 0.01 percent for those 50 or older. Nationwide, 88,536 persons were selected. Consistent with previous surveys in this series, the final respondent sample of 70,109 persons was representative of the U.S. general population (since 1991, the civilian, noninstitutionalized population) aged 12 or older. In addition, State samples were representative of their respective State populations. More detailed information on the disposition of the national screening and interview sample can be found in Appendix B.

A.2 Data Collection Methodology

The data collection method used in NSDUH involves in-person interviews with sample persons, incorporating procedures to increase respondents' cooperation and willingness to report honestly about their illicit drug use behavior. Confidentiality is stressed in all written and oral communications with potential respondents. Respondents' names are not collected with the data, and computer-assisted interviewing (CAI) methods are used to provide a private and confidential setting to complete the interview.

Introductory letters are sent to sampled addresses, followed by an interviewer visit. When contacting a dwelling unit (DU), the field interviewer (FI) asks to speak with an adult resident (aged 18 or older) of the household who can serve as the screening respondent. Using a handheld computer, the FI completes a 5-minute procedure with the screening respondent that involves listing all household members along with their basic demographic data. The computer uses the demographic data in a preprogrammed selection algorithm to select zero to two sample persons, depending on the composition of the household. This selection process is designed to provide the necessary sample sizes for the specified population age groupings. In areas where a third or more of the households contain Spanish-speaking residents, the initial introductory letters written in English are mailed with a Spanish version on the back. All interviewers carry copies of this letter in Spanish. If the interviewer is not certified bilingual, he or she will use preprinted Spanish cards to attempt to find someone in the household who speaks English and who can serve as the screening respondent or who can translate for the screening respondent. If no one is available, the interviewer will schedule a time when a Spanish-speaking interviewer can come to the address. In households where a language other than Spanish is encountered, another language card is used to attempt to find someone who speaks English to complete the screening.

The NSDUH interview can be completed in English or Spanish, and both versions have the same content. If the sample person prefers to complete the interview in Spanish, a certified bilingual interviewer is sent to the address to conduct the interview. Because the interview is not translated into any other language, if a sample person does not speak English or Spanish, the interview is not conducted.

Immediately after the completion of the screener, interviewers attempt to conduct the NSDUH interview with each sample person in the household. The interviewer requests the

selected respondent to identify a private area in the home to conduct the interview away from other household members. The interview averages about an hour and includes a combination of CAPI (computer-assisted personal interviewing, in which the interviewer reads the questions) and ACASI (audio computer-assisted self-interviewing).

The NSDUH interview consists of core and noncore (i.e., supplemental) sections. A core set of questions critical for basic trend measurement of prevalence estimates remains in the survey every year and comprises the first part of the interview. Noncore questions, or modules, that can be revised, dropped, or added from year to year make up the remainder of the interview. The core consists of initial demographic items (which are interviewer-administered) and self-administered questions pertaining to the use of tobacco, alcohol, marijuana, cocaine, crack cocaine, heroin, hallucinogens, inhalants, pain relievers, tranquilizers, stimulants, and sedatives. Topics in the remaining noncore self-administered sections include (but are not limited to) injection drug use, perceived risks of substance use, substance dependence or abuse, arrests, treatment for substance use problems, pregnancy and health care issues, and mental health issues. Noncore demographic questions (which are interviewer-administered and follow the ACASI questions) address such topics as immigration, current school enrollment, employment and workplace issues, health insurance coverage, and income. In practice, some of the noncore portions of the interview have remained in the survey, relatively unchanged, from year to year (e.g., current health insurance coverage, employment).

Thus, the interview begins in CAPI mode with the FI reading the questions from the computer screen and entering the respondent's replies into the computer. The interview then transitions to the ACASI mode for the sensitive questions. In this mode, the respondent can read the questions silently on the computer screen and/or listen to the questions read through headphones and enter his or her responses directly into the computer. At the conclusion of the ACASI section, the interview returns to the CAPI mode with the FI completing the questionnaire. Each respondent who completes a full interview is given a $30 cash payment as a token of appreciation for his or her time.

No personal identifying information about the respondent is captured in the CAI record. FIs transmit the completed interview data to RTI in Research Triangle Park, North Carolina, via home telephone analog lines.

After the data are transmitted to RTI, certain cases are selected for verification. The respondents are contacted by RTI to verify the quality of an FI's work based on information that respondents provide at the end of screening (if no one is selected for an interview at the DU or the entire DU is ineligible for the study) or at the end of the interview. For the screening interview, the adult DU member who served as the screening respondent provides his or her first name and telephone number to the FI, who enters the information into a handheld computer and transmits the data to RTI. For completed interviews, respondents write their home telephone number and mailing address on a quality control form and seal the form in a preaddressed envelope that FIs mail back to RTI. All contact information is kept completely separate from the answers provided during the screening or interview.

Samples of respondents who completed screenings or interviews are randomly selected for verification. These cases are called by telephone interviewers who ask scripted questions

designed to determine the accuracy and quality of the data collected. Any cases discovered to have a problem or discrepancy are flagged and routed to a small specialized team of telephone interviewers who recontact respondents for further investigation of the issue(s). Depending on the amount of an FI's work that cannot be verified through telephone verification, including bad telephone numbers (e.g., incorrect number, disconnected, not in service), a field verification may be conducted. Field verifications involve another FI returning to the sampled DU to verify the accuracy and quality of the data in person. If the verification procedures identify situations in which an FI has falsified data, the FI no longer works on NSDUH. All cases completed that quarter by the FI who falsified data are reworked by the FI conducting the field verification.

A.3 Data Processing

Data that FIs transmit to RTI are processed to create a raw data file in which no logical editing of the data has been done. The raw data file consists of one record for each transmitted interview. Cases are eligible to be treated as final respondents only if they provided data on lifetime use of cigarettes and at least 9 out of 13 of the other substances in the core section of the questionnaire. Written responses to questions (e.g., names of other drugs that were used) are assigned numeric codes as part of the data processing procedures. Even though editing and consistency checks are done by the CAI program during the interview, additional, more complex edits and consistency checks are completed at RTI. Additionally, statistical imputation is used to replace missing or ambiguous values after editing for some key variables. Analysis weights are created so that estimates will be representative of the target population. Details of the editing, imputation, and weighting procedures for 2011 will appear in the *2011 NSDUH Methodological Resource Book*, which is in process. Until that volume becomes available, refer to the *2010 NSDUH Methodological Resource Book* (RTI International, 2012).

A.3.1 Data Coding and Logical Editing

With the exception of industry and occupation data, coding of written answers that respondents or interviewers typed was performed at RTI for the 2011 NSDUH. These written answers include mentions of drugs that respondents had used or other responses that did not fit a previous response option (subsequently referred to as "OTHER, Specify" data). Coding of the "OTHER, Specify" variables was accomplished through computer-assisted survey procedures and the use of a secure Web site that allowed for coding and review of the data. The computer-assisted procedures entailed a database check for a given "OTHER, Specify" variable that contained typed entries and the associated numeric codes. If an exact match was found between the typed response and an entry in the system, the computer-assisted procedures assigned the appropriate numeric code. Typed responses that did not match an existing entry were coded through the Web-based coding system. Data on the industries in which respondents worked and respondents' occupations were assigned numeric industry and occupation codes by staff at the U.S. Census Bureau.

As noted above, the CAI program included checks that alerted respondents or interviewers when an entered answer was inconsistent with a previous answer in a given module. In this way, the inconsistency could be resolved while the interview was in progress. However, not every inconsistency was resolved during the interview, and the CAI program did not include checks for every possible inconsistency that might have occurred in the data.

Therefore, the first step in processing the raw NSDUH data was logical editing of the data. Logical editing involved using data from within a respondent's record to (a) reduce the amount of item nonresponse (i.e., missing data) in interview records, including identification of items that were legitimately skipped; (b) make related data elements consistent with each other; and (c) identify ambiguities or inconsistencies to be resolved through statistical imputation procedures (see Section A.3.2).

For example, if respondents reported that they never used a given drug, the CAI logic skipped them out of all remaining questions about use of that drug. In the editing procedures, the skipped variables were assigned codes to indicate that the respondents were lifetime nonusers. Similarly, respondents were instructed in the prescription psychotherapeutics modules (i.e., pain relievers, tranquilizers, stimulants, and sedatives) not to report the use of over-the-counter (OTC) drugs. Therefore, if a respondent's only report of lifetime use of a particular type of "prescription" psychotherapeutic drug was for an OTC drug, the respondent was logically inferred never to have been a nonmedical user of the prescription drugs in that psychotherapeutic category.

In addition, respondents could report that they were lifetime users of a drug but not provide specific information on when they last used it. In this situation, a temporary "indefinite" value for the most recent period of use was assigned to the edited recency-of-use variable (e.g., "Used at some point in the lifetime LOGICALLY ASSIGNED"), and a final, specific value was statistically imputed. The editing procedures for key drug use variables also involved identifying inconsistencies between related variables so that these inconsistencies could be resolved through statistical imputation. For example, if a respondent reported last using a drug more than 12 months ago and also reported first using it at his or her current age, both of those responses could not be true. In this example, the inconsistent period of most recent use was replaced with an "indefinite" value, and the inconsistent age at first use was replaced with a missing data code. These indefinite or missing values were subsequently imputed through statistical procedures to yield consistent data for the related measures, as discussed in the next section.

A.3.2 Statistical Imputation

For some key variables that still had missing or ambiguous values after editing, statistical imputation was used to replace these values with appropriate response codes. For example, a response is ambiguous if the editing procedures assigned a respondent's most recent use of a drug to "Used at some point in the lifetime," with no definite period within the lifetime. In this case, the imputation procedure assigns a value for when the respondent last used the drug (e.g., in the past 30 days, more than 30 days ago but within the past 12 months, more than 12 months ago). Similarly, if a response is completely missing, the imputation procedures replace missing values with nonmissing ones.

For most variables, missing or ambiguous values are imputed in NSDUH using a methodology called predictive mean neighborhoods (PMN), which was developed specifically for the 1999 survey and has been used in all subsequent survey years. PMN allows for the following: (1) the ability to use covariates to determine donors is greater than that offered in the hot-deck imputation procedure, (2) the relative importance of covariates can be determined by standard modeling techniques, (3) the correlations across response variables can be accounted for

by making the imputation multivariate, and (4) sampling weights can be easily incorporated in the models. The PMN method has some similarity with the predictive mean matching method of Rubin (1986) except that, for the donor records, Rubin used the observed variable value (not the predictive mean) to compute the distance function. Also, the well-known method of nearest neighbor imputation is similar to PMN, except that the distance function is in terms of the original predictor variables and often requires somewhat arbitrary scaling of discrete variables. PMN is a combination of a model-assisted imputation methodology and a random nearest neighbor hot-deck procedure. The hot-deck procedure within the PMN method ensures that missing values are imputed to be consistent with nonmissing values for other variables. Whenever feasible, the imputation of variables using PMN is multivariate, in which imputation is accomplished on several response variables at once. Variables imputed using PMN are the core demographic variables, core drug use variables (recency of use, frequency of use, and age at first use), income, health insurance, and noncore demographic variables for work status, immigrant status, and the household roster.

In the modeling stage of PMN, the model chosen depends on the nature of the response variable. In the 2011 NSDUH, the models included binomial logistic regression, multinomial logistic regression, Poisson regression, and ordinary linear regression, where the models incorporated the sampling design weights.

In general, hot-deck imputation replaces an item nonresponse (missing or ambiguous value) with a recorded response that is donated from a "similar" respondent who has nonmissing data. For random nearest neighbor hot-deck imputation, the missing or ambiguous value is replaced by a responding value from a donor randomly selected from a set of potential donors. Potential donors are those defined to be "close" to the unit with the missing or ambiguous value according to a predefined function called a distance metric. In the hot-deck procedure of PMN, the set of candidate donors (the "neighborhood") consists of respondents with complete data who have a predicted mean close to that of the item nonrespondent. The predicted means are computed both for respondents with and without missing data, which differs from Rubin's method where predicted means are not computed for the donor respondent (Rubin, 1986). In particular, the neighborhood consists of either the set of the closest 30 respondents or the set of respondents with a predicted mean (or means) within 5 percent of the predicted mean(s) of the item nonrespondent, whichever set is smaller. If no respondents are available who have a predicted mean (or means) within 5 percent of the item nonrespondent, the respondent with the predicted mean(s) closest to that of the item nonrespondent is selected as the donor.

In the univariate case (where only one variable is imputed using PMN), the neighborhood of potential donors is determined by calculating the relative distance between the predicted mean for an item nonrespondent and the predicted mean for each potential donor, then choosing those means defined by the distance metric. The pool of donors is restricted further to satisfy logical constraints whenever necessary (e.g., age at first crack use must not be less than age at first cocaine use).

Whenever possible, missing or ambiguous values for more than one response variable are considered together. In this (multivariate) case, the distance metric is a Mahalanobis distance, which takes into account the correlation between variables (Manly, 1986), rather than a Euclidean distance. The Euclidean distance is the square root of the sum of squared differences

between each element of the predictive mean vector for the respondent and the predictive mean vector for the nonrespondent. The Mahalanobis distance standardizes the Euclidean distance by the variance-covariance matrix, which is appropriate for random variables that are correlated or have heterogeneous variances. Whether the imputation is univariate or multivariate, only missing or ambiguous values are replaced, and donors are restricted to be logically consistent with the response variables that are not missing. Furthermore, donors are restricted to satisfy "likeness constraints" whenever possible. That is, donors are required to have the same values for variables highly correlated with the response. For example, donors for the age at first use variable are required to be of the same age as recipients, if at all possible. If no donors are available who meet these conditions, these likeness constraints can be loosened. Further details on the PMN methodology are provided by Singh, Grau, and Folsom (2002).

Although statistical imputation could not proceed separately within each State due to insufficient pools of donors, information about each respondent's State of residence was incorporated in the modeling and hot-deck steps. For most drugs, respondents were separated into three "State usage" categories as follows: respondents from States with high usage of a given drug were placed in one category, respondents from States with medium usage into another, and the remainder into a third category. This categorical "State rank" variable was used as one set of covariates in the imputation models. In addition, eligible donors for each item nonrespondent were restricted to be of the same State usage category (i.e., the same "State rank") as the nonrespondent.

In the 2011 NSDUH, the majority of variables that underwent statistical imputation required less than 5 percent of their records to be logically assigned or statistically imputed. Variables for measures that are highly sensitive or that may not be known to younger respondents (e.g., family income) often have higher rates of item nonresponse. In addition, certain variables that are subject to a greater number of skip patterns and consistency checks (e.g., frequency of use in the past 12 months and past 30 days) often require greater amounts of imputation.

A.3.3 Development of Analysis Weights

The general approach to developing and calibrating analysis weights involved developing design-based weights as the product of the inverse of the selection probabilities at each selection stage. Since 2005, NSDUH has used a four-stage sample selection scheme in which an extra selection stage of census tracts was added before the selection of a segment. Thus, the design-based weights, d_k, incorporate an extra layer of sampling selection to reflect the sample design change. Adjustment factors, $a_k(\lambda)$, then were applied to the design-based weights to adjust for nonresponse, to poststratify to known population control totals, and to control for extreme weights when necessary. In view of the importance of State-level estimates with the 50-State design, it was necessary to control for a much larger number of known population totals. Several other modifications to the general weight adjustment strategy that had been used in past surveys also were implemented for the first time beginning with the 1999 CAI sample.

Weight adjustments were based on a generalization of Deville and Särndal's (1992) logit model. This generalized exponential model (GEM) (Folsom & Singh, 2000) incorporates unit-specific bounds $(\ell_k, u_k), k \in s,$ for the adjustment factor $a_k(\lambda)$ as follows:

$$a_k(\lambda) = \frac{\ell_k(u_k - c_k) + u_k(c_k - \ell_k)\exp(A_k x_k'\lambda)}{(u_k - c_k) + (c_k - \ell_k)\exp(A_k x_k'\lambda)},$$

where c_k are prespecified centering constants, such that $\ell_k < c_k < u_k$ and $A_k = (u_k \quad \ell_k)/(u_k \quad c_k)(e_k \quad \ell_k)$. The variables $\ell_k, c_k,$ and u_k are user-specified bounds, and λ is the column vector of *p* model parameters corresponding to the *p* covariates *x*. The λ-parameters are estimated by solving

$$\sum\nolimits_s x_k d_k a_k(\lambda) - \tilde{T}_x = 0,$$

where $\tilde{T}_x$ denotes control totals that could be either nonrandom, as is generally the case with poststratification, or random, as is generally the case for nonresponse adjustment.

The final weights $w_k = d_k a_k(\ )$ minimize the distance function $\Delta(w, d)$ defined as

$$\Delta(w,d) = \sum_{k \in s} \frac{d_k}{A_k}\left\{(a_k \quad \ell_k)\log\frac{a_k - \ell_k}{c_k - \ell_k} \quad (u_k \quad a_k)\log\frac{u_k - a_k}{u_k - c_k}\right\}.$$

This general approach was used at several stages of the weight adjustment process, including (1) adjustment of household weights for nonresponse at the screener level, (2) poststratification of household weights to meet population controls for various household-level demographics by State, (3) adjustment of household weights for extremes, (4) poststratification of selected person weights, (5) adjustment of responding person weights for nonresponse at the questionnaire level, (6) poststratification of responding person weights, and (7) adjustment of responding person weights for extremes.

Every effort was made to include as many relevant State-specific covariates (typically defined by demographic domains within States) as possible in the multivariate models used to calibrate the weights (nonresponse adjustment and poststratification steps). Because further subdivision of State samples by demographic covariates often produced small cell sample sizes, it was not possible to retain all State-specific covariates (even after meaningful collapsing of covariate categories) and still estimate the necessary model parameters with reasonable precision. Therefore, a hierarchical structure was used in grouping States with covariates defined at the national level, at the census division level within the Nation, at the State group within the census division, and, whenever possible, at the State level. In every case, the controls for the total population within a State and the five age groups (12 to 17, 18 to 25, 26 to 34, 35 to 49, 50 or older) within a State were maintained except that, in the last step of poststratification of person weights, six age groups (12 to 17, 18 to 25, 26 to 34, 35 to 49, 50 to 64, 65 or older) were used. Census control totals by age, race, gender, and Hispanic origin were required for the

civilian, noninstitutionalized population of each State. Beginning with the 2002 NSDUH, the Population Estimates Branch of the U.S. Census Bureau has produced the necessary population estimates for the same year as each NSDUH survey in response to a special request.

Census control totals for the 2011 NSDUH weights were based on population estimates from the 2010 decennial census, whereas the control totals for the 2010 NSDUH weights still were based on the 2000 census. Section B.4.3 in Appendix B discusses the results of an investigation assessing the effects of using control totals based on the 2010 census instead of the 2000 census for estimating substance use in 2010.

Consistent with the surveys from 1999 onward, control of extreme weights through separate bounds for adjustment factors was incorporated into the GEM calibration processes for both nonresponse and poststratification. This is unlike the traditional method of winsorization in which extreme weights are truncated at prespecified levels and the trimmed portions of weights are distributed to the nontruncated cases. In GEM, it is possible to set bounds around the prespecified levels for extreme weights, then the calibration process provides an objective way of deciding the extent of adjustment (or truncation) within the specified bounds. A step was included to poststratify the household-level weights to obtain census-consistent estimates based on the household rosters from all screened households. An additional step poststratified the selected person sample to conform to the adjusted roster estimates. This additional step takes advantage of the inherent two-phase nature of the NSDUH design. The respondent poststratification step poststratified the respondent person sample to external census data (defined within the State whenever possible, as discussed above).

For certain populations of interest, 2 years of NSDUH data were combined to obtain annual averages. The person-level weights for estimates based on the annual averages were obtained by dividing the analysis weights for the 2 specific years by a factor of 2.

In the 2011 NSDUH, the GCO sample was integrated into the main study sample. The weighting process accounted for the oversampling without additional adjustment needing to be implemented. Special analysis weights were developed for studies focused on the gulf coast area, but these were not used for any estimates for this report.

Appendix B: Statistical Methods and Measurement

B.1 Target Population

The estimates of drug use prevalence from the National Survey on Drug Use and Health (NSDUH) are designed to describe the target population of the survey—the civilian, noninstitutionalized population aged 12 or older living in the United States. This population includes almost 98 percent of the total U.S. population aged 12 or older. However, it excludes some small subpopulations that may have very different drug use patterns. For example, the survey excludes active military personnel, who have been shown to have significantly lower rates of illicit drug use. The survey also excludes two groups that have been shown to have higher rates of illicit drug use: persons living in institutional group quarters, such as prisons and residential drug use treatment centers, and homeless persons not living in a shelter. Readers are reminded to consider the exclusion of these subpopulations when interpreting results. Appendix C describes other surveys that provide data for some of these populations.

B.2 Sampling Error and Statistical Significance

This report includes national estimates that were drawn from a set of tables referred to as "detailed tables" that are available at http://www.samhsa.gov/data/. The national estimates, along with the associated standard errors (SEs, which are the square roots of the variances), were computed for all detailed tables using a multiprocedure package, SUDAAN® Software for Statistical Analysis of Correlated Data. This software accounts for the complex survey design of NSDUH in estimating the SEs (RTI International, 2008). The final, nonresponse-adjusted, and poststratified analysis weights were used in SUDAAN to compute unbiased design-based drug use estimates.

The sampling error of an estimate is the error caused by the selection of a sample instead of conducting a census of the population. The sampling error may be reduced by selecting a large sample and/or by using efficient sample design and estimation strategies, such as stratification, optimal allocation, and ratio estimation. The use of probability sampling methods in NSDUH allows estimation of sampling error from the survey data. SEs have been calculated using SUDAAN for all estimates presented in this report using a Taylor series linearization approach that takes into account the effects of NSDUH's complex design features. The SEs are used to identify unreliable estimates and to test for the statistical significance of differences between estimates.

B.2.1 Variance Estimation for Totals

The variances and SEs of estimates of means and proportions can be calculated reasonably well in SUDAAN using a Taylor series linearization approach. Estimates of means or proportions, $\hat{p}_d$, such as drug use prevalence estimates for a domain d, can be expressed as a ratio estimate:

$$\hat{p}_d = \frac{\hat{Y}_d}{\hat{N}_d},$$

where $\hat{Y}_d$ is a linear statistic estimating the number of substance users in the domain d and $\hat{N}_d$ is a linear statistic estimating the total number of persons in domain d (including both users and nonusers). The SUDAAN software package is used to calculate direct estimates of $\hat{Y}_d$ and $\hat{N}_d$ (and, therefore, $\hat{p}_d$) and also can be used to estimate their respective SEs. A Taylor series approximation method implemented in SUDAAN provides the estimate for the SE of $\hat{p}_d$.

When the domain size, $\hat{N}_d$, is free of sampling error, an estimate of the SE for the total number of substance users is

$$\mathrm{SE}(\hat{Y}_d) = \hat{N}_d \mathrm{SE}(\hat{p}_d).$$

This approach is theoretically correct when the domain size estimates, $\hat{N}_d$, are among those forced to match their respective U.S. Census Bureau population estimates through the weight calibration process. In these cases, $\hat{N}_d$ is not subject to a sampling error induced by the NSDUH design. Section A.3.3 in Appendix A contains further information about the weight calibration process. In addition, more detailed information about the weighting procedures for 2011 will appear in the *2011 NSDUH Methodological Resource Book*, which is in process. Until that volume becomes available, refer to the *2010 NSDUH Methodological Resource Book* (RTI International, 2012).

For estimated domain totals, $\hat{Y}_d$, where $\hat{N}_d$ is not fixed (i.e., where domain size estimates are not forced to match the U.S. Census Bureau population estimates), this formulation still may provide a good approximation if it can be assumed that the sampling variation in $\hat{N}_d$ is negligible relative to the sampling variation in $\hat{p}_d$. This is a reasonable assumption for many cases in this study.

For some subsets of domain estimates, the above approach can yield an underestimate of the SE of the total when $\hat{N}_d$ was subject to considerable variation. Because of this underestimation, alternatives for estimating SEs of totals were implemented. Since the 2005 NSDUH report, a "mixed" method approach has been implemented for all detailed tables to improve the accuracy of SEs and to better reflect the effects of poststratification on the variance of total estimates. This approach assigns the methods of SE calculation to domains (i.e., subgroups for which the estimates were calculated) within tables so that all estimates among a select set of domains with fixed $\hat{N}_d$ were calculated using the formula above, and all other estimates were calculated directly in SUDAAN, regardless of what the other estimates are within the same table. The set of domains considered controlled (i.e., those with a fixed $\hat{N}_d$) was

restricted to main effects and two-way interactions in order to maintain continuity between years. Domains consisting of three-way interactions may be controlled in a single year but not necessarily in preceding or subsequent years. The use of such SEs did not affect the SE estimates for the corresponding proportions presented in the same sets of tables because all SEs for means and proportions are calculated directly in SUDAAN. As a result of the use of this mixed-method approach, the SEs for the total estimates within many detailed tables were calculated differently from those in NSDUH reports prior to the 2005 report.

Table B.1 at the end of this appendix contains a list of domains with a fixed $\hat{N}_d$ that were used in the weight calibration process. This table includes both the main effects and two-way interactions and may be used to identify the method of SE calculation employed for estimates of totals. For example, Table 1.23 in the 2011 detailed tables presents estimates of illicit drug use among persons aged 18 or older within the domains of gender, Hispanic origin and race, education, and current employment. Estimates among the total population (age main effect), males and females (age by gender interaction), and Hispanics and non-Hispanics (age by Hispanic origin interaction) were treated as controlled in this table, and the formula above was used to calculate the SEs. The SEs for all other estimates, including white and black or African American (age by Hispanic origin by race interaction) were calculated directly from SUDAAN. Estimates presented in this report for racial groups are for non-Hispanics. Thus, the domain for whites by age group in the weight calibration process in Table B.1 is a two-way interaction. However, published estimates for whites by age group in this report and in the 2011 detailed tables actually represent a three-way interaction: white by Hispanic origin (i.e., not Hispanic) by age group.

B.2.2 Suppression Criteria for Unreliable Estimates

As has been done in past NSDUH reports, direct estimates from NSDUH that are designated as unreliable are not shown in this report and are noted by asterisks (*) in figures containing such estimates. The criteria used to define unreliability of direct estimates from NSDUH are based on the prevalence (for proportion estimates), relative standard error (RSE) (defined as the ratio of the SE over the estimate), nominal (actual) sample size, and effective sample size for each estimate. These suppression criteria for various NSDUH estimates are summarized in Table B.2 at the end of this appendix.

Proportion estimates $(\hat{p})$, or rates, within the range $[0 < \hat{p} < 1]$, and the corresponding estimated numbers of users were suppressed if

$$\text{RSE}[-\ln(\hat{p})] > .175 \text{ when } \hat{p} \leq .5$$

or

$$\text{RSE}[-\ln(1-\hat{p})] > .175 \text{ when } \hat{p} > .5 .$$

Using a first-order Taylor series approximation to estimate $\text{RSE}[-\ln(\hat{p})]$ and $\text{RSE}[-\ln(1-\hat{p})]$, the following equation was derived and used for computational purposes when applying a suppression rule dependent on effective sample size:

$$\frac{\mathrm{SE}(\hat{p})/\hat{p}}{-\ln(\hat{p})} > .175 \text{ when } \hat{p} \le .5$$

or

$$\frac{\mathrm{SE}(\hat{p})/(1-\hat{p})}{-\ln(1-\hat{p})} > .175 \text{ when } \hat{p} > .5 .$$

The separate formulas for $\hat{p} \le .5$ and $\hat{p} > .5$ produce a symmetric suppression rule; that is, if $\hat{p}$ is suppressed, $1-\hat{p}$ will be suppressed as well (see Figure B.1 following Table B.2). When $.05 < \hat{p} < .95$, the symmetric properties of the rule produce a local minimum effective sample size of 50 at $\hat{p} = .2$ and at $\hat{p} = .8$. Using the minimum effective sample size for the suppression rule would mean that estimates of $\hat{p}$ between .05 and .95 would be suppressed if their corresponding effective sample sizes were less than 50. Within this same interval, a local maximum effective sample size of 68 is found at $\hat{p} = .5$. To simplify requirements and maintain a conservative suppression rule, estimates of $\hat{p}$ between .05 and .95 were suppressed if they had an effective sample size below 68.

In addition, a minimum nominal sample size suppression criterion (n = 100) that protects against unreliable estimates caused by small design effects and small nominal sample sizes was employed; Table B.2 shows a formula for calculating design effects. Prevalence estimates also were suppressed if they were close to 0 or 100 percent (i.e., if $\hat{p} < .00005$ or if $\hat{p} \ge .99995$).

Estimates of totals were suppressed if the corresponding prevalence rates were suppressed. Estimates of means that are not bounded between 0 and 1 (e.g., mean of age at first use) were suppressed if the RSEs of the estimates were larger than .5 or if the nominal sample size was smaller than 10 respondents.

B.2.3 Statistical Significance of Differences

This section describes the methods used to compare prevalence estimates in this report. Customarily, the observed difference between estimates is evaluated in terms of its statistical significance. Statistical significance is based on the p value of the test statistic and refers to the probability that a difference as large as that observed would occur because of random variability in the estimates if there were no difference in the prevalence estimates for the population groups being compared. The significance of observed differences in this report is reported at the .05 level. When comparing prevalence estimates, the null hypothesis (no difference between prevalence estimates) was tested against the alternative hypothesis (there is a difference in prevalence estimates) using the standard difference in proportions test expressed as

$$Z = \frac{\hat{p}_1 - \hat{p}_2}{\sqrt{\mathrm{var}(\hat{p}_1) + \mathrm{var}(\hat{p}_2) - 2\,\mathrm{cov}(\hat{p}_1, \hat{p}_2)}} ,$$

where $\hat{p}_1$ = first prevalence estimate, $\hat{p}_2$ = second prevalence estimate, $\text{var}(\hat{p}_1)$ = variance of first prevalence estimate, $\text{var}(\hat{p}_2)$ = variance of second prevalence estimate, and $\text{cov}(\hat{p}_1, \hat{p}_2)$ = covariance between $\hat{p}_1$ and $\hat{p}_2$. In cases where significance tests between years were performed, the prevalence estimate from the earlier year becomes the first estimate, and the prevalence estimate from the later year becomes the second estimate (e.g., 2010 is the first estimate and 2011 the second).

Under the null hypothesis, *Z* is asymptotically distributed as a standard normal random variable. Therefore, calculated values of *Z* can be referred to the unit normal distribution to determine the corresponding probability level (i.e., *p* value). Because the covariance term between the two estimates is not necessarily zero, SUDAAN was used to compute estimates of *Z* along with the associated *p* values using the analysis weights and accounting for the sample design as described in Appendix A. A similar procedure and formula for *Z* were used for estimated totals. Whenever it was necessary to calculate the SE outside of SUDAAN (i.e., when domains were forced by the weighting process to match their respective U.S. Census Bureau population estimates), the corresponding test statistics also were computed outside of SUDAAN.

When comparing population subgroups across three or more levels of a categorical variable, log-linear chi-square tests of independence of the subgroups and the prevalence variables were conducted using SUDAAN in order to first control the error level for multiple comparisons. If Shah's Wald *F* test (transformed from the standard Wald chi-square) indicated overall significant differences, the significance of each particular pairwise comparison of interest was tested using SUDAAN analytic procedures to properly account for the sample design (RTI International, 2008). Using the published estimates and SEs to perform independent *t* tests for the difference of proportions usually will provide the same results as tests performed in SUDAAN. However, where the significance level is borderline, results may differ for two reasons: (1) the covariance term is included in SUDAAN tests, whereas it is not included in independent *t* tests; and (2) the reduced number of significant digits shown in the published estimates may cause rounding errors in the independent *t* tests.

As part of a comparative analysis discussed in Chapter 8, prevalence estimates from the Monitoring the Future (MTF) study, sponsored by the National Institute on Drug Abuse (NIDA), were presented for recency measures of selected substances (see Tables 8.1 to 8.6). The analyses focused on prevalence estimates for 8th and 10th graders and prevalence estimates for young adults aged 19 to 24 for 2002 through 2011. Estimates for the 8th and 10th grade students were calculated using MTF data as the simple average of the 8th and 10th grade estimates. Estimates for young adults aged 19 to 24 were calculated using MTF data as the simple average of three modal age groups: 19 and 20 years, 21 and 22 years, and 23 and 24 years. Published results were not available from NIDA for significant differences in prevalence estimates between years for these subgroups, so testing was performed using information that was available.

For the 8th and 10th grade average estimates, tests of differences were performed between 2011 and the 9 prior years. Estimates for persons in grade 8 and grade 10 were considered independent, simplifying the calculation of variances for the combined grades. Across years, the estimates for 2011 involved samples independent of those in 2002 to 2009. For 2010 and 2011, however, the sample of schools overlapped 50 percent, creating a covariance in

the estimates. Design effects published in Johnston et al. (2012) for adjacent and nonadjacent year testing were used.

For the 19- to 24-year-old age group, tests of differences were done assuming independent samples between years an odd number of years apart because two distinct cohorts a year apart were monitored longitudinally at 2-year intervals. This is appropriate for comparisons of 2002, 2004, 2006, 2008, and 2010 data with 2011 data. However, this assumption results in conservative tests for comparisons of 2003, 2005, 2007, and 2009 data with 2011 data because testing did not take into account covariances associated with repeated observations from the longitudinal samples. Estimates of covariances were not available.

Complete details on testing between NSDUH and MTF can be found in Section B.2.3 in Appendix B of the 2010 national findings report (Center for Behavioral Health Statistics and Quality [CBHSQ], 2011). This discussion also includes variance estimation in the MTF data for testing between adjacent survey years.

B.3 Other Information on Data Accuracy

The accuracy of survey estimates can be affected by nonresponse, coding errors, computer processing errors, errors in the sampling frame, reporting errors, and other errors not due to sampling. These types of "nonsampling errors" and their impact are reduced through data editing, statistical adjustments for nonresponse, close monitoring and periodic retraining of interviewers, and improvement in quality control procedures.

Although these types of errors often can be much larger than sampling errors, measurement of most of these errors is difficult. However, some indication of the effects of some types of these errors can be obtained through proxy measures, such as response rates, and from other research studies.

B.3.1 Screening and Interview Response Rate Patterns

In 2011, respondents continued to receive a $30 incentive in an effort to maximize response rates. The weighted screening response rate (SRR) is defined as the weighted number of successfully screened households[11] divided by the weighted number of eligible households (as defined in Table B.3), or

$$SRR = \frac{\sum w_{hh} complete_{hh}}{\sum w_{hh} eligible_{hh}},$$

where w_{hh} is the inverse of the unconditional probability of selection for the household and excludes all adjustments for nonresponse and poststratification defined in Section A.3.3 of Appendix A. Of the 179,293 eligible households sampled for the 2011 NSDUH, 156,048 were screened successfully, for a weighted screening response rate of 87.0 percent (Table B.3). At the

[11] A successfully screened household is one in which all screening questionnaire items were answered by an adult resident of the household and either zero, one, or two household members were selected for the NSDUH interview.

person level, the weighted interview response rate (IRR) is defined as the weighted number of respondents divided by the weighted number of selected persons (see Table B.4), or

$$IRR = \frac{\sum w_i complete_i}{\sum w_i selected_i},$$

where w_i is the inverse of the probability of selection for the person and includes household-level nonresponse and poststratification adjustments (adjustments 1, 2, and 3 in Section A.3.3 of Appendix A). To be considered a completed interview, a respondent must provide enough data to pass the usable case rule.[12] In the 156,048 screened households, a total of 88,536 sample persons were selected, and completed interviews were obtained from 70,109 of these sample persons, for a weighted IRR of 74.4 percent (Table B.4). A total of 13,311 (18.1 percent) sample persons were classified as refusals or parental refusals, 2,917 (3.4 percent) were not available or never at home, and 2,199 (4.1 percent) did not participate for various other reasons, such as physical or mental incompetence or language barrier (see Table B.4, which also shows the distribution of the selected sample by interview code and age group). Among demographic subgroups, the weighted IRR was higher among 12 to 17 year olds (85.0 percent), females (76.1 percent), blacks (79.8 percent), persons in the South (76.9 percent), and residents of nonmetropolitan areas (77.0 percent) than among other related groups (Table B.5).

The overall weighted response rate, defined as the product of the weighted screening response rate and weighted interview response rate or

$$ORR = SRR \quad IRR$$

was 64.7 percent in 2011. Nonresponse bias can be expressed as the product of the nonresponse rate $(1 - R)$ and the difference between the characteristic of interest between respondents and nonrespondents in the population $(P_r - P_{nr})$. By maximizing NSDUH response rates, it is hoped that the bias due to the difference between the estimates from respondents and nonrespondents is minimized. Drug use surveys are particularly vulnerable to nonresponse because of the difficult nature of accessing heavy drug users. However, in a study that matched 1990 census data to 1990 NHSDA nonrespondents,[13] it was found that populations with low response rates did not always have high drug use rates. For example, although some populations were found to have low response rates and high drug use rates (e.g., residents of large metropolitan areas and males), other populations had low response rates and low drug use rates (e.g., older adults and high-income populations). Therefore, many of the potential sources of bias tend to cancel each other in estimates of overall prevalence (Gfroerer, Lessler, & Parsley, 1997a).

B.3.2 Inconsistent Responses and Item Nonresponse

Among survey participants, item response rates were generally very high for most drug use items. However, respondents could give inconclusive or inconsistent information about

[12] The usable case rule requires that a respondent answer "yes" or "no" to the question on lifetime use of cigarettes and "yes" or "no" to at least nine additional lifetime use questions.

[13] Prior to 2002, NSDUH was known as the National Household Survey on Drug Abuse (NHSDA).

whether they ever used a given drug (i.e., "yes" or "no") and, if they had used a drug, when they last used it; the latter information is needed to identify those lifetime users of a drug who used it in the past year or past month. In addition, respondents could give inconsistent responses to items such as when they first used a drug compared with their most recent use of a drug. These missing or inconsistent responses first are resolved where possible through a logical editing process. Additionally, missing or inconsistent responses are imputed using statistical methodology. These imputation procedures in NSDUH are based on responses to multiple questions, so that the maximum amount of information is used in determining whether a respondent is classified as a user or nonuser, and if the respondent is classified as a user, whether the respondent is classified as having used in the past year or the past month. For example, ambiguous data on the most recent use of cocaine are statistically imputed based on a respondent's data for use (or most recent use) of tobacco products, alcohol, inhalants, marijuana, hallucinogens, and nonmedical use of prescription psychotherapeutic drugs. Nevertheless, editing and imputation of missing responses are potential sources of measurement error. For more information on editing and statistical imputation, see Sections A.3.1 and A.3.2 of Appendix A. Details of the editing and imputation procedures for 2011 also will appear in the *2011 NSDUH Methodological Resource Book*, which is in process. Until that volume becomes available, refer to the *2010 NSDUH Methodological Resource Book* (RTI International, 2012).

B.3.3 Data Reliability

A reliability study was conducted as part of the 2006 NSDUH to assess the reliability of responses to the NSDUH questionnaire. An interview/reinterview method was employed in which 3,136 individuals were interviewed on two occasions during 2006 generally 5 to 15 days apart; the initial interviews in the reliability study were a subset of the main study interviews. The reliability of the responses was assessed by comparing the responses of the first interview with the responses from the reinterview. Responses from the first interview and reinterview that were analyzed for response consistency were raw data that had been only minimally edited for ease of analysis and had not been imputed (see Sections A.3.1 and A.3.2 in this report).

This section summarizes the results for the reliability of selected variables related to substance use and demographic characteristics. Reliability is expressed by estimates of Cohen's kappa (κ) (Cohen, 1960), which can be interpreted according to benchmarks proposed by Landis and Koch (1977, p. 165): (a) *poor* agreement for kappas less than 0.00, (b) *slight* agreement for kappas of 0.00 to 0.20, (c) *fair* agreement for kappas of 0.21 to 0.40, (d) *moderate* agreement for kappas of 0.41 to 0.60, (e) *substantial* agreement for kappas of 0.61 to 0.80, and (f) *almost perfect* agreement for kappas of 0.81 to 1.00.

The kappa values for the lifetime and past year substance use variables (marijuana use, alcohol use, and cigarette use) all showed almost perfect response consistency, ranging from 0.82 for past year marijuana use to 0.93 for lifetime marijuana use and past year cigarette use. The value obtained for the substance dependence or abuse measure in the past year showed substantial agreement (0.67), while the substance abuse treatment variable showed almost perfect consistency in both the lifetime (0.89) and past year (0.87). The variables for age at first use of marijuana and perceived great risk of smoking marijuana once a month showed substantial agreement (0.74 and 0.68, respectively). The demographic variables showed almost perfect agreement, ranging from 0.95 for current enrollment in school to 1.00 for gender. For further

information on the reliability of a wide range of measures contained in NSDUH, see the complete methodology report (Chromy et al., 2010).

B.3.4 Validity of Self-Reported Substance Use

Most substance use prevalence estimates, including those produced for NSDUH, are based on self-reports of use. Although studies generally have supported the validity of self-report data, it is well documented that these data may be biased (underreported or overreported). The bias varies by several factors, including the mode of administration, the setting, the population under investigation, and the type of drug (Aquilino, 1994; Brener et al., 2006; Harrison & Hughes, 1997; Tourangeau & Smith, 1996; Turner, Lessler, & Gfroerer, 1992). NSDUH utilizes widely accepted methodological practices for increasing the accuracy of self-reports, such as encouraging privacy through audio computer-assisted self-interviewing (ACASI) and providing assurances that individual responses will remain confidential. Comparisons using these methods within NSDUH have shown that they reduce reporting bias (Gfroerer, Eyerman, & Chromy, 2002). Various procedures have been used to validate self-report data, such as biological specimens (e.g., urine, hair, saliva), proxy reports (e.g., family member, peer), and repeated measures (e.g., recanting) (Fendrich, Johnson, Sudman, Wislar, & Spiehler, 1999). However, these procedures often are impractical or too costly for general population epidemiological studies (SRNT Subcommittee on Biochemical Verification, 2002).

A study cosponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute on Drug Abuse (NIDA) examined the validity of NSDUH self-report data on drug use among persons aged 12 to 25. The study found that it is possible to collect urine and hair specimens with a relatively high response rate in a general population survey, and that most youths and young adults reported their recent drug use accurately in self-reports (Harrison, Martin, Enev, & Harrington, 2007). However, there were some reporting differences in either direction, with some respondents not reporting use but testing positive, and some reporting use but testing negative. Technical and statistical problems related to the hair tests precluded presenting comparisons of self-reports and hair test results, while small sample sizes for self-reports and positive urine test results for opiates and stimulants precluded drawing conclusions about the validity of self-reports of these drugs. Further, inexactness in the window of detection for drugs in biological specimens and biological factors affecting the window of detection could account for some inconsistency between self-reports and urine test results.

B.3.5 Revised Estimates for 2006 to 2010

During regular data collection and processing checks for the 2011 NSDUH, data errors were identified. These errors resulted from fraudulent cases submitted by field interviewers and affected the data for Pennsylvania (2006 to 2010) and Maryland (2008 and 2009). Although all fraudulent interview cases were removed from the data files, the affected screening cases were not removed because they were part of the assigned sample. Instead, these screening cases were assigned a final screening code of 39 ("Fraudulent Case") and treated as incomplete with unknown eligibility. The screening eligibility status for these cases then was imputed. Those cases that were imputed to be eligible were treated as unit nonrespondents for weighting purposes; however, these cases were not treated differently from other unit nonrespondents in the weighting process (see Section A.3.3 in Appendix A). In Table B.3, cases that were imputed to

be eligible are classified with a final code of 39 ("Fraudulent Case"). The cases that were imputed to be ineligible did not contribute to the weights and are reported as "Other, Ineligible" in Table B.3. Because all of these cases were treated either as ineligible or as unit nonrespondents at the screening level, they were excluded from the interview data in Table B.4. However, some estimates for 2006 to 2010 in the 2011 national findings report and the 2011 detailed tables, as well as other new reports, may differ from corresponding estimates found in some previous reports or tables.

These errors had minimal impact on the national estimates and no effect on direct estimates for the other 48 States and the District of Columbia. In reports where model-based small area estimation techniques are used, estimates for all States may be affected, even though the errors were concentrated in only two States. In reports that do not use model-based estimates, the only estimates appreciably affected are estimates for Pennsylvania, Maryland, the mid-Atlantic division, and the Northeast region.

The 2011 national findings report and detailed tables do not include State-level or model-based estimates. However, they do include estimates for the mid-Atlantic division and the Northeast region. Single-year estimates based on 2006 to 2010 data and pooled 2008 and 2009 data may differ from previously published estimates. Tables and estimates based only on 2011 data are unaffected by these data errors.

Caution is advised when comparing data from older reports with data from more recent reports that are based on corrected data files. As discussed above, comparisons of estimates for Pennsylvania, Maryland, the mid-Atlantic division, and the Northeast region are of most concern, while comparisons of national data or data for other States and regions are essentially still valid. CBHSQ within SAMHSA is producing a selected set of corrected versions of reports and tables. In particular, CBHSQ has released a set of modified detailed tables that include revised 2006 to 2010 estimates for the mid-Atlantic division and the Northeast region for certain key measures. CBHSQ does not recommend making comparisons between unrevised 2006 to 2010 estimates and estimates based on 2011 data for the geographic areas of greatest concern.

B.4 Measurement Issues

B.4.1 Incidence

In epidemiological studies, incidence is defined as the number of new cases of a disease occurring within a specific period of time. Similarly, in substance use studies, incidence refers to the first use of a particular substance.

In the 2004 NSDUH national findings report (Office of Applied Studies [OAS], 2005), a new measure related to incidence was introduced and since then has become the primary focus of Chapter 5 in this national findings report series. The incidence measure is termed as "past year initiation" and refers to respondents whose date of first use of a substance was within the 12 months prior to their interview date. This measure is determined by self-reported past year use, age at first use, year and month of recent new use, and the interview date.

Since 1999, the survey questionnaire has allowed for collection of year and month of first use for recent initiates (i.e., persons who used a particular substance for the first time in a given survey year). Month, day, and year of birth also are obtained directly or are imputed for item nonrespondents as part of the data postprocessing. Additionally, the computer-assisted interviewing (CAI) instrument records and provides the date of the interview. By imputing a day of first use within the year and month of first use, a specific date of first use, $t_{fu,d,i}$, can be used for estimation purposes.

Past year initiation among persons using a substance in the past year can be viewed as an indicator variable defined as follows:

$$I_{(Past\ Year\ Initiate)}(i) = \begin{cases} 1 & \text{if } (DOI_i MOI_i YOI_i - t_{fu,d,i}) \leq 365 \\ 0 & \text{otherwise} \end{cases},$$

where DOI_i, MOI_i, and YOI_i denote the day, month, and year of the interview, respectively, and $t_{fu,d,i}$ denotes the date of first use.

The calculation of this estimate does not take into account whether a respondent initiated substance use while a resident of the United States. This method of calculation has little effect on past year estimates and allows for direct comparability with other standard measures of substance use because the populations of interest for the measures will be the same (i.e., both measures examine all possible respondents and are not restricted to those initiating substance use only in the United States).

One important note for incidence estimates is the relationship between main categories and subcategories of substances (e.g., illicit drugs would be a main category, and inhalants and marijuana would be subcategories in relation to illicit drugs). For most measures of substance use, any member of a subcategory is by necessity a member of the main category (e.g., if a respondent is a past month user of a particular drug, then he or she is also a past month user of illicit drugs in general). However, this is not the case with regard to incidence statistics. Because an individual can only be an initiate of a particular substance category (main or sub) a single time, a respondent with lifetime use of multiple substances may not, by necessity, be included as a past year initiate of a main category, even if he or she were a past year initiate for a particular subcategory because his or her first initiation of other substances within the main category could have occurred earlier.

In addition to estimates of the number of persons initiating use of a substance in the past year, estimates of the mean age of past year initiates of these substances are computed. Unless specified otherwise, estimates of the mean age at initiation in the past 12 months have been restricted to persons aged 12 to 49 so that the mean age estimates reported are not influenced by those few respondents who were past year initiates and were aged 50 or older. As a measure of central tendency, means are influenced heavily by the presence of extreme values in the data, and this constraint should increase the utility of these results to health researchers and analysts by providing a better picture of the substance use initiation behaviors among the civilian, noninstitutionalized population in the United States. This constraint was applied only to

estimates of mean age at first use and does not affect estimates of the numbers of new users or the incidence rates.

Although past year initiates aged 26 to 49 are assumed not to be as likely as past year initiates aged 50 or older to influence mean ages at first use, caution still is advised in interpreting trends in these means. For example, the estimate of 49,000 persons aged 26 to 49 who were past year initiates of marijuana in 2009 was significantly different from the estimate of 138,000 past year initiates in this age group in 2011 (Table B.6). However, the estimate of 210,000 past year marijuana initiates aged 26 to 49 in 2010 was not significantly different from the number in 2011. In addition, the mean age at first use of marijuana among past year marijuana initiates aged 26 to 49 was higher in 2010 than in 2011, but the mean ages at first use among past year initiates in this age group were similar between 2011 and other years (Table B.7).

Because NSDUH is a survey of persons aged 12 years old or older at the time of the interview, younger individuals in the sample dwelling units are not eligible for selection into the NSDUH sample. Some of these younger persons may have initiated substance use during the past year. As a result, past year initiate estimates suffer from undercoverage if a reader assumes that these estimates reflect all initial users instead of only for those above the age of 11. For earlier years, data can be obtained retrospectively based on the age at and date of first use. As an example, persons who were 12 years old on the date of their interview in the 2011 survey may report having initiated use of cigarettes between 1 and 2 years ago; these persons would have been past year initiates reported in the 2010 survey had persons who were 11 years old on the date of the 2010 interview been allowed to participate in the survey. Similarly, estimates of past year use by younger persons (age 10 or younger) can be derived from the current survey, but they apply to initiation in prior years and not the survey year.

To get an impression of the potential undercoverage in the current year, reports of substance use initiation reported by persons aged 12 or older were estimated for the years in which these persons would have been 1 to 11 years younger. These estimates do not necessarily reflect behavior by persons 1 to 11 years younger in the current survey. Instead, the data for the 11 year olds reflect initiation in the year prior to the current survey, the data for the 10 year olds reflect behavior between the 12th and 23rd months prior to this year's survey, and so on. A very rough way to adjust for the difference in the years that the estimate pertains to without considering changes in the population is to apply an adjustment factor to each age-based estimate of past year initiates. This adjustment factor can be based on a ratio of lifetime users aged 12 to 17 in the current survey year to the same estimate for the prior applicable survey year. To illustrate the calculation, consider past year use of alcohol. In the 2011 survey, 75,681 persons 12 years old were estimated to have initiated use of alcohol between 1 and 2 years earlier. These persons would have been past year initiates in the 2010 survey conducted on the same dates had the 2010 survey covered younger persons. The estimated number of lifetime users currently aged 12 to 17 was 8,610,370 for 2011 and 8,621,883 for 2010, indicating fewer overall initiates of alcohol use among persons aged 17 or younger in 2011. Thus, an adjusted estimate of initiation of alcohol use by persons who were 11 years old in 2011 is given by

$$(Estimated\ Past\ Year\ Initiates\ Aged\ 11)_{2010} \times \frac{(Estimated\ Lifetime\ Users\ Aged\ 12\ to\ 17)_{2011}}{(Estimated\ Lifetime\ Users\ Aged\ 12\ to\ 17)_{2010}} .$$

This yielded an adjusted estimate of 75,580 persons 11 years old on a 2011 survey date and initiating use of alcohol in the past year:

$$75,681 \times \frac{8,610,370}{8,621,883} = 75,580 .$$

A similar procedure was used to adjust the estimated number of past year initiates among persons who would have been 10 years old on the date of the interview in 2009 and for younger persons in earlier years. The overall adjusted estimate for past year initiates of alcohol use by persons 11 years of age or younger on the date of the interview was 163,428, or about 3.5 percent of the estimate based on past year initiation by persons 12 or older only (163,428 ÷ 4,699,084 = 0.0348). Based on similar analyses, the estimated undercoverage of past year initiates was 3.1 percent for cigarettes, 0.7 percent for marijuana, and 17.0 percent for inhalants.

The undercoverage of past year initiates aged 11 or younger also affects the mean age at first use estimate. An adjusted estimate of the mean age at first use was calculated using a weighted estimate of the mean age at first use based on the current survey and the numbers of persons aged 11 or younger in the past year obtained in the aforementioned analysis for estimating undercoverage of past year initiates. Analysis results showed that the mean age at first use was changed from 17.1 to 16.8 for alcohol, from 17.2 to 16.9 for cigarettes, from 17.5 to 17.4 for marijuana, and from 16.4 to 15.1 for inhalants. The decreases reported above are comparable with results generated in prior survey years.

B.4.2 Illicit Drug and Alcohol Dependence and Abuse

The 2011 NSDUH CAI instrumentation included questions that were designed to measure alcohol and illicit drug dependence and abuse. For these substances,[14] dependence and abuse questions were based on the criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV) (American Psychiatric Association [APA], 1994). Specifically, for marijuana, hallucinogens, inhalants, and tranquilizers, a respondent was defined as having dependence if he or she met three or more of the following six dependence criteria:

1. Spent a great deal of time over a period of a month getting, using, or getting over the effects of the substance.

2. Used the substance more often than intended or was unable to keep set limits on the substance use.

3. Needed to use the substance more than before to get desired effects or noticed that the same amount of substance use had less effect than before.

[14] Substances include alcohol, marijuana, cocaine, heroin, hallucinogens, inhalants, pain relievers, tranquilizers, stimulants, and sedatives.

4. Inability to cut down or stop using the substance every time tried or wanted to.

5. Continued to use the substance even though it was causing problems with emotions, nerves, mental health, or physical problems.

6. The substance use reduced or eliminated involvement or participation in important activities.

For alcohol, cocaine, heroin, pain relievers, sedatives, and stimulants, a seventh withdrawal criterion was added. A respondent was defined as having dependence if he or she met three or more of seven dependence criteria. The seventh withdrawal criterion is defined by a respondent reporting having experienced a certain number of withdrawal symptoms that vary by substance (e.g., having trouble sleeping, cramps, hands tremble).

For each illicit drug and alcohol, a respondent was defined as having abused that substance if he or she met one or more of the following four abuse criteria and was determined not to be dependent on the respective substance in the past year:

1. Serious problems at home, work, or school caused by the substance, such as neglecting your children, missing work or school, doing a poor job at work or school, or losing a job or dropping out of school.

2. Used the substance regularly and then did something that might have put you in physical danger.

3. Use of the substance caused you to do things that repeatedly got you in trouble with the law.

4. Had problems with family or friends that were probably caused by using the substance and continued to use the substance even though you thought the substance use caused these problems.

Criteria used to determine whether a respondent was asked the dependence and abuse questions during the interview included responses from the core substance use questions and the frequency of substance use questions, as well as the noncore substance use questions. Missing or incomplete responses in the core substance use and frequency of substance use questions were imputed. However, the imputation process did not take into account reported data in the noncore (i.e., substance dependence and abuse) CAI modules. Very infrequently, this may result in responses to the dependence and abuse questions that were inconsistent with the imputed substance use or frequency of substance use.

For alcohol and marijuana, respondents were asked the dependence and abuse questions if they reported substance use on more than 5 days in the past year, or if they reported any substance use in the past year but did not report their frequency of past year use. Therefore, inconsistencies could have occurred where the imputed frequency of use response indicated less frequent use than required for respondents to be asked the dependence and abuse questions originally. For alcohol, for example, about 42,000 respondents were past year alcohol users in 2011. Of these, fewer than 100 respondents (about 0.2 percent) were asked the alcohol dependence and abuse questions, but their final imputed frequency of use indicated that they used alcohol on 5 or fewer days in the past year.

For cocaine, heroin, and stimulants, respondents were asked the dependence and abuse questions if they reported past year use in a core drug module or past year use in the noncore special drugs module. Thus, the CAI logic allowed some respondents to be asked the dependence and abuse questions for these drugs even if they did not report past year use in the corresponding core module. For cocaine, for example, more than 1,500 respondents in 2011 were asked the questions about cocaine dependence and abuse because they reported past year use of cocaine or crack in the core section of the interview. Fewer than 10 additional respondents were asked these questions because they reported past year use of cocaine with a needle in the special drugs module despite not having previously reported past year use of cocaine or crack.

In 2005, two new questions were added to the noncore special drugs module about past year methamphetamine use: "Have you ever, even once, used methamphetamine?" and "Have you ever, even once, used a needle to inject methamphetamine?" In 2006, an additional follow-up question was added to the noncore special drugs module confirming prior responses about methamphetamine use: "Earlier, the computer recorded that you have never used methamphetamine. Which answer is correct?" The responses to these new questions were used in the skip logic for the stimulant dependence and abuse questions. Based on the decisions made during the methamphetamine analysis,[15] respondents who indicated past year methamphetamine use solely from these new special drug use questions (i.e., did not indicate methamphetamine use from the core drug module or other questions in the special drugs module) were categorized as NOT having past year stimulant dependence or abuse regardless of how they answered the dependence and abuse questions. Furthermore, if these same respondents were categorized as not having past year dependence or abuse of any other substance (e.g., pain relievers, tranquilizers, or sedatives for the psychotherapeutic drug grouping), then they were categorized as NOT having past year dependence or abuse of psychotherapeutics, illicit drugs, illicit drugs or alcohol, and illicit drugs and alcohol.

In 2008, questionnaire logic for determining hallucinogen, stimulant, and sedative dependence or abuse was modified. The revised skip logic used information collected in the noncore special drugs module in addition to that collected in questions from the core drug modules. Respondents were asked about hallucinogen dependence and abuse if they additionally reported in the special drugs module using Ketamine, DMT, AMT, Foxy, or *Salvia divinorum*; stimulant dependence and abuse if they reported additionally using Adderall®; and sedative dependence and abuse if they reported additionally using Ambien®. Complying with the previous decision to exclude respondents whose methamphetamine use was based solely on responses in a noncore module from being classified as having stimulant dependence or abuse, respondents who indicated past year hallucinogen, stimulant, or sedative use based solely on these special drug questions were categorized as NOT having past year dependence or abuse of the relevant substance regardless of how they answered the dependence and abuse questions.

Respondents might have provided ambiguous information about past year use of any individual substance, in which case these respondents were not asked the dependence and abuse questions for that substance. Subsequently, these respondents could have been imputed to be past year users of the respective substance. In this situation, the dependence and abuse data were

[15] See Section B.4.8 in the *Results from the 2008 National Survey on Drug Use and Health: National Findings* (OAS, 2009) for the methamphetamine analysis decisions.

unknown; thus, these respondents were classified as not having dependence or abuse of the respective substance. However, such a respondent never actually was asked the dependence and abuse questions.

B.4.3 Impact of Decennial Census Effects on NSDUH Substance Use Estimates

As discussed in Section A.3.3 in Appendix A, the person-level weights in NSDUH were calibrated to population estimates (or control totals) obtained from the U.S. Census Bureau. For the weights in 2002 through 2010, annually updated control totals based on the 2000 census were used. Beginning with the 2011 weights, however, the control totals from the Census Bureau were based on the 2010 census. As a result, there was a possibility that the change from the 2000 to the 2010 census as the basis for updating NSDUH control totals could result in demographic and geographic shifts in the U.S. population that were not accounted for in population estimates that were made during the period between the censuses (i.e., in the annually updated 2000 census-based control totals provided by the Census Bureau for the years 2002 to 2010). This is because for the years between each decennial census, the Census Bureau produces annual national-level postcensal population estimates, based on the most recent census data, applying adjustments to account for births to U.S.-resident women, deaths of U.S. residents, and net international migration.[16] With this estimation method, the postcensal estimates made for the years immediately following a census are likely to be the most accurate (e.g., 2002 postcensal estimates are expected to be more accurate than 2009 postcensal estimates). Therefore, the population control totals for 2010 based on the 2010 census, provided specifically for this study by the Census Bureau to SAMHSA, would presumably represent the characteristics of the population more accurately than the projections for 2010 that were based on the 2000 census. For NSDUH estimation purposes, the first set of control totals that incorporated data from the 2010 census for the regular NSDUH weighting processes was the 2011 control totals.

Table B.8 shows the estimated numbers of persons for the civilian, noninstitutionalized population aged 12 or older in 2010 based on both the 2000 census and the 2010 census. Overall, the estimated numbers for the 2010 population based on the 2000 census were similar to the 2010 census-based population characteristics, with a difference of less than 1 percent (0.7 percent). Larger differences were observed in several domains for race (e.g., American Indians or Alaska Natives, Native Hawaiians or Other Pacific Islanders, and persons reporting two or more races).[17]

Methods for Assessing Census Effects on Substance Use Estimates. For the 9-month period from April through December 2010, the Census Bureau produced control totals based on both the 2000 and 2010 censuses. To assess the decennial census effect on NSDUH estimates of substance use, the person-level poststratification adjustment also was done for the 2010 NSDUH respondents using the 2010 census-based control totals, leading to the creation of a second set of analysis weights for 2010. In order for analysis weights to be produced that reflect the entire year, the population estimates for the first quarter of 2010 were projected, and the annualized numbers were used in the poststratification adjustment. Therefore, there now were two sets of

[16] For details on how the Census Bureau creates the postcensal estimates, see http://www.census.gov/popest/methodology/2011-nat-st-co-meth.pdf.

[17] Unlike racial/ethnic groups discussed elsewhere in this report, race domains in this section include Hispanics in addition to persons who were not Hispanic.

weights for 2010: one based on the 2000 census and one based on the 2010 census. This evaluation was based on the premise that any difference between estimates based on these two weights could solely be attributed to the "census effect" because the underlying data were the same.

Estimates from 44 selected substance use tables that included estimated numbers, percentages, and mean ages at initiation were used to examine the effects on estimates in 2010 when weights were based on the 2010 census control totals compared with when weights were based on the 2000 census control totals. These tables are available at http://www.samhsa.gov/data/NSDUH/NSDUHCensusEffects/Index.aspx.[18]

In these tables, estimates for *2011* used weights that were poststratified to 2011 control totals based on the 2010 census. The following terms also were defined in the tables for estimates in 2010:

- *2010 (Old)*: estimates for 2010 with weights poststratified to 2010 control totals based on the 2000 census; and

- *2010 (New)*: estimates for 2010 with weights poststratified to 2010 control totals based on the 2010 census.

The estimates referred to as "2010 (Old)" represent the official NSDUH estimates for 2010.[19]

To assess the census effect, significance testing was conducted between 2011 and 2010 (Old) and between 2011 and 2010 (New). This evaluation examined whether differences between estimates for 2011 and those in 2010 would be significant (or not significant) depending on whether the estimates for 2010 were based on the control totals from the 2000 census or the 2010 census. Ideally, the change in control totals would not affect whether differences between 2010 and 2011 were statistically significant.

Results. Comparisons of the results of the significance tests between estimates for 2011 and corresponding estimates for 2010 that were based on population control totals from the 2010 census agreed over 94 percent of the time with results of comparisons between the 2011 estimates and those for 2010 that were based on population control totals from the 2000 census. In general, use of 2010 census control totals for the 2010 estimates had more of an impact on the estimated numbers of substance users than on the percentages. Estimates of the numbers of substance users were notably affected for American Indians or Alaska Natives and persons reporting two or more races. This impact of the 2010 census-based control totals on these subgroups is consistent with the data from Table B.8 indicating that these were the subgroups that saw the largest shifts in population totals. Hence, some caution is needed for interpreting differences between 2011 and NSDUH estimates for 2010 that are presented in this report and in

[18] Additional tables for perceived risk associated with substance use, need for and receipt of treatment, and driving under the influence of alcohol or other drugs also are available at http://www.samhsa.gov/data/NSDUH/NSDUHCensusEffects/Index.aspx, but they are not discussed in this section.

[19] Some 2010 (Old) estimates may differ from previously published estimates due to updates (see Section B.3).

the 2011 detailed tables, especially for estimated numbers of users, including those in the two racial/ethnic groups mentioned previously.

Table B.9 summarizes the results of 1,002 tests of statistical significance at the .05 level of significance across the 44 tables of estimates mentioned previously. Table B.9 does not include the results of 26 tests in which some estimates were suppressed because of low precision (see Section B.2.2). As noted previously, most of the differences between estimates for 2011 and 2010 (Old) and between estimates for 2011 and 2010 (New) were in agreement (947 tests or 94.5 percent of all tests); that is, statistical tests of the difference between 2011 and 2010 (Old) and tests of the difference between 2011 and 2010 (New) both were significant, or both were not significant at .05 level. There were no situations identified in which results of comparisons of mean ages at first use between 2011 and 2010 disagreed according to whether 2010 (Old) or 2010 (New) estimates were used among the 66 tests for this measure.

For 49 tests (4.9 percent), the difference between 2011 and 2010 (Old) was significant, but the difference between 2011 and 2010 (New) was not. Among these 49 tests, the majority (i.e., 30) involved situations in which the estimated number of users was significantly different between 2011 and the 2010 (Old) estimates, but the difference for 2011 versus 2010 (New) was not significant. For the remaining 19 situations, the disagreement involved estimated percentages who were users.

Of the 30 tests in which the estimated number of users was significantly different between 2011 and the 2010 (Old) estimates but the difference for 2011 versus 2010 (New) was not, 19 (or over half) were from the race/ethnicity domain. In particular, seven of these were for the estimated numbers of users among persons reporting two or more races.[20] For example, there was a statistically significant 35 percent increase in the estimated number of past month illicit drug users reporting two or more races when the estimate for 2011 was compared with 2010 (Old). When this estimate for 2011 was compared with the corresponding estimate for 2010 (New), however, the number changed by less than 7 percent, and the difference was not statistically significant. This effect was observed for the estimated numbers of past month illicit drug users, but not for the percentages of past month drug users reporting two or more races; differences in the percentages were not significant between 2011 and 2010 (Old) or between 2011 and 2010 (New). Similar results were observed for past month use of cigarettes and alcohol for this subgroup. In addition, the estimated number of past month alcohol users who were American Indians or Alaska Natives increased by 45 percent from 2010 to 2011 based on the 2010 (Old) estimate, but did not differ significantly between 2010 and 2011 based on the 2010 (New) estimate; differences in the percentages were not significant between 2011 and 2010 (Old) or between 2011 and 2010 (New).

Among the 19 tests in which the percentages differed between 2011 and 2010 (Old) but the percentages between 2011 and 2010 (New) were not significantly different, 7 tests also came from the race/ethnicity domain. The domains primarily affected by the change in population data from the 2000 to the 2010 censuses appear to be persons reporting two or more races and persons who were American Indians or Alaska Natives.

[20] See Tables 1.5A, 1.7A, 1.8A, and 1.11A at http://www.samhsa.gov/data/NSDUH/NSDUHCensusEffects/Index.aspx.

For six tests (all involving estimated numbers of users), the difference between 2011 and 2010 (Old) was not significant, but the difference would have been significant if the 2010 (New) estimate had been reported for 2010. Of these six tests, five involved age groups, including four that affected the numbers of youths aged 12 to 17 who were estimated to be lifetime users of cigarettes or inhalants, nonmedical users of pain relievers, or users of illicit drugs other than marijuana.[21] There were no tests involving percentages where the difference between 2011 and 2010 (Old) was not significant, but the difference would have been significant if the 2010 (New) estimate had been reported for 2010.

Table B.10 shows comparisons of tests of significance in the differences between 2011 and 2010 (New) and between 2011 and 2010 (Old). These comparisons take into account the direction of the difference between 2011 and 2010: (a) the 2011 estimate decreased from the 2010 estimate; (b) there was no difference between 2011 and 2010; and (c) the 2011 estimate increased from the 2010 estimate. The majority of the off-diagonal elements (i.e., where there was disagreement between the two differences) occurred in situations where there was a decrease in prevalence from 2010 to 2011 based on the 2010 (Old) estimate, but there was no difference between 2010 and 2011 based on 2010 (New) estimate (32 tests). There were 17 tests where there was a reported increase between 2010 and 2011 based on the 2010 (Old) estimate, but the difference would not have been significant if the weights for the 2010 estimate had been based on control totals from the 2010 census.

For the 2010 estimates, about 70 percent of the 2010 (New) estimates were lower than the 2010 (Old) estimates in the 44 tables that were examined. As shown in Table B.8, more persons in 2010 were estimated to be aged 12 to 17, female, and Hispanic, and fewer persons were estimated to be white based on the 2010 census control totals than on the 2000 census projections. As noted elsewhere in this report, substance use prevalence rates in 2011 were lower among youths aged 12 to 17 than among young adults aged 18 to 25 and were lower among females than males. In addition, whites in 2011 were more likely than persons in other racial/ethnic groups to be current alcohol users. Among youths and young adults in 2011, current cigarette smoking was more prevalent among whites than blacks. Consequently, population shifts between 2000 and 2010 that led to an increase in the population for demographic groups that are less likely to be substance users could affect substance use estimates according to the census on which the population control totals for analysis weights were based.

Conclusions. Due to changes in population sizes with the 2011 data based on the 2010 census control totals, especially for particular subgroups (e.g., persons reporting two or more races), caution is advised when comparing differences in estimated numbers between 2011 and prior years. Although the impact of the population changes is smaller for estimated percentages than for numbers of persons, some caution also is advised when comparing percentages between 2011 and prior years. There were only 19 instances where the difference between 2011 and 2010 (Old) percentages was significant but the difference between 2011 and 2010 (New) was not significantly different. However, the general result is that the 2010 (New) percentages for most estimates are lower than the 2010 (Old) estimates. The implication is that the *2011* estimates (percentages) may have been higher if weights based on the *2000* census had been used. As a result, downward trends involving 2011 data may be slightly overstated, and upward trends may

[21] See Tables 1.2A and 1.7A at http://www.samhsa.gov/data/NSDUH/NSDUHCensusEffects/Index.aspx.

be slightly understated. Therefore, if affected 2011 data show an upward trend, then in most cases, confidence can be placed in that trend. If the 2011 data show a decreasing trend, then less confidence can be placed in it. There are a few exceptions (e.g., for 12 to 17 year olds) that are discussed below.

However, as discussed earlier, the postcensal population estimates that define the control totals are not without error, and the effect on NSDUH estimates and trends due to the change from 2000-based to 2010-based control totals would be greatest for 2010 NSDUH estimates and for estimates for years closest to 2010. Conversely, the effect would be expected to be lowest for NSDUH estimates in years farthest from 2010 (e.g., 2002). As stated previously, less confidence might be placed in downward trends in some rates following the change to 2010 census-based control totals in 2011 because the new control totals tended to reduce those rates. Conversely, less confidence should also be placed on results showing increases in the numbers of substance users because the new control totals generally reflect a population increase. Nevertheless, given that the census effect would be greatest for 2010 estimates, findings of similar differences between 2011 and 2010 (regardless of whether 2010 estimates were based on 2000 or 2010 census control totals) can provide another indicator of the basic validity of the trend data.

Estimates for 12 to 17 and 12 to 20 Year Olds

For youths aged 12 to 17, the estimated numbers of lifetime and past month illicit drug, alcohol, and cigarette users showed results counter to those for the overall population aged 12 or older. Altogether, there were four comparisons for youths[22] where the 2010 (New) and 2011 estimates were significantly different, but the 2010 (Old) and 2011 estimates were not. In addition, for all lifetime and most past month numbers of users, the 2010 (New) estimate was larger than the 2010 (Old) estimate. This would suggest that some trends in the estimated numbers of illicit drug, cigarette, and alcohol users for 12 to 17 year olds between previous years and 2011 may overstate increases and understate decreases. Therefore, if the estimated numbers of illicit drug, cigarette, and alcohol users in 2011 showed a downward trend, then confidence can be placed in these trends in most instances. However, if the numbers of illicit drug, cigarette, and alcohol users in 2011 showed an increasing trend, then less confidence can be placed in the trend. Rates of lifetime and past month use of illicit drugs and cigarettes for 12 to 17 year olds appeared to be unaffected by the use of 2010 census-based control totals. [23]

However, for overall and subgroup estimates of underage drinking among persons aged 12 to 20 (i.e., past month alcohol use, binge alcohol use, and heavy alcohol use) the 2010 (New) estimates tended to be lower than the 2010 (Old) estimates.[24] In some situations, this resulted in the 2010 (Old) and 2011 estimates being significantly different, but the 2010 (New) and 2011 estimates were not. Therefore, the use of 2010 census-based control totals in 2011 may overstate some decreases in underage drinking between previous years and 2011.

[22] See Tables 1.2A and 1.7A at http://www.samhsa.gov/data/NSDUH/NSDUHCensusEffects/Index.aspx.
[23] See Tables 1.2B and 1.7B at http://www.samhsa.gov/data/NSDUH/NSDUHCensusEffects/Index.aspx.
[24] See Tables 1.11B, 1.12B, and 1.13B at http://www.samhsa.gov/data/NSDUH/NSDUHCensusEffects/Index.aspx.

Estimates for 18 to 25 Year Olds

Overall rates of use of illicit drugs, cigarettes, and alcohol for young adults aged 18 to 25 appeared to be affected by the changes in weights.[25] Most 2010 (New) estimates for the rates of use of different types of drugs, cigarettes, or alcohol were slightly lower than (but still significantly different from) the 2010 (Old) estimates. Again, this would imply that caution should be applied when interpreting some differences in illicit drug, alcohol, and cigarette use estimates between 2011 and previous years because of the risk of overstating decreases and understating increases in 2011. Despite these caveats, the comparisons just between 2010 and 2011 appear to be valid for estimates of past month use among young adults because there were no situations where the use the 2010 (Old) and 2010 (New) data affected whether the difference between the 2010 and 2011 estimates was statistically significant.

Estimates for Persons Aged 26 or Older

Similar to the data for 18 to 25 year olds, the overall rates of illicit drug, cigarette, and alcohol use for persons aged 26 or older appeared to be affected by the use of 2010 census-based control totals.[26] Because the 2010 (New) estimates were likely to be lower than the 2010 (Old) estimates, the concern remains of overstating decreases and understating increases between 2011 and previous years. Despite these caveats, the comparisons of past month use just between 2010 and 2011 appeared to be valid for percentages among adults aged 26 or older because there were no situations in which using the 2010 (Old) or 2010 (New) estimates affected whether the difference between 2010 and 2011 was statistically significant.

Alcohol Use Estimates for Persons Aged 21 or Older

The overall rates of past month alcohol use, binge alcohol use, and heavy alcohol use among persons aged 21 or older were lower for the 2010 (New) estimates than for the 2010 (Old) estimates.[27] Subgroup differences based on gender and race/ethnicity were inconsistent, with some (but not all) showing significant differences between 2010 (Old) and 2010 (New) estimates. Therefore, comparisons of alcohol use by adults of legal drinking age by gender and race/ethnicity over time also should be made cautiously. Despite these caveats, the comparisons just between 2010 and 2011 appeared to be valid for estimated percentages of past month alcohol use, binge alcohol use, and heavy alcohol use among persons aged 21 or older because there was only one situation in which use of the 2010 (Old) or 2010 (New) data affected whether the difference between the 2010 and 2011 estimates was statistically significant.

Initiation Data

Of the 66 comparisons for the numbers of past year initiates that compared 2010 (Old) or 2010 (New) estimates with 2011 estimates overall and by drug and gender, only one comparison

[25] See Tables 1.3B, 1.7B, and 1.8B at http://www.samhsa.gov/data/NSDUH/NSDUHCensusEffects/Index.aspx.

[26] See Tables 1.4B, 1.7B, and 1.8B at http://www.samhsa.gov/data/NSDUH/NSDUHCensusEffects/Index.aspx.

[27] See Tables 1.14B, 1.15B, and 1.16B at http://www.samhsa.gov/data/NSDUH/NSDUHCensusEffects/Index.aspx.

was affected by whether the 2010 (Old) or 2010 (New) estimate was used.[28] This suggests that comparisons of initiation data by drug and gender are essentially valid between 2010 and 2011. There were statistically significant differences between the 2010 (Old) and 2010 (New) estimates, but these differences were not in any consistent direction. This suggests that for interpretation of initiation trends—especially for 2010 and years closest to 2010—the potential census effect for each drug should be considered separately.

Of the 66 comparisons that compared 2010 (Old) or 2010 (New) estimates of the mean age at first use with 2011 estimates overall and by drug and gender, none of the comparisons were affected by whether the 2010 (Old) or 2010 (New) estimate was used.[29] This suggests that comparisons of mean age at initiation data by drug and gender are valid between 2010 and 2011. However, 2010 (Old) mean age at initiation estimates were consistently lower than corresponding 2010 (New) estimates. This suggests that some trend data showing decreases in 2011 may be overstating the decrease in mean initiation age and may be underestimating any increases in mean age at initiation for most drugs.

Subgroup Data

As mentioned earlier in this report, this evaluation also examined the potential for census effects on different subgroups, such as by gender, race/ethnicity, geographic divisions, and county type. As discussed earlier, 7 of the 19 estimates where the percentages differed between 2011 and 2010 (Old) but were not significantly different between 2011 and 2010 (New) were for race/ethnicity. However, there was no single dominant subgroup within these 7 results. Also, even though the race/ethnicity comparisons comprised the largest portion of the 19 that differed according to whether 2011 estimates were compared with 2010 (Old) or 2010 (New), these 7 race/ethnicity comparisons comprised only a very small proportion (5.8 percent) of the total of 121 race/ethnicity comparisons that were performed.

The evaluation presented in this report focused specifically on measures of substance use that are used in the 2011 national findings report and detailed tables. A separate analysis is being conducted to evaluate the impact of the weighting changes on mental health estimates in the 2011 mental health national findings report and associated detailed tables. Details on that evaluation will be available in Appendix B of the 2011 mental health findings report.

In addition to the standard 2010 analysis weights developed for the 2010 public use file, special weights that were poststratified to 2010 control totals will be available on the 2010 NSDUH public use file in late 2012.

[28] See Tables 1.17A, 1.18A, and 1.19A at http://www.samhsa.gov/data/NSDUH/NSDUHCensusEffects/Index.aspx.

[29] See Tables 1.20A, 1.21A, and 1.22A at http://www.samhsa.gov/data/NSDUH/NSDUHCensusEffects/Index.aspx.

Table B.1 Demographic and Geographic Domains Forced to Match Their Respective U.S. Census Bureau Population Estimates through the Weight Calibration Process, 2011

Main Effects	Two-Way Interactions
Age Group 12-17 18-25 26-34 35-49 50-64 65 or Older All Combinations of Groups Listed Above[1]	**Age Group × Gender** (e.g., Males Aged 12 to 17)
Gender Male Female	**Age Group × Hispanic Origin** (e.g., Hispanics or Latinos Aged 18 to 25)
Hispanic Origin Hispanic or Latino Not Hispanic or Latino	**Age Group × Race** (e.g., Whites Aged 26 or Older)
Race[2] White Black or African American	**Age Group × Geographic Region** (e.g., Persons Aged 12 to 25 in the Northeast)
Geographic Region Northeast Midwest South West	**Age Group × Geographic Division** (e.g., Persons Aged 65 or Older in New England)
Geographic Division New England Middle Atlantic East North Central West North Central South Atlantic East South Central West South Central Mountain Pacific	**Gender × Hispanic Origin** (e.g., Not Hispanic or Latino Males) **Hispanic Origin × Race** (e.g., Not Hispanic or Latino Whites)

[1] Combinations of the age groups (including but not limited to 12 or older, 18 or older, 26 or older, 35 or older, and 50 or older) also were forced to match their respective U.S. Census Bureau population estimates through the weight calibration process.

[2] Unlike racial/ethnic groups discussed elsewhere in this report, race domains in this table include Hispanics in addition to persons who were not Hispanic.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011.

Table B.2 Summary of 2011 NSDUH Suppression Rules

Estimate	Suppress if:
Prevalence Rate, $\hat{p}$, with Nominal Sample Size, *n*, and Design Effect, *deff* $\left(deff = \frac{n[\mathrm{SE}(\hat{p})]^2}{\hat{p}(1-\hat{p})} \right)$	(1) The estimated prevalence rate, $\hat{p}$, is < .00005 or ≥ .99995, or (2) $\frac{\mathrm{SE}(\hat{p}) \ / \ \hat{p}}{-\ln(\hat{p})} > .175$ when $\hat{p} \le .5$, or $\frac{\mathrm{SE}(\hat{p}) \ / \ (1-\hat{p})}{-\ln(1-\hat{p})} > .175$ when $\hat{p} > .5$, or (3) *Effective* $n < 68$, where *Effective* $n = \frac{n}{deff} \quad \frac{\hat{p}(1-\hat{p})}{\left[\mathrm{SE}(\hat{p})\right]^2}$, or (4) $n < 100$. Note: The rounding portion of this suppression rule for prevalence rates will produce some estimates that round at one decimal place to 0.0 or 100.0 percent but are not suppressed from the tables.
Estimated Number (Numerator of $\hat{p}$)	The estimated prevalence rate, $\hat{p}$, is suppressed. Note: In some instances when $\hat{p}$ is not suppressed, the estimated number may appear as a 0 in the tables. This means that the estimate is greater than 0 but less than 500 (estimated numbers are shown in thousands).
Mean Age at First Use, $\overline{x}$, with Nominal Sample Size, *n*	(1) $\mathrm{RSE}(\overline{x}) > .5$, or (2) $n < 10$.

deff = design effect; RSE = relative standard error; SE = standard error.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011.

Figure B.1 Required Effective Sample in the 2011 NSDUH as a Function of the Proportion Estimated

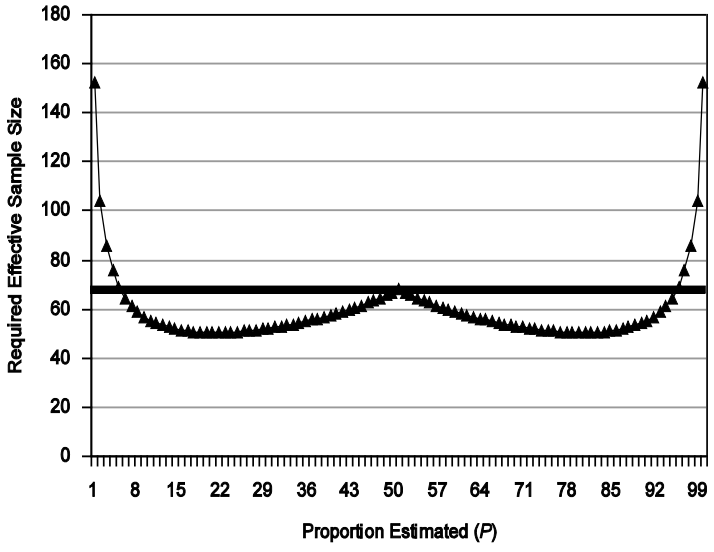


Table B.3 Weighted Percentages and Sample Sizes for 2010 and 2011 NSDUHs, by Final Screening Result Code

Final Screening Result Code	Sample Size 2010	Sample Size 2011	Weighted Percentage 2010	Weighted Percentage 2011
TOTAL SAMPLE	201,865	216,521	100.00	100.00
Ineligible Cases	35,333	37,228	17.20	16.86
Eligible Cases	166,532	179,293	82.80	83.14
INELIGIBLES	35,333	37,228	17.20	16.86
10 - Vacant	19,774	20,585	55.28	54.28
13 - Not a Primary Residence	8,234	8,612	24.20	24.71
18 - Not a Dwelling Unit	2,427	2,730	6.13	6.79
22 - All Military Personnel	323	370	0.88	0.96
Other, Ineligible[1]	4,575	4,931	13.51	13.26
ELIGIBLE CASES	166,532	179,293	82.80	83.14
Screening Complete	147,010	156,048	88.42	86.98
30 - No One Selected	88,085	94,342	52.50	51.82
31 - One Selected	32,322	34,246	19.49	19.37
32 - Two Selected	26,603	27,460	16.43	15.79
Screening Not Complete	19,522	23,245	11.58	13.02
11 - No One Home	3,111	3,124	1.79	1.71
12 - Respondent Unavailable	482	579	0.28	0.32
14 - Physically or Mentally Incompetent	423	513	0.25	0.27
15 - Language Barrier - Hispanic	65	66	0.04	0.04
16 - Language Barrier - Other	504	598	0.33	0.38
17 - Refusal	13,034	15,589	7.82	8.72
21 - Other, Access Denied[2]	1,070	2,080	0.64	1.24
24 - Other, Eligible	16	13	0.01	0.01
27 - Segment Not Accessible	0	0	0.00	0.00
33 - Screener Not Returned	79	87	0.04	0.04
39 - Fraudulent Case	736	595	0.37	0.30
44 - Electronic Screening Problem	2	1	0.00	0.00

NOTE: Some 2010 NSDUH data may differ from previously published data due to updates (see Section B.3 of this report).

[1] Examples of "Other, Ineligible" cases are those in which all residents lived in the dwelling unit for less than half of the calendar quarter and dwelling units that were listed in error.

[2] "Other, Access Denied" includes all dwelling units to which the field interviewer was denied access, including locked or guarded buildings, gated communities, and other controlled access situations.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011.

Table B.4 Weighted Percentages and Sample Sizes for 2010 and 2011 NSDUHs, by Final Interview Code

Final Interview Code	12+ Sample Size 2010	12+ Sample Size 2011	12+ Weighted Percentage 2010	12+ Weighted Percentage 2011	12-17 Sample Size 2010	12-17 Sample Size 2011	12-17 Weighted Percentage 2010	12-17 Weighted Percentage 2011	18+ Sample Size 2010	18+ Sample Size 2011	18+ Weighted Percentage 2010	18+ Weighted Percentage 2011
TOTAL	84,997	88,536	100.00	100.00	25,908	27,911	100.00	100.00	59,089	60,625	100.00	100.00
70 - Interview Complete	67,804	70,109	74.57	74.38	21,992	23,549	84.65	84.95	45,812	46,560	73.49	73.22
71 - No One at Dwelling Unit	1,170	1,159	1.39	1.36	202	227	0.65	0.72	968	932	1.47	1.43
72 - Respondent Unavailable	1,631	1,758	1.94	2.06	313	337	1.22	1.19	1,318	1,421	2.02	2.16
73 - Break-Off	21	31	0.03	0.04	4	6	0.01	0.01	17	25	0.04	0.05
74 - Physically/ Mentally Incompetent	877	1,003	1.81	2.01	210	219	0.95	0.74	667	784	1.91	2.15
75 - Language Barrier - Hispanic	126	114	0.19	0.20	7	7	0.03	0.03	119	107	0.21	0.22
76 - Language Barrier - Other	412	383	1.15	1.12	20	17	0.11	0.08	392	366	1.26	1.24
77 - Refusal	9,922	10,773	17.25	17.25	756	890	2.90	2.81	9,166	9,883	18.79	18.83
78 - Parental Refusal	2,286	2,538	0.87	0.89	2,286	2,538	9.01	9.02	0	0	0.00	0.00
91 - Fraudulent Case	21	29	0.03	0.05	1	7	0.00	0.05	20	22	0.04	0.05
Other[1]	727	639	0.74	0.64	117	114	0.46	0.37	610	525	0.78	0.66

NOTE: Some 2010 NSDUH data may differ from previously published data due to updates (see Section B.3 of this report).

[1] "Other" includes eligible person moved, data not received from field, too dangerous to interview, access to building denied, computer problem, and interviewed wrong household member.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011.

Table B.5 Response Rates and Sample Sizes for 2010 and 2011 NSDUHs, by Demographic Characteristics

Demographic Characteristic	Selected Persons 2010	Selected Persons 2011	Completed Interviews 2010	Completed Interviews 2011	Weighted Response Rate 2010	Weighted Response Rate 2011
TOTAL	84,997	88,536	67,804	70,109	74.57%	74.38%
AGE IN YEARS						
12-17	25,908	27,911	21,992	23,549	84.65%	84.95%
18-25	28,164	28,589	23,026	23,083	81.20%	80.48%
26 or Older	30,925	32,036	22,786	23,477	72.14%	71.96%
GENDER						
Male	41,782	43,436	32,826	33,779	73.11%	72.49%
Female	43,215	45,100	34,978	36,330	75.94%	76.14%
RACE/ETHNICITY						
Hispanic	12,985	13,441	10,699	10,993	78.31%	77.58%
White	55,272	57,389	43,373	44,629	73.52%	73.42%
Black	9,959	10,607	8,475	8,979	80.24%	79.78%
All Other Races	6,781	7,099	5,257	5,508	67.11%	67.74%
REGION						
Northeast	16,782	17,251	13,017	13,090	72.81%	69.86%
Midwest	24,139	24,570	19,301	19,258	74.81%	73.92%
South	25,597	28,122	20,769	22,980	76.24%	76.88%
West	18,479	18,593	14,717	14,781	73.17%	74.41%
COUNTY TYPE						
Large Metropolitan	38,139	38,889	29,828	30,113	73.33%	72.75%
Small Metropolitan	29,570	31,671	23,840	25,457	75.73%	75.84%
Nonmetropolitan	17,288	17,976	14,136	14,539	76.56%	76.98%

NOTE: Estimates are based on demographic information obtained from screener data and are not consistent with estimates on demographic characteristics presented in the 2010 and 2011 sets of detailed tables. Some 2010 NSDUH data may differ from previously published data due to updates (see Section B.3 of this report).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011.

Table B.6 Past Year Initiates of Marijuana and Any Illicit Drug among Persons Aged 26 or Older or Aged 26 to 49: Numbers in Thousands, 2002-2011

Drug/Age Group	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Marijuana, Aged 26 or Older	90	88	176	252	126	134	159	49[b]	247	182
Marijuana, Aged 26 to 49	90	56[a]	127	122	126	121	155	49[a]	210	138
Any Illicit Drug, Aged 26 or Older	268	324	479	579	415	326	419	433	457	368
Any Illicit Drug, Aged 26 to 49	251	209	333	379	405	250	350	205	366	270

* Low precision; no estimate reported.

[a] Difference between estimate and 2011 estimate is statistically significant at the .05 level.

[b] Difference between estimate and 2011 estimate is statistically significant at the .01 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2011.

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Table B.7 Mean Age at First Use of Marijuana and Any Illicit Drug among Past Year Initiates Aged 26 to 49, 2002-2011

Drug	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Marijuana	31.2	29.6	29.5	30.4	29.1	32.4	32.6	32.2	36.3[a]	29.5
Any Illicit Drug	34.8	32.8	31.6	34.0	33.9	32.9	35.1	31.7	37.2	33.0

* Low precision; no estimate reported.

[a] Difference between estimate and 2011 estimate is statistically significant at the .05 level.

[b] Difference between estimate and 2011 estimate is statistically significant at the .01 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2011.

Table B.8 Differences between the 2010 Civilian, Noninstitutionalized Population Counts Based on the 2000 and the 2010 Census, for Age, Gender, Hispanic Origin, and Race

Domains	2010 Population Based on 2000 Census	2010 Population Based on 2010 Census	Difference in 2010 Population Based on 2010 Census versus 2000 Census[1]	Percent Difference Relative to 2010 Population Based on 2000 Census[2]
TOTAL	253,619,107	255,331,811	1,712,704	0.68%
12 to 17	24,346,528	25,156,348	809,820	3.33%
18 to 25	34,072,349	34,010,012	-62,338	-0.18%
26 to 34	36,523,574	35,840,157	-683,416	-1.87%
35 to 49	62,042,733	62,422,429	379,696	0.61%
50-64	57,695,892	58,701,774	1,005,882	1.74%
65 or Older	38,938,030	39,201,090	263,060	0.68%
Male	123,430,407	123,422,261	-8,146	-0.01%
Female	130,188,700	131,909,550	1,720,850	1.32%
Hispanic	36,769,252	38,346,951	1,577,700	4.29%
Not Hispanic	216,849,855	216,984,859	135,004	0.06%
White[3]	204,032,161	202,851,643	-1,180,518	-0.58%
Black[3]	31,168,385	31,618,096	449,711	1.44%
American Indian or Alaska Native[3]	2,483,390	2,905,990	422,600	17.02%
Asian[3]	11,915,744	12,869,433	953,689	8.00%
Native Hawaiian or Other Pacific Islander[3]	460,327	527,384	67,057	14.57%
Two or More Races[3]	3,559,100	4,559,265	1,000,165	28.10%

NOTE: Population counts are annualized estimates of the 2010 population and reflect the population of the entire year.

[1] Difference between the number of people in the 2010 population overall or in a given subgroup from control totals based on the 2010 census and the corresponding number from control totals based on the 2000 census.

[2] Based on the following formula: {[(*2010 Population Based on 2010 Census*) ─ (*2010 Population Based on 2000 Census*)] ÷ (*2010 Population Based on 2000 Census*)} × 100.

[3] Unlike racial/ethnic groups discussed elsewhere in this report, race domains in this table include Hispanics in addition to persons who were not Hispanic.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010.

Table B.9 Outcomes of Statistical Tests between Estimates in 2011 and Estimates in 2010 According to Census Control Totals Used for 2010 Estimates

	2011 versus 2010 (New) Estimated Numbers, Significant	2011 versus 2010 (New) Estimated Numbers, Not Significant	2011 versus 2010 (New) Estimated Percentages, Significant	2011 versus 2010 (New) Estimated Percentages, Not Significant	2011 versus 2010 (New) Mean Age At First Use, Significant	2011 versus 2010 (New) Mean Age At First Use, Not Significant
2011 versus 2010 (Old), Significant	**33**	30	**45**	19	**0**	0
2011 versus 2010 (Old), Not Significant	6	**432**	0	**371**	0	**66**

2010 (Old) = Estimates for 2010 with weights poststratified to 2010 control totals based on the 2000 census; 2010 (New) = Estimates for 2010 with weights poststratified to 2010 control totals based on the 2010 census.

NOTE: There are 26 tests not included due to suppression, 13 each for totals and percentages. Tests were conducted at the .05 level of significance. Cells with bolded data indicate consistent outcomes between 2011 versus 2010 (New) and between 2011 versus 2010 (Old).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011.

Table B.10 Comparison of Differences between Estimates in 2011 and Estimates in 2010 According to Census Control Totals Used for 2010 Estimates and the Direction of the Statistical Test Outcomes

	2011 < 2010 (New), Number (Percent)	No Difference between 2011 and 2010 (New) Number (Percent)	2011 > 2010 (New), Number (Percent)
2011 < 2010 (Old)	**67 (6.7%)**	32 (3.2%)	0 (0.0%)
No Difference between 2011 and 2010 (Old)	5 (0.5%)	**869 (86.7%)**	1 (0.1%)
2011 > 2010 (Old)	0 (0.0%)	17 (1.7%)	**11 (1.1%)**

2010 (Old) = Estimates for 2010 with weights poststratified to 2010 control totals based on the 2000 census; 2010 (New) = Estimates for 2010 with weights poststratified to 2010 control totals based on the 2010 census.

NOTE: Significance testing is based on a 2-sided test at the 0.05 level of significance. Cells with bolded data indicate consistent outcomes between 2011 versus 2010 (New) and between 2011 versus 2010 (Old).

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011.

Appendix C: Other Sources of Data

There are sources of substance use data other than the National Survey on Drug Use and Health (NSDUH). It is useful to consider the results of these other studies when discussing NSDUH data because no single source of data can fully cover all issues associated with substance use in the United States. Each data source can contribute to a broader understanding of substance use and the relationships of substance use to other issues of interest. This appendix briefly describes several of these other data systems and presents selected comparisons with NSDUH results. In addition, this appendix describes surveys on substance use of populations not covered by NSDUH.

When evaluating the information presented here, it is important to consider and understand the methodological differences between the different surveys and the impact that these differences could have on estimates of the presence of substance use. Several studies have compared NSDUH estimates with estimates from other studies and have evaluated how differences may have been affected by differences in survey methodology (Gfroerer, Wright, & Kopstein, 1997b; Grucza, Abbacchi, Przybeck, & Gfroerer, 2007; Hennessy & Ginsberg, 2001; Miller et al., 2004). These comparisons suggest that the goals and approaches of surveys are often different, making comparisons between them difficult. Some methodological differences that have been identified as affecting comparisons include populations covered, sampling methods, modes of data collection, questionnaires, and estimation methods.

C.1 Other National Surveys of Substance Use

Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System (BRFSS)—a State-based system of health surveys—collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. The BRFSS surveys are cross-sectional telephone surveys conducted by State health departments with technical and methodological assistance from the Centers for Disease Control and Prevention (CDC). Every year, States conduct monthly telephone surveys of adults (aged 18 or older) in households using random-digit-dialing methods; persons living in group quarters (e.g., dormitories) are excluded. Since 1994, BRFSS has collected data from all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands using a computer-assisted telephone interviewing (CATI) design. More than 350,000 adults are interviewed each year. Beginning with the 2011 BRFSS, the sample design covers households using only cellular telephones. This change in coverage may affect estimates and comparability over time.

National estimates typically are presented as medians. BRFSS includes questions on alcohol consumption and tobacco use.

NSDUH and BRFSS rates of current alcohol use have been generally similar, but NSDUH has shown consistently higher rates of binge drinking than BRFSS. The use of audio computer-assisted self-interviewing (ACASI) in NSDUH, which is considered to be more anonymous and yields higher reporting of sensitive behaviors, was offered as an explanation for

the lower binge rates in BRFSS (Miller et al., 2004). Because BRFSS uses CATI, it may yield lower reports of some sensitive behaviors than NSDUH, which employs face-to-face data collection with ACASI for questions about these behaviors. Response rates also are higher in NSDUH than BRFSS, which could have resulted in differential nonresponse bias patterns in the two surveys.

For further details, see the CDC Web site at http://www.cdc.gov/brfss/.

Monitoring the Future (MTF)

The Monitoring the Future (MTF) study is an ongoing study of substance use trends and related attitudes among America's secondary school students, college students, and adults through age 50. The study is conducted annually by the Institute for Social Research at the University of Michigan through grants awarded by the National Institute on Drug Abuse (NIDA). The MTF and NSDUH are the Federal Government's largest and primary tools for tracking youth substance use. The MTF is composed of three substudies: (a) an annual survey of high school seniors initiated in 1975; (b) ongoing panel studies of representative samples from each graduating class (i.e., 12th graders) that have been conducted by mail since 1976; and (c) annual surveys of 8th and 10th graders initiated in 1991. Each spring, students in the 8th, 10th, and 12th grades complete a self-administered, machine-readable questionnaire during a regular class period. Approximately 50,000 students in about 420 public and private secondary schools are surveyed annually for the cross-sectional study, and approximately 2,400 persons who participated in the survey of 12th graders are followed longitudinally. The latest MTF was conducted in 2011. The MTF provides information on the use of alcohol, illicit drugs, and tobacco.

Comparisons between the MTF estimates and estimates based on students sampled in NSDUH generally have shown NSDUH substance use prevalence levels to be lower than MTF estimates (Table C.1).[30] The lower prevalences in NSDUH may be due to more underreporting in the household setting as compared with the MTF school setting and some overreporting in the school settings. However, findings presented in Chapter 8 of this report generally show parallel trends in the prevalence of substance use in NSDUH and MTF for both the annual cross-sectional data for youths and the longitudinal data for young adults.

The MTF does not survey dropouts or include students who were absent from school on the day of the survey. NSDUH has shown dropouts to have higher rates of illicit drug use (Gfroerer et al., 1997b). Therefore, the population of inference for the MTF school-based data collection is adolescents who were in the 8th, 10th, and 12th grades. Depending on the effects of the exclusion of dropouts and frequent absentees, data from MTF may not generalize to the population of adolescents as a whole, especially for older adolescents. The dropout rates among public school students in the 2008 to 2009 school year were 3.2 percent for 9th graders, 3.5 percent for 10th graders, 3.8 percent for 11th graders and 6.0 percent for 12th graders (Stillwell, Sable, & Plotts, 2011). Although these rates appear to be low, students dropping out of school in

[30] To examine estimates that are comparable with MTF data, NSDUH estimates presented in Table C.1 are based on data collected in the first 6 months of the survey year and are subset to ages 12 to 20.

each lower grade could have a cumulative effect on school-based survey estimates for adolescents in the higher grades.

For further details, see the MTF Web site at http://www.monitoringthefuture.org/.

National Comorbidity Survey (NCS)

The National Comorbidity Survey (NCS) was sponsored by the National Institute of Mental Health (NIMH), NIDA, and the W.T. Grant Foundation. It was designed to measure in the general population the prevalence of the illnesses described in the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition revised (DSM-III-R) (American Psychiatric Association [APA], 1987). The first wave of the NCS was a household survey of persons in the continental United States (i.e., excluding Alaska and Hawaii) that collected data from 8,098 respondents aged 15 to 54 in a face-to-face interview using paper-and-pencil interviewing (PAPI). These responses were weighted to produce nationally representative estimates. A random sample of 4,414 respondents also was administered an additional module that captured information on nicotine dependence. The interviews took place between 1990 and 1992. The NCS used a modified version of the Composite International Diagnostic Interview (the University of Michigan-CIDI) to generate DSM-III-R diagnoses.

There have been several recent follow-ups to and replications of the original NCS, including a 10-year follow-up of the baseline sample (NCS-2), a replication study conducted in 2001 to 2003 with a newly recruited nationally representative sample of 9,282 respondents aged 18 or older (NCS-R) (Kessler et al., 2004), and an adolescent sample of adolescents aged 13 to 17 (NCS-A) in 2001 to 2004 that included 904 adolescents from households that participated in the NCS-R and 9,244 respondents from a nationally representative sample of 320 schools (Kessler et al., 2009). As for the NCS, the samples for the NCS-2, NCS-R, and NCS-A excluded Alaska and Hawaii.

The NCS provides information on the use of alcohol, illicit drugs, and tobacco and on substance dependence or abuse. The NCS-R used an updated version of the CIDI that was designed to capture diagnoses of substance abuse or dependence using current DSM-IV criteria (APA, 1994). Interviews were conducted using computer-assisted personal interviewing (CAPI). It should be noted that in several NCS-R studies (e.g., Kessler, Chiu, Demler, Merikangas, & Walters, 2005), the diagnosis for abuse also includes those who meet the diagnosis for dependence. In contrast, NSDUH follows DSM-IV guidelines and limits the definition of abuse to persons who do not meet the criteria for dependence. To make the NCS definition of abuse comparable with that of NSDUH, the rate for dependence must be subtracted from the rate for abuse. Rates of alcohol dependence or abuse and rates of illicit drug dependence or abuse were generally lower in NCS-R than in NSDUH (Kessler et al., 2005).

For further details, see the NCS Web site at http://www.hcp.med.harvard.edu/ncs/.

National Health and Nutrition Examination Survey (NHANES)

The National Health and Nutrition Examination Survey (NHANES) has assessed the health and nutritional status of children and adults in the United States since the 1960s through the use of both survey and physical examination components. It is sponsored by the National

Center for Health Statistics (NCHS) and began as a series of periodic surveys in which several years of data were combined into a single data release. Since 1999, it has been a continuous survey, with interview data collected each year for approximately 5,000 persons of all ages. The target population for NHANES is the civilian, noninstitutionalized population regardless of age. Data for 2009-2010 are the most currently available for public use; 2 years of data are combined to protect respondent confidentiality.

NHANES interviews are conducted in respondents' homes. NHANES also collects physical health measurements and data on sensitive topics through ACASI in mobile examination centers (MECs), which travel to locations throughout the United States. The NHANES MEC interview includes questions on alcohol, illicit drug, and tobacco use.

Both NSDUH and NHANES use complex cluster sample designs that affect the precision of estimates. In addition, the smaller sample sizes for NHANES (i.e., 5,000 per year vs. 67,500 per year for NSDUH) are likely to yield estimates that are less precise than those in NSDUH. The sources of nonresponse and coverage bias also differ for the two surveys. For example, NHANES respondents have to travel to a MEC to respond to the substance use items, which may eliminate homebound respondents or affect the participation of respondents with limited access to transportation.

Combined NHANES data from 1999 to 2004 indicated that 13.0 percent of youths aged 12 to 17 had smoked cigarettes in the past 30 days, 21.1 percent had used alcohol in the past 30 days, and 10.4 percent were past month binge alcohol users. An estimated 21.1 percent of youths had ever tried marijuana, and 2.4 percent had ever used cocaine (Fryar, Merino, Hirsch, & Porter, 2009). NSDUH estimates for youths aged 12 to 17 in 2002 to 2004 ranged from 11.9 to 13.0 percent for past month use of cigarettes, from 17.6 to 17.7 percent for past month alcohol use, and from 10.6 to 11.1 percent for past month binge alcohol use. Lifetime use of marijuana in 2002 to 2004 among youths ranged from 19.0 to 20.6 percent, and lifetime use of cocaine ranged from 2.4 to 2.7 percent.

For further details, see the NHANES Web site at http://www.cdc.gov/nchs/nhanes.htm.

National Health Interview Survey (NHIS)

The National Health Interview Survey (NHIS) is a continuous nationwide sample survey that collects data using personal household interviews through an interviewer-administered CAPI system. The survey is sponsored by the NCHS and provides national estimates of the health status and behaviors of the civilian, noninstitutionalized population, including cigarette smoking and alcohol use among persons aged 18 or older. NHIS data have been collected since 1957. In 2010, data were derived from three core components of the survey: the Family Core, which collects information from all family members aged 18 or older in each household; the Sample Adult Core, which collects information from one adult aged 18 or older in each family; and the Sample Child Core, which collects information on youths under age 18 from a knowledgeable family member, usually a parent, in households with a child. In 2010, NHIS data were based on 89,976 persons in the Family Core, 27,157 adults in the Sample Adult Core, and 11,277 children in the Sample Child Core (NCHS, Division of Health Interview Statistics, 2011).

For further details, see the NCHS Web site at http://www.cdc.gov/nchs/nhis.htm.

National Longitudinal Alcohol Epidemiologic Survey (NLAES) and National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)

The National Longitudinal Alcohol Epidemiologic Survey (NLAES) was conducted in 1991 and 1992 by the U.S. Bureau of the Census for the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Face-to-face, interviewer-administered interviews were conducted with 42,862 respondents aged 18 or older in the contiguous United States. Despite the survey name, the design was cross-sectional.

The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) was conducted in 2001 and 2002, also by the U.S. Bureau of the Census for NIAAA, using a computerized interviewer-administered interview. The NESARC sample was designed to make inferences for persons aged 18 or older in the civilian, noninstitutionalized population of the United States, including Alaska, Hawaii, and the District of Columbia, and including persons living in noninstitutional group quarters. NESARC was designed to be a longitudinal survey. The first wave was conducted in 2001 and 2002, with a final sample size of 43,093 respondents aged 18 or older. The second wave was conducted in 2004 and 2005 (Grant & Dawson, 2006). A 1-year data collection period for the next wave of the survey (NESARC-III) began in 2012 with a new sample of approximately 46,500 adults.

The study contains assessments of drug use, dependence, and abuse and associated mental disorders. NESARC included an extensive set of questions, based on DSM-IV criteria (APA, 1994), designed to assess the presence of symptoms of alcohol and drug dependence and abuse in persons' lifetimes and during the prior 12 months. In addition, DSM-IV diagnoses of major mental disorders were generated using the Alcohol Use Disorder and Associated Disabilities Interview Schedule-version 4 (AUDADIS-IV), which is a structured diagnostic interview that captures major DSM-IV axis I and axis II disorders.

Research indicates that (a) prevalence estimates for substance use were generally higher in NSDUH than in NESARC; (b) rates of past year substance use disorder (SUD) for cocaine and heroin use were higher in NSDUH than in NESARC; (c) rates of past year SUD for use of alcohol, marijuana, and hallucinogens were similar between NSDUH and NESARC; and (d) prevalence estimates for past year SUD conditional on past year use were substantially lower in NSDUH for the use of marijuana, hallucinogens, and cocaine (Grucza et al., 2007). A number of methodological factors might have contributed to such discrepancies, including privacy and anonymity (questions about sensitive topics in NSDUH are self-administered, while similar questions are interviewer administered in NESARC, which may have resulted in higher use estimates in NSDUH) and differences in SUD diagnostic instrumentation (which may have resulted in higher SUD prevalence among past year substance users in NESARC).

For further details about NLAES, see Stinson et al. (1998). For an overview of NESARC findings, see Caetano (2006).

National Longitudinal Study of Adolescent Health (Add Health)

The National Longitudinal Study of Adolescent Health (Add Health) was conducted to measure the effects of family, peer group, school, neighborhood, religious institution, and community influences on health risks, such as tobacco, drug, and alcohol use. Add Health was initiated in 1994 and supported by grants from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) with cofunding from 21 other Federal agencies and foundations.

The study began in 1994-1995 (Wave I) with an in-school questionnaire administered to a nationally representative sample of students in grades 7 to 12 and followed up with an in-home interview. In Wave I, about 90,000 students in grades 7 to 12 were surveyed at 144 schools around the United States using brief, machine-readable questionnaires during a regular class period. Interviews also were conducted with about 20,000 students and their parents in the students' homes using a combined CAPI and ACASI design. In Wave II, conducted in 1996, about 15,000 students in grades 8 to 12 were interviewed a second time in their homes. In Wave III in 2001-2002, about 15,000 of the original Add Health respondents, then aged 18 to 26, were reinterviewed to investigate how adolescent experiences and behaviors are related to outcomes during the transition to adulthood. Wave IV was conducted in 2007-2008 when the approximately 15,000 respondents were aged 24 to 32. The study provides information on the use of alcohol, illicit drugs, and tobacco.

For further details, see the Add Health Web site at http://www.cpc.unc.edu/projects/addhealth.

Partnership Attitude Tracking Study (PATS)

The Partnership Attitude Tracking Study (PATS), an annual national research study that tracks attitudes about illegal drugs, is sponsored by the Partnership at Drugfree.org and the MetLife Foundation. PATS consists of two nationally representative samples—a teenage sample for students in grades 9 through 12 and a parent sample. Adolescents complete self-administered, machine-readable questionnaires during a regular class period with their teacher remaining in the room. The latest PATS surveys of teenagers and parents were conducted in 2011. The 2011 survey of adolescents included questions about use of cigarettes, alcohol, and illicit drugs. In 2011, 3,322 teenagers were surveyed nationwide in the 23rd wave of the survey conducted since 1987, and 821 parents or caregivers of children in grades 9 to 12 were surveyed (Partnership at Drugfree.org & MetLife Foundation, 2012).

In general, NSDUH estimates of substance use prevalence for adolescents are lower than PATS estimates for youths in that age group. In 2011, for example, PATS estimates of marijuana use among adolescents in grades 9 through 12 were 47 percent for lifetime use and 27 percent for use in the past month (Partnership at Drugfree.org & MetLife Foundation, 2012). Corresponding estimates of marijuana use from NSDUH for grades 9 through 12 were 29.3 percent for lifetime use and 13.3 percent for past month use (Table C.2). The differences in prevalence estimates are likely to be due to the different study designs. The youth portion of PATS is a school-based survey, which may elicit more reporting of sensitive behaviors than the home-based NSDUH.

For further details, see the Partnership at Drugfree.org Web site at http://www.drugfree.org/.

Youth Risk Behavior Survey (YRBS)

The Youth Risk Behavior Survey (YRBS) is a component of the CDC's Youth Risk Behavior Surveillance System (YRBSS), which measures the prevalence of six priority health risk behavior categories: (a) behaviors that contribute to unintentional injuries and violence; (b) tobacco use; (c) alcohol and other drug use; (d) sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including human immunodeficiency virus infection; (e) unhealthy dietary behaviors; and (f) physical inactivity. The YRBSS includes national, State, territorial, tribal, and local school-based surveys of high school students conducted every 2 years. The national school-based survey uses a three-stage cluster sample design to produce a nationally representative sample of students in grades 9 through 12 who attend public and private schools. The State and local surveys use a two-stage cluster sample design to produce representative samples of public school students in grades 9 through 12 in their jurisdictions. The YRBS is conducted during the spring, with students completing a self-administered, machine-readable questionnaire during a regular class period. The latest YRBS was conducted in 2011. For the 2011 national YRBS, 15,425 usable questionnaires were obtained in 158 schools.

In general, the YRBS school-based survey has found higher rates of substance use for youths than those found in NSDUH (Table C.2).[31] The lower prevalence rates in NSDUH are likely due to the differences in study design. As in the case of comparisons with estimates from the MTF, the lower prevalences in NSDUH may be due to more underreporting in the household setting, as compared with the YRBS school setting, and some overreporting in the school settings.

Similar to other school-based surveys, the population of inference for the YRBS is the population of adolescents who are in school, specifically those in the 9th through 12th grades. Consequently, the YRBS does not include data from dropouts. The YRBS makes follow-up attempts to obtain data from youths who were absent on the day of survey administration, but nevertheless does not obtain complete coverage of these youths. For these reasons, YRBS data are not intended to be used for making inferences about the adolescent population of the United States as a whole.

For further details, see the CDC Web site at http://www.cdc.gov/HealthyYouth/yrbs/.

C.2 Surveys of Populations Not Covered by NSDUH

Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel

The 2008 Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel was the 10th in a series of studies conducted since 1980. The sample

[31] To examine estimates that are comparable with YRBS data, NSDUH estimates presented in Table C.2 are based on data collected in the first 6 months of the survey year and are subset to ages 12 to 20.

consisted of 28,546 active-duty Armed Forces personnel worldwide who anonymously completed self-administered questionnaires that assessed substance use and other health behaviors. Members of the Coast Guard were included for the first time in the 2008 survey (Bray et al., 2009). The 2011 survey was fielded in August 2011 and included onsite and Internet survey administrations (Assistant Secretary of Defense for Health Affairs, 2011). The survey provides information about the use of alcohol, illicit drugs, and tobacco.

In recent administrations of this survey, comparisons with NSDUH data have consistently shown that, even after accounting for demographic differences between the military and civilian populations, the military personnel had higher rates of heavy alcohol use than their civilian counterparts, similar rates of cigarette use, and lower rates of illicit drug use.

Surveys of Inmates in State and Federal Correctional Facilities (SISCF, SIFCF)

The Survey of Inmates in State Correctional Facilities (SISCF) and the Survey of Inmates in Federal Correctional Facilities (SIFCF) have provided nationally representative data on State prison inmates and sentenced Federal inmates held in federally owned and operated facilities. The Survey of State Inmates was conducted in 1974, 1979, 1986, 1991, 1997, and 2004, and the Survey of Federal Inmates in 1991, 1997, and 2004. The 2004 SISCF was conducted for the Bureau of Justice Statistics (BJS) by the U.S. Census Bureau, which also conducted the SIFCF for the BJS and the Federal Bureau of Prisons. Both surveys provide information about current offense and criminal history, family background and personal characteristics, prior drug and alcohol use and treatment, gun possession, and prison treatment, programs, and services. The surveys are the only national source of detailed information on criminal offenders, particularly special populations such as drug and alcohol users and offenders who have mental health problems. Systematic random sampling was used to select the inmates, and the 2004 surveys of State and Federal inmates were administered through CAPI. In 2004, 14,499 State prisoners in 287 State prisons and 3,686 Federal prisoners in 39 Federal prisons were interviewed.

Prior drug use among State prisoners remained stable on all measures between 1997 and 2004, while the percentage of Federal inmates who reported prior drug use rose on most measures (Mumola & Karberg, 2006). For the first time, half of Federal inmates reported drug use in the month before their offense. In 2004, measures of drug dependence and abuse based on criteria in DSM-IV (APA, 1994) were introduced, and 53 percent of the State and 45 percent of Federal prisoners met the DSM-IV criteria for drug abuse or dependence. The survey results indicate substantially higher rates of drug use among State and Federal prisoners as compared with NSDUH's rates for the general household population.

For further details, see BJS's "All Data Collections" Web page at http://bjs.ojp.usdoj.gov/index.cfm?ty=dca.

Table C.1 Use of Specific Substances in Lifetime, Past Year, and Past Month among 8th, 10th, and 12th Graders in MTF and NSDUH: Percentages, 2010 and 2011

Drug/Current Grade Level	MTF Lifetime (2010)	MTF Lifetime (2011)	MTF Past Year (2010)	MTF Past Year (2011)	MTF Past Month (2010)	MTF Past Month (2011)	NSDUH Lifetime (2010)	NSDUH Lifetime (2011)	NSDUH Past Year (2010)	NSDUH Past Year (2011)	NSDUH Past Month (2010)	NSDUH Past Month (2011)
Marijuana												
8th Grade	17.3	16.4	13.7	12.5	8.0	7.2	8.3	8.7	7.1	6.6	3.1	3.3
10th Grade	33.4	34.5	27.5	28.8	16.7	17.6	27.4	27.5	22.1	23.2	10.9	11.3
12th Grade	43.8	45.5	34.8	36.4	21.4	22.6	37.6	39.8	29.9	30.5	17.1	18.0
Cocaine												
8th Grade	2.6	2.2	1.6	1.4	0.6	0.8	0.8	0.4	0.4	0.2	0.1	0.0
10th Grade	3.7	3.3	2.2	1.9	0.9	0.7	2.7	1.9	2.0	1.4	0.3	0.5
12th Grade	5.5	5.2	2.9	2.9	1.3	1.1	3.8	3.5	2.6	2.4	0.6	0.9
Inhalants												
8th Grade	14.5	13.1	8.1[a]	7.0	3.6	3.2	10.1	8.9	4.8	4.1	1.4	1.2
10th Grade	12.0[b]	10.1	5.7[b]	4.5	2.0	1.7	9.3	9.5	3.9	3.5	0.7	0.5
12th Grade	9.0	8.1	3.6	3.2	1.4	1.0	7.5	6.7	3.2	1.8	0.6	0.1
Cigarettes												
8th Grade	20.0	18.4	--	--	7.1	6.1	13.6	11.5	8.6	7.6	4.2	3.5
10th Grade	33.0[a]	30.4	--	--	13.6[a]	11.8	29.8	28.2	21.5	19.6	12.2	11.4
12th Grade	42.2[a]	40.0	--	--	19.2	18.7	42.2	42.4	31.6	30.8	21.9	21.8
Alcohol												
8th Grade	35.8[b]	33.1	29.3[a]	26.9	13.8	12.7	23.4	22.9	17.4	16.0	6.9	6.0
10th Grade	58.2[a]	56.0	52.1[a]	49.8	28.9	27.2	50.2	48.6	42.0	41.0	18.8	19.9
12th Grade	71.0	70.0	65.2	63.5	41.2	40.0	69.5[a]	64.5	60.3	56.9	33.8	34.5

MTF = Monitoring the Future; NSDUH = National Survey on Drug Use and Health.

-- Not available.

NOTE: NSDUH data have been drawn from January to June of each survey year and subset to persons aged 12 to 20 to be more comparable with MTF data. Some 2010 NSDUH estimates may differ from previously published estimates due to updates (see Section B.3 in Appendix B of this report).

[a] Difference between estimate and 2011 estimate is statistically significant at the .05 level.

[b] Difference between estimate and 2011 estimate is statistically significant at the .01 level.

Sources: National Institute on Drug Abuse, Monitoring the Future Study, University of Michigan, 2010 and 2011. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011 (January-June).

Table C.2 Lifetime and Past Month Substance Use among Students in Grades 9 to 12 in YRBS and NSDUH: Percentages, 2005, 2007, 2009, and 2011

Substance/ Period of Use	YRBS (2005)	YRBS (2007)	YRBS (2009)	YRBS (2011)	NSDUH (2005)	NSDUH (2007)	NSDUH (2009)	NSDUH (2011)
Marijuana								
Lifetime Use	38.4	38.1	36.8[a]	39.9	28.1	26.4[b]	27.8	29.3
Past Month Use	20.2[a]	19.7[b]	20.8[a]	23.1	11.2[b]	10.9[b]	12.0	13.3
Cocaine								
Lifetime Use	7.6	7.2	6.4	6.8	3.8[b]	3.8[b]	2.9	2.3
Past Month Use	3.4	3.3	2.8	3.0	0.8	0.6	0.4	0.5
Ecstasy								
Lifetime Use	6.3[b]	5.8[b]	6.7[a]	8.2	2.8[b]	2.9[b]	3.3[b]	4.3
Past Month Use	--	--	--	--	0.4[a]	0.4[a]	0.8	0.7
Inhalants								
Lifetime Use	12.4	13.3[b]	11.7	11.4	12.0[b]	10.7[b]	10.1[b]	8.1
Past Month Use	--	--	--	--	1.1[a]	1.1[a]	0.6	0.6
Cigarettes								
Lifetime Use	54.3[b]	50.3[b]	46.3	44.7	39.0[b]	35.2[b]	33.7[a]	31.3
Past Month Use	23.0[b]	20.0	19.5	18.1	17.0[b]	15.5	14.9	14.5
Alcohol								
Lifetime Use	74.3	75.0[b]	72.5	70.8	57.5[b]	57.6[b]	56.5[b]	52.4
Past Month Use	43.3[b]	44.7[b]	41.8[b]	38.7	26.0[a]	26.3[b]	25.8[a]	23.7

NSDUH = National Survey on Drug Use and Health; YRBS = Youth Risk Behavior Survey.

-- Not available.

NOTE: NSDUH data have been drawn from January to June of each survey year and subset to persons aged 12 to 20 to be more comparable with YRBS data. Some 2007 and 2009 NSDUH estimates may differ from previously published estimates due to updates (see Section B.3 in Appendix B of this report).

NOTE: Statistical tests for the YRBS were conducted using the "Youth Online" tool (see http://www.cdc.gov/HealthyYouth/yrbs/). Results of testing for statistical significance in this table may differ from published YRBS reports of change.

[a] Difference between estimate and 2011 estimate is statistically significant at the .05 level.

[b] Difference between estimate and 2011 estimate is statistically significant at the .01 level.

Sources: Centers for Disease Control and Prevention, Youth Risk Behavior Survey, 2005, 2007, 2009, and 2011. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, January-June for 2005, 2007, 2009, and 2011.

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Appendix E: List of Contributors

This National Survey on Drug Use and Health (NSDUH) report was prepared by the Center for Behavioral Health Statistics and Quality (CBHSQ), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS), and by RTI International (a trade name of Research Triangle Institute), Research Triangle Park, North Carolina. Work by RTI was performed under Contract No. HHSS283200800004C.

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2010 State Profile — Connecticut
National Survey of Substance Abuse Treatment Services (N-SSATS)

The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual survey of facilities providing substance abuse treatment. It is conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). N-SSATS is designed to collect data on the location, characteristics, services offered, and number of clients in treatment at alcohol and drug abuse treatment facilities (both public and private) throughout the 50 States, the District of Columbia, and other U.S. jurisdictions.

More information on N-SSATS methodology is available at the following URL: http://www.samhsa.gov/data/2k3/NSSATS/NSSATS.pdf

In Connecticut, 195 substance abuse treatment facilities were included in the 2010 N-SSATS, reporting that there were 28,250 clients in substance abuse treatment on March 31, 2010. The survey response rate in Connecticut was 91.0%.

Facility Operation

	Facilities		Clients in Treatment on March 31, 2010			
			All Clients		Clients Under Age 18	
	No.	%	No.	%	No.	%
Private non-profit	165	84.6	24,842	87.9	469	84.5
Private for-profit	15	7.7	1,861	6.6	62	11.2
Local, county, or community government	3	1.5	134	0.5	19	3.4
State government	8	4.1	683	2.4	5	0.9
Federal government	3	1.5	729	2.6	0	0.0
Dept. of Veterans Affairs	2	1.0	711	2.5	0	0.0
Dept. of Defense	1	0.5	18	0.1	0	0.0
Indian Health Service	0	0.0	0	0.0	0	0.0
Other	0	0.0	0	0.0	0	0.0
Tribal government	1	0.5	1	<.05	0	0.0
Total	**195**	**100.0**	**28,250**	**100.0**	**555**	**100.0**

Primary Focus of Facility

	Facilities		Clients in Treatment on March 31, 2010			
			All Clients		Clients Under Age 18	
	No.	%	No.	%	No.	%
Substance abuse treatment services	103	52.8	13,278	47.0	189	34.1
Mental health services	13	6.7	642	2.3	12	2.2
Mix of mental health & substance abuse treatment services	74	37.9	13,830	49.0	349	62.9
General health care	4	2.1	490	1.7	0	0.0
Other/unknown	1	0.5	10	<.05	5	0.9
Total	**195**	**100.0**	**28,250**	**100.0**	**555**	**100.0**

Substance Abuse Problem Treated

	Facilities[1, 2, 3]		Clients in Treatment on March 31, 2010		
			Clients[3]		Clients per 100,000 Pop.
	No.	%	No.	%	Aged 18 and Over
Clients with both alcohol and drug abuse	170	92.4	9,207	32.6	328
Clients with drug abuse only	163	88.6	15,725	55.7	574
Clients with alcohol abuse only	142	77.2	3,315	11.7	120
Total[2]	**184**		**28,247**	**100.0**	**1,022**

[1] Facilities may be included in more than one category.

[2] Facilities excluded because they were not asked or did not respond to this question: 11

[3] Sum of individual items may not agree with the total due to rounding.

Type of Care

	Facilities[1]		Clients in Treatment on March 31, 2010				
			All Clients			Clients Under Age 18	
	No.	%	No.	%	Median No. of Clients Per Facility	No.	%
Outpatient	**139**	**71.3**	**26,654**	**94.4**	**91**	**521**	**93.9**
Regular	120	61.5	10,720	37.9	55		
Intensive	76	39.0	1,584	5.6	14		
Day treatment/partial hospitalization	30	15.4	343	1.2	12		
Detoxification	30	15.4	376	1.3	8		
Methadone/buprenorphine	31	15.9	13,631	48.3	432		
Residential (non-hospital)	**52**	**26.7**	**1,278**	**4.5**	**15**	**34**	**6.1**
Short term	17	8.7	323	1.1	20		
Long term	39	20.0	921	3.3	14		
Detoxification	3	1.5	34	0.1	13		
Hospital Inpatient	**17**	**8.7**	**318**	**1.1**	**9**	**0**	**0.0**
Treatment	12	6.2	118	0.4	4		
Detoxification	16	8.2	200	0.7	12		
Total	**195**		**28,250**	**100.0**	**50**	**555**	**100.0**

[1]Facilities may provide more than one type of care.

Opioid Treatment Programs (OTPs)

	No.	%[1]
Facilities with OTPs	**41**	**3.5**
Clients in Facilities with OTPs		
Methadone	13,943	97.5
Buprenorphine	355	2.5
Total	**14,298**	**100.0**

[1] Percentage of all OTP facilities that are in this State or jurisdiction.

Facility Payment Options

	Facilities[1]	
	No.	%
Cash or self-payment	177	90.8
Private health insurance	131	67.2
Medicare	104	53.3
Medicaid	147	75.4
Other State-financed health insurance	154	79.0
Federal military insurance	77	39.5
Access to Recovery (ATR) vouchers[2]	66	33.9
No payment accepted	1	0.5
Accepts other payments	2	1.0
Sliding fee scale	145	74.4
Treatment at no charge for clients who cannot pay	120	61.5

[1] Facilities may accept more than one type of payment.

[2] Available only in AK, AZ, CA, CO, CT, DC, FL, HI, IA, ID, IL, IN, LA, MI, MO, MT, NJ, NM, OH, OK, RI, TN, TX, WA, WI, WY. Not applicable (N/A) in other areas.

Facility Licensing, Approval, Certification, or Accreditation

	Facilities[1]	
	No.	%
Any listed agency/organization	181	92.8
State substance abuse agency	129	66.2
State mental health department	117	60.0
State department of health	173	88.7
Hospital licensing authority	22	11.3
The Joint Commision	64	32.8
CARF[2]	68	34.9
NCQA[3]	6	3.1
COA[4]	21	10.8
Other State/Local Agency/Org	14	7.2

[1] Facilities may be licensed by more than one agency/organization.

[2] Commission on Accreditation of Rehabilitation Facilities

[3] National Committee for Quality Assurance

[4] Council on Accreditation

Facility Funding

	Facilities	
	No.	%
Receives Federal, State, county, or local government funds for substance abuse treatment programs	139	71.3

Types of Services Offered	Facilities No.	%
Assessment and Pre-Treatment Services	**186**	**95.4**
Screening for substance abuse	176	90.3
Screening for mental health disorders	161	82.6
Comprehensive substance abuse assessment/diagnosis	175	89.7
Comprehensive mental health assessment/diagnosis	112	57.4
Outreach to persons in the community who may need treatment	73	37.4
Interim services for clients when immediate admission is not possible	45	23.1
Testing	**184**	**94.4**
Breathalyzer/blood alcohol testing	150	76.9
Drug or alcohol urine screening	183	93.8
Screening for Hepatitis B	63	32.3
Screening for Hepatitis C	63	32.3
HIV testing	75	38.5
STD testing	54	27.7
TB screening	79	40.5
Counseling	**195**	**100.0**
Individual counseling	185	94.9
Group counseling	191	97.9
Family counseling	162	83.1
Marital/couples counseling	130	66.7
Transitional Services	**191**	**97.9**
Discharge planning	189	96.9
Aftercare/continuing care	151	77.4
Pharmocotherapies	**132**	**67.7**
Antabuse®	51	26.2
Naltrexone	48	24.6
Campral®	67	34.4
Nicotine replacement	46	23.6
Smoking cessation medications (non-nicotine)	41	21.0
Medications for psychiatric disorders	117	60.0
Methadone	54	27.7
Buprenorphine	37	19.0
Subutex®	8	4.1
Suboxone®	36	18.5
Ancillary Services	**194**	**99.5**
Case management services	143	73.3
Social skills development	138	70.8
Mentoring/peer support	104	53.3
Child care for clients' children	21	10.8
Assistance with obtaining social services	160	82.1
Employment counseling or training for clients	78	40.0
Assistance in locating housing for clients	114	58.5
Domestic violence--family or partner violence	75	38.5
Early intervention for HIV	63	32.3
HIV or AIDS education, counseling, or support	107	54.9
Hepatitis education, counseling, or support	78	40.0
Health education other than HIV/AIDS or hepatitis	102	52.3
Substance abuse education	187	95.9
Transportation assistance to treatment	88	45.1
Mental health services	150	76.9
Acupuncture	13	6.7
Residential beds for clients' children	7	3.6
Self-help groups	109	55.9
Smoking cessation program	53	27.2

Clinical/Therapeutic Approaches Used Always or Often or Sometimes	Facilities No.	%
Substance abuse counseling	195	100.0
Relapse prevention	192	98.5
Cognitive-behavioral therapy	185	94.9
12-step facilitation	168	86.2
Motivational interviewing	176	90.3
Anger management	178	91.3

Continued.

Clinical/Therapeutic Approaches Used Often or Sometimes (cont.)	Facilities No.	Facilities %
Brief intervention	168	86.2
Contingency management/motivational incentives	111	56.9
Trauma-related counseling	163	83.6
Rational emotive behavioral therapy	68	34.9
Matrix model	46	23.6
Community reinforcement plus vouchers	38	19.5
Other treatment approaches	28	14.4

Facility Capacity and Utilization Rate[1]

	Residential	Hospital Inpatient
Number of facilities	51	8
Number of clients[2]	1,268	216
Number of designated beds	1,284	259
Utilization rate (%)	98.8	83.4
No. of designated beds/facility (avg.)	25	32

[1] Excludes facilities not reporting both client counts and number of beds, facilities whose client counts were reported by another facility, facilities that included client counts from other facilities, and facilities that did not respond to this question.
[2] Number of clients on March 31, 2010.

Services in Sign Language for the Hearing Impaired and in Languages Other than English

	Facilities No.	Facilities %
Hearing impaired/sign language	53	27.2
Any language other than English	103	52.8
Services Provided by:		
On-call interpreter	6	5.8
Staff counselor	63	61.2
Both staff counselor and on-call interpreter	34	33.0
Languages Provided by Staff Counselor:[1]		
Spanish	96	99.0
American Indian/Alaska Native	0	0.0
Other	34	35.1

[1] Percentages based on the number of facilities reporting that they provided substance abuse treatment in a language other than English by a staff counselor only or by both staff counselors and on-call interpreters.

Data are from facilities that reported to N-SSATS for the survey reference date March 31, 2010. All material appearing in this report is in the public domain and may be reproduced without permission from SAMHSA. Citation of the source is appreciated.

Access the latest N-SSATS reports at:
http://www.samhsa.gov/data/DASIS.aspx#N-SSATS

Access the latest N-SSATS public use files at:
http://www.datafiles.samhsa.gov

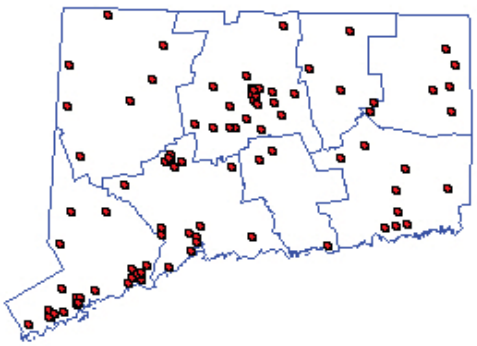
Other substance abuse reports are available at:
http://www.samhsa.gov/data/

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Behavioral Health Statistics and Quality
www.samhsa.gov/data/

Programs for Special Groups

	Facilities No.	Facilities %
Any program or group	158	81.0
Co-occurring disorders	111	56.9
Adult women	95	48.7
Adolescents	27	13.8
DUI/DWI offenders	18	9.2
Criminal justice clients	32	16.4
Adult men	77	39.5
Pregnant or postpartum women	30	15.4
Persons with HIV or AIDS	29	14.9
Seniors or older adults	14	7.2
Lesbian, gay, bisexual, or transgender clients	4	2.1
Other groups	13	6.7

Location of Treatment Facilities



- Access N-SSATS profiles for individual States at:
  http://wwwdasis.samhsa.gov/webt/NewMapv1.htm
- For information on individual facilities, access SAMHSA's Treatment Facility Locator at:
  http://findtreatment.samhsa.gov/

2009 State Profile — Connecticut
National Survey of Substance Abuse Treatment Services (N-SSATS)

The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual survey of facilities providing substance abuse treatment. It is conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). N-SSATS is designed to collect data on the location, characteristics, services offered, and number of clients in treatment at alcohol and drug abuse treatment facilities (both public and private) throughout the 50 States, the District of Columbia, and other U.S. jurisdictions.

More information on N-SSATS methodology is available at the following URL: http://oas.samhsa.gov/2k3/NSSATS/NSSATS.pdf

In Connecticut, 199 substance abuse treatment facilities were included in the 2009 N-SSATS, reporting that there were 24,831 clients in substance abuse treatment on March 31, 2009. The survey response rate in Connecticut was 93.7%.

Facility Operation

	Facilities		Clients in Treatment on March 31, 2009			
			All Clients		Clients Under Age 18	
	No.	%	No.	%	No.	%
Private non-profit	172	86.4	20,609	83.0	591	93.5
Private for-profit	11	5.5	1,944	7.8	20	3.2
Local government	3	1.5	94	0.4	11	1.7
State government	8	4.0	1,439	5.8	10	1.6
Federal government	4	2.0	745	3.0	0	0.0
Dept. of Veterans Affairs	3	1.5	710	2.9	0	0.0
Dept. of Defense	1	0.5	35	0.1	0	0.0
Indian Health Service	0	0.0	0	0.0	0	0.0
Other	0	0.0	0	0.0	0	0.0
Tribal government	1	0.5	0	0.0	0	0.0
Total	**199**	**100.0**	**24,831**	**100.0**	**632**	**100.0**

Primary Focus of Facility

	Facilities		Clients in Treatment on March 31, 2009			
			All Clients		Clients Under Age 18	
	No.	%	No.	%	No.	%
Substance abuse treatment services	117	58.8	15,386	62.0	386	61.1
Mental health services	10	5.0	1,066	4.3	15	2.4
Mix of mental health & substance abuse treatment services	65	32.7	7,674	30.9	222	35.1
General health care	6	3.0	695	2.8	1	0.2
Other/unknown	1	0.5	10	<.05	8	1.3
Total	**199**	**100.0**	**24,831**	**100.0**	**632**	**100.0**

Substance Abuse Problem Treated

	Facilities[1, 2]		Clients in Treatment on March 31, 2009		
			Clients[3]		Clients per 100,000 Pop. Aged 18 and Over
	No.	%	No.	%	
Clients with both alcohol and drug abuse	173	91.5	8,571	35.0	302
Clients with drug abuse only	162	85.7	13,078	53.3	478
Clients with alcohol abuse only	147	77.8	2,869	11.7	102
Total[2]	**189**		**24,519**	**100.0**	**881**

[1] Facilities may be included in more than one category.

[2] Facilities excluded because they were not asked or did not respond to this question: 10

[3] Sum of individual items may not agree with the total due to rounding.

Type of Care	Facilities[1]		Clients in Treatment on March 31, 2009				
			All Clients			Clients Under Age 18	
	No.	%	No.	%	Median No. of Clients Per Facility	No.	%
Outpatient	**144**	**72.4**	**23,166**	**93.3**	**73**	**593**	**93.8**
Regular outpatient	124	62.3	8,967	36.1	31		
Intensive outpatient	83	41.7	2,230	9.0	20		
Day treatment/partial hospitalization	32	16.1	418	1.7	8		
Detoxification	29	14.6	361	1.5	6		
Methadone/buprenorphine	39	19.6	11,190	45.1	231		
Residential	**55**	**27.6**	**1,320**	**5.3**	**16**	**35**	**5.5**
Short term	19	9.5	380	1.5	20		
Long term	41	20.6	887	3.6	15		
Detoxification	4	2.0	53	0.2	14		
Hospital Inpatient	**17**	**8.5**	**345**	**1.4**	**15**	**4**	**0.6**
Rehabilitation	13	6.5	173	0.7	8		
Detoxification	17	8.5	172	0.7	10		
Total	**199**		**24,831**	**100.0**	**48**	**632**	**100.0**

[1]Facilities may provide more than one type of care.

Opioid Treatment Programs (OTPs)

	No.	%[1]
Facilities with OTPs	**41**	**3.3**
Clients in Facilities with OTPs		
Methadone	11,126	97.4
Buprenorphine	294	2.6
Total	**11,420**	**100.0**

[1] Percentage of all OTP facilities that are in this state.

Facility Payment Options

	Facilities[1]	
	No.	%
Cash or self-payment	175	87.9
Private health insurance	130	65.3
Medicare	100	50.3
Medicaid	145	72.9
Other State-financed health insurance	152	76.4
Federal military insurance	67	33.7
Access to Recovery (ATR) vouchers[2]	75	37.7
No payment accepted	4	2.0
Accepts other payments	1	0.5
Sliding fee scale	147	73.9
Treatment at no charge for clients who cannot pay	128	64.3

[1] Facilities may accept more than one type of payment.

[2] Available only in AK, AZ, CA, CO, CT, DC, FL, HI, IA, ID, IL, IN, LA, MI, MO, MT, NJ, NM, OH, OK, RI, TN, TX, WA, WI, WY .

Facility Licensing, Approval, Certification, or Accreditation

	Facilities[1]	
	No.	%
Any listed agency/organization	191	96.0
State substance abuse agency	126	63.3
State mental health department	112	56.3
State department of health	181	91.0
Hospital licensing authority	28	14.1
The Joint Commision	80	40.2
CARF[2]	68	34.2
NCQA[3]	9	4.5
COA[4]	17	8.5
Other State/Local Agency/Org	22	11.1

[1] Facilities may be licensed by more than one agency/organization.

[2] Commission on Accreditation of Rehailitation Facilities

[3] National Committee for Quality Assurance

[4] Council for Accreditation

Facility Funding

	Facilities	
	No.	%
Receives Federal, State, county, or local government funds for substance abuse treatment programs	150	75.4

Types of Services Offered	Facilities No.	%
Assessment and Pre-Treatment Services	**194**	**97.5**
Screening for substance abuse	189	95.0
Screening for mental health disorders	170	85.4
Comprehensive substance abuse assessment/diagnosis	174	87.4
Comprehensive mental health assessment/diagnosis	110	55.3
Outreach to persons in the community who may need treatment	77	38.7
Interim services for clients when immediate admission is not possible	39	19.6
Testing	**192**	**96.5**
Breathalyzer/blood alcohol testing	155	77.9
Drug or alcohol urine screening	191	96.0
Screening for Hepatitis B	67	33.7
Screening for Hepatitis C	70	35.2
HIV testing	83	41.7
STD testing	62	31.2
TB screening	79	39.7
Counseling	**198**	**99.5**
Individual counseling	175	87.9
Group counseling	191	96.0
Family counseling	143	71.9
Marital/couples counseling	105	52.8
Transitional Services	**197**	**99.0**
Discharge planning	195	98.0
Aftercare/continuing care	154	77.4
Pharmocotherapies	**127**	**63.8**
Medications for psychiatric disorders	107	53.8
Nicotine replacement	49	24.6
Campral®	66	33.2
Antabuse®	54	27.1
Naltrexone	55	27.6
Buprenorphine	49	24.6
Subutex®	22	11.1
Suboxone®	47	23.6
Methadone	49	24.6
Ancillary Services	**198**	**99.5**
Case management services	143	71.9
Social skills development	135	67.8
Mentoring/peer support	101	50.8
Child care for clients' children	22	11.1
Assistance with obtaining social services	153	76.9
Employment counseling or training for clients	82	41.2
Assistance in locating housing for clients	122	61.3
Domestic violence	69	34.7
Early intervention for HIV	70	35.2
HIV or AIDS education, counseling, or support	113	56.8
Health education other than HIV/AIDS	96	48.2
Substance abuse education	187	94.0
Transportation assistance to treatment	85	42.7
Mental health services	150	75.4
Acupuncture	14	7.0
Residential beds for clients' children	8	4.0
Self-help groups	111	55.8

Clinical/Therapeutic Approaches Used Often or Sometimes	Facilities No.	%
Substance abuse counseling	195	98.0
Relapse prevention	189	95.0
Cognitive-behavioral therapy	191	96.0
12-step facilitation	154	77.4
Motivational interviewing	181	91.0
Anger management	177	88.9

Continued.

Clinical/Therapeutic Approaches Used Often or Sometimes (cont.)	Facilities No.	Facilities %
Brief intervention	159	79.9
Contingency management	116	58.3
Trauma-related counseling	168	84.4
Rational emotive behavioral therapy	82	41.2
Matrix model	46	23.1
Community reinforcement plus vouchers	42	21.1
Other treatment approaches	54	27.1

Facility Capacity and Utilization Rate[1]

	Residential	Hospital Inpatient
Number of facilities	54	7
Number of clients	1,296	221
Number of designated beds	1,343	243
Utilization rate (%)	96.5	90.9
No. of designated beds/facility (avg.)	25	35

[1] Excludes facilities not reporting both client counts and number of beds, facilities whose client counts were reported by another facility, facilities that included client counts from other facilities, and facilities that did not respond to this question

Programs for Special Groups

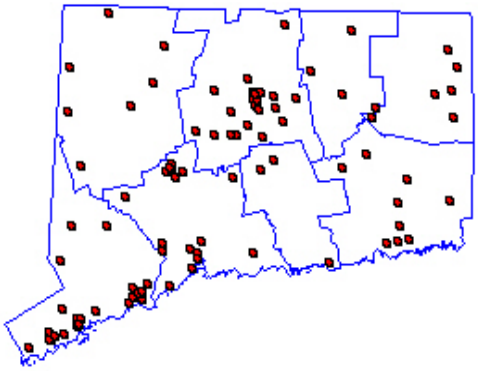
	Facilities No.	Facilities %
Any program or group	160	80.4
Co-occurring disorders	102	51.3
Adult women	85	42.7
Adolescents	31	15.6
DUI/DWI offenders	17	8.5
Criminal justice clients	31	15.6
Adult men	73	36.7
Pregnant or postpartum women	26	13.1
Persons with HIV or AIDS	34	17.1
Seniors or older adults	17	8.5
Gays or lesbians	6	3.0
Other groups	16	8.0

Services for the Hearing Impaired and in Languages Other than English

	Facilities No.	Facilities %
Hearing impaired/sign language	38	19.1
Any language other than English	102	51.3
Services Provided by:		
On-call interpreter	7	6.9
Staff counselor	71	69.6
Both staff counselor and on-call interpreter	24	23.5
Languages Provided by Staff Counselor:[1]		
Spanish	94	98.9
American Indian/Alaska Native languages	1	1.1
Other	30	31.6

[1] Percentages based on the number of facilities providing substance abuse treatment in a language other than English by a staff counselor.

Location of Treatment Facilities



Data are from facilities that reported to N-SSATS for the survey reference date March 31, 2009. All material appearing in this report is in the public domain and may be reproduced without permission from SAMHSA. Citation of the source is appreciated.

Access the latest N-SSATS reports at:
http://www.oas.samhsa.gov/dasis.htm#Reports

Access the latest N-SSATS public use files at:
http://www.icpsr.umich.edu/cocoon/SAMHDA/SERIES/00058.xml

Other substance abuse reports are available at:
http://www.oas.samhsa.gov/

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Office of Applied Studies
www.oas.samhsa.gov

• Access N-SSATS profiles for individual States at:
http://wwwdasis.samhsa.gov/webt/NewMapv1.htm

• For information on individual facilities, access SAMHSA's Treatment Facility Locator at:
http://findtreatment.samhsa.gov/

Substance Abuse Treatment Admissions by Primary Substance of Abuse, According to Sex, Age Group, Race, and Ethnicity
Year = 2010

Total	**No.**	51,981	9,211	10,702	2,732	1,885	8,350	11,697	2,569	523	110	117	27	604	84	47	3,323
	%	100.0	17.7	20.6	5.3	3.6	16.1	22.5	4.9	1.0	0.2	0.2	0.1	1.2	0.2	0.1	6.4
SEX																	
Male	**%**	71.7	74.8	74.5	58.2	72.0	78.1	70.1	62.6	62.3	66.4	64.1	55.6	59.1	52.4	68.1	67.0
Female	**%**	28.2	25.2	25.4	41.8	28.0	21.7	29.8	37.3	37.3	33.6	35.9	44.4	40.7	47.6	31.9	32.8
Unknown	**%**	0.1	0.1	0.1	0.0	0.0	0.2	0.1	0.0	0.4	0.0	0.0	0.0	0.2	0.0	0.0	0.2
Total	**%**	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
AGE AT ADMISSION																	
12-17 years	**%**	1.4	0.3	1.1	0.0	0.4	6.0	0.1	0.4	0.0	0.9	4.3	0.0	0.5	0.0	4.3	1.5
18-20 years	**%**	6.0	1.4	4.2	1.0	2.1	17.0	4.7	7.5	4.0	10.9	9.4	14.8	5.0	1.2	19.1	6.3
21-25 years	**%**	16.0	6.6	11.1	7.6	10.8	26.8	20.8	23.4	26.0	27.3	18.8	14.8	17.2	14.3	25.5	15.9
26-30 years	**%**	15.9	8.7	13.4	12.4	16.4	20.3	19.0	21.9	36.9	22.7	16.2	22.2	20.7	21.4	12.8	15.4
31-35 years	**%**	12.2	8.5	11.8	13.2	16.7	12.4	13.2	14.3	22.6	14.5	10.3	7.4	14.1	17.9	17.0	12.2
36-40 years	**%**	11.9	11.1	13.5	17.9	15.6	7.3	12.6	10.2	8.4	11.8	14.5	3.7	12.9	11.9	10.6	12.3
41-45 years	**%**	13.5	18.0	17.2	21.7	17.9	5.5	11.8	8.4	1.9	7.3	11.1	7.4	9.4	15.5	6.4	13.4
46-50 years	**%**	12.0	20.3	15.4	17.1	12.0	2.8	9.7	7.5	0.0	3.6	6.8	18.5	7.6	9.5	4.3	11.8
51-55 years	**%**	7.0	13.7	8.2	7.2	5.9	1.6	5.5	4.5	0.2	0.9	6.0	7.4	7.9	7.1	0.0	6.6
56-60 years	**%**	2.9	7.5	3.0	1.7	1.5	0.3	2.1	1.4	0.0	0.0	1.7	3.7	3.5	1.2	0.0	2.9
61-65 years	**%**	0.9	2.6	1.0	0.1	0.4	0.1	0.5	0.5	0.0	0.0	0.0	0.0	1.0	0.0	0.0	1.0
66 years and over	**%**	0.4	1.4	0.2	0.0	0.2	0.0	0.1	0.0	0.0	0.0	0.9	0.0	0.2	0.0	0.0	0.6
Unknown	**%**	0.1	0.0	0.1	0.1	0.2	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Total	**%**	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
RACE STATE: CONNECTICUT			Alcohol only	Alcohol with secondary drug	Cocaine (smoked)	Cocaine (other route)	Marijuana	Heroin	Other opiates	PCP	Hallucinogens	Amphetamines	Other stimulants	Tranquilizers	Sedatives	Inhalants	Other/Unknown
White	**%**	59.4	73.2	59.9	46.3	49.5	43.6	64.6	85.6	17.6	45.5	64.1	40.7	87.3	78.6	53.2	44.4
Black or African-American	**%**	16.7	9.6	20.9	30.9	17.8	30.7	8.2	3.0	49.7	34.5	16.2	14.8	2.0	6.0	25.5	13.8
American Indian or Alaska Native	**%**	0.4	0.5	0.5	0.5	0.4	0.5	0.3	0.3	0.2	0.9	0.0	0.0	0.3	0.0	2.1	0.4
Asian or Native Hawaiian or Other Pacific Islander	**%**	0.5	0.5	0.5	0.5	0.3	0.5	0.2	0.1	0.4	0.9	1.7	0.0	0.0	0.0	0.0	1.6
Other	**%**	11.8	7.9	8.9	11.3	17.0	15.6	15.8	5.3	19.1	11.8	4.3	22.2	4.3	10.7	14.9	11.1
Unknown	**%**	11.1	8.3	11.2	10.5	15.0	9.1	10.8	5.8	13.0	6.4	13.7	22.2	6.1	4.8	4.3	28.7
Total	**%**	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
ETHNICITY																	
Hispanic or Latino	**%**	20.5	14.1	17.8	18.7	27.7	26.8	24.7	9.2	32.9	23.6	12.8	40.7	8.8	11.9	25.5	22.1
Not Hispanic or Latino	**%**	74.9	81.1	78.7	78.1	68.4	65.7	72.7	86.9	57.7	73.6	82.9	55.6	88.4	86.9	72.3	67.9
Unknown	**%**	4.6	4.8	3.5	3.1	3.9	7.5	2.6	3.9	9.4	2.7	4.3	3.7	2.8	1.2	2.1	10.0
Total	**%**	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

PRIMARY SUBSTANCE

Click here to view descriptions of drug categories

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS)
Based on administrative data reported by States to TEDS through Oct 15, 2012
-- Quantity is zero

Substance Abuse Treatment Admissions by Primary Substance of Abuse, According to Sex, Age Group, Race, and Ethnicity
Year = 2011

STATE: CONNECTICUT		Total	PRIMARY SUBSTANCE														
			Alcohol only	Alcohol with secondary drug	Cocaine (smoked)	Cocaine (other route)	Marijuana	Heroin	Other opiates	PCP	Hallucinogens	Amphetamines	Other stimulants	Tranquilizers	Sedatives	Inhalants	Other/Unknown
Total	No.	62,407	11,631	12,456	3,418	2,133	7,828	15,556	3,503	803	146	125	26	754	89	70	3,869
	%	100.0	18.6	20.0	5.5	3.4	12.5	24.9	5.6	1.3	0.2	0.2	0.0	1.2	0.1	0.1	6.2
SEX																	
Male	%	70.3	72.2	71.3	57.1	70.1	78.1	70.0	63.2	61.8	65.1	68.8	69.2	65.9	62.9	68.6	68.8
Female	%	29.5	27.7	28.7	42.8	29.7	21.7	30.0	36.7	38.0	34.9	31.2	30.8	34.1	37.1	31.4	30.0
Unknown	%	0.2	0.1	0.0	0.0	0.2	0.2	0.0	0.1	0.2	0.0	0.0	0.0	0.0	0.0	0.0	1.3
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
AGE AT ADMISSION																	
12-17 years	%	0.9	0.2	1.3	0.0	0.1	3.9	0.1	0.1	0.2	2.1	1.6	0.0	0.1	0.0	5.7	1.6
18-20 years	%	5.8	1.7	5.8	1.8	2.8	16.4	4.2	6.9	4.1	15.8	8.0	23.1	3.3	3.4	21.4	7.8
21-25 years	%	16.1	6.8	13.6	7.3	11.9	29.2	19.0	24.1	25.5	21.9	12.8	38.5	13.4	22.5	24.3	15.4
26-30 years	%	15.8	8.8	12.7	10.1	16.1	21.1	19.7	22.5	36.2	19.9	19.2	15.4	22.7	14.6	11.4	14.0
31-35 years	%	12.4	9.6	11.8	13.3	15.9	12.8	13.1	14.4	22.7	11.6	14.4	3.8	16.2	18.0	11.4	11.7
36-40 years	%	11.0	10.5	11.2	15.6	12.5	7.5	12.3	9.2	7.8	8.2	11.2	11.5	10.3	6.7	7.1	12.1
41-45 years	%	12.9	16.1	14.9	20.5	17.4	4.4	12.7	7.5	2.5	10.3	13.6	3.8	12.1	12.4	5.7	12.7
46-50 years	%	12.2	19.3	14.8	19.0	13.2	2.9	9.8	7.6	0.6	4.8	6.4	0.0	11.0	9.0	8.6	11.4
51-55 years	%	7.5	14.4	8.7	9.1	7.0	1.2	5.7	4.7	0.1	3.4	4.8	3.8	7.0	7.9	1.4	7.1
56-60 years	%	3.5	8.2	3.7	2.7	2.4	0.4	2.3	2.3	0.1	2.1	3.2	0.0	2.4	4.5	0.0	3.5
61-65 years	%	1.1	3.1	1.0	0.5	0.4	0.1	0.7	0.4	0.0	0.0	4.0	0.0	0.4	0.0	1.4	1.5
66 years and over	%	0.4	1.3	0.3	0.1	0.1	0.0	0.2	0.1	0.0	0.0	0.8	0.0	0.5	1.1	0.0	1.1
Unknown	%	0.1	0.1	0.2	0.1	0.1	0.1	0.2	0.3	0.0	0.0	0.0	0.0	0.5	0.0	1.4	0.1
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
RACE																	
White	%	62.7	72.0	66.7	44.5	56.4	37.7	67.6	85.9	18.4	56.8	72.0	57.7	83.2	70.8	45.7	57.2
Black or African-American	%	17.3	10.4	19.9	34.6	19.2	34.5	9.2	2.5	47.8	26.0	14.4	23.1	2.5	13.5	24.3	20.8
American Indian or Alaska Native	%	0.5	0.5	0.8	0.6	0.8	0.5	0.3	0.6	1.1	0.0	0.8	0.0	0.3	0.0	0.0	0.4
Asian or Native Hawaiian or Other Pacific Islander	%	0.5	0.5	0.4	0.4	0.2	0.7	0.3	0.4	0.7	0.0	2.4	0.0	0.0	0.0	0.0	0.6
Other	%	17.4	15.4	10.6	18.7	20.8	24.6	21.3	9.4	30.1	14.4	8.8	11.5	13.5	13.5	27.1	17.7
Unknown	%	1.6	1.2	1.5	1.3	2.6	2.0	1.3	1.1	1.7	2.7	1.6	7.7	0.5	2.2	2.9	3.2
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
ETHNICITY																	
Hispanic or Latino	%	18.7	11.6	13.3	14.1	22.4	28.8	24.5	8.4	32.4	20.5	8.8	23.1	14.9	14.6	21.4	22.9
Not Hispanic or Latino	%	75.3	82.9	82.1	79.5	71.6	62.9	69.9	86.4	56.4	71.9	88.0	76.9	84.0	80.9	77.1	67.2
Unknown	%	6.0	5.4	4.6	6.4	6.0	8.3	5.5	5.2	11.2	7.5	3.2	0.0	1.2	4.5	1.4	9.8
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Click here to view descriptions of drug categories
SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS)
Based on administrative data reported by States to TEDS through Oct 15, 2012
-- Quantity is zero

National Survey on Drug Use and Health

The NSDUH Report

December 9, 2010

State Estimates of Drunk and Drugged Driving

In Brief

- Combined 2006 to 2009 data indicate that 13.2 percent of persons aged 16 or older (an estimated 30.6 million persons) drove under the influence of alcohol in the past year and 4.3 percent (an estimated 10.1 million persons) drove under the influence of illicit drugs in the same time period
- The rates of past year drunk driving were among the highest in Wisconsin (23.7 percent) and North Dakota (22.4 percent); the rates of drugged driving were among the highest in Rhode Island (7.8 percent) and Vermont (6.6 percent)
- When combined 2002 to 2005 data are compared with combined 2006 to 2009 data, the Nation as a whole experienced statistically significant reductions in the rates of drunk driving (from 14.6 to 13.2 percent) and drugged driving (from 4.8 to 4.3 percent); 12 States saw reductions in drunk driving rates, and 7 saw reductions in drugged driving rates

Driving under the influence of alcohol or illicit drugs poses a significant threat to public safety because these substances can impair perception, cognition, attention, balance, coordination, and other brain functions necessary for safe driving. Driving while impaired has been linked to reckless driving, car crashes, and fatal accidents. A review of several studies found that between 5 and 25 percent of drivers involved in motor vehicle accidents tested positive for drugs, and 18 percent of motor vehicle driver deaths involved drugs.[1] Furthermore, in 2008, 32 percent of all traffic-related deaths—nearly 12,000 deaths—were the result of alcohol-related crashes.[2]

Recognizing the dangers associated with driving under the influence of drugs, the 2010 *National Drug Control Strategy*, developed by the White House's Office of National Drug Control Policy, identified the prevention of drugged driving as a national priority.[3] In addition, a major component of the Substance Abuse and Mental Health Services Administration (SAMHSA) strategic initiative to reduce underage drinking and adult problem drinking is to reduce negative consequences, such as injuries resulting from impaired driving.[4]

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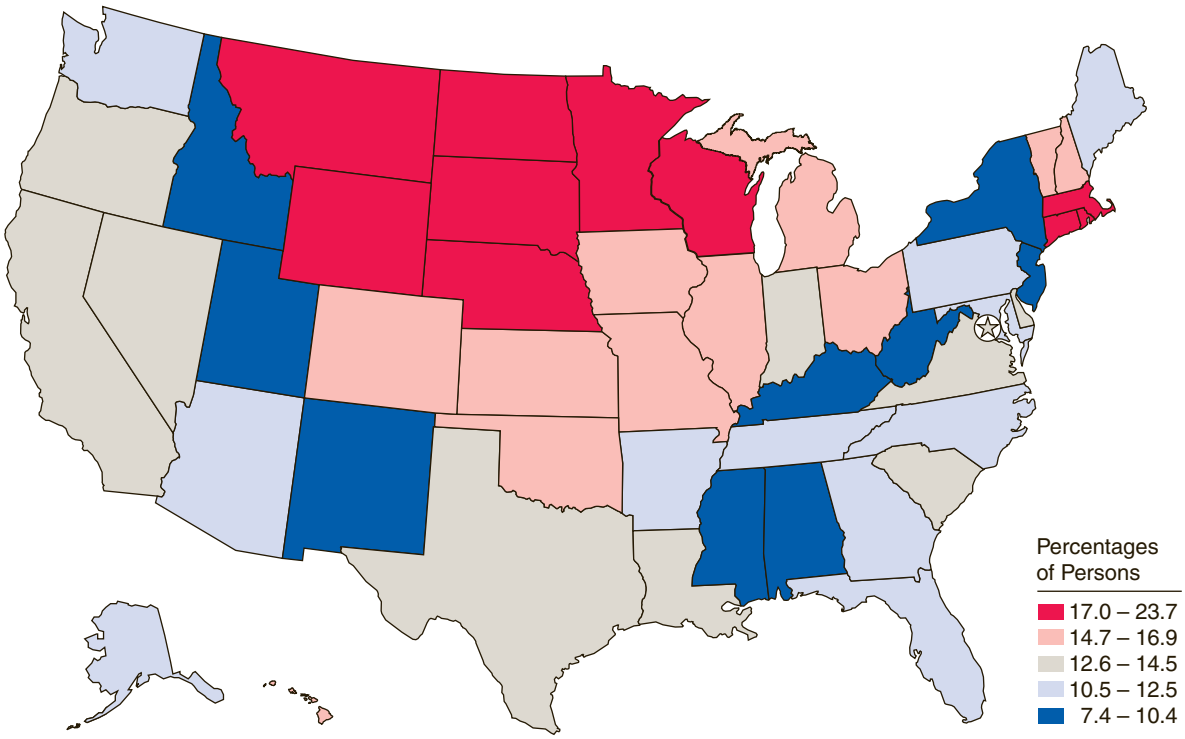
Figure 1. Percentages of Persons Aged 16 or Older Driving under the Influence of Alcohol in the Past Year, by State: 2006 to 2009



Source: 2006 to 2009 SAMHSA National Surveys on Drug Use and Health (NSDUHs).

The National Survey on Drug Use and Health (NSDUH) asks persons aged 12 or older if they had driven a vehicle while under the influence of alcohol or under the influence of illicit drugs in the past year. NSDUH defines illicit drugs as marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, or prescription-type drugs used nonmedically.[5] This issue of *The NSDUH Report* uses combined 2006 to 2009 data to present estimates of driving under the influence of alcohol (also referred to as "drunk driving") and driving under the influence of illicit drugs (also referred to as "drugged driving") among persons aged 16 or older by State (including the District of Columbia).[6]

State estimates are rank ordered from highest to lowest and divided into quintiles (fifths), which are presented in color-coded maps shown in Figures 1 and 2. States with the highest estimates fall into the top quintile and are shown in red on the maps; States with the lowest estimates are in the bottom quintile and are shown in blue.[7] Additionally, the combined 2006 to 2009 data are compared with the combined 2002 to 2005 data to examine changes over time.

Driving under the Influence of Alcohol

Combined 2006 to 2009 data indicate that 13.2 percent of persons aged 16 or older (an estimated 30.6 million persons) drove under the influence of alcohol in the past year. The rates of drunk driving were among the highest in Wisconsin (23.7 percent) and North Dakota (22.4 percent) and among the lowest in Utah (7.4 percent) and Mississippi (8.7 percent) (Figure 1).

Of the 10 States with the highest rates of drunk driving, 5 were in the Midwest (Minnesota, Nebraska, North Dakota, South Dakota, and Wisconsin), 3 were in the Northeast (Connecticut, Massachusetts, and Rhode Island), and 2 were in the West (Montana and Wyoming). Of the 9 States with the lowest rates of drunk driving, 4 were in the South (Alabama, Kentucky,

Table 1. Driving under the Influence of Alcohol in the Past Year among Persons Aged 16 or Older for the Total Population and States with Significant Reductions: 2002 to 2005 versus 2006 to 2009

State	Combined 2002 to 2005 (Percent)	Combined 2006 to 2009 (Percent)
Total United States	**14.6**	**13.2**
Alaska	14.8	11.1
Florida	13.7	10.9
Idaho	14.5	10.3
Illinois	16.1	14.7
Maryland	14.9	10.7
Michigan	18.7	15.9
Mississippi	11.4	8.7
Missouri	18.6	14.8
New Mexico	13.9	10.4
Pennsylvania	14.4	11.8
Texas	15.4	13.9
Washington	15.3	12.1

Source: 2002 to 2009 SAMHSA National Surveys on Drug Use and Health (NSDUHs).

Mississippi, and West Virginia), 3 were in the West (Idaho, New Mexico, and Utah), and 2 were in the Northeast (New Jersey and New York).[8]

Rates of past year drunk driving were higher among persons aged 16 to 25 than among those aged 26 or older (19.5 vs. 11.8 percent).

Trends in Driving under the Influence of Alcohol

When combined 2002 to 2005 data are compared with combined 2006 to 2009 data, the Nation as a whole experienced a statistically significant reduction in the rate of past year drunk driving (from 14.6 to 13.2 percent), as did 12 States: Alaska, Florida, Idaho, Illinois, Maryland, Michigan, Mississippi, Missouri, New Mexico, Pennsylvania, Texas, and Washington (Table 1). No States had a statistically significant increase in the rate of drunk driving.

Reductions in past year rates of drunk driving were found both among persons aged 16 to 25 (22.2 to 19.5 percent) and among persons aged 26 or older (12.9 to 11.8 percent).

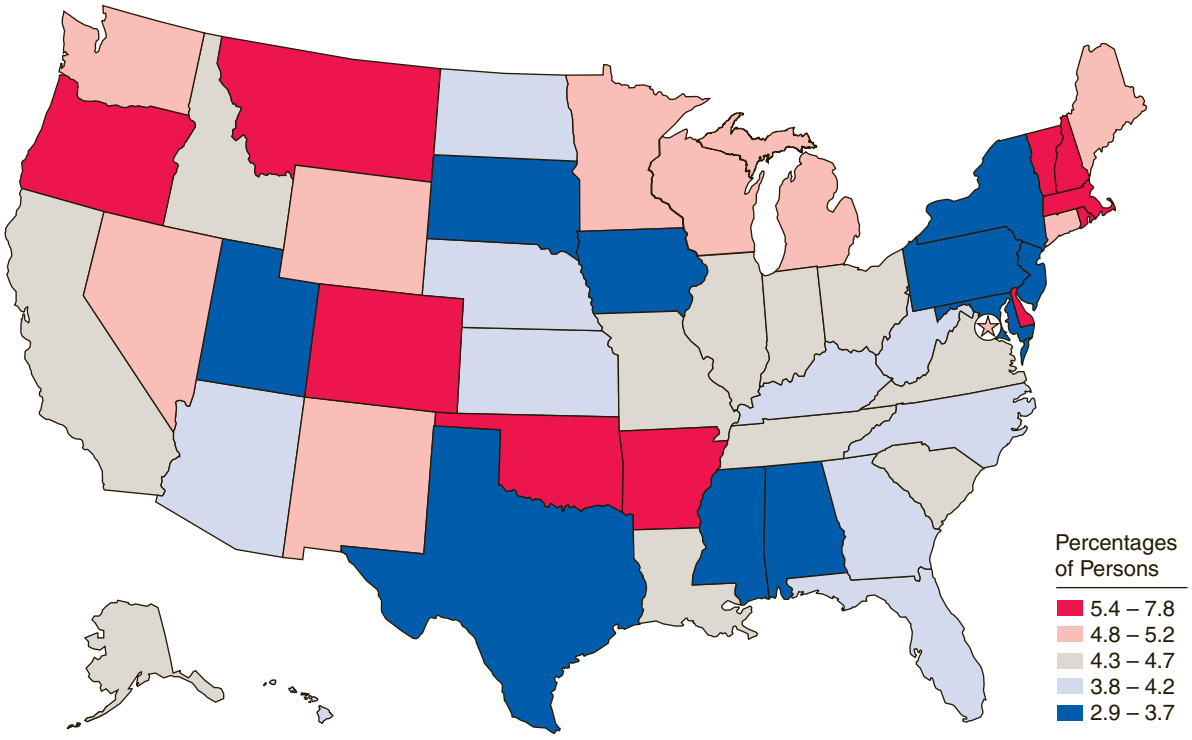
Driving under the Influence of Alcohol in Combination with Illicit Drugs

Combined 2006 to 2009 data indicate that one fifth of drunk drivers aged 16 or older (21.9 percent) drove under the influence of alcohol and illicit drugs at the same time; the rate was higher for drunk drivers aged 16 to 25 than for those aged 26 or older (38.7 vs. 15.8 percent). Comparisons of combined 2002 to 2005 data with combined 2006 to 2009 data indicate that similar percentages of drunk drivers in both time periods drove under the influence of illicit drugs and alcohol at the same time, overall and for both age groups.

Driving under the Influence of Illicit Drugs

Combined 2006 to 2009 data indicate that 4.3 percent of persons aged 16 or older (an estimated 10.1 million persons) drove under the influence of illicit drugs in the past year. The rates of drugged driving were among the highest in Rhode Island (7.8 percent) and Vermont (6.6

Figure 2. Percentages of Persons Aged 16 or Older Driving under the Influence of Illicit Drugs in the Past Year, by State: 2006 to 2009



Source: 2006 to 2009 SAMHSA National Surveys on Drug Use and Health (NSDUHs).

percent) and among the lowest in Iowa (2.9 percent) and New Jersey (3.2 percent) (Figure 2).

Of the 10 States with the highest rates of drugged driving, 4 were in the Northeast (Massachusetts, New Hampshire, Rhode Island, and Vermont), 3 were in the West (Colorado, Montana, and Oregon), and 3 were in the South (Arkansas, Delaware, and Oklahoma). Of the 10 States with the lowest rates of drugged driving, 4 were in the South (Alabama, Maryland, Mississippi, and Texas), 3 were in the Northeast (New Jersey, New York, and Pennsylvania), 2 were in the Midwest (Iowa and South Dakota), and 1 was in the West (Utah).

Rates of past year drugged driving were about 4 times higher among persons aged 16 to 25 than among those aged 26 or older (11.4 vs. 2.8 percent).

Trends in Driving under the Influence of Illicit Drugs

When combined 2002 to 2005 data are compared with combined 2006 to 2009 data, the Nation as a whole experienced a statistically significant reduction in the rate of past year drugged driving (from 4.8 to 4.3 percent), as did seven States: Alaska, California, Florida, Hawaii, Iowa, Michigan, and Pennsylvania (Table 2). No States had a statistically significant increase in the rate of drugged driving.

Reductions in past year rates of drugged driving were found both among persons aged 16 to 25 (12.9 to 11.4 percent) and among persons aged 26 or older (3.0 to 2.8 percent).

Driving under the Influence of Illicit Drugs in Combination with Alcohol

Combined 2006 to 2009 data indicate that two thirds of drugged drivers aged 16 or older (66.3 percent) drove under the influence of illicit drugs and alcohol at the same time; the rate was similar for drugged drivers aged 16 to 25 and those aged 26 or older (65.8 and 66.7 percent, respectively). Comparisons of combined 2002 to 2005 data with combined 2006 to 2009 data indicate

Table 2. Driving under the Influence of Illicit Drugs in the Past Year among Persons Aged 16 or Older for the Total Population and States with Significant Reductions: 2002 to 2005 versus 2006 to 2009

State	Combined 2002 to 2005 (Percent)	Combined 2006 to 2009 (Percent)
Total United States	**4.8**	**4.3**
Alaska	6.8	4.3
California	5.1	4.4
Florida	4.9	4.2
Hawaii	6.3	3.9
Iowa	4.9	2.9
Michigan	6.0	5.1
Pennsylvania	4.5	3.5

Source: 2002 to 2009 SAMHSA National Surveys on Drug Use and Health (NSDUHs).

that similar percentages of drugged drivers drove under the influence of illicit drugs and alcohol at the same time, overall and for both age groups.

Discussion

The Nation as a whole has seen reductions in the rates of drunk driving and drugged driving in recent years; however, each of these behaviors remains a serious problem in the United States. Although there is wide variation in the rates of impaired driving among States, no State is immune from this problem. The prevalence of impaired driving, particularly among persons aged 16 to 25, points to the need for continued prevention efforts, such as media campaigns, responsible alcohol sales and service training, sobriety checkpoints, and substance abuse assessment and treatment for those convicted of impaired driving,[9] to reduce the incidence of impaired driving and the harm it poses.

End Notes

[1] Kelly, E., Darke, S., & Ross, J. (2004). A review of drug use and driving: Epidemiology, impairment, risk factors and risk perceptions. *Drug and Alcohol Review, 23*, 319-344.

[2] National Highway Traffic Safety Administration, National Center for Statistics and Analysis. (2009). *Traffic safety facts, 2008 data: Alcohol-impaired driving* (DOT HS 811 155). Washington, DC: U.S. Department of Transportation. [Available as a PDF at http://www-nrd.nhtsa.dot.gov/Pubs/811155.PDF]

[3] Office of National Drug Control Policy. (2010). *National drug control strategy.* Washington, DC: The White House. [Available as a PDF at http://www.whitehousedrugpolicy.gov/publications/policy/ndcs10/ndcs2010.pdf]

[4] Substance Abuse and Mental Health Services Administration. (2010, October 1). *Leading change: A plan for SAMHSA's roles and actions 2011-2014.* Rockville, MD: U.S. Department of Health and Human Services. [Available as a PDF at http://www.samhsa.gov/about/sidocs/SAMHSA_SI_paper.pdf]

[5] NSDUH defines nonmedical use of prescription-type drugs as use not prescribed for the respondent by a physician or used only for the experience or feeling the drug(s) caused. Nonmedical use of any prescription-type pain reliever, sedative, stimulant, or tranquilizer does not include over-the-counter drugs; nonmedical use of stimulants includes methamphetamines.

[6] This report uses State estimates based solely on the weighted sample for each State and the District of Columbia (e.g., direct State estimates) and does not use the small area estimation (SAE) methodology. Therefore, this report's estimates should not be compared with the estimates in any previous NSDUH reports that use the SAE methodology.

[7] Estimates were divided into quintiles for ease of presentation and discussion, but differences between States and quintiles were not tested for statistical significance. In some instances, more than 10 or fewer than 10 States were assigned to each quintile because of ties in the estimated prevalence rates.

[8] The West has 13 States: AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, and WY. The South has 16 States plus the District of Columbia: AL, AR, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, and WV. The Northeast has 9 States: CT, MA, ME, NH, NJ, NY, PA, RI, and VT. The Midwest has 12 States: IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, and WI.

[9] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2010, July 30). *Impaired driving.* Retrieved November 10, 2010, from http://www.cdc.gov/MotorVehicleSafety/Impaired_Driving/impaired-drv_factsheet.html

Suggested Citation

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Findings from the SAMHSA 2002 to 2009 National Surveys on Drug Use and Health (NSDUHs)

State Estimates of Drunk and Drugged Driving

- Combined 2006 to 2009 data indicate that 13.2 percent of persons aged 16 or older (an estimated 30.6 million persons) drove under the influence of alcohol in the past year and 4.3 percent (an estimated 10.1 million persons) drove under the influence of illicit drugs in the same time period
- The rates of past year drunk driving were among the highest in Wisconsin (23.7 percent) and North Dakota (22.4 percent); the rates of drugged driving were among the highest in Rhode Island (7.8 percent) and Vermont (6.6 percent)
- When combined 2002 to 2005 data are compared with combined 2006 to 2009 data, the Nation as a whole experienced statistically significant reductions in the rates of drunk driving (from 14.6 to 13.2 percent) and drugged driving (from 4.8 to 4.3 percent); 12 States saw reductions in drunk driving rates, and 7 saw reductions in drugged driving rates

The National Survey on Drug Use and Health (NSDUH) is an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The combined 2002 to 2005 data used in this report are based on information obtained from 210,286 persons aged 16 or older, and the combined 2006 to 2009 data are based on information obtained from 213,350 persons aged 16 or older. The survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence.

The NSDUH Report is prepared by the Center for Behavioral Health Statistics and Quality (CBHSQ), SAMHSA, and by RTI International in Research Triangle Park, North Carolina. (RTI International is a trade name of Research Triangle Institute.)

Information on the most recent NSDUH is available in the following two-volume publication:

Office of Applied Studies. (2010). *Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of national findings* (HHS Publication No. SMA 10-4586Findings, NSDUH Series H-38A). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Office of Applied Studies. (2010). *Results from the 2009 National Survey on Drug Use and Health: Volume II. Technical appendices and selected prevalence tables* (HHS Publication No. SMA 10-4586Appendices, NSDUH Series H-38B). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Also available online: http://oas.samhsa.gov.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Substance Abuse & Mental Health Services Administration
Center for Behavioral Health Statistics and Quality
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November 2011

Prescription Painkiller Overdoses in the US



15,000

Nearly 15,000 people die every year of overdoses involving prescription painkillers.

1 in 20

In 2010, 1 in 20 people in the US (age 12 or older) reported using prescription painkillers for nonmedical reasons in the past year.

1 Month

Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for a month.

Deaths from prescription painkillers* have reached epidemic levels in the past decade. The number of overdose deaths is now greater than those of deaths from heroin and cocaine combined. A big part of the problem is nonmedical use of prescription painkillers—using drugs without a prescription, or using drugs just for the "high" they cause. In 2010, about 12 million Americans (age 12 or older) reported nonmedical use of prescription painkillers in the past year.

Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for a month. Although most of these pills were prescribed for a medical purpose, many ended up in the hands of people who misused or abused them.

Improving the way prescription painkillers are prescribed can reduce the number of people who misuse, abuse or overdose from these powerful drugs, while making sure patients have access to safe, effective treatment.

* "Prescription painkillers" refers to opioid or narcotic pain relievers, including drugs such as Vicodin (hydrocodone), OxyContin (oxycodone), Opana (oxymorphone), and methadone.

→ See page 4

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National Center for Injury Prevention and Control
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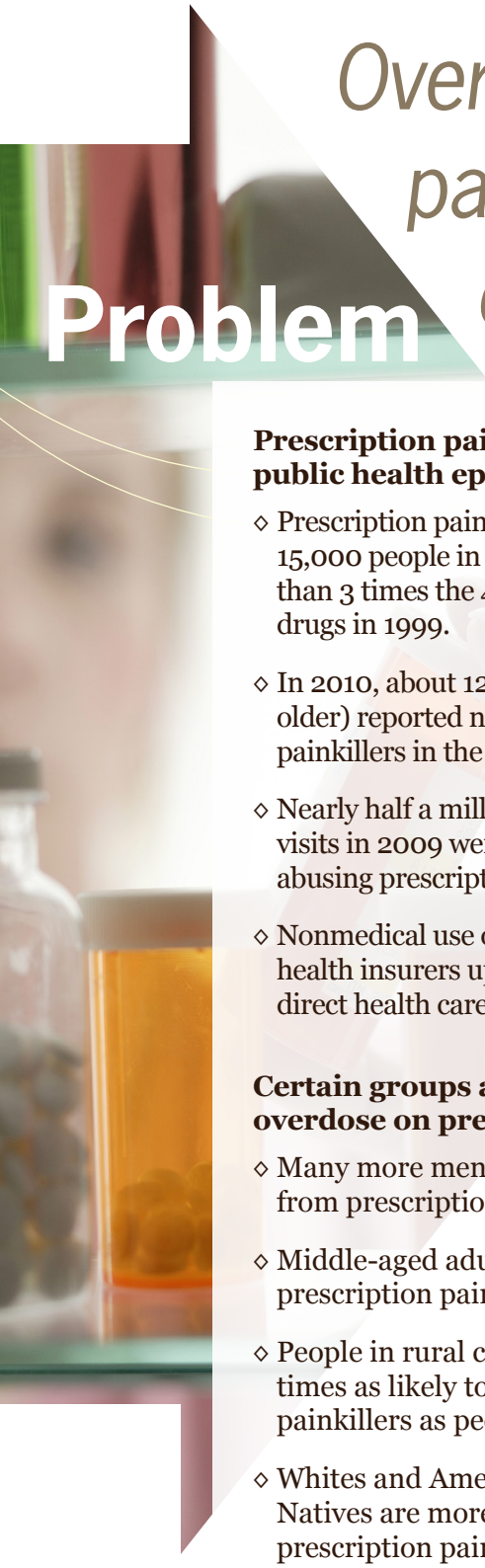


Problem

Overdose deaths from prescription painkillers have skyrocketed during the past decade.

Prescription painkiller overdoses are a public health epidemic.

- Prescription painkiller overdoses killed nearly 15,000 people in the US in 2008. This is more than 3 times the 4,000 people killed by these drugs in 1999.
- In 2010, about 12 million Americans (age 12 or older) reported nonmedical use of prescription painkillers in the past year.
- Nearly half a million emergency department visits in 2009 were due to people misusing or abusing prescription painkillers.
- Nonmedical use of prescription painkillers costs health insurers up to $72.5 billion annually in direct health care costs.

Certain groups are more likely to abuse or overdose on prescription painkillers.

- Many more men than women die of overdoses from prescription painkillers.
- Middle-aged adults have the highest prescription painkiller overdose rates.
- People in rural counties are about two times as likely to overdose on prescription painkillers as people in big cities.
- Whites and American Indian or Alaska Natives are more likely to overdose on prescription painkillers.
- About 1 in 10 American Indian or Alaska Natives age 12 or older used prescription painkillers for nonmedical reasons in the past year, compared to 1 in 20 whites and 1 in 30 blacks.

The supply of prescription painkillers is larger than ever.

- The quantity of prescription painkillers sold to pharmacies, hospitals, and doctors' offices was 4 times larger in 2010 than in 1999.
- Many states report problems with "pill mills" where doctors prescribe large quantities of painkillers to people who don't need them medically. Some people also obtain prescriptions from multiple prescribers by "doctor shopping."

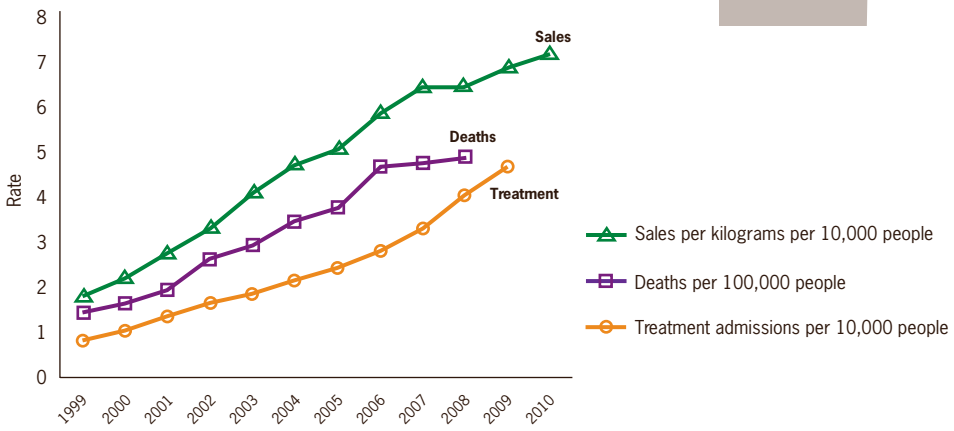
Some states have a bigger problem with prescription painkillers than others.

- Prescription painkiller sales per person were more than 3 times higher in Florida, which has the highest rate, than in Illinois, which has the lowest.
- In 2008/2009, nonmedical use of painkillers in the past year ranged from 1 in 12 people (age 12 or older) in Oklahoma to 1 in 30 in Nebraska.
- States with higher sales per person and more nonmedical use of prescription painkillers tend to have more deaths from drug overdoses.

Real Life Stories of the Epidemic

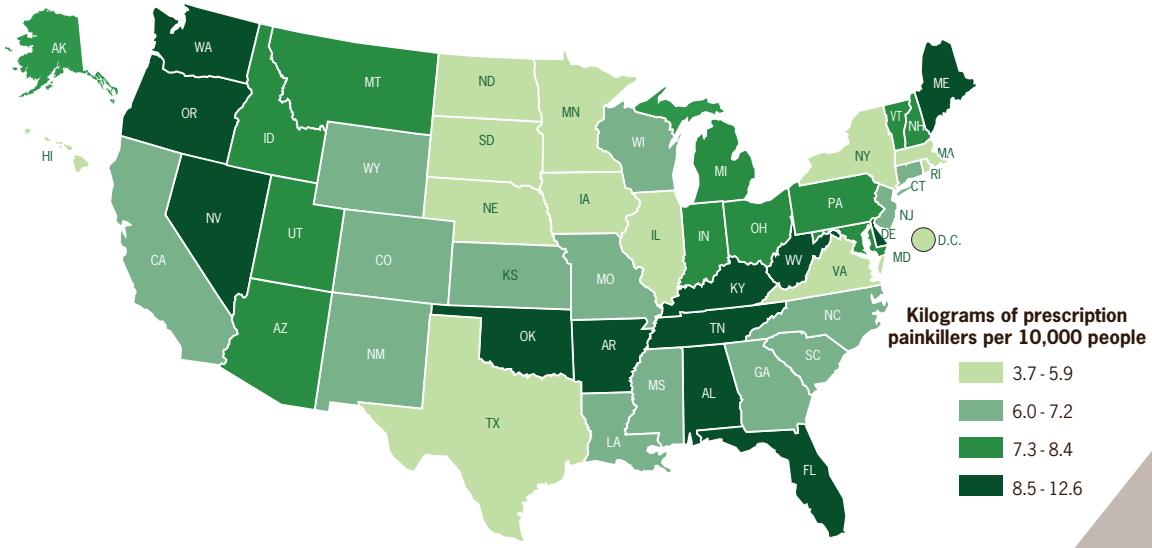
A West Virginia father, age 26, struggling for years with pain and addiction after shattering his elbow in a car crash, died from a prescription painkiller one week after telling his mother he wanted to go to rehab. In New Hampshire, a 20-year-old man overdosed on a prescription painkiller bought from a friend, becoming the 9th person that year to die from drug overdose in his community of 17,000. Stories such as these are all too common.

Rates of prescription painkiller sales, deaths and substance abuse treatment admissions (1999-2010)



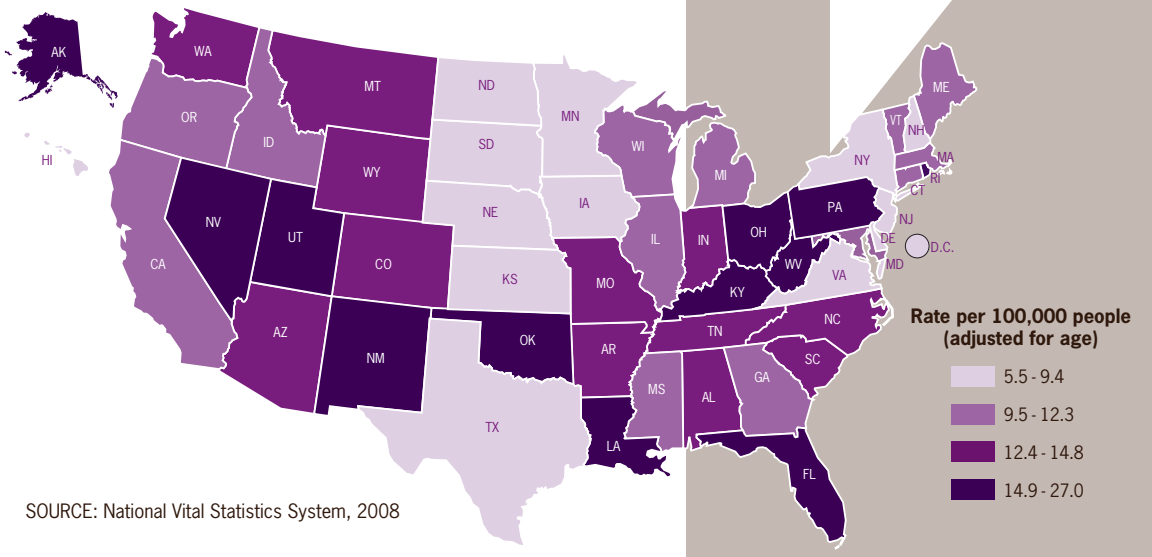
SOURCES: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009

Amount of prescription painkillers sold by state per 10,000 people (2010)



SOURCE: Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 2010

Drug overdose death rates by state per 100,000 people (2008)



SOURCE: National Vital Statistics System, 2008

What Can Be Done

The US government is

- ◇ Tracking prescription drug overdose trends to better understand the epidemic.
- ◇ Educating health care providers and the public about prescription drug abuse and overdose.
- ◇ Developing, evaluating and promoting programs and policies shown to prevent and treat prescription drug abuse and overdose, while making sure patients have access to safe, effective pain treatment.

States can

- ◇ Start or improve prescription drug monitoring programs (PDMPs), which are electronic databases that track all prescriptions for painkillers in the state.
- ◇ Use PDMP, Medicaid, and workers' compensation data to identify improper prescribing of painkillers.
- ◇ Set up programs for Medicaid, workers' compensation programs, and state-run health plans that identify and address improper patient use of painkillers.
- ◇ Pass, enforce and evaluate pill mill, doctor shopping and other laws to reduce prescription painkiller abuse.
- ◇ Encourage professional licensing boards to take action against inappropriate prescribing.
- ◇ Increase access to substance abuse treatment.

Individuals can

- ◇ Use prescription painkillers only as directed by a health care provider.
- ◇ Make sure they are the only one to use their prescription painkillers. Not selling or sharing them with others helps prevent misuse and abuse.
- ◇ Store prescription painkillers in a secure place and dispose of them properly.*
- ◇ Get help for substance abuse problems if needed (1-800-662-HELP).

Health insurers can

- ◇ Set up prescription claims review programs to identify and address improper prescribing and use of painkillers.
- ◇ Increase coverage for other treatments to reduce pain, such as physical therapy, and for substance abuse treatment.

Health care providers can

- ◇ Follow guidelines for responsible painkiller prescribing, including
  - Screening and monitoring for substance abuse and mental health problems.
  - Prescribing painkillers only when other treatments have not been effective for pain.
  - Prescribing only the quantity of painkillers needed based on the expected length of pain.
  - Using patient-provider agreements combined with urine drug tests for people using prescription painkillers long term.
  - Talking with patients about safely using, storing and disposing of prescription painkillers.*
- ◇ Use PDMPs to identify patients who are improperly using prescription painkillers.

* Information on the proper storage and disposal of medications can be found at www.cdc.gov/HomeandRecreationalSafety/Poisoning/preventiontips.htm.

For more information, please contact
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CONNECTICUT

Table 23. Selected Drug Use, Perceptions of Great Risk, Average Annual Marijuana Initiates, Past Year Substance Dependence or Abuse, Needing But Not Receiving Treatment, and Past Year Mental Health Measures in *Connecticut,* by Age Group: Estimated Numbers (in Thousands), Annual Averages Based on 2009-2010 NSDUHs

Measure	12+	12-17	18-25	26+	18+
ILLICIT DRUGS					
Past Month Illicit Drug Use[1]	281	30	98	153	251
Past Year Marijuana Use	407	48	146	213	359
Past Month Marijuana Use	227	25	88	113	202
Past Month Use of Illicit Drugs Other Than Marijuana[1]	111	12	34	65	99
Past Year Cocaine Use	50	3	19	28	47
Past Year Nonmedical Pain Reliever Use	122	14	42	66	107
Perception of Great Risk of Smoking Marijuana Once a Month	922	67	58	798	856
Average Annual Number of Marijuana Initiates[2]	37	17	18	2	20
ALCOHOL					
Past Month Alcohol Use	1,747	50	258	1,439	1,697
Past Month Binge Alcohol Use[3]	776	32	183	561	744
Perception of Great Risk of Drinking Five or More Drinks Once or Twice a Week	1,247	114	116	1,017	1,133
Past Month Alcohol Use (Persons Aged 12 to 20)	137[4]	--	--	--	--
Past Month Binge Alcohol Use (Persons Aged 12 to 20)[3]	95[4]	--	--	--	--
TOBACCO PRODUCTS					
Past Month Tobacco Product Use[5]	738	31	155	552	708
Past Month Cigarette Use	627	25	133	469	603
Perception of Great Risk of Smoking One or More Packs of Cigarettes per Day	2,152	195	248	1,709	1,957
PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT[6]					
Illicit Drug Dependence[1]	60	7	23	30	53
Illicit Drug Dependence or Abuse[1]	86	13	34	39	73
Alcohol Dependence	96	5	25	65	90
Alcohol Dependence or Abuse	231	14	70	148	218
Alcohol or Illicit Drug Dependence or Abuse[1]	276	20	85	171	256
Needing But Not Receiving Treatment for Illicit Drug Use[1,7]	73	12	30	31	61
Needing But Not Receiving Treatment for Alcohol Use[7]	221	13	67	141	208
PAST YEAR MENTAL HEALTH					
Had at Least One Major Depressive Episode[8,9]	--	22	29	137	166
Serious Mental Illness[9,10]	--	--	32	98	130
Any Mental Illness[9,11]	--	--	118	395	513
Had Serious Thoughts of Suicide	--	--	22	74	97

-- Not available.

NOTE: Estimates are based on a survey-weighted hierarchical Bayes estimation approach.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. These estimates include data from original methamphetamine questions but do not include new methamphetamine items added in 2005 and 2006. See Section B.4.8 in Appendix B of the *Results from the 2008 National Survey on Drug Use and Health: National Findings.*

[2] *Average annual number of marijuana initiates* = X_1 2, where X_1 is the number of marijuana initiates in the past 24 months.

[3] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

[4] Underage drinking is defined for persons aged 12 to 20; therefore, the "Total" estimate reflects that age group and not persons aged 12 or older.

[5] Tobacco Products include cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco.

[6] Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[7] Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs (or alcohol), but not receiving treatment for an illicit drug (or alcohol) problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

[8] Major depressive episode (MDE) is defined as in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), which specifies a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. There are minor wording differences in the questions in the adult and adolescent MDE modules. Therefore, data from youths aged 12 to 17 were not combined with data from persons aged 18 or older to get an overall estimate (12 or older).

[9] For more details, see Section A.11 in Appendix A of the report on *State Estimates of Substance Use and Mental Disorders from the 2009-2010 NSDUHs.*

[10] Serious mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a substance use disorder, that met the criteria found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) and resulted in serious functional impairment in carrying out major life activities.

[11] Any mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a substance use disorder, that met the criteria found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), regardless of the level of impairment in carrying out major life activities.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 and 2010 (Revised March 2012).

CONNECTICUT

Table 24. Selected Drug Use, Perceptions of Great Risk, Average Annual Rates of First Use of Marijuana, Past Year Substance Dependence or Abuse, Needing But Not Receiving Treatment, and Past Year Mental Health Measures in *Connecticut,* by Age Group: Percentages, Annual Averages Based on 2009-2010 NSDUHs

Measure	12+	12-17	18-25	26+	18+
ILLICIT DRUGS					
Past Month Illicit Drug Use[1]	9.52	10.54	26.07	6.70	9.42
Past Year Marijuana Use	13.79	16.77	39.03	9.31	13.47
Past Month Marijuana Use	7.69	8.86	23.56	4.96	7.56
Past Month Use of Illicit Drugs Other Than Marijuana[1]	3.77	4.16	9.07	2.86	3.73
Past Year Cocaine Use	1.69	1.04	5.13	1.21	1.76
Past Year Nonmedical Pain Reliever Use	4.12	5.00	11.08	2.88	4.03
Perception of Great Risk of Smoking Marijuana Once a Month	31.35	23.45	15.41	34.91	32.18
Average Annual Rate of First Use of Marijuana[2]	2.27	7.23	10.51	0.15	1.40
ALCOHOL					
Past Month Alcohol Use	59.38	17.75	68.76	62.98	63.79
Past Month Binge Alcohol Use[3]	26.35	11.19	48.82	24.56	27.96
Perception of Great Risk of Drinking Five or More Drinks Once or Twice a Week	42.38	40.28	30.82	44.52	42.60
Past Month Alcohol Use (Persons Aged 12 to 20)	31.94[4]	--	--	--	--
Past Month Binge Alcohol Use (Persons Aged 12 to 20)[3]	22.26[4]	--	--	--	--
TOBACCO PRODUCTS					
Past Month Tobacco Product Use[5]	25.07	10.81	41.34	24.18	26.58
Past Month Cigarette Use	21.31	8.76	35.47	20.54	22.64
Perception of Great Risk of Smoking One or More Packs of Cigarettes per Day	73.11	68.65	66.24	74.77	73.58
PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT[6]					
Illicit Drug Dependence[1]	2.02	2.40	6.01	1.32	1.98
Illicit Drug Dependence or Abuse[1]	2.91	4.42	9.05	1.72	2.75
Alcohol Dependence	3.24	1.93	6.74	2.84	3.38
Alcohol Dependence or Abuse	7.85	4.82	18.62	6.46	8.17
Alcohol or Illicit Drug Dependence or Abuse[1]	9.36	7.18	22.66	7.47	9.60
Needing But Not Receiving Treatment for Illicit Drug Use[1,7]	2.46	4.09	7.90	1.38	2.29
Needing But Not Receiving Treatment for Alcohol Use[7]	7.51	4.67	17.93	6.17	7.81
PAST YEAR MENTAL HEALTH					
Had at Least One Major Depressive Episode[8,9]	--	7.59	7.71	6.01	6.25
Serious Mental Illness[9,10]	--	--	8.55	4.27	4.87
Any Mental Illness[9,11]	--	--	31.54	17.27	19.27
Had Serious Thoughts of Suicide	--	--	5.95	3.25	3.63

-- Not available.

NOTE: Estimates are based on a survey-weighted hierarchical Bayes estimation approach.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. These estimates include data from original methamphetamine questions but do not include new methamphetamine items added in 2005 and 2006. See Section B.4.8 in Appendix B of the *Results from the 2008 National Survey on Drug Use and Health: National Findings*.

[2] *Average annual marijuana initiation rate* = $100 * \{[X_1 \quad (0.5 * X_1 \quad X_2)] \quad 2\}$, where X_1 is the number of marijuana initiates in the past 24 months and X_2 is the number of persons who never used marijuana. Both of the computation components, X_1 and X_2, are based on a survey-weighted hierarchical Bayes estimation approach. Note that the age group is based on a respondent's age at the time of the interview, not his or her age at first use.

[3] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

[4] Underage drinking is defined for persons aged 12 to 20; therefore, the "Total" estimate reflects that age group and not persons aged 12 or older.

[5] Tobacco Products include cigarettes, smokeless tobacco (i.e., chewing tobacco or snuff), cigars, or pipe tobacco.

[6] Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[7] Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs (or alcohol), but not receiving treatment for an illicit drug (or alcohol) problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

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[9] For more details, see Section A.11 in Appendix A of the report on *State Estimates of Substance Use and Mental Disorders from the 2009-2010 NSDUHs*.

[10] Serious mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a substance use disorder, that met the criteria found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) and resulted in serious functional impairment in carrying out major life activities.

[11] Any mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a substance use disorder, that met the criteria found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), regardless of the level of impairment in carrying out major life activities.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 and 2010 (Revised March 2012).

Hartford Courant

State Seeks To Divert Veterans From Jail To Treatment

October 15, 2012
By LISA CHEDEKEL,
Conn. Health I-Team Writer,

When the state Department of Veterans' Affairs recently advertised a job opening for a veterans' service officer, 73 veterans applied, many of them younger men and women who had served in Iraq and Afghanistan.

While they came from different backgrounds and zip codes, many had a common trait, Veterans' Affairs Commissioner Linda Schwartz said: "They are wound tighter than a clock. They've deployed two or three times, had a successful military career, and now here they are home, struggling with the aftereffects, looking for jobs. . . We are seeing a large group of people who are really on the edge."

Some of those people -- more than 1,000 a year, according to estimates -- have landed in Connecticut's criminal justice system, often charged with lower-level crimes such as DUI, disorderly conduct or breach of peace.

Starting this month, Connecticut will follow a number of other states in beginning a program aimed at identifying veterans who are arrested for minor crimes and diverting them from jails to treatment. The state's initiative has an unusual twist, allowing veterans to use the Accelerated Rehabilitation (AR) program twice, rather than just once. AR allows low-risk defendants to complete community treatment programs and avoid prosecution.

"It's a really important change for a group of people who can benefit from services already in place," said Margaret Middleton, executive director of the Connecticut Veterans Legal Center, which worked with the Veterans Legal Services Clinic at Yale Law School to lobby for the veterans' bill.

"Given the high incidence of PTSD and stress that our veterans are experiencing, we're concerned that their first introduction to the mental health system should come before incarceration, where possible."

The new diversion program coincides with a national study showing that Iraq and Afghanistan war veterans who have anger and irritability associated with combat trauma are more than twice as likely as other veterans to be arrested. The new study of a national sample of nearly 1,400 combat veterans found that while 9 percent overall reported being arrested since returning home from deployments,

23 percent of those with high irritability connected to post-traumatic stress disorder (PTSD) reported being arrested.

"Clinicians should be aware that veterans with PTSD who report very frequent symptoms of anger and irritability may be at increased risk of engaging in criminal behavior," the study, published this month in the Journal of Consulting and Clinical Psychology, concludes. The research team, led by the University of North Carolina- Chapel Hill School of Medicine, also noted strong correlations between criminal behavior and factors not related to military service, such as a troubled family background or history of substance abuse.

The researchers recommended that the courts and VA outreach programs "routinely recommend interventions targeting symptoms of anger and irritability."

In Connecticut, which has more than 245,000 veterans, 16,000 who served in Iraq and Afghanistan, the new initiative will allow defendants to access supervised diversion programs, which offer mental health treatment, without requiring that they have a formal psychiatric diagnosis. As veterans are identified as eligible, court support officers will work to connect them with existing drug-treatment programs and other services offered through the VA, the Connecticut Department of Veterans Affairs and the state Department of Mental Health and Addiction Services. That process has already started, with the diversion rules taking effect Oct. 1.

RockyHillPatch

Blumenthal Holds Forum on Prescription Drug Abuse

The goal of the roundtable was to educate the public on the dangers of prescription drugs.

By Joseph Wenzel IV - October 29, 2011

U.S. Sen. Richard Blumenthal led a panel discussion on prescription drug abuse Friday morning at the Connecticut Department of Veterans Affairs.

“This working roundtable was very important to take the next steps for stopping prescription drug abuse, which is one of the epidemic scourges in public health,” Blumenthal said. “People need to understand that their medicine cabinet can be a ticking time bomb. The best way to prevent a tragedy is to get rid of drugs no longer being used.”

In 2007, 28,000 people in the United States died from unintentional drug overdoses, mostly due to prescription drug abuse, according to Blumenthal.

One of those in attendance was the director of the Office of National Drug Control Policy, Gil Kerlikowske, who discussed the importance of getting rid of expired and unnecessary drugs.

“We learn an awful lot going around the country and from a result of listening to what people have done and seen. It gives us a chance to talk about what the administration’s position is on prescription drugs.”

The event was held at the State Veterans Home because officials wanted to raise awareness about the rise in veterans’ prescription drug abuse. Blumenthal said prescription drug abuse by veterans more than doubled from 2005 to 2008, shooting from from 5% to 12%.

“So it is definitely affecting veterans.”

Dr. Linda Schwartz, commissioner of the Connecticut Department of Veterans’ Affairs, said the department just finished a needs assessment of 650 veterans in Connecticut and found that prescription drug abuse in the state is in line with the national average.

Officials were shocked to learn that many of the soldiers returning from Iraq and Afghanistan are using steroids.

“I think it is a new issue,” Schwartz said.

Schwartz, however, was not surprised and said that many of them do it to keep with the “macho image.”

Some of the veterans who really need pain medicine are forced to quit "cold turkey" because of financial restraints.

Blumenthal added that prescription drugs are the second most commonly abused drugs, behind only marijuana.

“Prescription drug abuse is horrendously prevalent and pernicious.”

Kerlikowske said there are two problems involving young people and prescription drugs. One is that young people do not recognize that prescription drugs are dangerous and second that they are so “widely available.”

The key to stopping prescription drug abuse is education, Schwartz said.

“I think that it (education) is listed as the first pillar of the administration’s prescription drug control strategy," Kerlikowske said. "And it is not just education for the patients and physicians, but also the young people."

Schwartz said the people who prescribe drugs need to make sure their patients understand what they are taking and the side effects.

People should also be aware of the dangers of mixing prescription drugs with alcohol, Schwartz said.

"I think it is one of the things that we see here, people take something for pain and if it doesn’t work they will have a couple of drinks. And they feel no pain.”

National Drug Take Back day is Saturday. Check with your local police department or town hall on the location of your town’s drop off. About 100,000 pounds of prescription drugs are expected to be collected nationally, Kerlikowske said.

Published on *The Connecticut Mirror* (http://www.ctmirror.org)

Budget cuts eliminating beds for substance abuse treatment

Arielle Levin Becker
July 20, 2011

MIDDLETOWN--So far, in his 25-year career as a state employee providing addiction treatment services, Ken Kroll has worked at two facilities that have since closed their substance abuse programs.

Connecticut Valley Hospital, where he works now, has also cut back. And on Sept. 1, it will eliminate 20 detoxification beds and 60 rehabilitation beds for men.

"It just keeps shrinking," Kroll said Wednesday.

Ken Kroll and other CVH workers rally outside Merritt Hall

The planned closure of two rehabilitation units at the Middletown hospital's Merritt Hall, part of $1.6 billion in cuts announced last week, represents the elimination of more than 15 percent of the intensive substance abuse rehabilitation beds at facilities the state either operates or contracts with.

A ratified agreement between state employee unions and the administration of Gov. Dannel P. Malloy could avert the closures. But if the 60 rehabilitation beds are closed, the state will be left with 284 comparable beds, including 30 for women at CVH that will remain open, 21 beds at the state's Blue Hills campus in Hartford, and 233 run by private nonprofits.

Private substance abuse treatment providers are working with the state Department of Mental Health and Addiction Services to try to absorb the demand. The private facilities also offer detox services, but not with the level of medical care that Merritt Hall has, so some patients will likely go to acute care hospitals for detox when the 20 Merritt Hall beds are closed.

"Eighty beds is a huge, huge reduction in capacity on the substance abuse side," said Jeff Walter, President and CEO of Rushford, which provides substance abuse and mental health services.

Rushford has 42 beds for intensive rehabilitation--comparable to the beds the state is cutting--and 16 detox beds.

Walter said he doesn't think the existing providers can completely absorb the need created by the planned closures. The implications, he said, will be "pretty dire": Instead of treatment, people will end up in jail, emergency rooms, or hospitals that cost more.

"I hope this can be averted," said Walter, the longtime co-chair of the council that oversees the state's Behavioral Health Partnership, which handles mental health and substance abuse care for people in Medicaid and other state programs.

Rushford has some beds available now--not uncommon in the summer--but Walter said it's not clear how long that will last.

Bill Young, chief operating officer of Alcohol and Drug Recovery Centers, Inc., in Hartford, said his agency has "some small amount" of capacity in a program that's comparable to the rehabilitation units being closed. Overall, ADRC has 28 intensive rehabilitation beds and 35 detox beds.

"From our perspective, we can help out a little," Young said. "I guess the question becomes...when you add together all the small contributions that a bunch of providers within the system can make, is that enough?"

DMHAS is hoping that it will be. "Some providers currently have some unused capacity, which we will utilize," department spokesman James Siemianowski said.

Going forward, substance abuse services at state facilities will be reserved for patients with no insurance who meet the medical necessity criteria for the services. "We are the payor of last resort," Siemianowski said.

DMHAS closed admissions to the intensive residential programs for men on Wednesday, a move intended to give current patients enough time to receive treatment and get follow-up care in the community. Admissions to the detox program will be closed Aug. 15. Both dates were set based on customary lengths of stay, according to the department.

Siemianowski said the general hospitals in the state provide detox services at the level that Merritt Hall does now, and can adapt to demand. In addition, Blue Hills has 21 detox beds at a

lower level of medical care, while community providers that contract with the department have 130.

Patty Charvat, a spokeswoman for the Connecticut Hospital Association, said hospitals are particularly concerned about the closure of detox beds, which she said will lead people to seek services in emergency departments that are already at or near capacity.

"We are definitely anticipating that we'll be impacted by this closure, and it will start in the ED," she said.

During a rally outside Merritt Hall Wednesday, addiction services workers, many of whom received layoff notices, said they hoped an agreement on a concessions deal would make the cuts and layoffs unnecessary. Their union, the New England Health Care Employees Union, District 1199, SEIU, voted for the concession package.

But workers warned that the closure of the substance abuse beds would mean some people would be shut out from care altogether, with potentially dangerous consequences.

"Many patients here have been turned away by private sector agencies because of their complex issues or inability to pay," said Sarah Woolard-Raczka, an addiction counselor. She said the programs have at times had waiting lists of six weeks, and that the beds slated to be eliminated serve about 1,600 people a year.

"In the short term, it might look like money saved, but in the process, lives will be lost," she said.

Others said that patients who can't get into Merritt Hall could wind up in emergency departments, on the streets, or in jail.

"Or a community!" one worker shouted. "A community near you!" someone else added.

"If they live!" a third called out.

Ann Marie Rankins, a mental health worker who has worked at CVH for about 12 years and received a layoff notice, said patients have learned about the planned closure through the media and have asked what they will do now, if they'll just be left on the streets to die.

"At least we can find jobs," she said. "But our patients need somewhere to go."

THE MIDDLETOWN PRESS

CVH employees rally to save detox facility

Wednesday, September 9, 2009
By JENNIFER SPRAGUE, Press staff

MIDDLETOWN — Workers at the state-run Connecticut Valley Hospital say the possible closure of its drug and alcohol detoxification unit would have a detrimental effect on emergency rooms and the state's judicial system.

The 20-bed unit in Merritt Hall is one of two state-run detox units in Connecticut targeted for possible closure; the other is at Blue Hills Substance Abuse Service campus in Hartford.

At a rally Tuesday, more than 50 CVH employees blasted Gov. M. Jodi Rell for targeting the unit for possible closure. Carrying signs that said "Budget is broken, not detox" and "Close detox, people die," workers chanted "Shame on her" to the governor. A spokesman in Rell's office referred questions to the state Department of Mental Health and Addiction Services, which runs CVH.

DHMAS Spokesman Steve DiLella said the department is investigating whether the closures are feasible, and no decision has been made yet. He said DHMAS is researching bed usage and the ability of the health care system, at both private and public facilities in Connecticut, to provide detoxification services.

Blue Hills and CVH are two of three state-run detox units in the state; the third is a 10-bed facility in Bridgeport; there are also a number of privately-run facilities in the state.

"The majority of our clients don't have the resources to go to other facilities," said doctor Feliciano Leviste.

The unit at CVH serves many people who are homeless, unemployed and have no insurance, said registered nurse Irene Wilson. Recently, the unit has seen an increased number of veterans of the Iraq war who are addicted to opiates, she said.

The CVH detox unit served more than 1,100 clients in 2008; so far this year, an average of 88 people are admitted each month.

Wilson said closing the unit will have an "enormous impact" on emergency rooms and the state's judicial system. Hospital emergency rooms, she said, are equipped to address initial withdrawal symptoms, but the CVH unit provides necessary follow-up care.

"This is our specialty and what we are trained to do," Wilson said.

Doctor Anca Pralea said the program at CVH addresses physical and emotional issues

that come with addiction in a setting where clients can be monitored and treated 24 hours a day.

“Detox is more than a medical issue,” said social worker Elaine Lau. “Addiction is as much a psychological issue as a physical issue. Detox addresses the whole person. Detox is essential to getting our clients into recovery.”

Joe Cacace of Middletown, a former client, said the facility saved his life. He has been clean for seven months.

“I know it’s saved many lives,” he said. “Addicts will die out there. We need treatment, not to be jailed.”

Democratic state representatives Matt Lesser (Middletown, Middlefield, Durham), Jim O’Rourke (Cromwell, Middletown, Portland) and Russ Morin (Wethersfield) each spoke briefly at the rally.

O’Rourke said he knows of constituents who have sent their family members to detox facilities in other states because a bed was not available in Connecticut.

“We don’t have a surplus of beds here; we have a deficit,” he said.

Head nurse John Palomba estimated the unit is typically 80 to 100 percent occupied.

If the detox units are closed, DHMAS will still maintain its long-term rehabilitation facilities, DiLella said; CVH has an 80-bed rehab facility, and Blue Hills has 21 beds, he said.

Closure of the units would result in layoffs at the facility.

newstimes.com

Prescription drug abuse in Danbury area is stealing lives

Nanci G. Hutson, Staff Writer

Published: Monday, August 16, 2010

Ridgefield substance abuse therapist Liz Jorgensen is shocked that no one has hit the panic button yet over the latest drug abuse trends.

Statistics indicate prescription drug overdoses are killing nice kids from nice families in well-to-do communities all over the country.

Prescription drug use in Connecticut now kills more people under the age of 34 than car crashes, Jorgensen said, quoting a national study of figures from 2006 released this year.

Nationwide, 45,000 are killed in car crashes; 39,000 die from prescription drug overdoses, according to the study.

"Why isn't everybody freaking out?" asked Jorgensen, who owns Insight Counseling and leads educational seminars and workshops on substance abuse. "It's terrifying."

Jorgensen's professional network and private practice indicate an increasing number of teens are dying from the scourge of prescription drugs, particularly opiates that mimic heroin. She said kids do not perceive the addictive danger of these drugs.

Jorgensen said some teens get hooked on heroin when the price of narcotic painkillers gets too high.

In recent months, Jorgensen said she has sent 30 of her patients under age 22 to in-patient treatment for opiate abuse. They all started using strong painkillers and then moved toward heroin as a cheaper alternative.

One OxyContin pill -- a trademark version of the narcotic painkiller oxycodone -- costs about $80; a gram of cocaine is $50, and heroin is even cheaper at about $10 a bag, area experts said.

Jorgensen and other substance abuse specialists said opiates -- many found in bathroom cabinets and family medicine drawers -- are quite prevalent and accessible. Not only are they addictive, too often they can prove deadly when combined with other medications or alcohol.

The much-publicized death of a 17-year-old Newtown High School student, Danielle Jacobsen, just before her graduation ignited renewed concern about these troubling trends, according to area substance abuse specialists.

The investigation determined Jacobsen ingested a relatively unknown drug at a party in a Monroe condominium complex and early the next morning was found dead in a nearby pond.

Soon after news broke about Jacobsen's death, rumors started to circulate about teens who attend "pharm" parties, where unknown brands of prescription drugs are offered to guests.

Local substance abuse officials and police said they think that is relatively rare. Rather, they said, teens tend to sell or barter prescription drugs raided from family stashes, with some even stealing the drugs or altering medications they are able to buy over the counter.

"I don't think this `bowl thing' is exactly what it looks like," said Allison Fulton, executive director of the Housatonic Valley Coalition Against Substance Abuse. "But prescription drugs are out there.

Students don't just abuse narcotic painkillers, Fulton said.

She said she regularly hears of teens and young adults abusing attention deficit disorder and anti-anxiety drugs, as well as taking over-the-counter cough medications in higher doses than advised.

Cocaine is making a resurgence in some of the wealthier towns, and heroin use is clearly on the rise and readily available, she said.

Fulton also is highly concerned about underage drinking and marijuana use. She and others said that often is the beginning of drug exploration by teens and young adults. If not stopped early it can fuel addictions that lead them crave other drugs.

"It's pretty scary," Fulton said.

Newtown Parent Connection co-founder Dorrie Carolan said the availability of prescription drugs is cause for concern. In recent months, she has received calls about overdosing teens who ended up in emergency rooms and some in relapse after a period of sobriety.

Teens most vulnerable to these drugs tend to be those with lower self-esteem who are yearning for peer acceptance or approval, Carolan said.

"When they are high, they feel good," she said.

As for the cult or rare, drugs, Carolan said she doesn't hear much about that. Rather, it is opiates, prescription narcotics and heroin. She also hears from teens about marijuana experimentation, and the pot teens smoke today is far more potent than what their parents might have tried years ago.

Most disturbing, though, is teens mixing drugs and alcohol, she said.

"They all think they are invincible, nothing's going to happen," Carolan said, noting she has attended far too many funerals of teenagers whose friends' final goodbye is a night of drinking and drugging. "When there's a death, it raises awareness, but two weeks later everyone goes back to their day-to-day routines."

Some overdose deaths go unreported as such, deemed accidental or linked to some other health ailment, local specialists said. Families fear the stigma, so they stay silent.

But Carolan, a mother who helped create the coalition in 1999 as a response to the prescription drug overdose of her 28-year-old son, Brian, chooses to fight back by educating all those who can make a difference: parents, teachers, doctors, social service providers and their peers.

The coalition wants to ensure that addicted teens and their families find the right treatment the first time or for a relapse; embrace the success of a recently sober teen; and educate the entire community on prevention techniques and why this problem can affect everyone.

Carolan said teen drug abuse hurts senior citizens when they cross paths with an impaired driver; it hurts the unsuspecting student who shares the locker next to someone dealing drugs or the neighbor whose house is burglarized by someone looking for prescription medications.

"When we started Parent Connection, we figured it would be worth it if we saved one life. And we have seen many, many kids stay clean for years, and some of those kids have given a lot back to their community," Carolan said.

But the effort to halt drug abuse requires constant community vigilance, Carolan and others said.

Parents, schools, law enforcement, the medical profession, civic leaders, and the media need to be banging the drum about the realities so the danger is clear and easy access diminishes, the local experts said.

"What needs to happen is a whole culture shift," Fulton said, citing the success of the decades-long anti-smoking campaign that taught the public its health risks.

"We can't be Pollyanna about it. We have to create real awareness about what is going on ... and get kids to be more informed," Fulton said.

TESTIMONY OF MARY MARCUCCIO

Program Review & Investigations Committee; June 29, 2012
Access to Substance Abuse Treatment for Privately Insured Youth

Dear Sirs:

I appreciate this opportunity to share some thoughts on the issue of *Access to Substance Abuse Treatment for Privately Insured Youth*. Thank you for raising this subject for discussion and review.

I speak to you as the parent of a young drug user; my son became involved with drugs at 12 years old, he is now 23 and just beginning to make some needed changes. These years have given me extensive personal experience with drug addiction, which allowed me to create and manage a support group for families with drug addicted children. I have gained additional knowledge and experience while walking alongside numerous other families as they go through the drug process themselves. Below are some of my issues of concern:

**The unreasonable and unsound policies of private insurers and private pay facilities in restricting HOW and WHEN a youth gets into treatment

HOW: many facilities will tell a potential client (during the pre-auth/intake process) that they're *"not high enough"* – they don't meet the intake protocol based on levels of drugs in the urine sample; **kids will go out and get high in order to get into detox!!**

WHEN: most insurers require a client to ATTEND AND FAIL repeated outpatient programs before they will cover an inpatient stay at rehab; this philosophy is completely the reverse of **what should be** – which is extended longer term inpatient programs to start with, with outpatient as follow up only (studies have proven that longer term inpatient programs have much greater success than *any* outpatient programs)

**There are NOT ENOUGH private pay youth facilities/beds in Connecticut; this includes inpatient detox and rehab. In my work, I've encountered many parents who've taken their child out of state for immediate care, often not covered by their insurance plan—meaning that they must pay out of pocket

**In keeping with the previous item, the wait for a client to get into a facility (detox or rehab) can be *days or weeks*; this is absolutely unacceptable – as all clinical experience shows that IMMEDIATE treatment is most successful. In addition, many clients will opt to go to an emergency room to be seen immediately, often having to exaggerate or manufacture symptoms to meet emergency care protocol, in order to avoid the wait for a detox or rehab bed at a private pay facility

**The length of stay for detox and rehab programs is simply TOO SHORT; longer stays are necessary!

DETOX: most insurers require a detox patient to be discharged at/about 72 hours of care ----- According to well established research, CLINICALLY, 72 HOURS IS WHEN THE BODY IS AT ITS HIGHEST DETOX LEVEL AND THE HUMAN BIOLOGY IS MOST VULNERABLE ; they're literally discharging someone at the height of his withdrawal and when he's most likely to use drugs!! Substance abuse professionals agree that detoxes should be a *minimum* of at least 5 days for best results

REHAB: the average private pay client gets 14-28 days at an inpatient program; this is simply not enough time for the body, brain and psyche to have the opportunity to learn and habituate needed changes. Longer term inpatient stays are decidedly much more successful

**Because private insurers will only cover very short detox and rehab stays, many parents will take their child OFF of their private insurance coverage and put them onto one of the state funded insurance programs ---because they provide better coverage for longer periods of time. This switch is absolutely *part & parcel* of the protocol for many families once a child turns 18! (our family included!)

~On a personal note, our family was faced with an untenable choice when my son was 15 and in the throes of a horrific drug addiction: keep him on our private insurance and not get long term care, or relinquish custody to DCF in order for him to be on state insurance and get long term care!!
NO PARENT SHOULD EVER BE FACED WITH SUCH A DECISION!!!!!!

Unfortunately, *all drug users aren't created equal*; the brain function of a youth is very different from that of an adult, as we all know, yet this hasn't been taken into consideration sufficiently enough in most treatment programs. A young drug user will think differently, process differently, and react differently to treatment than his older adult counterpart. In my experience, staff and programs just aren't trained well enough in these differences, and are not keeping current on youth drug trends, leading to the needs of young users **not being sufficiently met

**Since most young users live at home with parents/family, the family should be better incorporated into the treatment process – this is not happening nearly as often or as well as it should be. Most insurers are "client" driven – will cover costs associated ONLY with the drug user/client, when in fact including counseling/therapy coverage for the supporting family *would be most advantageous*. If Johnny gets "fixed", but mom and dad are still "sick", how successful will his homebound process be??? My personal experience shows, and clinical research data supports, that the family of the drug user needs to receive counseling in order to make needed changes to *their* often uneducated and enabling behaviors.

Overall, the youth substance abuse treatment "system" is very broken, and desperately in need of repair. Insurance companies are the driving force behind this fracture, as they seem to view drug abuse/addiction with what I call "broken leg syndrome" --- *just patch him up and send him home*... This is very faulty logic, rooted in a completely ignorant and uneducated viewpoint. Insurance companies should be supporting longer term detox and rehab stays at the *onset* of the problem, spending monies on the *front end* – not the *back end*. The nickel and dime approach that they have now actually costs them much more in the long run because of repeated relapses and reoccurring treatment needs.

THANK YOU for your time and attention to this matter,

MARY MARCUCCIO

45 Woodruff St., Southington CT 06489

860-621-1682

Founder & Spokesperson, ***Parents 4 A Change Inc.*** www.parents4achange.net



Attachment E

In response to CON application item 4a:

List of key professional, administrative, clinical, and direct service personnel and their Curriculum Viate

- Peter Schorr
- Chrissy Gariano
- Scott Korogodsky
- Thomas Garofola
- Laura LeVan
- Todd Foont

Peter Schorr

489 Ridgefield Road, Wilton CT 06897

Professional Experience

Retreat at Lancaster County, Ephrata, PA **2011 – present**
President/CEO

Conceived of and managed the development of an 88,000 sf, 24-acre campus to provide inpatient substance abuse services. Closely managed every aspect, including acquisition, renovations, licensing, accreditation, program development and staff recruiting - successfully completed in six months.

Retreat at Lancaster County has been incredibly well received by the recovery, healthcare and local community. As a result, hospital/crisis admissions account for over 40% of Retreat's admissions. Additionally, Retreat has enjoyed the full support of the local government and law enforcement community. Retreat is now recognized as a premier facility with an attentive staff and superior clinical program. Retreat has also met or exceeded all admissions and revenue projections, profitable in month 2 of operations, and cash flow positive by month 5.

DRPS Management LLC, Miami Beach, FL **2008 – present**
Managing Director

DRPS managed the day to day operations of Malvern Institute located at 940 West King Road, Malvern, PA 19355, an 80-bed inpatient addictions detoxification and rehabilitation facility in Malvern, PA from July 2008 through June 2010. Responsibilities included all facets of operations including marketing, admissions, clinical and medical oversight, billing and collections. DRPS' tenure created tremendous growth at Malvern, both in terms of patient days and financial performance while instituting a comprehensive continuum of care model. Highlights include census increase of 30%, revenue increase of 86% ($4.7MM to $8.8MM), and expense increase of less than 20%. In addition, the outpatient facilities were expanded to not only enhance the existing programs, but to include additional treatment (Partial Hospitalization) at 2 locations, which added almost $100,000 per month to Malvern's revenue with a nominal increase in expense.

The Schorr Organization, New York, NY **1995 – present**
Founding Member/President

Responsible for all financial and administrative decisions for the company.

West Midtown Medical Group Inc, New York, NY **1997 – present**
President/C.E.O./C.F.O.

Oversee all administrative and financial services for management of West Midtown Medical group, a Primary Healthcare Center, located at 311 West 35th Street, New York, NY 10018, specializing in drug, alcohol and infectious diseases. West Midtown treats over 800 methadone and 235 alcohol and substance abuse patients per day. These patients use West Midtown's ambulatory clinic for their primary health care. Liaison between State, City, and Federal agencies. Involved in all aspects of negotiating for acquisitions for the company.

East Harlem Management Group, Inc., New York, NY **1991 - 1999**
President/C.E.O./C.F.O.

Created and established management company for primary care and HIV medical facility serving over 1400 patients annually in the East Harlem area. Responsible for all financial aspects for the facility. Liaison between community and local agencies.

Middle Eastern Textiles, New York, NY , Baku, Azerbaijan **1998 - 2003**
Founding Member/President

Negotiated with Azeri government for purchase of LVS cotton, the largest ginning operation in Barda, Azerbaijan.

The Luxor Group, New York, NY **1994 - 2002**
Founding Member/Vice President/C.F.O.

Responsible for all financial and administrative decisions for company. Involved in the negotiations with the Egyptian Government in purchasing largest beverage and brewery in Egypt. Responsible for family portfolio. The Luxor Group was the largest shareholder of publicly traded company that was sold in 2002 to Heineken for $258,000,000.

STH Management Group, Inc. New York, NY **1991 - present**
General Manager/C.F.O.

Helped create computer service corporation that specializes in data processing for the health field industry specifically the Methadone Maintenance field. Responsible for all financial and administrative aspects of operations including the main liaison between the computer company and the health facilities.

Richard Koeppel MMTP, New York, NY **1988 -1990**
Administrator

Oversee all administrative services for 1,000 patient Methadone Maintenance program.

Richard Koeppel MMTP, New York, NY **1985 -1988**
Addiction Counselor Supervisor

Responsible for the supervision of 10 addiction counselors and 500 Methadone patients. Coordinated all Federal, state, and city inspections

Richard Koeppel MMTP, New York **1980 - 1985**
Addictions Counselor

Addictions counselor, responsible for 50 patient caseload.

Education

University Of Utah, Salt Lake City., Utah	1976-1979
Queens College, Queens, NY	1974-1976

Associations

Licensed Private Pilot, PPA
Certified HIV Counselor, January, 1991
Notary Public, September 1980

Chrissy Gariano

31 Hillbrook Circle
Malvern, PA 19355
610-585-0247
gariano22@yahoo.com

Education:

Immaculata University, Immaculata, PA

- Master of Arts in Counseling Psychology, May 2000
- Certification in Secondary School Guidance Counselor, May 2000

Bloomsburg University, Bloomsburg, PA

- Bachelor of Arts in Sociology, December 1995

Work Experience:

Retreat at Lancaster County
Inpatient Drug and Alcohol Rehabilitation Center
Executive Director, July 2011 to present
Management of all departments and programs

- Member of Executive Interdisciplinary Management Team
- Review and update all policies and procedures for facility to ensure compliance with state and county regulations
- Program development for counselors and patients
- Ensure clinical team meets state regulations for trainings
- Lead team for preparation for state, county and CARF surveys
- Ensure staffing and scheduling for all departments
- On-call at all times for facility
-

Malvern Institute, Malvern, PA
Inpatient Drug and Alcohol Rehabilitation Center
Executive Director, September 2008 to June 2011
Clinical Director, June 2004 to September 2008
Clinical Supervisor/Acting Clinical Director, February 2003 to June 2004
Senior Counselor, September 2000 to February 2003
Counselor, May 2000 to September 2000

- Management of all departments and programs
- Review and update all policies and procedures for facility to ensure compliance with state and county regulations
- Program development for counselors and patients
- Ensure clinical team meets state regulations for trainings
- Leader for daily interdisciplinary clinical case conference
- Lead team for preparation for state, county and CARF surveys
- On-call at all times for facility

Scott Korogodsky

1500 Bay Road, Apt. 302, Miami Beach, FL 33139
Direct: (305) 542-0687 scottkoro@gmail.com

Computer Skills:

Sigmund Electronic Medical Records, Microsoft Word, Powerpoint and Excel

Experience

2011-Present **Retreat at Lancaster Cty/NR Pennsylvania Assoc.** **Ephrata, PA**
Director of Operations

- Determine, direct and participate in the overall development and implementation of information, information systems and non-clinical operations.
- Ensure that all information, medical record and financial systems are accurately maintained in an efficient and effective manner including: billing/collections, budgets, census reports, revenue/expense reports, and directives.
- Negotiate and secure contracts with various third-party payors.
- Develop and manage financial policies and day-to-day operations with regard to admissions, billing and collections, in accordance with governmental requirements and company goals.

2008-Present **Malvern Institute/DRPS Management LLC** **Malvern, PA**
Operations Manager

- Responsible for preparation and maintenance of operations and personnel budgets.
- Prepare daily and periodic reporting, including financial and census.
- Assist in process of negotiating and securing contracts with various local, regional and national payors.
- Manage daily charge and census reconciliation.
- Determine patient benefits, eligibility and financial responsibility prior to admission.
- Maintain computer and telephone systems.

2005-2008 **The Stonywell Group** **Ft. Lauderdale, FL**
Director of Operations

- Responsible for all phases of Commercial Loan prequalification including cash flow, income and tax return analysis, real estate valuation, lease analysis and overall credit worthiness.
- Review and qualify Construction Loan requests (both residential and commercial) including project and cost analysis, “as-is” and “as-complete” real estate valuation and overall feasibility of the project.
- Work with clients and potential clients to restructure financials and loan packages for presentation to banks and/or other investors.
- Insure compliance with lender and investor lending guidelines, including National Financial Institutions, local banks, mortgage banks and private investors.
- Negotiate pricing with lenders and investors to maximize company profitability while meeting client’s needs.
- Act as liaison between investor and client from processing through underwriting to closing.
- Manage small office network in the Windows Server 2003 environment, including day-to-day technical support.
- Create and implement forms and reporting materials necessary to a financial institution.
- Proven expertise in supporting and managing hardware, software and networking issues.
- Develop and execute email-marketing campaigns to achieve maximum market exposure while maintaining CAN-SPAM compliance.

2003-2005 **International Seaway Trading Corp.** **Boca Raton, FL**
Sales Manager

- Actively manage sales relationships with multiple customers, representing all retail tiers, to grow business, while meeting margin and delivery requirements.
- Obtain and maintain relationships with multiple factories to secure priority and accuracy of production.
- Ensure satisfaction of customer requirements including timing, proper product manufacturing and product design, color and material accuracy.

- Maintain strict price points and retail needs.
- Present products to customers and prospective customers meeting fashion & price point goals.
- Adapt product line or create new product to suit individual customer's requirements and specifications.
- Analyze current and future market trends to develop footwear products in line with fashion direction, price, profitability & salability.
- Responsible for the complete process of goods delivery including product sampling, production, receipt of finished product as well as tracking and analyzing retail sales.

2002-2003 BBC International, LLC Boca Raton, FL
Sales Representative
- Managed and grew $5 million account base: 10% revenue increase over previous year,
- Acquired over $200,000 in new business accounts.
- Exceeded goals of pricing, development and proper delivery of first cost footwear while meeting customer's margin requirements.
- Consulted clients on current and upcoming fashion trends as related to the footwear and apparel industries.

2001-2002 Carolina Shoe Co. Morganton, NC
Sales Representative - Midwest
- Managed territory of 100+ accounts in multi-state area. Accounts ranged from single store location to 30+ store retail chains.
- Developed new accounts.
- Created opportunities in retail location for prominent product placement.
- Influenced retailers to carry multiple Carolina Brands increasing sales and increasing product visibility.

1998-2001 Gold Xchange Marketing, Inc. Northbrook, IL
Graphic Designer/Sales Representative
- Developed and maintained key accounts.
- Grew account base by 700%
- Oversaw design and production of coupon books including output, print and mail distribution.
- Created layout of advertising and coupon books meeting strict deadlines and design specifications.
- Created and implemented marketing and sales tools resulting in 700% overall revenue growth.

1994-1998 Skechers USA, Inc. Manhattan Beach, CA
Field Service Manager
- Managed a nationwide staff of field service representatives.
- Maintained prominent visibility of products, displays and Point-of-Purchase materials in retail locations.
- Created and implemented national in-store marketing and point-of-purchase materials.
- Supplied detailed reports on inventory, placement and overall market conditions to retail clients.
- Coordinated local trade shows.
- Conducted product seminars and trunk shows with local merchants and national retailers.
- Developed sales presentations.
- Performed major operations to enhance presence at national trade shoes.

1990-1994 L.A. Gear, Inc. Santa Monica, CA
Trade Show Assistant

EDUCATION

1992 – 1996 Illinois State University Normal, IL
Major: Marketing

Thomas P. Garofola, Sr., MHS, LCADC
2064 Whitehorse Hamilton Square Road
Hamilton, New Jersey, 08690
(609) 587-3932 home (609) 529-7092 mobile
garofola.tom1@verizon.net

EDUCATION:

2000-2002 **MHS** Master of Human Services
Lincoln University, Lincoln, PA

1994-1997 **AAS** Associate in Applied Sciences (degree not received)
Essex County College, Newark, New Jersey

CERTIFICATION/LICENSES:

NJ Licensed Clinical Alcohol and Drug Counselor: NJ License #37LC00123600
Internationally Certified Alcohol and Drug Counselor: IC&RC/AODA Cert. #15494
Certified Clinical Supervisor: APCBNJ
Certified Criminal Justice Counselor: APCBNJ Cert. #258
Certified Pulmonary Resuscitation (CPR)
Approved AODA Trainer: APCBNJ

PROFESSIONAL EMPLOYMENT:

CEO/President – **Flynn Christian Fellowship Houses of New Jersey Inc:** Non-profit agency providing sober living transitional housing for adult males recovering from alcohol and/or drug abuse. December 2009 to present.

Vice President of Operations: September 2007 to December 2009

Director of Marketing – **Retreat at Lancaster County**: Newly opened (August 2011) private for profit, 120 bed multi-faceted drug and alcohol addiction treatment program serving adults 18 and older. National marketing approach with marketing coordinators in strategic geographic areas as well as strong web presence for business development. Referrals range from detoxification to 30-day treatment to long-term partial hospitalization, IOP and GOP. July 2011 to present

Senior Marketing Coordinator – **Malvern Institute:** Private for profit comprehensive addiction treatment agency servicing adult clients from all walks of life. Referrals range from detoxification to 30-day treatment to long-term partial hospitalization, IOP and GOP. Demographic area primarily served includes Northeastern United States from New England to the Delmarva Peninsula: September 2008 to July 2011.

Consultant – **Addiction Professionals Certification Board of New Jersey Inc:** Oral examination evaluator of prospective certified alcohol and drug counselors: 1997 to present.

Private Consultant – Providing substance abuse and alcohol evaluations for DWI and other legal cases for clients referred by Federal Aviation Authority as well as New Jersey based attorneys: November 2007 to present.

Service Coordinator – **SpecialCare Hospital Management (New Vision @ Palisades Medical Center/Trinitas Hospital):** National contract management behavioral healthcare firm providing inpatient medical/surgical stabilization service that treats patients with drug, alcohol and other related medical co-morbidities: January 2005 to April 2008.

Program Development Specialist 1 – **Governor's Council on Alcoholism and Drug Abuse:** State agency that provides statewide advocacy and coordination of alcohol, tobacco and other drugs of abuse (ATOD) services, comprehensive statewide Master Plan for ATOD, and a statewide alliance to prevent alcohol and drug abuse. Statewide coordinator of adult and juvenile criminal justice related addiction initiatives: June 2001 to September 2004.

Adolescent Home Care Therapist (part-time) **– Greater Trenton Behavioral Health Care:** Social service agency providing a wide array of social services including mental health treatment for at-risk and troubled youth in the Greater Trenton area. April 2004 to September 2005

Unit Supervisor – **Community Education Centers of America (Albert M "Bo" Robinson Education and Training Center):** Community-based substance abuse assessment/treatment halfway house for adult males returning to the community from the New Jersey prison system: February 1998 to June 2001.

Senior Counselor **– Correctional Medical Services:** 188 bed prison-based therapeutic community for substance abuse treatment in Garden State youth correctional facility: June 1997 to January 1998.

Senior Counselor – **Integrity Inc. Pride of Newark:** Intensive day program and outpatient drug and alcohol treatment program: May 1993 to June 1997.

Drug and Alcohol Counselor (part-time) – **New Hope Foundation:** 45 bed adolescent drug and alcohol treatment program and 20 bed detoxification unit: June 1996 to January 2000.

PROFESSIONAL MEMBERSHIPS: Past and Present

National Association of Alcoholism and Drug Abuse Counselors (NAADAC)

New Jersey Association of Alcoholism and Drug Abuse Counselors (NJAADAC)

Addiction Professionals Certification Board of New Jersey Inc. (APCBNJ)

National Council on Alcoholism and Drug Dependence (NCADD)

American Corrections Association (ACA)

Rutgers School of Alcohol and Drug Studies Alumni Association

Pi Gamma Mu Social Science Honor Society

Phi Theta Kappa International Honor Society
International EAP Association

PROFESSIONAL EXPERIENCE

Program Planning and Implementation

I have extensive experience in the development and implementation of treatment programs and training programs. This includes research, staff recruitment, training, responsibility for curriculum development and implementation, daily scheduling, and clinical supervision; monitoring programs to assure contract compliance and responding to funding sources. Experienced in assembling stakeholders and coordinating efforts to address criminal justice and ATOD abuse related issues statewide.

Clinical Supervision and Staff Training

Supervisory experience includes supervising front line staff in various treatment modalities. As a supervisor, I recruited, trained, evaluated, disciplined, and provided comprehensive clinical supervision to subordinates. In addition to my supervisory experience, I have trained counselors on the certification/licensure process, documentation procedures, and philosophy of therapeutic communities. Experienced in designing and implementing training programs for professionals from the criminal justice and addiction treatment fields.

Clinical Experience

I have extensive experience in all aspects of client care including assessment, individual counseling, group therapy, folder documentation, case management, training, and referrals. Experience in several modalities including hospital/medical model; therapeutic communities; detoxification, and criminal justice settings working with specific populations including indigent and homeless individuals, mentally ill chemical abusers, women, adolescent, and criminal justice populations.

Marketing Experience

Experienced in marketing a treatment service to increase daily census using proven effective strategies such as electronic marketing, cold call, media advertisement and more. Extensive professional resources and contact list developed from more than 15 years in the substance abuse, mental health, corrections and political/government arenas.

PRESENTATIONS:

Project coordinator and contributing writer for the Governor's Council on Alcoholism and Drug Abuse's 2004 Comprehensive Statewide Master Plan for Alcohol, Tobacco, and Other Drug Abuse (state document).

Presentation to the Hawthorne Gospel Church congregation on the importance of providing prison inmates with Bible Study Courses in an effort to lower recidivism by increasing prisoner's spirituality and faith while improving their attitudes and behaviors: Hawthorne, NJ (2003).

Designed, implemented, and participating panelist on "Drug Courts and the Municipal Alliances: A Roundtable Discussion on the Possibility of Partnership" Trenton, NJ (2003).
Panelist for the National Council on Alcoholism and Drug Dependence – New Jersey's Addiction Discrimination Policy Panel in New Jersey: Trenton, NJ (2003).

Designed and implemented several 6-session, 24 hour multidisciplinary training modules for law enforcement, criminal justice, social service, and substance abuse treatment professionals in the Greater Newark region: Newark, NJ (2003 & 2004).

Presentation to The Coalition of Community Corrections Providers of New Jersey on the Governors Council on Alcoholism and Drug Abuse's reorganizing efforts, strategic planning process, and advocacy methods used to coordinate statewide ATOD abuse initiatives: Newark, NJ (2002).

Presentation to UMDNJ Developmentally Disabled Program Advisory Board on the Governors Council on Alcoholism and Drug Abuse's reorganizing efforts, strategic planning process, and advocacy methods used to coordinate statewide ATOD abuse initiatives: Piscataway, NJ (2002).

Cross-culture training workshop for security personnel and substance abuse treatment staff working in several New Jersey criminal justice-based treatment facilities: Professional conduct in criminal justice-based treatment programs: Newark, NJ (2001).

Taught 16 hour Introduction to Counseling class for CADC credit for community-based treatment professionals working with a criminal justice population at 320-bed treatment facility: Trenton, NJ (2001).

Training for substance abuse treatment professionals in a criminal justice-based assessment and treatment facility: The importance of proper documentation in the treatment of substance abusing clients: Trenton, NJ (2000).

Successfully defended Master's thesis, "Action skills training to avoid recidivism: A training intervention to reduce recidivism among adult male substance abusers in the New Jersey criminal justice system" before a panel of evaluators, peers, and invited guests Philadelphia, PA (2002).

PUBLICATIONS:

Garofola, T. (2004). 2004 New Jersey Comprehensive Statewide Master Plan for Alcoholism, Tobacco and Other Drug Abuse. The Governor's Council on Alcoholism and Drug Abuse: Trenton NJ.

Garofola, T.P. (2002). Action skills training to avoid recidivism: A training intervention to reduce recidivism among adult male substance abusers in the New Jersey criminal justice system. Lincoln University, PA: Lincoln University Master of Human Services Program.
Garofola, T. (2002). ATP holds 25th annual training conference. The Bulletin: GCADA News and Information Quarterly, 3, (4), Trenton, NJ.

Garofola, T. (2002). Drug Court Bill Signed. The Bulletin: GCADA News and

Information Quarterly, 3, (3), Trenton, NJ.
Garofola, T. (2001). Drug court legislation approved. The Bulletin: GCADA News and Information Quarterly, 3, (2), Trenton, NJ.

AWARDS:

Received the President's Award for Commitment from the New Jersey Chapter of Employee Assistance Professionals (2009)

Received Certificate of Appreciation for Support and Dedication from the New Jersey County Coordinators Association. (2004)

Recognized in Who's Who in Medicine and Healthcare, 4th Edition 2002 – 2003 and 5th Edition 2004 – 2005

Received the 2002 Pi Gamma Mu, Ina Turner Gray Award For National Academic Recognition for academic distinction, consistent scholastic achievement, and best exemplifying the spirit of commitment and dedication to the community-at-large.

Received the Dedication and Service Award from the clients of the graduating class of Integrity House Inc. (1997).

Recognized in the 1994 – 1995 and 1995 – 1996 editions of the National Deans List Publication.

PROFESSIONAL/COMMUNITY/CIVIC ORGANIZATIONS

New Jersey Employee Assistance Professionals Association – Vice President (2010-present)

Flynn Christian Fellowship Houses of NJ: Vice President, Board of Directors (2005-2007)

Hudson County, NJ Serial Inebriate Program (SIP) Initiative: Member – (2010-Present)

New Jersey Medically Assisted Treatment Consortium (MATI): Member – (2010-Present)

Mayor's Parks and Recreation Advisory Board: Hamilton Township (2001-2003)

Hamilton Little Lads Basketball League: Assistant Director, Coach (2003 – present)

Hamilton Township Pop Warner Football Assoc: Vice President; Coach (1999 – 2007)

Nottingham Little League Baseball Association: Vice President, Manager, Coach (2001 – 2009)

Hamilton Area YMCA Youth Basketball League: Coach (2002)

Hamilton Little Lads Baseball League: Coach (2004)

Albert M "Bo" Robinson Education and Training Center Citizens Advisory Board: Member (2002 – 2008)

Patrick S. Biddulph Leukemia Foundation: Vice President Corporate Affairs (1999 - 2004)

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Laura L. LeVan

520 Reinholds Rd, Denver PA 17517 Cell: 610-996-0174 llevan311@hotmail.com

OBJECTIVE To obtain an admissions management position that enables me to utilize my experience with the Retreat organization and grow with the company.

EDUCATION **Endicott College**—Beverly, MA, Sept. 1999—May 2001
Widener University—Chester, PA, Jan. 2002—May 2004

EXPERIENCE

Retreat at Lancaster County, Ephrata PA

Director of Admissions, Aug 2011— Current

- Manage admissions and reception departments including schedule staffing for departments
- Work closely with medical and psychiatric teams to determine appropriateness of referrals, track referral sources for admissions daily, verify insurance benefits and administer multi-disciplinary assessments for new admissions
- Establish close relationships with referral sources, families and patients

Malvern Institute, Malvern, PA.

Director of Admissions, March 2009—July, 2011

- Managed admissions, reception and transportation departments including scheduled staffing for departments
- Worked closely with medical and psychiatric teams to determine appropriateness of referrals, verified insurance benefits and administered multi-disciplinary assessments for new admissions
- Established close relationships with referral sources, families and patients

Broomall Rehabilitation & Nursing Center, Broomall, PA.

Admissions Coordinator, March 2005—Sept 2008

- Participated in marketing events, accepted/denied new residents for admissions, prepared and completed admissions paperwork, participated in daily integrated team meetings, prepared census and corporate reports, and provided facility tours
- Selected by supervisor to be placed on facility committees

Sterling Healthcare & Rehabilitation Center, Media, PA.

Admissions Coordinator, Aug 2004—March 2005

- Screened incoming referrals, obtained resident's pertinent medical information, negotiated HMO rates, maintained accurate records of bed availability and admission reports, provided facility tours, and completed admissions paperwork

- Maintained open lines of communication with all facility departments
- Created process that enabled nursing administration to review referrals more efficiently

Activities Assistant, June 2001—Aug 2004

- Designed and implemented movement, spiritual awareness, sensory stimulation and recreational programs for all residents.
- Successfully utilized validation therapy to redirect residents with dementia
- Participated in training of dementia programs to new activities staff

Behavior health Designee, Winter 1999/ Summer & Winter 2000/ Summer 2001

- Administered Mini-Mental Status Exams, visited residents on a one-to-one basis, participated in weekly behavior meetings, and co-presented with Behavioral Health Specialist in weekly behavior plan meetings.

Receptionist, May 1997—Aug 1999 (weekends & holidays), Winter 2003—Summer 2004 (evenings)

- Directed incoming calls, typed documents for department heads, completed resident and employee filing, processed billing

Delaware County Court-Juvenile Probation Office, Chester, PA.

Service-learning: Mentor/Tutor, Feb. 2003—May 2004

- Tutored adolescents in various subjects on a one-to-one basis and in group settings, mentored adolescents and coordinated various field trips
- Managed tutors and adolescents after supervisor took leave of absence
- Presented at Atlantic Regional Service Learning Conference, Wyndham Hotel, Philadelphia, PA, Oct. 28, 2004

COMPUTER SKILLS Proficient in Word, Excel, and Power Point

Todd Foont

20201 E. Country Club Dr.
Aventura FL 33180
(561) 901-6148 foophun2@aol.com

Experience

Logistics and Facilities Manager — Retreat at Lancaster County
August 2012-Present — 1170 South State St. Ephrata Pa17522

120 Bed Inpatient Drug and Alcohol Facility

- Manage transportation department to facilitate patients transport to and from facility in a timely and cost effective manner.
- Supervise Maintenance staff to ensure efficient facility operations.
- Coordinate required periodic inspections
- Implement facility modifications and improvements as directed and/or in accordance with licensing/accreditation standards

Admissions and Transition House Manager — Malvern Institute
October 2009 -July 2009 — 940 West King Road, Malvern PA. 19355

80 Bed Inpatient Drug and Alcohol Facility, 24 Bed Transition House

- Managed 24 Bed Transition house, Transporting Patients to and from Out Patient
- Performed Random Drug Testing, Maintained Grounds

Property Manager — West Palm Mini Stor-It
October 2007-September 2009 — West Palm Beach FL. 33409

900 Unit Commercial Facility: storefronts, warehouses, and mini storage

- Responsible for leasing units, collections, monthly auctions, Evictions, advertising and maintaining property

Loan Officer — Century Financial Funding LLC
April 2007-August 2007 — Ft Lauderdale FL. 33309

- Generating and pricing loans
- Negotiations with mortgage brokers and lenders
- Initiation by promotion and advertisement
- Head officer of sales

Food and Beverage Service — Raleigh Hotel
August 2003-January 2007 — Miami Beach FL. 33139

- Bartending, wait staff, and customer service
- Financial responsibilities for opening and closing procedures
- Head of pool staff and service
- Operating hotel events

Service Writer JM Lexus
January 2000-2002 Margate FL. 33073

- Customer Service
- Service advisor
- Created Service repair orders
- Customer sales and up sales of maintenance

Sales Gold's Gym
December 1998-December 1999 Deerfield Beach FL. 33442

- Customer Service
- Daily maintenance of Facility
- Opening/Closing of customer accounts

Education

1996-2000 Lynn University, Boca Raton FL. 33431
B.A. - Hotel and Restaurant Management

Attachment F

In response to CON application item 4c:

Standard of Practice Guidelines that will be utilized in relation to this proposal

***Please Note**: In addition to the Connecticut Department of Mental Health and Addiction Services Practice Guidelines for Recovery-Oriented Behavioral Health Care , the ASAM Patient Placement Criteria, Second Edition, Revised ("ASAM PPC 2-R"), the most widely used and comprehensive set of guidelines for placement, continued stay and discharge of patients with addiction disorders, (officially required in over 30 states), along with additional internal standards and practices (delineated in Attachment B) will be utilized. Furthermore, 3 year CARF accreditation (their highest award) will be sought for this facility, as it was for Retreat at South Connecticut's sister facility, Retreat at Lancaster County (which was awarded this honor in April of 2012). Therefore, the CT DMHAS Practice Guidelines will be utilized as a "floor" for Retreat at South Connecticut's Standard of Practice, and Standard of Care.*



ASAM Patient Placement Criteria

Oversight and Revision

May 2011

To facilitate oversight of the ASAM Patient Placement Criteria (ASAM PPC), ASAM's Board of Directors has authorized a review process, executed by the Steering Committee of the Coalition for National Clinical Criteria, which has been in existence since the publication of the first edition of the ASAM PPC in 1991. The Steering Committee includes representatives of major organizations that are stakeholders in addiction treatment and therefore interested in applicability and validity of the PPC. This Steering Committee meets by teleconference every other month to receive and address feedback from these stakeholders' constituencies concerning the PPC and to seek their advice about any problems or new directions for the PPC. Collaboration with those representatives is active and continues to increase. (Full roster of members and their affiliations and Minutes of meetings are available on request).

The ASAM Patient Placement Criteria (ASAM PPC) text was first published in 1991 as an expert clinical consensus criteria set developed by an interdisciplinary workgroup.

Research beginning in 1994 under the leadership of David Gastfriend, M.D. at Harvard Medical School made the ASAM PPC the most researched and nationally accepted placement criteria in addiction treatment (Gastfriend, 2004). The U.S. federal government, through NIAAA, NIDA and CSAT, contributed about $6 million to its research validation from 1994-2006. This involved systematic conversion of each decision rule to one or more research quality, quantitative question and response item sets, and an algebraic algorithm to calculate the results of the PPC decision tree through computerized software. This allowed the PPC-1 to undergo testing for feasibility, reliability and predictive validity.

Changing service configurations in the field were recognized over the years between 1991 and 1995. These included the growth of ambulatory detoxification, the need to integrate opioid maintenance treatment into rehabilitation and growing distinctions in subspecialty services for medical and psychiatric needs. To address these needs, the PPC text was revised in 1996 and published as the PPC-2 through a similar interdisciplinary committee expert consensus process.

Based on emerging research data and continuing changing needs in the field, the PPC were again revised and published in 2001 as the PPC-2R through expert clinical consensus. The PPC-2R was then analyzed, computerized and tested in a study funded by the federal government of Belgium, in collaboration with Harvard Medical School. This study, which was presented to the International Society of Addiction Medicine in 2004, demonstrated the feasibility and predictive validity of the PPC-2R.

During this period, a decision was made that future revision should be driven primarily by two factors: 1) empirical data that indicate opportunity for improved predictive validity rather than by anecdotal input or face validity, and 2) treatment system changes. This is similar to the process that the American Psychiatric Association follows to revise the Diagnostic and Statistical Manual of Mental Disorders (DSM), in which any changes are made based on research data.

In 2006 the Steering Committee's review of ongoing research and policy data indicated that there was a need for changes in the PPC-2R criteria set, not in the current assessment dimensions or levels of care or criteria as currently written, but rather in terms of pharmacologic modalities. To address this need, therefore, a PPC-2R Supplement was published in 2010 to delineate criteria for the use of pharmacotherapies for Alcohol Use Disorders and specifically for detoxification (Dimension 1) and relapse (Dimension 5):The ASAM Patient Placement Criteria: PPC Supplement on Pharmacotherapies for Alcohol Use Disorders (Eds: Fishman MJ, Mee-Lee D, Shulman GD , Kolodner G, Wilford BB (2010). Lippincott Williams & Wilkins Philadelphia, PA).

Beginning in 2009, the PPC-2R began a three-year empirical evaluation, funded by the regional government of central Norway, with updates being presented from this multi-site study to the Steering

Committee for review and consideration of future needs. This evaluation is examining specific decision rule changes that may be needed to improve predictive validity.

The next step in the PPC updating process is that ASAM is beginning work on a PPC-2R Text Revision to coincide with the publication of the DSM-5 that will incorporate the changes in diagnostic criteria that are anticipated with that volume.

Additional recent references on the ASAM PPC:

Gastfriend DR (2004): Addiction Treatment Matching: Research Foundations of the American Society of Addiction Medicine (ASAM) Criteria. The Haworth Medical Press, Binghamton NY.

Mee-Lee D (2006): "Development and Implementation of Patient Placement Criteria" in "New Developments in Addiction Treatment". Academic Highlights. J Clin Psychiatry 67:11: 1805-1807.

Mee-Lee D, Gastfriend DR (2008): "Patient Placement Criteria", Chapter 6, pp79-91in Galanter M, Kleber HD (eds), Textbook of Substance Abuse Treatment 4th Edition. American Psychiatric Publishing, Inc. Washington, DC.

Mee-Lee D, Shulman GD (2009): "The ASAM Placement Criteria and Matching Patients to Treatment", Chapter 27 in Section 4, Overview of Addiction Treatment in "Principles of Addiction Medicine" Eds: Ries RK, Miller S, Fiellin DA, Saitz R. Fourth Edition. Lippincott Williams & Wilkins, Philadelphia PA. pp 387-399.

Gastfriend DR, Mee-Lee D (2010): "Patient Placement Criteria", Chapter 4, pp 99-123 in Marc Galanter & Herbert D. Kleber (eds) Psychotherapy for the Treatment of Substance Abuse Treatment 4th Edition. American Psychiatric Publishing, Inc. Washington, DC.

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Practice Guidelines for Recovery-Oriented Behavioral Health Care



Connecticut Department of Mental Health and Addiction Services

"No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his[/her] own person, free from all restraint or interference of others, unless by clear and unquestioned authority of law."

— United States Supreme Court

(Union Pacific Railway Co. v. Botsford)

Prepared for the Connecticut Department of Mental Health and Addiction Services by the Yale University Program for Recovery and Community Health (Tondora & Davidson, 2006).

Forward by Commissioner Thomas A. Kirk, Jr., Ph.D.

The document that you are about to read is an extraordinary one in its origins, its content, and its value as another step toward achieving and maintaining a recovery-oriented health care service system in Connecticut.

In my view, if not *the* most important, the following document is one of the most significant products to result within the last five years from the public/private partnership composed of persons in recovery, families, staff and leadership of DMHAS, prevention specialists, private nonprofit service providers, the academic community, and other advocates and stakeholders. This collective group has focused on assessing and improving the quality of services available for persons with mental illness and/or substance use disorders in the State of Connecticut.

Consider a few of its origins. Listening to the suggestions and continuing guidance of those who need or use our services is one of the most basic and essential characteristics of a recovery-oriented service system. Thus, beginning in 1999 we asked Advocacy Unlimited, Inc. and the Connecticut Community for Addiction Recovery, Inc. to work together to develop a set of **Recovery Core Values** that could serve as guideposts for DMHAS as it began the journey of restructuring its service system. The result was 27 principles divided into four categories: **Direction, Participation, Programming and Funding/Operations.** Go to www.dmhas.state.ct.us, click on major Initiatives, then "Recovery Initiative" for further information about the Recovery Core Values.

Well before 1999, there had been "champions" of recovery in any number of state and private service sectors who understood the meaning of "recovery" and the importance of it in the lives and care of the people receiving services. They now had the opportunity to speak in a louder voice and educate the rest of us. We all stand on the shoulders of those who came before us.

DMHAS later hosted a few statewide Recovery Conferences, established a Recovery Institute and Centers of Excellence, and conducted a series of consensus-building retreats for executive directors, medical and clinical leadership, and several other stakeholder groups within the mental health and addiction service communities and elicited their views about the concept of recovery, what it would mean for their activities, and what gaps needed to be addressed and barriers removed for us to achieve a recovery-oriented system.

All of the above, and other work, led to the signing in September 2002 of **Commissioner's Policy Statement No. 83 on "Promoting a Recovery-Oriented Service System."** This landmark policy designated the concept of recovery as the overarching goal, guiding principle, and operational framework for the system of care supported by the DMHAS. It incorporated the Recovery Core Values. It stated that:

> ***"We shall firmly embed the language, spirit, and culture of recovery throughout the system of services, in our interactions with one another and with those persons and families who trust us with their care."***

In addition, this policy envisioned and mandated services characterized by:

"…a high degree of accessibility, effectiveness in engaging and retaining persons in care

…effects shall be sustained rather than solely crisis-oriented or short-lived

…age and gender appropriate, culturally competent, and attend to trauma and other factors know to impact on one's recovery

…whenever possible, shall be provided within the person's home community, using the person's natural supports."

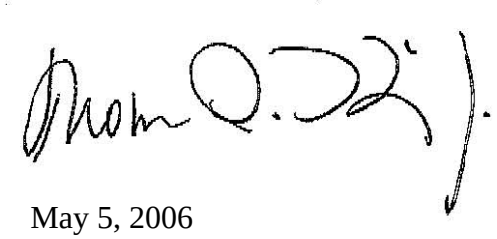
But how do you actually do a recovery-oriented service system? This key question remained after all of the above work and many current activities—too numerous to mention. Absent answers to this question, one may think "all this recovery stuff is conceptual … it has no real meaning or practical reality. The focus will not really change our system."

The following document answers this question by identifying eight domains of a recovery-oriented service system ranging from degree of participation of persons in recovery in the recovery planning and system development process to "Identifying and Addressing Barriers to Recovery." It then lists a dozen or so concrete, practical and well-researched action steps or guidelines in each domain. It answers questions like: "**You will know when you are placing primacy on the participation of people in recovery when…**"

The document gives examples, identifies potential barriers, and uses the words of people in recovery to explain what each domain means and what they can expect in that domain. It includes a glossary and distinguishes a **Deficit-based Perspective** from a **Recovery-oriented, Asset-based Perspective**. As service providers review their Agency Recovery Assessment Plans and as DMHAS fiscal, service, and quality staff go about their business, they now will have a roadmap to inform policy, develop outcomes and funding strategies, and a framework to monitor our fidelity with the guidelines of a recovery-oriented health care system. Persons in recovery and other recipients of services will know what to expect, what they need to be educated about, and what they have a right to demand in their interactions with the system.

It is said that successful initiatives have a thousand fathers and mothers and failed initiatives are orphans. I believe our journey to a recovery-oriented and transformed service system has many parents. I hope this document will help those who either cannot understand or who have not yet embraced a recovery-oriented service system to become another parent of this journey.

I would welcome any comments about the above or your opinion of this document at Thomas.Kirk@po.state.ct.us.



May 5, 2006

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Executive Summary

The notion of recovery has become the focus of a considerable amount of dialogue and debate between and among various constituencies within the mental health and addiction communities. Following a brief introduction to the topic, in which we clarify various sources of confusion about the term, these practice guidelines begin to operationalize the various components of DMHAS' vision of a recovery-oriented system of behavioral health care. This vision was first put forth in Commissioner's Policy #83, "Promoting a Recovery-Oriented Service System," and has since been embodied in various DMHAS education, training, and program development initiatives. These guidelines represent the first systematic effort to bring recovery into the concrete everyday practice of DMHAS-funded providers.

Defining our Terms

One major source of the confusion surrounding use of the term in recovery in behavioral health derives from a lack of clarity about the respective roles of behavioral health practitioners and those of people with behavioral health disorders themselves. For the purposes of this document, we offer the following two definitions which we have found to distinguish usefully between the process of recovery (in which the person him or herself is engaged) and the provision of recovery-oriented care (in which the practitioner is engaged).

> ***Recovery*** *refers to the ways in which a person with a mental illness and/or addiction* ***experiences*** *and* ***manages*** *his or her disorder in the process of reclaiming his or her life in the community.*

> ***Recovery-oriented care*** *is what psychiatric and addiction treatment and rehabilitation practitioners* ***offer*** *in support of the person's recovery.*

Practice Guidelines

A. Primacy of Participation

An essential characteristic of recovery-oriented behavioral health care is the primacy it places on the participation of people in recovery and their loved ones in all aspects and phases of the care delivery process. Participation ranges from the initial framing of questions or problems to be addressed and design of the capacity and needs assessments to be conducted, to the delivery, evaluation, and monitoring of care, to the design and development of new services, interventions, and supports.

Practice guidelines to be included in this domain:

A.1. People in recovery are routinely invited to share their stories with current service recipients and/or to provide training to staff.

A.2. People in recovery comprise a significant proportion of representatives to an agency's board of directors, advisory board, or other steering committees and work groups.

A.3. Agencies reimburse people for the time they spend providing input into services, providing peer support and mentoring, and/or providing educational and training sessions for clients or staff.

A.4. Each person served is provided with an initial orientation to agency practices.

A.5. Initial orientation is supplemented by the routine availability of information and agency updates to people in recovery and their loved ones.

A.6. Policies are established and maintained that allow people in recovery maximum opportunity for choice and control in their own care.

A.7. Measures of satisfaction are collected routinely and in a timely fashion from people in recovery and their loved ones.

A.8. Formal grievance procedures are established and made readily available to people in recovery and their loved ones to address their dissatisfaction with services.

A.9. Administration enforces ethical practice (e.g., "first, do no harm") through proactive human resource oversight.

A.10. Assertive efforts are made to recruit people in recovery for a variety of staff positions for which they are qualified.

A.11. Active recruitment of people in recovery for existing staff positions is coupled with ongoing support for the development of a range of peer-operated services that function independent of, but in collaboration with, professional agencies.

A.12. Self-disclosure by employed persons in recovery is respected as a personal decision and is not prohibited by agency policy or practice.

A.13. Staff encourage individuals to claim their rights and to make meaningful contributions to their own care and to the system as a whole.

A.14. The agency offers to host local, regional, state, and/or national events and advocacy activities for people in recovery and their loved ones.

B. Promoting Access and Engagement

For every one person who seeks and/or receives behavioral health care for a diagnosable psychiatric disorder or addiction there are from two (in mental health) to six (in addiction) individuals, with similar conditions, who will neither gain access to nor receive such care. Recovery-oriented practitioners promote access to care by facilitating swift and uncomplicated entry and by removing barriers to receiving care. Engagement involves making contact with the person rather than with the diagnosis or disability, building trust over time, attending to the person's stated goals and needs and, directly or indirectly, providing a range of services in addition to clinical care.

Practice guidelines to be included in this domain:

B.1. The service system has the capacity to go where the potential client is, rather than always insisting that the client come to the service.

B.2. People can access a wide range of services from many different points.

B.3. There is not a strict separation between clinical and case management functions.

B.4. Assessment of motivation is based on a stages of change model, and interventions incorporate motivational enhancement strategies which assist providers in meeting each person where he or she is.

B.5. Staff look for signs of organizational barriers or other obstacles to care before concluding that a client is non-compliant or unmotivated.

B.6. Agencies have "zero reject" policies that do not exclude people from care based on symptomatology, substance use, or unwillingness to participate in prerequisite clinical or program activities.

B.7. Agencies have an "open case" policy which dictates that a person's refusal of services, despite intensive and long-term engagement efforts, does not require that he or she be dropped from the "outreach" list.

B.8. The system builds on a commitment to and practice of motivational enhancement, with reimbursement for pre-treatment and recovery management supports.

B.9. Outpatient addiction treatment clinicians are paired with outreach workers to capitalize on the moment of crisis that can lead people to accept treatment, and to gain access to their appropriate level of care.

B.10. Mental health and addiction practitioners, including people in recovery, are placed in critical locales to assist in the early stages of engagement.

B.11. The agency employs staff with first hand experience of recovery who have a special ability to make contact with and engage people into care.

B.12. Housing and support options are available for people who are not yet interested in, or ready for, detoxification, but who may begin to engage in their own recovery if housing and support are available to them.

B.13. The availability of sober housing is expanded to make it possible for people to go immediately from residential or intensive outpatient treatment programs into housing that supports their recovery.

C. Ensuring Continuity of Care

Recovery is seldom achieved from a single episode of care, so practitioners, as well as people in recovery, families, and policy makers, need to recognize that there are no quick fixes in behavioral health. Similar to other chronic illnesses, previous treatment of a person's condition also should not be taken to be indicative of a poor prognosis, non-compliance, or the person's not trying hard enough to recover. Relapses in substance use and exacerbations of psychiatric symptoms are to be viewed as further evidence of the severity of the person's condition rather than as causes for discharge. All of these principles suggest that treatment, rehabilitation, and support are not to be offered through serial episodes of disconnected care offered by different providers, but through a carefully crafted system that ensures continuity of the person's most significant healing relationships and supports over time and across episodes and agencies.

Practice guidelines to be included in this domain:

C.1. The central concern of engagement shifts from: "How do we get the client into treatment?" to: "How do we nest the process of recovery within the person's natural environment?"

C.2. Services are designed to be welcoming to all individuals and there is a low threshold (i.e., minimal requirements) for entry into care.

C.3. Eligibility and reimbursement strategies for outreach and engagement strategies are established and refined by administrative leadership.

C.4. People have a flexible array of options from which to choose and options are not limited to what "programs" are available.

C.5. Individuals are not expected or required to progress through a pre-determined continuum of care in a linear or sequential manner.

C.6. In a Recovery Management Model, an individual's stage of change is considered at all points in time, with the focus of care on enhancing existing strengths and recovery capital.

C.7. Goals and objectives in the recovery plan are not defined by staff based on clinically-valued outcomes (e.g., reducing symptoms, increasing adherence), but rather are defined by the person with a focus on building recovery capital and pursuing a life in the community.

C.8. The focus of care shifts from preventing relapse to promoting recovery.

C.9. Valued outcomes are influenced by a commitment to ensuring continuity of care and generating long-term effects in the lives of people in recovery.

C.10. The range of valued expertise is expanded beyond specialized clinical and rehabilitative professionals and technical experts to include the contributions of multiple individuals and services. These individuals may include peers in paid or volunteer positions, mutual aid groups, indigenous healers, faith community leaders, primary care providers, and other natural supports.

C.11. Individuals are seen as capable of illness self-management and interventions support this as a valued goal of recovery-oriented services.

C.12. New technologies (e.g., tele-medicine and web-based applications and self-help resources) are incorporated as service options to enhance illness self-management treatment relationships.

C.13. Access is enhanced to housing, employment, and other supports that make recovery sustainable.

C.14. Policy formulation and legislative advocacy at the administrative level is coupled with on-going efforts to work collaboratively with a variety of state systems to ensure continuity of care.

C.15. To facilitate sustained recovery and community inclusion, advocacy efforts are extended beyond institutional policies and procedures to the larger community, including stigma-busting, community education, and community resource development activities.

D. Employing Strengths-Based Assessment

Focusing solely on deficits in the absence of a thoughtful analysis of strengths disregards the most critical resources an individual has on which to build in his or her efforts to adapt to stressful situations, confront environmental challenges, improve his or her quality of life, and advance in his or her recovery. Strengths-based approaches allow providers to balance critical needs that must be met with the resources and strengths that people possess to assist them in this process.

Practice guidelines to be included in this domain:

D.1. A discussion of strengths is a central focus of every assessment, care plan, and case summary.

D.2. Initial assessments recognize the power of simple, yet powerful, questions such as "What happened? And what do you think would be helpful? And what are your goals in life?"

D.3. Staff interpret perceived deficits within a strengths and resilience framework, as this will allow the individual to identify less with the limitations of their disorder.

D.4. While strengths of the individual are a focus of the assessment, thoughtful consideration also is given to potential strengths and resources within the individual's family, natural support network, service system, and community at large.

D.5. The diversity of strengths that can serve as resources for the person and his or her recovery planning team is respected.

D.6. In addition to the assessment of individual capacities, it is beneficial to explore other areas not traditionally considered "strengths," e.g., the individual's most significant or most valued accomplishments, ways of relaxing and having fun, ways of calming down when upset, personal heroes, educational achievements, etc.

D.7. Assessments explore the whole of people's lives while ensuring emphasis is given to the individual's expressed and pressing priorities.

D.8. Assessments ask people what has worked for them in the past and incorporate these ideas in the recovery plan.

D.9. Guidance for completing the assessment may be derived from interviewing strategies used within solution-focused approaches to care.

D.10. Illness self-management strategies and daily wellness approaches such as WRAP are respected as highly effective, person-directed, recovery tools, and are fully explored in the assessment process.

D.11. Cause-and-effect explanations are offered with caution, as such thinking can lead to simplistic resolutions that fail to address the person's situation. In addition, simplistic solutions may inappropriately assign blame for the problem to the individual, with blame being described as "the first cousin" of deficit-based models of practice.

D.12. Assessments are developed through in-depth discussion with the person as well as attempts to solicit collateral information regarding strengths from the person's family and natural supports.

D.13. Efforts are made to record the individual's responses verbatim rather than translating the information into professional language.

D.14. Staff are mindful of the power of language and carefully avoid the subtle messages that professional language has historically conveyed to people with psychiatric disorders, addictions, and their loved ones.

D.15. Practitioners avoid using diagnostic labels as a means of describing an individual, as such labels often yield minimal information regarding the person's experience or manifestation of the illness or addiction.

D.16. Language used is neither stigmatizing nor objectifying. "Person first" language is used to acknowledge that the disability is not as important as the person's individuality and humanity.

D.17. Exceptions to person-first and empowering language that are preferred by some persons in recovery are respected.

E. Offering Individualized Recovery Planning

All treatment and rehabilitative services and supports to be provided shall be based on an individualized, multi-disciplinary recovery plan developed in partnership with the person receiving these services and any others that he or she identifies as supportive of this process. While based on a model of collaboration, significant effort is taken to ensure that individuals' rights to self-determination are respected and that all individuals are afforded maximum opportunity to exercise choice in the full range of treatment and life decisions. The individualized recovery plan will satisfy the criteria of treatment, service, or care plans required by other bodies (e.g., CMS) and will include a comprehensive and culturally sensitive assessment of the person's hopes, assets, strengths, interests, and goals and will reflect a holistic understanding of his or her behavioral health conditions, general medical concerns, and desires to build or maintain a meaningful life in the community

Practice guidelines to be included in this domain:

E.1. Core principles of "person-centered" planning are followed in the process of building individualized recovery plans. For example:

E.1.1. Consistent with the "nothing about us, without us" dictum, staff actively partner with the individual in all planning meetings and/or case conferences regarding his or her recovery services and supports.

E.1.2. The individual has reasonable control as to the location and time of planning meetings, as well as to who is involved.

E.1.3. The language of the plan is understandable to all participants, including the focus person and his or her non-professional, natural supports. Where technical or professional terminology is necessary, this is explained to all participants in the planning process.

E.1.4. When individuals are engaged in rehabilitation services (e.g., housing social, or educational/employment areas), rehabilitation practitioners are involved in all planning meetings (at the discretion of the individual) and are given copies of the resulting plan.

E.1.5. Within the planning process, a diverse, flexible range of options must be available so that people can access and choose those supports that will best assist them in their recovery.

E.1.6. Goals are based on the individual's unique interests, preferences, and strengths, and objectives and interventions are clearly related to the attainment of these stated goals.

E.1.7. Planning focuses on the identification of concrete next steps, along with specific timelines, that will allow the person to draw upon existing strengths to move toward recovery and his or her vision for the future.

E.1.8. Assessments begin with the assumption that individuals are the experts on their own recovery, and that they have learned much in the process of living with and working through their struggles.

E.1.9. Information on rights and responsibilities of receiving services is provided at all recovery planning meetings.

E.1.10. The individual has the ability to select or change his or her service providers within relevant guidelines and is made aware of the procedures for doing so.

E.1.11. In the spirit of true partnership and transparency, all parties must have access to the same information if people are to embrace and effectively carry out responsibilities associated with the recovery plan.

E.1.12. The team reconvenes as necessary to address life goals, accomplishments, and barriers.

E.2. A wide range of interventions and contributors to the planning and care process are recognized and respected. For example:

E.2.1. Practitioners acknowledge the value of the person's existing relationships and connections.

E.2.2. The plan identifies a wide range of both professional supports and alternative strategies to support the person's recovery, particularly those which have been helpful to others with similar struggles.

E.2.3. Individuals are not required to attain, or maintain, clinical stability or abstinence before they are supported by the planning team in pursuing such goals as employment.

E.2.4. Goals and objectives are driven by a person's current values and needs and not solely by commonly desired clinical/professional outcomes.

E.3. Community inclusion is valued as a commonly identified and desired outcome. For example:

E.3.1. The focus of planning and care is on how to create pathways to meaningful and successful community life and not just on how to maintain clinical stability or abstinence.

E.3.2. Recovery plans respect the fact that services and practitioners should not remain central to a person's life over time, and exit criteria from formal services are clearly defined.

E.3.3. Recovery plans consider not only how the individual can access and receive needed supports from the behavioral health system and the community, but how the individual can, in turn, give back to others.

E.3.4. Practitioners are mindful of the limited resources available for specialized services and focus on community solutions and resources first by asking "Am I about to recommend or replicate a service or support that is already available in the broader community?"

E.4. The planning process honors the "dignity of risk" and "right to fail" as evidenced by the following:

E.4.1. Prior to appealing to coercive measures, practitioners relentlessly try different ways of engaging and persuading individuals in ways which respect their ability to make choices on their own behalf.

E.4.2. Unless determined to require conservatorship by a judge, individuals are presumed competent and entitled to make their own decisions.

E.4.3. Practitioners are encouraged to offer their expertise and suggestions respectfully within the context of a collaborative relationship, outlining for the person the range of options and their possible consequences.

E.4.5. In keeping with this stance, practitioners encourage individuals to write their own crisis and contingency plans.

E.5. Administrative leadership demonstrate a commitment to both outcomes and process evaluation. For example:

E.5.1. Outcomes evaluation is a continuous process involving expectations for successful outcomes in a broad range of life domains.

E.5.2. There is a flexible application of process tools, such as fidelity scales, to promote quality service delivery.

F. Functioning as a Recovery Guide

The sentiment that "we're not cases, and you're not our managers" has been accepted increasingly as a fundamental challenge to the ways in which behavioral health care is conceptualized within a recovery-oriented system. Rather than replacing any of the skills or clinical and rehabilitative expertise that practitioners have obtained through their training and experience, the recovery guide model offers a useful framework in which these interventions and strategies can be framed as tools that the person can use in his or her own recovery.

Practice guidelines to be included in this domain:

F.1. The primary vehicle for the delivery of most behavioral health interventions is the relationship between the practitioner and the person in recovery. The care provided must be grounded in an appreciation of the possibility of improvement in the person's condition, offering people hope and/or faith that recovery is "possible for me."

F.2. Providers assess where each person is in relation to the various stages of change with respect to the various dimensions of his or her recovery.

F.3. Care is based on the assumption that as a person recovers from his or her condition, the addiction or psychiatric disorder then becomes less of a defining characteristic and more simply one part of a multi-dimensional sense of identity that also contains strengths and competencies.

F.4. Interventions are aimed at assisting people in gaining autonomy, power, and connections with others.

F.5. Opportunities and supports are provided for the person to enhance his or her own sense of personal and social agency.

F.6. Individuals are allowed the right to make mistakes, and this is valued as an opportunity for them to learn.

F.7. People are allowed to express their feelings, including anger and dissatisfaction, without having these reactions attributed to the illness.

F.8. Care is not only attentive to cultural differences across race, ethnicity, and other distinctions of difference (e.g., sexual orientation), but incorporates this sensitivity at the level of the individual.

F.9. Rather than dwelling on the person's distant past or worrying about the person's long-term future, practitioners focus on preparing people for the next one or two steps of the recovery process by anticipating what lies immediately ahead, by focusing on the challenges of the present situation, and by identifying and helping the person avoid or move around potential obstacles in the road ahead.

F.10. Interventions are oriented toward increasing the person's recovery capital as well as decreasing his or her distress and dysfunction.

F.11. Practitioners are willing to offer practical assistance in the community contexts in which their clients live, work, learn, and play.

F.12. Care is not only provided in the community but is also oriented toward increasing the quality of a person's involvement in community life.

F.13. Efforts are made to identify sources of incongruence between the person and his or her environment and to increase person-environment fit.

F.14. In order to counteract the often hidden effects of stigma, practitioners explicitly draw upon their own personal experiences when considering the critical nature of various social roles in the lives of all individuals, continuing to view people in recovery squarely within the context of their daily lives.

F.15. Rather than devaluing professional knowledge, the "recovery guide" approach moves behavioral health much closer to other medical specialties in which it is the health care specialist's role to assess the person, diagnose his or her condition, educate the person about the costs and benefits of the most effective interventions available to treat his or her condition, and then provide the appropriate interventions.

F.16. Recovery is viewed as a fundamentally social process, involving supportive relationships with family, friends, peers, community members, and practitioners

G. Community Mapping and Development

Given its focus on life context, one tool required for effective recovery planning and the provision of recovery-oriented care is adequate knowledge of the person's local community, including its opportunities, resources, and potential barriers. Community mapping and development are participatory processes that involves persons in mapping the resources and capacities of a community's individuals, its informal associations, and its structured institutions, as a means of identifying existing, but untapped or overlooked, resources and other potentially hospitable places in which the contributions of people with disabilities and/or addiction will be welcomed and valued.

Practice guidelines to be included in this domain:

G.1. People in recovery are viewed primarily as citizens and not as clients and are recognized for the gifts, strengths, skills, interests, and resources they have to contribute to community life.

G.2. Community leaders representing a range of community associations and institutions work together with people in recovery to carry out the process of community development.

G.3. Opportunities for employment, education, recreation, social and civic involvement, and religious participation are regularly identified and are compiled in asset maps, capacity inventories, and community guides.

G.4. Asset maps and capacity inventories created collaboratively by actively involved community stakeholders reflect a wide range of *natural* gifts, strengths, skills, knowledge, values, interests, and resources available to a community through its individuals, associations, and institutions.

G.5. Value is placed on the less formal aspects of associational life that take place in neighborhood gatherings, block watch meetings, salons, coffee clatches, barbershops, book groups, etc.

G.6. Institutions do not duplicate services that are widely available in the community through individuals and associations.

G.7. Community development is driven by a creative, capacity-focused vision identified and shared by community stakeholders.

G.8. The relational process of gathering information about community assets and capacities through personal interviews and sharing of stories is recognized as being as important as the information that is collected.

H. Identifying and Addressing Barriers to Recovery

There currently are elements and characteristics of the service delivery system and the broader community that unwittingly contribute to the creation and perpetuation of chronicity and dependency in individuals with behavioral health disorders. There also are several aspects of behavioral health disorders and their place within contemporary society that complicate the person's efforts toward recovery. The competent behavioral health care practitioner will have tools and strategies for identifying and addressing these barriers to recovery.

Practice guidelines to be included in this domain:

H.1. There is a commitment at the local level to embrace the values and principles of recovery-oriented care and to move away from the dominant illness-based paradigm. Systemic changes that reflect this paradigm shift include the following:

H.1.1. Stakeholders understand the need for recovery-oriented system change as a civil rights issue which aims to restore certain elementary freedoms to American citizens with psychiatric disorders and/or addictions.

H.1.2. Stakeholders work together to move away from the criteria of "medical necessity" toward "human need," from managing illness to promoting recovery, from deficit-oriented to strengths-based, and from symptom relief to personally-defined quality of life.

H.1.3. The possibility of recovery, and responsibility for delivering recovery-oriented care, are embraced by stakeholders at all levels of the system.

H.2. Systemic structures and practices which impede the adoption of recovery-oriented practices are identified and addressed. Representative change strategies in this area include the following:

H.2.1. Sequential movement through a pre-existing continuum of care is no longer required, as it is inconsistent with a civil rights perspective and contradicts current knowledge suggesting that recovery is neither a linear process nor a static end product or result.

H.2.2. Agencies need to have coordinating structures to attend to both the prioritization and integration of the range of new initiatives, policies, and procedures they are attempting to implement at any given time.

H.2.3. Performance and outcome indicators need to reflect the fact that the desired goal of recovery-oriented care is to promote growth, independence, and wellness; goals which sometimes involve the taking of reasonable risks that may result in interim setbacks.

H.2.4. Continual quality assurance and independent audits are conducted by people in recovery and families trained in recovery-oriented care.

H.2.5. Initial placement and service design are driven as much by the person's perception of what services and supports would be most helpful as by the staff's assessments of what the individual seeking services needs.

H.2.6. Recovery plans respect the fact that services and practitioners should not remain central to a person's life over time.

H.2.7. To integrate employment within the larger system, the task of assisting people in entering employment and education is made inherent to the responsibilities of the entire practitioner network, including those not specifically charged with supported employment or education tasks.

H.3. Implementation of recovery-oriented care needs to be facilitated, rather than impeded, by funding, reimbursement, and accrediting structures. Change strategies to address this issue include:

H.3.1. Even though Medicaid is funded by federal dollars, it remains primarily a state-administered program, and considerable flexibility exists in using these dollars to support innovative, community-based, supports.

H.3.2. Within existing funding structures, training and technical assistance can be provided to practitioners attempting to implement recovery-oriented practices to assist them in learning how to translate the wishes of people in recovery into reimbursable service goals and to describe their interventions in a manner that will generate payment.

H.3.3. Rather than being an add-on to existing services, transformation to recovery-oriented care begins with discovering ways to be creative and flexible within the constraints of existing resources.

H.3.4. Self-directed funding opportunities should be considered both on a collective basis and through individualized budget programs.

H.4. Training and staff development is prioritized as an essential function to increase individual practitioners' competencies in providing recovery-oriented care. Necessary change strategies to address this issue include the following:

H.4.1. As consensus emerges regarding the knowledge and skills needed to implement recovery-oriented care, this information must lead to the development of competency models, and these models must be disseminated broadly as guidance for training programs and licensing bodies which prepare and accredit providers of behavioral health care.

H.4.2. Once established, competency models should be incorporated in all human resource activities as a means of promoting accountability and quality improvement.

H.4.3. An analysis of staff's current competencies and self-perceived training needs should guide the development of on-going skill-building activities at the agency level.

H.4.4. Competency-based training must be coupled with on-going mentorship, enhanced supervision, recovery-oriented case conferences, and opportunities for peer consultation.

H.4.5. Clinical directors and agency leaders should be involved in ongoing training initiatives so that there is consistency between proposed recovery-oriented practices and the system's administrative structures.

H.4.6. Recovery-oriented care does ***not*** imply that there is no longer any role for the practitioner to play. Rather, the provider's role has changed from that of all-knowing, all-doing caretaker to that of coach, architect, cheerleader, facilitator, mentor, or shepherd—roles that are not always consistent with one's clinical training or experiences.

H.4.7. Training initiatives need to support people in recovery and families to develop their own capacity to self-direct their care and life decisions.

H.5. Forces at the societal level which undermine recovery and community inclusion are identified and addressed. Necessary change strategies to address this issue include the following:

H.5.1. Behavioral health practitioners have significant expertise to address the lack of basic resources and opportunities in the broader community, and are prepared to offer supportive guidance and feedback at both the individual and community level.

H.5.2. Community collaborations and education must be coupled with efforts on the part of behavioral health practitioners to recognize instances of discrimination, to understand relevant disability legislation, and to effectively utilize state and local resources.

H.5.3. Agencies are cautioned to avoid the establishment of 'one stop shopping' service programs which may inadvertently contribute to the perpetuation of discriminatory and unethical practices on the part of community members. We must continue to work with community partners to uphold their obligation to respect people with behavioral health disorders as citizens who have the right to be treated according to the principles of law that apply to all other individuals

H.5.4. Professionals and service recipients should be mindful of the limited resources available for specialized services and should focus on community solutions and resources first by asking "Am I about to recommend or replicate a service or support that is already available in the broader community?"

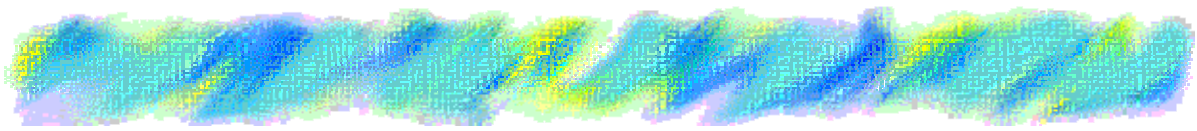
H.6. Certain internal barriers unique to behavioral health disorders are identified and addressed. Necessary change strategies to address these barriers include the following:

H.6.1. Staff appreciate the fact that, based on a complex interaction of the person's conditions and his or her past experiences in the behavioral health care system, people with behavioral health disorders may be reluctant to assume some of the rights and responsibilities promoted in recovery-oriented systems. They may initially express reluctance, fears, mistrust, and even disinterest when afforded the right to take control of their treatment and life decisions. Exploring and addressing the many factors influencing such responses is an important component of care.

H.6.2. Research indicates that many individuals with behavioral health disorders also have histories of trauma. Failure to attend to such histories may seriously undermine the treatment and rehabilitation enterprises, and further complicate the person's own efforts toward recovery.

H.6.3. Certain symptoms of illnesses may also pose direct impediments to the recovery process. In certain conditions, the elimination or reduction of symptoms may also come with great ambivalence, e.g., while episodes of mania can be destructive, they may include a heightened sense of creativity, self importance, and productivity that are difficult to give up. Being able to identify and address these and other sequelae requires knowledge and skill on the part of the clinical practitioner.

In each of the following sections, practitioners are given examples of what they are likely to hear from people in recovery when these guidelines have been implemented successfully. In addition, there is a list of recommended resources for further reading on transformation to recovery-oriented care, as well as a glossary of recovery-oriented language and examples of strengths-based conceptualizations that are proposed as alternatives to current deficit-based ones.



Introduction



The notion of recovery has become the focus of a considerable amount of dialogue and debate between and among various constituencies within the mental health and addiction communities. Prior to attempting to operationalize the various components of DMHAS' vision of a recovery-oriented system of care, we thought it important to clarify these confusions, some of which are due to the fact that the notion of recovery is in transition, moving gradually from a well-established vision among people with addictions or mental illnesses to exerting more influence on the practice of behavioral health care providers.

For example, being "in recovery" has long been the guiding vision and goal of self-help[1] within the addiction community. Primarily a force within self-help, however, this notion has not played as much of a role historically within the addiction service provider community, where concepts of treatment and relapse prevention have been more central. Having a fifty-year history of peaceful, if benign, co-existence, these two complementary approaches have recently entered into a period of partnership in which there is now considerable potential for them to build dynamically on each others' strengths to promote a unified and coherent vision of recovery among people with addictions.

Despite being a long-standing core value in addiction, the notion of "recovery" has emerged as a dominant force within mental health just within the last decade. Most recently, it has taken center stage through its prominent role in both the Surgeon General's *Report on Mental Health*[2] and the President's New Freedom Commission on Mental Health. In its influential *Final Report*, the Commission strongly recommended "fundamentally reforming" all of mental health care to be based on the goal of recovery[3]. In both of these reports, however—as well as in clinical and rehabilitative practice—there is considerable ambiguity and a tangible lack of clarity about what precisely is meant by recovery in mental health. As in addiction, much work remains to be done in mental health in developing a coherent and unified vision of recovery that can prove to be acceptable (as well as useful) to all involved parties.

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[1] Derived from Alcoholics Anonymous, these so-called "12-step" groups have expanded to include many other addictions and life conditions, and have consistently been shown to help promote and maintain abstinence.

[2] Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[3] Department of Health and Human Services. (2003). *Achieving the promise: Transforming mental health care in America*. Rockville, MD: Substance Abuse and Mental Health Services Administration, p. 4

Given its multiple and complicated parentage and the diverse constituencies involved, it is not surprising that it has been difficult to reach consensus on any one definition, or even on any one list of essential aspects, of the concept of recovery in behavioral health. For the sake of clarity—as well as to facilitate future discussions as these concepts continue to evolve—we propose the following distinction as a prelude to articulating the Guidelines that will be used to guide the development, monitoring, and evaluation of clinical and rehabilitative services and supports offered within a recovery-oriented system of behavioral health care. Rather than mutually exclusive, these two concepts are intended to be somewhat overlapping and complementary, with the eventual goal of being brought together into a unified vision that can be promoted equally by people in recovery, their loved ones, behavioral health care providers, and the community at large.



Defining our Terms

One major source of the confusion surrounding use of the term in recovery in behavioral health derives from a lack of clarity about the respective roles of behavioral health practitioners and those of people with behavioral health disorders themselves. For the purposes of this document, we offer the following two definitions which we have found to distinguish usefully between the process of recovery (in which the person him or herself is engaged) and the provision of recovery-oriented care (in which the practitioner is engaged).

- ***Recovery*** *refers to the ways in which a person with a mental illness and/or addiction* ***experiences*** *and* ***manages*** *his or her disorder in the process of reclaiming his or her life in the community.*

- ***Recovery-oriented care*** *is what psychiatric and addiction treatment and rehabilitation practitioners* ***offer*** *in support of the person's own recovery efforts.*

Recovery

Given that the notion of recovery derives from the self-help and self-advocacy communities in both addictions and mental health, the first definition of recovery refers to ***what people who have these conditions do to manage their mental illness and/or addiction and to claim or reclaim their lives in the community.*** In addition to managing the condition, this sense of recovery therefore also involves ***what people do to overcome the effects of being perceived as an addict or a mental patient***—including rejection from society, alienation from one's loved ones, poverty, substandard housing or homelessness, social isolation, unemployment, loss of valued social roles and identity, and loss of sense of self and purpose in life—in order to regain some degree of control over their own lives.

As experiences of being discriminated against are viewed as traumatic and irreversible, advocates also argue that a return to a pre-existing state of health (as another alternative definition of recovery) is not only impossible, but also would diminish the gains the person has had to make to overcome the disorder and its effects. Overcoming the scars of stigma requires the development and use of new muscles, often leaving people feeling stronger than prior to the onset of their illness.

Beginning with a common foundation, recovery in addiction and in mental health can then be seen to divide into two distinct, but at times parallel and at other times overlapping, paths. Before turning to the characteristics of recovery-oriented care, we provide a brief overview of the similarities and differences between these two paths to recovery. Given the high rate at which addiction and mental illness co-occur in the same person, we understand that any given individual may be involved in either, or both, of these paths at the same time. For the sake of clarity, it still may be useful to highlight a few of the salient differences between them prior to turning to their implications for care.



Addiction Recovery. Derived from the self-help community, people who are achieving or maintaining abstinence from drug or alcohol use following a period of addiction have described themselves as being "in" this form of recovery for over half a century. Being "in recovery" in this sense is meant to signify that the person is no longer actively using substances but, due to the long-term nature of addiction, continues to be vulnerable to relapses and therefore has to remain vigilant in

protecting his or her sobriety. In this tradition—in which continued vulnerability to relapse is seen as inherent to addiction—recovery does not connote cure, nor does it entail remission of the signs, symptoms, or other deficits of a disorder as is common to recovery in other medical illnesses. Unlike in most physical illnesses, people may consider themselves to be in recovery while continuing to be affected by their addiction.

People who are achieving or maintaining abstinence . . . have described themselves as being . . . in recovery for over half a century.

Based on this definition, it is possible that many people who have used substances to an extent that would have met current diagnostic criteria for an addition at one point earlier in their lives, but who are no longer actively using or having to focus on protecting their sobriety, would not consider themselves to be "in recovery." While for some people it may apply to the remainder of their lives, being in recovery from addiction appears to pertain more specifically to the period following active use in which the person is consciously and actively involved in remaining abstinent and in which there continues to be a sense of vulnerability to relapse. In this sense, recovery in addiction is not only hard-won but often has to be protected and reinforced through persistent vigilance and adherence to the self-help and other principles that made it possible in the first place.

In addition to being in recovery from the addiction, this process involves addressing the effects and side effects of the addiction as well. The self-help tradition recognizes that living life with an addiction generates many negative effects on one's life beyond the addiction *per se*, including detrimental effects on one's relationships, on one's ability to learn or work, and on one's self-esteem, identity, and confidence.

Recovery involves the person's efforts to abstain from substance use while resuming increasing responsibility for his or her overall life.

With the toxic effects of addiction spreading to the person's life as a whole, this sense of being in recovery involves the person's efforts to abstain from substance use while also resuming increasing responsibility for his or her life. It thus often involves returning to school or work, making amends to others who have been hurt, repairing damaged relationships, and, in general, learning how to live a clean and sober life.

It also is true that for many people, achieving recovery may be the first time they have known how to live without their addiction, tracing its origins back to their earlier lives even prior to actual substance use. For these people, a clean and sober life is not so much restored by abstinence as it is created for the first time; a gain which they credit to their recovery above and beyond sobriety. It is not unusual in

such cases for people in recovery to believe they are now a better person for having gone through the addiction and recovery process than if they had never become addicted in the first place.



Mental Health Recovery. It was this same sense of being "in recovery" that was first introduced into the mental health community approximately thirty years ago through the self-help/consumer movement. In the process of its introduction into mental health, this sense of recovery took on a few characteristics specific to the history of the perception and treatment of mental illness in society. Being associated initially with being liberated from mental hospitals (many, if not all, of the first self-advocates were former inpatients), the mental health self-help community viewed itself first and foremost as a civil rights movement rather than as part of any treatment or rehabilitative enterprise.

For people with mental illnesses, prior to denoting anything like a cure or improvement in their psychiatric condition, recovery meant having one's civil rights restored as a full and contributing member of society. It meant no longer being defined entirely by one's mental illness (i.e., as a mental patient) and having, as a result, one's major life decisions—as well as one's day-to-day life activities—determined by others. In addition to advocating for the radical reform of involuntary commitment laws and inpatient care, advocates have since been active in identifying ways in which community services also have unwittingly perpetuated many of the discriminatory practices historically seen in institutional settings.

. . . prior to denoting anything like a cure or improvement in [one's] psychiatric condition, recovery meant having one's civil rights restored as a full and contributing member of society.

Within mental health, then, two related but distinct uses of the term recovery have emerged. While not inconsistent with use of the term within addiction, the first of these two senses acquires a different emphasis as an advocacy issue. This sense of recovery is proposed as a fundamental challenge to the "mentalism" which advocates see as continuing to permeate health and human services and to influence the ways in which people with psychiatric disabilities are treated both inside and outside of

mental health[4]. Similar to racism, sexism, and other forms of prejudice, mentalism involves a set of attitudes and associated behaviors that have the effect of confining a segment of the general population to second-class citizen ship. In this case, the discrimination is based on the belief that people with mental illness are more like children than adults, unable to make their own decisions, to function independently, or to take care of themselves. They thereby require the care and direction of well-intended others in order to meet their basic needs—whether this care and direction be provided, as earlier, in hospital settings or, as is now more common, through community services.

. . . recovery [poses] a fundamental challenge to . . . "mentalism"

Within this historical context, recovery has come to be a powerful rallying cry and tool in the advocacy movement's efforts to counteract mentalism and its legacy in the lives of people with mental illnesses. It has been fueled both by the personal conviction of people in recovery and by over thirty years of clinical research findings which consistently have demonstrated a broad heterogeneity in outcome over time and across domains of functioning in serious mental illness. Research has shown that mental illness not only comes and goes over time and varies significantly in severity and duration, but that even when a person is actively experiencing psychosis, it most often affects only some of the person's abilities, leaving other abilities intact.

Rather than subsuming the entirety of the person, mental illnesses are better understood—even in their most severe form—as disabilities that co-exist with other areas of competence within the context of the person's life.

Rather than subsuming the entirety of the person, mental illnesses are better understood—even in their most severe form—as disabilities that co-exist with other areas of competence within the context of the person's life.[5] Just as we would not assume that someone with a visual, auditory, or mobility impairment was unable to take care of him or herself because he or she could not see, hear, or ambulate unassisted, we need not assume that a person's mental illness renders him or her unable or

[4] Chamberlin, J. (1984). Speaking for ourselves: An overview of the Ex-Psychiatric Inmates' Movement. *Psychosocial Rehabilitation Journal, 2*, 56-63.

[5] Beginning with the World Health Organization's International Pilot Study of Schizophrenia launched in 1967, there have been a series of long-term, longitudinal studies conducted around the world that have produced a consistent picture of a broad heterogeneity in outcome for severe psychiatric disorders. With respect to schizophrenia, this line of research has documented partial to full recovery in between 45-65% of each sample. In this context, recovery has been defined narrowly as amelioration of symptoms and other deficits associated with the disorder and a return to a pre-existing healthy state. We now know that up to two thirds of people achieve even this narrowly-defined form of recovery from psychosis, with many others able to function independently despite continued symptoms. For more on this research, see Davidson, L., Harding, C.M. & Spaniol, L. (2005). *Recovery from severe mental illnesses: Research evidence and implications for practice.* Boston, MA: Center for Psychiatric Rehabilitation of Boston University.

incompetent to be in control of his or her life. As other people with disabilities may require Braille signs, visual indicators of doorbells or ringing telephones, or wheelchairs, people with mental illness may require similar social and environmental supports in order to function optimally in community settings. While we have just begun to learn to identify and offer such supports, this represents a very promising, and important, area for future growth and development.

It is at this juncture that the civil rights movement in mental health meets up with the sense of recovery used in addiction in order to promote an alternative vision of mental health recovery. This second sense of recovery involves viewing psychiatric disorder as only one aspect of a person who otherwise has assets, interests, aspirations, and the desire and ability to continue to be in control of his or her own life. Paralleling in some ways addiction recovery, this sense of recovery involves the person's assuming increasing control over his or her illness while reclaiming responsibility for his or her life; a life that previously had been subsumed by the disorder.

Recovery involves viewing psychiatric disorder as only one aspect of a person who otherwise has assets, strengths, interests, aspirations, and the desire and ability to continue to be in control of his or her own life.

In other respects, however, this sense of recovery differs from recovery in addiction. For example, being in recovery from an addiction invariably involves some degree of abstinence; it requires a change in the person's condition from being controlled by the addiction to the addiction being under at least some degree of the person's control. While vulnerability to relapse remains a core element of addiction recovery, a person who continues to use cannot be viewed as in recovery; i.e., active substance use in the context of a lack of awareness of the addiction, or in the lack of any progress made toward decreasing use, precludes recovery.

The same cannot be said, however, for mental illness. In this respect, mental health recovery borrows from the disability rights movement in arguing that recovery remains possible even while a person's condition may not change. A person with paraplegia does not have to regain his or her mobility in order to have a satisfying life in the community. Being in recovery similarly cannot require a cure or remission of one's psychiatric disorder or a return to a pre-existing state of health. Rather, it involves a redefinition of one's illness as only one aspect of a multi-dimensional person who is capable of identifying, choosing, and pursuing personally meaningful aspirations despite continuing to suffer the effects and side effects of the illness.

With recovery in both addiction and mental health now defined, it becomes more evident why we have said that recovery is ***what the person does***. Addiction treatment providers are well aware that they have not been able to make a person stop using drugs or alcohol. In this sense, addiction recovery has always been in the hands of the person with the addiction. What may be different about recovery-oriented care in the addiction field are the number of things practitioners can now do over time to increase a person's desire to choose abstinence through the use of motivational enhancement strategies. In mental health, however, the idea that recovery is what the person with the mental illness does is a less commonly accepted notion. With the assumption that mental illness incapacitates the person in his or her entirety, more of the focus has been on what practitioners can do to and for the person to alleviate his or her symptoms and suffering and enhance his or her functioning.

This definition of . . . recovery in no way diminishes the importance of professional competence or the role of . . . health care practitioners.

It is important to note that defining recovery in mental health as pertaining to what the person with the mental illness does in no way diminishes the importance of professional competence or the role of mental health care practitioners. What it does, instead, is to shift the responsibility for deriving maximum benefit from health care services from the educated and caring people who provide them to the person him or herself who needs to use them. Rather than devaluing professional knowledge and experience, this approach moves psychiatry much closer to other medical specialties in which it is the health care specialist's role to assess the person, diagnose his or her condition, educate the person about the costs and benefits of the most effective interventions available to treat his or her condition, and then provide the appropriate interventions. No matter how expert or experienced the practitioner, it is then ideally left up to the person and his or her loved ones to make decisions about his or her own care. It is not the practitioner's role or responsibility to make such health care decisions ***for*** the person.[6] The idea of recovery extends this conventional model of care to behavioral health as well.

[6] Emergency medicine provides another exception in cases in which the issue of informed consent/permission to treat is suspended temporarily in order to perform life-saving measures. Such situations certainly occur in behavioral health as well, in which practitioners must take action to protect an individual or the public in the event of emergency or crisis situations as narrowly defined by statutory laws (e.g., suicidality, homicidality, and grave disability). In these cases, practitioners have solid legal ground on which to stand in making decisions for the person (i.e., against his or her will). As in medicine, however, this transfer of authority can only be a temporary measure, in effect only for as long as an acute episode takes to resolve. In all other cases, the decision of a judge is required in the state of Connecticut in order to terminate or otherwise place limits on a person's autonomy through the appointment of a conservator of person or other means.

From Recovery to Recovery-Oriented Care

In suggesting how behavioral health might come to resemble more closely other forms of medical care, we have arrived at the point where recovery—i.e., what the person with a behavioral health condition does—comes into contact with recovery-oriented care—i.e., what practitioners of mental health and substance abuse treatment and rehabilitation offer in support of the person's recovery. As we have suggested above, our focus on the process of recovery as the unique journey of each individual should not be taken to suggest that there is no longer an integral role for services and supports.

This is no more true in behavioral health than in other forms of medicine. When we suggest that someone who has been in an accident follow a graduated plan of convalescence and exercise in order to regain his or her physical functioning, for example, we do not thereby diminish the importance of the orthopedist's role in assessing the impact of the trauma, setting the broken bones, and prescribing an exercise plan, which may then need to be implemented with the assistance of a physical therapist and the support of the person's family.

We know that while broken bones may heal of their own accord—with or without detriment to the person's functioning—they are more likely to heal completely with timely and effective care. Similarly, while the person might eventually regain his or her functioning following an accident without a graduated exercise plan or physical therapy, he or she is more likely to do so in an expedient and uncomplicated fashion, and is less likely to suffer unexpected setbacks, with the guidance of competent and experienced experts. Based on these considerations, we reject both assertions, either that: 1) the person will not benefit from professional intervention or 2) the orthopedist is responsible for the person's recovery. Although it is unquestionably each person's own recovery, this recovery can be substantially supported and facilitated by the assistance of competent and experienced practitioners. The fact that we find it necessary to make this point, perhaps repeatedly, derives mostly from the history of stigma, discrimination, and prejudice against people with behavioral health conditions rather than from any wish to devalue or diminish the role of behavioral health practitioners.

What, then, is the most appropriate role for the behavioral health care provider in relation to recovery? Similar to the example provided above, what the person in recovery is most in need of is information about the nature of his or her difficulties, education about the range of effective interventions available to overcome or compensate for these difficulties, access to opportunities to utilize these interventions in regaining functioning, and the supports required in order to be successful in doing so.

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Drawing from the orthopedic analogy, the person will need to exercise and resume use of those faculties most directly affected by his or her trauma. In the case of behavioral health conditions, these faculties include the person's cognitive, social, and emotional life as well as his or her sense of self, personal and social identity, and belonging within his or her community. If a person with a broken leg does not try to walk again, he or she will not regain the use of the leg that was broken. If a person with a psychiatric or substance use disorder does not try to reclaim responsibility for his of her life, he or she will be unable to regain his or her functioning. This fact poses a fundamental challenge to the provision of recovery-oriented care.

Like the proverbial horse that cannot be made to drink, recovery-oriented practitioners can create or enhance access for people in recovery to a variety of educational, vocational, social, recreational, and affiliational activities in the community. They cannot, however, make the decisions ***for*** the person as to which, if any, of these activities he or she will participate in and find enjoyable or meaningful. The challenge confronting recovery-oriented practitioners may not, in this way, be unique to behavioral health. Cardiologists, for example, cannot make their patients stick to a heart-healthy diet any more than oncologists can keep some of their patients from smoking. What complicates the picture in the case of behavioral health is the perception that the person's decision-making capacity is itself among the faculties most directly affected by the illness.

As both psychiatric and substance use disorders are currently viewed primarily to be diseases of the brain, such a concern is understandable. In and of itself, however, this concern cannot be taken to lead inevitably to the conclusion that other, well-intentioned, people must therefore step in and make decisions for the person. In certain, limited, circumstances practitioners are legally authorized, if not also obligated, to do so. These circumstances include imminent risk of harm to the person and/or others (i.e., homicidality, suicidality, grave disability). In most other circumstances, however, practitioners are left in the difficult position of having to honor—if not actively support—the person's decisions, even in cases in which the practitioner is persuaded that it is the illness, rather than the person's best judgment, which is driving the decision-making process.

In the absence of conservatorship, guardianship, or other legal mechanisms, practitioners can educate, inform, discuss, debate, and attempt to persuade the person to embrace some options rather than others. If the person is ever to regain his or her functioning, however, in the end she or he will have to be accorded, in Pat Deegan's terms, the "dignity of risk" and the "right to failure."[7] As is true in most components of recovery-oriented care, it requires concerted effort and reflection—and perhaps supervision—as well as compassion, for behavioral health practitioners to continue to view and treat the person as sitting in the driver's seat of his or her own life. Given the damage that these disorders can do to the person's self-esteem and confidence, though, it is difficult to imagine how recovery can be achieved through other means.

As suggested in the definition above, recovery-oriented care takes as its primary aim offering people with psychiatric and/or addictive disorders a range of effective and culturally-responsive interventions from which they may choose those services and supports which they find useful in promoting or protecting their own recovery. As further defined in Commissioner's Policy #83 on Recovery:

> *A recovery-oriented system of care identifies and builds upon each person's assets, strengths, and areas of health and competence to support the person in achieving a sense of mastery over mental illness and/or addiction while regaining his or her life and a meaningful, constructive sense of membership in the broader community.*

While the goal of recovery-oriented care may appear, in this way, to be relatively clear and straightforward, the ways in which care can be used to promote recovery are neither so clear nor so straightforward—neither, unfortunately, are the ways in which care, as currently configured, may impede or undermine recovery. The following guidelines are offered as a beginning roadmap of this territory, bringing together what we think we know at this point about how care can best promote and sustain recovery, and how care may need to be transformed to no longer impede it. These guidelines are drawn from over two years of conversations with practitioners, people in recovery, families, and program managers, and are informed by the current professional literature on recovery and recovery-oriented practice.

These guidelines focus primarily on the concrete work of practitioners and provider agencies so as to provide practical and useful direction to individuals and collectives that are committed to implementing recovery-oriented care. We recog-

[7] Deegan, P.E. (1992). The Independent Living Movement and people with psychiatric disabilities: Taking back control over our own lives. *Psychosocial Rehabilitation Journal, 15*, 3-19.

nize, however, that many of the practices described will require a broader commitment of agency leadership to significant and on-going administrative restructuring. We offer these guidelines as only one piece of a much larger whole, but as an important step forward in the overall process of system transformation. Equally important steps were taken in the past through the development of practice standards for culturally competent care[8] (which therefore are not duplicated here), and future efforts are planned to address the crucial roles of prevention and early intervention and the need for ongoing evaluation and monitoring of the outcomes of care.



"Well, this is a very impressive résumé, young man. I think you're going to make a fine patient."

[8] State of Connecticut Department of Mental Health and Addiction Services Office of Multicultural Affairs. (2001). *Multicultural behavioral healthcare: Best practice standards and implementation guidelines*. Hartford, CT: State of Connecticut Department of Mental Health and Addiction Services

Practice Guidelines for

Recovery-Oriented Behavioral Health Care

A. Primacy of Participation

B. Promoting Access and Engagement

C. Ensuring Continuity of Care

D. Employing Strengths-Based Assessment

E. Offering Individualized Recovery Planning

F. Functioning as a Recovery Guide

G. Community Mapping, Development, and Inclusion

H. Identifying and Addressing Barriers to Recovery

A. The Primacy of Participation

An essential characteristic of recovery-oriented behavioral health care is the primacy it places on the participation of people in recovery and their loved ones in all aspects and phases of the care delivery process. Beginning with the Federal Rehabilitation Act of 1973 and reaffirmed in 1990 in Public Law 99-660, federal and state governments have mandated the involvement of people with behavioral health disorders in all components of designing and implementing systems of community-based behavioral health care. This mandate has been confirmed consistently in numerous federal and state statutes and regulations issued since, and forms the foundation of CT DMHAS's Recovery and System Transformation Initiative.

For the involvement of people in recovery and their families to be meaningful and substantive, it must go well beyond asking them to sign off on provider-driven treatment plans or to endorse the adoption or replication of practitioner-driven models of care. Recovery-oriented care requires that people in recovery be involved in all aspects and phases of the care delivery process, from the initial framing of questions or problems to be addressed and design of the capacity and needs assessments to be conducted, to the delivery, evaluation, and ongoing monitoring of care, to the design and development of new services, interventions, and supports.

As recovery is what the person with the behavioral health condition ***does***, rather than something that can be done ***to*** or ***for*** the person by a care provider, people in recovery, by definition, are understood to be the foremost experts on their own needs and preferences for assistance in managing their condition and reconstructing their lives. As a result, recovery-oriented care consistently elicits and is substantially informed by the input and involvement of people in recovery across all levels, from recovery planning led by individual clients (see Section E, Individualized Recovery Planning), to program development and evaluation, to policy formulation.

You will know that you are placing primacy on the participation of people in recovery when:

A.1.	People in recovery are routinely invited to share their stories with current service recipients and/or to provide training to staff.
A.2.	People in recovery comprise a significant proportion of representatives to an agency's board of directors, advisory board, or other steering committees and work groups. Persons in recovery are provided orientation to their committee role by the chair, and actively contribute to the group process. Their involvement in these groups is reflected in meeting minutes and in decision-making processes.

A.3. The input of people in recovery is valued, as embodied in the fact that the agency reimburses people for the time they spend participating in service planning, implementation, or evaluation activities, providing peer support and mentoring, and/or providing educational and training sessions for clients or staff. Where system involvement is a mutually negotiated volunteer activity, people in recovery are reimbursed for out of pocket expenses that may be associated with their participation.

A.4. Each person served is provided with an initial orientation to agency practices regarding client rights, complaint procedures, treatment options, advance directives, access to their records, advocacy organizations (e.g., PAMI, Human Rights Commission), rehabilitation and community resources, and spiritual/chaplaincy services. Contact information on program staff and agency leaders is made available. Provision of orientation is documented in the person's record.

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A.5. Initial orientation is supplemented by the routine availability of information and agency updates to people in recovery and their loved ones. This information is provided in a variety of formats (e.g., information tables, service directories, educational programs, newsletters, web postings, etc.) to enable people in recovery and their loved ones to make informed choices about treatments, rehabilitation, and supports and to provide meaningful input about program and agency performance. Feedback is regularly solicited from people in recovery and their loved ones regarding their informational needs.

A.6. Policies are established and maintained that allow people in recovery maximum opportunity for choice and control in their own care. For example, people in recovery are able to a) access their records with minimal barriers, b) incorporate psychiatric advance directives in their recovery and crisis plans, c) secure the services of local or state advocacy services as necessary, d) request transfer to an alternative provider within agency guidelines, and e) participate actively in agency planning activities. These policies and procedures are highlighted on agency admission and are routinely publicized throughout the agency through newsletters, educational postings, Consumer Empowerment Councils, etc. This process is particularly crucial within services such as "money management" where the line between providing a service and infringing on people's rights can easily be blurred in the absence of clear programmatic guidelines and safeguards.

A.7. Measures of satisfaction with services and supports are collected

routinely and in a timely fashion from people in recovery and their loved ones. These data are used in strategic planning and quality improvement initiatives to evaluate and make meaningful changes in programs, policies, procedures, and interventions. Feedback mechanisms are in place to inform people in recovery and their loved ones of changes and actions taken based on their input.

A.8. Formal grievance procedures are established and made readily available to people in recovery and their loved ones to address their dissatisfactions with services. People in recovery and their loved ones are fully informed about these procedures on a regular basis, and the frequency and focus of grievances are tracked to inform agency or program quality improvement processes.

A.9. Administration enforces ethical practice through proactive human resource oversight. This oversight prohibits the use of coercive practices, and holds all staff accountable for affording people in recovery maximum control over their own treatment and rehabilitation.

A.10. Assertive efforts are made to recruit people in recovery for a variety of staff positions for which they are qualified. These include positions for which their personal experience of disability and recovery make them uniquely qualified (e.g., peer support), as well as positions for which they are qualified by virtue of licensure (e.g., nursing, psychiatry) or other training or work experience (clerical, administrative, medical records, etc.). Assertive efforts include establishing mentoring programs for employees in recovery so they can advance in their skills and attain the necessary credentialing that will allow them to occupy a more diverse range of agency positions.

A.11. Active recruitment of people in recovery for existing staff positions is coupled with ongoing support for the development of a range of peer-operated services that function independent of, but in collaboration with, the professional agency. This will help to ensure that the recovery community's role is supported, while avoiding co-opting by transforming it into an adjunct service provider. As one example, recovery community centers operated by people in recovery should be available in all areas. Such recovery centers are neither treatment centers nor social clubs. They are places where people who are interested in learning about recovery can meet with other non-professionals to get support, learn about recovery and treatment resources, and simply find people to talk to. Agencies can demonstrate their support for peer-operated services by offering material and supervisory support to

emerging programs. For example, technical assistance or mentoring regarding business management, attainment of 501(c)3 status, human resource practices, etc., can greatly facilitate the establishment and long-term viability of emerging peer-operated services. Care should be taken to ensure capacity-building and enhanced independence in the peer-operated program over time. As with all community support programs, peer-operated services should be well integrated with the agency at large in terms of committee membership and with recovery planning at the individual level.

A.12. Self-disclosure by employed persons in recovery is respected as a personal decision and is not prohibited by agency policy or practice. Supervision is available to discuss the complex issues which can arise with self-disclosure.

A.13. Staff appreciate that many people in recovery may not, at first, share the understanding that they are the foremost experts on the management of their own condition. Persons who have come to depend upon services and professionals to alleviate their distress may neither believe themselves capable of being the expert nor recognize that they are entitled to occupy this role. Therefore, staff encourage individuals to claim their rights and to make meaningful contributions to their own care and to the system as a whole. For example, individuals are encouraged to become involved in local and state advocacy as a means of developing their confidence and skills in self-determination and collective action, agency efforts to enhance the participation of service users are widely publicized to the recovery community, and general education is offered regarding the necessity of active service-user involvement to achieve recovery outcomes. While people are to be encouraged to become involved at all levels of the system, not everyone will want to participate beyond the primary level of involvement, i.e., their personal recovery plan. As in other areas of self-determination, this too is respected as a valid choice.

A.14. The agency offers to host local, regional, and/or state events and advocacy activities for people in recovery and their loved ones, e.g., meetings of 12-step fellowships, Connecticut Community for Addiction Recovery, Advocacy Unlimited, and Focus on Recovery-United.

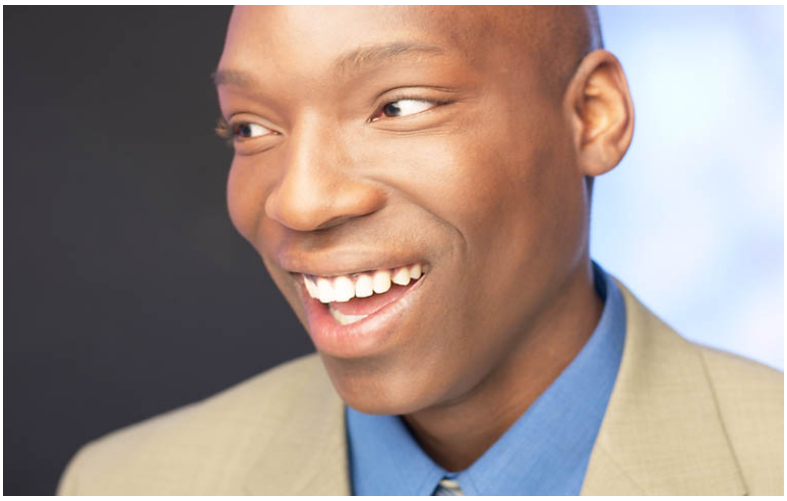
What you will hear from people in recovery when you are placing primacy on their participation:

- *You know, at first I thought, "What do I know or what could I possibly say at this meeting?" But then, I could tell that what I had to say made a difference. People were really listening to me. I finally got a place at the table!*

- *I knew I was in recovery when I could help somebody else that was in the same awful place I used to be. But I think about where I am today: healthy, and drug free, and being a real Grandma. And getting back in the work field as a peer provider makes me feel good; makes me understand that I can do this. I can really do this. And if I could do this, anybody can do this. Folks get hope when they look at me.*

- *I don't have to hide who I am–even the part of me that isn't well. Because it's that part of me and all the things I've experienced as a client here -- good and bad -- that gives me ideas for how things could change.*

- *I just didn't think my program was a good fit for me. I was sticking it out, but lots of other folks stopped showing up. But then, somebody came in and we had a great talk about what was working and what wasn't in the program. And some changes actually got made. Things are a lot better now. The group is packed every week!*



B. Promoting Access and Engagement

A core principle of the deinstitutionalization movement of the 1950s and beyond was that persons with psychiatric disabilities should receive mental health services in the least restrictive setting possible within their home communities. Community mental health centers and clinics were developed in large part in response to this principle. Unfortunately, many persons with psychiatric disabilities did not receive care due to a variety of factors such as: inadequate funding for community-based services, administrative and bureaucratic barriers that discouraged people from seeking care, expectations of motivation for treatment that did not take into account internal (to the clinic) or external (in the person's environment) barriers to care, a lack of knowledge of ways to engage people living in the community into mental health treatment, clients' avoidance of the mental health system because of previous negative experiences, and persons' inability to meet the requirements of treatment (e.g. appointment times, etc.) due to the exigencies of their lives of poverty and/or homelessness, or due to their psychiatric symptoms. Thus, many people who were eligible for services did not receive them, and suffered impoverished lives without adequate treatment, social support, or material resources in the community.

For these, and additional, reasons, the recent U.S. Surgeon General's *Report on Mental Health*[9] suggested that for every one person who seeks and receives specialty mental health care for a diagnosable psychiatric disorder, there remain two individuals, with similar conditions, who will neither gain access to nor receive such care. This report was followed by a supplement on culture, race, and ethnicity, which further identified lack of access to care as an even more formidable obstacle to recovery among people of color[10].

While this situation may seem dire, the proportion of people who access and receive care to those who are in need of such care is even worse in the case of addiction, with approximately 1 out of 7 people with an addiction actually receiving active behavioral health treatment. These facts clearly warrant the attention of the behavioral health system, including a greater focus on efforts to enhance access and engage people in care.

Access to care involves facilitating swift and uncomplicated entry into care, and can be increased through a variety of means. These include: 1) conducting outreach to persons who may not otherwise receive information about services or who may avoid institutional settings where services are provided; 2) establishing numerous points of entry into a wide range of treatment, rehabilitative, social, and

[9]Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
[10]Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

other support services. For example, a public health nurse working with a homeless outreach team facilitates a person's entry into behavioral health care, a clinician might help the person gain access to vocational services and entitlement income support, and, with the client's permission, all of these service providers meet with or talk to each other regularly to coordinate their work with the person; and 3) ensuring that information about services is made readily available and understandable to people through public education and information, liaison with other agencies, links to self-help groups, and other venues.

Access to care also involves removing barriers to receiving care, including bureaucratic red tape, intimidating or unwelcoming physical environments and program procedures, schedule conflicts, and modes of service provision that conflict with the life situations and demands of persons with psychiatric disabilities or addiction. It also means that access to care goes far beyond mere eligibility to receive services. Finally, access to care involves moving away from traditional philosophies of treatment—including hitting bottom (e.g., "Addicts can't be helped until they hit bottom and have lost everything") and incrementalism (e.g., "We can't house people with addictions until they've been in recovery for 6 months")—and toward stages of change approaches, recognizing that addressing basic needs, employment, and housing can enhance motivation for treatment and recovery.

Engagement into services is closely tied to access to care. Engagement involves making contact with the person rather than with the diagnosis or disability, building trust over time, attending to the person's stated needs and, directly or indirectly, providing a range of services in addition to clinical care. The process of engagement benefits from new understandings of motivational enhancement, which sees people standing at various points on a continuum from pre-readiness for treatment to being in recovery, rather than being either motivated or unmotivated.

Engagement involves sensitivity to the thin line between persuasion and coercion and attention to the power differential between the service provider and the client or potential client, and the ways in which these factors can undermine personal choice. Finally, methods of ensuring access and engagement are integrated within and are part of providing good clinical and rehabilitative care, not adjuncts or qualifications to them.

You will know that you are promoting access and engagement when:

B.1. The service system has the capacity to go where the potential client is, rather than always insisting that the client come to the service. Services and structures (e.g., hours of operation and locations of services) are designed around client needs, characteristics, and preferences.

B.2. The team provides, or can help the person gain swift access to, a wide range of services. People can access these services from many different points. In a "no wrong door" approach to providing an array of services, individuals can also self-refer to a range of service options (e.g., specialized rehabilitation supports) without the need for referral from a primary clinical provider. In addition, individuals can access DMHAS-funded rehabilitation programs without being mandated to participate in clinical care. However, self referrals will be subject to admission and oversight and need approval by a licensed entity to satisfy reimbursement and accreditation needs.

B.3. There is not a strict separation between clinical and case management functions, though there may be differences in expertise and training of the people providing these services. Services and supports address presenting clinical issues, but are also responsive to pressing social, housing, employment, and spiritual needs. For example, employment is valued as an important element of recovery. Skill building and finding employment are competencies included in all staff job descriptions, including clinical providers, with only the most difficult-to-place clients being referred to specialized programs.

B.4. The assessment of motivation is based on a stages of change model, and services and supports incorporate motivational enhancement strategies which assist providers in meeting each person at his or her own level. Training in these strategies is required for all staff who work with people with addictions in order to help move people toward recovery.

B.5. Staff and agencies look for signs of organizational barriers or other obstacles to care before concluding that a client is non-compliant with treatment or unmotivated for care, e.g., meeting the needs of women with children for daycare.

B.6. Agencies have "zero reject" policies that do not exclude people from care based on symptomatology, substance use, or unwillingness to participate in prerequisite clinical or program activities. For example, vocational rehabilitation agencies do not employ screening procedures based on arbitrary "work readiness" criteria, as such criteria have limited predictive validity regarding employment outcomes. In addition, such procedures suggest that individuals must attain, and maintain, clinical stability or abstinence before they can pursue a life in the community, when, in fact, employment and other meaningful activities are often a path through which people become stable in the first place.

B.7. Staff have an "open case" policy which dictates that a person's refusal of services, even despite intensive and long-term outreach and engagement, does not require that he or she be dropped from the "outreach" list. This person may still accept services at another time. Committee structures and supervision are in place to evaluate the fine line between assertive outreach versus potential harassment or coercion. In addition, the agency establishes guidelines regarding what defines an "active" versus an "outreach" client, and considers how such definitions impact program enrollment, documentation standards, 30 day drop out lists, case load definitions, and reimbursement strategies.

B.8. From an administrative perspective, the system builds on a commitment to and practice of motivational enhancement, with reimbursement for pre-treatment and recovery management supports. This includes flexibility in outpatient care, including low-intensity care for those who do not presently benefit from high-intensity treatment.

B.9. Outpatient substance abuse treatment clinicians are paired with outreach workers to capitalize on the moment of crisis that can lead people to accept treatment, and to gain access to their appropriate level of care.

B.10. Mental health professionals, addictions specialists, and people in recovery are placed in critical locales to assist in the early stages of engagement, e.g., in shelters, in courts, in hospital emergency rooms, and in community health centers. The agency develops and establishes the necessary memoranda of agreement and protocols to facilitate this co-location of services.

B.11. The team or agency employs staff with first person experience of recovery who have a special ability to make contact with and engage people into services and treatment.

B.12. Housing and support options are available for those who are not interested in, or ready for, detoxification, but who may begin to engage in their own recovery if housing and support are available to them. Provider ambivalence regarding harm reduction approaches and the issue of public support for persons who are actively using must be addressed in regard to this point.

B.13. The availability of sober housing is expanded to make it possible for people to go immediately from residential or intensive outpatient treatment programs into housing that supports their recovery.

What you will hear from people in recovery when you are promoting access and engagement:

- *I didn't want nothing to do with them at first. But, folks from the Center just kept showing up . . . they didn't drop me or let me get off on the wrong track… they didn't give up, they just stuck by me. It was like a velvet bulldozer.*

- *I hated going to their building. Everybody looked at me as I was walking up the block like "Oh, I wonder if he's a patient there – crazy and on dope." So, I just never went. But, they came to me on my own turn and my own terms. Today, I think my case manager is the reason I'm still alive.*

- *I got help with the kinds of things that were most important to me – like getting my daughter back, and putting food on the table for her. Since they were willing to help me with that stuff, I figured "Hey, maybe I should listen to what they are telling me and try out that program they keep talking about." Today I've been clean for 9 months…*

- *Nobody wanted anything to do with me before. It was always "Come back and see us when you get serious about your recovery… when you've got some clean urines." But, then, this program tried to help me out with getting this job I had wanted for a really long time. Now, I am working part time and I've finally got a reason to be sober every day.*

- *They knew when to take "no" for an answer. They didn't stay on my back all the time, but I knew they were always there for me if I needed them. Now I don't say "no" so often.*



C. Ensuring Continuity of Care

Recovery in both addiction and in mental health, in the sense in which we are using it in this document, refers to a prolonged or long-term process. It does not refer, that is, to an acute phenomenon such as recovery from the flu or from a broken bone. This is not to say that substance use or mental illness cannot also be acute in nature. Many people do, in fact, experience one episode of mental illness or a short-lived period of substance use and do not develop prolonged conditions to begin with.

For such people experiencing only one acute and delimited episode of either substance use or mental illness, however, the notion of recovery is unlikely to have much relevance. Such individuals are unlikely to consider themselves, or to refer to themselves, for example, as being "in recovery" from psychiatric or substance use disorders. In the face of the significant stigma and discrimination which continue to accrue to psychiatric and substance use disorders in the general public, these persons seldom disclose their psychiatric or addiction history or define themselves in terms of this isolated episode of illness, preferring to return quietly to the normal lives they led previously. Without giving much thought to the repercussions of their condition for their social role or sense of identity, such individuals are unlikely to describe themselves as being "in recovery" from anything.

For those individuals for whom being in recovery is a meaningful goal, the nature of their struggle with mental illness and/or addiction is likely to be sustained. In such cases—which, it should be acknowledged, comprise a significant segment of Connecticut citizens receiving care from DMHAS—an acute model of care is not the most useful or appropriate. Particularly in terms of system design, prolonged conditions call for longitudinal models that emphasize continuity of care over time and across programs. Consistent with the principles undergirding the "new recovery movement" in addictions, the long-term nature of addiction and mental illness suggests a number of parameters for developing new models of care that go beyond loosely linked acute episodes[11].

These models are based on the belief that full recovery is seldom achieved from a single episode of treatment, and that providers, as well as clients, families, and policy makers, should not be disappointed or discouraged by the fact that there are no quick fixes. Similar to (other) chronic medical illnesses, previous treatment of a person's condition also should not be taken to be indicative of a poor prognosis, of non-compliance, or of the person's not trying hard enough to recover. Relapses in substance use and exacerbations of psychiatric symptoms are to be viewed as further evidence of the severity of the person's condition rather than as causes for discharge (e.g., we do not discharge a person from the care of a cardiologist for having a

[11]White, W. (2001). The new recovery advocacy movement: A call to service. *Counselor, 2*(6), 64-67.

second or third heart attack). All of these principles suggest that treatment, rehabilitation, and support are not to be offered through serial episodes of disconnected care offered by different providers, but through a carefully crafted system of care that ensures continuity of the person's most significant healing relationships and supports over time and across episodes, programs, and agencies.

You will know that you are ensuring continuity of care when:

C.1. The central concern of engagement shifts from: "How do we get the client into treatment?" to: "How do we nest the process of recovery within the person's natural environment?" For example, people have often asked for meeting places and activities to be available on weekends, especially for those individuals who are in the early stages of their recovery.

C.2. Services are designed to be welcoming to all individuals and there is a low threshold (i.e., minimal requirements) for entry into care. There also is an emphasis on outreach and pre-treatment recovery support services that can ensure that individuals are not unnecessarily excluded from care. If a person is denied care, they receive written explanations as to why and are connected to appropriate alternatives including appointment and transportation.

C.3. Eligibility and reimbursement strategies for this group of individuals (i.e., outreach and pre-engagement) are established and refined as necessary over time by administrative leadership.

C.4. People have a flexible array of options from which to choose, and options are not limited to what "programs" are available. These options allow for a high degree of individualization and a greater emphasis on the physical/social ecology (i.e., context) of recovery.

C.5. Individuals are not expected or required to progress through a continuum of care in a linear or sequential manner. For example, individuals are not required to enroll in a group home as a condition of hospital discharge when this is determined solely by professionals to be the most appropriate level of care. Rather, within the context of a responsive continuum of care, individuals work in collaboration with their recovery team to select those services from within the array that meet their particular needs and preferences at a given point in time.

C.6. In a Recovery Management Model, an individual's stage of change is considered at all points in time and the focus of care is on enhancing existing strengths and recovery capital. The assessment of problems and needs is consistently coupled with an assessment of resources and strengths both in initial and in on-going recovery planning. This is best achieved by including the person's family/kinship network and/or any natural supports she or he believes would be supportive of recovery.

C.7. Goals and objectives in the recovery plan are not defined by practitioners based on clinically-valued outcomes (e.g., reducing symptoms, increasing adherence), but rather are defined by the person with a focus on building recovery capital and pursuing a life in the community.

C.8. The overall focus of care shifts from preventing relapse to promoting recovery. Services are not primarily oriented toward crisis or problem resolution, e.g., detoxification and stabilization. There is a full array of recovery support services, including proactive, preventive supports and post-crisis, community-based resources such as adequate safe housing, recovery community centers operated by people in recovery, sustained recovery coaching, monitoring with feedback, and early re-intervention if necessary. The concept of "aftercare" is irrelevant as all care is conceptualized as continuing care and there is a commitment to provide ongoing, flexible supports as necessary.

C.9. Valued outcomes are influenced by the system's commitment to ensuring continuity of care. For example, less emphasis is placed on a professional review of the short-term outcomes of single episodes of care (e.g., readmission or incarceration rates) and more emphasis is placed on the long-term effects of service combinations and sequences on those outcomes valued by the person such as quality of life domains including satisfaction with housing, relationships, and employment.

C.10. The range of valued expertise is expanded beyond specialized clinical and rehabilitative professionals and technical experts to include the contributions of multiple individuals and services. These individuals may include peers in paid or volunteer positions, mutual aid groups, indigenous healers, faith community leaders, primary care providers, and other natural supports. Valuing and incorporating such community resources in ongoing care planning is viewed as essential to decreasing dependence on formal behavioral health care and assisting the person to develop a more natural recovery network. In this spirit, the community, rather than the clinic, agency, or program, is viewed as the ultimate context for sustained recovery.

C.11. Individuals are seen as capable of illness self-management and interventions support this as a valued goal of recovery-oriented services. People are actively involved in all aspects of their care including policy development, assessment, goal setting, and evaluation. These different forms of involvement build capacity for independent community living and are powerful antidotes to the passivity and dependence that may have resulted from years of being a recipient of professionally-prescribed and delivered care. In the process of decreasing the power differential that traditionally has characterized relationships between clients and providers, care is conceptualized within a partnership or consultant framework in which services—while available over the long-term—may be time-limited and accessed by the person when and as she or he deems necessary.

C.12. New technologies (e.g., tele-medicine and web-based applications and self-help resources) are incorporated as service options to enhance illness self-management collaborative treatment relationships.

C.13. Access to housing, employment, and other supports that make recovery sustainable is enhanced. This includes changing policies and laws that restrict people's access to employment and home ownership, such having a criminal record for non-violent, one-time, drug-dealing offenses or offenses related to psychiatric disability.

C.14. Policy formulation and legislative advocacy at the administrative level is coupled with on-going efforts to work collaboratively with a variety of state systems to ensure continuity of care, e.g., with the Department of Corrections to put into place plans for re-entry, with resources such as Oxford Houses and rental assistance for people with substance use disorders coming out of jails and prisons.

C.15. In order to facilitate sustained recovery and community inclusion, advocacy efforts are extended beyond institutional policies and procedures to the larger community, including stigma-busting, community education, and community resource development activities.

What you will hear from people in recovery when you are ensuring continuity of care:

- *They were there for me – no strings attached. I didn't walk through the door and get a whole bunch of expectations dumped on me.*

- *People respected that I was doing the best I could. It was two steps forward one step back for a long time, but overall, I was moving in the right direction for the first time in as long as I could remember. But they stuck with me for the long haul. Now, I've been clean for 18 months, and someone still calls me everyday to check in–even if its just to day "Hi, How ya' doin'?"*

- *I didn't get kicked out of the program because I had a dirty urine–it used to be that happened every week. This time, I had been clean for two months. My case manager reminded of how good it was in those two months and I wanted to get back there.*

- *It used to be I was terrified of leaving detox. I'd go back to the same crappy environment and be back out on the streets in a matter of days. But, I got into some sober housing and it changed my life.*

- *They knew I needed to work on my recovery AND my life at the same time. That meant getting a part-time job, paying off my debts, working on my marriage, and learning how to enjoy myself again and to do it all drug-free.*



D. Employing Strengths-Based Assessment

As described above, traditional behavioral health services have been based on a narrow and acute medical model that perceives mental illnesses and addictions as diseases that can be treated and cured. While this approach works effectively for many people, for many others it primarily serves to add additional weight to their already heavy burdens. In this case, providers have had an unfortunate tendency to overlook the remaining and co-existing areas of health, assets, strengths, and competencies that the person continues to have at his or her disposal—what remains "right" with people—by focusing on the assessment and treatment of their deficits, aberrations, and symptoms—what is "wrong" with people. Emphasizing the negative in this way has led to a tremendous sense of hopelessness and despair among both clients and the behavioral health practitioners who serve them.

In addition, whether one has a psychiatric disability or an addiction, focusing solely on deficits in the absence of a thoughtful analysis of strengths disregards the most critical resources an individual has on which to build in his or her efforts to adapt to stressful situations, confront environmental challenges, improve his or her quality of life, and advance in his or her unique recovery journey. As the process of improvement depends, in the end, on the resources, reserves, efforts, and assets of and around the individual, family, or community, a recovery orientation thus encourages providers to view the glass as half full rather than half empty[12].

Following principles that have been articulated at length by Rapp and others[13], strengths-based approaches allow professionals to balance critical needs that must be met with the resources and strengths that individuals and families possess to assist them in this process. This perspective encourages providers to recognize that no matter how disabled, every person continues to have strengths and capabilities as well as the capacity to continue to learn and develop. The failure of an individual to display competencies or strengths is therefore not necessarily attributed to deficits within the person, but may rather, or in addition, be due to the failure of the service system and broader community to adequately elicit information in this area or to create the opportunities and supports needed for these strengths to displayed.

While system and assessment procedures have made strides in recent years regarding inquiry into the area of individual resources and capacities, simply *asking* an individual what strengths they possess or what things they think they are "good at" may not be sufficient to solicit the information that is critical to the recovery planning process. For example, many people who have prolonged conditions will at first report

[12]Saleeby, D. (2001). The diagnostics strengths manual. *Social Work, 46,* (2), 183-187.

[13]Rapp, C.A. (1998). *The Strengths Model: Case management with people suffering from Severe and Persistent Mental Illness*. New York: Oxford University Press.

that they have no strengths. Such a response should not be taken at face value, but rather to represent the years of difficulties and failures they may have endured and the degree of demoralization which has resulted. Over time, it is not uncommon for such individuals to lose touch with the healthier and more positive aspects of themselves and become unable to see beyond the "patient" or "addict" role.

When facing such circumstances, providers need to conceptualize one of their first steps as assisting this person to get back in touch with his or her previous interests, talents, and gifts. The guidelines below are intended to assist providers in conducting a comprehensive, strengths-based assessment that can help people to rediscover themselves as capable persons with a history, a future, and with strengths and interests beyond their symptoms, deficits, or functional impairments.

You will know that you are providing strengths-based assessment when:

D.1. A discussion of strengths is a central focus of every assessment, care plan, and case summary. Assessments begin with the assumption that individuals are the experts on their own recovery, and that they have learned much in the process of living with and working through their struggles. This strengths-based assessment is conducted as a collaborative process and all assessments in written form are shared with the individual.

D.2. Initial assessments recognize the power of simple, yet powerful, questions such as "What happened? And what do you think would be helpful? And what are your goals in life?" Self-assessment tools rating level of satisfaction in various life areas can be useful ways to identify diverse goal areas around which supports can then be designed.

D.3. Practitioners attempt to interpret perceived deficits within a strengths and resilience framework, as this will allow the individual to identify less with the limitations of their disorder. For example, an individual who takes their medication irregularly may automatically be perceived as "non-compliant," "lacking insight," or "requiring monitoring to take meds as prescribed." This same individual, however, could also be seen as "making use of alternative coping strategies such as exercise and relaxation to reduce reliance on medications" or could be praised for "working collaboratively to develop a contingency plan for when medications are to be used on an 'as-needed' basis."

D.4. While strengths of the individual are a focus of the assessment procedure, thoughtful consideration also is given to potential strengths and resources within the individual's family, natural support network, service system, and community at large. This is consistent with the view that recovery is not a solitary process but rather a journey toward interdependence within one's community of choice.

D.5. The diversity of strengths that can serve as resources for the person and his or her recovery planning team is respected. Saleeby, for example, has recommended conceptualizing strengths broadly to include the following dimensions: skills (e.g., gardening, caring for children, speaking Spanish, doing budgets); talents (e.g., playing the bagpipes, cooking); personal virtues and traits (e.g., insight, patience, sense of humor, self-discipline); interpersonal skills (e.g., comforting the sick, giving advice, mediating conflicts); interpersonal and environmental resources (e.g., extended family, good neighbors); cultural knowledge and lore (e.g., healing ceremonies and rituals, stories of cultural perseverance); family stories and narratives (e.g., migration and settlement, falls from grace and redemption); knowledge gained from struggling with adversity (e.g., how one came to survive past events, how one maintains hope and faith); knowledge gained from occupational or parental roles (e.g., caring for others, planning events); spirituality and faith (e.g., a system of meaning to rely on, a declaration of purpose beyond self); and hopes and dreams (e.g., personal goals and vision, positive expectations about a better future)[14].

D.6. In addition to the assessment of individual capacities, it is beneficial to explore other areas not traditionally considered "strengths," e.g., the individual's most significant or most valued accomplishments, ways of relaxing and having fun, ways of calming down when upset, preferred living environment, educational achievements, personal heroes, most meaningful compliment ever received, etc.

D.7. Assessment explores the whole of people's lives while ensuring emphasis is given to the individual's expressed and pressing priorities. For example, people experiencing problems with mental illness or addiction often place less emphasis on symptom reduction and abstinence than on desired improvements in other areas of life such as work, financial security, safe housing, or relationships. For this reason, it is beneficial to explore in detail each individuals' needs and resources in these areas.

[14]Saleeby, D. (2001). The diagnostics strengths manual. *Social Work*, *46*(2), 183-187.

D.8. Strengths-based assessments ask people what has worked for them in the past and incorporate these ideas in the recovery plan. People are more likely to use strategies that they have personally identified or developed rather than those that have been prescribed for them by others.

D.9. Guidance for completing a strengths-based assessment may be derived from certain interviewing strategies employed within solution-focused approaches to treatment. For example, DeJong and Miller recommend the following types of inquiry: exploring for exceptions (occasions when the problem could have occurred but did not), imagining a future when the problem has been solved and exploring, in detail, how life would then be different; assessing coping strategies, i.e., asking how an individual is able to cope despite the presence of such problems; and using scaling questions (where the individual rates his or her current experience of the problem) to elucidate what might be subtle signs of progress[15].

D.10. Illness self-management strategies and daily wellness approaches such as WRAP[16] are respected as highly effective, person-directed, recovery tools, and are fully explored in the strengths-based assessment process.

D.11. Cause-and-effect explanations are offered with caution in strengths-based assessment as such thinking can lead to simplistic resolutions that fail to address the person's situation. In addition, simplistic solutions may inappropriately assign blame for the problem to the individual, with blame being described as "the first cousin" of deficit-based models of practice[17]. For example, to conclude that an individual did not pay his or her rent as a direct consequence of his or her "non-compliance" with medications could lead to an intrusive intervention to exert control over the individual's finances or medication. Strengths-based assessments respect that problem situations are usually the result of complex, multi-dimensional influences, and explore with the person in more detail the various factors that led to his or her decisions and behavior (e.g., expressing displeasure with a negligent landlord).

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[15]DeJong, G. & Miller, S. (1995) How to interview for client strengths, *Social Work, (40),* 729-736.

[16]Copeland, M. (2002). *The depression workbook: A guide for living with depression and manic depression. Wellness Recovery Action Plan.* Oakland, CA: New Harbinger Publications.

[17]Cowger, C.D. (1994). Assessing client strengths: Clinical assessment for client empowerment. S*ocial Work 39*(3), 262-268.

D.12. Strengths-based assessments are developed through in-depth discussion with the individual as well as attempts to solicit collateral information regarding strengths from the individual's family and natural supports. Since obtaining all of the necessary information requires time and a trusting relationship with the person, a strengths-based assessment may need to be completed (or expanded upon) after the initial contact as treatment and rehabilitation unfold. While each situation may vary, the assessment is written up as soon as possible in order to help guide the work and interventions of the Recovery Planning Team. Modular approaches to service delivery, billing, and reimbursement are considered by local and state administrative leadership, e.g., certain information is gathered in the first 24 hours with additional areas being assessed by the end of one week, one month, etc.

D.13. Efforts are made to record the individual's responses verbatim rather than translating the information into professional language. This helps to ensure that the assessment remains narrative-based and person-centered. If technical language must be used, it is translated appropriately and presented in a person-first, non-offensive manner, e.g., avoiding the language of "dysfunction, disorder."

D.14. Practitioners are mindful of the power of language and carefully avoid the subtle messages that professional language has historically conveyed to people with psychiatric diagnoses, addictions, and their loved ones. Language is used that is empowering, avoiding the eliciting of pity or sympathy, as this can cast people with disabilities in a passive, "victim" role and reinforce negative stereotypes. For example, just as we have learned to refer to "people who use wheelchairs" as opposed to "the wheelchair bound" we should refer to "individuals who use medication as a recovery tool" as opposed to people who are "dependent on medication for clinical stability." In particular, words such as "hope" and "recovery" are used frequently in documentation and delivery of services.

D.15. Practitioners avoid using diagnostic labels as "catch-all" means of describing an individual (e.g., "she's a borderline"), as such labels yield minimal information regarding the person's actual experience or manifestation of their illness or addiction. Alternatively, a person's needs are not well captured by a label, but by an accurate description of his or her functional strengths and limitations. While diagnostic profiles may be required for other purposes (e.g., decisions regarding medication, justification of level of care), asset-based assessment places limited value on diagnosis per se. In addition, acknowledging

limitations and areas of need are not viewed as accepting one's fate as a mentally ill person or an addict. Rather, identifying and accepting one's current limitations is seen as a constructive step in the process of recovery. Gaining a sense of perspective on both strengths and weaknesses is critical in this process as it allows the person to identify, pursue, and achieve life goals despite the lingering presence of disability.

D.16. Language used is neither stigmatizing nor objectifying. At all times "person first" language is used to acknowledge that the disability is not as important as the person's individuality and humanity, e.g., "a person with schizophrenia" versus "a schizophrenic" or a "person with an addiction" versus "an addict." Employing person-first language does not mean that a person's disability is hidden or seen as irrelevant; however, it also is not to be the sole focus of any description about that person. To make it the sole focus is depersonalizing, and is no longer considered an acceptable practice.

D.17. Exceptions to person-first and empowering language that are preferred by some persons in recovery are respected. For instance, the personal preferences of some individuals with substance use disorders, particularly those who work the 12-Steps as a primary tool of their recovery, may at times be inconsistent with person-first language. Within the 12-Step Fellowship, early steps in the recovery process involve admitting one's powerlessness over a substance and acknowledging how one's life has become unmanageable. It is also common for such individuals to introduce themselves as: "My name is X and I am an alcoholic." This preference is respected as a part of the person's unique recovery process, and it is understood that it would be contrary to recovery principles to pressure the person to identify as "a person with alcoholism" in the name of person-first language or principles. Use of person-first language is in the service of the person's recovery; it is not a super-ordinate principle to which the person must conform. While the majority of people with disabilities prefer to be referred to in first-person language, when in doubt ask the person what he or she prefers.

What you will hear from people in recovery when you are employing strengths-based assessment:

- *I used to think my life was over, but my illness isn't a death sentence. Its just one small part of who I am. Sometimes I forget about those other parts – the healthy parts of me. But my counselor always reminds me. You really need someone like that in your life.*

- *Being in recovery means that I know I have certain limitations and things I can't do. But rather than letting these limitations be an occasion for despair and giving up, I have learned that in knowing what I can't do, I also open up the possibilities of all I can do.*[18]

- *I thought I was so alone in my problems. I may not feel as though I have much strength right now, but I realize I can draw strength from all the people around me… my friends, my neighbors, my pastor, and my counselors here at the Center.*

- *When they asked me about what I was good at and what sorts of things in my life made me happy, at first I didn't know who they were talking to. Nobody ever asked me those kinds of questions before. Just sitting through that interview, I felt better than before I had walked through the door!*

- *No one here treats me like a label. Just because I have schizophrenia, that doesn't tell you a whole lot. My roommate does too, but we couldn't be more different. Folks here take the time to get to know lots of things about me, not just the things that go along with my diagnosis.*



[18]Deegan,, P.E. (1993). Recovering our sense of value after being labeled mentally ill. *Journal of Psychosocial Nursing, 31*(4), 7-11.

E. Offering Individualized Recovery Planning

In accordance with the Connecticut General Statutes, as well as Federal and JCAHO guidelines regarding the need for individualized care, all treatment and rehabilitative services and supports to be provided shall be based on an individualized, multidisciplinary recovery plan developed in collaboration with the person receiving these services and any others that he or she identifies as supportive of this process. While based on a model of collaboration and partnership, significant effort will be taken to ensure that individuals' rights to self-determination are respected and that all individuals are afforded maximum opportunity to exercise choice in the full range of treatment and life decisions. The individualized recovery plan will satisfy the criteria of treatment, service, or care plans required by other bodies (e.g., CMS) and will include a comprehensive and culturally sensitive assessment of the person's hopes, assets, strengths, interests, and goals in addition to a holistic understanding of his or her behavioral health conditions and other medical concerns within the context of his or her ongoing life.

Typical examples of such life context issues include employment, education, housing, spirituality, social and sexual relationships, and involvement in meaningful and pleasurable activities. In order to ensure competence in these respective areas, including competence in addressing the person's cultural background and affiliations, the multi-disciplinary team will not be limited to physician/psychiatrists, nurses, psychologists, and social workers, but may also include rehabilitative and peer staff, and wherever possible, relevant community representatives and/or others identified by the person.

Building on the strengths-based assessment process, individualized recovery planning both encourages and expects the person to draw upon his or her strengths to participate actively in the recovery process. It is imperative throughout this process that providers maintain a belief in the individual's potential for growth and development, up to, and including, the ability to exit successfully from services. Providers also solicit the person's own hopes, dreams, and aspirations, encouraging individuals to pursue their preferred goals even if doing so presents potential risks or challenges.

For example, many people identify returning to work as a primary recovery goal. It is not uncommon for practitioners to advise against this step based on an assumption that an individual either is not "work ready" or that employment will be detrimental to his or her recovery (e.g., by endangering his or her disability benefits). While such advice is based on good intentions, it sends a powerful message to the individual and can reinforce self-doubts and feelings of inadequacy. Rather than discouraging the person from pursuing this goal, the practitioner can have a frank discussion with the person about his or her concerns while simultaneously

highlighting the strengths that the individual can draw upon to take the first step toward achieving this goal.

In this vein, individualized recovery planning explicitly acknowledges that recovery entails the person's taking risks to try new things, and is enhanced by the person having opportunities to learn from his or her own mistakes and their natural consequences. This represents an important source of progress in the person's efforts to rebuild his or her life in the community that—similar to exercising one's muscles—cannot proceed without an exertion of the person's own faculties.

You will know that you are offering Individualized Recovery Planning when:

E.1. **Core principles of "person-centered" planning are followed in the process of building individualized recovery plans. For example:**

E.1.1. Consistent with the "nothing about us, without us" dictum, providers actively partner with the individual in all planning meetings and/or case conferences regarding his or her recovery services and supports.

E.1.2. The individual has reasonable control as to the location and time of planning meetings, as well as to who is involved, including conserved persons who wish to have an advocate or peer support worker present. Planning meetings are conducted and services are delivered at a time that does not conflict with other activities that support recovery such as employment. The individual can extend invitations to any person she or he believes will be supportive of his or her efforts toward recovery. Invitations extended are documented in the recovery plan. If necessary, the person (and family as relevant) are provided with support before the meeting so that they can be prepared and participate as equals[19].

E.1.3. The language of the plan is understandable to all participants, including the focus person and his or her non-professional, natural supports. Where technical or professional terminology is necessary, this is explained to all participants in the planning process.

[19]Osher, D. & Keenan, S. (2001). From professional bureaucracy to partner with families. *Reaching Today's Youth, 5(3),* 9–15.

E.1.4. When individuals are engaged in rehabilitation services, the rehab practitioners are involved in all planning meetings (at the discretion of the individual) and are given copies of the resulting plan.

E.1.5. Within the planning process, a diverse, flexible range of options must be available so that people can access and choose those supports that will best assist them in their recovery. These choices and service options are clearly explained to the individual, and documentation reflects the options considered.

E.1.6. Goals are based on the individual's unique interests, preferences, and strengths, and objectives, and interventions are clearly related to the attainment of these stated goals. In the case of children and youth, the unique goals of the family are also considered, with the youth increasingly driving the process as he or she approaches the age of maturity. In cases in which preferred supports do not exist, the recovery team works collaboratively with the individual to develop the support or to secure an acceptable alternative.

E.1.7. Planning focuses on the identification of concrete next steps, along with specific timelines, that will allow the person to draw upon existing areas of strength to move toward recovery and his or her vision for the future. Individuals, including non-paid, natural supports who are part of the planning process, commit to assist the individual in taking those next steps. The person takes responsibility for his or her part in making the plan work. Effective recovery plans help people rise to this challenge regardless of their disability status.

E.1.8. A discussion of strengths is a central focus of all recovery plans (See Section #D). Assessments begin with the assumption that individuals are the experts on their own recovery, and that they have learned much in the process of living with and working through their struggles.

E.1.9. Information on rights and responsibilities of receiving services is provided at all recovery planning meetings. This information should include a copy of the mechanisms through which the individual can provide feedback to the practitioner and/or agency, e.g., protocol for filing a complaint or compliments regarding the provision of services.

E.1.10. The individual has the ability to select or change his or her service providers within eligible guidelines and is made aware of the procedures for doing so.

E.1.11. In the spirit of true partnership and transparency, all parties must have access to the same information if people are to embrace and effectively carry out responsibilities associated with the recovery plan[20]. Clients are automatically offered a copy of their written plans, assessments, and progress notes. Knowing ahead of time that a copy will be shared is a simple but powerful strategy that can dramatically impact both the language of the plan and the content of its goals and objectives.

E.1.12. The team reconvenes as necessary to address life goals, accomplishments, and barriers. Planning is characterized by celebrations of successes, and meetings can occur beyond regular, established parameters (e.g., 6-month reviews) and crises (e.g., "all-treaters" meetings to address hospitalization or relapse).

E.2. **A wide range of interventions and contributors to the planning and care process are recognized and respected. For example:**

E.2.1. Practitioners acknowledge the value of the person's existing relationships and connections. If it is the person's preference, significant effort is made to include these "natural supports" and unpaid participants as they often have critical input and support to offer to the team. Interventions should complement, not interfere with, what people are already doing to keep themselves well, e.g., drawing support from friends and loved ones[21].

E.2.2. The plan identifies a wide range of both professional supports and alternative strategies to support the person's recovery, particularly those which have been helpful to others with similar struggles. Information about medications and other treatments are combined with information about self-help, peer support, exercise, nutrition, daily maintenance activities, spiritual practices and affiliations, homeopathic and naturopathic remedies, etc.

E.2.3. Individuals are not required to attain, or maintain, clinical stability or abstinence before they are supported by the planning team in pursuing such goals as employment. For example, in some systems access and

[20]Osher, T., & Osher, D. (2001). The paradigm shift to true collaboration with families. *The Journal of Child and Family Studies, 10*(3), 47-60.

[21]Osher, D. and Webb, L. (1994). *Adult Literacy, Learning Disabilities, and Social Context: Conceptual Foundations for a Learner-Centered Approach*. Washington, DC, U.S. Department of Education.

referral to vocational rehabilitation programs may be controlled by a clinical practitioner, and people are often required to demonstrate "work readiness" or "symptomatic stability" as a prerequisite to entry. In addition to an abundant literature which has shown that screening procedures and criteria have limited predictive validity, this structure also neglects that fact that activities such as working are often the path through which people become clinically stable in the first place.

E.2.4. Goals and objectives are driven by the person's current values and needs and not solely by commonly desired clinical/professional outcomes, e.g., recovery is a process that may or may not begin with the individual understanding or appreciating the value of abstinence or of taking medications.

E.3. **Community inclusion is valued as a commonly identified and desired outcome. For example:**

E.3.1. The focus of planning and care is on how to create pathways to meaningful and successful community life and not just on how to maintain clinical stability or abstinence. Person-centered plans document areas as physical health, family and social relationships, employment/education, spirituality, housing, social relations, recreation, community service and civic participation, etc., unless such areas are designated by the person as not-of-interest. For example, traditional planning has often neglected the spiritual and sexual aspects of peoples' lives. Achieving interdependence with natural community supports is a valued goal for many people in recovery who express a strong preference to live in typical housing, to have friendships and intimate relationships with a wide range of people, to work in regular employment settings, and to participate in school, worship, recreation, and other pursuits alongside other community members[22]. Such preferences often speak to the need to reduce time spent in segregated settings designed solely to support people labeled with a behavioral health disorder.

E.3.2. Recovery plans respect the fact that services and practitioners should not remain central to a person's life over time, and exit criteria from formal services are clearly defined. Given the unpredictability of illness, and life more generally, however, readmission also remains uncomplicated, with avenues clearly defined for people on discharge.

[22]Reidy, D. (1992). Shattering illusions of difference. *Resources, 4*(2), 3-6.

E.3.3. Recovery plans consider not only how the individual can access and receive needed supports from the behavioral health system and the community, but how the individual can, in turn, give back to others. People have identified this type of reciprocity in relationships as being critical to building recovery capital and to the recovery process as a whole. Therefore, individuals should be encouraged to explore how they can make meaningful contributions in the system or in the community, e.g., through advocacy, employment, or volunteering.

E.3.4. A focus on community is consistent not only with person-centered care principles but with the need for fiscal efficiency. Practitioners and people in recovery should be mindful of the limited resources available for specialized services and should focus on community solutions and resources first by asking "Am I about to recommend or replicate a service or support that is already available in the broader community?" At times this has direct implications for the development of service interventions within recovery plans, e.g., creating on-site health and fitness opportunities such as exercise classes without first exploring to what extent that same opportunity might be available in the broader community through public recreational departments, YMCAs, etc. If natural alternatives are available in the community, individuals should be informed of these opportunities and to the extent to which what is offered is culturally responsive and accessible, they should be supported in pursuing activities of choice in integrated settings.

E.4. **The planning process honors the "dignity of risk" and "right to fail" as evidenced by the following:**

E.4.1. Prior to appealing to coercive measures, practitioners try different ways of engaging and persuading individuals in ways which respect their ability to make choices on their own behalf.

E.4.2. Unless determined to require conservatorship by a judge, individuals are presumed competent and entitled to make their own decisions. As part of their recovery, they are encouraged and supported by practitioners to take risks and try new things. Only in cases involving imminent risk of harm to self or others is a practitioner authorized to override the decisions of the individual. Person-centered care does not take away a practitioner's obligation to take action to protect the person or the public in the event of emergent or crisis situations, but limits the authority of practitioners to specifically delimited circumstances involving imminent risk as defined by relevant statutes.

E.4.3. In all other cases, practitioners are encouraged to offer their expertise and suggestions respectfully within the context of a collaborative relationship, clearly outlining for the person his or her range of options and possible consequences. Practitioners support the dignity of risk and sit with their own discomfort as the person tries out new choices and experiences that are necessary for recovery.

E.4.5. In keeping with this stance, practitioners encourage individuals to write their own crisis and contingency plans (such as psychiatric advanced directives or the crisis plans of the WRAP model). Ideally, such plans are directed by the individual but developed in collaboration with the entire team so as to share responsibility and resources in preventing or addressing crises[23]. Such plans provide detailed instructions regarding preferred interventions and responses in the event of crisis, and maximize an individual's ability to retain some degree of autonomy and self-determination at a time when he or she is most likely to have these rights taken away. This plan is kept in an accessible location and can be made available for staff providing emergency care.

E.5. **Administrative leadership demonstrate a commitment to both outcomes and process evaluation. For example:**

E.5.1. Outcomes evaluation in a provider-driven paradigm is typically limited to change in specific agency functions (e.g., length of hospital stays) as well as by the need to protect the image of the agency (e.g., consumer satisfaction)[24]. In a consumer or family-driven paradigm, in contrast,

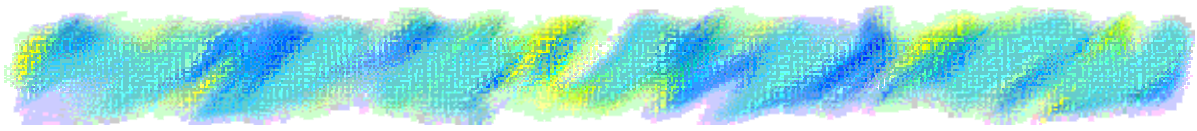
evaluation is a continuous process and expectations for successful outcomes in a broad range of quality of life dimensions (e.g., in areas such as employment, social relationships, community membership, etc.) are high. The maintenance of clinical stability alone is not accepted as a treatment outcome as the experience of recovery is about much more than the absence of symptoms or distress.

[23]Kendziora, K. T., Bruns, E., Osher, D., Pacchiano, D., & Mejia, B. (2001). *Wraparound: Stories from the Field.* Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.
[24]Osher, T. & Osher, D. (2001). The paradigm shift to true collaboration with families. *The Journal of Child and Family Studies, 10*(3), 47-60.

E.5.2. There is a flexible application of process tools, such as the Assessment of Person-Centered Planning Facilitation Integrity Questionnaire[25], to promote quality service delivery. Assuming attention is paid to the larger organizational culture, process tools can be helpful in defining the practice and then monitoring its effective implementation[26].

What you will hear from people in recovery when you are offering individualized recovery planning:

- *It's amazing what you can do when you set your mind to it … especially when you're no longer supposed to have one!*
- *It made such a huge difference to have my pastor there with me at my planning meeting. He may not be my father, but he is the closest thing I've got. He knows me better than anyone else in the world and he had some great ideas for me.*
- *I had been working on my recovery for years. Finally, it felt like I was also working on my LIFE!*
- *Not everybody thought it was a good idea for me to try to get my daughter back. But they realized that without her, I didn't have a reason to be well. So, we figured out a plan for what to do if I couldn't handle the stress, and my whole team has stood beside me every step of the way. Was it "too stressful" at times? You bet! But every day is a blessing now that I wake up and see her smiling face!*



[25] Holburn, S. (2001). How science can evaluate and enhance person-centered planning. *Research and Practice for Persons with Severe Disabilities, 27*(4), 250-260.

[26] Osher, T., Osher, D. & Blau, G. (2005a). Family-driven Care: A working definition. Alexandria, VA: Federation of Families for Children's Mental Health. http://ffcmh.org/systems_whatis.htm.

F. Functioning as a Recovery Guide

The sentiment that "we're not cases, and you're not managers"[27] has been accepted increasingly as a fundamental challenge to the ways in which behavioral health care is conceptualized within a recovery-oriented system. During this time, the predominant vehicle for offering services to many adults with serious disabilities has evolved from the team-based and *in vivo* approach of intensive case management to the introduction of strengths-based and rehabilitative forms of case management that attempt to shift the goals of care from stabilization and maintenance to enhanced functioning and community integration.

From the perspective of recovery, however, even these inherited models of case management limit the progress that otherwise could be made in actualizing the shift from a deficit- and institution-based framework to a recovery paradigm. This paradigm calls for innovative models of community-based practice that move beyond the management of cases, and beyond merely semantic changes that introduce new terms for old practices, to the creation of a more collaborative model which respects the person's own role in directing his or her life and, within that context, his or her own treatment (in much the same way that people, in collaboration with their health care professionals, make decisions about their own medical care for other conditions such as hypertension). One such model that is emerging within DMHAS is that of the community or recovery guide.

Rather than replacing any of the skills or clinical and rehabilitative expertise that practitioners have obtained through their training and experience, the recovery guide model offers a useful framework in which these interventions and strategies can be framed as tools that the person can use in his or her own recovery. In addition, the recovery guide model, as depicted on the following page, offers both providers and people in recovery a map of the territory they will be exploring together.

Prior to attempting to embark with a client on his or her journey of recovery, however, practitioners appreciate that the first step in the process of treatment, rehabilitation, or recovery is often to engage in a relationship a reluctant, disbelieving, but nonetheless suffering, person. In this sense, practitioners accept that most people with behavioral health disorders will not know that they have an addiction or psychiatric disorder at first, and therefore will frequently not seek help on their own. The initial focus of care is thus on the person's own understanding of his or her predicament (i.e., not necessarily the events or difficulties which brought him or her into contact with care providers), and on the ways in which the practitioner can be of assistance in addressing this predicament, regardless of how the person understands it at the time.

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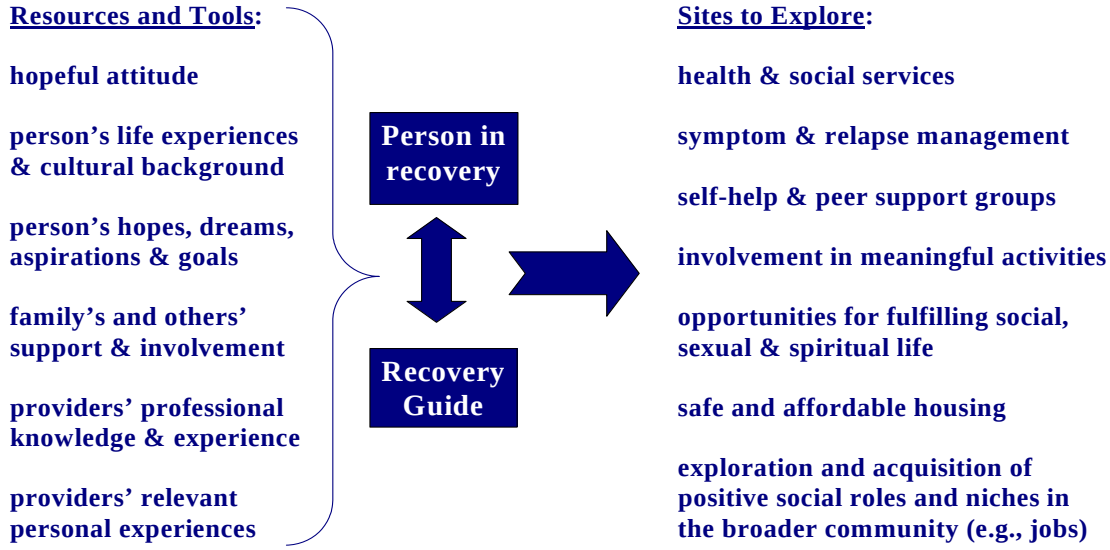
[27] Everett, B. & Nelson, A. (1992). We're not cases and you're not managers. *Psychosocial Rehabilitation Journal, 15(4),* 49-60.

Figure 1. Conceptual Model for the Recovery Guide



It also is important to note that within this model, care incorporates the fact that the lives of people in recovery did not begin with the onset of their disorders, just as their lives are not encompassed totally by substance abuse or psychiatric treatment and rehabilitation. Based on recognition of the fact that people were already on a journey prior to the onset of their disorders, and therefore prior to coming into contact with care, the focus of care shifts to the ways in which this journey was impacted or disrupted by each person's disorder(s).

For example, practitioners strive to identify and understand how the person's substance use or psychiatric disorder has impacted on or changed the person's aspirations, hopes, and dreams. If the person appears to be sticking resolutely to the hopes and dreams he or she had prior to onset of the disorder, and despite of or without apparent awareness of the disorder and its disabling effects, then what steps need to be taken for him or her to get back on track or to take the next step or two along this track? Rather than the reduction of symptoms or the remediation of deficits—goals that we assume the person will share with care providers—it is the person's own goals for his or her life beyond or despite his or her disability that drive the treatment, rehabilitation, and recovery planning and efforts.

You will know that you are functioning as a Recovery Guide when:

F.1. The primary vehicle for the delivery of most behavioral health interventions is the relationship between the practitioner and the person in recovery. The care provided must be grounded in an appreciation of the possibility of improvement in the person's condition, offering people hope and/or faith that recovery is "possible for me." Practitioners convey belief in the person even when he or she cannot believe in him or herself and serve as a gentle reminder of his or her potential. In this sense, staff envision a future for the person beyond the role of "mental patient" or "addict" based on the person's own desires and values and share this vision with the person through the communication of positive expectations and hope.

F.2. Providers assess where each person is in relation to the various stages of change (e.g., pre-contemplation, preparation, etc.) with respect to the various dimensions of his or her recovery. Interventions are appropriate to the stages of change relevant to each focus of treatment and rehabilitation (e.g., a person may be in an action phase related to his or her substance use disorder but be in pre-contemplation related to his or her psychiatric disorder).

F.3. Care is based on the assumption that as a person recovers from his or her condition, the addiction or psychiatric disorder then becomes less of a defining characteristic of self and more simply one part of a multidimensional sense of identity that also contains strengths, skills, and competencies. Services elicit, flesh out, and cultivate these positive elements at least as much as, if not more than, assessing and ameliorating difficulties. This process is driven by the person in recovery through inquiries about his or her hopes, dreams, talents, and skills, as well as perhaps the most important question of "How can I be of help?"

F.4. Interventions are aimed at assisting people in gaining autonomy, power, and connections with others. Practitioners regularly assess the services they are providing by asking themselves: "Does this person gain power, purpose (valued roles), competence (skills), and/or connections (to others) as a result of this interaction?" and, equally important: "Does this interaction interfere with the acquisition of power, purpose, competence, or connections to others?"

F.5. Opportunities and supports are provided for the person to enhance his or her own sense of personal and social agency. For example, practitioners understand that medication is only one tool in a person's "recovery tool box" and learn about alternative methods and self-management strategies in which people use their own experiences and

knowledge to apply wellness tools that work best for them. Sense of agency involves not only feeling effective and able to help oneself but also being able to positively impact the lives of others. Providers can achieve this by thoughtfully balancing when to do for someone, do with someone, or when to let someone do for him or herself. Knowing when to hold close and support and protect, when to encourage someone while offering support, when to let someone try alone and perhaps stumble, and when to encourage a person strongly to push themselves is an advanced, but essential, skill for practitioners to develop. While these are intuitive skills that all practitioners must struggle to refine over time, prior to taking action it is always beneficial for practitioners to ask the question: "Am I about to do for this person something she or he could manage to do more independently." Strong messages of low expectations and incapability are given, and reinforced, every time unnecessary action is undertaken for a person, instead of with them.

F.6. Individuals are allowed the right to make mistakes, and this is valued as an opportunity for them to learn. People in recovery report that they have found meaning in adverse events and failures and that these have subsequently helped them to advance in their recovery. In accordance with this, practitioners recognize that their role is not necessarily to help people avoid adversity or to protect them from failure. For example, the re-experiencing of symptoms can be viewed as a part of the recovery process and not necessarily a failure or setback. The "dignity of risk" ensues following a thoughtful and proactive planning process in which practitioners work collaboratively with individuals to develop relapse prevention plans, including advance directives which specify personal and treatment preferences in the event of future crises.

F.7. People are allowed to express their feelings, including anger and dissatisfaction, without having these reactions attributed to symptoms or relapse.

F.8. Care is not only attentive to cultural differences across race, ethnicity, and other distinctions of difference (e.g., sexual orientation), but incorporates this sensitivity at the level of the individual. Only an individual-level process can ensure that practitioners avoid stereotyping people based on broad or inaccurate generalizations (e.g., what all lesbians want or need), and enable them instead to tailor services to the specific needs, values, and preferences of each person, taking into account each individual's ethnic, racial, and cultural affiliations.

F.9. Rather than dwelling on the person's distant past or worrying about the person's long-term future, practitioners focus on preparing people for the next one or two steps of the recovery process by anticipating what lies immediately ahead, by focusing on the challenges of the present situation, and by identifying and helping the person avoid or move around potential obstacles in the road ahead. Although the practitioner deemphasizes the person's early personal history (because it may not be relevant) and long-term outcome (because it cannot be predicted), either of these perspectives may be invoked should they prove useful in the current situation. Especially as these issues pose barriers to recovery, practitioners utilize appropriate clinical skills within the context of a trusting relationship in order to enhance the person's capacity to overcome, compensate for, or bypass these barriers (see section #H below).

F.10. Interventions are oriented toward increasing the person's recovery capital as well as decreasing his or her distress and dysfunction (see Sections #C and #H). Grounded in a person's "life-context," interventions take into account each person's unique history, experiences, situations, developmental trajectory, and aspirations. In addition to culture, race, and ethnicity, this includes less visible but equally important influences on each person's development, including both the traditional concerns of behavioral health practitioners (e.g., family composition and background, history of substance use and relapse triggers) as well as less common factors such as personal interests, hobbies, and role models that help to define who each person is as an individual and as a member of his or her network.

F.11. Practitioners are willing to offer practical assistance in the community contexts in which their clients live, work, and play. In order to effectively address "individuals' basic human needs for decent housing, food, work, and 'connection' with the community," practitioners are willing to go where the action is, i.e., they get out of their offices and out into the community[28]. They are prepared to go out to meet people on their own turf and on their own terms, and to "offer assistance which they might consider immediately relevant to their lives"[29].

[28] Curtis, L.& Hodge, M. (1994). Old standards, new dilemmas: Ethics and boundaries in community support services. *Psychosocial Rehabilitation Journal, 18(2),* 13-33.

[29] Rosen, A. (1994). Case management: The cornerstone of comprehensive local mental health services. *Australian Hospital Association, Management Issues* Paper No. 4. April, 47-63.

F.12. Care is not only provided in the community but is also oriented toward increasing the quality of a person's involvement in community life. Thus, the focus of care is considered more important than locus of where it is provided. The focus of care includes the process of overcoming the social and personal consequences of living with psychiatric and/or substance use disorders. These include gaining an enhanced sense of identity and meaning and purpose in life and developing valued social roles and community connections despite a person's continued symptoms or disability. Supporting these goals requires that practitioners have an intimate knowledge of the communities in which their clients live, the community's available resources, and the people who are important to them, whether it is a friend, parent, employer, landlord, or grocer. Practitioners also are knowledgeable about informal support systems that are in communities such as support groups, singles clubs, and other special interest groups, and actively pursue learning more about other possibilities that exist to help people connect.

F.13. Efforts are made to identify sources of incongruence between the person and his or her environment and to increase person-environment fit. This is done both by helping the person assimilate into his or her environment (through symptom management, skill acquisition, etc.) and by helping the community to better accommodate people with disabilities (through education, stigma reduction, the creation of niches, etc.), with the common goal being to develop "multiple pathways" into and between members of communities.

F.14. In order to counteract the often hidden effects of stigma, practitioners explicitly draw upon their own personal experiences when considering the critical nature of various social roles in the lives of all individuals (e.g., being a parent, a worker, a friend, etc), continuing to view people in recovery squarely within the context of their daily lives (i.e., as opposed to within institutional settings).

F.15. Community-focused care supplements, and is not meant to be a substitute for, the practitioner's existing expertise and services. Rather than devaluing professional knowledge and experience, the "recovery guide" approach moves psychiatry much closer to other medical specialties in which it is the health care specialist's role to assess the person, diagnose his or her condition, educate the person about the costs and benefits of the most effective interventions available to treat his or her condition, and then provide the appropriate interventions. There is an expectation that practitioners engage in on-going professional education so that they are aware of, and can deliver, a wide range

of evidence-based and emerging practices. But no matter how expert or experienced the practitioner, it is then ideally left up to the person and his or her loved ones to make decisions about his or her own care.

F.16. Recovery is viewed as a fundamentally social process, involving supportive relationships with family, friends, peers, community members, and practitioners. Interventions serve to minimize the role that professionals play in people's lives over time and maximize the role of natural supports. While the provider-person relationship can be a powerful component of the healing and recovery process, individuals must also develop and mobilize their own natural support networks to promote sustained recovery and independent community life.

What you will hear from people in recovery when you are functioning as a recovery guide:

- *She believed in me, even when I didn't believe in myself. Hope was the biggest gift she could have given me… and it saved my life.*

- *When he asked me, "So how can I best be of help!" I thought, "Oh great, I've really got a green one. You are supposed to be the professional–you tell me!" But I get it now. I need to decide what I need to move ahead in my recovery. And I needed to know it was OK to ask people for that. That was the key.*

- *When she ever showed up on my doorstep with a bag of clothes so my baby could start kindergarten, I knew this one was different. I couldn't care about myself or my recovery until I knew my kids were OK. She didn't pity me, or look for a pat on the back. She just knew, this was what I needed and it made all the difference in my recovery.*

- *I was terrified of going back to that hospital. My case manager couldn't guarantee me that it wouldn't happen again. But we sat down together and did a plan for how to make things different if there ever was a "next time." Knowing my dog would get fed, making sure somebody talked to my landlord so I wouldn't get evicted, and being able to write down how the staff could help me if I lost control… All those things made the idea of going back less scary.*

G. Community Mapping and Development

Given its focus on life context, one tool required for effective recovery planning is adequate knowledge of the person's local community, including its opportunities, resources, and potential barriers. This knowledge is to be obtained and updated regularly at a community-wide level for the areas in which a program's service recipients live, but also is to be generated on an individual basis contingent on each person's interests, talents, and needs.

Historically falling under the purview of social work and rehabilitation staff, the function of identifying, cataloguing, and being familiar with community resources both within and beyond the formal behavioral health system can be carried out by staff from any discipline with adequate training and supervision. In most cases, however, this expertise will reside with local community-based providers rather than with inpatient or residential staff located at a distance from the person's community of origin. In such cases, close coordination between inpatient/residential and outpatient staff will be required to obtain and integrate this information into the individualized recovery plan. Regardless of how it is provided, a comprehensive understanding of the community resources and supports that are available to address the range of a person's needs as he or she identifies them is essential to the recovery planning process across the continuum of care.

Asset-based community development is one essential strategy for developing this comprehensive understanding of local resources and supports. Based on the pioneering work of Kretzmann and McKnight ("Building Communities from the Inside Out"), asset-based community development (ABCD) is a widely recognized capacity-focused approach to community development that can help open doors into communities for persons who have been labeled or otherwise marginalized, and through which people in recovery can build social capital and participate in community life as citizens rather than clients.

Through the cultivation of mutually beneficial relationships, ABCD has been shown to be an effective technology for capitalizing upon the internal capacities of low-income urban neighborhoods and rural communities, particularly as the depth and extent of associational life in these communities is often vastly underestimated[30]. Whereas community development has historically been deficit- or problem-based and fueled by "needs assessments" and "needs maps," ABCD operates on the premise that every person in a community has gifts, strengths, skills, and resources to be contributed to the community and that community life is shaped, driven, and

[30]Kretzmann, J.P. &, McKnight, J.L. (1993). Building Communities from the Inside Out. Chicago, IL. ACTA Publications.

sustained by the contributions of an involved and interdependent citizenry. Capacity, strength, and resources are also derived from community associations (religious, civic, recreational, political, social, etc.) and from community institutions (schools, police, libraries, parks, human services, etc.).

Asset-based community development is a fully participatory process that involves all persons in mapping the resources and capacities of a community's individuals, its informal associations, and its structured institutions, as a means of identifying existing, but untapped or overlooked, resources and other potentially hospitable places in which the contributions of people with disabilities will be welcomed and valued[31]. Information about individuals, community associations, and institutions is collected through the sharing of stories and in one-on-one interviews that foster the development of personal relationships.

The relationships, resource maps, and capacity inventories that result from this process serve to guide on-going community development and provide a means by which people can expand their existing social networks and involvement in community activities. Pride in past achievements is strengthened, new opportunities for creative endeavor are discovered, resiliency is experienced, and hope is sustained. It is important to note that the primary producers of outcomes in this process are not institutions but individuals strengthened by enhanced community relationships. ABCD ultimately helps people in recovery derive great benefit from access to a range of naturally occurring social, educational, vocational, spiritual, and civic activities involved in their return to valued roles in the life of their community.

You will know you are engaged in community mapping and development when:

G.1. People in recovery and other labeled and/or marginalized persons are viewed primarily as citizens and not as clients and are recognized for the gifts, strengths, skills, interests, and resources they have to contribute to community life.

G.2. Community leaders representing a range of community associations and institutions work together with people in recovery to carry out the process of community development.

[31] McKnight, J. (1992). Redefining community. *Journal of Social Policy, Fall/Winter,* 56-62.

G.3. People in recovery and other community members experience a renewed sense of empowerment and social connectedness through voluntary participation in civic, social, recreational, vocational, religious, and educational activities in the community. Therefore, opportunities for employment, education, recreation, social involvement, civic engagement, and religious participation are regularly identified and are compiled in asset maps, capacity inventories, and community resource guides. These informational resources are made available to individuals on their initial agency orientation and are updated over time as knowledge about the local community grows.

G.4. Asset maps and capacity inventories created collaboratively by actively involved community stakeholders reflect a wide range of *natural* gifts, strengths, skills, knowledge, values, interests, and resources available to a community through its individuals, associations, and institutions. In other words, they are not limited to social and human services or professional crisis or emergency services.

G.5. High value is placed on the less formal aspects of associational life that take place, for instance, in neighborhood gatherings, block watch meetings, coffee clatches, salons, barbershops, book groups, knitting and craft circles, restaurants, pubs, diners, etc.

G.6. Institutions do not duplicate services that are widely available in the community through individuals and associations.

G.7. Community development is driven by a creative, capacity-focused vision identified and shared by community stakeholders. It is neither deficit-oriented nor driven by needs assessments and needs maps.

G.8. The relational process of gathering information about community assets and capacities through personal interviews and sharing of stories is recognized as being as important as the information that is collected.

What you will hear from people in recovery when you are engaged in community mapping and development:

- *I just wanted to get back to my life: my friends, and my job, and my church activities. My recovery was important, but it didn't matter so long as I didn't have those things in my life to look forward to. It was those things that kept me going in my darkest days.*

- *Just having a place to hang out, where I blend in with the crowd… where no one knows me as a patient on the ACT team. That is when I am most peaceful.*

- *It wasn't enough for me to just get better. I appreciated everyone's help, but I felt like such a charity case all the time. What really made a difference was when my counselor helped me to get a volunteer position at the local nursing home. Sometimes I read to the folks, or we play cards. It may not be fancy, but it feels right to me. I don't just have to take help from everybody else, I have valuable things to give back in return.*

- *I knew all about the places where folks could go to get help if you had a problem with drugs or mental illness. What I had forgotten about was how to have FUN! My case manager gave me this terrific list of low-cost activities that happen right around the corner from my apartment, and I never even knew this stuff was right under my nose. It's opened up a whole new world for me. I made some great friends, and one of them is even looking for some part-time help in her art store--so I'm gonna get a job out of it too! Things happen in the strangest ways sometimes…*

- *My yoga class at the mental health center got cancelled, and instead, they gave us a coupon to try out some free lessons at the city Rec Department. At first I was so disappointed. But once I tried it out, I loved it. I now take pilates in addition to yoga and I also joined a hiking club. I feel healthier physically and mentally…*



H. Identifying and Addressing Barriers to Recovery

To this point, our guiding assumption has been that behavioral health disorders are illnesses like any others and that, with few exceptions, seeking and receiving care for these disorders should resemble care provided for other medical conditions. Although we have made a point of stressing the need for outreach and engagement to ensure access to care, we otherwise may have given the reader the impression that people with behavioral health disorders are educated consumers of health care and that they will naturally act on their own behalf in making appropriate choices in this and other domains.

Experienced providers will no doubt consider such a perspective simplistic and naïve, and will suggest that up to 80% of the work entailed in treating behavioral health disorders is devoted to helping people to arrive at such a position of being willing to receive care for their conditions. Once a person accepts that he or she has a behavioral health disorder and agrees to participate in treatment and/or rehabilitation, the bulk of the more difficult work may appear to be done. We appreciate this sentiment, and agree that it may take a generation or more before many more people experiencing these conditions will be able to access and benefit from care in such a straightforward and uncomplicated manner.

For the foreseeable future, there will continue to be two major sources of complications—and of considerable suffering—that make accessing and benefiting from care a labor intensive and difficult process. These two types of barriers to recovery reside both external to the person, in societal stigma and discrimination and in the ways in which care has historically been structured and provided, and internal to the person, intrinsic to the nature of the illnesses themselves. In order to promote recovery, providers must be able to identify and address the variety of barriers encountered in each of these domains.

In terms of external barriers, there currently are elements and characteristics of the service delivery system and the broader community that unwittingly contribute to the exacerbation of symptoms and the creation and perpetuation of chronicity and dependency in individuals with behavioral health disorders. Foremost among these is the discrimination that continues to affect people with mental illnesses and/or addictions in society at large and, even more importantly, within the behavioral health system itself.

This discrimination results in people with behavioral health disorders being viewed and treated as second-class citizens in a variety of life domains. One byproduct of repeated discrimination is that people come to view and treat themselves as second-class citizens as well. What advocates within the mental health community have come to call “internalized stigma” presents a significant obstacle to

recovery, undermining the self-confidence and self-esteem required for the person to take steps toward improving his or her life. The demoralization and despair that are associated with internalized stigma and feelings of inferiority also tap the person's sense of hope and initiative, adding further weight to the illness and its effects.

Beyond the impact of stigma and discrimination, there are a variety of ways in which the health care system and the broader community make recovery more difficult. These range from the lack of affordable housing and accessible, high quality medical care to the employment disincentives built in to entitlement programs, to the punitive aspects of some care settings and programs (e.g., in which people are discharged for manifesting the symptoms of their illness). Identifying and assisting the person to overcome these barriers to the degree that is possible is an important component of the work of the recovery-oriented behavioral health care practitioner.

In terms of internal barriers, there are several aspects of behavioral health disorders and their place within contemporary society that complicate and undermine the person's efforts. For example, while trauma may not be intrinsic to behavioral health per se, there is considerable evidence that suggests that people experiencing behavioral health disorders at the present time have a greatly increased chance of having experienced a history of trauma earlier in their lives, as well as being at increased risk for exposure to trauma and victimization currently.

Perhaps more directly as a consequence of the illness itself, there also are symptoms of behavioral health disorders that pose their own barriers. The hallucinations and delusions often found in psychotic illnesses, for example, may compete as a source of information with that being offered to the person by health care practitioners, thereby discouraging the person from taking prescribed medications or otherwise participating in treatment or rehabilitation. The heightened sense of creativity and self-importance that often accompanies episodes of mania similarly may lead a person down a path that diverges from the one preferred by his or her loved ones and care providers. As destructive as they may appear to the person's loved ones or care providers, giving up delusions or mania often comes with its own costs. As a young man with a psychotic disorder once poignantly asked: "If you had the choice between being a CIA operative or a mental patient, which would you choose?"

Accepting that these and other elements associated with the disorders themselves undermine a person's efforts to cope with his or her illness, recovery-oriented practitioners become familiar with these issues and adept in working proactively with the person to overcome or bypass their destructive impact. Many of the skills and techniques traditionally utilized by clinicians within the context of office-based practice find their greatest utility and effectiveness in this domain, whether offered inside, or outside, of the office.

You will know you are addressing external and internal barriers to recovery when:

H.1. **There is a commitment at the local level to embrace the values and principles of recovery-oriented care and to move away from the dominant illness-based paradigm. The practices identified throughout this document can only grow in a culture that fully embraces recovery principles and values. Systemic changes that reflect this paradigm shift include the following:**

H.1.1. Stakeholders understand the need for recovery-oriented system change as a civil rights issue which aims to restore certain elementary freedoms (e.g., self-determination, community inclusion, etc.) to American citizens with psychiatric diagnoses and/or addictions.

H.1.2. Stakeholders work together to move away from the criteria of "medical necessity" toward "human need,"[35] from managing illness to promoting recovery, from deficit-oriented to strengths-based, and from symptom relief to personally-defined quality of life. Perhaps most critical is the fundamental shift in power involved in realigning systems to promote recovery-oriented care—the shift away from prioritizing expert knowledge over respect for personal autonomy and self-determination[32].

H.1.3. The possibility of recovery, and the responsibility to deliver recovery-oriented care, must be embraced by all stakeholders at all levels of the system. While many exciting things are occurring in agencies across the country, recovery-oriented change tends to occur in a fairly fragmented manner with a relatively small number of progressive practitioners or advocates taking on a large amount of responsibility for carrying out the recovery mission. For example, certain programs and staff in behavioral health systems (e.g., peer staff, rehabilitation providers, community-based case managers, etc.) are uniquely positioned to be leaders in the mission to provide recovery-oriented care, and the contributions of these programs should be respected and capitalized upon. Taking a lead in the recovery mission is a natural fit for such programs for a variety of reasons including their structure as private-

[35] Tondora, J., Pocklington, S., Gorges, A., Osher, D. & Davidson, L. (2005). *Implementation of person-centered care and planning: From policy to practice to evaluation.* Washington D.C.: Substance Abuse and Mental Health Services Administration.
[36] Osher, T. & Osher, D. (2001). The paradigm shift to true collaboration with families. *The Journal of Child and Family Studies, 10*(3), 47-60; WNYCCP. (2005). *Foundations of person-centeredness. Training curriculum*, Western New York Care Coordination Program. Rochester, NY: Coordinated Care Services.

non profit entities, their rehabilitation expertise, lower pressure and demands to deliver only medically necessary care, and their direct affiliations with the state or national consumer/recovery movement. However, agencies and systems must guard against the complacency which results when recovery is seen as being a "nice add-on," but "not part of my job" or as being manifest only in "special" (sometimes "token") programs that are split off from the functioning of the agency as a whole. Recovery-oriented system change will only take hold and thrive if it is understood that it is the shared mission of all stakeholders and that the task of promoting recovery—as the overarching aim of all behavioral health services—is a part of everyone's job. Resources and guidelines are emerging which define exactly what that job is depending on what one's role is as a practitioner (e.g., primary clinician, peer specialist, supported employment specialist) within the system.

H.2. **Systemic structures and practices which inhibit the adoption of recovery-oriented practices are identified and addressed. Representative change strategies in this area include the following:**

H.2.1. Well intentioned efforts to provide a full "continuum" of care have led to a system in which people are sometimes expected to enter in, and progress through, a range of services in a sequential fashion as they "stabilize" and move toward enhanced functioning and greater independence. The misapplication of this model has led to systems of care in which individuals are then expected to jump through hoops in order to earn their way into less restrictive settings (e.g., an expectation that they prove they can prepare three meals a day or keep their living space clean before they can move out of a group home) or to earn the right to participate in preferred services (e.g., an expectation that they comply with medication or outpatient psychotherapy groups before they will be referred to a supported employment program).

In addition to there being an accumulating body of evidence which demonstrates the failure of such a continuum approach, this sequential movement through a pre-existing continuum of supports is inconsistent with the civil rights perspective noted above and it contradicts current knowledge suggesting that recovery is neither a linear process or a static end product or result. Rather, it is for many a life-long experience that involves an indefinite number of incremental steps in various life domains, with people moving fluidly between the various domains over time (as opposed to moving through these dimensions in a systematic, linear process). Rather than a pre-established continuum of services,

what is necessary is a flexible array of supports that each person can choose from at different points in time depending upon his or her phase of recovery and unique needs and preferences. This array should be constantly evolving based on the input of persons in recovery, the experience of practitioners, and the research literature.

H.2.2. There is often a lack of clarity regarding system priorities when agencies attempt to implement numerous initiatives simultaneously, e.g., evidence-based practice versus recovery-oriented programming. While such initiatives may not be incompatible, competing demands–even complementary ones–can diffuse the effort and resources of the agency and inhibit the adoption of any new practices. It is critical that there are coordinating structures to attend to both the prioritization and integration of new initiatives, policies, and procedures.

H.2.3. The structure of certain outcome indicators places significant pressures on agency staff to operate in a manner that they see as inconsistent with recovery-oriented care. For example, staff might like to support persons in making choices regarding their housing preferences, such as moving to a less intensive level of supported housing. They may legitimately be concerned; however, that they will be held accountable should the result of such an individual's choice ultimately be a negative one. This accountability is not limited to the potential adverse events themselves, but is further accentuated through the agency's collection of mandatory performance data, such as statistics regarding the number of individuals who move from "housed" to "homeless." The resulting need to portray the agency's performance on such indicators as positive creates a strong incentive for the maintenance of stability as a desired outcome in and of itself. In contrast, a desired goal of recovery-oriented care is to promote growth, independence, and wellness; goals which sometimes involve the taking of reasonable risks that may result in interim set-backs. At both the agency and system level, quality management tools and outcome indicators should be examined and mechanisms should be built in to track the trade-off which sometimes exists as we support individuals in taking risks to grow and advance in their recovery.

H.2.4. Processes for continual quality assurance and independent audits by people in recovery and families trained in recovery-oriented care need to be funded and coordinated. Outcomes and assessment of quality should not focus solely on the rating of services/supports, but on whether the choices people make are personally meaningful and whether recovery-oriented care leads to a valued community life.

H.2.5. Initial placement and service design currently is driven by practitioners' assessments of what the individual seeking services needs. While this assessment should remain a critical element of the referral process, it should be coupled with questions, directed to the person and answered in his or her own words, which solicit the individual's perception of what services and supports would be most helpful. Individuals must be engaged as active partners in their care from the outset of treatment. This can only be achieved with greater transparency in the system of care as a whole and with greater involvement of the person and family in all important, decision-making processes, including the decision of initial level of care and team/program assignment.

H.2.6. Recovery plans respect the fact that services and practitioners should not remain central to a person's life over time. Currently, many behavioral health systems lack clearly defined exit criteria and it is not uncommon for individuals to feel as if they will be attached to the formal system for life following their entry into care. This perpetuates a sense of chronicity through which individuals lose hope that they will be able to resume a meaningful and productive daily life beyond treatment. In contrast, exit criteria should be established and used to engage people in a collaborative decision-making process regarding the potential advantages and risks of moving to a lower level of care, with effort being made to respect the individual's desire to "graduate" whenever possible. When an individual is strongly advised by the recovery team against "graduation," there should be evidence in the recovery plan of concrete steps being taken by the individual and the team to reach this ultimate goal. In establishing exit criteria, agencies must take caution to avoid punitive measures by which individuals are discharged from services for displaying symptoms of their illness or addition.

H.2.7. Despite legislative advances in the past decade, the structure of federal and state disability, benefits, and vocational programs continue to impede the wish of many individuals of entering, or reentering, the workforce, thereby excluding them from an activity which many have described as a cornerstone of recovery. Rigid definitions of disability, earnings limits which perpetuate poverty, a lack of supported employment programs, and complex referral procedures drastically reduce the likelihood that individuals will access necessary services and return to meaningful employment. To integrate employment within the larger system of care, the task of assisting people in entering employment and education must be inherent in the responsibilities of the entire practitioner network, including those not specifically charged with work service or supported education activities.

H.3. **The implementation of recovery-oriented care is facilitated, rather than impeded, by funding, reimbursement, and accreditation structures. Intrinsic to any dialogue regarding systemic barriers to recovery-oriented care is the need to address funding structures that recognize a limited range of clinical interactions as reimbursable services, and documentation requirements that hinder creative formulation of recovery-oriented goals and objectives. Necessary change strategies to address these barriers include the following:**

H.3.1. Rules and regulations dictating eligibility and reimbursement for Medicaid and other public supports must be adapted at the federal and state level over time for greater relevance to innovative, recovery-oriented approaches. Even though Medicaid is funded by federal dollars, it remains primarily a state-administered program, and considerable flexibility exists already in using these dollars to support innovative, community-based, recovery-oriented services and supports.

H.3.2. Within existing funding structures, training and technical assistance can be provided to practitioners attempting to implement recovery-oriented practices to assist them in learning how to translate the wishes of people in recovery into reimbursable service goals and to describe their interventions in a manner that will generate payment.

H.3.3. Operating in this manner is consistent with the growing understanding that recovery-oriented practices cannot be an add-on to existing care for which additional funding must always be secured. Rather, recovery-oriented care begins with discovering ways to be creative and flexible within the constraints of existing resources. In some cases, for example, braiding funds may enable collaborations to move beyond funding silos to provide people with flexible, highly individualized services[33]. Programs that successfully utilize such alternatives must be explored for expansion[34].

H.3.4. Self-directed funding opportunities should be considered both on a collective basis and through individualized budget programs. The Florida "Self-Directed Care" initiative is an example of such a program

[33]Osher, D., Dwyer, K. & Jackson, S. (2004). *Safe, supportive, and successful schools step by step*. Longmont, CO: Sopris West; Poirier, J., Osher, D. & Tierney, M. (in press). Understanding the new environment of public school funding: How pupil services are funded. In C. Franklin, M.B. Harris & C. Allen- Meares (Eds.) *School social work and mental health workers training and resource manual*. New York: Oxford University Press.

[34]Blessing, Tierney, Osher, Allegretti-Freeman, & Abrey. (2005). *Person-centered planning: Learning from other communities,* Washington D.C.: Substance Abuse and Mental Health Services Administration. .

which shifts fiscal control from the hands of service providers to the hands of service users. Within this program, participants are given control of their service dollars and then are free to shop around to weave together the type and frequencies of services that may best respond to their individual interests and preferences. While this approach has proponents, there is also an inherent tension and uncertainty about whether there is any guarantee that high quality services will be available to purchase if there are no consistent funding underpinnings. A robust practitioner network is needed and it must be easily accessible[35].

H.4. **Training and staff development is prioritized as an essential function to increase individual practitioners' competency in providing recovery-oriented care. Necessary change strategies to address this issue include the following:**

H.4.1. As consensus emerges regarding the knowledge and skills needed to implement recovery-oriented care, this information must lead to the development of competency models, and these models must be disseminated broadly as guidance for training programs and licensing bodies which prepare and accredit future and current providers of mental health care. For example, competency models regarding the delivery of recovery-oriented care should be used to address training gaps in pre-certification curriculum as well as ongoing professional development activities.

H.4.2. Once established, competency models—which are largely under-utilized in general in behavioral health—should be incorporated in all human resource activities (e.g., hiring, routine performance evaluation, promotion decisions, staff development targets, etc.) as a means of promoting accountability and quality improvement.

H.4.3. An analysis of staff's current competencies and self-perceived training needs should guide the development of on-going skill-building activities at the agency level. For example, practitioners are frustrated by the fact that they are overwhelmed by a constant stream of change mandates for which they receive little or no training or support. There

[35]Jonikas, J., Cook, J., Fudge, C., Hiebechuk, F. & Fricks, L. (2005). *Charting a meaningful life: Planning ownership in person/family-centered planning.* Washington D.C.: Substance Abuse and Mental Health Services Administration.

are beneficial, self-reflective tools (e.g., the CAI, RSA, RKI, etc.[36]) that can be used to conduct a training needs analysis which identifies both strengths and areas in need of improvement as it relates to the provision of recovery-oriented care. Gaps in skill sets can be identified and prioritized for development by training administrators.

H.4.4. Training in and of itself will not allow providers to develop the enhanced skill set and the increased sense of efficacy that will allow them to carry out the complex responsibilities and roles of the recovery-oriented practitioner. Competency-based training must be coupled with on-going mentor support, enhanced supervision, recovery-oriented case conferences, and opportunities for peer consultation.

H.4.5. Directors of clinical services and agency leaders should be involved in ongoing training initiatives so that there is consistency in proposed recovery-oriented practices and the system's administrative structures. This allows direct care staff to feel supported and respected and it allows agency leadership the opportunity to proactively identify, and address, any systemic barriers that prohibit the adoption of recovery-oriented practices.

H.4.6. Training and staff development activities must be sensitive to the role confusion which can result with the adoption of recovery-oriented practice. Recovery-oriented care does ***not*** imply that there is no longer any role for the practitioner to play in the treatment and recovery process. Rather, the provider's role has changed from that of all-knowing, all-doing caretaker to that of coach, architect, cheerleader, facilitator, mentor, or shepherd[37]–roles that are not always consistent with one's clinical training or experiences. One effective educational strategy may be using a combination of literature, outcomes/efficacy data, and personal accounts such as recovery dialogues to help practitioners learn the new roles of advisor, mentor, or supports broker[38].

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[36]Campbell-Orde, T., Chamberlin, J., Carpenter, S. & Leff, S. (2005). *Measuring the promise: A compendium of recovery measures, Volume II.* Boston: Human Services Research Institute.

[37]Adams, N. & Grieder, D. (2005). *Treatment planning for person-centered care: The road to mental health and addiction recovery*. San Diego, CA, US: Elsevier Academic Press; Davidson, L., Tondora, J., Staeheli, M., O'Connell, M.J., Frey, J. & Chinman, M.J. (2006). Recovery guides: An emerging model of community-based care for adults with psychiatric disabilities. In A. Lightburn & P. Sessions (Eds.), *Community-based clinical practice*. Oxford University Press, New York.

[38]Jonikas, Cook, Fudge, Hiebechuk & Fricks. (2005). *op cit.*

Further, those involved in educating providers about self-determination and recovery-oriented care have found that acknowledging staff's fears and doubts, rather than dismissing or shaming them, is more likely to lead them to accept a new role in their clients' lives[39]. The application of sophisticated and effective clinical practices in the larger context of collaborative partnerships and self-determination is a training area that requires ongoing attention.

H.4.7. No matter how competent the workforce, no matter how ripe the culture, and no matter how compatible the funding mechanisms, recovery-oriented care will not become a reality unless people in recovery and their families understand it, are supported in using it, and come to demand it as a basic expectation of quality care. It is imperative that training initiatives regarding recovery-oriented care not neglect the needs of people in recovery and families to develop their own capacity to self-direct their treatment and life decisions. Some may already do this with great skill and acumen. Others may be reluctant to assume the seat of power, having been socialized by their culture[40] or taught by professionals and agencies that their preferred role is one of deferential compliance[41]. Ideally, training initiatives put all stakeholders, including people in recovery, families, and practitioners, at the same table.

H.5. **Forces at the societal level (e.g., stigma, discrimination, lack of basic resources, etc.) which undermine recovery and community inclusion are identified and addressed. Necessary change strategies to address this issue include the following:**

H.5.1. A lack of basic resources and opportunities (e.g., jobs, affordable housing, primary medical care, educational activities) in the broader community significantly complicates the task of recovery for persons with behavioral health disorders. This lack of resources and opportunities often stems from inadequate knowledge and skills on the part of community organizations regarding how to create welcoming and accessible environments for all people. Behavioral health practitioners have significant expertise to address this skill and knowledge gap, and should be prepared to offer supportive guidance and feedback at both

[39]Holburn, S. & Vietze, P. (2002). *Person-centered planning: Research, practice, and future directions.* Baltimore: Paul Brookes Publishing.
[40]Harry, B., Kalyanpur, M. & Day, M. (1999). *Building cultural reciprocity with families.* Baltimore, MD: Paul Brooks.
[41]Katz, E. & Danet, B. (1973). *Bureaucracy and the public*. New York: Basic Books.

the individual and community level. For example, consultation with a community employer regarding the impact of a certain medication on an individual's stamina can lead to a reasonable accommodation in the work place which allows greater productivity and success on the job– an outcome which is ultimately beneficial to both the individual and the employer. Provided appropriate support and consultation, many community members are excellent collaborators and can become facilitators of the recovery and community inclusion process.

H.5.2. Despite the promise of such collaborations, discrimination against people with behavioral health disorders will most likely continue for the foreseeable future. Community collaborations and education must therefore be coupled with efforts on the part of behavioral health practitioners to recognize instances of discrimination, to understand relevant disability legislation (e.g., the Americans with Disabilities Act), and to effectively utilize state and local resources (e.g., the Connecticut Legal Rights Project, the Office of Protection and Advocacy, the Equal Opportunity Employment Commission, advocacy organizations, etc.). This type of knowledge also must be built within the consumer community so that people in recovery can protect themselves by recognizing and rectifying experiences of discrimination.

H.5.3. Agencies are cautioned to avoid the establishment of 'one stop shopping' service programs. In an effort to respond simultaneously to individuals' multi-dimensional needs while also protecting them from the experience of stigma and discrimination, there is a tendency for agencies to develop "in-house" alternatives to community activities based on concern that the community will never accept or welcome individuals with behavioral health disorders. As a result, agencies often create in artificial settings, activities that already exist in the natural community. For example, developing in house medical clinics, movie nights, GED classes, social events, etc. Agencies which fall into this trap of providing a one stop shop for the needs of people with mental illness or addiction inadvertently contribute to the development of chronic "patient hood" as well as the perpetuation of discriminatory and unethical practices on the part of community members. We must continue to work with community partners to uphold their obligation to respect people with behavioral health disorders as citizens who have the right to be treated according to the principles of law that apply to all other individuals[42].

[42]National Council on Disability. (2000). *From privileges to rights: People labeled with psychiatric disabilities speak for themselves*. Downloaded from http://www.ncd.gov/newsroom/publications/privileges.html

H.5.4. A focus on promoting access to community opportunities is consistent not only with recovery-oriented principles but with the need for fiscal efficiency. Professionals and service recipients should be mindful of the limited resources available for specialized services and should focus on community solutions and resources first by asking "Am I about to recommend or replicate a service or support that is already available in the broader community?"At times this has direct implications for the development of service interventions within recovery plans, e.g., creating on-site health and fitness opportunities such as exercise classes without first exploring to what extent that same opportunity might be available in the broader community through public recreational departments, YMCAs, etc. If natural alternatives are available in the community, the individual should be informed of these opportunities and then supported in accessing them based on his or her preferences.

H.6. **Certain internal barriers unique to behavioral health disorders are identified and addressed. Necessary change strategies to address these barriers include the following:**

H.6.1. It is important to acknowledge that people with behavioral health disorders may be reluctant to assume some of the rights and responsibilities promoted in recovery-oriented systems. They may initially express reluctance, fears, mistrust, and even disinterest when afforded the right to take control of their treatment and life decisions. It is critical to explore and address the multiple factors influencing such responses, as they often result from a complex interaction of the person's conditions and his or her past experiences in the behavioral health care system. As suggested by Jonikas and colleagues[43], there are many factors involved when people in recovery "resist" recovery-oriented system change, including a lack of trust that human service systems or various care providers will cede control, service eligibility criteria that require an emphasis on illness and crisis in order to receive assistance; learned helplessness consequent from years of dependency (especially for those in institutional settings); an inability to, or discomfort with, articulating personal preferences and ideas; and feelings of pressure that they must "get it right the first time" or else be blamed for their failures when assuming greater control in the recovery process. Significant training and skill building within the recovery community is necessary to

[43] Jonikas, Cook, Fudge, Hiebechuk & Fricks. (2005). *op cit.*

address this internal barrier and to support people in embracing expanded roles and responsibilities. Education and ongoing support and mentoring is perhaps best offered through mental health advocacy organizations and peer-run programs.

H.6.2. Individuals with serious behavioral health disorders often have histories of trauma which impact on treatment and recovery. For example, while trauma may not be intrinsic to behavioral health per se, there is considerable evidence that suggests that people living with behavioral health disorders at the present time have a greatly increased chance of having experienced a history of trauma earlier in their lives as well as being at increased risk for future victimization[44]. Evidence also suggests that the failure to attend to a person's history of sexual and/or physical abuse will seriously undermine the treatment and rehabilitation enterprise, leading to a poor prognosis, while approaches that are responsive to trauma significantly improve treatment effectiveness and outcomes. Similar processes resulting from patterns of relating in a person's family context or immediate social environment may pose additional barriers to the person's recovery. Within the context of urban poverty and violence, e.g., the only incentive offered by abstinence may be a decreased immunity to the horrors that a person faces on a daily basis.

H.6.3. The above barriers represent more of an interaction between a person's condition and his or her experiences in the behavioral health system and the community at large. In addition, the symptoms of certain illnesses themselves may also pose direct impediments to the recovery process. As we described above, for example, hallucinations and delusions may compete with the information a person is receiving from health care professionals, thereby discouraging the person from taking prescribed medications or participating in other treatment or rehabilitation. Similarly, impairments in such areas as working memory, executive processes, language, attention and concentration, and problem solving[45] can undermine a person's abilities to articulate and assert his

[44]Sells, D., Rowe, M., Fisk, D. & Davidson, L. (2003). Violent victimization of persons with co-occurring psychiatric and substance use disorders. *Psychiatric Services, 54*(9), 1253-1257.

[45]Saykin, A., Gur, R.C., Gur, R.E., Mozley, D., Mozley, R.H., Resnick, S., Kester, B. & Stafinick, P. (1991). Neuropsychological function in schizophrenia: Selective impairment in memory and learning. *Archives of General Psychiatry, 48,* 618-624.; Bell, M. & Lysaker, P. (1995). Psychiatric symptoms and work performance among people with severe mental illness, *Psychiatric Services*, 46(5), 508-510; Westermeyer, J. & Harrow, M. (1987). Factors associated with work impairments in schizophrenic and nonschizophrenic patients. In R. Grinker & M. Harrow (Eds.), *Clinical research in schizophrenia: A multidimensional approach.* p. 280-299. Springfield: Charles Thomas Books; Cornblatt, B. & Erlenmeyer-Kimling, L. (1984). Early attentional predictors of adolescent behavioral disturbances in children at risk for schizophrenia. In Watt, N.F., James, A.E. (eds.). (1984). *Children at risk for schizophrenia: A longitudinal perspective.* (pp. 198-211). New York,

or her personal wants, needs, and preferences in the context of a relationship with a clinical practitioner. Such cognitive impairments may be further aggravated by negative symptoms that are currently considered to be among the most unremitting and malignant of the impairments associated with psychosis[46]. These include a lack of goal-directed activity, withdrawal, apathy, and affective flattening, all of which can create the impression that individuals are not interested in taking an active role in their care, thereby placing them at increased risk of being underestimated and undervalued as partners in the recovery planning process. In certain conditions, the elimination or reduction of symptoms may also come with great ambivalence, e.g., while episodes of mania can be destructive, they may include a heightened sense of creativity, self importance, and productivity that are difficult to give up. Being able to identify and address these and other sequelae requires knowledge and skill on the part of the clinical practitioner. There must be a commitment to ongoing professional development regarding emerging evidence-based and recovery-oriented practices which allow people to manage, or bypass, their symptoms to build a personally gratifying life in the community.

What you will hear from people when you are addressing external and internal barriers to recovery:

- *My mental illness was the least of my worries when it came to getting back to work after I got discharged from the hospital. I was terrified about losing my benefits and my employer gave me a really hard time when I asked if I could come in a half hour late one morning in order to see my doctor. My therapist and I sat down and he helped me sort out what would happen to my benefits and gave me some great information about how I could talk to my boss and request some accommodations that would help me be successful on the job. I have been back now for almost a year, and I just got the Employee of the Month Award.*

- *I used to get so pissed when I got asked to sign off on the treatment plans my doctor had to send to the insurance company. Half the time, I could barely tell that it was MY plan. It didn't reflect any of the things I had said were*

NY, US: Cambridge University Press; Seltzer, J., Cassens, G., Ciocca, C. & O'Sullivan, L. (1997). Neuro-psychological rehabilitation in the treatment of schizophrenia. *Connecticut Medicine, 61*(9), 597-608.

[46]Torrey, E.F. (1988). *Surviving schizophrenia: A family manual (Rev. ed.).* New York: Harper & Row.

important. My new doctor explained to me how the insurance and billing things work. And then we worked on the plan together. It still wasn't perfect, but at least I kind of knew where he was coming from and that he really HAD heard what I was trying to say.

- *All those years I spent in Social Skills groups, I met the same 20 people I knew from Clozaril Clinic and the Clubhouse. It didn't exactly expand my social horizons! Now I am playing basketball in one of the city leagues and there is this girl I've got my eye on who comes to the games. My therapist and I have been talking a lot about how I could strike up a conversation with her.*

- *The thought of getting discharged was so terrifying to me I almost didn't want to get well. But my case manager and I made sure that I had people and places I could go to for support when I needed it–and these folks had been involved in our work all along. It made a huge difference in my feeling good about taking the next step.*

- *I just didn't buy it when my clinician started talking to me about this thing called "consumer-driven care"… But she proved to me that she was for real in terms of making some changes in how we worked together— even referred me to a local self-advocacy center. I had been sitting back letting other folks call the shots, and then complaining when things got messed up. A Peer Specialist at the advocacy center called me out on it. I realized that I had gotten real comfortable letting other folks make decisions for me, and I know now that I gotta take charge of my own recovery and the Peers at the Center are helping me to do that…*



Recommended Resources for Further Reading



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APPENDIX

Glossary of Recovery-Oriented Language

Examples of Strength-Based Conceptualizations

Glossary of Recovery-Oriented Language

Creation of a recovery-oriented system of care requires behavioral health care practitioners to alter the way they look at mental illness and addiction, their own roles in facilitating recovery from these conditions, and the language they use in referring to the people they serve. The following glossary and associated tables are intended as tools for providers to use as they go about making these changes in practice.[47] Not meant to be exhaustive, this material will be further enhanced in the process of implementing recovery-oriented practices across the state.

Given its central role in the remaining definitions, we will start with the term "recovery" itself, followed by a list, in alphabetical order, of other key terms.

Recovery: there are several different definitions and uses of this term in behavioral health. In the addiction recovery community, for example, this term refers to the achievement and maintenance of abstinence from alcohol, illicit drugs, and other substances (e.g., tobacco) or activities (e.g., gambling) to which the person has become addicted, vigilance and resolve in the face of an ongoing vulnerability to relapse, and pursuit of a clean and sober lifestyle.

In mental health there are several other forms of recovery. For those fortunate people, for example, who have only one episode of mental illness and then return to their previous functioning with little, if any, residual impairment, the usual sense of recovery used in primary care is probably the most relevant. That is, such people recover from an episode of psychosis or depression in ways that are more similar to, rather than different from, recovery from other acute conditions.

Persons who recover from an episode of major affective disorder or psychosis, but who continue to view themselves as vulnerable to future episodes, may instead consider themselves to be "in recovery" in ways that are more similar to, than different from, being in recovery from a heart attack or chronic medical condition. Many others will recover from serious mental illness over a longer period of time, after perhaps 15 or more years of disability, constituting an additional sense of recovery found in some other medical conditions such as asthma. More extended periods of disability are often associated with concerns about the effects and side effects of having been labeled with a mental illness as well as with the illness itself, leading some people to consider themselves to be in recovery also from the trauma of having been treated as mental patients.

[47] Credit for many of the addiction entries goes to William White, with text appreciatively borrowed and adapted from his unpublished manuscript *The Language of Addiction Recovery: An Annotated Glossary.*

Finally, those people who view taking control of their illness and minimizing its disruptive impact on their lives as the major focus of their efforts might find the sense of recovery used in the addiction self-help community to be most compatible with their own experiences. Such a sense of recovery has been embraced, for instance, among some people who suffer from co-occurring psychiatric and addictive disorders who consider themselves to be in "dual recovery."

For purposes of simplicity and clarity, the Connecticut Department of Mental Health and Addiction Services has adopted the following single definition to capture the common elements of these various forms of recovery:

"Recovery involves a process of restoring or developing a meaningful sense of belonging and positive sense of identity apart from one's condition while rebuilding a life despite or within the limitations imposed by that condition."

Other Key Terms

Abstinence-Based Recovery: is the resolution of alcohol- and other drug-related problems through the strategy of complete and enduring cessation of the non-medical use of alcohol and other drugs. The achievement of this strategy remains the most common definition of recovery in addiction, but the necessity to include it in this glossary signals new conceptualizations of recovery that are pushing the boundaries of this definition (see partial recovery, moderated recovery, and serial recovery).

Affirmative Business: see Social Cooperative/Entrepreneurialism

Asset-Based Community Development: a technology for identifying and charting the pathways and destinations in the local community most likely to be welcoming and supportive of the person's efforts at community inclusion. A first step is the development of local resource maps (see below). A strategy of community preparation is then used to address gaps identified in the resource maps through educational and other community building activities aimed at decreasing stigma and creating a more welcoming environment in partnership with local communities.

Asset Mapping: part of asset-based community development (above) referring to the process of identifying opportunities in local communities for people in recovery to take up and occupy valued social roles in educational, vocational, social, recreational, and affiliational (e.g., civic, spiritual) life. Although not a literal "map" (i.e., as in contained on a piece of paper), asset mapping involves developing and utilizing virtual or mental landscapes of community life that highlight resources, assets, and opportunities that already exist in the person's local community.

Choice: a key concept in recovery-oriented care, choice refers to the central role people with psychiatric disabilities and/or addictions play in their own treatment, rehabilitation, recovery, and life. Within the behavioral health system, people in recovery need to be able to select services and supports from among an array of meaningful options (see menu below) based on what they will find most responsive to their condition and effective in promoting their recovery. Both inside and outside of the behavioral health system, people in recovery have the right and responsibility for self-determination and making their own decisions, except for those rare circumstances in which the impact of the illness or addition contributes to their posing imminent risks to others or to themselves.

Citizenship: a strong connection to the rights, resources, roles, and responsibilities that society offers people through public institutions and associational life.

Community Supports: material and instrumental resources (including other people), and various forms of prostheses that enable people to compensate for enduring disabilities in the process of pursuing and being actively involved in naturally-occurring community activities of their choice.

Consumer: literally means someone who purchases services or goods from others. Historically has been used in mental health advocacy to offer a more active and empowered status to people who otherwise were being described as "clients" or "mental patients." Given the fact that people in recovery have not really viewed themselves as consumers in the traditional sense (ala Ralph Nader), this term has never really generated or been met with wide-spread use.

Continuity of Care/Contact: is a phrase used to underscore the importance of sustained, consistent support over the course of recovery. Such support can come from living within a community of shared experience and hope, but also can refer to the reliable and enduring relationship between the individual in recovery and his or her recovery coach. Such sustained continuity is in marked contrast to the transience of relationships experienced by those who have moved through multiple levels of care or undergone multiple treatment relationships.

Disparities in Healthcare: differences in access, quality, and/or outcomes of health care based on such issues as race, ethnicity, culture, gender, sexual or religious orientation, social class, or geographic region.

Empowerment: is the experience of acquiring power and control over one's own life decisions and destiny. Within the addiction recovery context, there are two different relationships to power. Among the culturally empowered (those to whom value is ascribed as a birthright), addiction-related erosion of competence is often countered by a preoccupation with power and control. It is not surprising then that

the transformative breakthrough of recovery is marked by a deep experience of surrender and an acceptance of powerlessness. In contrast, the culturally disempowered (those from whom value has been systematically withheld) are often attracted to psychoactive drugs in their desire for power, only to discover over time that their power has been further diminished. Under these conditions, the initiation of recovery is often marked by the assumption of power and control rather than an abdication or surrender of power.

Within the mental health context, empowerment typically refers to a person first taking back control of his or her own health care decisions prior to regaining control of his or her major life decisions and destiny. As such, "empowerment" has been used most by advocacy groups in their lobbying efforts to make mental healthcare more responsive and person-centered. In either community, empowerment is meant to be inspiring, horizon-raising, energizing, and galvanizing. The concept of empowerment applies to communities as well as individuals. It posits that the only solution to the problems of addiction and/or mental health in disempowered communities lies within those very communities. It is important to note that, by definition, one person cannot "empower" another, as to do so undermines the very premise of the term, which attributes power over the person's decisions, recovery journey, and life to the person him or herself.

Evidence-Based Practices: are clinical, rehabilitative, and supportive practices that have scientific support for their efficacy (under ideal conditions) and effectiveness (in real world settings). Advocacy of evidence-based practice is a commitment to use those approaches that have the best scientific support, and, in areas where research is lacking, a commitment to measure and use outcomes to elevate those practices that have the greatest impact on the quality of life of individuals, families and communities.

Faith-Based Recovery: is the resolution of alcohol and other drug problems within the framework of religious experience, beliefs, and rituals and/or within the mutual support of a faith community. Faith-based recovery frameworks may serve as adjuncts to traditional recovery support programs or serve as alternatives to them.

Harm Reduction (as a stage of recovery): is most often viewed as an alternative to, and even antagonistic to, recovery, but can also be viewed as a strategy of initiating or enhancing early recovery. The mechanisms through which this can occur include preventing the further depletion of recovery capital, increasing recovery capital when it does not exist, and enhancing the person's readiness for recovery via the change-encouraging relationships through which harm reduction approaches are delivered.

Inclusion: refers to a person's right to be afforded access to, and to participate in, naturally occurring community activities of his or her choice.

Illness Self-management: is the mastery of knowledge about one's own illness and assumption of primary responsibility for alleviating or managing the symptoms and limitations that result from it. Such self-education and self-management shifts the focal point in disease management from the expert caregiver to the person with the illness.

Individualized Care: see Person-Centered Care.

Indigenous Healers and Institutions: are people and organizations in the natural environment of the recovering person who offer words, ideas, rituals, relationships, and other resources that help initiate and/or sustain the recovery process. They are distinguished from professional healers and institutions not only by training and purpose, but through relationships that are culturally-grounded, enduring, and often reciprocal and/or non-commercialized.

Initiating Factors: are those factors that spark a commitment to recovery and an entry into the personal experience of recovery. Factors which serve this recovery priming function are often quite different than those factors that later serve to sustain recovery. Recovery-initiating factors can exist within the person and/or within the person's family and social environment as well as in the behavioral health system. These factors can include pain-based experiences, e.g., anguish, exhaustion, and boredom with addictive lifestyle; death of someone close; external pressure to stop using; experiences of feeling humiliated; increased health problems; failures or rejections; or suicidal thoughts. Less well-recognized, however, are the hope- and pleasure-based experiences: pursuing interests and experiencing enjoyment and success; exposure to recovery role models; new intimate relationships; marriage, parenthood, or other major positive life change; a religious experience; or new opportunities.

Jump Starts: see Initiating Factors.

Menu (of services and/or supports): an array of options from which people can then choose to utilize those services and/or supports they expect will be most effective in assisting them to achieve their goals and most responsive to their individual, familial, and socio-cultural values, needs, and preferences.

Micro Enterprise: see Social Cooperative/Entrepreneurialism.

Moderated Recovery: is the resolution of alcohol or other drug problems through reduction of alcohol or other drug consumption to a sub-clinical level (shifting the

frequency, dosage, method of administration, and contexts of drug use) that no longer produces harm to the individual or society. The concept takes on added utility within the understanding that alcohol and other drug problems exist on a wide continuum of severity and widely varying patterns of acceleration and deceleration. The prospects of achieving moderated recovery diminish in the presence of lower age of onset, heightened problem severity, the presence of co-occurring psychiatric illness, and low social support. The most common example of moderated resolution can be found in studies of people who develop alcohol and other drug-related problems during their transition from youth to adulthood. Most of these individuals do not go on to develop enduring substance-related problems, but instead moderate their use through the process of maturation.

Motivational Interventions: is a non-confrontational approach to eliciting recovery-seeking behaviors that was developed by Miller and Rollnick. This approach emphasizes relationship-building (expressions of empathy), heightening discrepancy between an individual's personal goals and present circumstances, avoiding argumentation (activation of problem-sustaining defense structure), rolling with resistance (emphasizing respect for the person experiencing the problem and his or her sense of necessity and confidence to solve the problem), and supporting self-efficacy (expressing confidence in the individual's ability to recovery and expressing confidence that they will recovery). As a technique of preparing people to change, motivational interviewing is an alternative to waiting for an individual to "hit bottom" and an alternative to confrontation-oriented intervention strategies.

Multiple Pathways of Recovery: reflects the diversity of how people enter into and pursue their recovery journey. Multiple pathway models contend that there are multiple pathways into psychiatric disorder and addiction that unfold in highly variable patterns, courses and outcomes; that respond to quite different treatment approaches; and that are resolved through a wide variety of recovery styles and support structures. This is particularly true among ethnic minority and religious communities, but diversity is to be found wherever there are people of different backgrounds.

Mutual Support/Aid Groups: are groups of individuals who share their own life experiences, strengths, strategies for coping and hope about recovery. Often called "self-help" groups, they more technically involve an admission that efforts at self-help have failed and that the help and support of others is needed. Mutual aid groups are based on relationships that are personal rather than professional, reciprocal rather than fiduciary, free rather than fee-based, and enduring rather than transient (see also Indigenous Healers and Institutions).

Natural Recovery: is a term used to describe those who have initiated and sustained recovery from a behavioral health disorder without professional intervention or

involvement in a formal mutual aid group. Since people in this form of recovery neither access nor utilize behavioral health services, it is difficult to establish the prevalence or nature of this process, but it is believed to be common.

New Recovery Advocacy Movement: depicts the collective efforts of grassroots recovery advocacy organizations whose goals are to: 1) provide an unequivocal message of hope about the potential of long term recovery from behavioral health disorders, and 2) to advocate for public policies and programs that help initiate and sustain such recoveries. The core strategies of the New Recovery Advocacy Movement are: 1) recovery representation, 2) recovery needs assessment, 3) recovery education, 4) recovery resource development, 5) policy (rights) advocacy, 6) recovery celebration, and 7) recovery research.

Natural Support: technical term used to refer to people in a variety of roles who are engaged in supportive relationships with people in recovery outside of behavioral health settings. Examples of natural supports include family, friends, and other loved ones, landlords, employers, neighbors, or any other person who plays a positive, but non-professional, role in someone's recovery.

Partial Recovery: is 1) the failure to achieve full symptom remission (abstinence or the reduction of alcohol/drug use below problematic levels), but the achievement of a reduced frequency, duration, and intensity of use and reduction of personal and social costs associated with alcohol/drug use, or 2) the achievement of complete abstinence from alcohol and other drugs but a failure to achieve parallel gains in physical, emotional, relational, and spiritual health. Partial recovery may precede full recovery or constitute a sustained outcome.

Peer: within behavioral health, this term is used to refer to someone else who has experienced first-hand, and is now in recovery from, a mental illness and/or addiction.

Peer-Delivered Services: any behavioral health services or supports provided by a person in recovery from a mental illness and/or addiction. This includes, but is not limited to, the activities of peer specialists or peer support providers (see below), encompassing also any conventional behavioral health intervention which a person in recovery is qualified to provide. Examples of these activities range from medication assessment and administration by psychiatrists and nurses who disclose that they are in recovery to illness management and recovery education by peers trained in providing this evidence-based psychosocial intervention. An underlying assumption here is that there is "value added" to any service or support provided by someone who discloses his or her own recovery journey, as such disclosure serves to combat stigma and inspire hope.

Peer-Operated or Peer-Run Programs: a behavioral health program that is developed, staffed, and/or managed by people in recovery. In contrast to peer-run businesses (described below) which are self-sustaining and able to generate profits, peer-run programs are typically private-non-profit and oriented to providing behavioral health services and supports such as respite care, transportation to and from healthcare appointments, recovery education, and advocacy.

Peer-Run Businesses: see Social Cooperative/Entrepreneurialism

Peer Specialist: a peer (see above) who has been trained and employed to offer peer support to people with behavioral health conditions in any of a variety of settings. These settings may range from assertive or homeless outreach in shelters, soup kitchens, or on the streets, to part of a multi-disciplinary inpatient, intensive outpatient, or ambulatory team, to roles within peer-run or peer-operated programs (see below).

Peer Support: while falling along a theoretical continuum, peer support differs both from traditional mutual support groups as well as from consumer-run drop-in centers or businesses. In both mutual support groups and consumer-run programs, the relationships peers have with each other are thought to be reciprocal in nature; even though some peers may be viewed as more skilled or experienced than others, all participants are expected to benefit. Peer support, in contrast, is conceptualized as *involving one or more persons who have a history of significant improvement in either a mental illness and/or addiction and who offers services and/or supports to other people with mental illnesses or addictions who are considered to be not as far along in their own recovery process.*

Person-Centered Care: behavioral health care that is based on the person's and/or family's self-identified hopes, aspirations, and goals, which build on the person's and/or family's own assets, interests, and strengths, and which is carried out collaboratively with a broadly-defined recovery management team that includes formal care providers as well as others who support the person's or family's own recovery efforts and processes, such as employers, landlords, teachers, and neighbors.

Person in Recovery: a person who has experienced a mental illness and/or addiction and who has made progress in learning about and managing his or her behavioral health condition and in developing a life outside of, or in addition to, this condition.

Recovery Capital: is the quantity and quality of internal and external resources that one can bring to bear on the initiation and maintenance of recovery from a life-changing disorder. In contrast to those achieving natural recovery, most people with

psychiatric or addictive disorders entering treatment have never had much recovery capital or have dramatically depleted such capital by the time they seek help.

Recovery Celebration: is an event in which recovered and recovering people assemble to honor the achievement of recovery. Such celebrations serve both healing and mutual support functions but also (to the extent that such celebrations are public) serve to combat social stigma attached to addiction or mental illness by putting a human face on behavioral health disorders and by conveying living proof of the possibility and enduring nature of recovery from these disorders.

Recovery Coach/Guide (Recovery Support Specialist): is a person who helps remove personal and environmental obstacles to recovery, links the newly recovering person to the recovery community and his or her broader local community, and, where not available in the natural community, serves as a personal guide and mentor in the management of personal and family recovery.

Recovery Community (Communities of Recovery): is a term used to convey the sense of shared identity and mutual support of those persons who are part of the social world of recovering people. The recovery community includes individuals in recovery, their family and friends, and a larger circle of "friends of recovery" that include both practitioners working in the behavioral health fields as well as recovery supporters within the wider community. Recovery management is based on the assumption that there is a well-spring of untapped hospitality and service within this community that can be mobilized to aid those seeking recovery for themselves and their families. "Communities of recovery" is a phrase coined by Kurtz to convey the notion that there is not one but multiple recovery communities and that people in recovery may need to be introduced into those communities where the individual and the group will experience a goodness of "fit." The growth of these divergent communities reflects the growing varieties of recovery experiences.

Recovery Management: is the provision of engagement, education, monitoring, mentoring, support, and intervention technologies to maximize the health, quality of life, and level of productivity of persons with severe behavioral health disorders. Within the framework of recovery management, the "management" of the disorder is the responsibility of the person with the disorder. The primary role of the professional is that of the recovery consultant, guide, or coach.

Recovery-Oriented Practice: a practice oriented toward promoting and sustaining a person's recovery from a behavioral health condition. DMHAS policy defines recovery-oriented practice as one that "*identifies and builds upon each individual's assets, strengths, and areas of health and competence to support the person in managing his or her condition while regaining a meaningful, constructive, sense of membership in the broader community.*"

Recovery-Oriented Systems of Care: are systems of health and human services that affirm hope for recovery, exemplify a strengths-based orientation, and offer a wide spectrum of services and supports aimed at promoting resilience and long term recovery from behavioral health disorders.

Recovery Planning and Recovery Plans: in contrast to a treatment or service plan, is developed, implemented, revised, and regularly evaluated by the client. Consisting of a master recovery plan and regular implementation/action plans, the recovery plan covers life domains in addition to behavioral health issues (e.g., physical, finances, employment, legal, family, social life, personal, education, and spiritual). In mental health settings, recovery planning follows the principles described above under person-centered care.

Recovery Priming: see Initiating Factors.

Recovery Support Services: are designed to 1) remove personal and environmental obstacles to recovery, 2) enhance identification and participation in the recovery community, and 3) enhance the quality of life of the person in recovery. Such services include outreach, engagement and intervention services; recovery guiding or coaching, post-treatment monitoring and support; sober or supported housing; transportation; child care; legal services; educational/vocational supports; and linkage to leisure activities.

Serial Recovery: is the process through which individuals with multiple concurrent or sequential problems resolve these problems and move toward optimum level of functioning and quality of life. Serial recovery refers to the process of sequentially shedding two or more drugs, or to the overlapping processes involved in recovering from addiction and co-occurring psychiatric or other physical disorders.

Social Cooperative/Entrepreneurialism: the development and operation of small businesses ("micro enterprises") by people in recovery based on their talents and interests and in partnership with their local community. The resulting businesses offer goods and services to the general public and may be either for profit or not for profit, but should be at least financially self-sustaining, although perhaps subsidized through tax breaks or other government means.

Spirituality: refers to a system of religious beliefs and/or a heightened sense of perception, awareness, performance, or being that informs, heals, connects, or liberates. For people in recovery, it is a connection with hidden resources within and outside of the self. There is a spirituality that derives from pain, a spirituality that springs from joy or pleasure, and a spirituality that can flow from the simplicity of daily life. For many people, the spiritual has the power to sustain them through adversity and inspire them to make efforts toward recovery. For some, this is part of

belonging to a faith community, while for others is may be the spirituality of fully experiencing the subtlety and depth of the ordinary as depicted in such terms as harmony, balance, centeredness, or serenity. All of these can be part of the many facets of recovery.

Triggering Mechanisms: see Initiating Factors.

User/Service Recipient: a person who receives or uses behavioral health services and/or supports, preferred by some people as an alternative to "consumer" or "person in recovery."

Valued-Based Practice: a practice which has not yet accrued a base of evidence demonstrating its effectiveness in promoting recovery, but for which there are other persuasive reasons to view it as having been a helpful resource, and as being a helpful resource in the future, for people with behavioral health conditions. Examples of value-based practices include peer-based services that offer hope, role modeling, and mentoring and culturally-specific programs oriented toward cultural subgroups.

WRAP (Wellness Recovery Action Planning): a self-help approach to illness management and wellness promotion developed by Mary Ellen Copeland.

Moving from a Deficit-Based to a Strengths-Based Approach to Care

The following are examples of how language, thinking, and practice shift in the evolution of a recovery-oriented system of care

Presenting Situation	Deficit-based Perspective		Recovery-oriented, Asset-based Perspective	
	Perceived Deficit	Intervention	Perceived Asset	Intervention
Person re-experiences symptoms	Decompensation, exacerbation, or relapse	Involuntary hospital-ization; warning or moralizing about "high risk" behavior (e.g., substance use or "non-compliance")	Re-experiencing symptoms as a normal part of the recovery journey; an opportunity to develop, implement, and/or apply coping skills and to draw meaning from managing an adverse event	Express empathy and help person avoid sense of demoralization; highlight how long it may have been since symptoms had reappeared; provide feedback about the length of time it takes to achieve sustained change; offer advice on strategies to cope; reinforce sense of self-efficacy
Person demonstrates potential for self-harm	Increased risk of suicide	Potentially intrusive efforts to "prevent suicide"	Indicators of potential for self-harm are important signals to respond differently. The person is likely to have a weakened sense of efficacy and feel demoralized, and thus may require additional support. On the other hand, the person has already survived tragic circumstances and extremely difficult ordeals, and should be praised for his or her prior resilience and perseverance.	Rather than reducing risk, the focus is on promoting safety. Supportive, ongoing efforts are oriented to "promote life," e.g., enabling people to write their own safety/ prevention plans and advance directives. Express empathy; reinforce efficacy and autonomy; enhance desire to live by eliciting positive reasons and motivations, with the person, not the provider, being the source of this information.
Person takes medication irregularly	Person lacks insight regarding his or her need for meds; is in denial of illness; is non-compliant with treatment; and needs monitoring to take meds as prescribed.	Medication may be administered, or at least monitored, by staff; staff may use cigarettes, money, or access to resources as incentives to take meds; person is told to take the meds or else he or she will be at risk of relapse or decompensation, and therefore may need to be hospitalized.	Prefers alternative coping strategies (e.g., exercise, structures time, spends time with family) to reduce reliance on medication; has a crisis plan for when meds should be used. Alternatively, behavior may reflect ambivalence regarding medication use which is understandable and normal, as appro-ximately half of people with any chronic health condition (e.g., diabetes, asthma) will not take their medication as prescribed.	Individual is educated about the risks and benefits of medication; offered options based on symptom profile and side effects; and is encouraged to consider using meds as one tool in the recovery process. In style and tone, individual autonomy is respected and decisions are ultimately the person and his or her loves one's to make. Explore person's own perspective on symptoms, illness, and medication and invite him or her to consider other perspectives. Person is resource for important ideas and insights into the problem and is invited to take an active role in problem solving process.

Presenting Situation	Deficit-based Perspective		Recovery-oriented, Asset-based Perspective	
	Perceived Deficit	Intervention	Perceived Asset	Intervention
Person makes poor decisions	Person's judgment is impaired by illness or addiction; is non-compliant with directives of staff; is unable to learn from experience	Potentially invasive and controlling efforts to "minimize risk" and to protect the person from failure, rejection, or the other negative consequences of his or her decisions	Person has the right and capacity for self-direction (i.e., Deegan's "dignity of risk" and the "right to fail"), and is capable of learning from his or her own mistakes. Decisions and taking risks are viewed as essential to the recovery process, as is making mistakes and experiencing disappointments and set backs. People are not abandoned to the negative consequences of their own actions, however, as staff stand ready to assist the person in picking up the pieces and trying again.	Discuss with the person the pros, cons, and potential consequences of taking risks in the attempt to maximize his or her opportunities for further growth and development. This dialogue respects the fact that all people exercise poor judgment at times, and that making mistakes is a normal part of the process of pursuing a gratifying and meaningful life. Positive risk taking and working through adversity are valued as means of learning and development. Identify discrepancies between person's goals and decisions. Avoid arguing or coercion, as decisions made for others against their will potentially increase their learned helplessness and dependence on professionals.
Person stays inside most of the day	Person is withdrawing and becoming isolative; probably a sign of the illness; can only tolerate low social demands and needs help to socialize	Present the benefits of spending time outside of the house; offer the person additional services to get the person out of the house to a clubhouse, drop-in center, day program, etc.	Person prefers to stay at home; is very computer savvy; and has developed skills in designing web pages; frequently trades e-mails with a good network of NET friends; plays postal chess or belongs to collectors clubs; is a movie buff or enjoys religious programs on television. Person's reasons for staying home are seen as valid.	Explore benefits and drawbacks of staying home, person's motivation to change, and his or her degree of confidence. If staying home is discordant with the person's goals, begin to motivate for change by developing discrepancies. If leaving the house is important but the person lacks confidence, support self-efficacy, provide empathy, offer information/advice, respond to confidence talk, explore hypothetical change, and offer to accompany him or her to initial activities.
Person denies that he or she has a mental illness and/or addiction	Person is unable to accept illness or lacks insight	Educate and help the person accept diagnoses of mental illness and/or addiction; facilitate grieving loss of previous self	Acceptance of a diagnostic label is not necessary and is not always helpful. Reluctance to acknowledge stigmatizing designations is normal. It is more useful to explore the person's understanding of his or her predicament and recognize and explore areas for potential growth.	In addition to exploring person's own understanding of his or her predicament, explore symptoms and ways of reducing, coping with, or eliminating distress while eliciting ways to live a more productive, satisfying life.

Presenting Situation	Deficit-based Perspective		Recovery-oriented, Asset-based Perspective	
	Perceived Deficit	**Intervention**	**Perceived Asset**	**Intervention**
Person sleeps during the day	Person's sleep cycle is reversed, probably due to illness; needs help to readjust sleep pattern, to get out during the day and sleep at night.	Educate the person about the importance of sleep hygiene and the sleep cycle; offer advice, encouragement, and interventions to reverse sleep cycle	Person likes watching late-night TV; is used to sleeping during the day because he or she has always worked the night shift; has friends who work the night shift so prefers to stay awake so she or he can meet them after their shift for breakfast. Person's reasons for sleeping through the day are viewed as valid.	Explore benefits and drawbacks of sleeping through the day, the person's motivation to change, the importance of the issue and his or her degree of confidence. If sleeping through the day is discordant with the person's goals, begin to motivate change by developing discrepancy, as above.
Person will not engage in treatment	Person is non-compliant, lacks insight, or is in denial	Subtle or overt coercion to make person take his or her medications, attend 12-step or other groups, and participate in other treatments; alternatively, discharge person from care for non-compliance	Consider range of possible reasons why person may not be finding available treatments useful or worthy of his or her time. It is possible that he or she has ambivalence about treatment, has not found treatment useful in the past, did not find treatment responsive to his or her needs, goals, or cultural values and preferences. Also consider factors outside of treatment, like transportation, child care, etc. Finally, appreciate the person's assertiveness about his or her preferences and choices of alternative coping and survival strategies	Compliance, and even positive behaviors that result from compliance, do not equate, or lead directly, to recovery. Attempts are made to understand and support differences in opinion so long as they cause no critical harm to the person or others. Providers value the "spirit of noncompliance" and see it as sign of the person's lingering energy and vitality. In other words, he or she has not yet given up. Demonstrate the ways in which treatment could be useful to the person in achieving his or her own goals, beginning with addressing basic needs or person's expressed needs and desires; earn trust.
Person reports hearing voices	Person needs to take medication to reduce voices; if person takes meds, he or she needs to identify and avoid sources of stress that exacerbate symptoms	Schedule appointment with nurse or psychiatrist for med evaluation; make sure person is taking meds as prescribed; help person identify and avoid stressors	Person says voices have always been there and views them as a source of company, and is not afraid of them; looks to voices for guidance. Alternatively, voices are critical and disruptive, but person has been able to reduce their impact by listening to walkman, giving them stern orders to leave him or her alone, or confines them to certain parts of the day then they pose least interference. Recognize that many people hear voices that are not distressing.	Explore with person the content, tone, and function of his or her voices. If the voices are disruptive or distressing, educate person about possible strategies for reducing or containing voices, including but not limited to medication. Ask person what has helped him or her to manage voices in the past. Identify the events or factors that make the voices worse and those that seem to make the voices better or less distressing. Plan with the person to maximize the time he or she is able to manage or contain the voices.



Attachment G

In response to CON application items 2 & 5e:

Real estate property appraisal

***Please Note*: This document is included for multiple purposes. Area/Neighborhood Analysis (pages 5-17) and Market Analysis (pages 18-24) are particularly responsive to issues raised in CON application item # 2**

MAY 8, 2012

SELF CONTAINED APPRAISAL OF THE
PROPOSED RETREAT AT SOUTH CONNECTICUT
915 ELLA T. GRASSO BLVD.
NEW HAVEN, CT 06520

PREPARED FOR
MR. DAVID SILBERSTEIN
COAL NEW HAVEN, LLC
C/O COAL CAPITAL GROUP, LLC

PRIVILEGED AND CONFIDENTIAL

www.cbizvaluation.com  ***info@cbizvaluation.com***

CBIZ VALUATION GROUP, LLC
VALUATION, FINANCIAL ADVISORY & LITIGATION SUPPORT

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PRIVILEGED AND CONFIDENTIAL

May 8 , 2012

Mr. David Silberstein
Coal New Haven LLC
C/O Coal Capital Group LLC
1100 Coney Island Avenue, Suite 300
Brooklyn, NY 11230

Reference: Proposed Retreat at South Connecticut
915 Ella T. Grasso Blvd.
New Haven, CT 06520

Dear Mr. Silberstein:

As requested, CBIZ Valuation Group, LLC has prepared an appraisal of the market value of the fee simple and leased fee estate in the above referenced property. The intended use of the appraisal is for business planning. The intended user of the report is Coal New Haven, LLC.

CBIZ Valuation Group, LLC's analyses, opinions and conclusions were developed, and this report is intended to conform to the Uniform Standards of Professional Appraisal Practice of the Appraisal Foundation and the requirements of the Code of Professional Ethics and Standards of Professional Appraisal Practice of the Appraisal Institute.

The subject property consists of a former skilled nursing facility. The facility contains a total of 58,477 square feet of gross building area (includes 7,858 square feet of finished basement space for support and services). The improvements are situated on a 2.70 acre (117,612 square foot) parcel of land. Current ownership is vested in the name of OHI (Connecticut), Inc.

The subject is under contract to be purchased by Coal New Haven, LLC for a purchase price of $2,400,000. The subject will be undergoing renovations which include adding a 4,950 square foot gym, updating all interior finishes throughout the facility, paving, landscaping, new lighting, and exterior updates. The projected costs of these renovations are $1,713,278. A copy of the bid is presented in the addenda section of the report. Once completed, the property is to be leased to NR Connecticut, LLC (a related party to Coal New Haven, LLC) who will operate an alcohol and substance abuse facility.

The effective date of "As Is" valuation is March 27, 2012 which coincides with our physical observation of the property and the effective date of the "As Complete" valuation is October 1, 2012, the expected completion date of the improvements and the expected date of

occupancy for the tenant. The concluded value reflects the value of the building, land, and site improvements.

The fee simple and leased fee estate values, as of March 27, 2012 and November 1, 2012, for the subject are as follows:

TWO MILLION NINE HUNDRED THOUSAND DOLLARS
$2,900,000 "AS IS – FEE SIMPLE"

THREE MILLION NINE HUNDRED THOUSAND DOLLARS
$3,900,000 "AS COMPLETE" – FEE SIMPLE

SIXTEEN MILLION EIGHT HUNDRED THOUSAND DOLLARS
$16,800,000 "AS COMPLETE – LEASED FEE"

This appraisal is subject to the standard assumptions and limiting conditions, extraordinary assumptions and/or hypothetical conditions which are set forth in detail in the body of the report section of this report.

If you have any questions, feel free to call Linda R. Atkinson at 314-692-5818. Thank you for choosing CBIZ Valuation Group, LLC.

Respectfully submitted,

CBIZ Valuation Group, LLC

CBIZ Valuation Group, LLC

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SUMMARY OF SALIENT FACTS

Property Identification		
Name		Former University Skilled Care & Rehabilitation
Address		915 Ella T. Grasso Boulevard New Haven, CT, 06520
Property Owner		OHI (Connecticut) INC
Property Description		
Property Type		Vacant Nursing Home
Map/Book/Lot/Unit		342/0151/2500
Zoning Designation		RM-1: Residential Low-Middle Density
Gross Building Area (SF) - "As Is"		58,477
Net Rentable Area (SF) - "As Is"		58,477
Gross Building Area (SF) - "As Complete"		63,427
Number of Buildings		One
Stories		Two
Year Built (original one story structure)		1973
Year Renovated (addition of 2nd floor and total renovation)		1996
Latest Renovation		2012
Land Area (SF)		117,612
Land Area (Acres)		2.70
Flood Hazard Data (FEMA)		
Flood Zone		X AE
Community Map Number		09009C0437H
Effective Map Date		12/17/2010
Highest and Best Use		
As Vacant		Residential
As Improved		Continued Use
Valuation Information		
Date of Inspection		March 27, 2012
Date of As Is Value		March 27, 2012
Date of As Complete Value		November 1, 2012
Interest Appraised		Fee Simple and Leased Fee
Intended Use		Business Planning
Final Value Indicators Fee Simple		
Cost Approach		Not Employed
Sales Comparision Approach As Is	$	2,900,000
Sales Comparision Approach As	$	3,900,000
Income Approach		Not Employed
Final Value Indicators Leased Fee		
Cost Approach		Not Employed
Sales Comparision Approach		Not Employed
Income Approach As Complete	$	16,800,000
Final Value Conclusion - Fee Simple As Is	**$**	**2,900,000**
Final Value Conclusion - Fee Simple As Complete	**$**	**3,900,000**
Final Value Conclusion - Leased Fee As Complete	**$**	**16,800,000**

INTRODUCTION

IDENTIFICATION OF THE PROPERTY

The subject property consists of a former skilled nursing facility. The facility contains a total of 58,477 square feet of gross building area (includes 7,858 square feet of finished basement space for support and services). The improvements are situated on a 2.70 acre (117,612 square foot) parcel of land. Current ownership is vested in the name of OHI (Connecticut), Inc.

The subject is under contract to be purchased by Coal New Haven, LLC for a purchase price of $2,400,000. The subject will be undergoing renovations which include adding a new 4,950 square foot gym, updating all interior finishes throughout the facility, paving, landscaping, new lighting, and exterior updates. The projected costs of these renovations are $1,713,278. A copy of the bid is presented in the addenda section of the report. Once completed, the property is to be leased to NR Connecticut, LLC (a related party to Coal New Haven, LLC) who will operate an alcohol and substance abuse facility.

PURPOSE /PROPERTY RIGHTS /EFFECTIVE DATES

The purpose of the appraisal is to estimate the market value of the subject's fee simple and leased fee estates on an "As Is" and ""As Complete" basis as of March 27, 2012 and October 1, 2012 respectively.

INTENDED USE AND INTENDED USERS OF THE APPRAISAL

This report has been prepared for the sole use of the client, Coal New Haven, LLC (or its successors-in-interest). This report is to be used by the client for business planning. Other than to the client, the appraisers disclaim any responsibility for the contents of this report.

DATE OF REPORT

This report is transmitted on May 8, 2012. John M. Rimar made an on-site visual observation of the property on March 27, 2012.

DEFINITIONS OF TERMS

Pertinent definitions and terms are included in the report or the Addendum and are *italicized*.

PROPERTY OWNERSHIP & HISTORY

As of the effective valuation date, title to the subject property is vested in the name of OHI (Connecticut), Inc. The subject is under contract to be purchased by Coal New Haven, LLC for a purchase price of $2,400,000. The buyer and seller are currently in a due diligence period which has been extended through June 30, 2012. A copy of the contract and subsequent amendments are located in the addenda section of the report.

EXTRAORDINARY ASSUMPTIONS AND HYPOTHETICAL CONDITIONS

There were two extraordinary assumptions as noted below and no hypothetical conditions included in our analysis and report.

- The subject property is undergoing numerous renovations estimated at a cost of $1,713,278. It is assumed that these renovations are completed in the manner and quality as presented to us by management. Any change could have a material impact on the value conclusions contained in this report.
- The Leased Fee Estate value conclusion assumes that the real estate lease between Coal New Haven, LLC. and NR Connecticut Associates, LLC commences on the date of closing of the transaction. Any change could have a material impact on the value conclusions contained in this report.

COMPETENCY PROVISION

USPAP cites the Competency Rule which states that before agreeing to perform an assignment, an appraiser must have the experience to complete the engagement competently; or the appraiser must take steps necessary to complete the assignment by personal study, association with experienced appraiser, or other measures. In this case the appraiser must disclose to the client the lack of knowledge or experience prior to taking the assignment. The appraisers participating in the assignment do have the experience to comply with the competency provision.

ENGAGEMENT SCOPE

This appraisal is described as a Self Contained *report*. The following scope was completed by CBIZ Valuation Group, LLC (CVG) for this assignment:

- Analyzed regional, city, and market area.
- Conducted a visual on-site observation of the property (site and improvements) and the market area or neighborhood relevant to the subject property.
- Reviewed relevant supporting data.
- Reviewed data regarding taxes, zoning, utilities, easements, and city services.
- Considered comparable land sales, improved sales and comparable rental information as applicable to the assignment.
- Analyzed the data and applied the applicable approaches to value.

Specific attention is drawn to the Letter of Transmittal, Qualifications, Definitions, Certification, General Assumptions and Limiting Conditions, and Significant Issues for further understanding of the *scope of the appraisal.* The subject site and improvement descriptions are based on a personal observation of the property and relevant supporting data as available. The observation is not a substitute for thorough engineering studies.

AREA/NEIGHBORHOOD ANALYSIS

New Haven is the second-largest city in Connecticut and the sixth-largest in New England. With a population of 127,481 people, New Haven is the principal municipality in the Greater New Haven metropolitan area New Haven County), which had a total population of 824,008 in 2000. It is located in on New Haven Harbor, on the northern shore of Long Island Sound. New Haven is centrally located about 140 miles southeast of Boston, MA, 80 miles northeast of New York City, and about 40 miles south of Hartford, CT. New Haven is a major center for business activity, architecture, culture, and entertainment and world-class research and education.

New Haven is at the dawn of a new era for business growth. They have become the bio-tech capital of Connecticut with Greater New Haven hosting 39 (20 in New Haven proper) of the State's 52 firms. The City is in the midst of a notable transformation designed to render this New England city even more as a destination city. A massive $1.5 billion agenda is designed to grow the downtown, where nearly half of the city's jobs are centered, renew the waterfront and take advantage of an excellent transportation system. Projects include the new $500 million Yale-New Haven Cancer Center, a new home for Gateway Community College and one of the first LEED Gold certified projects and largest recent private development, the $180 million 360 State Street development, which will result in 500 new housing units.

A map showing the subject in relation to the rest of the region is below.



New Haven was founded in 1638 by English puritans, and a year later eight streets were laid out in a four-by-four grid, creating what is now commonly known as the "Nine Square Plan", now recognized by the American Institute of Certified Planners as a National Historic Planning Landmark. The central common block is New Haven Green, a 16-acre square, now a National Historic Landmark and the center of Downtown New Haven.

New Haven is the home of the Ivy League school Yale University. The university is an integral part of the city's economy, being New Haven's biggest taxpayer and employer. Health care (hospitals and biotechnology), professional services (legal, architectural, marketing, and engineering), financial services, and retail trade also help to form an economic base for the city.

TRANSPORTATION

New Haven is connected to New York City by both commuter rail, regional rail and intercity rail, provided by Metro-North Railroad (commuter rail), Shoreline East (commuter rail), and Amtrak (regional and intercity rail) respectively, allowing New Haven residents to commute to work in New York City (just under two hours by train). The city's main railroad station is the historic beaux-arts Union Station, which serves Metro-North trains to New York and Shore Line East commuter trains to New London. An additional station was opened in 2002, named State Street Station, to provide Shore Line East and a few peak-hour Metro-North passengers easier access to and from Downtown.

Union Station is further served by four Amtrak lines: the Northeast Regional and the high-speed rail Acela Express provide service to New York, Washington DC and Boston, and rank as the first and second busiest routes in the country; the New Haven-Springfield Line provides service to Hartford and Springfield, Massachusetts; and the Vermonter provides service to both Washington and upstate Vermont, 15 miles (24 km) from the Canadian border.

Metro-North has the third highest daily ridership among commuter rails in the country, with an average weekday ridership of 276,000 in 2009. Of the 276,000 Metro-North riders, 112,000 rode the New Haven Line each day, which would make the New Haven Line seventh in the country in daily ridership if it were alone an entire commuter rail system. Shore Line East ranked nineteenth in the country, with an average daily ridership of 2,000.

As of 2011, a high-speed, intercity commuter rail from the City of New Haven's Union Station to the City of Springfield, Massachusetts' Union Station has been awarded hundreds of millions of dollars in both state and federal funding. Connecticut and Massachusetts officials "expect to complete all design work on the New Haven–Hartford–Springfield Commuter Rail Line in 2013, and launch the new rail service in 2016." As of 2011, the densely-populated New Haven-Hartford-Springfield Corridor – which, as of the 2010 Census, has a population of over 2.4 million and over 200,000 university students – is connected only by Interstate 91, one of the most congested highways in the United States.

The New Haven Division of Connecticut Transit (CT Transit), the state's bus system, is the second largest division in the state with 24 routes. All routes originate from the New Haven Green, making it the central transfer hub of the city. Service is provided to 19 different

municipalities throughout Greater New Haven. A map of the New Haven Division routes can be seen here, a map of downtown stops can be seen here, and a list of schedules can be seen here.

CT Transit's Union Station Shuttle provides free service from Union Station to the New Haven Green and several New Haven parking garages. Peter Pan and Greyhound bus lines have scheduled stops at Union Station and connections downtown can be made via the Union Station Shuttle. A private company operates the New Haven/Hartford Express which provides commuter bus service to Hartford. The Yale University Shuttle provides free transportation around New Haven for Yale students, faculty, and staff.

The New Haven Division buses follow routes that had originally been covered by trolley service. Horse-drawn streetcars began operating in New Haven in the 1860s, and by the mid-1890s, all the lines had become electric. In the 1920s and 1930s, some of the trolley lines began to be replaced by bus lines, with the last trolley route converted to bus in 1948. The City of New Haven is in the very early stages of considering the restoration of streetcar (light-rail) service, which has been absent since the postwar period.

New Haven lies at the intersection of Interstate 95 on the coast – which provides access southwards and/or westwards to the western coast of Connecticut and to New York City, and eastwards to the eastern Connecticut shoreline, Rhode Island, and eastern Massachusetts – and Interstate 91, which leads northward to the interior of Massachusetts and Vermont and the Canadian border. I-95 is infamous for traffic jams increasing with proximity to New York City; on the east side of New Haven it passes over the Quinnipiac River via the Pearl Harbor Memorial, or "Q Bridge", which often presents a major bottleneck to traffic. I-91, however, is relatively less congested, except at the intersection with I-95 during peak travel times.

The Oak Street Connector (Route 34) intersects I-91 at exit 1, just south of the I-95/I-91 interchange, and runs northwest for a few blocks as an expressway spur into downtown before emptying onto surface roads. The Wilbur Cross Parkway (Route 15) runs parallel to I-95 west of New Haven, turning northwards as it nears the city and then running northwards parallel to I-91 through the outer rim of New Haven, and Hamden, offering an alternative to the I-95/I-91 journey (restricted to non-commercial vehicles). Route 15 in New Haven is also the site of the only highway tunnel in the state (officially designated as Heroes Tunnel), running through West Rock, home to West Rock Park and the Three Judges Cave.

In addition to these expressways, the city also has several major surface arteries. U.S. Route 1 (Columbus Avenue, Union Avenue, Water Street, Forbes Avenue) runs in an east-west direction south of downtown serving Union Station and leading out of the city to Milford, West Haven, East Haven and Branford. The main road from downtown heading northwest is Whalley Avenue (partly signed as Route 10 and Route 63) leading to Westville and Woodbridge. Heading north towards Hamden, there are two major thoroughfares, Dixwell Avenue and Whitney Avenue. To the northeast are Middletown Avenue (Route 17), which leads to the Montowese section of North Haven, and Foxon Boulevard (Route 80), which leads to the Foxon section of East Haven and to the town of North Branford. To the west is Route 34, which leads to the city of Derby. Other major intracity arteries are Ella Grasso Boulevard (Route 10) west of downtown, and College Street, Temple Street, Church Street, Elm Street, and Grove Street in the downtown area.

Traffic safety is a major concern for drivers, pedestrians and cyclists in New Haven. In addition to many traffic-related fatalities in the city each year, since 2005, over a dozen Yale students, staff and faculty have been killed or injured in traffic collisions on or near the campus.

The closest major commercial airport is Bradley international Airport located about 50 miles to the north. Bradley International Airport (IATA: BDL, ICAO: KBDL, FAA LID: BDL) is a joint civil-military public airport located in Windsor Locks on the border with East Granby and Suffield, in Hartford County, Connecticut, United States. It is owned by the State of Connecticut. The airport is situated in the towns of Windsor Locks, Suffield and East Granby, about halfway between Hartford and Springfield. It is Connecticut's busiest commercial airport with 350 daily operations and the second-busiest airport in New England after Boston's Logan International Airport. The three largest carriers at Bradley International Airport are Southwest Airlines, Delta Air Lines and US Airways with market shares of 25.8%, 20.5%, and 9.0% respectively. Continental Airlines and United Airlines, which are owned by the same company, have a combined market share of about 15%. As a dual-use military facility with the U.S. Air Force, the airport is also home to Bradley Air National Guard Base and the 103d Airlift Wing (103 AW) of the Connecticut Air National Guard.

Tweed New Haven Regional Airport is located within the city limits three miles (5 km) east of the business district, and provides daily service to Philadelphia through US Airways. Bus service between Downtown New Haven and Tweed is available via the CT Transit New Haven Division 'Bus G'. Taxi service and rental cars (including service by Hertz, Avis,

Enterprise and Budget) are available at the airport. Travel time from Tweed to downtown takes less than 15 minutes by car.

New Haven Harbor is home to The Port of New Haven, a deep-water seaport with three berths capable of hosting vessels and barges as well as the facilities required to handle break bulk cargo. The port has the capacity to load 200 trucks a day from the ground or via loading docks. Rail transportation access is available, with a private switch engine for yard movements and private siding for loading and unloading. Approximately 400,000 square feet (40,000 m2) of inside storage and 50 acres (200,000 m2) of outside storage are available at the site. Five shore cranes with a 250-ton capacity and 26 forklifts, each with a 26-ton capacity, are also available.

ECONOMY AND DEMOGRAPHICS

Pertinent demographic, economic and education data for New Haven, New Haven County, and the state of Connecticut are contained in the table on the following page.

Local & Regional Characteristics

	New Haven	New Haven County/MSA	Connecticut
Population			
2000 Population	123,626	824,008	3,405,565
2010 Population	127,481	851,493	3,535,787
2015 Population (proj.)	128,249	859,693	3,568,891
2000-2010 Change	*3%*	*3%*	*4%*
2010-2015 Change	*1%*	*1%*	*1%*
Housing			
% Owner-Occupied	25%	58%	61%
Median Home Value	$ 168,056	$ 237,672	$ 259,656
Economic			
Median HH Income	$ 39,189	$ 62,374	$ 70,340
Per Capita Income	$ 20,974	$ 30,479	$ 36,065
Unemployment Rate **02/2012**	11.7%	8.9%	8.2%
Unemployment Rate **02/2011**	14.0%	10.5%	9.7%
Largest Emp. Sector	Services	Services	Services
2nd Largest Emp. Sector	Retail Trade	Manufacturing	Retail Trade
3rd Largest Emp. Sector	Manufacturing	Retail Trade	Manufacturing
Transportation			
Average Commute Time (mins.)	22.2	23.2	24.4
Education			
High School Graduates	31%	32%	29%
Associate Degrees	5%	7%	8%
Bachelor's Degrees	13%	17%	20%
Advanced Degrees	18%	15%	15%

Source: ESRI, U.S. Bureau of Labor Statistics

New Haven's economy originally was based in manufacturing, but the postwar period brought rapid industrial decline; the entire Northeast was affected, and medium-sized cities with large working-class populations, like New Haven, were hit particularly hard. Simultaneously, the growth and expansion of Yale University further affected the economic shift. Today, over half (56%) of the city's economy is now made up of services, in particular education and health care; Yale is the city's largest employer, followed by Yale – New Haven Hospital. Other large employers include St. Raphael Hospital, Smilow Cancer Hospital, Southern Connecticut State University, Assa Abloy Manufacturing, the Knights of Columbus headquarters, Higher One, Alexion Pharmaceuticals, Covidien and United

Illuminating. Yale and Yale-New Haven are also among the largest employers in the state, and provide more $100,000+-salaried positions than any other employer in Connecticut.

Industry sectors: Agriculture (.6%), Construction and Mining (4.9%), Manufacturing (2.9%), Transportation and Utilities (2.9%), Trade (21.7%), Finance and Real Estate (7.1%), Services (55.9%), Government (4.0%)

The US Census Bureau estimates a 2010 population of 127,481; the 2010 census lists 47,094 households and 25,854 families within the central municipality, the City of New Haven. The population density is 6,859.8 people per square mile (2,648.6/km²). There are 52,941 housing units at an average density of 2,808.5 per square mile (1,084.4/km²). The city's demography is shifting rapidly: New Haven has always been a city of immigrants and currently the Latino population is growing rapidly. Previous influxes among ethnic groups have been: African-Americans in the postwar era, and Irish, Italian and (to a lesser degree) Slavic peoples in the prewar period.

As of the 2010 US Census, of the 47,094 households, 29.3% have children under the age of 18 living with them, 27.5% include married couples living together, 22.9% have a female householder with no husband present, and 45.1% are non-families. 36.1% of all households are made up of individuals and 10.5% have someone living alone who is 65 years of age or older. The average household size is 2.40 and the average family size 3.19.

The ages of New Haven's residents are: 25.4% under the age of 18, 16.4% from 18 to 24, 31.2% from 25 to 44, 16.7% from 45 to 64, and 10.2% who were 65 years of age or older. The median age is 29 years, which is statistically very young. There are 91.8 males per 100 females. For every 100 females age 18 and over, there are 87.6 males.

The median household income in the city is $39,189, and the per capita income is $20,974. About 20.5% of families and 24.4% of the population live below the poverty line, including 32.2% of those under age 18 and 17.9% of those age 65 or over.

In 2006 the New York Times described New Haven as one of the poorest cities in the United States. As of 2001, the New Haven-Stamford-Bridgeport-Danbury metropolitan area had the third-highest per capita income in the country, behind San Francisco and Silicon Valley, California.

It is estimated that 14% of New Haven residents are pedestrian commuters, ranking it at number four by highest percentage in the United States. This is primary due to New Havens' small size (geographically) and the presence of Yale University.

GOVERNMENT

Typical of New England towns, New Haven is governed via the mayor-council system. Connecticut municipalities (like those of neighboring states Massachusetts and Rhode Island) provide nearly all local services (such as fire and rescue, education, snow removal, etc.) as county government has been completely abolished since 1960. New Haven County merely refers to a grouping of towns and a judicial district, not a governmental entity. New Haven is a member of the South Central Connecticut Regional Council of Governments (SCRCOG), a regional agency created to facilitate coordination between area municipal governments and state and federal agencies, in the absence of county government.

John DeStefano, Jr., the current mayor of New Haven, has served eight consecutive terms and was re-elected for a record ninth term in November 2009. Mayor DeStefano has focused his tenure on improving education and public safety, as well as on economic development. Notable initiatives include the Livable City Initiative, begun in 1996, which promotes homeownership and removes blight, and the Citywide Youth Initiative. In 1995, DeStefano launched a 15-year, $1.5 billion School Construction Program, already half finished, to replace or renovate every New Haven public school. The mayor is elected by the entire city.

The city council, called the Board of Aldermen, consists of thirty members, each elected from single member wards. New Haven is served by the New Haven Police Department and the New Haven Fire Department.

New Haven lies within Connecticut's 3rd congressional district and has been represented by Rosa DeLauro since 1991. Martin Looney and Toni Harp represent New Haven in the Connecticut State Senate, and the city lies within six districts (numbers 92 through 97) of the Connecticut House of Representatives.

The Greater New Haven area is served by the New Haven Judicial District Court and the New Haven Superior Court, both headquartered at the New Haven County Courthouse. The

United States District Court for the District of Connecticut has an office in New Haven, located in the Richard C. Lee U.S. Courthouse.

EDUCATION

New Haven is a notable center for higher education. Yale University, at the heart of downtown, is one of the city's best known features and its largest employer. New Haven is also home to Southern Connecticut State University, part of the Connecticut State University System, and Albertus Magnus College, a private institution. Gateway Community College has a campus in New Haven, located in the Long Wharf district; Gateway is in the process of consolidating into one campus and will move downtown into a new state-of-the-art campus (on the site of the old Macy's building) which is slated to open for the Fall 2012 semester.

There are several institutions immediately outside of New Haven, as well. Quinnipiac University and the Paier College of Art are located just to the north, in the town of Hamden. The University of New Haven is located not in New Haven but in neighboring West Haven.

New Haven Public Schools is the school district serving New Haven, Connecticut. Wilbur Cross High School and Hillhouse High School are New Haven's two largest public secondary schools.

Hopkins School, a private school, was founded in 1660 and is the fifth-oldest educational institution in the United States. New Haven is home to a number of other private schools as well as public magnet schools including High School in the Community, Hill Regional Career High School, Co-op High School, New Haven Academy, ACES Educational Center for the Arts, and the Sound School, all of which draw students from New Haven and suburban towns. New Haven is also home to two Achievement First charter schools, Amistad Academy and Elm City College Prep. It is also home to Common Ground, an environmental charter school.

HOSPITALS AND MEDICAL FACILITIES

The New Haven area supports several medical facilities that are considered some of the best hospitals in the country. There are two major medical centers downtown: Yale – New Haven Hospital has four pavilions, including the Yale – New Haven Children's Hospital and

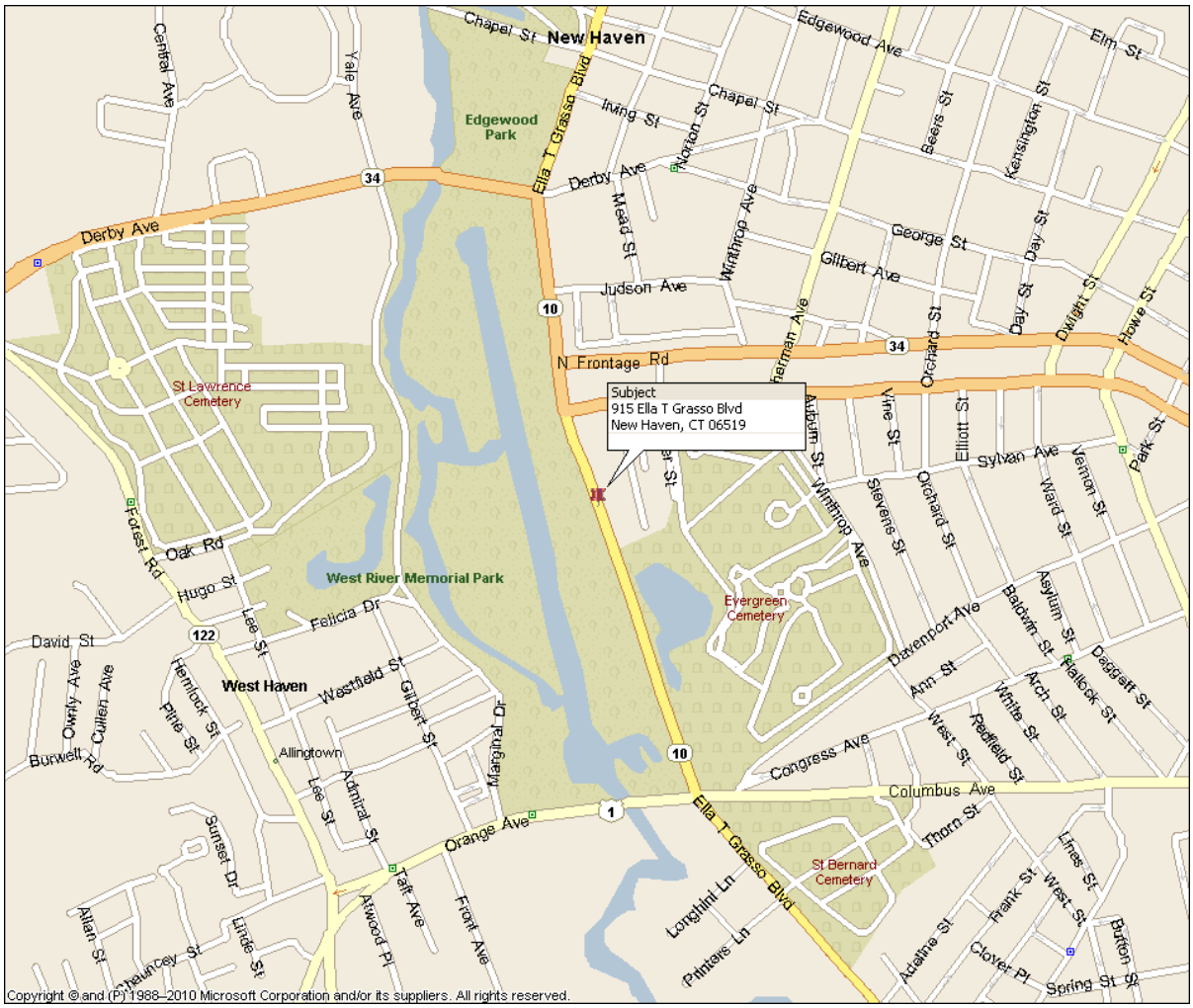
the Smilow Cancer Hospital; the Hospital of Saint Raphael is several blocks north, and touts its excellent cardiac emergency care program. The Hospital of St. Raphael recently merged its operations with Yale – New Haven. Smaller downtown health facilities are the Temple Medical Center located downtown on Temple Street, Connecticut Mental Health Center, across Park Street from Y-NHH, and the Hill Health Center, which serves the working-class Hill Neighborhood. A large Veterans Affairs hospital is located in neighboring West Haven. To the west in Milford is Milford Hospital and to the north in Meriden is the MidState Medical Center.

Yale and New Haven are working to build a medical and biotechnology research mecca in the city and Greater New Haven region, and are succeeding to some extent. The city, state and Yale together run Science Park,[151] a large site three blocks north-west of Yale's Science Hill campus area.[152] This multi-block site, approximately bordered by Mansfield Street, Division Street, and Shelton Avenue is the former home of Winchester's and Olin Corporation's 45 large-scale factory buildings. Currently, sections of the site are large-scale parking lots or abandoned structures, but there is also a large remodeled and functioning area of buildings (leased primarily by a private developer) with numerous Yale employees, financial service and biotech companies.

A second biotechnology district is being planned for the median strip on Frontage Road, on land cleared for the never-built Route 34 extension.[152] As of late 2009, a Pfizer drug-testing clinic, a medical laboratory building serving Yale – New Haven Hospital, and a mixed-use structure containing parking, housing and office space, have been constructed on this corridor.[152] A former SNET telephone building at 300 George Street is being converted into lab space, and has been so far quite successful in attracting biotechnology and medical firms.

NEIGHBORHOOD

The subject is located on the east side of Ella T Grasso Blvd. to the west of the central business district of New Haven. The subject property's neighborhood is primarily a mixed commercial/residential area with a mix of residential, commercial, and industrial uses along Ella T. Grasso Blvd. and residential uses along side streets and interior roads. Following is a map of the neighborhood.



Surrounding Land Uses

There is single family development adjoin the property to the east and north, multifamily to the south, and West River Memorial Park to the west across Ella T. Grasso Blvd.

Development Trend

The immediate area around the subject is characterized by residential development, mostly single family with some multifamily, a park, and a cemetery. There are commercial uses, retail, small office, and service oriented businesses, located to the south of the subject around the US Route 1 interchange and along US Route 1 and Ella T. Grasso Blvd. to the

south. Much of the development took place over 30 to 40 years ago. Some of the buildings have received updating and expansion over the years. However, there is little in terms of new construction in the immediate neighborhood. There is a good housing base in the area. Housing is either single or multi-family units.

Linkage Attributes

The neighborhood is served by Ella T. Grasso Blvd. which runs north/south. US Route 1/Columbus Ave. provides access to the central business district, Yale University and Medical School to the east of the subject. State Route 34/Legion Ave. which is just north of the subject runs east/west and provides access to Yale New Haven Hospital. The neighborhood roads are adequately maintained. Overall, traffic in the neighborhood is considered moderate.

CONCLUSION

The area has a good economic base and an affordable cost of living. The region has many positive attributes including its central location to New York, Boston, and Hartford. It has good infrastructure and diverse workforce. Given the current economic situation, however, the region has experienced hesitation in new construction and increases in unemployment.

MARKET ANALYSIS

Coal Connecticut LLC ("CCL"), a unit of the Coal Capital Group ("CCG"), is in the process of establishing a facility to operate a 105 bed, high-end, luxury Drug and Alcohol Rehabilitation Facility, to be known as Retreat at South Connecticut and located in New Haven, CT ("Retreat"). CCL's operating arm will provide its expertise and more than 50 years cumulative experience operating similar facilities to the project.

Retreat will attract upscale private pay and fully insured patients to its exclusive treatment center through national and regional marketing programs. Retreat is centrally located in New Haven, Connecticut, within 80 mile of New York City and 140 miles of Boston. The two-story 63,000 sq. ft. building will provide state-of-the-art facilities and amenities necessary to operate Retreat, including patient rooms, common areas, a dining room, full kitchen, a treatment center, administrative offices and a fitness center.

As the only luxury rehabilitation center in Southern Connecticut, Retreat will treat patients in a setting that has ideal conditions for healing, with focused and specialized services to be provided in a secure, nurturing and non-institutional environment. The property also includes large administrative offices and ample clinical areas to provide group space for all levels of care.

Retreat will be licensed by the State of Connecticut Department of Public Health and accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

An estimated 23 million individuals in the US need drug and alcohol treatment, including almost three million individuals in the region. CCL will achieve its occupancy projections (approximately 1,500 admissions per year at stabilization) its revenue goals through an aggressive marketing and referral program within its specific market niche of privately-paying and privately insured upscale clients.

In order to realize its goals, Retreat needs to only attract one in every 3,500 individuals in the region and only one in every 27,000 individuals nationwide who require treatment.
Because of the high margins typical to the chemical dependence rehabilitation industry (and specifically within the high-end niche of the industry), break-even at the Retreat will be achieved at a 28% occupancy. This occupancy level will be realized and exceeded within a few weeks of opening.

THE NATIONAL SUBSTANCE ABUSE MARKET

According to the U.S. Department of Health & Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) 2008 National Survey on Drug Use and Health (www.samhsa.gov):

- 23.1 Million persons were classified as needing treatment for illicit drug and/or alcohol abuse.
    - 2.3 Million of these individuals received treatment at a specialty facility; therefore, 20.8 Million persons needed treatment for an illicit drug and/or alcohol use problem but did not receive treatment in the past year.
    - Of the 20.8 Million persons needing but not receiving treatment, 1.0 Million reported that they felt the need for treatment for their illicit drug or alcohol use problem.
- 24.9 Million persons over 18 were estimated to have Serious Psychological Distress (SPD).
    - 10.9 Million of these individuals received some form of treatment, including in and outpatient treatment and prescription medication.
    - 5.6 Million adults who have SPD and were also dependent on or abused illicit drugs or alcohol.
- Of the 30.4 Million adults that have had a Major Depressive Episode (MDE) in their lifetimes, over half of these had an episode in the last year.
    - Nearly 4 Million of these individuals were dependant on illicit drugs and/or abused alcohol.
- 10.5 Million Adults reported an unmet need for treatment or counseling. Of these, 4.8 Million received no treatment while the other 5.6 Million received some treatment but felt their needs were unmet.

INDUSTRY AND COMPETITION FROM NATIONWIDE PROVIDERS

The SAMHSA Report characterizes the Substance Abuse Treatment Industry as follows:

- 13,371 reporting facilities in 2005:
    - 61% of treatment facilities were private nonprofit; 27% were private for-profit; 8% were operated by local governments; 3% were operated by State

governments; 2% were operated by the Federal Government and 1% were operated by tribal governments; and
    - 38% of all facilities (5,100) offered programs for persons with both co-occurring mental health and substance abuse disorders (i.e. dual diagnosis).
- 89% of all clients were in outpatient treatment; 10% in non-hospital residential treatment and 1% in hospital inpatient treatment:
    - Clients increased 8% from 2000 to 1,081,049 in 2005.

Market Niche

In addition to patients from the State of Connecticut, Retreat will primarily attract patients from the regional states (New York, Massachusetts, Rohde Island and northern New Jersey) as well as patients from other states and from abroad. Typically, travel costs are a minor consideration to the Retreat's prospective patient population.

Retreat is designed and will be positioned to cater to a high-end, private-pay and private insurance clientele. Of the 10 most famous luxury clinics in the world, six are located in the United States, mostly in the west:

Clinic	Location	Rates
Promises	Malibu, CA	$33,000 /month
Passages	Malibu, CA	$40-$50,000/month
The Meadows Clinic	Wickenburg, AZ	$1,000/day
Caron Foundation	Wernersville, PA	$28,000/month
Cottonwood de Tucson	Tucson, AZ	$1,000-1,430/day
Betty Ford Clinic	Rancho Mirage, CA	$40,000/month
Cirque Lodge	Sundance, UT	Varies

As a high-end luxury recovery clinic in the region, Retreat will satisfy an unmet demand for its services and will achieve high fees. Through CCL'S 50 years combined experience in the region, as well as the combined reach of CCL's affiliated facilities, Retreat has already

developed a referral network for upscale patients that will help the company reach its short and long-term occupancy and revenue goals.

In addition to Retreat's comprehensive continuum of care treatment model, Retreat offers specialized treatment plans to individuals with unique needs. Professionals, Health Care workers, First Responders, Veterans, Labor Union members will all receive additional programming focusing on their distinctive needs. Mental Health counselors and other trained professionals will address these populations' needs including physical, emotional and psychological stress, access to 12 step networks, reintegration, pain management, etc.

LOCAL SUBSTANCE ABUSE MARKET IN THE REGION

The table below reflects the most recent data for the region that was provided by the National Office of Applied Studies of the Substance Abuse and Mental Health Services Administration:

	Admitted to Rehabilitation	Need but did not receive treatment: Illicit Drugs	Need but did not receive treatment: Alcohol
Connecticut		58,000	210,000
Delaware	8,461	18,000	42,000
District of Columbia	2,261	15,000	47,000
Maryland	68,693	102,000	315,000
New Jersey	59,800	112,000	414,000
New York	307,531	369,000	943,000
Pennsylvania	69,435	168,000	589,000
Virginia	31,781	131,000	416,000
Regional Total	44,812	973,000	2,976,000

Even if 100% overlap (i.e. dual addiction) existed between alcohol and drug abusers, the market for treatment within the region is almost three million individuals with less than 16% (592,774) individuals) actually receiving treatment.

Facts (SAMHSA 2011)

1) CT is in the top 10 states for (ALL AGE GROUPS):
   a) Past Month Illicit Drug Use
   b) Past Month Marijuana Use
   c) Past Year Marijuana Use
   d) Past month Alcohol Use

2) CT is above the national average (and increasing) for:
   a) Past Year Alcohol Dependence or Abuse
   b) Past Year Dependence on or Abuse of Illicit Drugs

3) CT's rate of unmet need for treatment is among the highest in the nation for Drug Abuse (11% 18-25 year olds population in 06)

4) CT's rate of unmet treatment for alcohol use among 18-25 year olds increased from 18% to 22% from 02-06 and remains among the highest in the nation.

MARKET PENETRATION

At stabilization in Year 3, The Facility will treat 1,500 patients per year with an average stay of 21 days. The majority of these patients will come from the region.

- To meet its in-state projections, RSC needs to attract less than half of .06% of the three million individuals from the region who need treatment.

It is an unfortunate reality in the rehabilitation business that many clients return for additional inpatient treatment. Therefore, the actual number of new patients needed each year for The Facility to meet its projections is considerably less than the figure mentioned above. In addition, clients receiving inpatient care at The Facility create business for the company's outpatient services.

Marketing Strategy

CCL will market the services and treatment offered at The Facility through the following methods:

- Company Website;
- In-House Sales and Marketing Team;
- Comprehensive Referral Plan;
- Comprehensive international marketing program;
- Advertising;
- In-House Call Center;
- Event Planning;
- Medical School Affiliations;
- Synergies with future DRPS facilities;
- Corporate Speaker Bureau; and
- Conferences.

OPERATIONS

CCL's operating arm is in the process of filling several key positions and will continue to recruit top professionals to its team. CCL's operating arm is managed by Peter Schorr, a 25 year veteran in the high-end substance abuse top-tier management field.

After Four months of extensive renovations, Mr. Schorr opened Retreat at Lancaster County in Ephrata, PA. The property, which houses a Facility of approximately 88,000 square feet over 24 acres with 5 buildings, provides state-of-the-art facilities and amenities necessary to operate a high-end, inpatient Drug and Alcohol detox and rehab center. The buildings include patient rooms and common areas, a dining room and full kitchen, a treatment center, administrative offices and a gymnasium/fitness center. Client rooms have been fully refurbished from floor to ceiling, including all furniture, beds and flooring. Each room features locally handmade furniture, full size beds, granite counters and ceramic tile showers.

Retreat at Lancaster County has been incredibly well received by the recovery, healthcare and local community. Through word-of-mouth and patient referrals, Retreat is now recognized as a premier facility with an attentive staff and superior clinical program. As a result, hospital-referred admissions account for 40% of Retreat's admissions. Additionally,

through local press, a pre-opening open house and support of State Senator Mike Brubaker, Retreat has enjoyed the full support of the local government and law enforcement community.

CCL Financial Highlights

- CCL will generate higher revenues per bed than its competitors through an extensive referral program that focuses on high-end, private pay (i.e. non Medicare and/or Medicaid) patients and on comprehensive outpatient services.
- As local onsite owners and operators, CCL will focus on Retreat and other synergistic projects. CCL will have tight financial and operational control and does not have the large corporate overhead and decentralized management of its national competitors.
- Low Break-Even - Retreat will break-even with 28% occupancy (29 beds). CCL estimates that this would happen in Month 1 of operation due to the extensive backlog of referrals already generated.

Retreat at Lancaster County - Actual Performance

Retreat at Lancaster County's has been a tremendous early success. After 6 months of operations, the facility is over 80% capacity (census of 101 on Feb 1, 2012) and exceeding its financial and admissions goals. Retreat had become profitable in its second month of operations and cash flow positive (monthly) by its fourth month.

SITE DESCRIPTION

The subject site was physically observed on March 27, 2012 by John M. Rimar. The site consists of a single parcel of land which is located on the east side of Ella T. Grasso Blvd. on the western side of New Haven.

The site consists of 2.70 acres and is situated on the east side of Ella T. Grasso Blvd. It has a physical address 915 Ella T. Grasso Blvd. The property is also identified by parcel #342-0151-2500 as identified by the New Haven City Assessor. The property has approximately 450 feet frontage along Ella T. Grasso Blvd. Access is granted to the property via two curb cuts on the northern and southern portion of the site. The site is irregular in shape and has a level grade with Ella T. Grasso Blvd. except at the very rear (western) portion of the site which is below grade from the adjoining property.

SOIL CONDITIONS

No geological engineering report has been furnished for our review, nor has such a study been commissioned for the purpose of this appraisal. Our physical inspection did not reveal any other drainage or topographical problems that would adversely affect the marketability of the subject property. There was no additional visual evidence than that previously discussed of any inadequate soil support or drainage conditions; as such, there appears to be no further impediments to the reasonable development of the site. For the purpose of this assignment, it is assumed, based on existing on-site and nearby improvements, the subject's topsoil and subsoil conditions are stable and adequate to support the existing improvements as indicated herein.

UTILITIES

All normal utilities are adequate and directly available to the site.

ENVIRONMENTAL HAZARDS

There was a Phase 1 environmental study being performed on the subject property at the time of CBIZ's inspection, but a copy is not yet available. The value estimate rendered in this report is predicated on the assumption there is no environmental hazards on or in the property that would cause a loss in value. No evidence of hazardous waste or toxic

materials were visible at the time of the site visit. CVG has no knowledge of the existence of these substances on or in the subject property. However, CVG is not qualified to detect hazardous waste or toxic materials.

EASEMENTS, COVENANTS, CONDITIONS & RESTRICTIONS

A title report was not provided to CBIZ. It is assumed there are no easements or other restrictions that would have a material impact on the subject.

ZONING

According to the New Haven Zoning Office, the subject is located in the RM-1 district, the designation for Residential Low-Middle Density. This district exists for the protection of areas that have been and are being developed predominantly for low-middle density dwellings of various types. Accordingly, the use of land and buildings within this area is limited in general to dwellings at a density of about 12 dwelling units per acre, and to such non-residential uses as generally support and harmonize with a middle density area.

Permitted uses within the RM-1 zone include a variety of residential buildings including single-family, two-family and multi-family. There are a variety of non-residential uses permitted in the RM-1 district which include, among other uses, general and special hospitals, outpatient clinics and public health centers; excluding private offices for doctors, convalescent homes, rest homes, nursing homes, sanitariums, homes for the aged and disabled (not to include elderly), and orphanages. Noise, odors, electrical disturbance, radioactive particles and rays, and all possible disturbing aspects connected with the operation of such uses shall be enclosed, screened or otherwise controlled to the extent that the operation of any such use shall not unduly interfere with the use and enjoyment of properties or streets in the surrounding area.

Based on the above, utilization of the subject site as a facility for addiction and behavioral medicine is a legally permitted and conforming use.

FLOOD INFORMATION

The site is located primarily in Zone X with one small portion of the site appearing to be in zone AE according to Flood Hazard Map number 09009C0437H, dated December 17, 2010. Zone X is an area of minimal flooding potential. Zone AE is a Special Flood Hazard Areas subject to inundation by the 100-year flood determined in a Flood Insurance Study by detailed methods. However, based on the map, it appears this area may only invoice a minor portion of the southwest corner of the site. The improvements are clearly in zone X. A copy of the flood map is located in the addenda section of the report.

PARCEL MAP



CONCLUSION

The subject's site is easily accessible and has adequate frontage.

IMPROVEMENTS DESCRIPTION

The following description of the subject improvements is based upon an on-site visual observation, information obtained from the owner, and county assessment data.

The building is a 58,477 gross square foot, average quality, Class D improvement. This includes 7,858 square feet of finished basement space for support and services. The structure was constructed in 1967 as a skilled nursing home. The subject property underwent a major expansion and renovation in 1996 which included a 10,687 square foot 2nd story addition to the core of the building and a complete interior renovation of the remainder of the building.

The improvement features wood framing and a foundation of concrete. Exterior walls consist of a combination of brick and vinyl siding. Additional exterior wall features include aluminum framed entrance doors and windows.

The floor structure includes concrete slab at grade and wood floor joists over the middle portion of the building where the basement is situated.

The roof structure consists of a combination of shingled hip type and flat with rubber membrane. All sections consist of a wood or steel truss system.

Ceilings are primarily of two foot by two foot suspended acoustical times with some areas of painted gypsum board. Floor coverings consist of linoleum in most areas including patient rooms, hallways and office areas with, ceramic tile and carpet in selected areas and quarry tile in the kitchen.

Plumbing fixtures are standard and of average quality. Each patient room includes an in-room sink and toilet. In addition, the facility is equipped with various common rest areas and shower facilities.

Heat is provided by baseboard radiant heat which is supplied by a gas fired hot water boilers with domestic hot water coil.

Air conditioning is supplied by a chilled water system with central air handling units.

The subject is fully sprinklered by a wet system.

Electrical features consist primarily of fluorescent and incandescent fixtures. Special features include a smoke and fire alarm system, security system, emergency exit lighting and a paging system.

Other building features include a drive-through entrance canopy, balconies (second floor) and concrete patio areas (first floor) for the patient rooms and a fireplace in the reception area.

Overall, the facility is considered to be in average to good condition.

SITE IMPROVEMENTS

Site improvements consist of asphalt paving, concrete paving and sidewalks, exterior lighting, wood fencing, signage, a patio area, and general landscaping.

Overall, the land improvements are considered to be in fair/average condition.

AGE/CONDITION

The subject property was constructed in 1967 with a major addition and renovation in 1996. It has an actual weighted average age of 39 years. Due to the additional and renovations in 1996, its effective age is estimated at 25 years “As Is” and 10 years “As Complete”. The subject has a total economic life of 50 years which results in a remaining economic life of 25 years “As Is” and 35 years “As Complete”. The site improvements are considered to be in average condition.

AMERICANS WITH DISABILITIES ACT

The Americans with Disabilities Act (ADA) became effective in 1992. We did not make a specific compliance survey and analysis of this property to determine whether or not the building is in conformity with the various detailed requirements of the ADA. It is possible that a compliance survey of the property, together with a detailed analysis of the ADA, could reveal that the property will not comply with one or more of the requirements of the act. If so, this fact could have a negative effect on the value of the property. Since we have no direct

evidence relating to this issue, we did not consider possible non-compliance with the requirements of the ADA in estimating the value of the property. The extent of investigation and methodology conforms to our interpretation of USPAP requirements.

FUNCTIONAL UTILITY

The subject property appears to be functional and conforms to surrounding property uses. Functional utility does not appear to be an issue.

CONCLUSION

The subject improvements are currently in average to good condition. The purchaser has presented a plan renovate the facility. Overall the property is functional and is well suited for the proposed rehabilitation use.

REAL ESTATE TAXES AND ASSESSMENTS

PROPERTY TAXES AND ASSESSMENT DATA

Taxes are a function of value, as estimated by Lancaster County. Theoretically, tax values are supposed to be at 100 percent of market value; however, in practice, tax values are often less than market value. Taxes are calculated by multiplying the tax value by the assessment ratio to arrive at the assessed value. The assessed value is then multiplied by the applicable mill rate to obtain the indicated tax burden. Below are the 2010 assessment and taxes for the subject property.

Assessment and Tax Information

	2011	2010
	Parcel	Parcel
	342/0151/2500	342/0151/2500
Appraised Values		
Land	$ 710,200	$ 710,200
Building	$ 2,970,500	$ 4,104,000
Total	$ 3,680,700	$ 4,814,200
Assessed Values		
Land	$ 497,140	$ 497,140
Building	$ 2,079,350	$ 2,872,800
Total	$ 2,576,490	$ 3,369,940
Assessment Ratio	70.00%	70.00%
Ad Velorium Tax Rate	N/A	4.59%
Effective Tax Rate	N/A	3.21%
Total Taxes	**N/A**	**$ 154,567**

(a) Applies to real estate only. Taxes on personal property, improvement fixtures, etc., if any, are excluded from the analysis.

Source: New Haven County Tax Assessor

MARKETING AND REASONABLE EXPOSURE TIME ANALYSIS

MARKETING TIME

The Financial Institutions Reform, Recovery and Enforcement Act of 1989 (FIRREA) requires the derivation of marketing time. Similarly, USPAP addresses reasonable marketing time, which is defined as follows:

The reasonable marketing time is an estimate of the amount of time it might take to sell a property interest in real estate at the estimated market value level during the period immediately after the effective date of an appraisal. (Advisor Opinion AO-7, USPAP, Adopted September 16, 1992)

The key factor in marketing time is that it is presumed to occur *after* the effective valuation date.

REASONABLE EXPOSURE TIME

The Uniform Standards of Professional Appraisal Practice (USPAP) require the derivation of reasonable exposure time. It is defined as follows:

The estimated length of time the property interest being appraised would have been offered on the market prior to the hypothetical consummation of a sale at market value on the effective date of the appraisal; a retrospective estimate based upon an analysis of past events assuming a competitive and open market. (Statement on Appraisal Standards No. 6, USPAP, Approved for general distribution September 16, 1992)

The key factor in exposure time is that it is presumed to occur *before* the effective valuation date.

MARKETING & REASONABLE EXPOSURE TIME ANALYSIS

We conclude that the subject's marketability is average given its special use nature. The value estimate contained in this report is consistent with recent sales and the return parameters are considered adequate to generate investor interest in the subject property. Given the value of the property relative to surrounding property values, a concluded marketing period for the subject is considered to be 12 to 24 months given the current

economic conditions. This period is based on review of the market and demand for properties similar to the subject.

The concept of reasonable exposure time encompasses not only adequate, sufficient and reasonable time, but also adequate, sufficient and reasonable effort. The estimated exposure time is based on analysis of statistical information, sales notification, interviews and market conditions. We are of the opinion that the reasonable exposure time for the subject property would be 12 to 24 months.

HIGHEST AND BEST USE

DEFINITION

Highest and best use may be defined as, "the reasonable probable and legal use of vacant land or an improved property, which is physically possible, appropriately supported, financially feasible, and that results in the highest land value" (Appraisal of Real Estate, 12th Edition, Page 305).

Because the use of land can be limited by the presence of improvements, highest and best use is determined separately for the site as though vacant and available to be put to its highest and best use, and for the property as improved.

Highest and best use must meet four criteria. It must be:

- physically possible,
- legally permissible,
- financially feasible, and
- maximally productive.

PROCEDURE

The highest and best use analysis is performed in two parts:

- the highest and best use of the land as though vacant; and
- the highest and best use of the land as though improved.

In the analysis of highest and best use of the land as though vacant, it is assumed that the land is vacant or can be made vacant by removal of existing improvements. The highest and best use of the land as though vacant addresses the questions of what use should be made of the land; and when and what type of improvement, if any, should be built on the site. The analysis of highest and best use of the land as improved considers the alternative uses of an improved property.

Both parts of the highest and best use are important to the appraisal process in several ways. For instance, the highest and best use analysis helps to establish what types of

properties are considered comparable, and often, the highest and best use can reveal problems of functional or external obsolescence.

HIGHEST AND BEST USE AS VACANT

Physically Possible

The subject's site is 2.70 acres. The site is well located and served by necessary utilities. There are no adverse soil conditions of which the appraisers are aware. The shape of the parcel does not result in any specific development limitations. From a physical standpoint, overall, the site is considered adequate for many types of residential development.

Legally Permissible

The subject main site is zoned RM-1, Residential Low-Medium Density by the City of New Haven, which allows for the development of a variety of residential uses and limited non-residential uses.

Financially Feasible

Financial feasibility is shaped by the economic and competitive forces prevailing in the local market. One indication of financial feasibility is whether there is an active market for land and/or the presence of new construction in the local area. Based on the market analysis and trends, there appears to be average demand for residential development in this submarket.

Maximally Productive

After considering the subject's location characteristics, allowable land uses, and current economic climate, the maximally productive use would reasonably appear to be for residential development consistent with current zoning restrictions.

As Vacant Conclusion

The concluded highest and best use of the subject as if vacant is for residential development as demand warrants.

HIGHEST AND BEST USE AS IMPROVED

The highest and best use as improved may determine that:

- no changes are necessary to the existing improvements; or that
- some changes or conversions are required; or that
- the property should be demolished and replaced.

In the foregoing analysis it was determined that residential development was the highest and best use as vacant as it was legally permissible, physically possible, and maximally productive. The subject site is currently improved with a two-story, rehab facility. We are satisfied that the highest and best use of the subject property “as improved” is for continued use of the subject property as rehab facility as there is no other use that would create more profitable us of the subject property at this time.

THE APPRAISAL PROCESS

The appraisal process is an orderly analytical procedure wherein data is acquired, classified, analyzed and then processed into a value indication by various appraisal techniques. The three approaches applied are the Cost, Income Capitalization and the Sales Comparison. These represent the three alternatives available to an investor.

The Cost Approach is the sum of the estimated land value and the cost new of the improvements less accrued deprecation. The Cost Approach is based on the premise that an informed purchaser would pay no more for an existing property than it would to cost to replace/reproduce a substitute property with equal utility and without undue delay.

The Income Capitalization Approach is based on the premise that a prudent investor would pay no more for a property than they would for another investment with similar risk and return characteristics. Since the value of an investment can be considered equal to the present worth of anticipated future benefits in the form of dollar income or amenities, this approach estimates the present value of the net cash flow stream that the property is capable of producing. This income is capitalized at a rate that should reflect an appropriate amount of risk to the investor and the amount of income necessary to support debt service.

The Sales Comparison Approach is the process of comparing and analyzing prices paid for properties having a satisfactory degree of similarity to the subject. This approach is based on the principle of substitution, which implies that a prudent purchaser will pay no more to buy a property than they would to buy a comparable substitute property in a similar location and without undue delay.

Each approach has its strengths and weaknesses, depending on the type of property being appraised and the quality of data available. In most instances, one or more of these approaches will produce a more reliable value indication than the other approach, or approaches. Therefore, the final step in the appraisal process is the Reconciliation of all the value indications into the formulation of a final opinion of value. This step usually begins with a discussion of the merits of each approach and an analysis of the reliability of the data used in each. It concludes with a statement of the final opinion of value.

As for the valuation of the subject, only the Sales Comparison Approach and Income Approaches were applicable. The Cost Approach has not been used due to the advanced

age of the subject property and the difficulty of estimating the subject's accrued depreciation. The Sales Comparison Approach was employed to estimate the "As Is" and "As Complete" value of the subject property in fee simple estate. The Income Approach was employed to estimate the leased fee value of the subject based on a proposed lease that will be executed upon completion of the acquisition and renovations.

In concluding a value for the property in question, the applicable approaches are analyzed and reconciled with the most meaningful data given greatest weight in the valuation process.

All applicable approaches are described in detail in the following sections.

SALES COMPARISON APPROACH

The Sales Comparison Approach is based on the proposition that an informed purchaser would pay no more for a property than the cost to acquire an existing one with the same utility. Comparable sales data are analyzed according to similarities and differences with the subject property.

One of the most common units of comparison is the price per unit. Other units of comparison may be appropriate depending upon the property type, unique subject characteristics, or local market customs. This method assumes that buyers and sellers assess properties based on a typical market unit of comparison. Sales are typically adjusted by percentages or specific dollar amounts to reflect inferior and/or superior characteristics when compared with the subject.

Another typical alternative is to compare sales based on an economic basis. The most common of these are the potential gross income multiplier (PGIM) and effective gross income multiplier (EGIM). These methods assume that similar properties are purchased based on their income-producing characteristics, and that there is a relationship between income and sales prices. Another useful economic comparison is the NOI per square foot of the property versus the NOI per square foot of the sales relative to their sales price per square foot of building area.

In either case, the reliability of the Sales Comparison Approach is contingent upon the quantity and quality of data available. The approach is most reliable when there are sufficient sales, of reasonable comparability, for which reasonably accurate data can be confirmed.

As discussed previously the subject property is under contract to be purchased and will be renovated immediately upon completion of the acquisition. The application of the sales comparison approach entails estimating the market value on both an as is and as complete basis. Due to the lack of comparable sales in the local market the search for comparable data was expanded to include sale data on a national basis. Research of the market revealed four sales and two listings. The Sales Comparison Approach in this report uses the price per square foot method of analysis.

COMPARABLE SALES DATA

As discussed on the previous page, four sales and two listings were researched. A summary of the sales is presented on the following page and is followed by a map showing the locations of the sales.

	Subject	Sale 1	Sale 2	Sale 3	Sale 4	Listing 1	Listing 2
Name	Former University Skilled Care & Rehabilitation	Former Skilled Nursing Facility	Former Skilled Nursing Facility	Former Madison Health Care Center	Former Darien Health Care Center	Former Marshall Manor	Former Skilled Nursing Facility
Address	915 Ella T. Grasso	2200 N. Flamingo Ave.	4301 Washington Ave.	7465 Madison Ave	599 Boston Post Rd	8636 Anderson Ave.	171 Rope Ferry Road
City	New Haven	Bethany	Evansville	Indianapolis	Darien	Marshall	Waterford
State	CT	OK, 73008	IN, 47714	IN, 46227	CT, 06820	VA, 20115	CT, 06385
Grantor	N/A	Alsco Investment 10, LLC	Trinity Village, LLC	Windsor Manor Healthcare Investors	599 Boston Post Road LLC	The Cadle Company II, Inc.	N/A
Grantee	N/A	ADP Properties, LTD	105218 Investments,	Ide Management	Darien Alf Property LLC	N/A (Listing)	N/A (Listing)
Property Rights Conveyed	Fee Simple	Fee Simple	Fee Simple	Fee Simple	Fee Simple	Fee Simple	Fee Simple
Parcel Number	342/0151/2500	R173800901	09-720-17-125-008	49-15-18-134-002.000-500	000014-000000-000033	6969-57-1607-000	000653-000000-000900
Date of Sale	N/A	Feb-08	Jan-10	Oct-09	Aug-11	Mar-12	Mar-12
Document Number	N/A	10855-481	2010-103	116542	1428-0135	N/A	N/A
Condition of Sale	Assumes	Arms Length	Arms Length	Arms Length	Arms Length	Arms Length	Arms Length
Year Built	1973	1968	1969	1989	1962	1995	1940
Gross Building Area (SF)	58,477	62,746	51,924	48,070	68,741	72,000	33,882
Buildings	One	One	One	One	One	One	One
Stories	Two	One	One	One	Three	Two	One
Building Type/Use	Vacant Nursing Home	Nursing Home	Nursing Home	Skilled Nursing Facility	Skilled Nursing Facility	Assisted Living Building	Skilled Nursing Facility
Land Area (SF)	117,612	185,322	203,033	285,318	72,310	435,600	94,961
Land to Building Ratio	2.01	2.95	3.91	5.94	1.05	6.05	2.80
Condition of Property	Average	Average	Average	Average	Average	Average	Average
Sale Price	N/A	$ 2,300,000	$1,700,000	2,700,000	5,500,000	$ 3,200,000	$ 2,500,000
Price/SF	N/A	$ 36.66	$ 32.74	$ 56.17	$ 80.01	$ 44.44	$ 73.79
NOI	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cap Rate	N/A	N/A	N/A	N/A	N/A	N/A	N/A



DISCUSSION/ANALYSIS OF THE DATA

The following paragraphs summarize the basis for the adjustments to the sales and salient features of the comparable properties.

The following paragraphs explain how adjustments are typically computed.

Property Rights

This adjustment accounts for differences in the level of property rights transferred such as fee simple estates, leased fee estates and/or leasehold estates. Occasionally, an adjustment is made by buyers for specific tenants in leased fee properties or for lack of full

ownership in leasehold properties. The adjustment is typically market derived by reviewing differences in sale prices for similar properties with differing levels of property rights.

Financing Terms

Most sales are financed with interest rates and terms typical of what was available in the market place at the time of the respective sales. Most sales do not involve preferential financing and are considered to be cash equivalent transactions, with no adjustment for financing necessary. Occasionally, an adjustment is required for favorable financing terms. The adjustment is typically based on a calculation of the value of the favorable financing.

Conditions of Sale

Most sales are exposed to the open market and not considered to have been influenced by special motivating factors. Thus, adjustments are not made for conditions of sale. At times, however, a property may be sold in an extraordinary circumstance which can either positively or negatively affect the sales price (as is often the case when a property is purchased by an adjacent user). The adjustment is typically market derived by reviewing differences in sale prices for such properties as compared to the market.

Market Conditions

Sales are typically adjusted for time or market conditions. The market condition adjustments by analyzing the CoStar Commercial Repeat-Sale Indices (CCRSI) at the time the sales occurred.

Location

Where applicable, sales are adjusted for location, access and visibility. The location adjustment is based on the observed difference in sale prices for comparable buildings at differing locations as well as the relative difference in land values at differing locations.

Land-to-Building Ratio

Where applicable, sales are adjusted for land-to-building ratio. Typically, a larger land-to-building ratio is beneficial in that more land is available for expansion or larger parking areas. Conversely, a smaller land-to-building ratio is less attractive to buyers.

Age/Condition

The sales are adjusted for differences in age and condition. Buyers will pay a higher price for newer properties, versus older properties despite similar conditions. This is due to the lengthier remaining economic life of newer properties. This adjustment is also based on the observed condition of each comparable property. The comparables have been adjusted upward based on their actual age and accounting for any remodels of the properties prior to the sale of each property.

Construction Type/Quality

Where applicable, the sales are adjusted for differences in quality of construction and overall design. This adjustment accounts for differences in masonry, metal and wood construction as well as limited versus full service hotel costs and attributes. This adjustment also accounts for, where appropriate, differences in the overall quality of interior finish and exterior architecture. The quality of construction adjustment is based on the cost difference between varying construction types and levels of quality within that construction type.

Size

Size and value typically have an inverse relationship, with price per unit decreasing as the overall quantity increases. Typically, larger buildings sell at a lower unit price than smaller buildings. This adjustment is also generally based on the cost differences between buildings of varying sizes with the overall total cost per square foot decreasing as the size of the building increases. This adjustment is specifically based on review of the market.

Economic Factors

Sometimes it is necessary to adjust the comparables for economic factors which may affect their net operating income and the resulting sales prices. These factors may include such items as special revenue items or operating expenses.

Sale 1	
	
Property Identification	
Name	Former Skilled Nursing Facility
Address	2200 N. Flamingo Ave.
City, State	Bethany, OK, 73008
Parcel Number	R173800901
Property Description	
Building Type/Use	Nursing Home
Gross Building Area (SF)	62,746
Land Area (SF)	185,322
Year Built	1968
Buildings	One
Stories	One
Condition	Average
Land to Building Ratio	2.95
Sale Information	
Grantor	Alsco Investment 10, LLC
Grantee	ADP Properties, LTD
Sale Date	Feb-08
Document Number	10855-481
Property Rights Conveyed	Fee Simple
Sale Price	$2,300,000
Sale Price/SF	$36.66
Income Information	
Net Operating Income (NOI)	N/A
Sale Price	N/A
Capitalization Rate	N/A

Sale 1 is a former skilled nursing facility that was constructed in 1968 located in Bethany, Oklahoma. It contains a gross building area of 62,746 and is situated on an 185,322 square feet. It sold in February 2008 for $2,500,000 or $36.66 per square foot. This sale was overall considered inferior to the subject property. It was inferior to the subject property with regard to location, age and condition, and size. It was superior to the subject property with regard to market conditions (the overall real estate market declined since the date of the sale), land to building ratio, construction type/quality. After adjustments this sale reflected an adjusted price of $48.29 per square foot.

Sale 2	
	
Property Identification	
Name	Former Skilled Nursing Facility
Address	4301 Washington Ave.
City, State	Evansville, IN, 47714
Parcel Number	09-720-17-125-008
Property Description	
Building Type/Use	Nursing Home
Gross Building Area (SF)	51,924
Land Area (SF)	203,033
Year Built	1969
Buildings	One
Stories	One
Condition	Average
Land to Building Ratio	3.91
Sale Information	
Grantor	Trinity Village, LLC
Grantee	105218 Investments, LLC
Sale Date	Jan-10
Document Number	2010-103
Property Rights Conveyed	Fee Simple
Sale Price	$1,700,000
Sale Price/SF	$32.74
Income Information	
Net Operating Income (NOI)	N/A
Sale Price	$1,700,000
Capitalization Rate	N/A

Sale 2 is healthcare facility located in Evansville, IN. It contains 51,924 square feet and is situated on a 202,033 square foot site. It was constructed in 1969. It sold in January 2010 for $1,700,000 or $32.74 per square foot. This sale was overall considered inferior to the subject property. It was inferior to the subject property with regard to location and age/condition. It was superior to the subject property with regard to land to building ratio and construction type/quality. After adjustments this sale reflected an adjusted price of $39.94 per square foot.

Sale 3	
	
Property Identification	
Name	Former Madison Health Care Center
Address	7465 Madison Ave
City, State	Indianapolis, IN, 46227
Parcel Number	49-15-18-134-002.000-500
Property Description	
Building Type/Use	Skilled Nursing Facility
Gross Building Area (SF)	48,070
Land Area (SF)	285,318
Year Built	1989
Buildings	One
Stories	One
Condition	Average
Land to Building Ratio	5.94
Sale Information	
Grantor	Windsor Manor Healthcare Investors
Grantee	Ide Management Group
Sale Date	Oct-09
Document Number	116542
Property Rights Conveyed	Fee Simple
Sale Price	$2,700,000
Sale Price/SF	$56.17
Income Information	
Net Operating Income (NOI)	N/A
Sale Price	$2,700,000
Capitalization Rate	N/A

Sale 3 is a healthcare facility located in Indianapolis, Indiana. It contains 48,070 square feet and is situated on a 285,318 square foot site. It was constructed in 1989. It sold in October 2009 for $2,700,000 or $56.17 per square foot. This sale was overall considered superior to the subject property. It was inferior to the subject property with regard to location. It was superior to the subject property with regard to market conditions (the overall real estate market declined since the date of the sale), land to building ratio, age/condition, and construction type/quality. After adjustments this sale reflected an adjusted price of $48.49 per square foot.

Sale 4	
	
Property Identification	
Name	Former Darien Health Care Center
Address	599 Boston Post Rd
City, State	Darien, CT, 06820
Parcel Number	000014-000000-000033
Property Description	
Building Type/Use	Skilled Nursing Facility
Gross Building Area (SF)	68,741
Land Area (SF)	72,310
Year Built	1962
Buildings	One
Stories	2
Condition	Average
Land to Building Ratio	1.05
Sale Information	
Grantor	599 Boston Post Road LLC
Grantee	Darien Alf Property LLC
Sale Date	Aug-11
Document Number	1428-0135
Property Rights Conveyed	Fee Simple
Sale Price	$5,500,000
Sale Price/SF	$80.01
Income Information	
Net Operating Income (NOI)	N/A
Sale Price	$5,500,000
Capitalization Rate	N/A

Sale 4 is former skilled nursing facility constructed in 1962. It contains 68,741 square feet and is situated on a 72,310 square foot site. It sold in August 2011 for $5,500,000 or $96.49 per square foot. This sale was overall considered superior to the subject property. It was inferior to the subject property with regard to land to building ratio, age/condition, and size. It was superior to the subject property with regard to location. After adjustments this sale reflected an adjusted price of $72.81 per square foot.

Listing 1	
	
Property Identification	
Name	Former Marshall Manor
Address	8636 Anderson Ave.
City, State	Marshall, VA, 20115
Parcel Number	6969-57-1607-000
Property Description	
Building Type/Use	Assisted Living Building
Gross Building Area (SF)	72,000
Land Area (SF)	435,600
Year Built	1995
Buildings	One
Stories	Two
Condition	Average
Land to Building Ratio	6.05
Sale Information	
Grantor	The Cadle Company II, Inc.
Grantee	N/A (Listing)
Sale Date	Mar-12
Document Number	N/A
Property Rights Conveyed	Fee Simple
Sale Price	$3,200,000
Sale Price/SF	$44.44
Income Information	
Net Operating Income (NOI)	N/A
Sale Price	$3,200,000
Capitalization Rate	N/A

Listing 1 is former nursing facility located in Marshall, Virginia. It is currently listed for sale for $3,200,000. It is a 72,000 square foot facility built in 1995. It is situated on a 435,600 square foot site. The indicated listing price per square foot is $44.44. The sale was overall considered slightly inferior to the subject property. It required downward adjustments for conditions of sale, land to building ratio, age/condition, and construction type/quality. It was inferior to the subject property with regard to location and size. After adjustments, the sale indicates a price of $43.44 per square foot.

Listing 2	
	
Property Identification	
Name	Former Skilled Nursing Facility
Address	171 Rope Ferry Road
City, State	Waterford, CT, 06385
Parcel Number	000653-000000-000900
Property Description	
Building Type/Use	Skilled Nursing Facility
Gross Building Area (SF)	33,882
Land Area (SF)	94,961
Year Built	1940
Buildings	One
Stories	One
Condition	Average
Land to Building Ratio	2.80
Sale Information	
Grantor	N/A
Grantee	N/A (Listing)
Sale Date	Mar-12
Document Number	N/A
Property Rights Conveyed	Fee Simple
Sale Price	$2,500,000
Sale Price/SF	$73.79
Income Information	
Net Operating Income (NOI)	N/A
Sale Price	$2,500,000
Capitalization Rate	N/A

Listing 2 is former skilled nursing facility located in Waterford, Connecticut. It is currently listed for sale for $2,500,000. It is a 33,882 square foot facility built in 1940. It is situated on a 94,961 square foot site. The indicated listing price per square foot is $73.79. The sale was overall considered superior to the subject property. It required downward adjustments for conditions of sale, location, land to building ratio, construction type/quality and size. It was inferior to the subject property with regard to age/condition and was adjusted upward. After adjustments, the sale indicates a price of $57.70 per square foot.

Adjustment Grid

The following table summarizes the adjustments made to the comparable sales.

	Sale 1	Sale 2	Sale 3	Sale 4	Listing 1	Listing 2
Unadjusted Price/SF	**$ 36.66**	**$ 32.74**	**$ 56.17**	**$ 80.01**	**$ 44.44**	**$ 73.79**
Transactional Adjustments						
Property Rights	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Subtotal	*$ 36.66*	*$ 32.74*	*$ 56.17*	*$ 80.01*	*$ 44.44*	*$ 73.79*
Financing Terms	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Subtotal	*$ 36.66*	*$ 32.74*	*$ 56.17*	*$ 80.01*	*$ 44.44*	*$ 73.79*
Conditions of Sale	0.00%	0.00%	0.00%	0.00%	-15.00%	-15.00%
Subtotal	*$ 36.66*	*$ 32.74*	*$ 56.17*	*$ 80.01*	*$ 37.78*	*$ 62.72*
Expend. Immediately After Sale	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Subtotal	*$ 36.66*	*$ 32.74*	*$ 56.17*	*$ 80.01*	*$ 37.78*	*$ 62.72*
Market Conditions	-15.00%	0.00%	-3.00%	0.00%	0.00%	0.00%
Subtotal	*$ 31.16*	*$ 32.74*	*$ 54.48*	*$ 80.01*	*$ 37.78*	*$ 62.72*
Property Adjustments						
Location	40.00%	35.00%	20.00%	-50.00%	50.00%	-7.00%
Land to Building Ratio	-5.00%	-23.00%	-18.00%	25.00%	-16.00%	-10.00%
Age/Condition	23.00%	15.00%	-8.00%	15.00%	-15.00%	15.00%
Construction Type/Quality	-5.00%	-5.00%	-5.00%	0.00%	-5.00%	-5.00%
Size	2.00%	0.00%	0.00%	1.00%	1.00%	-1.00%
Economic Factors	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Subtotal	*55.00%*	*22.00%*	*-11.00%*	*-9.00%*	*15.00%*	*-8.00%*
Adjusted Price/SF	**$ 48.29**	**$ 39.94**	**$ 48.49**	**$ 72.81**	**$ 43.44**	**$ 57.70**

Source: CBIZ Valuation Group, LLC

CONCLUSION

Value Conclusion		
Minimum	$	39.94
Maximum	$	72.81
Average	$	51.78
Median	$	48.39
Concluded Price per Square Foot	**$**	**50.00**
Size		58,477
Value Conclusion	$	2,923,850
Total	$	2,923,850
Rounded	**$**	**2,900,000**

After adjustments the adjusted sale prices of the comparables range between $39.94 and $72.81 per square foot with an average and median of $51.78 and $48.39 per square foot. The concluded value of the subject property is $50.00 per square foot. When the concluded price per square foot is applied to the subject's total area of 58,477 square feet it indicates total value of $2,900,000 (rounded) on an "As Is" basis by the Sales Comparison Approach.

As discussed previously, the subject property is scheduled to undergo renovations upon closing of the sale. The Sales Comparison Approach analysis also entailed an analysis on an "As Complete" basis upon completion of renovations. The "As Complete" analysis is as of the expected date of completion of the renovations on November 1, 2012. The "As Complete" analysis utilizes the same sales previously discussed however, the effective age and size of the subject property is adjusted to reflect the condition of the subject upon completion of the renovations. Presented on the following page is a summary of the Sales Comparison Approach on an "As Complete" basis.

	Sale 1	Sale 2	Sale 3	Sale 4	Listing 1	Listing 2
Unadjusted Price/SF	**$ 36.66**	**$ 32.74**	**$ 56.17**	**$ 80.01**	**$ 44.44**	**$ 73.79**
Transactional Adjustments						
Property Rights	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Subtotal	*$ 36.66*	*$ 32.74*	*$ 56.17*	*$ 80.01*	*$ 44.44*	*$ 73.79*
Financing Terms	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Subtotal	*$ 36.66*	*$ 32.74*	*$ 56.17*	*$ 80.01*	*$ 44.44*	*$ 73.79*
Conditions of Sale	0.00%	0.00%	0.00%	0.00%	-15.00%	-15.00%
Subtotal	*$ 36.66*	*$ 32.74*	*$ 56.17*	*$ 80.01*	*$ 37.78*	*$ 62.72*
Expend. Immediately After Sale	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Subtotal	*$ 36.66*	*$ 32.74*	*$ 56.17*	*$ 80.01*	*$ 37.78*	*$ 62.72*
Market Conditions	-15.00%	0.00%	-3.00%	2.00%	0.00%	0.00%
Subtotal	*$ 31.16*	*$ 32.74*	*$ 54.48*	*$ 81.61*	*$ 37.78*	*$ 62.72*
Property Adjustments						
Location	40.00%	35.00%	20.00%	-50.00%	50.00%	-7.00%
Land to Building Ratio	-6.00%	-25.00%	-19.00%	25.00%	-16.00%	-12.00%
Age/Condition	45.00%	38.00%	15.00%	38.00%	8.00%	38.00%
Construction Type/Quality	-5.00%	-5.00%	-5.00%	0.00%	-5.00%	-5.00%
Size	0.00%	-2.00%	-2.00%	-1.00%	-1.00%	-3.00%
Economic Factors	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Subtotal	*74.00%*	*41.00%*	*9.00%*	*12.00%*	*36.00%*	*11.00%*
Adjusted Price/SF	**$ 54.21**	**$ 46.16**	**$ 59.39**	**$ 91.40**	**$ 51.38**	**$ 69.62**

Source: CBIZ Valuation Group, LLC

Value Conclusion		
Minimum	$	46.16
Maximum	$	91.40
Average	$	62.03
Median	$	56.80
Concluded Price per Square Foot	**$**	**62.00**
Size		63,427
Value Conclusion	$	3,932,474
Total	$	3,932,474
Rounded	**$**	**3,900,000**

After adjustments the adjusted sale prices of the comparables range between $46.16 and $91.40 per square foot with an average and median of $62.03 and $56.80 per square foot. The concluded value of the subject property is $62.00 per square foot. When the concluded price per square foot is applied to the subject's total area of 63,427 it indicates a total value of $3,900,000 on an "As Complete" basis by the Sales Comparison Approach.

INCOME APPROACH

The income approach is based on the principle that value is created by the expectation of future income. This approach is particularly applicable in the case of income-producing properties. One technique to convert income to value is direct capitalization. In this method, net operating income (NOI) is estimated based on deducting estimated operating expenses from effective gross income. The estimated NOI is capitalized into an indication of value using a market derived overall capitalization rate. Direct capitalization is typically most applicable in a stabilized environment in which a property has an income stream that is generally reflective of market rent patterns.

A second technique is the discounted cash flow analysis. The first step in this method is to estimate the annual cash flows for the subject during a typical holding period (usually ten years). The cash flows are based on projected NOI, less capital expenditures (tenant improvement allowances, leasing commissions, and other capital). In addition to the annual cash flows, the NOI from the reversion value expected to be received upon sale at the end of the holding period is estimated as an additional cash flow in the last year of the holding period. This estimate is based upon capitalizing the NOI in the year following the reversion year by an appropriate reversion capitalization rate, and deducting selling costs. The annual cash flows, plus the cash flow from the reversion, are converted to a present value by applying an annual discount rate.

As discussed previously, upon completion of the sale and renovations, the owner intends to enter into a lease to lease the property to a third party who will operate the facility. The proposed lease will be between Coal New Haven, LLC (the owner) and NR Connecticut, LLC (the tenant). The lease is expected to commence on November 1, 2011 for a 20 year term. The initial lease rate is $1,800,000 for the commencement year, and then increases to $2,000,000 in year 2 and $2,200,000 in year 3. Beginning in year 4 the rent will increase by 3% each year. The lease is a triple net lease whereby all expenses are the responsibility of the tenant except for a small management and administrative expense. There are no renewal options. Presented below is a summary of the lease terms.

Lease Summary	
Lessor	Coal New Haven, LLC
Lessee	NR Connecticut, LLC
Commencement Date	###############
Term (Years)	20
Options	None
Expiration Date	October 31, 2032
Valuation Date	###############
Year 1	$1,800,000
Year 2	$2,000,000
Year 3	$2,200,000
Year 4	$2,266,000
Year 5	$2,333,980
Year 6	$2,403,999
Year 7	$2,476,119
Year 8	$2,550,403
Year 9	$2,626,915
Year 10	$2,705,723
Year 11	$2,786,894
Year 12	$2,870,501
Year 13	$2,956,616
Year 14	$3,045,315
Year 15	$3,136,674
Year 16	$3,230,774
Year 17	$3,327,697
Year 18	$3,427,528
Year 19	$3,530,354
Year 20	$3,636,265
Net Rentable Area	58,477

The income capitalization approach in this report uses the discounted cash flow analysis method to estimate the leased fee value of the subject property. The discounted cash flow method is most appropriate when there are tenants with varying lease expirations or the properties are not at stabilized occupancy.

VACANCY AND COLLECTION LOSS

The subject property will be a single tenant property with a long term lease in place; consequently, no adjustment is made for vacancy and collection loss.

EXPENSE REIMBURSEMENTS

The subject has been analyzed on a NNN basis whereby the tenant would be responsible paying all expenses directly except for a minor management/administrative fee.

Management and Administration Expenses

Management and administration fees typically range from 1% to 5% of effective gross income. Due to the single tenant nature of the subject property, management and administration expenses were estimated at 2% of rent revenue.

DISCOUNTED CASH FLOW ANALYSIS

Presented below are the market assumptions used to derive the discounted cash flow analysis. It is followed by the cash flow projection and present value schedules.

Contract Rent

The lease contract indicates a stated rent of $1,800,000 for year 1, $2,000,000 for year 2, and $2,200,000 for year 3. Beginning in year 4 the rent will increase 3% per year until the expiration of the lease.

Expense Growth Rates

The management and administrative expense was projected at 2% of rental income.

Lease Terms

The initial lease is a 20 year lease with no renewal options.

Discount Rate

The discount rate was projected based on the most recent publications of the Korpacz Investor Survey for medical properties (medical office buildings), Realty Rates Health Care/Senior Housing and Korpacz Investor Survey National Net Lease rates. Presented below is a summary of these rates that were available as of the date of valuation.

Discount Rate Analysis

	Min	Max	Average
PWC 1stQ12 MOB Market (Non-Institutional)	8.00%	17.00%	11.57%
Realty Rates 1stQ12- Health Care/Senior Housing	8.03%	18.20%	13.62%
PWC 1stQ12 National net Lease Market	7.00%	9.00%	8.16%
		Concluded	**13.00%**

The discount rates vary from 7.00% to 18.20%. The average discount rate ranges from 8.16% to 13.62%. The subject property is somewhat of a unique property and does not have an operating history. For these reasons, a rate slightly above the average is considered appropriate. A discount rate of 13% was considered appropriate for the subject property.

Reversion Property Value

Upon expiration of the lease, the property is assumed to be sold based on the property value at the end of the lease. At the end of the 20 year lease, the subject property will have a physical age of nearly 65 years and while it will have been renovated in 2012, it is likely that the improvements will be at the end of their economic life. For these reasons, the estimated reversion value has been estimated based on the current land value grown at a 1% annual growth rate. The estimate land value and reversion is presented below. The estimated leased fee value using the discounted cash flow is presented after the land valuation analysis.

Sales Comparison – Land

	Subject	Sale 1	Listing 1	Listing 2	Listing 3
Location	915 Ella T. Grasso Boulevard	494 Quinnipiac Ave	271 Peck Ln	135 Sanford Street	1146-1154 Quinnipiac Ave
City	New Haven	New Haven	Orange	Hamden	New Haven
State	CT	CT, 06513	CT, 06477	CT, 06514	CT, 06513
Grantor	N/A	New Alliance Bank	N/A	Elm Street Builders Inc	Q Realty LLC
Grantee	N/A	Continuum of Care Inc.	Listing	Listing	Listing
Assessor's Parcel No.	342/0151/2500	Multiple	N/A	2628/041	Multiple
Date of Sale	Current	Feb-11	Mar-12	Mar-12	Mar-12
Recording Information	N/A	8656-0138	N/A	N/A	N/A
Conditions of Sale	Market Based	Foreclosure	Arms Length	Arms Length	Arms Length
Sale Price	N/A	$ 330,000	$ 1,299,000	$ 850,000	$ 419,000
Gross Size (SF)	117,612	76,230	174,240	119,790	158,123
$/SF	N/A	$ 4.33	$ 7.46	$ 7.10	$ 2.65
Gross Size (Acres)	2.70	1.75	4.00	2.75	3.63
$/Acre	N/A	$ 188,571	$ 324,750	$ 309,091	$ 115,427
Shape	Irregular	Rectangular	Irregular	N/A	Irregular
Frontage	450 Feet	N/A	N/A	N/A	N/A
Topography	Gen. Level	Level	Level	Level	Level
Zoning/Use	RM-1	Mixed	Residential	Multifamily	Residential

	Sale 1	Listing 1	Listing 2	Listing 3
Unadjusted Price/SF	**$4.33**	**$7.46**	**$7.10**	**$2.65**
Transactional Adjustments				
Property Rights	0.00%	0.00%	0.00%	0.00%
Subtotal	*$4.33*	*$7.46*	*$7.10*	*$2.65*
Financing Terms	0.00%	0.00%	0.00%	0.00%
Subtotal	*$4.33*	*$7.46*	*$7.10*	*$2.65*
Conditions of Sale	10.00%	-10.00%	-10.00%	-10.00%
Subtotal	*$4.76*	*$6.71*	*$6.39*	*$2.38*
Expend. Immediately After Sale	0.00%	0.00%	0.00%	5.00%
Subtotal	*$4.76*	*$6.71*	*$6.39*	*$2.50*
Market Conditions	0.00%	0.00%	0.00%	0.00%
Subtotal	*$4.76*	*$6.71*	*$6.39*	*$2.50*
Property Adjustments				
Location	0.00%	0.00%	20.00%	20.00%
Size	-4.00%	4.00%	0.00%	3.00%
Shape	0.00%	0.00%	0.00%	0.00%
Frontage	0.00%	0.00%	0.00%	0.00%
Topography	0.00%	0.00%	0.00%	0.00%
Availability of Utilities	0.00%	0.00%	0.00%	0.00%
Zoning/Use	0.00%	0.00%	0.00%	0.00%
Site Infastructure	0.00%	0.00%	0.00%	0.00%
Subtotal	*-4.00%*	*4.00%*	*20.00%*	*23.00%*
Adjusted Price/SF	**$ 4.57**	**$ 6.98**	**$ 7.66**	**$ 3.08**

Source: CBIZ Valuation Group, LLC

Residual Land Value Conclusion		
Minimum	$	3.08
Maximum	$	7.66
Average	$	5.57
Median	$	5.77
Concluded Price per Square Foot	$	5.60
Size		117,612
Value Conclusion	$	658,627
Growth @ 1.00% Annually		1.2202
Subtotal	$	803,650
Less: Demolition @ $3.71	$	(234,680)
Residual Value	$	568,970
Rounded	**$**	**570,000**

DCF

Lease Period (Yrs)	Period Starting	Period Ending	Period Rent	Expenses	NOI	Reversion	PV Factor	PV
1	11/1/2012	10/31/2013	$1,800,000	$36,000	$1,764,000	$0	0.8850	$1,561,140
2	11/1/2013	10/31/2014	$2,000,000	$40,000	$1,960,000	$0	0.7831	$1,534,876
3	11/1/2014	10/31/2015	$2,200,000	$44,000	$2,156,000	$0	0.6931	$1,494,324
4	11/1/2015	10/31/2016	$2,266,000	$45,320	$2,220,680	$0	0.6133	$1,361,943
5	11/1/2016	10/31/2017	$2,333,980	$46,680	$2,287,300	$0	0.5428	$1,241,547
6	11/1/2017	10/31/2018	$2,403,999	$48,080	$2,355,919	$0	0.4803	$1,131,548
7	11/1/2018	10/31/2019	$2,476,119	$49,522	$2,426,597	$0	0.4251	$1,031,546
8	11/1/2019	10/31/2020	$2,550,403	$51,008	$2,499,395	$0	0.3762	$940,272
9	11/1/2020	10/31/2021	$2,626,915	$52,538	$2,574,377	$0	0.3329	$857,010
10	11/1/2021	10/31/2022	$2,705,723	$54,114	$2,651,608	$0	0.2946	$781,164
11	11/1/2022	10/31/2023	$2,786,894	$55,738	$2,731,156	$0	0.2607	$712,012
12	11/1/2023	10/31/2024	$2,870,501	$57,410	$2,813,091	$0	0.2307	$648,980
13	11/1/2024	10/31/2025	$2,956,616	$59,132	$2,897,484	$0	0.2042	$591,666
14	11/1/2025	10/31/2026	$3,045,315	$60,906	$2,984,408	$0	0.1807	$539,283
15	11/1/2026	10/31/2027	$3,136,674	$62,733	$3,073,940	$0	0.1599	$491,523
16	11/1/2027	10/31/2028	$3,230,774	$64,615	$3,166,159	$0	0.1415	$448,011
17	11/1/2028	10/31/2029	$3,327,697	$66,554	$3,261,143	$0	0.1252	$408,295
18	11/1/2029	10/31/2030	$3,427,528	$68,551	$3,358,978	$0	0.1108	$372,175
19	11/1/1930	10/31/2031	$3,530,354	$70,607	$3,459,747	$0	0.0981	$339,401
20	11/1/1931	10/31/1932	$3,636,265	$72,725	$3,563,539	$570,000	0.0868	$358,791
						Total		$16,845,508
						Rounded		**$16,800,000**
						Per Sq. Ft.		$287.29

RECONCILIATION

The appraiser was engaged to form an opinion of the market value of the fee simple estate on an “As Is” and “As Complete” basis and the leased fee estate on an “As Complete” basis. In analyzing the fee simple estate “As Is” and “As Complete” and one approach, the Sales Approach was employed. The Income Approach discounted cash flow analysis was used to estimate the leased fee “As Complete” value.

The value conclusions based on each applicable approach are summarized below, subject to any hypothetical conditions and/or extraordinary assumptions.

Summary of Value Conclusions

	Fee Simple	Leased Fee
Cost Approach	Not Employed	Not Employed
Sales Comparision Approach "As Is"	$ 2,900,000	Not Employed
Sales Comparison Approach "As Complete"	$ 3,900,000	Not Employed
Income Approach "As Complete"	Not Employed	$ 16,800,000
Reconciled As Is Fee Simple and Leased Fee Value	**$ 2,900,000**	**Not Employed**
Reconciled As Complete/Stablized Fee Simple and Lease	**$ 3,900,000**	**$ 16,800,000**

In arriving at the fee simple final value conclusion, the applicable approaches to value were considered and employed to estimate the value of the subject’s fee simple estate.

Based on research and analyses contained in this report, our conclusion is that the market value of the fee simple estate on an “As Is” basis in the subject property as of March 27, 2012, is:

TWO MILLION NINE HUNDRED THOUSAND DOLLARS

$2,900,000

Based on research and analyses contained in this report, our conclusion is that the market value of the fee simple estate on an “As Complete” basis in the subject property as of November 1, 2012, is:

THREE MILLION NINE HUNDRED THOUSAND DOLLARS

$3,900,000

Based on research and analyses contained in this report, our conclusion is that the market value of the leased fee estate on an “As Complete” basis in the subject property as of November 1, 2012, is:

SIXTEEN MILLION EIGHT HUNDRED THOUSAND DOLLARS

$16,800,000

ASSUMPTIONS AND LIMITING CONDITIONS

This valuation by CBIZ Valuation Group, LLC ("CBIZ") is subject to and governed by the following Assumptions and Limiting Conditions and other terms, assumptions and conditions contained in the engagement letter.

1. Any legal description or plats reported herein are assumed to be accurate. Any sketches, surveys, plats, photographs, drawings or other exhibits are included only to assist the intended user to better understand and visualize the subject property, the environs, and the competitive data. We have made no survey of the property and assume no responsibility in connection with such matters.
2. The appraiser has not conducted any engineering or architectural surveys in connection with this appraisal assignment. Information reported pertaining to dimensions, sizes, and areas is either based on measurements taken by the appraiser or the appraiser's staff or was obtained or taken from referenced sources and is considered reliable. No responsibility is assumed for the costs of preparation or for arranging geotechnical engineering, architectural, or other types of studies, surveys, or inspections that require the expertise of a qualified professional.
3. No responsibility is assumed for matters legal in nature. Title is assumed to be good and marketable and in fee simple unless discussed otherwise in the report. The property is considered to be free and clear of existing liens, easements, restrictions, and encumbrances, except as noted.
4. Unless otherwise noted herein, it is assumed there are no encroachments or violations of any zoning or other regulations affecting the subject property and the utilization of the land and improvements is within the boundaries or property lines of the property described.
5. CBIZ Valuation Group, LLC assumes there are no private deed restrictions affecting the property which would limit the use of the subject property in any way.
6. It is assumed the subject property is not adversely affected by the potential of floods.
7. It is assumed all water and sewer facilities (existing and proposed) are or will be in good working order and are or will be of sufficient size to adequately serve any proposed buildings.
8. Unless otherwise noted within the report, the depiction of the physical condition of the improvements described herein is based on an on-site visual observation. No liability is assumed for the soundness of structural members since no engineering tests were conducted. No liability is assumed for the condition of mechanical equipment, plumbing, or electrical components, as complete tests were not made. No responsibility is assumed for

hidden, unapparent or masked property conditions or characteristics that were not clearly apparent during our on-site observation.

9. If building improvements are present on the site, no significant evidence of termite damage or infestation was observed during our on-site visual observation, unless so noted in the report. No termite inspection report was available, unless so noted in the report. No responsibility is assumed for hidden damages or infestation.
10. Any proposed or incomplete improvements included in this report are assumed to be satisfactorily completed in a workmanlike manner or will be thus completed within a reasonable length of time according to plans and specifications submitted.
11. No responsibility is assumed for hidden defects or for conformity to specific governmental requirements, such as fire, building, and safety, earthquake, or occupancy codes, except where specific professional or governmental inspections have been completed and reported in the appraisal report.
12. The property is assumed to be under financially sound, competent and aggressive ownership.
13. The appraisers assume no responsibility for any changes in economic or physical conditions which occur following the effective date of this report that would influence or potentially affect the analyses, opinions, or conclusions in the report. Any subsequent changes are beyond the scope of the report.
14. The value estimates reported herein apply to the entire property. Any proration or division of the total into fractional interests will invalidate the value estimates, unless such proration or division of interests is set forth in the report.
15. Any division of the land and improvement values estimated herein is applicable only under the program of utilization shown. These separate valuations are invalidated by any other application.
16. Unless otherwise noted in the report, only the real property is considered, so no consideration is given to the value of personal property or equipment located on the premises or the costs of moving or relocating such personal property or equipment.
17. Mark the appropriate box:
    - ☐ Unless otherwise stated, it is assumed ownership includes subsurface oil, gas, and other mineral rights. No opinion is expressed as to whether the property is subject to surface entry for their exploration or removal. The contributing value, if any, of these rights has not been separately identified.
    - ☒ Unless otherwise stated, it is assumed the rights of ownership exclude subsurface oil, gas, and/or mineral assets. For this reason, the contributing value, if any, of these

rights or whether the property is available for subsurface entry to facilitate their exploration and/or extraction have not been considered.

18. Any projections of income and expenses, including the reversion at time of resale, are not predictions of the future. Rather, they are our best estimate of current market thinking of what future trends will be. No warranty or representation is made that these projections will materialize. The real estate market is constantly fluctuating and changing. It is not the task of an appraiser to estimate the conditions of a future real estate market, but rather to reflect what the investment community envisions for the future in terms of expectations of growth in rental rates, expenses, and supply and demand.
19. Unless subsoil opinions based upon engineering core borings were furnished, it is assumed there are no subsoil defects present, which would impair development of the land to its maximum permitted use or would render it more or less valuable. No responsibility is assumed for such conditions or for engineering which may be required to discover them.
20. CBIZ Valuation Group, LLC representatives are not experts in determining the presence or absence of hazardous substances, defined as all hazardous or toxic materials, wastes, pollutants or contaminants (including, but not limited to, asbestos, PCB, UFFI, or other raw materials or chemicals) used in construction or otherwise present on the property. We assume no responsibility for the studies or analyses which would be required to determine the presence or absence of such substances or for loss as a result of the presence of such substances. Appraisers are not qualified to detect such substances. The client is urged to retain an expert in this field.
21. We are not experts in determining the habitat for protected or endangered species, including, but not limited to, animal or plant life (such as bald eagles, gophers, tortoises, etc.) that may be present on the property. We assume no responsibility for the studies or analyses which would be required to determine the presence or absence of such species or for loss as a result of the presence of such species.
22. No environmental impact studies were either requested or made in conjunction with this analysis. The appraiser hereby reserves the right to alter, amend, revise, or rescind any of the value opinions based upon any subsequent environmental impact studies, research, and investigation.
23. The appraisal is based on the premise that there is full compliance with all applicable federal, state, and local environmental regulations and laws unless otherwise stated in the report; further, that all applicable zoning, building, and use regulations and restrictions of all types have been complied with unless otherwise stated in the report; further, it is assumed that all required licenses, consents, permits, or other legislative or administrative

authority, local, state, federal and/or private entity or organization have been or can be obtained or renewed for any use considered in the value estimate.

24. Neither all nor any part of the contents of this report or copy thereof shall be conveyed to the public through advertising, public relations, news, sales, or any other media, without the prior written consent and approval of the appraisers. This limitation pertains to any valuation conclusions, the identity of the analyst or the firm and any reference to the professional organization of which the appraiser is affiliated or to the designations thereof.
25. Although the appraiser has made, insofar as is practical, every effort to verify as factual and true all information and data set forth in this report, no responsibility is assumed for the accuracy of any information furnished the appraiser either by the client or others. If for any reason, future investigations should prove any data to be in substantial variance with that presented in this report, the appraiser reserves the right to alter or change any or all analyses, opinions, or conclusions and/or estimates of value.
26. If this report has been prepared in a so-called “public non-disclosure” state, real estate sales prices and other data, such as rents, prices, and financing, are not a matter of public record. If this is such a “non-disclosure” state, although extensive effort has been expended to verify pertinent data with buyers, sellers, brokers, lenders, lessors, lessees, and other sources considered reliable, it has not always been possible to independently verify all significant facts. In these instances, the appraiser may have relied on verification obtained and reported by appraisers outside of our office. Also, as necessary, assumptions and adjustments have been made based on comparisons and analyses using data in the report and on interviews with market participants. It is suggested the client consider independent verification as a prerequisite to any transaction involving sale, lease, or other significant commitment of funds to the subject property.
27. This report is null and void if used in any connection with a real estate syndicate or syndication, defined as a general or limited partnership, joint venture, unincorporated association, or similar organization formed for or engaged in investment or gain from an interest in real property, including but not limited to a sale, exchange, trade, development, or lease of property on behalf of others or which is required to be registered with the U.S. Securities and Exchange Commission or any Federal or State Agency which regulates investments made as a public offering.
28. The American Disabilities Act of 1990 (ADA) sets strict and specific standards for handicapped access to and within most commercial and industrial buildings. Determination of compliance with these standards is beyond appraisal expertise and, therefore, has not been attempted by the appraisers. For purposes of this appraisal, we are assuming the building is in compliance; however, we recommend an architectural

inspection of the building to determine compliance or requirements for compliance. We assume no responsibility for the cost of such determination and our appraisal is subject to revision if the building is not in compliance.

29. This appraisal report has been prepared for the exclusive benefit of Coal New Haven, LLC. It may not be used or relied upon by any other party. Any party who uses or relies upon any information in this report, without the preparer's written consent, does so at their own risk.
30. Coal New Haven, LLC agrees to indemnify and hold harmless CBIZ Valuation Group, LLC and its affiliates, partners, agents, and employees from and against any losses, claims, damages, or liabilities, which may be asserted by any person or entity who may receive our report, except to the extent of any losses, claims, damages or liabilities (or actions in respect thereof) arising by reason of the gross negligence or willful misconduct of CBIZ Valuation Group, LLC in preparing the report and will reimburse CBIZ Valuation Group, LLC for all expenses (including counsel fees) as they are incurred by CBIZ Valuation Group, LLC in connection with investigating, preparing, or defending any such action or claim.
31. In any circumstance in which the foregoing indemnification is held by a court to be unavailable to CBIZ Valuation Group, LLC, Coal New Haven, LLC, and CBIZ Valuation Group, LLC shall contribute to any aggregate losses, claims, damages or liabilities (including the related fees and expenses) to which Coal New Haven, LLC and CBIZ Valuation Group, LLC may be subject in such proportion that CBIZ Valuation Group, LLC shall be responsible only for that portion represented by the percentage that the fees paid to CBIZ Valuation Group, LLC for the portion of its services or work product giving rise to the liability bears to the value of the transaction giving rise to such liability.
32. CBIZ Valuation Group, LLC has completed an on-site visual observation of the subject property which consisted of less than inspecting 100% of the interior and exterior of the improvements. Accordingly, CBIZ Valuation Group, LLC reserves the right to amend the appraised value and appraisal conclusions if engineering reports or other evidence is found, which would materially impact the reported conclusions.
33. The right is reserved by the appraiser to make adjustments to the analyses, opinions, and conclusions set forth in this report as may be required by consideration of additional or more reliable data that may become available. No change of this report shall be made by anyone other than the appraiser or appraisers. The appraiser(s) shall have no responsibility for any unauthorized change(s) to the report.
34. If the client instructions to the appraiser were to inspect only the exterior of the improvements in the appraisal process, the physical attributes of the property were

observed from the street(s) as of the observation date of the appraisal. Physical characteristics of the property were obtained from tax assessment records, available plans, if any, descriptive information, and interviewing the client and other knowledgeable persons. It is assumed the interior of the subject property is consistent with the exterior conditions as observed and that other information relied upon is accurate.

35. The submission of this report constitutes completion of the services authorized. It is submitted on the condition the client will provide reasonable notice and customary compensation, including expert witness fees, relating to any subsequent required attendance at conferences, depositions, and judicial or administrative proceedings. In the event the appraiser is subpoenaed for either an appearance or a request to produce documents, a best effort will be made to notify the client immediately. The client has the sole responsibility for obtaining a protective order, providing legal instruction not to appear with the appraisal report and related work files and will answer all questions pertaining to the assignment, the preparation of the report, and the reasoning used to formulate the estimate of value. Unless paid in whole or in part by the party issuing the subpoena or by another party of interest in the matter, the client is responsible for all unpaid fees resulting from the appearance or production of documents regardless of who orders the work.
36. Acceptance or use of this report constitutes agreement by the client and any other users that any liability for errors, omissions or judgment of the appraiser is limited to the amount of the fee charged for the appraisal.
37. Use of this appraisal report constitutes acknowledgement and acceptance of the general assumptions and limiting conditions, special assumptions (if any), extraordinary assumptions (if any), and hypothetical conditions (if any) on which this estimate of market value is based.
38. If provided, the estimated insurable value is included at the request of the client and has not been performed by a qualified insurance agent or risk management underwriter. This cost estimate should not be solely relied upon for insurable value purposes. The appraisers are not familiar with the definition of insurable value from the insurance provider, the local governmental underwriting regulations, or the types of insurance coverage available. These factors can impact cost estimates and are beyond the scope of the intended use of this appraisal. The appraisers are not cost experts in cost estimating for insurance purposes.

Special limiting conditions vary with each appraisal. They are classified as either extraordinary assumptions, or hypothetical conditions. The extraordinary conditions imposed on this appraisal are as follows:

1. The subject property is undergoing numerous renovations estimated at a cost of $1,713,278. It is assumed that these renovations are completed in the manner and quality as presented to us by management. Any change could have a material impact on the value conclusions contained in this report.

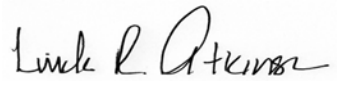
2. The Leased Fee Estate value conclusion assumes that the real estate lease between Coal New Haven, LLC. and NR Connecticut Associates, LLC commences on the date of closing of the transaction. Any change could have a material impact on the value conclusions contained in this report.

CERTIFICATION

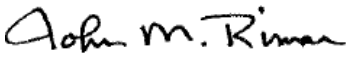
The signers of this appraisal report, do, by their signatures on this report, certify that to the best of their knowledge and belief:

- The statements of fact contained in this report are true and correct.
- The reported analyses, opinions, and conclusions are limited only by the reported assumptions and limiting conditions, and is our personal, impartial, and unbiased professional analyses, opinions and conclusions.
- We have no present or prospective interest in the property that is the subject of this report, and has no personal interest with respect to the parties involved.
- We have no bias with respect to the property that is the subject of this report or to the parties involved with assignment.
- Our engagement in this assignment was not contingent upon developing or reporting predetermined results.
- Our compensation is not contingent upon the reporting of a predetermined value or direction in value that favors the cause of the client, the amount of the value estimate, the attainment of a stipulated result, or the occurrence of a subsequent event.
- We have performed no services, as an appraiser or in any other capacity, regarding the property that is the subject of this report within the three-year period immediately preceding acceptance of this assignment.
- Our analyses, opinions and conclusions were developed, and this report has been prepared, in conformity with the Uniform Standards of Professional Appraisal Practice of the Appraisal Foundation and the requirements of the Code of Professional Ethics and Standards of Professional Appraisal Practice of the Appraisal Institute. In addition, this report conforms to the requirements of the Financial Institution Reform, Recovery and Enforcement Act (FIRREA).
- The use of this report is subject to the requirements of the Appraisal Institute relating to review by its duly authorized representatives.
- As of the date of this report, Linda R. Atkinson has completed requirements of the continuing education program of the Appraisal Institute.
- As of the date of this report, john M. Rimar has completed the Standards and Ethics Education Requirement of the Appraisal Institute for Associate Members.
- John M. Rimar has made a personal inspection of the property that is the subject of this report.
- Paul Douglass provided significant professional assistance to the persons signing this report.
- Linda R. Atkinson and John M. Rimar have extensive experience in the appraisal/review of similar property types.
- This appraisal assignment was not based on a requested minimum valuation, a specific valuation, or approval of a loan.

Respectfully submitted,
CBIZ Valuation Group, LLC

By: 

Linda R. Atkinson, MAI
Managing Director

By: 

John M. Rimar
Senior Manager
License Pending

Retreat
at South Connecticut

Attachment H

In response to CON application item 5e:

Floor plans

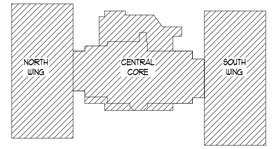


NORTH

1 PROPOSED FIRST FLOOR PLAN

SCALE: 3/32"=1'-0"

PATIENT ROOM :	NORTH WING:	35
	SOUTH WING:	44
		79 BEDS
DETOX ROOM :	CENTER SECTION:	26 BEDS
TOTAL:		105 BEDS



KEY PLAN

SCALE: N.T.S.

Salient architects
8 E. PALISADE AVE.
ENGLEWOOD, NJ 07631
T: 201-567-0032 F: 201-567-9556
www.salientassociates.com

MERK CONSTRUCTION INC.
"A Different Contracting Experience"

NOT FOR CONSTRUCTION

Charles J. Whelan, AIA
CT - 10239

CLIENT:
NR CONNECTICUT LLC

PROJECT:
915 ELLA T. GRASSO BLVD
NEW HAVEN, CT 06519

DWG. TITLE:
BUILDING PLANS

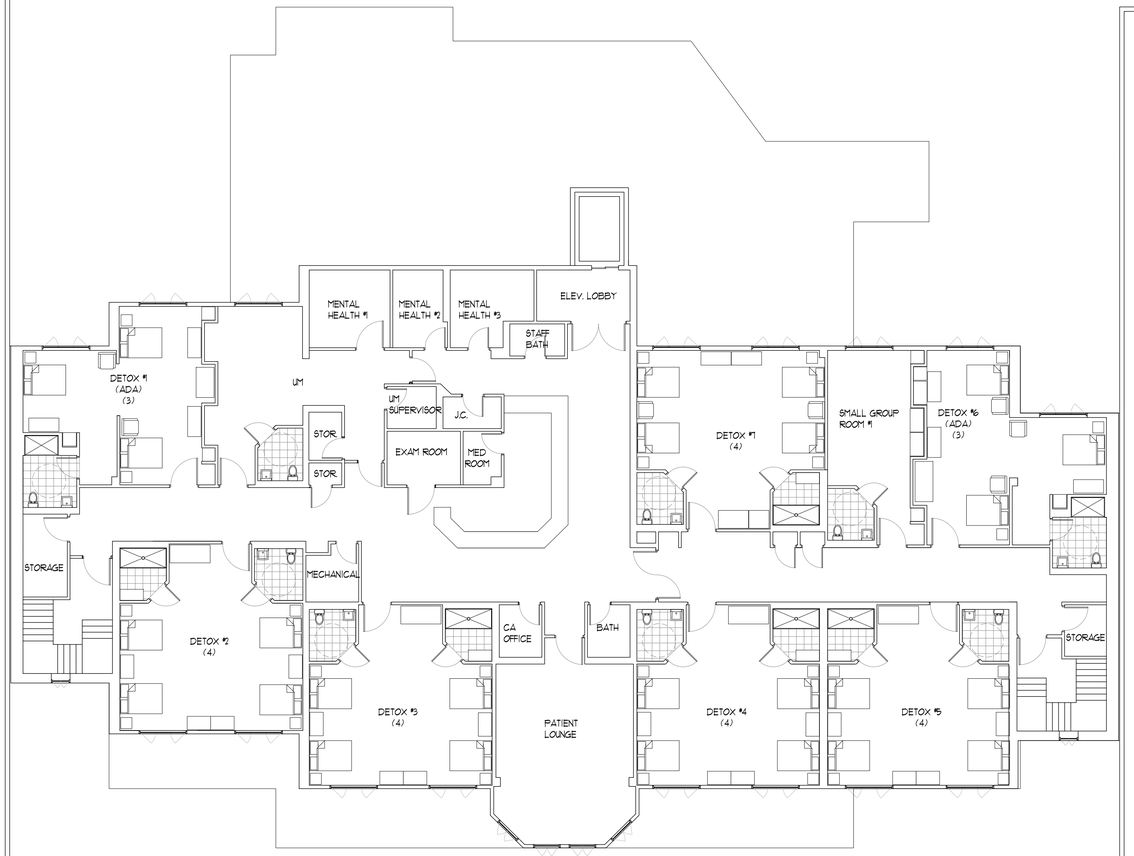
PROJECT NO:
RETREAT AT SOUTH CONNECTICUT

NO	DATE	DESCRIPTION	INT.
1	1/15/13	HEALTH DEPT. APPLICATION DWGS.	VFA

CHECKED BY:

SHEET NUMBER:
1 of 2

NYC DOB NUMBER / DWG NO.
A-1

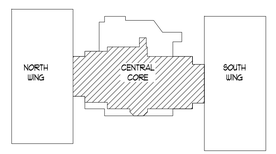


NORTH

1 PROPOSED SECOND FLOOR PLAN

SCALE: 3/32"=1'-0"

DETOX ROOMS: 26 BEDS



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CT - 10239

CLIENT:
NR CONNECTICUT LLC

PROJECT:
915 ELLA T. GRASSO BLVD
NEW HAVEN, CT 06519

DWG. TITLE:
BUILDING PLANS

PROJECT NO:
RETREAT AT SOUTH CONNECTICUT

NO	DATE	DESCRIPTION	INIT.
1	5/15/12	HEALTH DEPT. APPLICATION DWGS	VFA

CHECKED BY:

SHEET NUMBER:
2 of 2

NYC DOB NUMBER / DWG NO:
A-2



Attachment I

In response to CON application items 5e, 5f and 7:

Lease

***Please Note*: This document is included for multiple purposes. In particular, see Article 5 of the Lease regarding renovation financing, and startup capital.**

LEASE

BETWEEN

COAL NEW HAVEN, LLC

as Lessor

AND

NR CONNECTICUT, LLC

as Lessee

Dated: February 2, 2012

Premises: 915 Ella T. Grasso Blvd., New Haven, CT

INDEX

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EXHIBITS

A	Prmises
A-1	Rent
B	Memorandum of Lease
C	Work Letter
D	[Reserved]
E	Insurance Requirements
F.	[Reserved]
G.	Accounts Payable

LEASE

THIS LEASE (this "**Lease**") is made as of the 2nd day of February, 2012, between **COAL NEW HAVEN, LLC a Connecticut limited liability company**, as "Lessor", having an office for the conduct of business at 1100 Coney Island Avenue, Brooklyn, NY 11230, and **NR** CONNECTICUT, **LLC,** a Connecticut limited liability company, as "**Lessee**", having an office for the conduct of business at 915 Ella T. Grasso, Blvd., New Haven, CT.

WITNESSETH:

The parties hereto, for themselves, and their administrators, legal representatives, successors and permitted assigns, hereby covenant as follows:

ARTICLE A

CERTAIN LEASE PROVISIONS

1.	Address for the Premises:	915 Ella T. Grasso Blvd. New Haven, CT
2.	(a) Term:	Twenty (20) year(s) and _____ months, beginning on the Term Commencement Date and ending on the Term Expiration Date.
	(b) Term Commencement Date:	Rent shall commence on the Commencement Date.
	(c) Term Expiration Date:	Twenty years and ___ months after Term Commencement Date
3.	Rent for the Premises: Base Rent for the Premises shall be payable as follows:	Term: Rent shall be payable on the first day of each month as per Exhibit A-1 annexed hereto.
4.	Use of Premises:	Inpatient and outpatient substance abuse and addiction rehabilitation facility, and uses normally incident thereto ("Permitted Facility") for [redacted] 105 beds. As permitted
5.	Address for Notice: For Lessor:	**COAL NEW HAVEN, LLC** 1100 Coney Island Avenue, Brooklyn, NY Attention: David Silberstein
	For Lessee:	**NR CONNECTICUT, LLC** 915 Ella T. Grasso, Blvd., New Haven, CT Attention: Peter Schorr

ARTICLE B

CERTAIN DEFINITIONS

"**Affiliate**" means, with respect to any Person, any other Person (a) that directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, such Person; (b) that directly or indirectly beneficially owns or holds ten percent (10%) or more of any class of capital stock or other ownership interests of such Person having ordinary voting power to elect a majority of the board of directors (or similar governing body) of such Person (the "**Voting Stock**"); or (c) ten percent (10%) or more of the Voting Stock of which is directly or indirectly beneficially owned or held by the Person in question. As used in this definition, the term "control" means the possession, directly or indirectly, of the power to direct or cause direction of the management and policies of a Person, whether through the ownership of Voting Stock, by contract, or otherwise.

"**Alterations**" is defined in Section 5.4.

"**Bankruptcy Code**" means the provisions of 11 U.S.C. Section 101 et seq. or any statute of similar purpose or nature as more particularly set forth in Section 9.10.

"Base Rent" is defined in Article A, Section 3.

"**Building**" means any of the buildings, building equipment and Improvements now or hereafter erected on the Land, except Lessee's Personal Property.

"**Business Day**" is every day which CitiBank, N.A., based in New York, New York, is open for the ordinary conduct of business.

"**Claims**" is defined in Section 11.3.

"Commencement Date" is the date the Lessor grant Lessee possession of the Premises.

"**Default**" means an Event of Default or the occurrence of an event or condition which with notice or lapse of time or both would become an Event of Default.

"**Default Rate**" means the lesser of (i) four percent (4%) over the prime rate announced from time to time by Citibank, N.A. in New York, New York, as such prime reference rate may be adjusted and announced from time to time, or if unavailable, the parties shall use the prime reference rate of any New York regional bank selected by Lessor, or (ii) the applicable maximum lawful rate.

"**Deficiency**" is defined in Section 12.3(c).

"**Environmental Laws**" is defined in Section 18.10.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended, and all rules and regulations from time to time promulgated thereunder.

"**Event of Default**" is defined in Section 12.1.

"Facility" shall mean the skilled substance abuse and addiction rehabilitation facility operated on the Premises and from or at which health care services are provided.

"**Force Majeure**" is defined in Section 21.15.

"**GAAP**" means generally accepted accounting principles, applied on a "consistent basis", as set forth in Opinions of the Accounting Principles Board of the American Institute of Certified Public Accountants and/or in statements of the Financial Accounting Standards Board and/or their respective successors and which are applicable in the circumstances as of the date in question.

"**Governmental Authority**" means any nation or government, any state or political subdivision thereof, and any entity exercising executive, legislative, judicial, regulatory, or administrative functions of or pertaining to government.

"**Hazardous Substances**" is defined in Section 18.11.

"Health Care Licenses" shall mean all licenses, permits, accreditations, provider numbers, approvals, qualifications, certifications, and other authorizations granted by any Health Care Regulatory Agency or other governmental authority, accreditation organization or Third Party Payor relating to or affecting the residential and other health care facilities on the Premises, the ownership, operation, maintenance, management, use, regulation, development, expansion or construction thereof, the provision of health care services thereon, and/or the reimbursement of healthcare costs relating thereto.

"Health Care Regulatory Agency" shall mean all federal, state and local governmental and quasi-governmental agencies, boards, authorities and bodies and accreditation organizations having jurisdiction over the residential and other health care facilities on the Premises, the ownership, operation, maintenance, management, use, regulation, development, expansion or construction thereof, the provision of health care services thereon, the reimbursement of health care costs relating thereto, or which grant, issue or regulate any Health Care Licenses.

"**HHS**" is defined in Section 20(b).

"**Impositions**" is defined in Section 3.1.

"**Improvements**" means all Buildings and any other improvements now or hereafter erected on the Land.

"**Indemnified Parties**" is defined in Section 11.3.

"**Land**" means that certain real property described on **Exhibit A** attached hereto and incorporated herein by this reference.

"**Lessor**" is defined in the introductory paragraph to this Lease.

"**Lease**" means this Lease made between Lessor, as Lessor, and Lessee, as Lessee.

"**Lease Year**" is defined in Section 2.1(b).

"Leased Personal Property" means all of the inventory, furniture, fixtures (including trade fixtures), equipment, signs, telephone, telecommunications and other building systems and other personal property included with the Buildings on the Closing Date and any and all replacements thereof, whether purchased or placed in the Buildings by Lessor or Lessee.

"**Lien**" means any lien, mortgage, security interest, tax lien, pledge, charge, hypothecation, assignment, preference, priority, or other encumbrance of any kind or nature whatsoever (including, without limitation, any conditional sale or title retention agreement), whether arising by contract, operation of law, or otherwise.

"Lost Beds" is defined in Section 7.8.

"**Mortgage**" is defined in Section 3.2.

"**Mortgagee**" is defined in Section 3.2.

"**Non-Disturbance Agreement**" is defined in Section 10.1.

"Original Beds" is defined in Section 7.8.

"**Permitted Facility**" is defined in Article A, Section 4.

"**Person**" means any individual, corporation, limited liability company, business trust, association, company, partnership, joint venture, Governmental Authority, or other entity.

"**Premises**" means the Land, the Improvements, the Buildings and the Leased Personal Property.

"**Projections**" means, as to any Person, such Person's, forecasted consolidated balance sheets, profit and loss statements, cash flow statements, capitalization statements and budgets, all materially consistent with such Person's historical financial statements, together with appropriate supporting details and a statement of underlying assumptions.

"Reduction Percentage" is defined in Section 7.8.

"**Remedial Work**" is defined in Section 18.7.

."**Rent**" is defined in Section 2.3.

"**Requirements**" is defined in Section 11.1.

"**Restoration**" is defined in Section 7.1.

"**Retainage**" is defined in Section 7.2.

"**Subleases**" is defined in Section 9.7.

"**Subsidiary**" means a Person of which an aggregate of more than fifty percent (50%) or more of the capital stock or other ownership interests thereof is owned of record or beneficially by such other Person, or by one or more Subsidiaries of such other Person, or by such other Person and one or more Subsidiaries of such Person, (a) if the holders of such capital stock or other ownership interests (i) are ordinarily, in the absence of contingencies, entitled to vote for the election of a majority of the directors (or other individuals performing similar functions) of such Person, even though the right so to vote has been suspended by the happening of such a contingency, or (ii) are entitled, as such holders, to vote for the election of a majority of the directors (or individuals performing similar functions) of such Person, whether or not the right so to vote exists by reason of the happening of a contingency, or (b) in the case of capital stock or other ownership interests which are not issued by a corporation, if such ownership interests constitute a majority voting interest.

"**SubLessee**" is defined in Section 9.4.

"Supplementary Rent" is defined in Section 2.2

"**Taking**" means a taking of the Premises or any damage to the Premises related to the exercise of the power of eminent domain and including a voluntary conveyance to any agency, authority, public utility, person, or corporate entity empowered to condemn property in lieu of court proceedings.

"**Term**" is defined in Article A, Section 2(a).

"**Term Commencement Date**" is set forth in Article A, Section 2(b).

"**Term Expiration Date**" is defined in Article A, Section 2(c).

"Third Party Payor" shall mean Medicare, Medicaid, Tricare, commercial and private insurers, employee assistance programs, HMOs, preferred provider organizations and any other governmental or commercial organization which maintains a healthcare reimbursement program or policy.

"**Threshold Amount**" is defined in Section 5.4(h).

"**Transfer**" is defined in Section 9.1.

"Work" is defined in Section 5.5.

ARTICLE 1

PREMISES AND TERM; SERIES OF LEASES

Section 1.1. During the Term, Lessor, in consideration of the rents herein reserved and of the terms, provisions, covenants and agreements on the part of Lessee to be kept, observed and performed, does hereby lease and demise the Premises and all Personal Property of the Lessor unto Lessee, and Lessee does hereby hire and take the Premises and all Personal Property of the Lessor from Lessor, subject to each and every matter affecting title to the Premises, including, without limitation, all of the following which are in effect as of the Commencement Date: all easements, rights of way, covenants, conditions and restrictions, liens, encumbrances, encroachments, licenses, notices of pendency, charges, zoning laws, ordinances, regulations, building codes, Requirements and other governmental laws, rules and orders affecting the Premises, and other exceptions to Lessor's title, whether or not the same are of public record.

Section 1.2. Lessee shall lease the Premises for the Term, unless sooner terminated as hereinafter provided or pursuant to law.

Section 1.3. [Reserved]

Section 1.4. [Reserved]

Section 1.5. Leased Personal Property. This Lease and the "Premises" shall include the Leased Personal Property and all of Lessee's obligations under this Lease with respect to the Premises(including without limitation, the bond net lease provisions of Section 2.4 below) shall apply with the same force and effect to the Leased Personal Property. Upon any termination of the Lease, Lessor shall be entitled to possession of the Leased Personal Property on the same basis as provided herein with respect to the real property covered by this Lease. In the event that any of the Leased Personal Property is subject to an underlying lease or financing (collectively, "Personal Property Lease or Financing"), Lessee shall be exclusively responsible for payment of all rent, principal and interest and other charges and performance of all obligations and requirements of such Personal Property Lease or Financing. All such Leased Personal Property is provided "AS IS" and Lessor makes no representations, warranties or assurances relating thereto, or as to the completeness, condition, operation or suitability of the Leased Personal Property. Any listing of Leased Personal Property is for the benefit of the Lessor only, to identify such property as owned by Lessor and does not constitute a representation or warranty as to existence or completeness of any item of Leased Personal Property. In the event of any deficiency in the Leased Personal Property, or if any Leased Personal Property is missing, or upon the termination of any Personal Property Lease or Financing, this Lease shall continue in full force and effect and there shall be no reduction of rent or other obligations of Lessee hereunder, and such events shall not affect the joint and several obligations of Lessee and all other Lessees under all of the Leases as set forth in Section 1.3 above, which shall survive and remain in full force and effect. In the event that any Leased Personal Property requires replacement, maintenance, or upgrading, for any reason whatsoever, Lessee shall be obligated to provide for the same at its own cost and expense, Lessor shall have no obligations therefor and such replacement shall become Leased Personal Property.

ARTICLE 2

BASE RENT; SUPPLEMENTARY RENT; SECURITY DEPOSIT

Section 2.1. (a) Lessee shall pay to Lessor as Base Rent for the Premises during the Term the amounts stated in Article A, Section 3. Base Rent shall be payable in equal monthly installments in advance on the first day of each and every month during the Term, without previous demand notice or presentment therefor and without abatement, offset or deduction of any kind whatsoever, other than as expressly provided for herein. Notwithstanding the foregoing, Lessee shall pay the partial month's installment of Base Rent (with respect to the remaining days of the month in which the Commencement Date occurs) upon the Commencement Date of this Lease. If Lessee fails to pay any installment of Base Rent on or before the tenth day of the calendar month, Lessee shall owe Lessor, in addition to the installment of Base Rent, interest on such installment at the Default Rate.

(b) As used herein the term **"Lease Year"** means a period of 12 calendar months commencing on the first day of January of the year following the Commencement Date and ending on the day immediately preceding the first anniversary thereof.

Section 2.2. Lessee shall also pay and discharge, commencing on the Term Commencement Date, as supplementary rent (the **"Supplementary Rent"**) all other amounts, liabilities and obligations of whatsoever nature relating to the Premises, including, without limitation, all Impositions, those arising under any Requirements, easements, restrictions, or other similar agreements affecting the Premises or any adjoining property thereto, and all interest and penalties that may accrue thereon in the event of Lessee's failure to pay such amounts when due, and all damages, costs and expenses which Lessor may incur by reason of any Default of Lessee or failure on Lessee's part to comply with the terms of this Lease, all of which Lessee hereby agrees to pay within ten (10) days after written demand or as is otherwise provided herein. Upon any failure by Lessee to pay any of the Supplementary Rent, such unpaid Supplementary Rent shall accrue interest at the Default Rate and Lessor shall have all legal, equitable and contractual rights, powers and remedies provided either in this Lease or by statute, at law, in equity or otherwise in the case of nonpayment of the Base Rent. The term Supplementary Rent shall be deemed rent for all purposes hereunder other than with respect to Lessee's internal accounting procedures.

Section 2.3. All Base Rent and Supplementary Rent payable hereunder (collectively, **"Rent"**) shall be made payable to Lessor and sent to Lessor's address set forth in Article A, or to such other person or persons or at such other place as may be designated by written notice from Lessor to Lessee, from time to time, at least thirty (30) days in advance, and shall be made in United States currency which shall be legal tender for all debts, public and private. Lessor may opt to receive all Rent payable hereunder when due by wire transfer of immediately available funds to an account designated from time to time by Lessor; such option shall become effective five (5) Business Days after Lessor's written request. Notwithstanding the foregoing, Impositions shall be payable to the parties to whom they are due, except as otherwise provided herein.

Section 2.4. This Lease shall be deemed and construed to be a bond lease, absolutely net to Lessor, and Lessee shall pay to Lessor, absolutely net throughout the Term, the Rent, free of any charges, assessments, impositions or deductions of any kind and without abatement, deduction or set-off whatsoever, other than as expressly provided for herein. Under no circumstances or conditions, whether now existing or hereafter arising, or whether beyond the present contemplation of the parties, shall Lessor be expected or required to make any payment of any kind whatsoever or be under any other express or implied obligation or liability hereunder, except as herein otherwise expressly set forth in Section 3.5, and Lessee hereby waives any laws, statutes or other Requirements to the contrary. Lessee shall pay all costs, expenses and charges of every kind and nature relating to the Premises, including, without limitation, all taxes, costs of improvements, maintenance, repairs, alterations, additions, replacements, and insurance and other Impositions, except debt service on any Mortgage or any other indebtedness of Lessor, which may arise or become due or payable prior to, during or after (but attributable to a period falling prior to or within) the Term; *provided, however,* that Lessee's obligation to pay or fund any escrows, reserves, and other requirements imposed by any Mortgage. Lessee's obligation to pay Rent hereunder shall not terminate prior to the date defined herein for the expiration of the Term, notwithstanding the exercise by Lessor of any or all of its rights under Article 12 hereof or otherwise and, except as expressly provided for herein, the obligations of Lessee hereunder shall not be affected by reason of: any damage to or destruction of the Premises or any part thereof, any Taking of the Premises or any part thereof or interest therein by condemnation or otherwise, any prohibition, interruption, limitation, restriction or prevention of Lessee's use, occupancy or enjoyment of the Premises or any part thereof, or any interference with such use, occupancy or enjoyment by any person or for any reason, any matter affecting title to the Premises, any eviction by paramount title or otherwise, any default by Lessor hereunder, the impossibility, impracticability or illegality of performance by Lessor, Lessee or both, any action of any governmental authority, Lessee's acquisition of ownership of all or part of the Premises (unless this Lease shall be terminated by a writing signed by all Persons, including any Mortgagee, having an interest in the Premises), any breach of warranty or misrepresentation, or any other cause whether similar or dissimilar to the foregoing and whether or not Lessee shall have notice or knowledge thereof and whether or not such cause shall now be foreseeable. The parties intend that the obligations of Lessee under this Lease shall be separate and independent covenants and agreements and shall continue unaffected unless such obligations have been modified or terminated pursuant to an express provision of this Lease.

ARTICLE 3

IMPOSITIONS

Section 3.1. From and after the Commencement Date and throughout the Term, Lessee shall pay and discharge not later than thirty (30) days before any fine, penalty, interest or cost may be added thereto for the non-payment thereof, all taxes, assessments, water rents, storm and sewer rents and charges, duties, impositions, license and permit fees, assessments payable to any owner's association or similar entity, governmental levies and charges, charges for public utilities of any kind, together with any interest or penalties imposed upon the late payment thereof, which, pursuant to past, present or future law, during, prior to or after (but attributable to a period falling prior to or within) the Term, shall have been or shall be levied, charged, assessed, imposed upon or grow or become due and payable out of or for or have become a lien

on the Premises or any part thereof, any Improvements or personal property in or on the Premises, the Rents and income payable by Lessee or on account of any use of the Premises and such franchises as may be appurLessee to the use and occupation of the Premises (all of the foregoing being hereinafter referred to as "**Impositions**"); *provided, however,* that Lessee's obligation to pay or fund any escrows, reserves, and other requirements imposed by any Mortgage. Lessee, upon request from Lessor, shall submit to Lessor the proper and sufficient receipts or other evidence of payment and discharge of the same. The certificate, advice, or bill of non-payment of any Imposition from the appropriate official designated by law to make or issue the same or to receive payment of any Imposition shall be prima facia evidence that such Imposition is due and unpaid at the time of the making or issuance of such certificate, advice, or bill of non-payment. If any Impositions are not paid when due under this Lease, Lessor shall have the right, but shall not be obligated, to pay the same following written notice to Lessee of such payment, provided Lessee does not contest the same as herein provided. If Lessor shall make such payment, Lessor shall thereupon be entitled to repayment by Lessee on demand as Supplementary Rent hereunder.

Section 3.2. Lessee shall have the right to protest and contest any Impositions imposed against the Premises or any part thereof. If Lessee so elects to contest, Lessee shall, prior to the prosecution or defense of any such claim, notify Lessor in writing of its decision to pursue such contest and, to the extent procedurally required, or to prevent jeopardizing any license, permit or certification, including, without limitation, any Health Care License or Medicare and Medicaid certifications under Titles XVIII and XIX of the Social Security Act of 1935, as amended, because of nonpayment thereof, Lessee shall pay the amount in question prior to initiating the contest. Lessee's right to contest is conditioned upon the following: (i) such contest is done at Lessee's sole cost and expense, (ii) nonpayment will not subject the Premises or any part thereof to sale or other liability by reason of such nonpayment, (iii) such contest shall not subject Lessor or the holder (the "**Mortgagee**") of any mortgage or deed of trust (a "**Mortgage**") encumbering all or any part of the Premises to the risk of any criminal or civil liability, and (iv) Lessee shall provide such security as may reasonably be required by Lessor or any Mortgagee or under the terms of any Mortgage to ensure payment of such contested Imposition. Lessor agrees to execute and deliver to Lessee any and all documents reasonably required for such purpose and to cooperate with Lessee in every reasonable respect in such contest, but without any cost or expense to Lessor. If Lessor should actually receive proceeds of any such contest to the extent Lessee had paid in advance the amount in question, Lessor shall remit the same to Lessee. If Lessor owns the fee interest in the Premises, then at the request of the Lessor, or at Lessee's own initiative, Lessee may elect to take commercially reasonable steps to file and enforce tax certiorari proceedings to reduce tax affecting the Premises, all at Lessee's own expense; *provided, however,* that if Lessee shall decline to take such steps after a request by Lessor, Lessor may take such steps at Lessor's own expense.

Section 3.3. To the extent permitted by law, Lessee shall have the right to apply for the conversion of any Impositions to make the same payable in annual installments over a period of years, and upon such conversion Lessee shall pay and discharge said annual installments as they shall become due and payable but in any event before delinquency. Lessee shall pay all such deferred installments prior to the expiration or sooner termination of the Term, notwithstanding that such installments shall not then be due and payable; *provided, however,* that any Impositions (other than one converted by Lessee so as to be payable in annual installments as aforesaid)

relating to a fiscal period of the taxing authority, a part of which is included in a period of time after the Expiration Date, shall (whether or not such Impositions shall be assessed, levied, confirmed, imposed or become payable, during the Term) be prorated between Lessor and Lessee as of the Expiration Date, so that Lessor shall pay that portion of such Impositions which relate to that part of such fiscal period included in the period of time after the Expiration Date, and Lessee shall pay the remainder thereof.

Section 3.4. Lessee shall not be obligated to pay any franchise, excise, corporate, estate, inheritance, succession, capital, levy or transfer tax of Lessor or any income, profits or revenue tax upon the income of Lessor.

Section 3.5. In the event that Lessor is required pursuant to the terms of any Mortgage to make monthly or other tax escrow payments to any Mortgagee or if a Default shall occur, Lessee agrees that, within thirty (30) days after the first written demand made by Lessor, it shall: (i) deposit with Lessor or Mortgagee, within thirty (30) days after the first demand therefore and on the first day of each month thereafter until thirty (30) days prior to the date when the next installment of Impositions is due to the authority or other Person to whom the same is paid, an amount equal to said next installment of Impositions divided by the number of months over which such deposits are to be made; and (ii) thereafter during the Term deposit with Lessor or Mortgagee an amount each month estimated by Lessor or Mortgagee to be adequate to create a fund which, as each succeeding installment of Impositions becomes due, will be sufficient, thirty (30) days prior to such due date, to pay such installment in full. Lessor or Mortgagee shall use reasonable efforts to cause the monthly deposits to be equal in amount, but neither of them shall be liable in the event that such required deposits are unequal. If at any time the amount of any Imposition is increased or Lessor or Mortgagee believes that it will be, said monthly deposits shall be increased within five (5) Business Days after written demand by Lessor or Mortgagee so that, thirty (30) days prior to the due date for each installment of Impositions, there will be deposits on hand with Lessor or Mortgagee sufficient to pay such installments in full. To the extent permitted by applicable law, Lessor or Mortgagee shall not be required to deposit any such amounts in an interest bearing account. For the purpose of determining whether Lessor or Mortgagee has on hand sufficient moneys to pay any particular Imposition at least thirty (30) days prior to the due date therefor, deposits for each category of Imposition shall be treated separately, it being the intention that Lessor shall not be obligated to use moneys deposited for the payment of an item not yet due and payable to the payment of an item that is due and payable. Notwithstanding the foregoing, it is understood and agreed that (a) to the extent permitted by applicable law, deposits provided for hereunder may be held by Lessor or Mortgagee in a single bank account and commingled with other funds of Lessor or Mortgagee, and (b) Lessor or Mortgagee, may, if Lessee fails to make any deposit required hereunder, use deposits made for any one item for the payment of the same or any other item of Rent. If this Lease shall be terminated by reason of any Event of Default, all deposits then held by Lessor shall be applied by Lessor on account of any and all sums due under this Lease; if there is a resulting deficiency, Lessee shall pay the same, and if there is a surplus, Lessee shall be entitled to a refund of the surplus.

Section 3.6. If Lessor ceases to have any interest in the Premises, Lessor shall transfer to the person or entity who owns or acquires such interest in the Premises from Lessor and is the transferee of this Lease, the deposits made pursuant to Section 3.5 hereof relating to the Premises

covered by this Lease, subject, however, to the provisions thereof. Upon such transfer of the Premises and the deposits, the transferor shall be deemed to be released from all liability with respect thereto and Lessee agrees to look to the transferee solely with respect thereto, and the provisions hereof shall apply to each successive transfer of the said deposits.

Section 3.7. The provisions of this Article 3 shall survive the expiration or earlier termination of this Lease.

ARTICLE 4

USE AND OPERATION OF PREMISES, NET LEASE

Section 4.1. The Premises may be used and occupied only for the purposes set forth in Article A, Section 4. Lessee shall not create or suffer to exist any public or private nuisance, hazardous or illegal condition or waste on or with respect to the Premises. For purposes of this Article 4, "**waste**" as used herein, includes, but is not limited to, loss or threat of loss of: (i) any certification for participation in the fee reimbursement Program, (ii) any Health Care License, (iii) any certificate of need rights, or (iv) any governmental certification or license. This Article 4 shall survive the expiration or earlier termination of this Lease.

Section 4.2. It is the intention of the Lessor and the Lessee that this Lease is a triple net lease and that the Rent shall be paid by Lessee to Lessor throughout the term hereof, free of any expense, charge, or other deduction, except only as otherwise expressly provided for herein. Notwithstanding anything to the contrary contained in this Lease, Lessor shall have no obligation to furnish any services or systems to maintain or repair (including any and all structural or capital repairs), replace, or improve the premises or any portion thereof, whether required by any law or by any action or inaction of Lessee, its agents, employees, or invitees, or to make any payment hereunder, it being the express intention of the parties hereto that all such furnishing, maintenance, repair, replacement, and improvement shall be the sole responsibility of Lessee at Lessee's sole cost and expense

ARTICLE 5

CONDITION OF PREMISES, ALTERATIONS AND REPAIRS

Section 5.1 The parties acknowledge that Lessee has examined the Premises, is familiar with the physical condition, expenses, operation and maintenance, zoning, Requirements, status of title and use that may be made of the Premises and every other matter or thing affecting or related to the Premises, **and is leasing the same in its "As Is" condition. Lessor has not made and does not make any representations or warranties whatsoever with respect to the Premises or otherwise with respect to this Lease, express or implied, including any warranty regarding the suitability of the Premises for their intended commercial purposes.** Lessee assumes all risks resulting from any defects (patent or latent) in the Premises or from any failure of the same to comply with any Requirement or other governmental law or regulation applicable to the Premises or the uses or purposes for which the same may be occupied. Notwithstanding the foregoing, Lessor shall be obligated to provide Lessee, to be disbursed on

an approved budget and as agreed by the parties, with (a) a supplemental fund in an amount up to $500,000.00 for furniture and fixtures ("Fixtures Fund"), (b) a repair, renovations and leasehold improvements fund not to exceed $1,600,000.00 to be disbursed on an as incurred basis with 180 days after the Commencement Date, (c) a working capital fund of $1,500,000.00 (the "Working Capital Fund"), and (d) a start-up working capital Fund ("Start-Up Fund") of up to $1,000,000.00. All costs of repair, renovations and leasehold improvements fund exceeding $1,600,000.00, and a furniture and fixtures fund exceeding $500,000.00 shall be the sole obligation of the Lessee .

Section 5.2 At Lessee's sole cost and expense, whether or not Lessee is in occupancy of all of the Buildings, Lessee shall maintain and keep all of the Buildings on the Premises and the adjoining sidewalks, curbs, driveways and common areas, if any, clean and in at least the same level of condition and repair as on the Closing Date, free of accumulations of dirt, rubbish, snow and ice, and Lessee shall make all repairs and replacements, structural and non-structural, ordinary and extraordinary, foreseen and unforeseen, and shall perform all maintenance, necessary to maintain the Premises and any sidewalks, curbs, driveways and common areas in at least the same level of condition and repair as on the Closing Date. When used in this Section 5.2, the term **"repairs"** shall include all necessary or desirable additions, alterations, improvements, replacements, renewals and substitutions. All repairs made by Lessee shall be equal in quality and class to the original work and shall be made in compliance with all Requirements. Lessor shall not be required to furnish any services or facilities or to maintain or make any repairs or alterations to the Premises, and Lessee hereby assumes the full and sole responsibility for the condition, operation, repair, replacement, maintenance and management of the Premises and all costs and expenses incidental thereto, including adequate security for each of the Buildings, whether or not Lessee is then occupying each of the Buildings. Lessee shall have the roof inspected with reasonable frequency by an appropriate consultant reasonably acceptable to Lessor, at Lessee's expense. Lessee shall, at is sole cost and expense, repair, replace and maintain the roof in at least the same level of condition and repair as on the Closing Date. Notwithstanding the foregoing standard of maintaining the Premises in at least the same level of condition and repair as on the Closing Date, if the Requirements mandate a higher standard, then Lessee shall be obligated to cause the Premises to comply with such higher standard.

Section 5.3 Lessor shall not be responsible for the cost of any alterations or replacements of or maintenance or repairs to the Premises of any nature whatsoever, structural or non-structural, ordinary or extraordinary, foreseen or unforeseen, whether or not now in the contemplation of the parties. To the extent not prohibited by law, Lessee hereby waives and releases all rights now or hereinafter conferred by statute or otherwise which would have the effect of limiting or modifying any of the provisions of this Article 5.

Section 5.4 Lessee shall have the right at any time and from time to time during the Term to make, at its sole cost and expense, changes, alterations, additions or improvements (collectively, **"Alterations"**) in or to the Premises, subject, however, in each case to all of the following:

(a) No Alteration shall be undertaken except after thirty (30) days' prior written notice to Lessor, *provided that* no such notice shall be required with respect to (i) any

nonstructural Alteration involving an estimated cost of less than the Threshold Amount (as estimated by a licensed third party architect or contractor selected by Lessee and reasonably approved by Lessor) or (ii) any Alteration made by Lessee on an emergency basis, in which case Lessee shall notify Lessor in writing of such emergency Alteration as soon as practicable.

(b) No structural Alteration, and no other Alteration involving an estimated cost of more than the Threshold Amount (as estimated by a licensed third party architect or contractor selected by Lessee and reasonably approved by Lessor), shall be made without the prior written consent of Lessor, which consent may be withheld in Lessor's reasonable discretion.

(c) Any Alteration shall, when completed, be of such a character as not to reduce the value of the Premises (except for de minimus reductions) below its value immediately before such Alteration as determined by Lessor in its reasonable discretion.

(d) If, under the provisions of any Mortgage, the consent of the holder of such Mortgage shall be required for any such work or Alterations, the written consent of the holders of such Mortgages must be obtained before the commencement of any work.

(e) No Alteration shall be made by Lessee if the same would materially reduce the square footage of the Building being altered or weaken, temporarily or permanently, the structure of the Building being altered or any part thereof, or enable Lessee to conduct activity inconsistent with the limitations upon its use as stated in Article 4. For purposes of this subsection (e), a material reduction shall be deemed to mean a reduction of the square footage of the Building being altered of two percent (2%) or more; *provided, however,* that in the event such a material reduction of the square footage of the Building being altered is contemplated by Lessee, no such Alteration shall be made without Lessor's written consent, which consent may be withheld in Lessor's reasonable discretion.

(f) The reasonable cost and expense of Lessor's and Mortgagee's review of any plans and specifications required to be furnished to Lessor and Mortgagee pursuant to Section 5.5 hereof shall be paid by Lessee to Lessor, within thirty (30) days after written demand, or, at the option of Lessor, as Supplementary Rent. Such cost shall not exceed two (2%) percent of the projected Alteration project costs.

(g) The provisions and conditions of Section 5.5 shall apply to any work performed by Lessee under this Section 5.4.

(h) For purposes of Sections 5.4 and 5.5, the "**Threshold Amount**" shall mean, for each applicable Building per calendar year, an amount equal to $250,000 per Building.

(i) For purposes of Sections 5.4 and 5.5, notice of whether Lessor's consent has been given or withheld shall be delivered to Lessee within ten (10) Business Days following receipt of Lessee's written request (provided, however, that such time period shall be extended for a reasonable period in the event Lessor determines, in its reasonable discretion, that it is prudent to engage a third party to review the plans and specifications, if any, pertaining to such contemplated Alteration).

Section 5.6 Lessee agrees that all Alterations, repairs, Restoration and other work which Lessee shall be required or permitted to do under the provisions of this Lease (each hereinafter called the "**Work**") shall be at Lessee's sole cost and expense and (i) performed in a good, workmanlike manner, and in accordance with all Requirements, as well as any plans and specifications therefor which shall have been approved by Lessor (if such approval is required hereunder), (ii) commenced and completed promptly and (iii) done in all cases upon, in compliance with and subject to the terms of any Non-Disturbance Agreement and, to the extent not inconsistent with any term thereof, all of the following terms and conditions:

(j) If the Work shall involve (i) any structural repair, Alterations, Restoration or other Work, or (ii) more than the Threshold Amount (as estimated in writing by a licensed third party architect or contractor selected by Lessee and reasonably approved by Lessor), then the Work shall not be commenced until detailed plans and specifications (including layout, architectural, mechanical and structural drawings), prepared by a licensed architect reasonably satisfactory to Lessor shall have been submitted to and approved by Lessor, which approval may be withheld in Lessor's reasonable discretion.

(k) No Work costing more than the Threshold Amount shall be undertaken except under the supervision of a licensed architect or other appropriate design professional reasonably satisfactory to Lessor.

(l) All Work shall be commenced only after all required municipal and other governmental permits, authorizations and approvals shall have been obtained by Lessee, at its own cost and expense, and the originals or certified copies thereof delivered to Lessor. Lessor will, on Lessee's written request, execute any documents necessary to be signed by Lessor to obtain any such permits, authorizations and approvals, *provided that* Lessee shall discharge any expense or liability of Lessor in connection therewith.

(m) If the Work will cost more than $100,000 (as estimated in writing by a licensed third party architect or contractor selected by Lessee and reasonably approved by Lessor), it shall not be commenced until Lessee shall have obtained and delivered to Lessor, either (i) a performance bond and a labor and materials payment bond (issued by a corporate surety licensed to do business in the State in which the Premises are located and satisfactory to Lessor in its reasonable discretion), each in an amount equal to the estimated cost of such Work and in form otherwise satisfactory to Lessor in its reasonable discretion, or (ii) such other security or evidence of ability to pay the estimated cost of such Work as shall be satisfactory to Lessor in its reasonable discretion.

(n) The cost of all Work shall be paid promptly, in cash, so that the Premises and Lessee's leasehold estate therein shall at all times be free from (i) liens for labor or materials supplied or claimed to have been supplied to the Premises or Lessee, and (ii) chattel mortgages, conditional sales contracts, title retention agreements, security interests and agreements, and financing agreements and statements. Lessee shall, upon Lessor's request, provide Lessor evidence of such payment satisfactory to Lessor in Lessor's reasonable discretion, which evidence may include partial and final lien releases and waivers from any and all appropriate parties.

(o) At all times when any Work is in progress, Lessee shall maintain or cause to be maintained with such companies and for such periods as Lessor may require (i) worker's compensation insurance covering all persons employed in connection with the Work, in an amount at least equal to the minimum amount of such insurance required by law (with a waiver of subrogation satisfactory to Lessor in its sole and absolute discretion); and (ii) for the mutual protection of Lessor, Lessee and any Mortgagee, (1) builder's risk insurance, completed value form, covering all physical loss, in an amount satisfactory to Lessor in its sole and absolute discretion, and (2) commercial general liability insurance against all hazards, with limits for bodily injury or death to any one person, for bodily injury or death to any number of persons in respect of any one accident or occurrence, and for property damage in respect of one accident or occurrence in such amounts as Lessor in its reasonable discretion may require. Such commercial general liability insurance may be satisfied by the insurance required under Section 6.1(a), but may be effected by an endorsement, if obtainable, upon the insurance policy referred to in said Section. The provisions and conditions of Article 6 hereof shall apply to any insurance which Lessee shall be required to maintain or cause to be maintained under this subsection. All contractors, subcontractors, vendors, materialmen and others performing any Work on the Premises or providing any supplies or materials in connection with Work on the Premises must be licensed and qualified to perform such services and/or provide such supplies and shall be required to maintain insurance of each of the types set forth above in such amounts as Lessor in its sole and absolute discretion requires, naming Lessor and all Mortgagees as additional named insureds and Lessee shall obtain and supply to Lessor evidence of such required insurance.

(p) Upon completion of any Work, Lessee, at Lessee's expense, shall obtain certificates of final approval of such Work required by any governmental or quasi-governmental authority and shall furnish Lessor with copies thereof, together with (i) "as-built" plans and specifications for such Work (if the cost of such Work exceeds the Threshold Amount), and (ii) final lien waivers and releases from any and all appropriate parties.

(q) The conditions of Section 5.4 shall have been complied with, to the extent applicable to the Work.

Section 5.5 Following the delivery of prior reasonable notice, any Work shall be subject to inspection at reasonable times during normal business hours and without disruption to the business of Lessee, by Lessor, its architect and Mortgagee, or their duly authorized representatives, and if Lessor's architect or Mortgagee upon any such inspection shall be of the opinion that the Work is not being performed substantially in accordance with the provisions of this Article 5 or the plans and specifications, or that any of the materials or workmanship are not of good quality or are unsound or improper, Lessee shall correct any such failure and shall immediately replace any unsound or improper materials or workmanship.

Section 5.6 All fixtures, structures and other improvements (other than Lessee's Personal Property) installed in or upon the Premises at any time during the Term (except for Lessee's trade fixtures, furniture and equipment) shall become the property of Lessor and shall remain upon and be surrendered with the Premises. All property permitted or required to be removed by Lessee at the end of the Term remaining in the Premises after Lessee's removal shall be deemed abandoned and may, at the election of Lessor, either be retained as Lessor's property or may be removed from the Premises by Lessor at Lessee's expense. Lessee shall be responsible for, and

shall reimburse Lessor within ten (10) days after written demand therefor, any damage to the Premises caused in whole or in part by the removal or demolition of Lessee's fixtures, structures or other improvements which Lessee is required to remove pursuant to this Section 5.7 or which Lessee elects under the provisions of this Lease to remove. The provisions of this Section 5.7 shall survive the expiration or earlier termination of the Term.

Section 5.7 Compliance with Health Care Requirements. Notwithstanding any other provision of this Lease, Lessee shall be exclusively responsible at its own expense for determination and assurance that the condition of the Premises and the Facility and all repairs, Alterations and Work are in full compliance with all Requirements of Health Care Licenses and Health Care Regulatory Agencies and for obtaining any approvals or consents of Health Care Regulatory Agencies in connection with any Alterations or Work.

ARTICLE 6

INSURANCE TO BE COORDINATED WITH SUBLEASE and MANAGEMENT AGREEMENT

Section 6.1. Throughout the Term, Lessee shall, at its own cost and expense, provide and keep in force (subject to Section 6.9 permitting Lessor to provide property, fire and building insurance coverage at Lessee's expense), for the benefit of Lessor, Lessee and any Mortgagee:

(a) broad form commercial general liability insurance and professional liability insurance (including owner's protective liability coverage on operations of Lessee and/or Lessee's independent contractors engaged in construction, personal injury, and blanket contractual liability insurance) protecting and indemnifying Lessor, Lessee and any Mortgagee against all claims for damages to person or property or for loss of life or of property occurring upon, in, or about the Premises, written on a claims made or occurrence basis with claim limits as set forth on Exhibit E hereto. Such coverage shall contain endorsements: (i) deleting any liquor liability exclusion (if alcohol is sold on the Premises); (ii) including cross-liability; and (iii) waiving the insurer's rights of subrogation against Lessor for events of which Lessor is not, but Lessee is, covered; *provided, however,* that with regard to the requirements of waiver of subrogation against Lessor, Lessee shall utilize its best efforts to obtain such waiver in any insurance policy procured by Lessee, and if it cannot do so, Lessor shall have the right to procure, at Lessee's expense, an insurance policy containing such waiver if it can do so at the same or better price and on substantially the same terms and conditions;

(b) property insurance in Premises and all installations, additions and improvements which may now or hereafter be erected thereon against "ALL RISK" of loss or damage, including hurricane and flood coverage, in an amount sufficient to prevent Lessor and Lessee from becoming co-insurers and in any event in an amount not less than one hundred percent (100%) of the actual replacement value thereof (*i.e.,* including the cost of debris removal) as determined by Lessor in its reasonable discretion from time to time. Such coverage shall contain an agreed value endorsement reasonably acceptable to Lessor;

(c) business interruption insurance covering risk of loss due to the occurrence of any of the hazards covered by the insurance to be maintained by Lessee described in Section

6.1(b) with coverage in a face amount of not less than the aggregate amount, for a period of twelve (12) months following the insured-against peril, of 100% of all Rent (which includes all Impositions and other amounts specified in the definition of Rent) to be paid by Lessee under this Lease; such coverage shall contain an agreed value endorsement acceptable to Lessor;

(d) worker's compensation insurance (including employers' liability insurance), with a waiver of subrogation satisfactory to Lessor in its reasonable discretion, covering all persons employed at the Premises by Lessee to the extent required by the laws and statutes of the State in which the Premises are located, including, without limitation, during the course of work to the Premises; *provided, however,* that with regard to the requirements of waiver of subrogation against Lessor, Lessee shall utilize its best efforts to obtain such waiver in any insurance policy procured by Lessee, and if it cannot do so, Lessor shall have the right to procure, at Lessee's expense, an insurance policy containing such waiver if it can do so at the same or better price and on substantially the same terms and conditions;

(e) boiler insurance, if applicable, in an amount not less than one hundred percent (100%) of the actual replacement value thereof and of any improvements in which any such boiler is located (including the cost of debris removal but excluding foundations and excavations) as determined by Lessor in its reasonable discretion from time to time;

(f) if sprinkler systems are located in the Buildings, sprinkler leakage insurance in amounts approved by Lessor in its reasonable discretion; and

(g) Equipment coverage and elevator liability coverage, if applicable, in amounts approved by Lessor in its reasonable discretion.

Section 6.2. Whenever under the terms of this Lease Lessee is required to maintain insurance for the benefit of Lessor, (i) Lessor shall be an additional insured in all such liability insurance policies, and (ii) either Lessor or Mortgagee, as specified in Section 6.3, shall be named as loss payee in all such casualty insurance policies. In the event that the Premises shall be subject to a Mortgage, the commercial general liability insurance shall name the Mortgagee (together with any trustee or servicer therefor) as an additional insured and all other insurance provided hereunder shall name the Mortgagee as an additional insured or, as provided in Section 6.3, loss payee under a standard "non-contributory mortgagee" endorsement or its equivalent. All policies of insurance shall provide that such coverage shall be primary and that any insurance maintained separately by Lessor or the Mortgagee shall be excess insurance only. The original certificates (on Accord Form 27 or its equivalent in the case of casualty and on insurance company letterhead in the case of liability) and legible copies of the original policies (or binders therefor if the policies have not yet been prepared) shall be delivered to Lessor and any Mortgagee.

Section 6.3. The loss under all insurance policies insuring against property damage to the Buildings shall be payable to Mortgagee or, if there is none, to Lessor, subject to Section 7.2. All property insurance policies required by this Lease shall provide that all adjustments for claims with the insurers in excess of Fifty Thousand Dollars ($50,000.00) (exclusive of any deductible) shall be made with Lessor, Lessee and any Mortgagee. Subject to the terms of any

Mortgage, any adjustments for claims with the insurers involving sums of Fifty Thousand Dollars ($50,000.00) (exclusive of any deductible) or less shall be made with Lessor and Lessee.

Section 6.4. All of the above-mentioned insurance policies and/or certificates shall be obtained by Lessee and delivered to Lessor on or prior to the date hereof, and thereafter as provided for herein, and shall be written by insurance companies: (i) rated A- or better in "Best's Insurance Guide" (or any substitute guide acceptable to Lessor); (ii) authorized to do business in the state where the Premises are located; and (iii) of recognized responsibility and which are reasonably satisfactory to Lessor and any Mortgagee. Any deductible amounts under any property insurance policy hereunder shall not exceed $100,000 per occurrence and any deductible amounts under any liability insurance policy hereunder shall not exceed $100,000 per occurrence.

Section 6.5. At least five (5) days prior to the expiration of any policy or policies of such insurance, Lessee shall renew such insurance, by delivering to Lessor or Mortgagee, within the said period of time insurance binders evidencing the coverage described in this Article 6, and as promptly as practicable thereafter, the original policies or certificates of insurance, endorsed in accordance with Section 6.2 hereof, together with; *provided, however*, that if the Premises are owned in fee by the Lessor and subject to a Mortgage, Lessee shall utilize its best efforts to obtain such renewal and deliver original policies and certificates of insurance thirty (30) days prior to expiration of any policy of insurance. All coverage described in this Article 6 shall be endorsed to provide Lessor and Mortgagee with thirty (30) days' notice of cancellation or change in terms. If Lessee shall fail to procure the insurance required under this Article 6 in a timely fashion or to deliver such policies or certificates to Lessor, Lessor may, at its option and in addition to Lessor's other remedies for a Default by Lessee, upon written notice to Lessee, procure the same for the account of Lessee, and the cost thereof shall be immediately paid to Lessor as Additional Rent.

Section 6.6. Lessee shall not violate, in any material respect, any of the conditions of any of the said policies of insurance.

Section 6.7. Lessee shall not carry separate or additional insurance affecting the coverage described in this Article 6, concurrent in form and contributing in the event of any loss or damage to the Premises with any insurance required to be obtained by Lessee under this Lease, unless such separate or additional insurance shall comply with and conform to all of the provisions and conditions of this Article 6. Lessee shall promptly give notice to Lessor of such separate or additional insurance.

Section 6.8. The insurance required by this Lease, at the option of Lessee, may be effected by blanket and/or umbrella policies issued to Lessee covering the Premises and other properties owned or leased by Lessee, *provided that* the policies otherwise comply with the provisions of this Lease and allocate to the Premises the specified coverage, without possibility of reduction or coinsurance by reason of, or damage to, any other premises named therein, and if the insurance required by this Lease shall be effected by any such blanket or umbrella policies, Lessee shall furnish to Lessor or Mortgagee certified copies or duplicate originals of such policies in place of the originals, with schedules thereto attached showing the amount of insurance afforded by such policies applicable to the Premises.

Section 6.9. Lessor May Obtain Property Insurance at Lessee's Expense. Lessor may, in its sole discretion, designate that with respect to property, fire and related building insurance coverages as described in Sections 6(b), 6(e), 6(f) and 6(g) of this Lease, Lessor or Lessor's Affiliates may obtain some or all of such insurance coverages otherwise required to be obtained by Lessee under this Lease at the expense of Lessee, and in such event, Lessee shall pay to Lessor, as Supplementary Rent, the premiums and all other costs of such insurance, on a timely basis when required to be paid by Lessor. Such insurance which is obtained by Lessor or Lessor's Affiliates shall be at costs and on terms no less favorable than prevailing market terms for similar insurance available to Lessee, and shall offer customer service which is at least at the level otherwise available to Lessee on the date of this Lease. Lessor may cause such insurance which it obtains to be provided by or through an insurance carrier or insurance agency which is an Affiliate of Lessor.

ARTICLE 7

DAMAGE OR DESTRUCTION

Section 7.1. If the Premises or any Building or any part thereof shall be damaged or destroyed by fire or other casualty (including any casualty for which insurance was not obtained or obtainable) of any kind or nature, ordinary or extra-ordinary, foreseen or unforeseen, (a) Lessor shall pay over to Lessee, upon the terms set forth in Section 7.2, any moneys which may be recovered by Lessor from property insurance, (b) this Lease shall be unaffected thereby and shall continue in full force and effect, and (c) Lessee shall, only to the extent of the availability of and utilizing such insurance proceeds, expeditiously and in a good and workmanlike manner, cause such damage or destruction to be remedied or repaired (the "**Restoration**") by restoring the Premises to substantially the same condition and configuration immediately prior to such damage or destruction. All Restoration work shall be performed in accordance with the provisions of this Lease, including, without limitation, the provisions of Section 5.4 and 5.5 hereof. Lessee hereby waives the provisions of any law or statute to the contrary and agrees that the provisions of this Article 7 shall govern and control in lieu thereof. If Lessee shall fail or neglect to restore the Premises with reasonable diligence, or having so commenced such Restoration, shall fail to complete the same with reasonable diligence, or if prior to the completion of any such Restoration by Lessee, this Lease shall expire or be terminated for any reason, Lessor shall have the right, but not the obligation, to complete such Restoration at Lessee's cost and expense and the cost thereof shall be payable within five (5) days after written demand as Additional Rent, together with interest thereon from the date of demand until paid at the Default Rate. In addition, if Lessor so completes the Restoration as provided hereunder, Lessor shall be entitled to a reasonable supervisory fee from Lessee to compensate Lessor for administering the Restoration.

Section 7.2. Subject to the provisions of this Article 7, unless Lessor, the insurance carrier, or the holder of any Mortgage elects in their discretion to perform the Restoration (being under no obligation to do so), Lessor shall pay over to Lessee from time to time, upon the following terms, any moneys which may be received by Lessor from property insurance provided by Lessee but, in no event, to any extent or in any sum exceeding the amount actually collected by Lessor upon the loss; *provided, however,* that Lessor, before paying such moneys over to Lessee, shall be entitled to reimburse or pay itself therefrom to the extent, if any, of (i)

the expenses paid or incurred by Lessor in the collection of such moneys, and (ii) any other amounts then outstanding and owing to Lessor under this Lease. Lessor shall pay to Lessee, as herein provided, the aforesaid insurance proceeds which may be received by Lessor for the purpose of Restoration to be made by Lessee to restore the Premises to a value which shall be not less than a value substantially similar to the value of the Premises prior to such fire or other casualty. Prior to making any Restoration, Lessee shall furnish Lessor with an estimate of the cost of such Restoration, prepared by a licensed third party architect or contractor selected by Lessee and reasonably approved by Lessor. Such insurance moneys shall be paid to Lessee (or, at Lessor's option, directly to the party to whom such payment is due) from time to time thereafter in installments as the Restoration progresses, within five (5) business days after application to be submitted by Lessee to Lessor showing the cost of labor and material incorporated in the Restoration, or incorporated therein since the last previous application (assuming such proceeds are available from the insurer). If any vendor's, mechanic's, laborer's, or materialman's lien is filed against the Premises or any part thereof, or if any public improvement lien is created or permitted to be created by Lessee and is filed against Lessor, or any assets of, or funds appropriated to, Lessor, Lessee shall not be entitled to receive any further installment until such lien is satisfied or otherwise discharged, unless such lien is contested by Lessee in good faith and Lessee has obtained and delivered a bond issued by a surety, in an amount and in form otherwise satisfactory to Lessor in its reasonable discretion. The amount of any installment to be paid to Lessee shall be such proportion of the total insurance moneys received by Lessor as the cost of labor and materials theretofore incorporated by Lessee in the Restoration bears to the total estimated cost of the Restoration by Lessee, less (a) all payments theretofore made to Lessee out of said insurance proceeds, and (b) ten percent (10%) of the amount so determined (the "**Retainage**"). Notwithstanding the foregoing, Lessor shall not withhold the Retainage from any installment provided (i) such installment constitutes the final payment due a contractor or materialman, or (ii) the contractor is bonded and Lessee furnishes to Lessor payment and performance bonds and labor and material bonds of Lessee's contractor complying with the Requirements and otherwise satisfactory to Lessor in its reasonable discretion, naming Lessor as co-obligee, in which event Lessor shall withhold from such installment the same percentage withheld by Lessee pursuant to the construction contract. Upon completion of and payment for the Restoration by Lessee, including reimbursement to Lessee of the Retainage or other amount, as applicable, the balance of any and all insurance proceeds held by Lessor shall be paid to Lessee. In the event that the insurance proceeds are insufficient for the purpose of paying for the Restoration, Lessee shall nevertheless be required to make the Restoration and pay any additional sums required for the Restoration in accordance with the provisions of Section 7.4 hereof. Notwithstanding the foregoing, if Lessor makes the Restoration at Lessee's expense, as provided in Section 7.1 hereof, then Lessor shall use any amounts held by Lessor to pay for the cost of such Restoration.

Section 7.3. The following shall be conditions precedent to each payment made to Lessee (or to any other party) as provided in Section 7.2 above:

(a) there shall be submitted to Lessor the certificate of the aforesaid architect or contractor stating (i) that the sum then requested to be withdrawn either has been paid by Lessee and/or is justly due to contractors, subcontractors, materialmen, engineers, architects or other persons (whose names and addresses shall be stated) who have rendered or furnished certain services or materials for the work and giving a brief description of such services and

materials and the principal subdivisions or categories thereof and the several amounts so paid or due to each of such persons in respect thereof, and stating in reasonable detail the progress of the work up to the date of said certificate, (ii) that no part of such expenditures has been or is being made the basis, in any previous or then pending request, for the withdrawal of insurance money or has been made out of the proceeds of insurance received by Lessee, (iii) that the sum then requested does not exceed the value of the services and materials described in the certificate, and (iv) that the balance of any insurance proceeds held by Lessor, together with such other sums, if any, which Lessee has made or will (for which evidence of Lessee's intention and ability shall be to Lessor's satisfaction in its sole and absolute discretion) make available for the Restoration in accordance with Section 7.4 hereof and to Lessor's satisfaction (in its sole and absolute discretion) will be sufficient upon completion of the Restoration to pay for the same in full, and stating in reasonable detail an estimate of the cost of such completion;

(b) there shall be furnished to Lessor an official search, or a certificate of a title insurance company satisfactory to Lessor in its sole and absolute discretion, or other evidence satisfactory to Lessor in its sole and absolute discretion, showing that there has not been filed any vendor's, mechanic's, laborer's or materialman's statutory or other similar lien affecting the Premises or any part thereof, or any public improvement lien created or permitted to be created by Lessee affecting Lessor, or the assets of, or funds appropriated to, Lessor, which has not been discharged of record, except such as will be discharged upon payment of the amount then requested to be withdrawn, or unless any such lien is contested by Lessee in good faith and Lessee has obtained and delivered a bond issued by a surety, in an amount and in form otherwise satisfactory to Lessor in its sole and absolute discretion; and

(c) at the time of making such payment, no Default shall have occurred and be continuing.

Section 7.4. If the estimated cost of any Restoration, determined as provided in Section 7.2 hereof, exceeds the net insurance proceeds by an amount equal to or greater than $250,000, then, prior to the commencement of any Restoration, Lessee hereby covenants to deposit with Lessor a bond, cash or other security satisfactory to Lessor (in its sole and absolute discretion) in the amount of such excess, to be held and applied by Lessor in accordance with the provisions of Section 7.2 hereof, as security for the completion of the work, free of public improvement, vendors', mechanics', laborers' or materialmen's statutory or other similar liens.

Section 7.5. As material consideration to Lessor for its agreement to enter into this Lease, the parties agree that subject to Section 7.7 and 7.8 this Lease shall not terminate or be forfeited or be affected in any manner, and there shall be no reduction or abatement of the Rent payable hereunder, by reason of damage to or total, substantial or partial destruction of the Premises or any part thereof or by reason of the unLesseeability of the same or any part thereof, for or due to any damage or destruction of the Premises from any cause whatsoever, and, notwithstanding any law or statute, present or future, Lessee waives any and all rights to quit or surrender the Premises or any part thereof on account of any damage or destruction of the Premises. Lessee expressly agrees that its obligations hereunder, including the payment of Rent payable by Lessee hereunder, shall continue as though the Premises had not been damaged or destroyed and without abatement, suspension, diminution or reduction of any kind.

Section 7.6. Any different procedure for the Restoration of the Premises which may be required under any Mortgage shall take precedence over and be in lieu of any contrary procedure provided for in this Lease.

Section 7.7. Rent Abatement under Certain Circumstances of Destruction. If there has been damage to the physical plant of the Premises such that Lessee is not able to operate the facility as a Permitted Facility, Lessee shall be obligated to proceed with a Restoration in accordance with the requirements of this Article VII, *provided, however,* Lessee shall be entitled to (a) a complete abatement of the Base Rent under this Lease during the period of Restoration and until the Facility is certified for acceptance of patients or residents, as applicable ("Recertification Date"), *provided that* Lessee is diligently proceeding to complete the Restoration in accordance with this Article VII and to obtain such certification and (b) a partial abatement of Base Rent under this Lease during the one year period following the Recertification Date(the "Ramp Up Year"), under which the Base Rent shall increase, in each month, by 1/12 of the Base Rent otherwise in effect at such time, such that on completion of the Ramp Up Year, the full Base Rent is being paid by Lessee. If there is an Event of Default under this Lease, Lessee shall not be entitled to any abatement of rent under this Section 7.7.

ARTICLE 8

CONDEMNATION

Section 8.1. Lessee, immediately upon obtaining knowledge of the institution of any proceeding for a Taking, shall notify Lessor and Mortgagee thereof and Lessor and Mortgagee shall be entitled to participate in any Taking proceeding. Subject to the provisions of this Article 8, Lessee hereby irrevocably assigns to Mortgagee or to Lessor, in that order, any award or payment to which Lessee is or may be entitled by reason of any Taking, whether the same shall be paid or payable for Lessee's leasehold interest hereunder or otherwise.

Section 8.2. If the whole of the Premises shall be permanently subject to a Taking such that the Lessee is not able to operate the facility for the purposes utilized prior to any notice of taking, then on the earlier of the date of the vesting of title to the Premises or the date of taking of possession of the Premises (the "Ending Date"): (i) this Lease shall terminate, (ii) all Rent required to be paid by Lessee under this Lease shall be pro-rated up to such date, (iii) Lessor shall be entitled to any and all awards in connection with such condemnation on account of Lessor's fee simple interest in the Land and the Buildings, with such proceeds going first to pay any outstanding amounts owed to Mortgagee, (iv) Lessee shall be entitled to receive any and all awards on account of Lessee's Personal Property, moving expenses and interruption of or damage to Lessee's business, with such proceeds going first to pay any outstanding amounts owed to Mortgagee, (v) with respect to any award or payment on account of the value of the leasehold interest represented by this Lease, (a) in the event this Lease is deemed by the applicable condemning authority to be an above market lease to the economic benefit of Lessor, Lessor shall be entitled to receive any and all awards or payments on account of the leasehold interest represented by this Lease, and (b) in the event this Lease is deemed by the applicable condemning authority to be a below market lease to the economic benefit of Lessee, Lessee shall be entitled to receive any and all awards or payments on account of the leasehold interest represented by this Lease; *provided, however,* in either such event, such proceeds shall first go to

pay any outstanding amounts owed to Mortgagee. Upon such termination, this Lease shall be of no further force and effect, except that any obligation or liability of either party, actual or contingent, under this Lease which has accrued on or prior to such termination date or which is expressly designated to survive termination shall survive and any prepayment of Rent shall be prorated between the parties.

Section 8.3. In the event of a permanent partial Taking of one or more of the Buildings, in which the portion of the premises taken is such that the Lessee may continue to operate the facility as a Permitted Facility, this Lease shall be unaffected by such Taking, and Lessee shall, subject to Section 8.3(iii), continue to pay the Base Rent and Supplementary Rent pursuant to Article 2, and the following shall apply:

(i) Lessor shall be entitled to receive the entire award in any proceeding with respect to such Taking without deduction therefrom for any estate vested in Lessee by this Lease and Lessee shall receive no part of such award;

(ii) Notwithstanding the foregoing, in the event this Section 8.3 is applicable, Lessor shall pay over to Lessee from time to time any moneys which may be received by Lessor on account of exercise of the power of eminent domain with respect to the Premises, which are (x) necessary for Lessee to repair and restore the Premises such that the remaining portion of the facility may continue to be operated by Lessee as a Permitted Facility, (y) represent an award for the loss of Lessee's Personal Property, moving expenses and interruption of or damage to Lessee's business; *provided, however,* that Lessor, before paying such moneys over to Lessee, shall be entitled to reimburse or pay itself therefrom to the extent, if any, of (i) the reasonable expenses paid or incurred by Lessor in the collection of such moneys, and (ii) any other amounts then outstanding and owing to Lessor under this Lease. Such moneys shall be paid over to Lessee on the terms and subject to the conditions set forth in Article 7, as if, for this purpose, such moneys were insurance proceeds resulting from casualty to the Premises. Lessee agrees to undertake such Restoration on such terms and subject to such conditions; to the extent of the availability of such proceeds.

Section 8.4. If only unimproved land shall be the subject of a Taking and Sections 8.2 and 8.3 do not apply, this Lease shall be unaffected by such Taking, and Lessee shall continue to pay the Base Rent and Supplementary Rent pursuant to Article 2, and Lessor shall be entitled to receive the entire award in any proceeding with respect to such Taking without deduction therefrom for any estate vested in Lessee by this Lease and Lessee shall receive no part of such award.

Section 8.5. If the use or occupancy of all or any part of the Premises shall be the subject of a temporary Taking during the Term of this Lease, Lessee shall be entitled, except as hereinafter set forth, to receive that portion of the award for such temporary Taking which represents compensation for the use and occupancy of the Premises and, if so awarded, for the temporary Taking of Lessee's Personal Property and for moving expenses, and that portion which represents reimbursement for the cost of Restoration of the Premises. This Lease shall be and remain unaffected by such temporary Taking and Lessee shall be responsible for all obligations hereunder not affected by such temporary Taking and shall continue to pay in full when due the Base Rent and Supplementary Rent and all other sums required to be paid by

Lessee pursuant to the provisions of this Lease. If the period of temporary use or occupancy shall extend beyond the Expiration Date, that part of the award which represents compensation for the use or occupancy of the Premises (or a part thereof) shall be divided between Lessor and Lessee so that Lessee shall receive so much thereof as represents the period to and including the Expiration Date and Lessor shall receive so much as represents the period subsequent to the Expiration Date and Lessor shall be entitled to receive that portion which represents reimbursement for the cost of Restoration of the Premises. All moneys received by Lessee as, or as part of, an award for temporary use and occupancy for a period beyond the date to which the sums to be paid by Lessee hereunder have been paid by Lessee shall be received, held and applied by Lessee as a trust fund for payment of all sums payable by Lessee hereunder.

Section 8.6. Each party agrees to execute and deliver to each other and to applicable governmental authorities all documents and instruments that may be required to effectuate the provisions of this Article VIII.

ARTICLE 9

ASSIGNMENT AND SUBLETTING

Section 9.1. Lessee shall not directly or indirectly (i) sell, assign, sublease or otherwise transfer, directly or indirectly, this Lease, all or any portion of Lessee's estate or interest in this Lease or the Premises, (ii) permit any assignment of this Lease or any estate or interest therein by operation of law, (iii) grant any sublease, license, concession, or other right of occupancy of all or any portion of the Premises, (iv) permit the use of the Premises by any parties other than Lessee, (v) mortgage, encumber, pledge, grant a security interest in, collaterally assign or conditionally transfer this Lease or any Leased Personal Property incorporated in or used in connection with the Premises or any Subleases or any of the rents, issues and profits from a sublease operator or any other commercial sublessee or Lessee's estate or interest in the Premises or (vi) any sale or transfer of capital stock, membership interests, partnership interests, trust units, or any other equity interest in Lessee (collectively, a "**Transfer**"), without Lessor's prior written consent, which consent may be granted or withheld in Lessor's sole and absolute discretion. For purposes of this Article 9, the terms "**control**" or "**controls**" shall mean possession, direct or indirect, of the power to direct or to cause the direction of, the management and policies of any person or entity, whether through the ownership of voting securities, or partnership interest, by contract or otherwise. Any attempted Transfer in violation of the terms and covenants of this Section 9.1 shall be void. Notwithstanding the foregoing, the consent of Lessor shall not be required to any Transfer to any other direct or indirect subsidiary or parent of Lessee, so long as the transferee is 100% directly or indirectly owned and controlled by National Rehabilitation Associates, LLC (collectively referred to as a "Subsidiary Transfer"). If Lessor consents in writing to a Transfer, or if a Subsidiary Transfer is made, (1) Lessee shall nevertheless at all times remain fully responsible and liable for payment of the Rent and for compliance with all of Lessee's other duties, obligations and covenants under this Lease, (2) the transferee shall be required to execute and deliver an assumption of all obligations of the Lessee hereunder, pursuant to an instrument satisfactory to Lessor, and (3) the Transfer shall be conditioned upon obtaining and securing all necessary Health Care Licenses.

Section 9.2. If Lessee requests Lessor's consent to a Transfer, Lessor shall be given not less than thirty (30) days' advance written notice of the proposed Transfer, which notice shall be delivered to Lessor together with (i) a true and complete copy of the proposed instrument(s) of the Transfer, and (ii) such other information and documents as Lessor may request in its sole and absolute discretion. No Transfer may be proposed or consummated during the continuance of a Default or an Event of Default.

Section 9.3. Any consent by Lessor under this Article 9 shall apply only to the specific transaction thereby authorized and shall not relieve Lessee from the requirement of obtaining the prior written consent of Lessor to any further Transfer of this Lease. No Transfer of all or a portion of this Lease shall release or relieve the original named Lessee (or any previously approved transferee) from any obligations of the Lessee hereunder, and the original named Lessee (or any previously approved transferee) shall remain liable for the performance of all obligations of Lessee hereunder.

Section 9.4. If Lessor consents in writing to Transfer involving a sublease or assignment of the Premises, Lessee shall cause each permitted subLessee, assignee or occupant (a "**SubLessee**") to comply with its obligations under its respective sublease, and Lessee shall diligently enforce all of its rights as the Lessor thereunder in accordance with the terms of such sublease and this Lease.

Section 9.5. The fact that a violation or breach of any of the terms, provisions or conditions of this Lease results from or is caused by an act or omission by any of the SubLessees shall not relieve Lessee of Lessee's obligation to cure the same. Lessee shall take all necessary steps to prevent any such violation or breach.

Section 9.6. If this Lease is assigned, or if the Premises or any part thereof is subleased or occupied by anybody other than Lessee, Lessor may, after an Event of Default by Lessee, and in addition to any other remedies herein provided or provided by law, collect all rent becoming due to Lessee directly from the SubLessees, and apply the net amount collected to the Rent herein reserved and all other sums due to Lessor by Lessee hereunder, but no such assignment, sublease, occupancy or collection shall be deemed a waiver of this covenant, or the acceptance of the SubLessee as Lessee, or a release of Lessee from the further performance by Lessee of the terms, covenants, and conditions on the part of Lessee to be observed or performed hereunder. Lessee hereby authorizes and directs any such SubLessee to make such payments of rent directly to Lessor, or into any cash management system required by any Mortgagee, upon receipt of notice from Lessor. In the event that amounts payable under such assignment or sublease exceed the sums due to Lessor by Lessee hereunder, Lessor shall be entitled to receive all of such excess proceeds and Lessee hereby agrees to immediately pay over to Lessor all such excess upon Lessee's receipt of same. No direct collection by Lessor from any such SubLessee shall be construed to constitute a novation or a release of Lessee from the further performance of its obligations hereunder. After any assignment or subletting, Lessee's liability hereunder shall continue notwithstanding any subsequent modification or amendment hereof or the release of any subsequent Lessee hereunder from any liability, to all of which Lessee hereby consents in advance. The consent by Lessor to any Transfer shall not in any way be construed to relieve Lessee from obtaining the express written consent of Lessor to any further Transfer.

Section 9.7. To secure the prompt and full payment by Lessee of the Rent and the faithful performance by Lessee of all the other terms and conditions herein contained on its part to be kept and performed, Lessee hereby assigns, transfers and sets over unto Lessor, subject to the conditions hereinafter set forth, all of Lessee's right, title and interest in and to all permitted subleases, assignments and occupancy agreements (collectively, the "**Subleases**") and hereby confers upon Lessor, its agents and representatives, a right of entry (subject to prior notice) in, and sufficient possession of, the Premises to permit and insure the collection by Lessor of the rentals and other sums payable under the Subleases, and further agrees that the exercise of said right of entry and qualified possession by Lessor shall not constitute an eviction of Lessee from the Premises or any portion thereof and that should said right of entry and possession be denied Lessor, its agent or representative, Lessor, in the exercise of said right, may use all requisite force to gain and enjoy the same without responsibility or liability to Lessee, its servants, employees, guests or invitees, or any Person whomsoever; *provided, however,* that such assignment shall become operative and effective only if (a) a Default shall occur and be continuing or (b) this Lease and the Term shall be cancelled or terminated pursuant to the terms, covenants and conditions hereof or (c) there occurs repossession under a dispossess warrant or other re-entry or repossession by Lessor under the provisions hereof or (d) a receiver for the Premises is appointed, and then only as to such of the subleases that Lessor may elect to take over and assume. At any time and from time to time within ten (10) days after Lessor's written demand, Lessee promptly shall deliver to Lessor a schedule of all Subleases, setting forth the names of all SubLessees, with a photostatic copy of each of the Subleases. Upon reasonable request of Lessor, Lessee shall permit Lessor and its agents and representatives to inspect all Subleases affecting the Premises. Lessee covenants that each Sublease shall provide that the SubLessee thereunder shall be required from time to time, upon request of Lessor or Lessee, to execute, acknowledge and deliver, to and for the benefit of Lessor, an estoppel certificate confirming with respect to such Sublease the information set forth in Section 14.1 hereof.

Section 9.8. Lessee covenants and agrees that all Subleases hereafter entered into affecting the Premises shall provide that (a) they are subject to this Lease and that the principals of the SubLessee acknowledge that they have read this Lease and accept the terms hereof, (b) the term thereof should end not less than one (1) day prior to the Expiration Date hereof, unless Lessor shall consent otherwise, which consent may be withheld in Lessor's sole and absolute discretion, (c) the SubLessees will not do, authorize or execute any act, deed or thing whatsoever or fail to take any such action which will or may cause Lessee to be in violation of any of its obligations under this Lease, (d) the SubLessees will not pay rent or other sums under the Subleases with Lessee for more than one (1) month in advance, (e) the SubLessees shall give to Lessor at the address and otherwise in the manner specified in Section 21.8 hereof, a copy of any notice of default by Lessee as the Lessor under the Subleases at the same time as, and whenever, any such notice of default shall be given by the SubLessees to Lessee, and (f) in the event of the termination or expiration of this Lease prior to the Expiration Date hereof, any such SubLessee, at Lessor's election, shall be obligated to attorn to and recognize Lessor as the lessor under such Sublease, in which event such Sublease shall continue in full force and effect as a direct lease between Lessor and the SubLessee upon all the terms and conditions of such Sublease, except as hereinafter provided. Any attornment required by Lessor of such SubLessee shall be effective and self-operative as of the date of any such termination or expiration of this Lease without the execution of any further instrument; *provided, however,* that such SubLessee shall agree, upon the request of Lessor, to execute and deliver any such instruments in recordable form and

otherwise in form and substance satisfactory to Lessor in its sole and absolute discretion to evidence such attornment. With respect to any attornment required by Lessor of any SubLessee hereunder, (i) at the option of Lessor, Lessor shall recognize all rights and obligations of Lessee as the lessor under such sublease and the SubLessee thereunder shall be obligated to Lessor to perform all of the obligations of the SubLessee under such Sublease and (ii) Lessor shall have no liability, prior to its becoming lessor under such Sublease, to such SubLessee nor shall the performance by such SubLessee of its obligations under the Sublease, whether prior to or after any such attornment, be subject to any defense, counterclaim or setoff by reason of any default by Lessee in the performance of any obligation to be performed by Lessee as lessor under such Sublease, nor shall Lessor be bound by any prepayment of more than one (1) month's rent unless such prepayment shall have been expressly approved in writing by Lessor. The provisions of this Section 9.8 shall survive the expiration or earlier termination of the Term.

Section 9.9. If Lessee assumes this Lease and proposes to assign the same pursuant to the provisions of Title 11 of the United States Code or any statute of similar purpose or nature (the "**Bankruptcy Code**") to any person or entity who shall have made a bona fide offer to accept an assignment of this Lease on terms acceptable to the Lessee, then notice of such proposed assignment shall be given to Lessor by Lessee no later than fifteen (15) days after receipt of such offer by Lessee, but in any event no later than ten (10) days prior to the date that Lessee shall file any application or motion with a court of competent jurisdiction for authority and approval to enter into such assumption and assignment. Such notice shall set forth (a) the name and address of the assignee, (b) all of the terms and conditions of such offer, and (c) the proposal for providing adequate assurance of future performance by such person under the Lease, including, without limitation, the assurance referred to in Section 365 of the Bankruptcy Code. Any person or entity to which this Lease is assigned pursuant to the provisions of the Bankruptcy Code shall be deemed without further act or deed to have assumed all of the obligations arising under this Lease from and after the date of such assignment. Any such assignee shall execute and deliver to Lessor upon demand an instrument confirming such assumption.

Section 9.10. The term "**adequate assurance of future performance**" as used in this Lease shall mean (in addition to the assurances called for in Bankruptcy Code Section 365(1)) that any proposed assignee shall, among other things, (a) deposit with Lessor on the assumption of this Lease an amount equal to the greater of (i) two (2) times the then monthly Base Rent and Supplementary Rent or (ii) such other amount deemed by the Bankruptcy Court to be reasonably necessary for the adequate protection of Lessor under the circumstances, as security for the faithful performance and observance by such assignee of the terms and obligations of this Lease, (b) furnish Lessor with financial statements of such assignee for the prior three (3) fiscal years, as finally determined after an audit and certified as correct by a certified public accountant, which financial statements shall show a net worth at least equal to the amount of the deposit referenced in (a) above, (c) if determined by the Bankruptcy Court to be appropriate under the circumstances, grant to Lessor a security interest in such property of the proposed assignee as Lessor shall deem necessary to secure such assignee's future performance under this Lease, and (d) provide such other information or take such action as Lessor, in its reasonable judgment, shall determine is necessary to provide adequate assurance of the performance by such assignee of its obligations under the Lease.

Section 9.11. If, at any time after Lessee may have assigned Lessee's interest in this Lease in a proceeding of the type described in Section 12.1(g), this Lease shall be disaffirmed or rejected in any proceeding of the types described in Section 12.1(g) hereof, or in any similar proceeding, or in the event of termination of this Lease by reason of any such proceeding or by reason of lapse of time following notice of termination given pursuant to Article 12 based upon any of the events of default set forth in said Section 12.1(g), Lessee, upon request of Lessor given within thirty (30) days next following any such disaffirmance, rejection or termination (and actual notice thereof to Lessor in the event of a disaffirmance or rejection or in the event of termination other than by act of Lessor), shall (a) pay to Lessor all Base Rent and Supplementary Rent due and owing by the assignee to Lessor under this Lease to and including the date of such disaffirmance, rejection or termination, and (b) as "Lessee", enter into a new lease with Lessor for a term commencing on the effective date of such disaffirmance, rejection or termination and ending on the expiration date of the Term, unless sooner terminated as in such lease provided, at the same Base Rent and Supplementary Rent upon the then executory terms, covenants and conditions as are contained in this Lease, except that (i) Lessee's rights under the new lease shall be subject to the possessory rights, if any, of the assignee under this Lease and the possessory rights of any person claiming through or under such assignee or by virtue of any statute or of any order of any court, (ii) such new lease shall require all defaults existing under this Lease to be cured by Lessee with due diligence, and (iii) such new lease shall require Lessee to pay all Base Rent and Supplementary Rent reserved in this Lease which, had this Lease not been so disaffirmed, rejected or terminated, would have accrued under the provisions of this Lease after the date of such disaffirmance, rejection or termination with respect to any period prior thereto. If Lessee shall default in its obligation to enter into said new lease for a period of ten (10) days next following Lessor's request therefor, then in addition to all other rights and remedies by reason of such default, either at law or in equity, Lessor shall have the same rights and remedies against Lessee as if Lessee had entered into such new lease and such new lease had thereafter been terminated as of the commencement date thereof by reason of Lessee's default thereunder.

Section 9.12. (a) Licenses, certificates or permits, trade names, reservations or allocations held in the name of the Lessee, an agent or representative of the Lessee, or the Facility, which relate to the operation of the Permitted Facility business in the Premises, and the name of the facility, as then known to the general public, shall upon Lessor's written request from and after termination of this Lease upon an Event of Default, be assigned by Lessee to a replacement licensed operator of the Facility and/or, or a subsequent lessee identified by Lessor, to the extent permitted by law. If Lessee fails to make or refuses to recognize the assignment of any licenses, permits or certificates, trade names, reservations or allocations referred to herein, this provision of this Lease shall constitute an act of assignment to the replacement licensed operator and/or lessee identified by Lessor to the extent such assignment is permitted by law.

(b) The present number of beds utilized in the Premises shall not be transferable by Lessee to others or to other locations unless approved in advance by Lessor in writing, which approval may be withheld in Lessor's sole and absolute discretion.

(c) Lessee shall not abandon or surrender any licenses, permits, certificates or authorizations required for or which relate to the operation of the Premises as a Permitted Facility without prior notice to, and receipt of written approval from, Lessor. Lessee shall not act or fail to act in any manner which will cause any licenses, permits or certificates to be

revoked or not renewed by any federal, state or local government authority having jurisdiction thereof.

(d) Lessee shall not file bankruptcy, become insolvent, permit itself to become subject to any action seeking the appointment of a trustee, receiver, liquidator, custodian or similar official of Lessee or a substantial part of its assets, permit itself to become subject to any action of involuntary receivership, fail to pay its debts as they become due, or take any corporate action to authorize any of the foregoing without the prior written consent of Lessor.

Section 9.13. The provisions of Sections 9.7, 9.8, 9.9, 9.12 and 9.13 hereof shall survive the expiration or earlier termination of this Lease.

ARTICLE 10

SUBORDINATION

Section 10.1. This Lease shall be subject and subordinate to all Mortgages now or hereinafter in effect and to all renewals, modifications, consolidations, replacements and extensions of any such Mortgages; *provided, however,* that, subject to the provision of Section 10.3 of this Lease, the Mortgagee of such Mortgage shall execute and deliver to Lessee an agreement (on such Mortgagee's standard form) to the effect that, if there shall be a foreclosure of its Mortgage, such Mortgagee will not make Lessee a party defendant to such foreclosure, unless necessary under applicable law for the Mortgagee to foreclose, or if there shall be a foreclosure of such Mortgage, such Mortgagee shall not evict Lessee, disturb Lessee's leasehold estate or rights hereunder, in all events, *provided that* no Default then exists (any such agreement, or any agreement of similar import, from a Mortgagee being hereinafter called a "**Non-Disturbance Agreement**"), and Lessee shall attorn to the Mortgagee or any successor-in-interest to Lessor or the Mortgagee including without limitation, any such party which takes title by foreclosure, deed in lieu of foreclosure or alternative procedure. The transfer of the title to the Premises or any Underlying Lease to any Mortgagee or any successor in interest to the Lessor or Mortgagee by foreclosure, deed in lieu of foreclosure or any alternative procedure shall not be considered a default or breach by Lessor of this Lease, and shall not affect the joint and several obligations of Lessee and all the other Lessees under all of the Leases as set forth in Section 1.3 above, which shall survive and remain in full force and effect. This Section 10.1 shall be self-operative and no further instrument of subordination shall be required to make the interest of any Mortgagee superior to the interest of Lessee hereunder. Notwithstanding the previous sentence; however, Lessee shall, together with the Mortgagee, execute and deliver promptly any certificate or agreement that Lessor and any Mortgagee may reasonably request in confirmation of such subordination. The standards (i.e., time and manner of giving such consent and standard of reasonableness, if applicable) of a Mortgagee's consent with respect to this Lease shall be materially consistent with those to which Lessor is subject under this Lease. Any Non-Disturbance Agreement may be made on the condition that neither the Mortgagee nor anyone claiming by, through or under such Mortgagee shall be:

(a) liable for any act or omission of any prior Lessor (including, without limitation, the then defaulting Lessor);

(b) subject to any defense or offsets which Lessee may have against any prior Lessor (including, without limitation, the then defaulting Lessor) which arise prior to the date such Mortgagee (or someone acquiring at a foreclosure sale related to the Mortgagee's Mortgage) acquires title to the Premises;

(c) bound by any payment of Rent which Lessee might have paid for more than the current month to any prior Lessor (including, without limitation, the then defaulting Lessor);

(d) bound by any obligation to make any payment to Lessee which was required to be made prior to the time such Lessor succeeded to any prior Lessor's interest;

(e) bound by any obligation to perform any work or to make improvements to the Premises;

(f) bound by any modification, amendment or supplement to this Lease made without the prior written consent of the Mortgagee; or

(g) bound by any security deposit for Lessee's obligations under this Lease unless such deposit is actually received by Mortgagee.

If required by any Mortgagee, Lessee promptly shall join in any Non-Disturbance Agreement to indicate its concurrence with the provisions thereof and its agreement, in the event of a foreclosure of any Mortgage to attorn to such Mortgagee, as Lessee's Lessor hereunder. Lessee shall promptly so accept, execute and deliver any Non-Disturbance Agreement proposed by any Mortgagee which conforms with the provisions of this Section 10.1. Any Non-Disturbance Agreement may also contain other terms and conditions as may otherwise be required by any Mortgagee which do not increase Lessee's monetary obligations or materially and adversely affect the rights or obligations of Lessee under this Lease.

Section 10.2. Lessee hereby agrees to give to any Mortgagee copies of all notices given by Lessee of default by Lessor under this Lease at the same time and in the same manner as, and whenever, Lessee shall give any such notice of default to Lessor, and shall require any subLessee to give notice on similar terms. Such Mortgagee shall have the right to remedy any default under this Lease, or to cause any default of Lessor under this Lease to be remedied, and for such purpose Lessee hereby grants such Mortgagee such period of time as may be reasonable to enable such Mortgagee to remedy, or cause to be remedied, any such default in addition to the period given to Lessor for remedying, or causing to be remedied, any such default which is a default. Lessee shall accept performance by such Mortgagee of any term, covenant, condition or agreement to be performed by Lessor under the Lease with the same force and effect as though performed by Lessor. No default under the Lease shall exist or shall be deemed to exist (i) as long as such Mortgagee, in good faith, shall have commenced to cure such default and shall be prosecuting the same to completion with reasonable diligence, subject to force majeure, or (ii) if possession of the Premises is required in order to cure such default, or if such default is not susceptible of being cured by such Mortgagee, as long as such Mortgagee, in good faith, shall have notified Lessee that such Mortgagee intends to institute proceedings under the Mortgage and, thereafter, as long as such proceedings shall have been instituted and shall prosecute the

same with reasonable diligence and, after having obtained possession, prosecutes the cure to completion with reasonable diligence. The Lease shall not be assigned (subject to the provisions of Article 9) by Lessee or modified, amended or terminated without such Mortgagee's prior written consent in each instance, which consent shall not be unreasonably withheld or delayed. In the event of the termination of the Lease by reason of any default thereunder or for any other reason whatsoever except the expiration thereof, upon such Mortgagee's written request, given within thirty (30) days after any such termination, Lessee, within fifteen (15) days after receipt of such request, shall execute and deliver to such Mortgagee or its designee or nominee a new lease of the Premises for the remainder of the Term of the Lease upon all of the terms, covenants and conditions of this Lease. Neither such Mortgagee nor its designee or nominee shall become liable under the Lease unless and until such Mortgagee or its designee or nominee becomes, and then only for so long as such Mortgagee or its designee or nominee remains, the fee owner of the Premises. Such Mortgagee shall have the right, without Lessee's consent, to foreclose the Mortgage or to accept a deed in lieu of foreclosure of such Mortgage.

Section 10.3. Inability to Obtain Non-Disturbance Agreement. Lessor shall use its commercially reasonable best efforts to obtain from the Mortgagee of the Mortgage the Non-Disturbance Agreement referred to in Section 10.1 above, but Lessor does not assure that such Non-Disturbance Agreement can be obtained. Notwithstanding the inability to obtain such Non-Disturbance Agreement, this Lease shall continue in full force and effect, *provided, however,* that in such event except during the Initial Term, (a) Lessor and Lessor's Affiliates can only subject this Lease to Mortgages whose annual aggregate debt service does not exceed the annual aggregate rent payable under this Lease, (b) Lessor and Lessor's Affiliates shall permit Lessee and Lessee's Affiliates to cure any defaults by Lessor and Lessor's Affiliates under such Mortgages by the payment of debt service thereunder and (c) Lessor and Lessor's Affiliates, and Lessee and Lessee's Affiliates, shall implement a lock box arrangement whereby rent payable monthly under this Lease shall first be applied to pay the debt service due under such Mortgages, with any balance payable monthly to the Lessor and Lessor's Affiliates.

Section 10.4. Reserves Required by Mortgage. Lessee shall have the exclusive obligation to obtain and provide at its own expense all reserves, capital replacement sinking funds, escrows, cash collateral accounts, letters of credit, insurance deposits, bonds and other financial requirements imposed by the holder of any Mortgage.

ARTICLE 11

OBLIGATIONS OF LESSEE

Section 11.1. Whether or not Lessee is in occupancy of all of the Buildings, Lessee shall promptly comply with all laws, ordinances, orders, rules, regulations, and requirements of all Federal, state, municipal or other governmental or quasi-governmental authorities or bodies then having jurisdiction over the Premises (or any part thereof) and/or the use and occupation thereof by Lessee, whether any of the same relate to or require (i) structural changes to or in and about the Premises, or (ii) changes or requirements incident to or as the result of any use or occupation thereof or otherwise (collectively, the "**Requirements**"), and subject to Article 7, Lessee shall so perform and comply, whether or not such laws, ordinances, orders, rules, regulations or requirements shall now exist or shall hereafter be enacted or promulgated and whether or not the

same may be said to be within the present contemplation of the parties hereto. The foregoing shall include, without limitations, present and future compliance with the provisions of the Americans with Disabilities Act. In addition, Lessee will comply with the applicable provisions of ERISA and of the regulations and published interpretations thereunder and shall furnish to Lessor promptly after any officer of Lessee either knows, or has a reasonable basis to know, notice that any violation or other reportable event (including the events set forth in Section 4043(b) of ERISA) has occurred.

Section 11.2. Lessee agrees to give Lessor notice of any notice, assessment, claim, demand, communication, violation, summons, complaint, investigation, termination, suspension, or revocation made, issued or adopted by any of the governmental departments or agencies or authorities hereinbefore mentioned affecting in a material adverse manner (i) the Premises, (ii) Lessee's use thereof or (iii) the financial condition of Lessee, a copy of which is served upon or received by Lessee, or a copy of which is posted on, or fastened or attached to the Premises, or otherwise brought to the attention of Lessee, by mailing within five (5) Business Days after such service, receipt, posting, fastening or attaching or after the same otherwise comes to the attention of Lessee, a copy of each and every one thereof to Lessor. At the same time, Lessee will inform Lessor as to the Work which Lessee proposes to do or take in order to comply therewith. Notwithstanding the foregoing, however, if such Work would require any Alterations which would, in Lessor's opinion, reduce the value of the Premises or change the general character, design or use of any of the Buildings or other improvements thereon, and if Lessee does not desire to contest the same, Lessee shall, if Lessor so requests, defer compliance therewith in order that Lessor may, if Lessor wishes, contest or seek modification of or other relief with respect to such Requirements, so long as Lessee is not put in violation of any law, ordinance, rule, regulation or requirement enacted, passed, promulgated, made, issued or adopted by any such governmental departments or agencies or authorities, but nothing herein shall relieve Lessee of the duty and obligation, at Lessee's expense, to comply with such Requirements, or such Requirements as modified, whenever Lessor shall so direct.

Section 11.3. Except in the case of the gross negligence or willful misconduct of Lessor or its agents (**but the following indemnity shall specifically cover such party's simple, as opposed to gross negligence**), Lessee shall defend, protect, indemnify and save harmless Lessor, its Affiliates, any partners, members or managers of Lessor, any partners, members or managers of any partners, members or managers of Lessor and any partners, members, managers, officers, stock-holders, trustees, directors or employees of any of the foregoing (collectively, "**Indemnified Parties**"), from and against and shall reimburse such parties for (a) any and all liabilities, obligations, losses, penalties, costs, charges, judgments, claims, causes of actions, suits, damages and expenses (collectively, "**Claims**") (1) arising from or under this Lease or Lessee's use, occupancy and operations of, in or about the Premises during the Term, or (2) arising from the ownership, operation, maintenance, management, use, regulation, development, expansion or construction of the Facility and/or provision of health services from or at the Facility during the Term of this Lease, including without limitation, claims of Health Care Regulatory Agencies and Third Party Payors, Recoupment Claims, claims by or through patients, residents, customers of such Facility or services, and Professional Liability and General Liability ("PLGL") Claims, in each case which are attributable to occurrences during the Term that the Facility is leased by Lessee, *provided, however,* that with respect to PLGL Claims, such indemnification shall not extend to unaffiliated third party beneficiaries or (3) which may be

imposed upon or incurred or paid by or asserted against the Indemnified Parties by reason of or in connection with (i) any accident, injury, death or damage to any person or property occurring in, on or about the Premises or any portion thereof or any adjacent street, alley, sidewalk, curb, driveway or passageway; (ii) any changes, alterations, repairs and anything done in, on or about the Premises or any part thereof in connection with such changes, alterations and repairs; (iii) the use, non-use, occupation, condition, operation, maintenance or management of the Premises or any part thereof, or any adjacent street, alley, sidewalk, curb, driveway or passageway; (iv) any negligent act on the part of Lessee or any of its agents, contractors, servants, employees, space Lessees, licensees, assignees, or subLessees; (v) the performance of any labor or services or the furnishing of any materials or other property in respect of the Premises or any part thereof; (vi) any violation by Lessee (or by any agent, contractor, or licensee then upon or using the Premises) of any provision of this Lease (beyond the expiration of all applicable notice and cure periods), including, but not limited to, Article VII hereof, or any breach of any law, regulation, or ordinance by Lessee or its agents, concessionaires, contractors, servants, vendors, materialmen or suppliers; or (vii) the condition of the Premises, or of any buildings or other structures now or hereafter situated thereon, or the fixtures or personal property thereon or therein, to the extent such events described in the foregoing clauses (i) through (vii) occur during the Term (excluding from this clause (vii) any environmental or other condition of the Premises existing on the Commencement Date); and (b) all costs, expenses and liabilities incurred, including actual, customary and reasonable attorney's fees and disbursements through and including appellate proceedings, in or in connection with any of such Claims. If any action or proceeding shall be brought against any of the Indemnified Parties by reason of any such Claims, Lessee, upon notice from any of the Indemnified Parties, shall resist and defend such action or proceeding, at its sole cost and expense by counsel to be selected by Lessee but otherwise satisfactory to such Indemnified Party in its reasonable discretion. Lessee or its counsel shall keep each Indemnified Party fully apprised at all times of the status of such defense. If Lessee shall fail to defend such action or proceeding, such an Indemnified Party may retain its own attorneys to defend or assist in defending any such claim, action or proceeding, and Lessee shall pay the actual, customary and reasonable fees and disbursements of such attorneys. The terms and provisions of this Section 11.3 shall not in any way be affected by the absence of insurance covering such occurrence or claim or by the failure or refusal of any insurance company to perform any obligation on its part. The provisions of this Section 11.3 shall survive the expiration or earlier termination of this Lease. Neither Lessor nor Lessee shall enter into any settlement of a Claim which would impose a monetary liability on the other party, without the written consent of such other party. Any insurance proceeds actually received by an Indemnified Party shall be credited against the indemnification otherwise to be provided herein. An Indemnified Party shall give prompt written notice to Lessee of any Claim for which it seeks indemnification hereunder, but delay in providing such notice shall not relieve Lessee of its indemnification obligations, except to the extent such delay materially prejudiced Lessee's ability to defend such Claim.

Section 11.4. If at any time prior to or during the Term (or within the statutory period thereafter if attributable to Lessee), any mechanic's or other lien or order for payment of money, which shall have been either created by, caused (directly or indirectly) by, or suffered against Lessee, shall be filed against the Premises or any part thereof, Lessee, at its sole cost and expense, shall cause the same to be discharged by payment, bonding or otherwise, within sixty (60) days after Lessee receives notice of the filing thereof unless such lien or order is contested by Lessee in good faith and Lessee provides sufficient security or evidence of financial ability, in

each case to the satisfaction of Lessor (in its sole and absolute discretion), to pay the amount of such lien or order. Lessee shall, upon notice and request in writing by Lessor, defend for Lessor, at Lessee's sole cost and expense, any action or proceeding which may be brought on or for the enforcement of any such lien or order for payment of money, and will pay any damages and satisfy and discharge any judgment entered in such action or proceeding and save harmless Lessor from any liability, claim or damage resulting therefrom. In default of Lessee's procuring the discharge of any such lien as aforesaid Lessor may, without notice, and without prejudice to its other remedies hereunder, procure the discharge thereof by bonding or payment or otherwise, and all cost and expense which Lessor shall incur shall be paid by Lessee to Lessor as Supplementary Rent forthwith.

Section 11.5. Lessor shall not under any circumstances be liable to pay for any work, labor or services rendered or materials furnished to or for the account of Lessee upon or in connection with the Premises, and no mechanic's or other lien for such work, labor or services or material furnished shall, under any circumstances, attach to or affect the reversionary interest of Lessor in and to the Premises or any alterations, repairs, or improvements to be erected or made thereon. Nothing contained in this Lease shall be deemed or construed in any way as constituting the request or consent of Lessor, either express or implied, to any contractor, subcontractor, laborer or materialman for the performance of any labor or the furnishing of any materials for any specific improvement, alteration to or repair of the Premises or any part thereof, nor as giving Lessee any right, power or authority to contract for or permit the rendering of any services or the furnishing of any materials on behalf of Lessor that would give rise to the filing of any lien against the Premises.

Section 11.6. Neither Lessor nor its agents shall be liable for any loss of or damage to the property of Lessee or others by reason of casualty, theft or otherwise, or due to any interruption or failure of any services or use or the operation or management of the Premises, or due to any building on the Premises being defective or improperly constructed, or being or becoming out of repair, or for any injury or damage to persons or property resulting from any cause of whatsoever nature (**nor shall such party be liable for any such loss which is caused by or arises from the simple negligence of Lessor or its agents**), unless caused by or due to the gross negligence or willful misconduct of Lessor, its agents, servants or employees.

Section 11.7. Lessor shall not be required to furnish to Lessee any facilities or services of any kind whatsoever, including, but not limited to, water, steam, heat, gas, oil, hot water, and/or electricity, all of which Lessee represents and warrants that Lessee has obtained from the public utility supplying the same, at Lessee's sole cost and expense. Upon Lessee's written request, however, Lessor agrees to cooperate with Lessee (at no cost to Lessor) with respect to such services.

ARTICLE 12

DEFAULT BY LESSEE; REMEDIES

Section 12.1. Each of the following shall be deemed an event of default (an "**Event of Default**") and a breach of this Lease by Lessee:

(a) The failure of Lessee to pay within five (5) Business Days of when due any portion of any installment of Base Rent, Supplementary Rent or any other monetary charge due from Lessee under this Lease.

(b) The failure of Lessee to comply with or observe any of the other provisions, agreements, conditions, covenants or terms contained in this Lease, or if such failure is of such a nature that it can be remedied, then if such failure shall continue for ten (10) days after written notice by Lessor to Lessee (or if such default is of such a nature that it cannot be completely remedied within said ten (10) day period, then if Lessee does not agree in writing within such ten (10) day period to cure the same, commence and thereafter diligently prosecute the cure and complete the cure within thirty (30) days after such original written notice of default by Lessor to Lessee).

(c) If Lessee shall Transfer all or any of its interest in the Premises or this Lease without strict compliance with Article 9 of this Lease.

(d) The (i) initiation of any proceeding whereupon the estate or interest of Lessee in the Premises, or any portion thereof, or in this Lease is levied upon or attached, or (ii) taking of Lessee's leasehold estate by execution or other process of law other than as provided in Article 8, which proceeding or taking, as the case may be, is not vacated, discharged, dismissed or otherwise reversed within ninety (90) days thereafter.

(e) [Reserved]

(f) Lessee shall desert, vacate or fail to physically occupy any portion of the Premises.

(g) If (i) Lessee shall commence any case, proceeding or other action (A) under any existing or future law of any jurisdiction, domestic or foreign, relating to bankruptcy, insolvency, reorganization or relief of debtors, seeking to have an order for relief entered with respect to Lessee, or seeking to adjudicate Lessee a bankrupt or insolvent, or seeking reorganization, arrangement, adjustment, liquidation, dissolution, composition or other relief with respect to Lessee or Lessee's debts, or (B) seeking appointment of a receiver, trustee, custodian or other similar official for Lessee or for all or any substantial part of Lessee's property; or (ii) Lessee shall become insolvent or make a general assignment for the benefit of Lessee's creditors or shall make a transfer in fraud of creditors; or (iii) there shall be commenced against Lessee any case, proceeding or other action of a nature referred to in clause (i) above (including involuntary bankruptcy) or seeking issuance of a warrant of attachment, execution, distraint or similar process against all or any substantial part of Lessee's property, which case, proceeding or other action (A) results in the entry of an order for relief or (B) remains undismissed, undischarged or unbonded for a period of sixty (60) days; or (iv) Lessee shall take any action consenting to or approving of any of the acts set forth in clause (i) or (ii) above; or (v) Lessee shall generally not, or shall be unable to, pay Lessee's debts as they become due or shall admit in writing Lessee's inability to pay Lessee's debts.

(h) [Reserved]

(i) If Lessee is a corporation (or partnership or limited liability company) and shall cease to exist as a corporation (or partnership or limited liability company) in good standing in the state of its incorporation (or formation) (unless Lessee simultaneously becomes incorporated (or formed) and in good standing in another state) or if Lessee is a partnership or limited liability company or other entity and Lessee shall be dissolved or otherwise liquidated, then if Lessee does not completely remedy such default immediately (or if Lessee's only knowledge of such default is by receipt of written notice of such default, then within the ten (10) day period following receipt of such written notice).

(j) Lessee fails or refuses to execute any certificate or agreement that Lessor or Mortgagee may reasonably request confirming the subordination required pursuant to Article 10 or estoppel certificate required pursuant to Article 14 within ten (10) days after Lessee's receipt thereof.

(k) Any revocation, termination, suspension or other loss of any Health Care License relating to the Facility or health care services provided at or from the Facility or the taking of any action by a Health Care Regulatory Agency requiring the suspension, closure or inability to operate the Facility as a Permitted Facility in the ordinary course of business (*provided, however,* that in the case of a suspension or other action which is temporary and not irrevocable, and which does not require a closure of the facility, the Lessee shall have failed to fully cure the applicable violations and restore full use of the Health Care License within ninety (90) days after the action was initially taken).

(l) Any suspension, debarment or disqualification of Lessee or its principals from being a health care provider, government contractor, holder of any Health Care License or recipient of reimbursement from any Third Party Payor.

Section 12.2. Upon the occurrence of an Event of Default, Lessor may, at any time thereafter, without limiting Lessor in the exercise of any right or remedy at law or in equity that Lessor may have by reason of such Event of Default, at its option pursue any one or more of the following remedies without any further notice or demand whatsoever:

(a) Terminate this Lease by issuing written notice of termination to Lessee, in which event Lessee shall immediately surrender the Premises to Lessor, but if Lessee shall fail to do so, Lessor may without notice and without prejudice to any other remedy Lessor may have, peaceably enter upon and take possession of the Premises and expel or remove Lessee and its effects without being liable to prosecution or any claim for damages therefor, and upon any such termination, Lessee agrees that in addition to its liability for the payment of arrearages of Base Rent, Supplementary Rent and other sums due and owing by Lessee to Lessor under this Lease upon such termination, Lessee shall be liable to Lessor for damages. Lessee shall pay to Lessor as damages on the same days as Base Rent and other payments which are expressed to be due under the provisions of this Lease, the total amount of such Base Rent and other payments plus a reimbursement for all unamortized Lessee allowances and concessions, less such part, if any, of such payments that Lessor shall have been able to collect from a new Lessee upon reletting; *provided, however,* that Lessor shall have no obligation to this Lessee to relet the Premises so as to mitigate the amount for which Lessee is liable. Lessor shall have the right at any time to demand final settlement. Upon demand for a final settlement, Lessor shall have the right to

receive, and Lessee hereby agrees to pay, as damages for Lessee's breach, the total rental provided for in this Lease for the remainder of the Term (the "Reserved Rent").

(b) Enter upon and take possession of the Premises without terminating this Lease and expel or remove Lessee and its effects therefrom without being liable to prosecution or any claim for damages therefor, and Lessor may relet the Premises for the account of Lessee. Lessee shall pay to Lessor all arrearages of Base Rent, Supplementary Rent and other sums due and owing by Lessee to Lessor, and Lessee shall also pay to Lessor during each month of the unexpired Term the installments of Base Rent and other sums due hereunder, less such part, if any, that Lessor shall have been able to collect from a new Lessee upon reletting; *provided, however,* that Lessor shall have no obligation to this Lessee to relet the Premises so as to mitigate the amount for which Lessee is liable. In the event Lessor exercises the rights and remedies afforded to it under this Section 12.2(b) and then subsequently elects to terminate this Lease, Lessee shall be liable to Lessor for damages as set forth in Section 12.2(a) above and Lessor shall have the right at any time to demand final settlement as provided therein.

(c) Upon termination of this Lease after an Event of Default, cause the transfer of Health Care Licenses relating to the Facility and the operation and management of the Facility and leasing of the Premises to any replacement operator, manager or Lessee of the facility identified by Lessor, to the extent permitted by law, and seek the approval of Health Care Regulatory Agencies in connection therewith, in which event Lessee shall cooperate with Lessor to transfer all books and records relating to the Facility and transition services to the replacement operator Lessee so as to provide continuation of patient care and minimize disruption.

(d) Enforce, by all legal suits and other means, its rights hereunder, including the collection of Rent and other sums payable by Lessee hereunder, without re-entering or resuming possession of the Premises and without terminating this Lease.

(e) Lessor may do whatever Lessee is obligated to do by the provisions of this Lease, may peaceably enter the Premises in order to accomplish this purpose and may make any expenditure or incur any obligation for the payment of money in connection therewith, including, without limitation, reasonable attorneys' fees and expenses. Lessee agrees to reimburse Lessor immediately upon demand for any expenses which Lessor may incur in its actions pursuant to this Section 12.2(e), with interest thereon at the Default Rate from the date of demand until paid and such amount shall be deemed to be Additional Rent hereunder. Lessee further agrees that Lessor shall not be liable for damages resulting to Lessee from such action, unless caused by the gross negligence or willful misconduct of Lessor.

(f) Upon termination of this Lease following an Event of Default, to the extent permitted by law and in compliance with the requirements of Health Care Licenses and Health Care Regulatory Agencies, and in coordination with a transition to a replacement facility operator or manager: Lessor may peaceably enter upon the Premises and change, alter, or modify the door locks on all entry doors of the Premises, and permanently or temporarily exclude Lessee, and its agents, employees, representatives and invitees, from the Premises. In the event that Lessor either permanently excludes Lessee from the Premises or terminates this Lease on account of Lessee's default, Lessor shall not be obligated thereafter to provide Lessee with a key to the Premises at any time, regardless of any amounts subsequently paid by Lessee.

If Lessor elects to exclude Lessee from the Premises temporarily without permanently repossessing the Premises or terminating this Lease, then Lessor shall not be obligated to provide Lessee with a key to reenter the Premises until such time as all delinquent rent and other amounts due under this Lease have been paid in full and all other defaults, if any, have been cured and Lessee shall have given Lessor evidence reasonably satisfactory to Lessor that Lessee has the ability to comply with its remaining obligations under this Lease; and if Lessor temporarily excludes Lessee from the Premises, Lessor shall have the right thereafter to permanently exclude Lessee from the Premises or terminate this Lease at any time before Lessee pays all delinquent rent, cures all other defaults and furnishes such evidence to Lessor. A key to the Premises will be furnished to Lessee only during Lessor's normal business hours. Lessor's exclusion of Lessee from the Premises shall not constitute a permanent exclusion of Lessee from the Premises or a termination of this Lease unless Lessor so notifies Lessee in writing. Lessor shall not be obligated to place a written notice on the Premises on the front door thereof explaining Lessor's action or stating the name, address or telephone number of any individual or company from which a new key may be obtained. In the event Lessor permanently or temporarily excludes Lessee from the Premises or terminates this Lease, and Lessee owns property that has been left in the Premises but which is not subject to any statutory or contractual lien or security interest held by Lessor as security for Lessee's obligations, Lessee shall have the right to promptly so notify Lessor in writing, specifying the items of property not covered by any such lien or security interest and which Lessee desires to retrieve from the Premises. Lessor shall have the right to either (i) escort Lessee to the Premises to allow Lessee to retrieve Lessee's property not covered by any such lien or security interest, or (ii) remove such property itself and make it available to Lessee at a time and place designated by Lessor. In the event Lessor elects to remove such property itself as provided in the immediately preceding clause (ii), Lessor shall not be obligated to remove such property or deliver it to Lessee unless Lessee shall pay to Lessor, in advance, an amount of cash equal to the amount that Lessor estimates Lessor will be required to expend in order to remove such property and make it available to Lessee, including all moving or storage charges theretofore or thereafter incurred by Lessor with respect to such property. If Lessee pays such estimated amount to Lessor and the actual amount incurred by Lessor differs from the estimated amount, Lessee shall pay any additional amounts to Lessor on demand or Lessor shall refund any excess amounts paid by Lessee to Lessee on demand.

Pursuit of any of the foregoing remedies shall not preclude pursuit of any of the other remedies herein provided or any other remedies provided by law or equity. Exercise of such remedies shall be in compliance with the requirements of Health Care Licenses and Health Care Regulatory Agencies, and in coordination with a transition to a replacement facility operator or manager. Any entry by Lessor upon the Premises may be by use of a master or duplicate key or electronic pass card or any locksmith's entry procedure or other means. Any reletting by Lessor shall be without notice to Lessee, and if Lessor has not terminated this Lease, the reletting may be in the name of Lessee or Lessor, as Lessor shall elect. Any reletting shall be for such term or terms (which may be greater or less than the period which, in the absence of a termination of this Lease, would otherwise constitute the balance of the Term) and on such terms and conditions (which may include free rent, rental concessions or Lessee inducements of any nature) as Lessor in its sole and absolute discretion may determine, and Lessor may collect and receive any rents payable by reason of such reletting. In the event of any reletting, Lessee shall pay to Lessor on demand the cost of renovating, repairing and altering the Premises for a new Lessee or Lessees, and the cost of advertisements, brokerage fees, reasonable attorney's fees and other costs and

expenses incurred by Lessor in connection with such reletting. In the event any rentals actually collected by Lessor upon any such reletting for any calendar month are in excess of the amount of rental payable by Lessee under this Lease for the same calendar month, the amount of such excess shall belong solely to Lessor and Lessee shall have no right with respect thereto. In the event it is necessary for Lessor to institute suit against Lessee in order to collect the rental due hereunder or any deficiency between the rental provided for by this Lease for a calendar month and the rental actually collected by Lessor for such calendar month, Lessor shall have the right to allow such deficiency to accumulate and to bring an action upon several or all of such rental deficiencies at one time. No suit shall prejudice in any way the right of Lessor to bring a similar action for any subsequent rental deficiency or deficiencies.

Section 12.3. Subject to the terms of Section 12.2 above, upon the exercise by Lessor of any of the remedies contained in this Lease, at law or in equity:

(a) Lessee shall pay to Lessor all Rent payable under this Lease by Lessee to Lessor to the date upon which this Lease or Lessee's right to possess the Premises shall have been terminated or to the date of re-entry upon the Premises Lessor, as the case may be. Additionally, Lessee shall pay to Lessor all costs incurred by Lessor (including court costs and reasonable attorneys' fees and expenses) in (i) obtaining possession of the Premises, (ii) removing and storing Lessee's or any other occupant's property, (iii) repairing any damage to the Premises, and (iv) performing any of Lessee's unperformed obligations.

(b) No re-entry or taking possession of the Premises by Lessor shall be construed as an election on its part to terminate this Lease, unless a written notice of such intention be given to Lessee by Lessor. Notwithstanding any such reletting or re-entry to take possession, Lessor may at any time thereafter elect to terminate this Lease for a previous then continuing uncured default. No act or thing done by the Lessor or its agents during the term hereby granted shall be deemed an acceptance of a surrender of the Premises, and no agreement to accept a surrender of the Premises shall be valid unless the same be made in writing by Lessor.

Section 12.4. No taking possession of and/or reletting the Premises, or any part thereof, shall relieve Lessee of its liabilities and obligations hereunder, all of which shall survive such expiration, termination, repossession or reletting.

Section 12.5. To the extent not prohibited by law, Lessee hereby waives and releases all rights now or hereafter conferred by statute or otherwise which would have the effect of limiting or modifying any of the provisions of this Article 12. Lessee shall execute, acknowledge and deliver any instruments which Lessor may request, whether before or after the occurrence of an Event of Default, evidencing such waiver or release.

Section 12.6. The Rent payable by Lessee hereunder and each and every installment thereof, and all costs, actual, customary and reasonable attorneys' fees and disbursements and other expenses which may be incurred by Lessor in enforcing the provisions of this Lease on account of any delinquency of Lessee in carrying out the provisions of this Lease shall be and they hereby are declared to constitute a valid lien upon the interest of Lessee in this Lease and in the Premises.

Section 12.7. Suit or suits for the recovery of damages, or for a sum equal to any installment or installments of Rent payable hereunder or any deficiencies or other sums payable by Lessee to Lessor pursuant to this Article 12, may be brought by Lessor from time to time at Lessor's election, and nothing herein contained shall be deemed to require Lessor to await the date whereon this Lease or the Term would have expired by limitation had there been no Event of Default by Lessee and termination.

Section 12.8. Nothing contained in this Article 12 shall limit or prejudice the right of Lessor to prove and obtain as liquidated damages in any bankruptcy, insolvency, receivership, reorganization or dissolution proceeding an amount equal to the maximum allowed by a statute or rule of law governing such proceeding and in effect at the time when such damages are to be proved, whether or not such amount shall be greater than, equal to or less than the amount of the damages referred to in any of the preceding Sections of this Article 12.

Section 12.9. Except as otherwise expressly provided herein or as prohibited by applicable law, Lessee hereby expressly waives the service of any notice of intention to re-enter provided for in any statute, or of the institution of legal proceedings to that end, and Lessee, for and on behalf of itself and all persons claiming through or under Lessee, also waives any and all right of redemption provided by any law or statute now in force or hereafter enacted or otherwise, or re-entry or repossession or to restore the operation of this Lease in case Lessee shall be dispossessed by a judgment or by warrant of any court or judge or in case of re-entry or repossession by Lessor or in case of any expiration or termination of this Lease.

Section 12.10. No failure by Lessor to insist upon the strict performance of any covenant, agreement, term or condition of this Lease or to exercise any right or remedy consequent upon a breach thereof, or receipt or acceptance of Rent with knowledge of or during the continuance of any such breach, shall constitute a waiver or relinquishment of any such breach or of such covenant, agreement, term or condition. No covenant, agreement, term or condition of this Lease to be performed or complied with by Lessee, and no breach thereof, shall be waived, altered or modified except by a written instrument executed by Lessor. No waiver of any breach shall affect or alter this Lease, but each and every covenant, agreement, term and condition of this Lease shall continue in full force and effect with respect to any other then existing or subsequent breach thereof.

Section 12.11. In the event of any breach by Lessee of any of the covenants, agreements, terms or conditions contained in this Lease, Lessor shall be entitled to a decree compelling performance of any of the provisions hereof and the restraint by injunction of the violation or attempted or threatened violation of any of the terms, covenants and conditions of this Lease, and shall have the right to invoke any rights and remedies allowed at law or in equity or by statute or otherwise as though re-entry, summary proceedings, and other remedies were not provided for in this Lease. The rights granted to Lessor in this Lease shall be cumulative of every other right or remedy which Lessor may otherwise have at law or in equity, and the exercise of one or more rights or remedies shall not prejudice or impair the concurrent or subsequent exercise of other rights or remedies.

Section 12.12. Lessee shall pay to Lessor all reasonable costs and expenses, including, without limitation, reasonable attorneys' fees and disbursements, incurred by Lessor in any

action or proceeding to which Lessor may be made a party by reason of any act or omission of Lessee. Lessee also shall pay to Lessor all reasonable costs and expenses, including, without limitation, actual, customary and reasonable attorneys' fees and disbursements, incurred by Lessor in enforcing any of the covenants and provisions of this Lease and incurred in any action brought by Lessor against Lessee on account of the provisions hereof, and all such costs, expenses and attorneys' fees and disbursements may be included in and form a part of any judgment entered in any proceeding brought by Lessor against Lessee on or under this Lease. All of the sums paid or obligations incurred by Lessor as aforesaid, with interest and costs, shall be paid by Lessee to Lessor on demand.

Section 12.13. If Lessee shall fail to pay any installment of Base Rent or Supplementary Rent within ten (10) days after the date when such payment is due, Lessee shall pay to Lessor, in addition to such payment of Base Rent or Supplementary Rent, as the case may be, interest on the amount unpaid at the Default Rate, computed from the date such payment was due to and including the date of payment.

Section 12.14. Upon the occurrence of any Event of Default which is not immaterial (other than a monetary default under Section 12.1(a) for failure to pay Rent), then unless and until such Event of Default is cured to the satisfaction of Lessor, the Base Rent for each Lease Year shall be increased by the Designated Amount (as defined herein) per annum, and each monthly installment of Base Rent shall be increased by one-twelfth of such increase in annual Base Rent. Upon the cure of the Event of Default, the Base Rent shall, for periods after such cure, revert to the Base Rent without such Designated Amount increase. The "**Designated Amount**" shall be $10,000 for the first such occurrence, $100,000 for the second such occurrence and five (5%) percent over the existing Base Rent for the third and each subsequent occurrence.

ARTICLE 13

NO WAIVER

Section 13.1. No receipt of moneys by Lessor from Lessee after the termination or cancellation of this Lease or termination of Lessee's right to possess the Premises (or after the giving of any notice of the termination of this Lease or Lessee's right to possess the Premises) shall reinstate, continue or extend the Term, or affect any notice theretofore given to Lessee, or affect or otherwise operate as a waiver of the right of Lessor to enforce the payment of Base Rent or Supplementary Rent then due, or thereafter falling due, or operate as a waiver of the right of Lessor to recover possession of the Premises by proper suit, action, proceeding or remedy; it being agreed that, after the service of notice to terminate or cancel this Lease or Lessee's right to possess the Premises, or the commencement of suit, action or summary proceedings, or any other remedy, or after a final order or judgment for the possession of the Premises, Lessor may demand, receive and collect any moneys due, or thereafter falling due, without, in any manner whatsoever, affecting such notice, proceeding, suit, action, order or judgment; and any and all such moneys collected shall be deemed to be payments on account of the use and occupation of the Premises or, at the election of Lessor, on account of Lessee's liability hereunder. The acceptance of any check or payment bearing or accompanied by any endorsement, legend or statements shall not, of itself, constitute any change in or termination of this Lease.

Section 13.2. The failure of Lessor to enforce any agreement, condition, covenant or term, by reason of its breach by Lessee shall not be deemed to void, waive or affect the right of Lessor to enforce the same agreement, condition, covenant or term on the occasion of a subsequent default or breach, provided that Lessor shall be under no obligation to enforce any agreement, condition, covenant or term breached by Lessee. No surrender of the Premises by Lessee (prior to any termination of this Lease) shall be valid unless consented to in writing by Lessor.

ARTICLE 14

ESTOPPEL CERTIFICATE; CONSENT

Section 14.1. Lessee agrees that it shall, at any time and from time to time upon not less than ten (10) days' prior notice by Lessor, execute, acknowledge and deliver to Lessor a statement in writing certifying that this Lease is unmodified and in full force and effect (or if there have been any modifications, that the Lease is in full force and effect as modified and stating the modifications), the Base Rent and Supplementary Rent payable and the dates to which the Base Rent and Supplementary Rent have been paid, that the address for notices to be sent to Lessee is as set forth in this Lease, stating whether or not Lessor is in default in keeping, observing or performing any term, covenant, agreement, provision, condition or limitation contained in this Lease and, if in default, specifying each such default, the Commencement Date and Expiration Date for the current Term, that Lessee is in possession of the Premises, and any other matters requested by Lessor; it being intended that any such statement delivered pursuant to this Article 14 may be relied upon by Lessor or any prospective purchaser of the Premises or any Mortgagee thereof or any assignee of any Mortgage upon the Premises.

Section 14.2. Lessor expects to secure financing, on one or more occasions, of its interest in the Premises by, among other things, assigning Lessor's interest in this Lease and the sums payable hereunder to Mortgagee. Lessee agrees, upon not less than ten (10) days' prior notice by Lessor, to execute, acknowledge and deliver to Lessor a consent to any such assignment addressed to the applicable Mortgagee in such Mortgagee's standard form and Lessee will produce such certificates and other documents as may be requested by Mortgagee.

Section 14.3. Lessor agrees that it shall, at any time and from time to time upon not less than ten (10) days' prior notice by Lessee, execute, acknowledge and deliver to Lessee a statement in writing certifying that this Lease is unmodified and in full force and effect (or if there have been any modifications, that the Lease is in full force and effect as modified and stating the modifications), the Base Rent and Supplementary Rent payable and the dates to which the Base Rent and Supplementary Rent have been paid, that the address for notices to be sent to Lessor is as set forth in this Lease, stating whether or not Lessee is in default in keeping, observing or performing any term, covenant, agreement, provision, condition or limitation contained in this Lease and, if in default, specifying each such default, the Commencement Date and Expiration Date for the current Term, that Lessee is in possession of the Premises, and any other matters requested by Lessee; it being intended that any such statement delivered pursuant to this Article 14 may be relied upon by Lessee or any prospective purchaser of the Premises or any Mortgagee thereof or any assignee of any Mortgage upon the Premises.

ARTICLE 15

QUIET ENJOYMENT

Section 15.1. Lessee, upon payment of the Rents herein reserved and upon the due performance and observance of all the covenants, conditions and agreements herein contained on Lessee's part to be performed and observed, including without limitation, the maintenance by Lessee of all necessary Health Care Licenses for the Facility in good standing and the compliance by Lessee with all Requirements of Health Care Regulatory Agencies, shall and may at all times during the Term peaceably and quietly have, hold and enjoy the Premises without any manner of suit, trouble or hindrance of and from any person claiming by, through or under Lessor, subject, nevertheless, to the terms and provisions of this Lease.

ARTICLE 16

SURRENDER

Section 16.1. Lessee shall, on the last day of the Term, or upon the sooner termination of the Term, quit and surrender to Lessor the Premises (including the Leased Personal Property) vacant, free of all equipment, furniture and other movable personal property owned by Lessee, and in the same level of condition and repair as on the Closing Date, reasonable wear and tear, and damage from condemnation and from Lessee's Election not to restore under Section 7.7 after casualty excepted, and Lessee shall remove or demolish all of the fixtures, structures and other improvements which Lessor shall have elected to cause Lessee to remove pursuant to and in accordance with Section 5.7 hereof; *provided, however,* that at the termination of the Lease, Lessee shall allow the successor Lessee to use Lessee's Personal Property for a reasonable period of time until such successor Lessee is able to acquire replacements for such Lessee's Personal Property, as long as the successor Lessee shall pay Lessee the reasonable rental value for such use. Lessee further agrees and acknowledges that termination of this Lease for any reason or no reason shall not affect the Health Care Licenses and that the Health Care Licenses shall at all times and under all circumstances remain the property of Lessor. Upon termination of this Lease, Lessor may, to the extent permitted by law, cause the transfer of Health Care Licenses relating to the Facility and the operation and management of the Facility and leasing of the Premises to any replacement operator, manager or Lessee of the Facility designated by Lessor and seek the approval of Health Care Regulatory Agencies in connection therewith, in which event Lessee shall cooperate with Lessor to transfer all books and records relating to the Facility and transition services to the new operator Lessee so as to provide continuation of patient care and minimize disruption. Lessee's obligation to observe and perform this covenant shall survive the expiration or earlier termination of the Term. In the event that Lessee fails to surrender the Premises as aforesaid, Lessor shall have the right to exercise the applicable remedies upon the occurrence of an Event of Default. Lessee shall have the right, as long as it is not in default under this Lease, upon the expiration of the Term(but subject to the temporary use by the successor Lessee referred to above), to remove from the Premises all of Lessee's Personal Property, whether or not the same be attached to the real estate, *provided that* Lessee shall at its own cost and expense reasonably restore and repair any damage to the Premises caused by the removal of Lessee's Personal Property. Such removal shall be done upon advance notice, at a mutually convenient time approved by Lessor and without disruption of the successor Lessee's

business operations. The term "ordinary wear and tear" as used herein shall not be construed as permitting any missing items or components of any item of Leased Personal Property. Upon surrender, Lessee shall provide any additional documentation reasonably requested by Lessor relating to redelivery of or Lessor's interest in each item of Leased Personal Property.

Section 16.2. Upon the expiration of the Term, all Base Rent and Supplementary Rent and other items payable by Lessee under this Lease shall be apportioned to the date of termination.

Section 16.3. Lessee acknowledges that possession of the Premises must be surrendered to Lessor at the expiration or sooner termination of the term of this Lease. The parties recognize and agree that the damage to Lessor resulting from any failure by Lessee to timely surrender possession of the Premises as aforesaid will be extremely substantial, will exceed the amount of the Base Rent, Additional Rent and Supplementary Rent theretofore payable hereunder, and will be impossible to accurately measure. Lessee therefore agrees that if possession of the Premises is not surrendered to Lessor upon the expiration or sooner termination of the term of this Lease, then Lessee shall pay to Lessor, as liquidated damages for each month and for each portion of any month during which Lessee holds over in the Premises after the expiration or sooner termination of the term of this Lease, a sum equal to the higher of the then fair market rental value of the Premises, taking into account the effect of all material factors reasonably relevant to such determination, or two (2) times the aggregate of the Base Rent and Supplementary Rent which was payable under this Lease with respect to the last month of the term hereof. Nothing herein contained shall be deemed to permit Lessee to retain possession of the Premises after the expiration or sooner termination of the term of this Lease; and in the event of any unauthorized holding over, Lessee shall indemnify Lessor against all claims for damages by any other lessee or prospective lessee to whom Lessor may have leased all or any part of the Premises effective before or after the expiration or termination of the Term of this Lease. If Lessee holds over in possession after the expiration or termination of the term of the Lease, such holding over shall not be deemed to extend the term or renew this Lease, but the tenancy thereafter shall continue as a tenancy from month to month upon the terms and conditions of this Lease at the Base Rent and Supplementary Rent as herein increased. Lessee hereby waives the benefit of any law or statute in effect in the state where the Premises is located which would contravene or limit the provisions set forth in this Section 16.3. This provision shall survive the expiration or earlier termination of this Lease.

ARTICLE 17

ACCESS

Section 17.1. Lessor shall at all times during the Term have the right and privilege to enter the Premises at reasonable times during business hours, following notice from Lessor and so long as such entry does not unduly interfere with Lessee's normal business operations, for the purpose of inspecting the same or for the purpose of showing the same to prospective purchasers or Mortgagees thereof. Lessor shall also have the right and privilege at all times during the Term to post notices of nonresponsibility for work performed by or on behalf of Lessee and, during the last one (1) year of the Term, Lessor shall have the right and privilege following reasonable notice from Lessor and so long as such entry does not unduly interfere with Lessee's normal

business operations, to enter the Premises at reasonable times during business hours for the purpose of exhibiting the same to prospective new Lessees.

Section 17.2. Lessor shall at all times during the Term have the right to enter the Premises or any part thereof, following written notice from Lessor and so long as such entry does not unduly interfere with Lessee's normal business operations, for the purpose of making such repairs or Alterations therein as Lessor deems necessary or advisable following the failure of Lessee to make any such repairs or Alterations beyond any applicable notice and cure period, but such right of access shall not be construed as obligating Lessor to make any repairs to or replacements to the Premises or as obligating Lessor to make any inspection or examination of the Buildings. Notwithstanding the foregoing, in the event of an emergency, Lessor shall have the right to enter the Premises or any part thereof without prior notice to Lessee.

ARTICLE 18

ENVIRONMENTAL MATTERS

Section 18.1. Lessee will not use, generate, manufacture, produce, store, release, discharge or dispose of in, on, under, from or about the Premises or transport to or from the Premises any Hazardous Substance and will not allow or suffer any other person or entity to do so (except for non-material quantities of substances which are customarily used in the ordinary operation of a nursing home and for which Lessee has obtained any necessary permits, collectively, "Immaterial Use").

Section 18.2. Lessee shall keep and maintain the Premises in compliance with, and shall not cause, permit or suffer the Premises to be in violation of any Environmental Law.

Section 18.3. Lessee shall give prompt written notice to Lessor of:

(i) any use, generation, manufacture, production, storage, release, discharge or disposal of any Hazardous Substance in, on, under, from or about the Premises or the migration thereof to or from other property, in each case, during the Term (other than Immaterial Use);

(ii) the commencement, institution or threat of any proceeding, inquiry or action by or written notice from any local, state or federal governmental authority with respect to the use or presence of any Hazardous Substance in, on, under, from or about the Premises or the migration thereof from or to other property, in each case, during the Term;

(iii) all claims made or threatened by any third party against Lessee or the Premises relating to any damage, contribution, cost recovery, compensation, loss or injury resulting from any Hazardous Substance, in each case, during the Term;

(iv) any occurrence or condition on the Premises, in each case, during the Term, that could cause the Premises or any part thereof to be subject to any restrictions on the ownership, occupancy, transferability or use under any Environmental Law; and

(v) any claims for the incurrence of expense by any governmental authority or others in connection with the assessment, containment or removal of any Hazardous Substance located on, under, from or about the Premises, in each case, during the Term.

Lessor shall give prompt written notice to Lessee of any of the facts, events or circumstances set forth in (ii) and (iii) above, including all claims under Environmental Laws commenced or threatened against Lessor with respect to the Premises during the Term.

Section 18.4. Lessor shall have the right, but not the obligation, to join and participate in, as a party if it so elects, any legal proceedings or actions initiated with respect to the Premises in connection with any Environmental Law. In the event that Lessee refuses or fails to defend any such legal proceedings or actions concerning matters for which Lessee has primary responsibility under this Article 18, Lessor shall have the right, but not the obligation to defend proceedings or actions using counsel chosen by Lessor, and Lessee shall reimburse Lessor for its actual, customary and reasonable attorney's fees incurred in connection with such defense.

Section 18.5. Without Lessor's prior written consent, which consent shall not be unreasonably withheld or delayed, Lessee shall not take any remedial action, other than pursuant to the plan developed in accordance with Section 18.8, in response to the presence of any Hazardous Substance in, on, under, from or about the Premises, nor enter into any settlement, consent or compromise which might, in Lessor's judgment, impair the value of Lessor's interest in the Premises under this Lease; *provided, however,* that Lessor's prior consent shall not be necessary if the presence of Hazardous Substance in, on, under, from or about the Premises either poses an immediate threat to the health, safety or welfare of any individual or is of such a nature that an immediate remedial response is necessary and it is not reasonably practical or possible to obtain Lessor's consent before taking such action. In such event Lessee shall notify Lessor as soon as practicable of any action so taken. Lessor agrees not to withhold its consent, where such consent is required hereunder, if a particular remedial action is ordered by a court or any agency of competent jurisdiction.

Section 18.6. (a) Lessee shall protect, indemnify and hold harmless Lessor, its Affiliates, each Mortgagee, their respective directors, officers, partners, managers, members (including any partners, members or managers of any partners, members or managers of Lessor), employees, agents, successors and assigns (and any partners, members or managers of any of the foregoing) from and against any and all claim, loss, damage, cost, expense, liability, fines, penalties, charges, administrative and judicial proceedings and orders, judgments, remedial action requirements, enforcement actions of any kind (including, without limitation, attorneys' fees and costs) directly or indirectly arising out of or attributable to, in whole or in part, (i) the breach of any of the covenants, representations and warranties of this Article 18 by the Lessee, or (ii) the use, generation, manufacture, production, storage, release, threatened release, discharge or disposal of a Hazardous Substance in, on, under, from or about the Premises that first occurs during the Term ("**Post Commencement Hazardous Substance Release**") or (iii) any violation or liability under any Environmental Law arising from any other activity carried on or undertaken on the Premises during the Term by Lessee or any employees, agents, contractors or subcontractors of Lessee or any third persons occupying or present on the Premises during the Term, including, without limitation: (i) all consequential damages; (ii) the costs of any required or necessary repair, cleanup or detoxification of the Premises and the preparation and

implementation of any closure, remedial or other required plans including, without limitation: (A) the costs of removal or remedial action incurred by the United States Government or the state in which the Premises are located, or response costs incurred by any other person, or damages from injury to, destruction of, or loss of natural resources, including the costs of assessing such injury, destruction or loss, incurred pursuant any Environmental Law; (B) the clean-up costs, fines, damages or penalties incurred pursuant to the provisions of applicable state law; and (C) the cost and expenses of abatement, correction or clean-up, fines, damages, response costs or penalties which arise from the provisions of any other statute, state or federal; and (iii) liability for personal injury or property damage, including damages assessed for the maintenance of the public or private nuisance, response costs or for the carrying on of an abnormally dangerous activity.

This indemnity is intended to be operable under 42 U.S.C. Section 9607(e)(1), and any successor section thereof and shall survive expiration or earlier termination of this Lease and any transfer of all or a portion of the Premises by Lessee.

(b) The foregoing indemnity shall in no manner be construed to limit or adversely affect Lessor's rights under this Article 18, including, without limitation, Lessor's rights to approve any Remedial Work or the contractors and consulting engineers retained in connection therewith.

(c) The foregoing indemnity shall not apply to any Pre-Commencement Hazardous Substance Release (as defined below) or any contamination of the Premises caused by the gross negligence or willful misconduct of Lessor or its agents or employees (**but such indemnity shall specifically cover such party's simple negligence**).

Section 18.7. In the event that any investigation, site monitoring, containment, cleanup, removal, restoration or other remedial work of any kind or nature (the "**Remedial Work**") is required by any applicable local, state or federal law or regulation, any judicial order, or by any governmental entity or person because of, or in connection with, any Post Commencement Hazardous Substance Release, Lessee shall within thirty (30) days after written demand for performance thereof by Lessor (or such shorter period of time as may be required under any applicable law, regulation, order or agreement), commence to perform, or cause to be commenced, and thereafter diligently prosecute to completion within such period of time as may be required under any applicable law, regulation, order or agreement (or as otherwise required by Lessor), all such Remedial Work at Lessee's sole expense in accordance with the requirements of any applicable governmental authority or Environmental Law. All such Remedial Work shall be performed by one or more contractors, approved in advance in writing by Lessor, which approval may be withheld by Lessor's sole and absolute discretion, and under the supervision of a consulting engineer approved in advance in writing by Lessor. All costs and expenses of such Remedial Work shall be paid by Lessee, including, without limitation, the charges of such contractor(s) and/or the consulting engineer, and Lessor's actual, customary and reasonable attorneys' fees and costs incurred in connection with monitoring or review of such Remedial Work. In the event Lessee shall fail to timely commence, or cause to be commenced, or fail to complete such Remedial Work within the time required above, Lessor may, but shall not be required to, cause such Remedial Work to be performed and all reasonable costs and expenses

thereof, or incurred in connection therewith shall become part of the indebtedness secured hereby.

Section 18.8. In the event that Lessor believes that there may be a violation or threatened violation by Lessee of any Environmental Law or a violation or threatened violation by Lessee of any covenant under this Article 18, Lessor is authorized, but not obligated, by itself, its agents, employees or workmen to enter at any reasonable time following notice, so long as such entry does not unduly interfere with Lessee's normal conduct of business, upon any part of the Premises for the purposes of inspecting the same for Hazardous Substances and Lessee's compliance with this Article 18, and such inspections may include, without limitation, soil borings. If such inspection reveals any violation of Environmental Law or violation by Lessee of any covenant under this Article 18 or the existence of any Post Commencement Hazardous Substance Release (other than an immaterial technical violation or liability), Lessee agrees to pay to Lessor, within ten (10) days after Lessor's written demand, all actual, customary and reasonable expenses, costs or other amounts incurred by Lessor in performing any inspection for the purposes set forth in this Section 18.8.

Section 18.9. All costs and expenses incurred by Lessor under this Article 18 shall be immediately due and payable as Supplementary Rent within ten (10) days after written demand and shall bear interest at the Default Rate from the date of notice of such payment by Lessor and the expiration of any grace period provided herein until repaid.

Section 18.10. "**Environmental Laws**" shall mean any federal, state or local law, statute, ordinance or regulation pertaining to health, industrial hygiene, hazardous waste or the environmental conditions in, on, under, from or about the Premises, including, without limitation, the laws listed in the definition of Hazardous Substances below.

Section 18.11. "**Hazardous Substances**" shall mean any element, compound, chemical mixture, contaminant, pollutant, material, waste or other substance which is defined, determined or identified as a "hazardous substance", "hazardous waste" or "hazardous material" under any federal, state or local statute, regulation or ordinance applicable to a Real Property, as well as any amendments and successors to such statutes and regulations, as may be enacted and promulgated from time to time, including, without limitation, the following: (i) the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (codified in scattered sections of 26 U.S.C., 33 U.S.C., 42 U.S.C. and 42 U.S.C. § 9601 et. seq.); (ii) the Resource Conservation and Recovery Act of 1976 (42 U.S.C. § 6901 et. seq.); (iii) the Hazardous Materials Transportation Act (49 U.S.C. § 1801 et. seq.); (vi) the Toxic Substances Control Act (15 U.S.C. § 2601 et. seq.); (v) the Clean Air Act (33 U.S.C. § 1251 et. seq.); (vi) the Clean Air Act (42 U.S.C. § 7401 et. seq.) ; (vii) the Safe Drinking Water Act (21 U.S.C. § 349; 42 U.S.C. § 201 and § 300f et. seq.); (viii) the National Environmental Policy Act of 1969 (42 U.S.C. § 3421); (ix) the Superfund Amendment and Reauthorization Act of 1986 (codified in scattered sections of 10 U.S.C., 29 U.S.C., 33 U.S.C. and 42 U.S.C.); and (x) Title III of the Superfund Amendment and Reauthorization Act (40 U.S.C. § 1101 et. seq.).

Responsibility for Pre-Closing Conditions. Neither Lessor nor Lessee makes or provides any representation, warranty or indemnity with regard to the presence or existence of Hazardous Substances located or present in, on under or from the Premises, or the compliance of the

Premises with Environmental Laws, or other environmental condition of the Premises, on or prior to the Closing Date. As between Lessor and Lessee, Lessee shall be responsible for the first $10,000 (Ten Thousand Dollars) of costs and expenses of Remedial Work in connection with any Pre-Commencement Hazardous Substance Release (as defined herein) at the Premises, and Lessor shall be responsible for any excess over such amount of costs and expenses of Remedial Work in connection with any Pre-Commencement Hazardous Substance Release. **"Pre-Commencement Hazardous Substance Release"** is defined as the use, generation, manufacture, production, storage, release, threatened release, discharge or disposal of a Hazardous Substance in, on, under, from or about the Premises that first occurs prior to the Commencement Date. Lessor and Lessee shall cooperate in the enforcement of remedies against third parties which may be responsible for environmental conditions at the Premises on or prior to the Closing Date.

Section 18.12. Medical Waste and Drug Compliance. Lessee shall be responsible for safe and secure storage, transport and off-site disposal of medical waste materials, including without limitation, infectious waste and radioactive materials, and shall cause the promulgation and compliance by the Facility and all personnel with protocols for storage and disposal of such waste and compliance with Requirements relating thereto. Lessee shall be responsible for the safe and secure storage and dispensation of pharmaceuticals, drugs and controlled substances at the Facility and shall cause the promulgation and compliance by the Facility and all personnel with protocols for storage and dispensation of such pharmaceuticals, drugs and controlled substances and compliance with Requirements relating thereto.

Section 18.13. All representations, warranties, covenants and indemnities of Lessee in this Article 18 shall continue to be binding upon Lessee, and its successors and assigns, after the expiration or earlier termination of this Lease.

ARTICLE 19

FINANCIAL AND REGULATORY REPORTING COVENANTS

Section 19.1. Reporting Requirements. Lessee will furnish to Lessor:

(a) Annual Audited Financial Statements. As soon as available, and in any event within one hundred twenty (120) days after the end of each fiscal year of Lessee, beginning with the fiscal year ending 2009, (i) a copy of the annual audit report of the Lessee for such fiscal year containing balance sheets and statements of income, retained earnings, and cash flow as at the end of such fiscal year and for the fiscal year then ended, in each case setting forth in comparative form the figures for the preceding fiscal year, all in reasonable detail and audited and certified on an unqualified basis by reputable firm of independent certified public accountants, to the effect that such report has been prepared in accordance with GAAP; (ii) individual operating statements for the facility at the premises of this Lease and each other Lease and (iii) a copy of Projections for Lessee's fiscal year immediately following the fiscal year which is the subject of the financial statements delivered pursuant to clause (i) preceding.

(b) Notice of Litigation. Promptly after receipt by Lessee of notice of the commencement thereof, notice of all actions, suits, and proceedings before any Governmental

Authority or arbitrator affecting Lessee or any Subsidiary which, if determined adversely to Lessee or such Subsidiary, could result in a judgment equal to or greater than $250,000.

(c) Notice of Regulatory Actions. Promptly after receipt by Lessee of the notice of commencement thereof, notice of (i) any audit, investigation, claim (excluding adjustments, complaints, and corrective activity in the ordinary course of business) (including without limitation, Recoupment Claims), proceeding, settlement, judgment, consent order, or corporate integrity agreement by or imposed by any Health Care Regulatory Agency, (ii) any suspension, debarment or disqualification of Lessee or any of Lessee's Affiliates from being a health care provider, government contractor, holder of any Health Care License or recipient of reimbursement from any Third Party Payor, (iii) any suspension, termination, or revocation of any Health Care License of Lessee or any of Lessee's Affiliates or (iv) any self or voluntary disclosure of any overpayment to a Third Party Payor by Lessee or any of Lessee's Affiliates.

(d) Notice of Settlement Negotiations. Lessee shall provide the Lessor with reasonable notice of any and all settlement discussions and/or negotiations (excluding adjustments, complaints and corrective activity in the ordinary course of business) between representatives of the Lessee and any Health Care Regulatory Agency, including without limitation negotiations with respect to any Claim (including without limitation, Recoupment Claims), settlement agreement, consent order or corporate integrity agreement between Lessee and its Affiliates and any Health Care Regulatory Agency ("Settlement Discussions"). In connection with Settlement Discussions, (i) Lessee shall timely provide Lessor with copies of any and all documents that the Lessee intends to submit, or that Lessee receives, in connection with any Settlement Discussions, and (ii) Lessee shall advise Lessor as to the status of the Settlement Discussions.

(e) No receipts of any such notice under subsections (d), (e) and (f) shall impose any obligation on Lessor to take any action or to enforce its rights hereunder or otherwise remedy the circumstances leading to such notice.

ARTICLE 20

LICENSED FACILITY OPERATION; ACCESS TO BOOKS AND RECORDS

Section 20.1. The parties agree that if this Lease is determined to be governed by §1861(v)(1)(i) of the Social Security Act (§952 of the Omnibus Reconciliation Act of 1980) and the regulations promulgated in implementation thereof at 42 CFR Part 420, the parties each agree to make available to the Comptroller General of the United States, the Department of Health and Human Services ("**HHS**") nd any state or municipal agency with jurisdiction thereof and their duly authorized representatives, the books, documents and records of either of the parties and such other information as may be required by the Comptroller General or Secretary of HHS to verify the nature and extent of the costs of services provided by either of the parties. If either of the parties carry out the duties of this Lease through a subcontract worth $10,000 or more over a twelve (12) month period with a related organization, the subcontract will also contain an access clause to permit access by the Secretary, Comptroller General and their representatives to the related organization's books and records.

Section 20.2. During the Term of this Lease, Lessee shall (i) no less often than quarterly, provide Lessor with a copy of Lessee's most recent profit and loss statement and balance sheet, (ii) provide Lessor with a copy of each cost report Lessee may submit to the State or any other governmental agency or administrator of a public program, (iii) provide Lessor with a true, correct and complete copy of each survey, study, investigatory report, etc. performed by or on behalf of any federal, state or local governmental authority, (iv) provide Lessor with true, correct and complete copies of all monthly census information and/or data, and (v) produce any other financial information as may be reasonably requested by Lessor from time to time, including, without limitation, census information and data.

Section 20.3. Lessee shall operate the Facility as a Permitted Facility. Lessor is merely the lessor of the real property which is the subject of this Lease and shall have no liability in connection with the operation of the Facility or the provision of health care services from or at the facility. Lessee shall have the exclusive responsibility (i) as the operator, licensee and provider of the Facility and all health care services provided from or at the Facility, independent and separate from Lessor; (ii) for securing and maintaining in full force and effect all Health Care Licenses relating to such Facility and services; (iii) for compliance with all Requirements including without limitation all Requirements of Health Care Regulatory Agencies and under Health Care Licenses, (iv) for quality control of such Facility and services, and (v) for all computer systems, software, record keeping, data bases and privacy requirements relating to the Facility, all of which shall be provided at Lessee's own expense.

Section 20.4. For purposes of satisfying the requirements of any Mortgage, or any refinancing, sale or appraisal process, Lessor shall have the right (but not the obligation) to conduct such inspections, audits, visitations and quality control reviews, of the Facility and services provided by Lessee from or at the Facility as Lessor may desire, and for such purposes Lessee shall provide to Lessor and its representatives access to Lessee's books and records relating to such facilities and services during normal business hours upon reasonable notice. No such inspection, audit, visitation or quality control review conducted by Lessor or its representatives or any report resulting therefrom shall modify or reduce in any way Lessee's obligations under this Lease or as the exclusive operator, licensee and provider of the Facility and health care services from or at the Facility.

Section 20.5. Lessor and Lessee shall be independent contractors and nothing in this Lease shall be construed as creating a partnership, joint venture, employment, agency, license or franchise relationship. Lessee shall not have any authority to create any obligation binding upon Lessor.

Section 20.6. All employees, contractors, consultants, professionals and providers relating to the Facility and health care services provided from or at the Facility shall be deemed to be employees or contractors of Lessee and not of Lessor. Lessee shall by the closing date, hire and assume all responsibilities with respect to employees of the Facility, as promised in the Assignment and Assumption Agreement of even date herewith between Lessor as assignor and Lessee as assignee.

Section 20.7. Lessee shall have the exclusive obligation to obtain and provide at its own expense all deposits, bonds, insurance, letters of credit, working capital, cash collateral, reserves,

patient trust fund accounts and other financial requirements of Health Care Licenses to operate and provide health care services at the Facility.

Section 20.8. Lessee shall assume and shall have the exclusive responsibility for all Claims of overpayment or recoupment made by Third Party Payors, including without limitation, Medicaid and Medicare, relating to the provision of health care services from or at the Facility, including both (i) those attributable to periods on or prior to the date of those Lease and (ii) those attributable to periods from and after the date of this Lease (collectively, "Recoupment Claims"). Lessee shall continue to have such exclusive responsibility for Recoupment Claims regardless of whether Lessee assumes and utilizes the Medicare/Medicaid provider numbers of the Facility in existence prior to the date of this Lease or Lessee obtains new Medicare/Medicaid provider numbers for the Facility.

Section 20.9. [Reserved]

Section 20.10. [Reserved]

Section 20.11. The parties acknowledge that Lessee and Lessee's Affiliates, which are experienced operators of health care facilities similar to the Facility, have conducted all of their own due diligence, examination and inspection regarding the Facility and the business of providing health care services from and at the Facility and are entirely familiar with all business, financial, liability, physical premises, operational and regulatory aspects, and every other matter or thing affecting or related to the health care business operated at the Facility, and that Lessee **is leasing the same in its "As Is" condition. Lessor has not made and does not make any representations or warranties whatsoever with respect to the health care business conducted at and from the Facility or otherwise with respect to this Lease, express or implied**, and Lessee is not relying on Lessor or its Affiliates in connection with any decision to enter into this Lease. Lessee assumes all risks resulting from any defects (patent or latent) in the Premises or from any failure of the same to comply with any Requirement or other governmental law or regulation applicable to the Premises or the uses or purposes for which the same may be occupied; *provided, however,* that Lessee's obligation to pay or fund any escrows, reserves, and other requirements imposed by any Mortgage.

ARTICLE 21

MISCELLANEOUS PROVISIONS

Section 21.1. It is mutually agreed by and between Lessor and Lessee that the respective parties shall and they hereby do waive trial by jury in any action, proceeding or counterclaim brought by either of the parties hereto against the other on any matters whatsoever arising out of or in any way connected with this Lease, Lessee's use or occupancy of the Premises, and/or any claim of injury or damage excluding any claim for personal injury or property damage.

Section 21.2. With the prior written consent of Lessor, which may be withheld in its reasonable discretion, Lessee may place one or more signs on the Premises to indicate the nature of the business of Lessee and such parties. Any sign shall be lawful under applicable sign codes and subdivision covenants.

Section 21.3. (a) The term "**Lessor**" as used herein shall mean only the owner or the mortgagee in possession for the time being of the Premises, so that in the event of any sale, transfer or conveyance of the Premises Lessor shall be and hereby is entirely freed and relieved of all agreements, covenants and obligations of Lessor thereafter accruing hereunder and it shall be deemed and construed without further agreement between the parties or their successors in interest or between the parties and the purchaser, transferee or grantee at any such sale, transfer conveyance that such purchaser, transferee or grantee has assumed and agreed to carry out any and all agreements, covenants and obligations of Lessor hereunder.

(b) The term "**Lessee**" as used herein shall mean the Lessee named herein, and from and after any valid and approved Transfer in whole of said Lessee's interest under this Lease pursuant to the provisions of Article 9, shall mean only the assignee or transferee thereof; but the foregoing shall not release the assignor or transferor from liability under this Lease.

(c) The words "**enter**", "**re-enter**", "**entry**" and "**re-entry**" as used in this Lease shall not be restricted to their technical legal meaning.

(d) The use herein of the neuter pronoun in any reference to Lessor or Lessee shall be deemed to include any individual Lessor or Lessee, and the use herein of the words "**successor and assigns**" or "**successors or assigns**" of Lessor or Lessee shall be deemed to include the heirs, executors, administrators, representatives and assigns of any individual Lessor or Lessee.

Section 21.4. The headings herein are inserted only as a matter of convenience and for reference and in no way define, limit or describe the scope or intent of this Lease nor in any way affect this Lease.

Section 21.5. [Reserved]

Section 21.6. This Lease contains the entire agreement between the parties and may not be extended, renewed, terminated or otherwise modified in any manner except by an instrument in writing executed by the party against whom enforcement of any such modification is sought. All prior understandings and agreements between the parties and all prior working drafts of this Lease are merged in this Lease, which alone expresses the agreement of the parties. The parties agree that no inferences shall be drawn from matters deleted from any working drafts of this Lease.

Section 21.7. The agreements, terms, covenants and conditions herein shall bind and inure to the benefit of Lessor and Lessee and their respective heirs, personal representatives, successors and, except as is otherwise provided herein, their assigns.

Section 21.8. Notice whenever provided for herein shall be in writing and shall be given either by personal delivery, overnight express mail or by certified or registered mail, return receipt requested, to Lessor at the address hereinabove set forth; and to Lessee at the address hereinabove set forth; or to such other persons or at such other addresses as may be designated from time to time by written notice from either party to the other. Notices shall be deemed given (i) when delivered personally if delivered on a Business Day (or if the same is not a Business Day, then the next Business Day after delivery), (ii) two (2) Business Days after being deposited

in the United States mail, registered or certified mail, postage prepaid, return receipt requested or (iii) if delivery is made by Federal Express or a similar, nationally recognized overnight courier service for 9:00 a.m. delivery, then on the date of delivery (or if the same is not a Business Day, then the next Business Day after delivery), if properly sent and addressed in accordance with the terms of this Section 21.8.

Section 21.9. If any provision of this Lease shall be invalid or unenforceable, the remainder of the provisions of this Lease shall not be affected thereby and each and every provision of this Lease shall be enforceable to the fullest extent permitted by law.

Section 21.10. Lessor and Lessee each represent and warrant to the other party that such party has not dealt with any real estate broker in connection with this Lease and Lessor and Lessee agree to indemnify the other party and save the other party harmless from any and all claims for brokerage commissions by any other person, firm, corporation or other entity claiming through such party to have brought about this Lease transaction. The provisions of this Section 21.10 shall survive the expiration or earlier termination of this Lease.

Section 21.11. Lessee is and shall be in exclusive control and possession of the Premises and Lessee shall operate the Facility on the Premises at Lessee's sole and absolute discretion without control, interference or direction from Lessor or agents of Lessor (except as expressly set forth to the contrary in this Lease), and Lessor shall not, in any event whatsoever, be liable for any injury or damage to any property or to any person happening in, on or about the Premises, nor for any injury or damage to any property of Lessee, or of any other person or persons contained therein unless the same is caused by Lessor's gross negligence or willful misconduct. The provisions hereof, including without limitation Article 17, permitting Lessor to enter and inspect the Premises are made for the purpose of enabling Lessor to be informed as to whether Lessee is complying with the agreements, terms, covenants and conditions hereof, and if Lessor so desires, to do such acts as Lessee shall fail to do. Lessee agrees to look solely to Lessor's interests in the Premises for recovery of any judgment from Lessor and in no event shall Lessor (or its partners, shareholders, officers, directors or affiliates) ever be personally liable for any such judgment.

Section 21.12. A memorandum of this Lease as set forth on **Exhibit B** attached hereto and incorporated herein by this reference may be recorded by Lessor. The memorandum of lease shall not under any circumstances mention the rental payments.

Section 21.13. The parties took equal part in drafting this Lease and no rule of construction that would cause any of the terms hereof to be construed against the drafter shall be applicable to the interpretation of this Lease.

Section 21.14. Time is strictly of the essence with respect to each and every term and provision of this Lease.

Section 21.15. The time within which either party hereto shall be required to perform any act under this Lease, other than the payment of money, shall be extended by a period of time equal to the number of days during which performance of such act is delayed by strikes, lockouts, acts of God, governmental restrictions, failure or inability to secure materials or labor

by reason of priority or similar regulation or order of any governmental or regulatory body, enemy action, civil disturbance, fire, unavoidable causalities or any other cause beyond the reasonable control of either party hereto.

Section 21.16. Lessee hereby waives its statutory lien against rent under applicable law.

Section 21.17. Lessor and Lessee each waive any claim or defense based upon the characterization of this Lease as anything other than a true lease and irrevocably waive any claim or defense which asserts that the Lease is anything other than a true lease. Lessor and Lessee covenant and agree that they will not assert that this Lease is anything but a true lease. Lessor and Lessee each stipulate and agree not to challenge the validity, enforceability or characterization of the lease of the Premises as a true lease and further stipulate and agree that nothing contained in this Lease creates or is intended to create a joint venture, partnership (either de jure or de facto), equitable mortgage, trust, financing device or arrangement, security interest or the like. Lessor or Lessee each shall support the intent of the parties that the lease of the Premises pursuant to this Lease is a true lease and does not create a joint venture, partnership (either de jure or de facto), equitable mortgage, trust, financing device or arrangement, security interest or the like, if, and to the extent that, any challenge occurs.

Section 21.18. Lessee acknowledges and agrees that Lessee's obligations to pay rent hereunder, and the rights of Lessor in and to such Rent, shall be absolute, unconditional and irrevocable. Except as expressly provided for in this Lease, Lessee shall not have any right to terminate this Lease or to be released, relieved, or discharged from any obligations or liabilities hereunder (including, without limitation, the payment of Rent) or entitled to any abatement, suspension, determent, reduction, setoff, counterclaim or defense for any reason whatsoever, including, without limitation, any of the following reasons:

(a) Any defect in, damage to, or destruction of, the Premises or any portion thereof;

(b) Any condemnation, confiscation, requisition, or other taking or sale of the possession, use, occupancy, or title to the Premises or any portion thereof;

(c) Any limitation, restriction, deprivation, or prevention of, or any interference with, the use, occupancy, or possession of the Premises or any portion thereof;

(d) Any set-off, abatement, counterclaim, suspension, recoupment, reduction, rescission, defense or other right or claim that Lessee may have against Lessor, any vendor or manufacturer of or contractor or subcontractor for the Premises or any part of any thereof, or any other person for any reason whatsoever;

(e) The inadequacy, incorrectness, or failure of the description of the Premises or any portion thereof;

(f) Any bankruptcy, insolvency, reorganization, composition, readjustment, liquidation, dissolution, or other proceeding affecting Lessor, any assignee of Lessor, or Lessee or any action with respect to this Lease which may be taken by any receiver, trustee, or liquidator (or other similar official), or by any court;

(g) Force majeure;

(h) Any title defect, lien or matter affecting title to the Premises or eviction by paramount title or otherwise; or

(i) Any default by Lessor under this Lease or the impossibility or illegality of performance by Lessor, Lessee or both.

Lessee hereby waives, to the extent permitted by applicable law, any and all rights that it may now have or that at any time hereafter may be conferred upon it, by statute or otherwise, to modify, terminate, cancel, quit or surrender this Lease or to effect or claim any diminution or reduction of rent payable by Lessee hereunder, except in accordance with the express terms hereof. Lessee agrees that, if for any reason whatsoever this Lease shall be terminated in whole or in part by operation of law or otherwise (except as expressly permitted under this Lease), then Lessee shall pay, to the maximum extent permitted by applicable law, to Lessor or any other person entitled thereto, an amount equal to each installment of Rent and other sums due at the time such payment would have become due and payable in accordance with the terms hereof had this Lease not been terminated in whole or in part. Each payment of Rent and other sums due made by Lessee hereunder shall be final and Lessee shall not seek or have any right to recover all or any part of such payment from Lessor or any person for any reason whatsoever. It is the intention of the parties hereto that the obligations of Lessee hereunder shall be separate and independent covenants and agreements, that the Rent or other sums payable by Lessee hereunder shall continue to be payable in all events and that the obligations of Lessee hereunder shall continue unaffected, unless the requirement to pay or perform the same shall have been abated, reduced or terminated pursuant to an express provision of this Lease.

Section 21.19. Officer's Certificate. On the execution of this Lease, Lessee has delivered an Officer's Certificate as to the corporate/LLC execution, delivery and authorization of this Lease, good standing of the Lessee and incumbency of persons signing the Lease.

Section 21.20. Governing Law/Consent to Jurisdiction/Venue. Irrespective of the place of execution and/or delivery of this Lease or the location of the Premises, this Lease shall be governed by and shall be construed in accordance with, the laws of the State of Connecticut applicable to agreements entered into and to be performed entirely within Connecticut without regarding to conflicts of law principles, *provided, however,* that if, notwithstanding such agreement as to the application of the governing law of the State of Connecticut by the parties, local law in the jurisdiction where the Premises are located requires local law to govern particular claims under this Lease, then to the extent of such requirement, such local law shall govern. The Lessor and the Lessee hereby consent and submit to the exclusive jurisdiction of the state and Federal courts located in with respect to any claim or litigation arising hereunder or any alleged breach of the covenants or provisions contained herein, and acknowledge that proper venue in any matter so claimed or litigated shall be in the state and Federal courts located in Harrisburg, Connecticut provided, however, that (1) Lessor shall be permitted, in addition, if required by local law in the jurisdiction where the Premises are located, to bring any action against Lessee and/or to enforce this Lease in the jurisdiction where the Premises are located and (2) Lessee shall be permitted, in addition, if required by local law in the jurisdiction where the

Premises are located to bring any action against Lessor and/or to enforce this Lease in the jurisdiction where the Premises are located.

[SIGNATURES FOLLOW]

The parties hereto have executed this Lease as of the day and year first above set forth.

Lessor: **COAL NEW HAVEN, LLC**

By: _____
Name: David Silberstein
Title: Managing Member

Lessee: NR **CONNECTICUT, LLC**

By: _____
Name: Peter Schorr
Title: Managing Member

EXHIBIT A

Land and Buildings

Premises located at 915 Ella T. Grasso, Blvd., New Haven, CT
As per Attached Metes and Bounds Description

EXHIBIT A-1

RENT

Annual Base rent, payable in monthly installments:

Commencement Year –	$1,800,000 (pro rated)
Lease Year 2	$2,000,000 per year
Lease Year 3	$2,200,000 per year
Years 4 through 20	Prior year's rent plus 3% increase every year over the prior year (E.g Years 4: $2,266,000) Year 5: ($2,333,980)

EXHIBIT C

WORK LETTER

During the period commencing on the Commencement Date and ending six months therafter, Lessor agrees to pay for the following repairs and improvements "as Incurred", upon compliance with the provisions hereof and due presentation of detailed invoices , provided that same shall not exceed the sum of $1,600,000 in the aggregate. Any excess repairs and improvements shall be at Lessee's sole cost and expense.

Attachment J

In response to CON application item 5e:

Source of funds

Fulton Bank
LISTENING IS JUST THE BEGINNING.℠

October 24, 2012

Mr. David Silberstein
Coal New Haven, LLC
1100 Coney Island Ave
Brooklyn, NY 11230

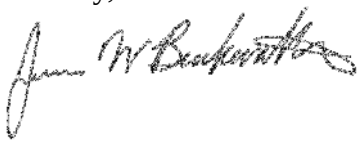
RE: 915 Ella T Grasso Blvd, New Haven, CT

Dear Mr. Silberstein,

Please accept this letter as confirmation that Fulton Bank provided a $7,500,000 financing package to Coal New Haven, LLC ("CNH") for the development of the property located at 915 Ella T Grasso Blvd, New Haven, CT ("the property"). On August 23, 2012, CNH and Fulton Bank executed loan documents for the entire $7,500,000 transaction with approximately $3,200,000 advanced for the initial acquisition and development costs of the property. The remaining available balance of $4,300,000 will be utilized by CNH to fund the additional costs associated with this project including but not limited to, the renovation of the property and for furniture, equipment and the startup costs of CNH's tenant, NR Connecticut, LLC.

If you have any questions regarding the above structure, please do not hesitate to contact me directly at (717) 291-2657.

Sincerely,



J. Whit Buckwalter
Vice President

Retreat
at South Connecticut

Attachment K

In response to CON application item 7:

Financial Attachments I & II, and supporting documentation

Retreat at South Connecticut

In Response to CON Application Question 7 - Financial attachement I

13. B i. Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: **Description**	**FY Actual Results**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**	**FY Projected W/out CON**	**FY Projected Incremental**	**FY Projected With CON**
NET PATIENT REVENUE										
Non-Government			$12,596,215	$12,596,215		$17,700,710	$17,700,710		$20,032,140	$20,032,140
Medicare			$0	$0		$0	$0		$0	$0
Medicaid and Other Medical Assistance			$0	$0		$0	$0		$0	$0
Other Government			$0	$0		$0	$0		$0	$0
Total Net Patient Patient Revenue	$0	$0	$12,596,215	$12,596,215	$0	$17,700,710	$17,700,710	$0	$20,032,140	$20,032,140
Other Operating Revenue			$0			$0			$0	
Revenue from Operations	$0	$0	$12,596,215	$12,596,215	$0	$17,700,710	$17,700,710	$0	$20,032,140	$20,032,140
OPERATING EXPENSES										
Salaries and Fringe Benefits			$6,148,924	$6,148,924		$7,030,851	$7,030,851		$7,241,777	$7,241,777
Professional / Contracted Services			$637,039	$637,039		$712,282	$712,282		$728,105	$728,105
Supplies and Drugs			$554,840	$554,840		$677,688	$677,688		$744,370	$744,370
Bad Debts			$629,811	$629,811		$885,036	$885,036		$1,001,607	$1,001,607
Other Operating Expense			$1,659,000	$1,659,000		$1,730,940	$1,730,940		$1,764,868	$1,764,868
Subtotal	$0	$0	$9,629,613	$9,629,613	$0	$11,036,797	$11,036,797	$0	$11,480,727	$11,480,727
Depreciation/Amortization			$50,000	$50,000		$50,000	$50,000		$50,000	$50,000
Interest Expense			$0	$0		$0	$0		$0	$0
Lease Expense			$914,400	$914,400		$2,014,832	$2,014,832		$2,215,277	$2,215,277
Total Operating Expenses	$0	$0	$10,594,013	$10,594,013	$0	$13,101,629	$13,101,629	$0	$13,746,004	$13,746,004
Income (Loss) from Operations	$0	$0	$2,002,202	$2,002,202	$0	$4,599,081	$4,599,081	$0	$6,286,136	$6,286,136
Non-Operating Income			$0	$0		$0	$0		$0	$0
Income before provision for income taxes	$0	$0	$2,002,202	$2,002,202	$0	$4,599,081	$4,599,081	$0	$6,286,136	$6,286,136
Provision for income taxes(1)			$600,661	$600,661		$1,379,724	$1,379,724		$1,885,841	$1,885,841
Net Income	$0	$0	$1,401,541	$1,401,541	$0	$3,219,357	$3,219,357	$0	$4,400,295	$4,400,295
Retained earnings, beginning of year		$0		$0	$0		$0	$0		$0
Retained earnings, end of year										
FTEs			101.5	101.5		125	125		140	140

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

(1) Although Income tax provision is calculated at 30%, the entity, as a Limited Liability Company, will not be subject to income taxes. Income tax will "pass through" and is the responsibility of the individual members.

Retreat at South Connecticut

In Response to CON Application Question 7 - Financial attachement II

12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description: Substance Abue,
Type of Unit Description: Inpatient and Outpatient
# of Months in Operation: 0

FY 2013 **FY Projected Incremental** Total Incremental Expenses: **Total Facility by** **Payer Category:**	(1)	(2) Rate*	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$1,363	22,880	$31,182,875.00	$18,586,660	$0	$629,811	$11,966,404	$9,964,203	$2,002,201
Uninsured		$0		$0				$0	$0	$0
Total NonGovernment		$0		$31,182,875	$18,586,660	$0	$629,811	$11,966,404	$9,964,203	$2,002,201
Total All Payers		$0	0	$31,182,875	$18,586,660	$0	$629,811	$11,966,404	$9,964,203	$2,002,201

FY 2014 **FY Projected Incremental** Total Incremental Expenses: **Total Facility by** **Payer Category:**	(1)	(2) Rate*	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$1,450	29,040	$42,107,500.51	$24,406,790	$0	$885,036	$16,815,675	$12,216,593	$4,599,081
Uninsured		$0		$0				$0	$0	$0
Total NonGovernment		$0		$42,107,501	$24,406,790	$0	$885,036	$16,815,675	$12,216,593	$4,599,081
Total All Payers		$0	0	$42,107,501	$24,406,790	$0	$885,036	$16,815,675	$12,216,593	$4,599,081

FY 2015 **FY Projected Incremental** Total Incremental Expenses: **Total Facility by** **Payer Category:**	(1)	(2) Rate*	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$1,445	31,680	$45,788,998.46	$25,756,860	$0	$1,001,607	$19,030,531	$12,744,397	$6,286,134
Uninsured		$0		$0				$0	$0	$0
Total NonGovernment		$0		$45,788,998	$25,756,860	$0	$1,001,607	$19,030,531	$12,744,397	$6,286,134
Total All Payers		$0	0	$45,788,998	$25,756,860	$0	$1,001,607	$19,030,531	$12,744,397	$6,286,134

* Rate is average of gross rate of all services

Retreat
at South Connecticut

In response to CON Application Question 7.c, 7.d & 7.e: This summrizes the volume/revenue/expense for the first four years of operations. Considering the CON Application is for a new facility, both incremental and total volume/revenue/expense are attributable to the proposal. Data is based upon the sister facility - Retreat at Lancaster County, Ephrata, PA. Retreat has been in operation since August 2011, and is the latest of facilities owned/operated by management. Both Retreat at Lancaster County and the proposed facility are similar in terms of size, operations, staffing requirements, etc. Revenue and growth rates will be similar to Retreat at Lancaster County as the patient mix and payors will be the same. Summaries are provided in Financial Attachment I & II.

Full Rate (per diem)(1)	
Inpatient Detox	$1,695
Inpatient Rehab	$1,495
Partial Hospitalization (PHP)	$795
Intensive Outpatient (IOP)	$495
General Outpatient (GOP)	$295

***Pro Forma* Income Statements**	**Year 1**	**Year 2**	**Year 3**	**Year 4**
# of Beds	105	105	105	105
x Average Occupancy	61%	77%	84%	84%
= Total Average Occupied Beds per Day	63.6	80.7	88.0	88.0
x 365 Days = Patient Days per Year	**22,880**	**29,040**	**31,680**	**31,680**
Revenue Sources and Analysis				
Average Net Fee (1)	$477	$500	$524	$547
= Total Income per Inpatient Day	$477	$500	$524	$547
= Total Net Inpatient Revenues	**$10,916,906**	**$14,531,979**	**$16,590,420**	**$17,327,772**
+ Total Outpatient Income (see Exhibit)	**$1,049,498**	**$2,283,696**	**$2,440,113**	**$2,449,931**
= Total Patient Revenue	**$11,966,404**	**$16,815,675**	**$19,030,533**	**$19,777,703**
Expenses	**Year 1**	**Year 2**	**Year 3**	**Year 4**
Salaries and Wages	$5,081,755	$5,810,621	$5,984,940	$5,984,940
Employee Benefits (% of wages)	$1,067,169	$1,220,230	$1,256,837	$1,256,837
Pharmaceuticals (ppd)	$62,920	$79,860	$87,120	$87,120
Supplies: Food (ppd)	$320,320	$421,080	$475,200	$475,200
Supplies	$171,600	$176,748	$182,050	$182,050
Professional Fees	$99,600	$102,588	$105,666	$105,666
Purchased Services	$537,439	$609,694	$622,439	$622,439
Rent	$914,400	$2,014,832	$2,215,277	$2,215,277
Utilities	$273,000	$321,360	$331,001	$331,001
Repairs and Maintenance	$12,000	$12,360	$12,731	$12,731
Travel and Entertainment	$30,000	$30,900	$31,827	$31,827
Insurance	$240,000	$247,200	$254,616	$254,616
Advertising and Marketing	$240,000	$247,200	$254,616	$254,616
Real Estate Taxes	$144,000	$148,320	$152,770	$152,770
Management Fees	$600,000	$600,000	$600,000	$600,000
Depreciation	$50,000	$50,000	$50,000	$50,000
Misc. Expense	$120,000	$123,600	$127,308	$127,308
Total Operating Expenses	**$9,964,203**	**$12,216,593**	**$12,744,397**	**$12,744,397**
= Net Operating Income	**$2,002,202**	**$4,599,081**	**$6,286,136**	**$7,033,306**
Operating Margin	**16.7%**	**27.3%**	**33.0%**	**35.6%**

(1) "Average Net Fee" is Net of Contractual Allowance
(2) Property taxes will be escrowed

Retreat
at South Connecticut

In response to CON Application Question 7.c, 7.d & 7.e: This summrizes the outpatient Net Revenue for the first four years of operations. Considering the CON Application is for a new facility, both incremental and total Outpatient Net Revenue are attributable to the proposal. Data is based upon the sister facility - Retreat at Lancaster County, Ephrata, PA. Retreat has been in operation since August 2011, and is the latest of facilities owned/operated by management. Both Retreat at Lancaster County and the proposed facility are similar in terms of size, operations, staffing requirements, etc. Revenue and growth rates will be similar to Retreat at Lancaster County as the patient mix and payors will be the same. Summaries are provided in Financial Attachment I & II.

Full Rate (per diem)(1)	
Inpatient Detox	$1,695
Inpatient Rehab	$1,495
Partial Hospitalization (PHP)	$795
Intensive Outpatient (IOP)	$495
General Outpatient (GOP)	$295

Revenues for Outpatient and Group Services	**Year 1**	**Year 2**	**Year 3**	**Year 4**
PHP Units	3,525	7,300	7,800	7,800
PHP ADR	242	257	257	258
PHP Net Revenue	851,922	1,874,531	2,002,923	2,012,741
Outpatient Units	1,763	3,650	3,900	3,900
Outpatient ADR	112	112	112	112
Outpatient Net Revenue	197,576	409,165	437,190	437,190
= Total Outpatient Revenue/Yr	**$1,049,498**	**$2,283,696**	**$2,440,113**	**$2,449,931**

Notes: (1) Rates are Net of Contractual Allowance

Retreat
at South Connecticut

In response to CON Application Question 7.c, 7.d & 7.e: This summrizes the details Cash FLow projections for the first years of operations. Considering the CON Application is for a new facility, both incremental and total Outpatient Net Revenue are attributable to the proposal. Data is based upon the sister facility - Retreat at Lancaster County, Ephrata, PA. Retreat has been in operation since August 2011, and is the latest of facilities owned/operated by management. Both Retreat at Lancaster County and the proposed facility are similar in terms of size, operations, staffing requirements, etc. Revenue and growth rates will be similar to Retreat at Lancaster County as the patient mix and payors will be the same; therefore, Occupancy based Cash Flow projections will be similar to Retreat.

First Year Cash Flow Analysis

Month	Admits	Inpatient Revenues	Outpatient & Group Revenues	Total Collections (2)	Total Expenses (1)	Cash Flow	Burn Rate
Yr 1 Mo 1	70	734,792		-	645,619	(645,619)	(645,619)
Yr 1 Mo 2	75	787,277	29,773	604,918	683,190	(78,273)	(723,892)
Yr 1 Mo 3	75	787,277	44,660	735,914	705,361	30,553	(693,339)
Yr 1 Mo 4	80	839,762	59,546	821,874	707,965	113,909	(579,429)
Yr 1 Mo 5	85	892,247	74,433	878,937	728,566	150,371	(429,058)
Yr 1 Mo 6	85	892,247	89,319	910,924	769,593	141,331	(287,727)
Yr 1 Mo 7	95	997,217	96,762	990,141	946,859	43,282	(244,445)
Yr 1 Mo 8	95	997,217	104,206	1,021,458	948,364	73,094	(171,351)
Yr 1 Mo 9	95	997,217	119,092	1,048,290	948,873	99,417	(71,934)
Yr 1 Mo 10	95	997,217	126,535	1,061,536	949,878	111,658	39,724
Yr 1 Mo 11	95	997,217	148,865	1,078,097	957,121	120,976	160,700
Yr 1 Mo 12	95	997,217	156,308	1,088,406	972,814	115,592	276,292
Total	**1,040**	**10,916,906**	**1,049,498**	**10,240,495**	**9,964,203**	**276,292**	

notes:
(1) Total Expenses include Fixed Expenses & Variable Expenses
(2) Collections will be according to the following schedule:

	SP	Comm
% of Pts	10%	90%
0-30 Days	70%	55%
31-60 Days	15%	20%
61-90 Days	10%	15%
91-120	0%	5%

Year 1 Ramp Up of Projected Occupancy

Month	Ad-mits	Patient Days	Days in Month	Average Census		
Yr 1 Mo 1	70	1540	30	51	Length of Stay	22 days
Yr 1 Mo 2	75	1650	30	55		
Yr 1 Mo 3	75	1650	30	55		
Yr 1 Mo 4	80	1760	30	59		
Yr 1 Mo 5	85	1870	30	62		
Yr 1 Mo 6	85	1870	30	62		
Yr 1 Mo 7	95	2090	30	70		
Yr 1 Mo 8	95	2090	30	70		
Yr 1 Mo 9	95	2090	30	70		
Yr 1 Mo 10	95	2090	30	70		
Yr 1 Mo 11	95	2090	30	70		
Yr 1 Mo 12	95	2090	30	70		
Totals	**1,040**	**22880**	**360**	**63.6**		

Retreat
at South Connecticut

Break Even Analysis for Year 1

	Year 1
# of Beds	105
x Average Occupancy	32.7%
= Total Occupied Beds per Day	34
x 365 Days = Patient Days per Year	**12,532**
Average Revenue per Patient Day	
Average Net Fee	$477
= Total Income per Patient Day	$477
= Total Net Inpatient Revenues	**$5,979,618**
+ Total Outpatient Revenue (1)	**$574,851**
= Total Patient Revenue	
less Fixed Operating Expenses	-$6,310,924
less Variable Operating Expenses (2)	-$236,295
= Net Operating Income	**$7,252**
Annual Break Even Occupancy	**33% or 34 ADC**

notes:
(1) Total Outpatient Revenue is adjusted as a % of inpatient revenue
(2) Variable Expenses adjusted for occupancy level

Retreat
at South Connecticut

In response to CON Application Question 7.c, 7.d & 7.e: This details the volume/revenue/expense for the first year of operations. Considering the CON Application is for a new facility, both incremental and total volume/revenue/expense are attributable to the proposal. Summaries are provided in Financial Attachment I & II. Volume data is further detailed in CON Application 6.b.; facility will need to attract less than 1% of those Needing, but not receiving treatment. Data is based upon the sister facility - Retreat at Lancaster County, Ephrata, PA. Retreat has been in operation since August 2011, and is the latest of facilities owned/operated by management. Both Retreat at Lancaster County and the proposed facility are similar in terms of size, operations, staffing requirements, etc. Revenue and growth rates will be similar to Retreat at Lancaster County as the patient mix and payors will be the same.

	Yr 1 Mo 1	Yr 1 Mo 2	Yr 1 Mo 3	Yr 1 Mo 4	Yr 1 Mo 5	Yr 1 Mo 6	Yr 1 Mo 7	Yr 1 Mo 8	Yr 1 Mo 9	Yr 1 Mo 10	Yr 1 Mo 11	Yr 1 Mo 12	Yr 1 Total
Month Days	30	30	30	30	30	30	30	30	30	30	30	30	360
Beds Available	105	105	105	105	105	105	105	105	105	105	105	105	105
Admissions	70	75	75	80	85	85	95	95	95	95	95	95	1,040
Utilization	49%	52%	52%	56%	59%	59%	66%	66%	66%	66%	66%	66%	61%
Patient Days (22 day avg LOS)	1,540	1,650	1,650	1,760	1,870	1,870	2,090	2,090	2,090	2,090	2,090	2,090	22,880
ADC	51.33	55.00	55.00	58.67	62.33	62.33	69.67	69.67	69.67	69.67	69.67	69.67	63.56
ADR	477	477	477	477	477	477	477	477	477	477	477	477	477
Total Inpatient Net Revenue	734,792	787,277	787,277	839,762	892,247	892,247	997,217	997,217	997,217	997,217	997,217	997,217	10,916,906
Total PHP Net Revenue		24,168	36,252	48,336	60,420	72,504	78,546	84,588	96,672	102,714	120,840	126,882	851,922
Total Outpatient Net Revenue		5,605	8,408	11,210	14,013	16,815	18,216	19,618	22,420	23,821	28,025	29,426	197,576
Total Net Revenue	734,792	817,050	831,936	899,308	966,680	981,566	1,093,980	1,101,423	1,116,309	1,123,753	1,146,082	1,153,526	11,966,404
Expense													
Salaries and Wages	343,982	371,219	389,534	389,534	404,407	435,414	454,480	454,480	454,480	454,480	459,628	470,115	5,081,755
Employee Benefits (% of wages)	72,236	77,956	81,802	81,802	84,926	91,437	95,441	95,441	95,441	95,441	96,522	98,724	1,067,169
Pharmaceuticals (ppd)	4,235	4,538	4,538	4,840	5,143	5,143	5,748	5,748	5,748	5,748	5,748	5,748	62,920
Supplies: Food (ppd)	21,560	23,100	23,100	24,640	26,180	26,180	29,260	29,260	29,260	29,260	29,260	29,260	320,320
Supplies	14,300	14,300	14,300	14,300	14,300	14,300	14,300	14,300	14,300	14,300	14,300	14,300	171,600
Professional Fees	8,300	8,300	8,300	8,300	8,300	8,300	8,300	8,300	8,300	8,300	8,300	8,300	99,600
Purchased Services	41,139	41,911	41,920	42,682	43,444	43,953	44,464	45,968	46,478	47,482	48,496	49,501	537,439
Rent	1,200	1,200	1,200	1,200	1,200	1,200	151,200	151,200	151,200	151,200	151,200	151,200	914,400
Utilities	19,000	21,000	21,000	21,000	21,000	24,000	24,000	24,000	24,000	24,000	24,000	26,000	273,000
Repairs and Maintenance	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	12,000
Travel and Entertainment	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	30,000
Insurance	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	240,000
Advertising and Marketing	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	240,000
Real Estate Taxes	12,000	12,000	12,000	12,000	12,000	12,000	12,000	12,000	12,000	12,000	12,000	12,000	144,000
Management Fees	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	600,000
Depreciation	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	50,000
Misc. Expense	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	120,000
Total Expense	645,619	683,190	705,361	707,965	728,566	769,593	946,859	948,364	948,873	949,878	957,121	972,814	9,964,203
Net Income	89,173	133,860	126,576	191,343	238,114	211,973	147,121	153,059	167,436	173,875	188,962	180,711	2,002,202

Pro-Forma Budget Year 1

Retreat
at South Connecticut

In response to CON Application Question 7.c, 7.d & 7.e: This details the volume/revenue/expense for the second year of operations. Considering the CON Application is for a new facility, both incremental and total volume/revenue/expense are attributable to the proposal. Summaries are provided in Financial Attachment I & II. Volume data is further detailed in CON Application 6.b.; facility will need to attract less than 1% of those Needing, but not receiving treatment. Data is based upon the sister facility - Retreat at Lancaster County, Ephrata, PA. Retreat has been in operation since August 2011, and is the latest of facilities owned/operated by management. Both Retreat at Lancaster County and the proposed facility are similar in terms of size, operations, staffing requirements, etc. Revenue and growth rates will be similar to Retreat at Lancaster County as the patient mix and payors will be the same.

	Yr 2 Mo 1	Yr 2 Mo 2	Yr 2 Mo 3	Yr 2 Mo 4	Yr 2 Mo 5	Yr 2 Mo 6	Yr 2 Mo 7	Yr 2 Mo 8	Yr 2 Mo 9	Yr 2 Mo 10	Yr 2 Mo 11	Yr 2 Mo 12	Yr 2 Total
Month Days	30	30	30	30	30	30	30	30	30	30	30	30	360
Beds Available	105	105	105	105	105	105	105	105	105	105	105	105	105
Admissions	100	100	105	105	110	110	110	115	115	115	115	120	1,410
Utilization	70%	70%	73%	73%	77%	77%	77%	80%	80%	80%	80%	84%	77%
Patient Days (22 day avg LOS)	2,200	2,200	2,310	2,310	2,420	2,420	2,420	2,530	2,530	2,530	2,530	2,640	29,040
ADC	73.33	73.33	77.00	77.00	80.67	80.67	80.67	84.33	84.33	84.33	84.33	88.00	80.67
ADR	500	500	500	500	500	500	500	500	500	500	500	500	500
Total Inpatient Net Revenue	1,100,908	1,100,908	1,155,953	1,155,953	1,210,998	1,210,998	1,210,998	1,266,044	1,266,044	1,266,044	1,266,044	1,321,089	14,531,979
Total PHP Net Revenue	141,232	154,071	154,071	154,071	154,071	154,071	160,491	160,491	160,491	160,491	160,491	160,491	1,874,531
Total Outpatient Net Revenue	30,828	33,630	33,630	33,630	33,630	33,630	35,031	35,031	35,031	35,031	35,031	35,031	409,165
Total Net Revenue	1,272,967	1,288,609	1,343,654	1,343,654	1,398,699	1,398,699	1,406,520	1,461,566	1,461,566	1,461,566	1,461,566	1,516,611	16,815,675
Expense													4,563
Salaries and Wages	484,218	484,218	484,218	484,218	484,218	484,218	484,218	484,218	484,218	484,218	484,218	484,218	5,810,621
Employee Benefits (% of wages)	101,686	101,686	101,686	101,686	101,686	101,686	101,686	101,686	101,686	101,686	101,686	101,686	1,220,230
Pharmaceuticals (ppd)	6,050	6,050	6,353	6,353	6,655	6,655	6,655	6,958	6,958	6,958	6,958	7,260	79,860
Supplies: Food (ppd)	31,900	31,900	33,495	33,495	35,090	35,090	35,090	36,685	36,685	36,685	36,685	38,280	421,080
Supplies	14,729	14,729	14,729	14,729	14,729	14,729	14,729	14,729	14,729	14,729	14,729	14,729	176,748
Professional Fees	8,549	8,549	8,549	8,549	8,549	8,549	8,549	8,549	8,549	8,549	8,549	8,549	102,588
Purchased Services	50,288	50,297	50,552	50,552	50,806	50,806	50,811	51,065	51,065	51,065	51,065	51,320	609,694
Rent	167,903	167,903	167,903	167,903	167,903	167,903	167,903	167,903	167,903	167,903	167,903	167,903	2,014,832
Utilities	26,780	26,780	26,780	26,780	26,780	26,780	26,780	26,780	26,780	26,780	26,780	26,780	321,360
Repairs and Maintenance	1,030	1,030	1,030	1,030	1,030	1,030	1,030	1,030	1,030	1,030	1,030	1,030	12,360
Travel and Entertainment	2,575	2,575	2,575	2,575	2,575	2,575	2,575	2,575	2,575	2,575	2,575	2,575	30,900
Insurance	20,600	20,600	20,600	20,600	20,600	20,600	20,600	20,600	20,600	20,600	20,600	20,600	247,200
Advertising and Marketing	20,600	20,600	20,600	20,600	20,600	20,600	20,600	20,600	20,600	20,600	20,600	20,600	247,200
Real Estate Taxes	12,360	12,360	12,360	12,360	12,360	12,360	12,360	12,360	12,360	12,360	12,360	12,360	148,320
Management Fees	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	600,000
Depreciation	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	50,000
Misc. Expense	10,300	10,300	10,300	10,300	10,300	10,300	10,300	10,300	10,300	10,300	10,300	10,300	123,600
Total Expense	1,013,734	1,013,744	1,015,896	1,015,896	1,018,048	1,018,048	1,018,053	1,020,205	1,020,205	1,020,205	1,020,205	1,022,356	12,216,593
Net Income	259,233	274,865	327,758	327,758	380,651	380,651	0 388,467	441,361	441,361	441,361	441,361	494,254	4,599,081

Pro-Forma Budget Year 2

Retreat
at South Connecticut

In response to CON Application Question 7.c, 7.d & 7.e: This details the volume/revenue/expense for the third year of operations. Considering the CON Application is for a new facility, both incremental and total volume/revenue/expense are attributable to the proposal. Summaries are provided in Financial Attachment I & II. Volume data is further detailed in CON Application 6.b.; facility will need to attract less than 1% of those Needing, but not receiving treatment. Data is based upon the sister facility - Retreat at Lancaster County, Ephrata, PA. Retreat has been in operation since August 2011, and is the latest of facilities owned/operated by management. Both Retreat at Lancaster County and the proposed facility are similar in terms of size, operations, staffing requirements, etc. Revenue and growth rates will be similar to Retreat at Lancaster County as the patient mix and payors will be the same.

	Yr 3 Mo 1	Yr 3 Mo 2	Yr 3 Mo 3	Yr 3 Mo 4	Yr 3 Mo 5	Yr 3 Mo 6	Yr 3 Mo 7	Yr 3 Mo 8	Yr 3 Mo 9	Yr 3 Mo 10	Yr 3 Mo 11	Yr 3 Mo 12	Yr 3 Total
Month Days	30	30	30	30	30	30	30	30	30	30	30	30	360
Beds Available	105	105	105	105	105	105	105	105	105	105	105	105	105
Admissions	120	120	120	120	120	120	120	120	120	120	120	120	1,440
Utilization	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%
Patient Days (22 day avg LOS)	2,640	2,640	2,640	2,640	2,640	2,640	2,640	2,640	2,640	2,640	2,640	2,640	31,680
ADC	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00
ADR	524	524	524	524	524	524	524	524	524	524	524	524	524
Total Inpatient Net Revenue	1,382,535	1,382,535	1,382,535	1,382,535	1,382,535	1,382,535	1,382,535	1,382,535	1,382,535	1,382,535	1,382,535	1,382,535	16,590,420
Total PHP Net Revenue	166,910	166,910	166,910	166,910	166,910	166,910	166,910	166,910	166,910	166,910	166,910	166,910	2,002,923
Total Outpatient Net Revenue	36,433	36,433	36,433	36,433	36,433	36,433	36,433	36,433	36,433	36,433	36,433	36,433	437,190
Total Net Revenue	1,585,878	1,585,878	1,585,878	1,585,878	1,585,878	1,585,878	1,585,878	1,585,878	1,585,878	1,585,878	1,585,878	1,585,878	19,030,533
Expense													4,875
Salaries and Wages	498,745	498,745	498,745	498,745	498,745	498,745	498,745	498,745	498,745	498,745	498,745	498,745	5,984,940
Employee Benefits (% of wages)	104,736	104,736	104,736	104,736	104,736	104,736	104,736	104,736	104,736	104,736	104,736	104,736	1,256,837
Pharmaceuticals (ppd)	7,260	7,260	7,260	7,260	7,260	7,260	7,260	7,260	7,260	7,260	7,260	7,260	87,120
Supplies: Food (ppd)	39,600	39,600	39,600	39,600	39,600	39,600	39,600	39,600	39,600	39,600	39,600	39,600	475,200
Supplies	15,171	15,171	15,171	15,171	15,171	15,171	15,171	15,171	15,171	15,171	15,171	15,171	182,050
Professional Fees	8,805	8,805	8,805	8,805	8,805	8,805	8,805	8,805	8,805	8,805	8,805	8,805	105,666
Purchased Services	51,870	51,870	51,870	51,870	51,870	51,870	51,870	51,870	51,870	51,870	51,870	51,870	622,439
Rent	184,606	184,606	184,606	184,606	184,606	184,606	184,606	184,606	184,606	184,606	184,606	184,606	2,215,277
Utilities	27,583	27,583	27,583	27,583	27,583	27,583	27,583	27,583	27,583	27,583	27,583	27,583	331,001
Repairs and Maintenance	1,061	1,061	1,061	1,061	1,061	1,061	1,061	1,061	1,061	1,061	1,061	1,061	12,731
Travel and Entertainment	2,652	2,652	2,652	2,652	2,652	2,652	2,652	2,652	2,652	2,652	2,652	2,652	31,827
Insurance	21,218	21,218	21,218	21,218	21,218	21,218	21,218	21,218	21,218	21,218	21,218	21,218	254,616
Advertising and Marketing	21,218	21,218	21,218	21,218	21,218	21,218	21,218	21,218	21,218	21,218	21,218	21,218	254,616
Real Estate Taxes	12,731	12,731	12,731	12,731	12,731	12,731	12,731	12,731	12,731	12,731	12,731	12,731	152,770
Management Fees	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	600,000
Depreciation	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	50,000
Misc. Expense	10,609	10,609	10,609	10,609	10,609	10,609	10,609	10,609	10,609	10,609	10,609	10,609	127,308
Total Expense	1,062,033	1,062,033	1,062,033	1,062,033	1,062,033	1,062,033	1,062,033	1,062,033	1,062,033	1,062,033	1,062,033	1,062,033	12,744,397
Net Income	523,845	523,845	523,845	523,845	523,845	523,845	523,845	523,845	523,845	523,845	523,845	523,845	6,286,136

Pro-Forma Budget Year 3

Retreat
at South Connecticut

In response to CON Application Question 7.c, 7.d & 7.e: This details the volume/revenue/expense for the fourth year of operations. Considering the CON Application is for a new facility, both incremental and total volume/revenue/expense are attributable to the proposal. Summaries are provided in Financial Attachment I & II. Volume data is further detailed in CON Application 6.b.; facility will need to attract less than 1% of those Needing, but not receiving treatment. Data is based upon the sister facility - Retreat at Lancaster County, Ephrata, PA. Retreat has been in operation since August 2011, and is the latest of facilities owned/operated by management. Both Retreat at Lancaster County and the proposed facility are similar in terms of size, operations, staffing requirements, etc. Revenue and growth rates will be similar to Retreat at Lancaster County as the patient mix and payors will be the same.

	Yr 4 Mo 1	Yr 4 Mo 2	Yr 4 Mo 3	Yr 4 Mo 4	Yr 4 Mo 5	Yr 4 Mo 6	Yr 4 Mo 7	Yr 4 Mo 8	Yr 4 Mo 9	Yr 4 Mo 10	Yr 4 Mo 11	Yr 4 Mo 12	Yr 4 Total
Month Days	30	30	30	30	30	30	30	30	30	30	30	30	360
Beds Available	105	105	105	105	105	105	105	105	105	105	105	105	105
Admissions	120	120	120	120	120	120	120	120	120	120	120	120	1,440
Utilization	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%
Patient Days (22 day avg LOS)	2,640	2,640	2,640	2,640	2,640	2,640	2,640	2,640	2,640	2,640	2,640	2,640	31,680
ADC	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00	88.00
ADR	547	547	547	547	547	547	547	547	547	547	547	547	547
Total Inpatient Net Revenue	1,443,981	1,443,981	1,443,981	1,443,981	1,443,981	1,443,981	1,443,981	1,443,981	1,443,981	1,443,981	1,443,981	1,443,981	17,327,772
Total PHP Net Revenue	176,729	166,910	166,910	166,910	166,910	166,910	166,910	166,910	166,910	166,910	166,910	166,910	2,012,741
Total Outpatient Net Revenue	36,433	36,433	36,433	36,433	36,433	36,433	36,433	36,433	36,433	36,433	36,433	36,433	437,190
Total Net Revenue	1,657,142	1,647,324	1,647,324	1,647,324	1,647,324	1,647,324	1,647,324	1,647,324	1,647,324	1,647,324	1,647,324	1,647,324	19,777,703
Expense													4,875
Salaries and Wages	513,707	513,707	513,707	513,707	513,707	513,707	513,707	513,707	513,707	513,707	513,707	513,707	6,164,488
Employee Benefits (% of wages)	107,879	107,879	107,879	107,879	107,879	107,879	107,879	107,879	107,879	107,879	107,879	107,879	1,294,542
Pharmaceuticals (ppd)	7,260	7,260	7,260	7,260	7,260	7,260	7,260	7,260	7,260	7,260	7,260	7,260	87,120
Supplies: Food (ppd)	40,920	39,600	39,600	39,600	39,600	39,600	39,600	39,600	39,600	39,600	39,600	39,600	476,520
Supplies	15,626	15,626	15,626	15,626	15,626	15,626	15,626	15,626	15,626	15,626	15,626	15,626	187,512
Professional Fees	9,070	9,070	9,070	9,070	9,070	9,070	9,070	9,070	9,070	9,070	9,070	9,070	108,836
Purchased Services	52,436	52,430	52,430	52,430	52,430	52,430	52,430	52,430	52,430	52,430	52,430	52,430	629,170
Rent	184,645	184,645	184,645	184,645	184,645	184,645	184,645	184,645	184,645	184,645	184,645	184,645	2,215,735
Utilities	28,411	28,411	28,411	28,411	28,411	28,411	28,411	28,411	28,411	28,411	28,411	28,411	340,931
Repairs and Maintenance	1,093	1,093	1,093	1,093	1,093	1,093	1,093	1,093	1,093	1,093	1,093	1,093	13,113
Travel and Entertainment	2,732	2,732	2,732	2,732	2,732	2,732	2,732	2,732	2,732	2,732	2,732	2,732	32,782
Insurance	21,855	21,855	21,855	21,855	21,855	21,855	21,855	21,855	21,855	21,855	21,855	21,855	262,254
Advertising and Marketing	21,855	21,855	21,855	21,855	21,855	21,855	21,855	21,855	21,855	21,855	21,855	21,855	262,254
Real Estate Taxes	13,113	13,113	13,113	13,113	13,113	13,113	13,113	13,113	13,113	13,113	13,113	13,113	157,353
Management Fees	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	600,000
Depreciation	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	50,000
Misc. Expense	10,927	10,927	10,927	10,927	10,927	10,927	10,927	10,927	10,927	10,927	10,927	10,927	131,127
Total Expense	1,085,694	1,084,368	1,084,368	1,084,368	1,084,368	1,084,368	1,084,368	1,084,368	1,084,368	1,084,368	1,084,368	1,084,368	13,013,737
Net Income	571,448	562,956	562,956	562,956	562,956	562,956	562,956	562,956	562,956	562,956	562,956	562,956	6,763,966

Pro-Forma Budget Year 4

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

April 24, 2013

VIA FAX ONLY

Peter Schorr
President / CEO
NR Connecticut, LLC
12 New City Street
Essex, CT 06426

RE: Certificate of Need Application, Docket Number 13-31828-CON
NR Connecticut, LLC-d/b/a/Retreat at South Connecticut
Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut

Dear Mr. Schorr:

On March 25, 2013, the Office of Health Care Access ("OHCA") received your Certificate of Need ("CON") application filing on behalf of NR Connecticut, LLC-d/b/a/Retreat at South Connecticut ("Applicant") proposing to establish a 105 beds residential substance abuse facility in New Haven, with an associated cost of $7,500,000.

OHCA has reviewed the CON application and requests the following additional information pursuant to General Statutes §19a-639a(c). The page numbers given in each question refer to the submitted initial Certificate of Need ("CON") application.

1. Please provide a discussion and any available supporting information about how the Applicant determined the clear public need for the proposed facility and for the number of beds proposed.

2. Does the Applicant have any relationships with any other providers in Connecticut and out -of-state? If so, provide letters from those providers that demonstrate that they will refer patients to your proposed facility. What is the projected split between in-state and out-of-state referrals?

3. In response to Question 3a on page 30 concerning projected volume, Table 1 did not include the units for the numbers listed in each column. Provide details on how to quantify the projected volume in Table 1 (group/individual counseling sessions, bed days, # of admissions, clinic visits, etc). For each client at each level of service, report the average number of units (e.g., individual/group sessions, number of bed days) that each person is projected to use.

4. Please provide additional information concerning the service level identified by the Applicant as "Rehabilitation."

5. Using the information reported above, please complete the following table.

Table 2: Projected Volume by Fiscal Year

Service Type*	FY 2013		FY 2014		FY 2015		FY 2015	
	No. of Persons	Total Number of Units	No. of Persons	Total Number of Units	No. of Persons	Total Number of Units	No. of Persons	Total Number of Units
Residential Detoxification								
Rehabilitation								
Partial Hospitalization								
Intensive Outpatient								
Outpatient								

* Identify each service/ type and add lines as necessary.

6. In response to Question 3c and 3d on page 30, the Applicant states questions are not applicable. Provide a discussion on the facility identified as "Retreat at Lancaster County" and report the following information for each service type, as appropriate, for the most recent fiscal year or as otherwise indicated:
    a. Number of beds available or capacity of program;
    b. Number of persons provided services and their state(s) of origin;
    c. Number of persons provided services by age group using 18-25 yrs. 25-40 yrs. and 41 and older;
    d. Units of service provided by service level;
    e. The average daily census for residential programs;
    f. Number of clients by service level on the last day of the most recent month; and
    g. Number of persons on waiting list by service level for the most recent month end.

7. The Applicant stated that it will be admitting patients from out-of-state. How does the Applicant plan to accommodate these patients if they need to continue treatment in one of the proposed outpatient programs?

8. Provide documentation that demonstrates that the Applicant has contacted the State of Connecticut Department of Mental Health and Addiction Services to provide information related to the admission and discharge status of clients at existing behavioral health facilities in the greater New Haven area.

9. Place a checkmark (✓) in the "Need for Proposal" column for each license that the Applicant is seeking from the State's Department of Public Health (DPH) in relation to the proposal.

   Information concerning DPH licensure may be obtained by contacting Sandra Bauer, DPH Facility Licensing, at (860) 509- 8023 or Sandra.Bauer@ct.gov.

Table 3: Licenses Needed for the Proposal

License	Needed for Proposal
Psychiatric Outpatient Clinic for Adults	
Facility for the Care or the Treatment of Substance Abusive or Dependent Persons (Outpatient)	
Mental Health Day Treatment Facility	

10. On page 656, the Applicant presented a fee schedule. Will the proposed rates be the same for all payers, including self-pay? Does the Applicant have a sliding-fee scale? Please provide a discussion.

11. Explain how the Applicant will serve Medicare and/or Medicaid patients. If the proposed facility receives a referral for a Medicare or Medicaid patient or a patient under age 18 or over age 65, how will these referrals be handled?

12. On page 658, it is stated that the Applicant projects to have 70, 75 and 75 patients in the first three months of operation. Provide details as to the source of projected numbers and the rationale used. Discuss how the Applicant expects to achieve this projection.

13. Provide the audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet or statement of operation).

14. On page 17 and 34, it is stated that the total estimated capital expenditure for this project is $7,500,000. However, the public notice published in the "New Haven Register" stated $8,500,000. Please revise or explain the variance.

15. Please provide an organizational chart for NR Connecticut, LLC and for Retreat for South Connecticut.

16. The Applicant provided the list of Retreat at Lancaster County's officers and directors and their Curricula Vitae. Will these officers and directors serve at the proposed facility and split time between sites? If not, provide all the additional Curricula Vitae not included in the initial CON submission for officers and directors who will serve at the proposed facility.

17. Provide the policies and procedures that will be utilized in relation to the proposal. Explain the quality assurance program. What level of staff will be responsible for quality assurance on-site?

18. Provide details regarding the clinical (e.g., physicians, nurses, social workers, counselors, etc.) FTEs that will serve the proposed facility.

In responding to the questions contained in this letter, please repeat each question before providing your response. **Paginate and date** your response, i.e., each page in its entirety. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using Page 368 and reference "Docket Number: 13-31828-CON." Submit one (1) original and six (6) hard copies of your response. In addition, please submit a scanned copy of your response, in an Adobe format (.pdf) including all attachments on CD. If available, a copy of the response in MS Word should also be copied to the CD.

If you have any questions concerning this letter, please feel free to contact Laurie Greci at (860) 418-7032 or me at (860) 418-7007.

Sincerely,

A. Veyberman

Ali Veyberman
Health Care Analyst

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3450
RECIPIENT ADDRESS	98607670456
DESTINATION ID	
ST. TIME	04/24 16:31
TIME USE	01'07
PAGES SENT	5
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: PETER SCHORR

FAX: 860.767.0456

AGENCY: RETREAT AT SOUTH CT

FROM: OHCA

DATE: 04/24/13 **Time:**

NUMBER OF PAGES: 5
(including transmittal sheet

Comments:
Docket Number: 13-31828-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS

Phone: (860) 418-7001 *Fax: (860) 418-7053*

Greer, Leslie

From: Greci, Laurie
Sent: Tuesday, May 28, 2013 11:53 AM
To: wbeccaro@snet.net
Cc: Riggott, Kaila; Veyberman, Alla; Greer, Leslie; Siembab, Lauren
Subject: Retreat at South Connecticut - OHCA Docket 13-31828-CON

Dear Attorney Beccaro,

The completeness letter sent to Peter Schorr from OHCA on April 24, 2013, concerning the Certificate of Need application of Retreat at South Connecticut to establish a residential substance abuse treatment facility in New Haven, contains the following:

"*8. Provide documentation that demonstrates that the Applicant has contacted the State of Connecticut Department of Mental Health and Addiction Services to provide information related to the admission and discharge status of clients at existing behavioral health facilities in the greater New Haven area."*

Please send a Freedom of Information request to the Department of Mental Health and Addiction Services (DMHAS) to obtain the requested information. Send your request to:

Doreen DelBianco, Legislative Program Manager
Office of the Commissioner
Department of Mental Health and Addiction Services

Telephone: 860-418-6967
Email: Doreen.DelBianco@po.state.ct.us.
Mailing address: 410 Capitol Avenue
P.O. Box 341431 #14COM
Hartford, CT 06134

Ms. DelBianco will handle your FOI request.

Sincerely,

Laurie K. Greci

Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

Greer, Leslie

From: Greci, Laurie
Sent: Monday, June 03, 2013 2:59 PM
To: peter@retreatmail.com
Cc: Riggott, Kaila; Greer, Leslie
Subject: OHCA Docket 13-31828-CON

Dear Mr. Schorr,

DMHAS Region 2 includes the following towns:

> Ansonia, Bethany, Branford, Chester, Clinton, Cromwell, Deep River, Derby, Durham, East Haddam, East Hampton, East Haven, Essex, Guilford, Haddam, Hamden, Killingworth, Lyme, Madison, Meriden, Middlefield, Middletown, Milford, New Haven, North Branford, North Haven, Old Lyme, Old Saybrook, Orange, Portland, Seymour, Shelton, Wallingford, Westbrook, West Haven, Woodbridge.

The towns list above encompass those that may be considered in the "greater New Haven" area. OHCA can only recommend that you review the list of towns in context to your proposal that includes CT residents and out-of-state residents as potential clients. It may be appropriate for you to request that DMHAS run a data report for DMHAS Regions 1 through 5 and then for the individual towns listed above.

Please do not hesitate to ask any additional questions. I will not be in the office tomorrow (Tuesday) so it may take an additional day to response.

Regards,

Laurie

Laurie K. Greci
Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

DANNEL P. MALLOY
GOVERNOR

PATRICIA A. REHMER, MSN
COMMISSIONER

June 3, 2013

Peter Schorr, CEO
Retreat at South Connecticut
c/o Law Offices of William P. Beccaro
12 New City Street
Essex, CT 06426
Peter@retreatmail.com

Subject: Freedom of Information Request:

- Provide documentation that demonstrates that the Applicant has contacted DMHAS to provide information related to the admissions and discharge status of clients at existing behavioral health facilities in the Greater New Haven area.

Dear Mr. Schorr:

Your Freedom of Information request was received on 5-30-13. Please clarify if you need admission/discharge information about 3.7 detox services in the Greater New Haven area? Should we focus on the towns in Region 2, or is there an official definition of "Greater New Haven" to use? Once this information is clarified, I estimate it will take approximately five business days to research the requested information and get back to you.

In accordance with Section 1-212 of the Connecticut General Statutes, please note that there is a charge of $.25 per page for all documents provided in response to Freedom of Information requests. Once we have determined the total number of pages involved, we will notify you of the cost. If the cost exceeds $10, then upon receipt of your check for the amount due, made out to the Department of Mental Health and Addiction Services, the documents will then be copied and sent to you. If the amount is under $10 then once notified, please make arrangements to come to DMHAS to collect the documents.

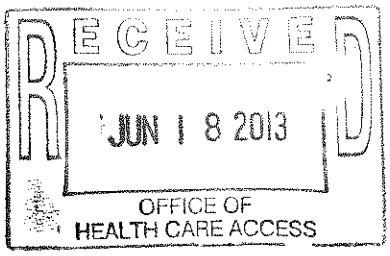
In the interim, if you have questions or require additional assistance, please let me know. Thank you.

Sincerely,

Doreen Del Bianco
Legislative Program Manager

(AC 860) 418-7000
410 Capitol Avenue, P.O. Box 341431, Hartford, Connecticut 06134
www.dmhas.state.ct.us
An Equal Opportunity Employer

Retreat
at South Connecticut



June 17, 2013

Ms. Lisa A Davis
Deputy Commissioner
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS # 13HCA
Hartford, CT 06134

RE: Docket Number: 13-31828-CON - Retreat at South Connecticut - Certificate of Need Application

Dear Ms. Davis:

On behalf of Retreat at South Connecticut, I am pleased to submit the following responses to the questions contained in your completeness response letter.

As requested, I have included an original and six hard copies in three-ring binders, along with electronic files on a CD disc.

Please do not hesitate to contact me at (860) 767-8632, should you have questions, or I may be of further assistance. I look forward to working with you on this matter.

Sincerely yours,

William P. Beccaro
on behalf of Retreat at South Connecticut

WPB/jv
Attachments
cc: Mr. Peter Schorr, *et. al.* - Retreat at South Connecticut

NR CONNECTICUT, LLC
D/B/A RETREAT AT SOUTH CONNECTICUT

Certificate of Need Application for 105 beds in order to provide residential detoxification and evaluation as well as rehabilitation and recovery-oriented care services

Docket Number: 13-31828-CON
Response to Office of Health Care Access requests for additional information

June 17, 2013

Retreat
at South Connecticut

QUESTION 1

Please provide a discussion and any available supporting information about how the Applicant determined the clear public need for the proposed facility and for the number of beds proposed

1) Please provide a discussion and any available supporting information about how the Applicant determined the clear public need for the proposed facility and for the number of beds proposed

Peter Schorr, founder and CEO of Retreat at Lancaster County, located in Ephrata, Pennsylvania, is a long time resident of Weston, Connecticut. Within a year of opening the Pennsylvania facility, it became apparent to him that there was a tremendous unmet need throughout the Northeast for the type of services Retreat offers. Proprietary research and publicly available documentation supported his conclusion - that there is a growing need for expanding private-pay and private insurance in-patient substance abuse services in the State of Connecticut. As a result, Mr. Schorr had a discussion with Melanie Dillon, staff attorney for the State of Connecticut Department of Health, who confirmed that the State lacked the substance abuse beds necessary to service its growing addiction problem. Subsequent discussions with other state officials further strengthened this conclusion.

With the need firmly established, Mr. Schorr began a search for a suitable location for an inpatient substance abuse facility. A parcel of land in Milford with appropriate zoning was identified. However, before the Milford parcel was considered further, the New Haven property (a former nursing home) that is the subject of this proposal became available. The focus shifted to New Haven since the Milford parcel required ground-up construction and the New Haven property with its existing building could be made operational in a shorter period of time. The New Haven facility was chosen because it offered multiple advantages - in timing, size, location and design. Furthermore, the Retreat at South Connecticut will benefit from New Haven's large pool of an available work force at all levels, seeking employment opportunities.

Experience gained from the Pennsylvania's facility's operation indicates that the optimum number of beds for the Retreat modality is between 100 and 120. The New Haven facility has a capacity of 105 beds, which is within the optimum range. Additionally, the facility has ample space to provide a full range of therapeutic services and ancillary care.

Retreat
at South Connecticut

QUESTION 2

Does the Applicant have any relationships with any other providers in Connecticut and out-of-state? If so, provide letters from those providers that demonstrate that they will refer patients to your proposed facility. What is the projected split between in-state and out-of-state referrals?

2) Does the Applicant have any relationships with any other providers in Connecticut and out-of- state? If so, provide letters from those providers that demonstrate that they will refer patients to your proposed facility. What is the projected split between in-state and out-of-state referrals?

Retreat at South Connecticut has relationships with a number of providers and referral sources in Connecticut and its surrounding states. Additionally, Retreat at South Connecticut will share the existing referral network of its sister facility in Lancaster.

Attached are letters from several providers who will refer patients to Retreat at South Connecticut. Retreat expects to draw approximately 75% of its patients from within the state. This figure was derived by using the Lancaster facility model, and applying it to the Connecticut market.

Nancy S. Scherlong, LCSW PO Box 912; Carmel, NY 10512 914.572.3167
Offices in Brewster and Pleasantville, NY and in Ridgefield, CT

May 24, 2013

To Whom It May Concern:

I recently met with one of your outreach coordinators and she mentioned you are possibly working with the State of Connecticut to open a new treatment facility for people struggling with the disease of Addiction. As a psychotherapist with an office in Ridgefield, CT I wanted to offer my support due to the difficulty I have when trying to find proper placement for clients who carry commercial insurance and need inpatient treatment for addiction in the State of Connecticut.

I am elated and would like to know more details as they are made available and look forward to working with the Retreat. I have been impressed with your clinical programs and experience in the field of addiction and with the quality of care you provide. I speak on behalf of myself and my colleagues when I say we look forward to sending referrals to you when your facility opens in the State of Connecticut.

Please feel free to contact me at any time either by phone or email.

Best regards,

Nancy S. Scherlong, LCSW
Nancy S Scherlong, LCSW
158 Danbury Rd, Suite 7
Ridgefield, CT 06877

NScherlongcsw@aol.com

Sonya k Rencevicz msw lcsw
PSYCHOTHERAPY
203-552-5280

two benedict place
greenwich, Ct 06830

skrmsw@optonline.net
www.heretohelpyouheal.com

May 22, 2013

State of Connecticut

To Whom It May Concern:

As a professional who has worked with clients in need substance abuse treatment in the State of Connecticut for the past 20 years, I have long since felt there is a shortage of quality treatment beds for the large number of individuals within this geographical area that requiring management of their drug and alcohol dependency. Many of these individuals are motivated for treatment, yet reluctant to travel out of state to receive it.

I am pleased to know that the Retreat at South Connecticut is interested in opening a facility to provide substance abuse treatment in Connecticut. I have worked with this group previously (the Retreat at Lancaster County) and found their administration and staff to be both an excellent resource and extremely dedicated to providing high quality substance abuse treatment for individuals in need.

I look forward to being able to refer my clients suffering from chemical dependency to the Retreat at South Connecticut knowing these clients will have access to high quality care in Connecticut.

Please feel free to contact me if you have any questions.

Respectfully,

Sonya Rencevicz lcsw

Canel Lodge No. 700

Affiliated with I.A.M. District Lodge No. 26

International Association of Machinists and Aerospace Workers, AFL-CIO

82 Saybrook Road - Higganum, CT 06441
Telephone: (860) 345-2098
Fax: (860) 345-2387

August 28, 2012

To whom it may concern,

My name is Jerry Marcil and I am the coordinator of the Employee Assistance Program for over 4000 Machinist Union members and their families. The majority of the employees I serve work and live in Connecticut. One of the difficulties I have encountered over the past 12 years, is finding available beds that accept commercial insurance for our employees that require treatment for alcohol and/or substance abuse. Most of the men and women that require treatment end up going out of the state which can be very difficult on families and the patient themselves.

I was excited to learn that The Retreat at Lancaster County is planning to open a treatment facility in New Haven. As someone who assists people in getting into treatment I can assure that these beds are needed and that a facility in our state that accepts commercial insurance is desperately needed.

Sincerely,

Jerry Marcil
District 26 Senior EAP Coordinator

Howard Permut
President

Metro-North Railroad

August 29, 2012

To Whom It May Concern,

This statement is being written with the hope of influencing decisions being made regarding the additions and/or approvals of substance abuse treatment facilities in the state of Connecticut, particularly in New Haven County. Presently for the many commercially insured residents of the state, treatment choices for inpatient detox units (no Connecticut facilities provide the option of outpatient detox) and inpatient/rehabilitation units are extremely limited. For the many employees of Metro North Railroad living or working in Connecticut, this can and often does present a treatment dilemma for them and their families. From the perspective of those of us in the field who regularly need treatment referral resources for our clients, there is a huge need for these services in Connecticut, again, particularly in New Haven County.

Bruce Pollack, Mgr. Metro-North RR Employee Assistance Program



Lighthouse Services, LLC
Addictions and Recovery Consulting

To whom it may concern,

As an Addictions Counselor and Sober Coach in Fairfield County I work with alcoholics, addicts, and their families. One of my goals is to have treatment that is affordable, accepts insurance and meets the needs of people who are in need of help. I recently heard you maybe opening a facility in New haven CT. I'm very interested in speaking with you and wish to voice my growing concern as a professional. I recognize the need for addiction treatment beds that accept commercial insurance is necessary in helping the many residents of Ct that have insurance and need treatment. The issue of appropriate Substance abuse services needs to be available to everyone. I believe that a treatment center that accepts commercial insurance would truly support the fight on addiction in the State of CT.

I've recommended your program in Lancaster, PA to many area hospitals in CT. and I've received very positive feedback about your programs.

Please keep me updated on what's happening in New Haven.

Best Regards,

Lori Williams CAC, SCCD

Lori Williams CAC, SCCD

Lighthouse Services, LLC

Sobercoachct.com

Retreat
at South Connecticut

QUESTION 3

In response to Question 3a on page 30, concerning projected volume, Table 1 did not include the units for the numbers listed in each column, Provide details on how to quantify the projected volume in Table 1 (group/individual counseling, bed days, # of admissions, clinical visits, etc.) For each client at each level of service, report the average number of units (e.g., individual/group sessions, number of bed days) that each person is projected to use.

3) In response to Question 3a on page 30, concerning projected volume, Table 1 did not include the units for the numbers listed in each column, Provide details on how to quantify the projected volume in Table 1 (group/individual counseling, bed days, # of admissions, clinical visits, etc.) For each client at each level of service, report the average number of units (e.g., individual/group sessions, number of bed days) that each person is projected to use.

Please see Table 1 attached following this page.

IN RESPONSE TO QUESTION 3

Table 1: Projected Volume	Projected Volume (First 3 Full Operational FYs)**			
	FY2013	FY2014	FY2015	FY2016
Service type***				
Residential Detoxification	5280	7260	7920	7920
Residential Rehabilitation	15,840	21,780	23,760	23,760
Partial Hospitalization	2203	4563	4875	4875
Intensive Outpatient	1322	2738	2925	2925
Outpatient	1763	3650	3900	3900
Total	26,408	39,991	43,380	43,380

*** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.*	*** Identify each service/procedure type and add lines as necessary.*

Retreat
at South Connecticut

QUESTION 4

Please provide additional information concerning the service level identified by the applicant as "Rehabilitation".

4) Please provide additional information concerning the service level identified by the applicant as "Rehabilitation".

The inpatient rehabilitation process begins with a comprehensive medical and clinical evaluation of the patient. A psychiatric evaluation will also be conducted as needed. The patient is then stabilized medically and clinically and enters into a comprehensive step-by-step program. An orientation plan is provided by the patient's designated primary therapist, outlining the programs offered, rules and regulations and what the patient may expect during their stay. The program mandates individual and group therapy. In individual therapy the personal needs of the patient are thoroughly addressed. In group therapy the patient collaborates with other patients; producing positive continuous peer support. Individual therapy is provided twice weekly and group therapy is held daily. Additional counseling and therapy is constantly available from clinical and other specialists, as needed.

The patient's prime therapist, a clinical specialist and other professional staff work in tandem to educate and help the patient alter their habits and behavior. Rehabilitation at Retreat is an organized process that is accomplished in stages. It creates a safe atmosphere where patients can reflect on their lives and build the foundations that will enable them to conquer their addiction and achieve long-lasting positive results.



QUESTION 5

Using the information reported above, please complete the following table:

5) Using the information reported above, please complete the following table:

Please see Table 2 attached following this page.

IN RESPONSE TO QUESTION 5

TABLE 2:

Service Type	FY 2013		FY 2014		FY 2015		FY 2016	
	Number of persons	*Total Number of Units*	*Number of persons*	*Total Number of Units*	*Number of persons*	*Total Number of Units*	*Number of persons*	*Total Number of Units*
Residential Detoxification	960	5280	1320	7260	1440	7920	1440	7920
Residential Rehabilitation	960	15,840	1320	21,780	1440	23,760	1440	23,760
Partial Hospitalization	150	2203	206	4563	225	4875	225	4875
Intensive Outpatient	90	1322	124	2738	135	2925	135	2925
Outpatient	120	1763	165	3650	180	3900	180	3900



QUESTION 6

In response to Question 3c and 3d on page 30, the Applicant states questions that are not applicable. Provide a discussion on the facility identified as "Retreat at Lancaster County" and report the following information for each service type, as appropriate, for the most recent fiscal year or as otherwise indicated:

a) Number of beds available or capacity of program;
b) Number of persons provided services and their state(s) of origin;
c) Number of persons provided services by age group using 18-25 yrs. 25-40 yrs. and 41 and older;
d) Units of service provided by service level;
e) The average daily census for residential programs;
f) Number of clients by service level on the last day of the most recent month; and
g) Number of clients on waiting list by service level for the most recent month end.

6) In response to Question 3c and 3d on page 30, the Applicant states questions that are not applicable. Provide a discussion on the facility identified as "Retreat at Lancaster County" and report the following information for each service type, as appropriate, for the most recent fiscal year or as otherwise indicated:

a) Number of beds available or capacity of program;
b) Number of persons provided services and their state(s) of origin;
c) Number of persons provided services by using 18-25 yrs. 25-40 yrs. and 41 and older;
d) Units of service provided by service level;
e) The average daily census for residential programs;
f) Number of clients by service level on the last day of the most recent month; and
g) Number of clients on waiting list by service level for the most recent month end.

Please see charts entitled "in response to question 6" attached following this page.

In response to Question 6a

Bed Type	Number of Beds
Residential Detoxification	30
Residential Rehabilitation	90
Total Residential Beds	120

In response to Question 6b

State of Origin	Number of Persons
PA	1383
NJ	426
MD	173
NY	90
DE	35
RI	15
VA	14
WV	14
CT	12
FL	9
DC	7
MI	7
NH	3
OH	3
OK	3
MA	2
TN	2
WA	2
CA	1
GA	1
IL	1
IN	1
UT	1
NC	1

In response to Question 6c

Age	18-25	26-40	41+	Total
Number of Patients	999	528	679	2206
Percentage of Patients	45.3%	23.9%	30.8%	100.0%

In Response to Question 6d

Level of Service	Number of Patients
Residential Detoxification	8267
Residential Rehabilitation	26786
Partial Hospitalization	5444
Intensive Outpatient	2730
Outpatient	519

In response to Question 6e

Level of Service	Average Daily Census
Residential Detoxifiction	22.65
Residential Rehabilitation	73.39
Total	**96.04**

In response to Question 6f

April 30, 2013	
Level of Service	**Number of Clients**
Detox	28
Rehab	87
PHP	3
IOP	37
OP	13

In response to Question 6g

Bed Type	Number of people on Waiting List
Residential Detoxification	0
Residential Rehabilitation	0
Total Residential Beds	0

Retreat
at South Connecticut

QUESTION 7

The applicant stated that it will be admitting patients from out-of-state. How does the Applicant plan to accommodate these patients if they need to continue treatment in one of the proposed outpatient programs?

7) The applicant stated that it will be admitting patients from out-of-state. How does the Applicant plan to accommodate these patients if they need to continue treatment in one of the proposed outpatient programs?

The venues Retreat utilizes for aftercare treatment include: recovery houses, residential extended care facilities, and several levels of outpatient therapy facilities. Upon completion of the inpatient treatment program and prior to discharge, a team consisting of the patient's primary therapist, an aftercare specialist and other support personnel, working in coordination with the patient and their family, will consider the patient's recovery status and recommend suitable aftercare treatment. Consideration will be given to the merits of selecting a suitable facility near the patient's residence or near their family's residence. Regardless of the selected location, within the state or without, the team will monitor and evaluate the performance of the aftercare facilities that the patient will be attending, continue to monitor the patient's status and progress, and provide intervention and follow-up services as needed.

QUESTION 8

Provide documentation that demonstrates that the Applicant has contacted the State of Connecticut Department of Mental Health and Addiction Services to provide information related to the admissions and discharge status of clients at existing behavioral health facilities in the Greater New Haven area.

8) Provide documentation that demonstrates that the Applicant has contacted the State of Connecticut Department of Mental Health and Addiction Services to provide information related to the admissions and discharge status of clients at existing behavioral health facilities in the Greater New Haven area.

The pertinent documents and correspondence are attached following this page.

Retreat
at South Connecticut

May 30, 2013

Doreen DelBianco - Legislative Program Manager
Department of Mental Health and Addiction Services
410 Capitol Avenue
P.O. Box 341431 #14COM
Hartford, CT 06134

Freedom of Information Request

Dear Ms. DelBianco:

Pursuant to the Freedom of Information Act, Connecticut General Statutes Section 1-200 *et. seq*., we respectfully request all relevant information pertaining to the following:

> *"Provide documentation that demonstrates that the Applicant has contacted the State of Connecticut Department of Mental Health and Addiction Services to provide information related to the admissions and discharge status of clients at existing behavioral health facilities in the Greater New haven area."*

We make this request so that we may be able to properly answer a question posed in connection with a Certificate of Need application we have presently pending at OCHA. If there are any fees for searching or copying this information, we are happy to pay them, but respectfully ask you to inform us in advance if the cost for same exceeds $500.00.

Would you please direct correspondence, questions, and answers regarding the above to:

Retreat at South Connecticut
c/o Law Offices of William P. Beccaro
12 New City Street
Essex, CT 06426
Telephone: 860-767-8632

Thank you in advance for your consideration. If you have any questions or require other information, please feel free to contact me at any time.

Best Regards,

Peter Schorr
CEO

cc: William P. Beccaro, Esq.

STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

DANNEL P. MALLOY
GOVERNOR

PATRICIA A. REHMER, MSN
COMMISSIONER

June 10, 2013

Peter Schorr, CEO
Retreat at South Connecticut
c/o Law Offices of William P. Beccaro
12 New City Street
Essex, CT 06426
Peter@retreatmail.com

Subject: Freedom of Information Request:

- Provide documentation that demonstrates that the Applicant has contacted DMHAS to provide information related to the admissions and discharge status of clients at existing behavioral health facilities in the Greater New Haven area.

Dear Mr. Schorr:

Enclosed is the document in our possession that is responsive to your request and which can be released to you. I hope this information will be helpful to you.

This will conclude your request and if you have any other questions or require additional assistance, please let me know. Thank you.

Sincerely,

Doreen Del Bianco
Freedom of Information Officer

(AC 860) 418-7000
410 Capitol Avenue, P.O. Box 341431, Hartford, Connecticut 06134
www.dmhas.state.ct.us
An Equal Opportunity Employer

From 7/1/2011 through 6/30/2012				
		Admitted	Discharged	Unduplicated
				Active
Partial Hospitalization Services	PHP	641	531	1138
Standard IOP	IOP	3317	3194	3226
Standard Outpatient	Outpatient	16235	15644	19637
Medically Monitored Detox 3.7D	Residential Services	9944	9947	6967
Intermediate/Long Term Res.Tx 3.5	Residential Services	2667	2636	3049

QUESTION 9

Place a checkmark (✓) in the "Need for Proposal" column for each license that the Applicant is seeking from the State's Department of Public Health (DPH) in relation to the proposal

9) Place a checkmark (✓) in the "Need for Proposal" column for each license that the Applicant is seeking from the State's Department of Public Health (DPH) in relation to the proposal

License	Needed for Proposal
Psychiatric Outpatient Clinic for Adults	
Facility for the Care of the treatment of substance Abusive or Dependent Persons (Outpatient)	✓
Mental Health Day Treatment Facility	

Retreat at South Connecticut

QUESTION 10

On page 656, the Applicant presented a fee schedule. Will the proposed rates be the same for all payers, including self-pay? Does the Applicant have a sliding-fee scale? Please provide a discussion

10) On page 656, the Applicant presented a fee schedule. Will the proposed rates be the same for all payers, including self-pay? Does the Applicant have a sliding-fee scale? Please provide a discussion

The proposed rates will be the same for all payers, including self-pay. Retreat at South Connecticut does not offer a sliding fee scale.

The average net fee rate is computed at a standard negotiated discount from the Full Rate Fee Schedule. Such a schedule is analogous to the *"rack rate schedule"* common in the hospitality industry, whereby the actual room rates are discounted from the respective rack-rate.

Retreat
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QUESTION 11

Please explain how the Applicant will serve Medicare and/or Medicaid patients. If the proposed facility receives a referral for a Medicare or Medicaid patient or a patient under age 18 or over age 65, how will these referrals be handled?

11) Please explain how the Applicant will serve Medicare and/or Medicaid patients. If the proposed facility receives a referral for a Medicare or Medicaid patient or a patient under age 18 or over age 65, how will these referrals be handled?

Retreat does not directly serve Medicare and/or Medicaid patients and patients under the age of 18. If Retreat receives such a referral, they would direct that referral to other facilities that do accept them. Retreat's admissions department, in coordination with its marketing team, will provide information and guidance to these individuals and assist them in locating an appropriate facility. If the prospective patients are not familiar with the process and require further assistance, Retreat's staff will provide direct referrals and help facilitate their admission process.

QUESTION 12

On page 658, it is stated that the Applicant projects to have 70, 75, and 75 patients in the first three months of operation. Provide details as to the source of projected numbers and the rationale used. Discuss how the Applicant expects to achieve this projection.

12) On page 658, it is stated that the Applicant projects to have 70, 75, and 75 patients in the first three months of operation. Provide details as to the source of projected numbers and the rationale used. Discuss how the Applicant expects to achieve this projection.

These projected census numbers are the result of extensive market research and proprietary analysis, coupled with the experience at Retreat at Lancaster County. Key management, marketing, and administrative staff will be empowered to tap into the market well before the New Haven facility opens its doors to admit patients. Substantial efforts will be expanded by the staff to finalize various referrals and provider agreements and to publicize and inform the health-care community of Retreat at South Connecticut's pending opening. Retreat at South Connecticut will also benefit from the tremendous success of Retreat at Lancaster County and capitalize on the well-known reputation of that facility's distinguished operating modality.

The analysis mentioned above was derived by studying data from Retreat at Lancaster County. This data shows a direct correlation between the percentage of total patients admitted and the referral source. As an example, the chart below shows the breakdown of admissions for February through April 2013. Our market and statistical analysis suggests that the Retreat at South Connecticut will follow a similar pattern.

Admissions at Retreat at Lancaster County	**February 2013**		**March 2013**		**April 2013**	
SOURCES (shown below)	**Number admitted**	**%**	**Number admitted**	**%**	**Number admitted**	**%**
HOSPITALS/ MEDICAL FACILITIES	62	*39%*	44	*30%*	68	*39%*
INDEPENDENT THERAPISTS/ DOCTORS	4	*2%*	4	*3%*	3	*2%*
MEDIA	14	*9%*	15	*10%*	9	*5%*
WORD OF MOUTH	19	*12%*	22	*15%*	19	*11%*
PRIOR PATIENTS	45	*28%*	45	*31%*	55	*31%*
INDEPENDENT ORGANIZATIONS	15	*9%*	9	*6%*	15	*9%*
INSURANCE COMPANIES	2	*1%*	7	*5%*	4	*2%*
LEGAL	0	*0%*	0	*0%*	2	*1%*
TOTALS	***161***	***100%***	***146***	***100%***	***175***	***100%***



QUESTION 13

Provide the audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g. unaudited balance sheet or statement of operation).

13) Provide the audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g. unaudited balance sheet or statement of operation).

Retreat at South Connecticut is not yet operational and no financial statements exist. However, at the suggestion of Office of Health Care Access we would be happy to make available the audited financial statements of Retreat at Lancaster County for 2011 and 2012. Due to the confidential nature of these statements, we respectfully suggest that we provide them for review in-person, at a time and place convenient to OHCA.

Retreat
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QUESTION 14

On page 17 and 34, it is stated that the total estimated capital expenditure for this project is $7,500.000. However, the public notice published in the "New Haven Register" stated $8,500,000. Please revise or explain the variance.

14) On page 17 and 34, it is stated that the total estimated capital expenditure for this project is $7,500.000. However, the public notice published in the "New Haven Register" stated $8,500,000. Please revise or explain the variance

The $1,000,000 difference is due to providing for working capital in order to fund the operation of the facility during its first operating quarter. Although it is anticipated that the Retreat at South Connecticut will achieve a positive cash flow during its first year of operation, a cash deficit of approximately $733,000 is projected during the first few months, because initial payments from third party payers generally lag the billing by several months.

This special initial funding is not treated as an asset in the application. For additional details, please see *"Attachment K – Financial Attachments and supporting documentation"*, on page 658, detailing the initial monthly projected cash flow and collection schedule.

The total actual capital expenditure budgeted for the project is $7,500,000. However, the notice published in the *"New Haven Register"* includes the initial liquidity needed subsequent to opening, as part of the total project outlays.

QUESTION 15

Please provide an organizational chart or NR Connecticut, LLC and for Retreat at South Connecticut

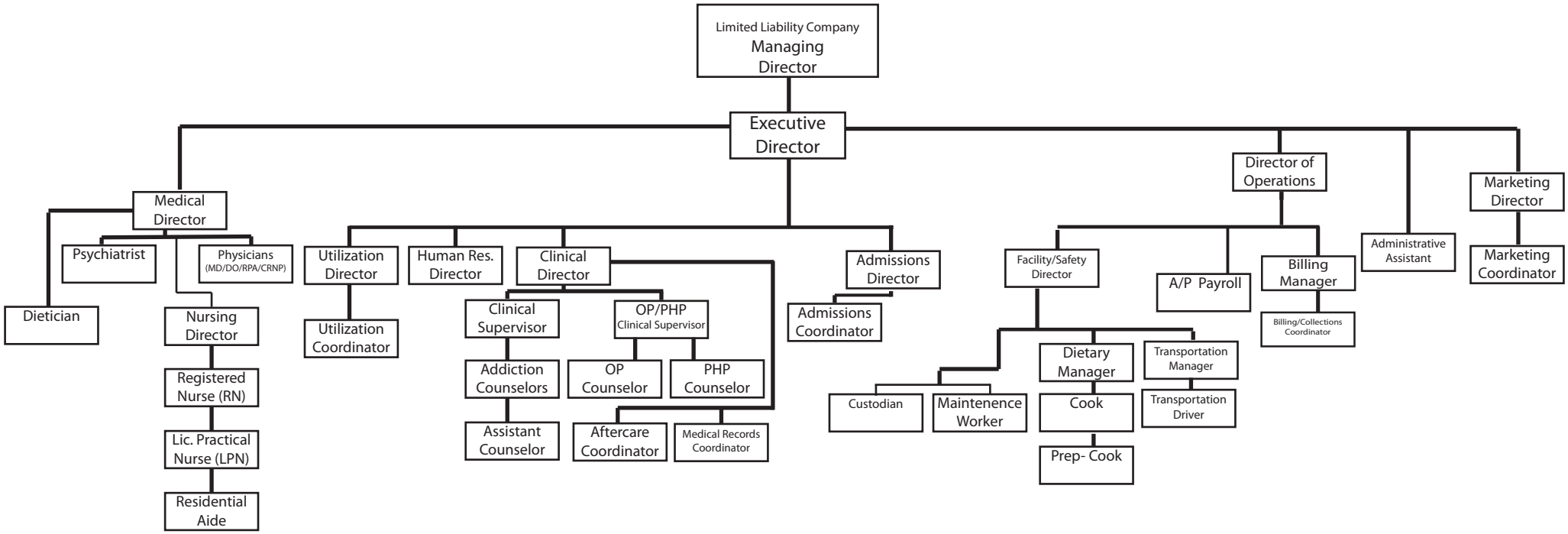
15) Please provide an organizational chart or NR Connecticut, LLC and for Retreat at South Connecticut

Please see the organizational chart (attached following this page)

Retreat at South Connecticut

Organizational Chart

May 2013



Retreat
at South Connecticut

QUESTION 16

The Applicant provided a list of Retreat at Lancaster County's officers and directors and their Curricula Vitae. Will these officers and directors serve at the proposed facility and split time between sites? If not, provide all the additional Curricula Vitae not included in the initial CON submission for officers and directors who will serve at the proposed facility.

16) The Applicant provided a list of Retreat at Lancaster County's officers and directors and their Curricula Vitae. Will these officers and directors serve at the proposed facility and split time between sites? If not, provide all the additional Curricula Vitae not included in the initial CON submission for officers and directors who will serve at the proposed facility.

The listed officers and directors will be relocating, and devoting their time to Retreat at South Connecticut. Retreat at Lancaster County has hired replacement staff to assume the duties of these officer and directors. Additional personnel will be hired from within the State of Connecticut and the City of New Haven and trained at the New Haven facility.

Retreat
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QUESTION 17

Provide the policies and procedures that will be utilized in relation to the proposal. Explain the quality assurance program. What level of staff will be responsible for quality assurance on-site?

17) Provide the policies and procedures that will be utilized in relation to the proposal. Explain the quality assurance program. What level of staff will be responsible for quality assurance on-site?

Attached are the policies and procedures utilized at Retreat at Lancaster County. They are continually reviewed and updated to reflect current standards, laws and regulations. These policies and procedures are fully compliant with the Commission on the Accreditation of Rehabilitation Facilities (CARF). Retreat at South Connecticut will employ these policies and procedures, and they will be modified as necessary to reflect State of Connecticut requirements.

Based on these policies and procedures, Retreat at Lancaster County has obtained the highest available three-year accreditation from CARF.

The Director of Utilization Management and Organizational Improvement will be the individual responsible for quality assurance on site.

Please also see the Policies and Procedures manual (Attachment "A") which appears at the end of this submission

Retreat
at South Connecticut

QUESTION 18

Provide details regarding the clinical (e.g., physicians, nurses, social workers, counselors, etc) FTE's that will serve the proposed facility

18) Provide details regarding the clinical (e.g., physicians, nurses, social workers, counselors, etc) FTE's that will serve the proposed facility

The attached schedules show actual details for the clinical and medical departments at Retreat at Lancaster County. Retreat at South Connecticut will follow a similar staffing structure, designed to provide the best and most qualified care to its patients.

Please see the staffing schedules attached following this page.

Year 1 Staffing

Job #	Direct Care Services	Yr 1 Mo 1 FTE	Yr 1 Mo 2 FTE	Yr 1 Mo 3 FTE	Yr 1 Mo 4 FTE	Yr 1 Mo 5 FTE	Yr 1 Mo 6 FTE	Yr 1 Mo 7 FTE	Yr 1 Mo 8 FTE	Yr 1 Mo 9 FTE	Yr 1 Mo 10 FTE	Yr 1 Mo 11 FTE	Yr 1 Mo 12 FTE	Clinical
DC001	Dir. of Nursing	0	0	1	1	1	1	1	1	1	1	1	1	Dir. of Nursing
DC002	Nurse, R.N. 1	1	1	1	1	1	1	1	1	1	1	1	1	Nurse, R.N. 1
DC003	Nurse, R.N. 2	1	1	1	1	1	1	1	1	1	1	1	1	Nurse, R.N. 2
DC004	Nurse, R.N. 3	1	1	1	1	1	1	1	1	1	1	1	1	Nurse, R.N. 3
DC005	Nurse, R.N. 4	0	0	0	0	0	1	1	1	1	1	1	1	Nurse, R.N. 4
DC006	Nurse, R.N. 5	0	0	0	0	0	0	0	0	0	0	0	0	Nurse, R.N. 5
DC007	Nurse, R.N. 6	0	0	0	0	0	0	0	0	0	0	0	0	Nurse, R.N. 6
DC008	Nurse, R.N. 7	0	0	0	0	0	0	0	0	0	0	0	0	Nurse, R.N. 7
DC009	Nurse, R.N. 8	0	0	0	0	0	0	0	0	0	0	0	0	Nurse, R.N. 8
DC010	Nurse, LPN 1 (Pharm)	1	1	1	1	1	1	1	1	1	1	1	1	Nurse, LPN 1 (Pharm)
DC011	Nurse, LPN 2	1	1	1	1	1	1	1	1	1	1	1	1	Nurse, LPN 2
DC012	Nurse, LPN 3	1	1	1	1	1	1	1	1	1	1	1	1	Nurse, LPN 3
DC013	Nurse, LPN 4	1	1	1	1	1	1	1	1	1	1	1	1	Nurse, LPN 4
DC014	Nurse, LPN 5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	Nurse, LPN 5
DC015	Nurse, LPN 6	1	1	1	1	1	1	1	1	1	1	1	1	Nurse, LPN 6
DC016	Nurse, LPN 7	1	1	1	1	1	1	1	1	1	1	1	1	Nurse, LPN 7
DC017	Nurse, LPN 8	1	1	1	1	1	1	1	1	1	1	1	1	Nurse, LPN 8
DC018	Nurse, LPN 9	0.8	0.8	0.8	0.8	0.8	1	1	1	1	1	1	1	Nurse, LPN 9
DC019	Nurse, LPN 10	0	0	0	0	0	1	1	1	1	1	1	1	Nurse, LPN 10
DC020	Nurse, LPN 11	0	0	0	0	0	1	1	1	1	1	1	1	Nurse, LPN 11
DC021	Nurse, LPN 12	0	0	0	0	0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	Nurse, LPN 12
DC012	Nurse, LPN 13	0	0	0	0	0	0	0	0	0	0	0	0	Nurse, LPN 13
DC013	Nurse, LPN 14	0	0	0	0	0	0	0	0	0	0	0	0	Nurse, LPN 14
DC014	Nurse, LPN 15		0	0	0	0	0	0	0	0	0	0	0	Nurse, LPN 15
DC015	Nurse, LPN 16		0	0	0	0	0	0	0	0	0	0	0	Nurse, LPN 16
DC016	Nurse, LPN 17		0	0	0	0	0	0	0	0	0	0	0	Nurse, LPN 17
DC017	Nurse, LPN 18		0	0	0	0	0	0	0	0	0	0	0	Nurse, LPN 18
DC018	Nurse, LPN 19		0	0	0	0	0	0	0	0	0	0	0	Nurse, LPN 19
DC019	Nurse, LPN 20		0	0	0	0	0	0	0	0	0	0	0	Nurse, LPN 20
DC022	Nursing Asst./CA 1	1	1	1	1	1	1	1	1	1	1	1	1	Nursing Asst./CA 1
DC023	Nursing Asst./CA 2	1	1	1	1	1	1	1	1	1	1	1	1	Nursing Asst./CA 2
DC024	Nursing Asst./CA 3	1	1	1	1	1	1	1	1	1	1	1	1	Nursing Asst./CA 3
DC025	Nursing Asst./CA 4	1	1	1	1	1	1	1	1	1	1	1	1	Nursing Asst./CA 4
DC026	Nursing Asst./CA 5	1	1	1	1	1	1	1	1	1	1	1	1	Nursing Asst./CA 5
DC027	Nursing Asst./CA 6	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	Nursing Asst./CA 6
DC028	Nursing Asst./CA 7		1	1	1	1	1	1	1	1	1	1	1	Nursing Asst./CA 7
DC029	Nursing Asst./CA 8		0	0	0	0	0	0	0	0	0	0	0	Nursing Asst./CA 8
DC030	Primary Addiction Cslr 1	1	1	1	1	1	1	1	1	1	1	1	1	Primary Addiction Cslr 1
DC031	Primary Addiction Cslr 2	1	1	1	1	1	1	1	1	1	1	1	1	Primary Addiction Cslr 2
DC032	Primary Addiction Cslr 3	1	1	1	1	1	1	1	1	1	1	1	1	Primary Addiction Cslr 3
DC033	Primary Addiction Cslr 4	1	1	1	1	1	1	1	1	1	1	1	1	Primary Addiction Cslr 4
DC034	Primary Addiction Cslr 5	1	1	1	1	1	1	1	1	1	1	1	1	Primary Addiction Cslr 5
DC035	Primary Addiction Cslr 6	1	1	1	1	1	1	1	1	1	1	1	1	Primary Addiction Cslr 6
DC036	Primary Addiction Cslr 7		1	1	1	1	1	1	1	1	1	1	1	Primary Addiction Cslr 7
DC037	Primary Addiction Cslr 8		0	0	0	1	1	1	1	1	1	1	1	Primary Addiction Cslr 8
DC038	Primary Addiction Cslr 9		0	0	0	0	0	1	1	1	1	1	1	Primary Addiction Cslr 9
DC039	Primary Addiction Cslr 10		0	0	0	0	0	0	0	0	0	0	1	Primary Addiction Cslr 10
DC040	Primary Addiction Cslr 11		0	0	0	0	0	0	0	0	0		0	Primary Addiction Cslr 11
DC041	Primary Addiction Cslr 12		0	0	0	0	0	0	0	0	0	0	0	Primary Addiction Cslr 12
DC042	Primary Addiction Cslr 13		0	0	0	0	0	0	0	0	0	0	0	Primary Addiction Cslr 13
DC043	Primary Addiction Cslr 14		0	0	0	0	0	0	0	0	0	0	0	Primary Addiction Cslr 14
DC044	Primary Addiction Cslr 15		0	0	0	0	0	0	0	0	0	0	0	Primary Addiction Cslr 15
DC045	Primary Addiction Cslr 16		0	0	0	0	0	0	0	0	0	0	0	Primary Addiction Cslr 16
DC046	Clinical Supervisor 1	1	1	1	1	1	1	1	1	1	1	1	1	Clinical Supervisor 1
DC047	Clinical Supervisor 2	1	1	1	1	1	1	1	1	1	1	1	1	Clinical Supervisor 2
DC048	Clinical Supervisor 3	0	0	0	0	1	1	1	1	1	1	1	1	Clinical Supervisor 3
DC049	Clinical Supervisor 4	0	0	0	0	0	0	0	0	0	0	0	0	Clinical Supervisor 4
DC050	Clinical Supervisor 5	0	0	0	0	0	0	0	0	0	0	0	0	Clinical Supervisor 5
DC051	Clinical Supervisor 6		0	0	0	0	0	0	0	0	0	0	0	Clinical Supervisor 6
DC052	Clinical/Site Director	0	0	0	0	0	1	1	1	1	1	1	1	Clinical/Site Director
DC053	Counselor - Mental Health 1	1	1	1	1	1	1	1	1	1	1	1	1	Counselor - Mental Health 1
DC054	Counselor - Mental Health 2	1	1	1	1	1	1	1	1	1	1	1	1	Counselor - Mental Health 2
DC055	Counselor - Mental Health 3							1	1	1	1	1	1	Counselor - Mental Health 3
DC056	Counselor - Mental Health 4												1	Counselor - Mental Health 4
DC057	Counselor - Mental Health 5													Counselor - Mental Health 5
DC058	Counselor - Mental Health 6													Counselor - Mental Health 6
DC059	Addiction Counselor 1	1	1	1	1	1	1	1	1	1	1	1	1	Addiction Counselor 1
DC060	Addiction Counselor 2	1	1	1	1	1	1	1	1	1	1	1	1	Addiction Counselor 2
DC061	Addiction Counselor 3	1	1	1	1	1	1	1	1	1	1	1	1	Addiction Counselor 3
DC062	Addiction Counselor 4	1	1	1	1	1	1	1	1	1	1	1	1	Addiction Counselor 4
DC063	Addiction Counselor 5	1	1	1	1	1	1	1	1	1	1	1	1	Addiction Counselor 5
DC064	Addiction Counselor 6	1	1	1	1	1	1	1	1	1	1	1	1	Addiction Counselor 6
DC065	Addiction Counselor 7			1	1	1	1	1	1	1	1	1	1	Addiction Counselor 7
DC066	Addiction Counselor 8						0.5	0.5	0.5	0.5	0.5	0.5	0.5	Addiction Counselor 8
DC067	Addiction Counselor 9						0.5	0.5	0.5	0.5	0.5	0.5	0.5	Addiction Counselor 9
DC068	Addiction Counselor 10							1	1	1	1	1	1	Addiction Counselor 10
DC069	Addiction Counselor 11													Addiction Counselor 11
DC070	Addiction Counselor 12													Addiction Counselor 12
DC071	Dir. Of UM	1	1	1	1	1	1	1	1	1	1	1	1	Dir. Of UM
DC072	Utilization Staff 1	1	1	1	1	1	1	1	1	1	1	1	1	Utilization Staff 1
DC073	Utilization Staff 2			1	1	1	1	1	1	1	1	1	1	Utilization Staff 2
DC074	Utilization Staff 3							1	1	1	1	1	1	Utilization Staff 3
DC075	Utilization Staff 4												1	Utilization Staff 4
DC076	Medical Records	0	0	0	0	0	1	1	1	1	1	1	1	Medical Records
DC077	Outpatient Director	1	1	1	1	1	1	1	1	1	1	1	1	Outpatient Director
DC078	PHP Counselor	0	1	1	1	1	1	1	1	1	1	1	1	PHP Counselor
DC079	OP Counselor	0	1	1	1	1	1	1	1	1	1	1	1	OP Counselor
DC080	Certified Rec. Counselor	0	1	1	1	1	1	1	1	1	1	1	1	Certified Rec. Counselor
DC081	Psychiatrist	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	Psychiatrist
DC082	Medical Director	1	1	1	1	1	1	1	1	1	1	1	1	Medical Director
	Clinical Total	**37.3**	**42.3**	**45.3**	**45.3**	**47.3**	**54**	**58**	**58**	**58**	**58**	**59**	**61**	**Clinical Total**

In response to Question 18

RETREAT AT LANCASTER COUNTY - SAMPLE NURSING SCHEDULE

5/1/2013	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri
DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Nurse Manager	D1	D1	D1			D1	D1	D1	D1	D1			D1	D1	D1	D1	D1			D1	D1	D1	D1	D1			D1	D1	D1	D1	D1
Nurse Manager	D1	D1	D1			D1	D1	D1	D1	D1			D1	D1	D1	D1	D1			D1	D1	D1	D1	D1			D1	D1	D1	D1	D1
DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
LPN	D3B		D1	D1	D1	D1		D1	D1	D1			D3A	D3A	D3A		D1	D3A	D3A		D1	D1	D1	D1			D1	D1	D1		D1
LPN	D1	D1	D1			D3B	D1	D1		D3B	D1	D1	D1		D1	D3B	D1			D1	D1	D1		D3B	D3A	D1	D3B		D3B		D3B
LPN	D1	D1		D3A	D3A		D1	D3A	D3A	D1			D1	D1	D1	D1		D1	D1	D1		D3B	D3A	D1			D1		D1		
LPN	D3A	D3A	D3B			D3A	D3A	D3B		D3A	D3A	D3A	D3B		D3B	D3A	D3A			D3A	D3A	D3A		D3A	D3A	D3B	D3B		D3A		D3A
LPN		D3B	D3B			D1	D3B		D3B		D1	D1		D3B		D1				D3B	D3B		D3B		D1	D1		D3A		D1	D1
LPN				D1	D1													D3B	D3B												
LPN																															
LPN											D3B	D3B													D1	D3A					
RN				D3B	D3B				D1									D1	D1											D3B	
RN																	D3B											D3B			
RN	D3B	D1	D3B			D1	D1	D1	D1				D3B	D1	D1	D1				D1	D1	D1	D1				D1	D1	D1	D1	
TOTAL																															
EVENING																															
LPN		E3	E1			E1	E1		E1	E1	E1	E1	E1	E3		E3	E1			E1	E1		E1	E1	E1	E1	E3	E3		E1	E1
LPN	E1	E1		E1	E1	E3		E1	E3	E3				E1	E1	E1		E1	E1	E3		E1	E3	E3			E1	E1	E1		
LPN	E1	E1	E1			E1	E1	E3		E1	E1	E1	E1		E3	E3	E1			E1	E1	E3		E1	E1	E1	E3		E3	E1	E1
LPN	E3		E3			E1	E3	E3	E1		D3B	D3B	E3	E1			E3		N1	E3	E3	E1	E1		D1	D3A		E1		E3	E3
LPN	E1	E1		E3	E3		E3	E1	E3	E3			E3		E1	E1	E3	E1	E1		E3	E3	E3	E3			E1	E1	E1		E1
RN				E1	E1										E1			E3	E3									E1		
LPN			E3	E3	E3					E3	E3								E3						E3	E3	E1	E1			
LPN	E3						E1								E3														E3		
RN		E3										E3													E3	E3					
TOTAL																															
POOL																															
LPN																															
RN	D3B	D1				D1	D1	D1	D1																						
RN																															
LPN				N1	N1													N1	N1												
RN		N1										N1																			
NIGHT																															
RN	N1		N1	N3	N3	N1		N1	N1		N1	N1	N1		N1	N1	N1	N3		N1	N1	N1	N1		N1	N1	N1	N1		N1	N1
LPN	N1	N1		N1	N1		N1	N1	N1	N1			N1	N1	N1	N1		N1	N3		N1	N1	N1	N1			N1	N1	N1	N1	
LPN	N3	N3	N1			N3		N3	N3	N3				N3	N3		N3			N3		N3	N3	N3			N3	N3	N3		N1
LPN		N3	N3			N1	N1		N3	N3	N3	N3	N3	N3		N3	N1			N1	N3		N3	N1	N3	N3	N3	N3		N3	N3
RN							N1	N1						N1	N1	N1						N1		N1	N1	N1			N1	N1	N1
RN							N1	N1																							
TOTAL																															
	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
LPN												6p-1130		630p				7p-1130													
LPN																			N1												

CODES

Key- D1/ Detox dayshift	
D3A-630am/D3B-7am	S3- 9p-530am rehab
E1 - detox/ E3 Rehab	N1-detox
S1 - 9p-530am detox	N3- Rehab

In response to Question 18

RETREAT AT LANCASTER COUNTY - SAMPLE THERAPIST SCHEDULE

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	Day																														
Primary Therapist - Lead	BS-Family Studies			Split	D	D	D	D			D	D	D		D	D		D	D	D	D	D			D	D	D	D	D		
Primary Therapist	MS-Psychology				D	D	D	D	D		D	D	D	D	D			D	D	D	D	D			D		D	D	D	D	
Primary Therapist	MA-Marriage Therapy-BA-Psychology	Hike		D		D	D	D	D		D	D	D	D	D			D		D	D	D	D(SM)		D	D	D	D	D		
Primary Therapist	AS Psychology-BS phychology			D	D	D	D	D				D	D	D	D		D	D	D	D	D	D			D	D	D	D	T		
Primary Therapist	MHS-BA-Psychology-AA-Psychology		D	D	D	D	D	D			D	D	D	D	D			D	D		D	D		D	Split	D	D	D	D		
Primary Therapist	MS-Psychology-BA-Psychology			D	D	D	D	D			D	D		D	D	D		D	D	V	V	V			V	V	V	V	V		
Primary Therapist	BS-Psychology			D	D		D	D		D	D	D	D	D	D			T	D	D	D	D			D	D		D	D		D
Primary Therapist	BA-Liberal Arts-MS-Community Counseling	D																		D	D	D			D	D	D	D	D		
Primary Therapist - Lead	MS-Psychology- BA-Psychology, CAC		D	D	D	D	D	H			D	D	D	D	D			D		D	D	D		D	D	D	D	D	D		
Primary Therapist	MS-Psychology			D	T	D	D	D			D		D	D	D		D	D	D	D	D	D			D	D	D	D	D		
Primary Therapist	BA-psychology/MA-Counseling	D		D	D	D	D	D			D	D	D	D	D			D	D	D	D	V			V	V		D	D	D(KM)	
Primary Therapist	BSW-Social Work			D	D	D	D			D	D	D	D	D	V			V	V	V	D	D			D	D	D	D			D
Primary Therapist	BS-social science/MA-sociology			D	D	D	D	D			D	D	D	D		D		D	D	D	V	V			D	D	D	D	D		
Primary Therapist	BS -Psych-LSW, CAC	D		D	D	D	D	D			Split	D	D	D	D				D	D	D	D	D	D		D	D	D	D	D		
Primary Therapist	MA-Pastoral Counseling	Hike		D	D	D		D	D		D	D	D	D	D			D	D	D	D	D			D	D	D		D	D	
Primary Therapist	MA-Marriage Coun-BS Misic Therapy	D		D	D	D	D	D			D	D	D	D	D			D	D		D	D	D		D	D	D	D	D		
Clinical Specialist	MA-Clinical PSYCH																														
Clinical Specialist	CETII-MA-Sociology-BA-Clinical Sociology																														
Clinical Specialist	MS-Psychology																														
Clinical Specialist	MS-Human Services, CAC, LPC		D	D	D	D	D	D			D	D	D	D	D			D	D	D	D			D	D	D	D	D	D		
	PART-TIME																														
Therapist	BA-Counseling	D							D	D						D	D						D						D	D
Therapist	BA Sociolgy		D							D							D							D						D
Therapist	ME- BA -Administration	Hike	D																				Hike	D					T		
Therapist	Ma-Human Services- BA -Government & Polical Affairs	OFF	OFF																				OFF								
Therapist	MHW-BA-Speech comm								D	D						D	D													D	D
Therapist	BS social work-MS social work	D(t)																													
Therapist	BS-Psy-MA-Psy		D(1)							D(1)							D(1)							D(1)							D(1)
Therapist	BA-Addictions studies	D	D						D	D						D	D						D	D						D	D
	CLINICAL SUPERVISORS																														
Clinical Supervisor	MS-Administration Justice-BS -Criminial Justice, CAC		OFF	V	D	D	D	D			D	T9-1	D	D		D		T	D	D	D	D			D	D	D	D	D		
Clinical Supervisor	BA-Psych-MBA-MA-Counseling, CAC, LPC			D	D	D	D	Tam			D	D	D		D		D	D	D	V	V		Hike		D	D	D	D	D		
Clinical Supervisor	MA Psychology-BA Psychology	D	D	D	D	D			D	D	T	T	T	T	T			D	D	D			D	D	D	D	D			D	D
Clinical Supervisor	BS-Rehab Services/ Masters Humanities, CAC	S	S	S	X	X	S	S	P	P	S	X	X	S	S	S	S	S	X	X	S	S	S	S	S	X	X	S	S	S	S
	EVENING																														
Asst. Couselor	HS-Diploma	X	X	S	S	S	S	S	X	X	S	S	S	S	S	X	X	S	S	S	S	S	X	X	S	S	S	S	S	X	X
Therapist	BS-Psychology	X	X	E	E	E	E	X	E	E	E	E	E	P	X	X	X	E	E	E	E	X	E	E	E	E	E	E	X	X	X
Therapist	MS-Psych-BA-Bible/Psych	E	P	X	E	E	E	E	X	X	X	E	E	E	E	E	E	X	E	E	E	E	X	X	X	E	E	E	E	E	E
Asst. Couselor	HS-Diploma	E	E	E	E	X	E	E	X	X	E	E	X	E	E	E	E	E	E	X	E	E	X	X	E	E	X	E	E	E	E
Therapist	CRS & CAAP	E	E	E	E	E	E	X	X	X	E	E	E	E	X	E	E	E	E	E	E	X	X	X	E	E	E	E	X	E	E
Asst. Couselor	HS-Diploma	E	E	E	E	E	X	P	X	X	E	X	E	E	E	E	E	E	E	E	X	E	X	X	E	E	E	E	X	E	E
Asst. Couselor	HS-Diploma	X	X	E	X	E	E	E	E	E	E	E	E	X	P	X	X	E	X	E	E	E	E	E	E	X	E	E	E	X	X
Therapist	BS- Organization Psych	X	X	X	E	E	E	E	E	E	X	E	E	E	E	X	X	X	E	E	E	E	E	E	X	E	E	E	E	X	X
Therapist	BS-Crminal Justice	X	X	E	X	E	E	E	E	E	E	X	E	E	E	X	X	E	X	E	E	E	P	P	P	X	P	P	P	X	X
Therapist	BA-Arts- MS Art Therapy	E	E	E	E	X	E	E	X	X	E	E	X	E	E	E	E	E	E	X	E	E	X	X	E	E	E	E	E	E	E
	NIGHT/PT																														
Therapist	AA- Business-BS-General Studies	N	N	X	X	N	N	N	X	X	N	N	N	N	N	X	N	X	X	N	N	N	X	X	N	N	N	N	N	N	N
Therapist	BA-Psychology	X	X	N	N	N	X	X	N	N	N	N	N	N	N	X	X	N	N	N	X	X	N	N	N	N	N	N	T	X	X
Therapist	MS Human Services	E	E	E	E	E	E	X	X	E	E	E	E	E	X	X	E	E	E	E	E	X	X	E	E	E	E	E	X	X	E
Therapist	Ma-Human Services- BA -Government & Polical Affairs								E																						
Therapist	MHW-BA-Speech comm																														
Therapist	BA-Addictions studies	E	E																				E								
Therapist	AA-Applied science	X	X						E	E						E	E						X	E						E	E
Therapist	BA-Counseling		E																												
Therapist	BS social work-MS social work	E	E						X	X													E	E							

CODES

V - Vacation	**P - Personal**
H - Holiday	**SN - Off due to SNOW**
S - Sick - Call-out	**T- Training**
S - Sick - Planned	**B - Bereavement**
JD - Jury Duty	NS - No show

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

July 8, 2013

VIA ELECTRONIC MAIL ONLY

Peter Schorr
President / CEO
NR Connecticut, LLC
12 New City Street
Essex, CT 06426

RE: Certificate of Need Application; Docket Number: 13-31828-CON
NR Connecticut, LLc-d/b/a Retreat at South
Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut

Dear Mr. Schorr:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of July 8, 2013.

If you have any questions regarding this matter, please feel free to contact me at (860) 418-7007.

Sincerely,

A. Veyberman

Alla Veyberman
Healthcare Analyst

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3559
RECIPIENT ADDRESS	98607670456
DESTINATION ID	
ST. TIME	07/08 13:31
TIME USE	00'29
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: PETER SCHORR

FAX: 860.767.0456

AGENCY: RETREAT AT SOUTH CT

FROM: OHCA

DATE: 07/08/13 **Time:**

NUMBER OF PAGES: 2
(including transmittal sheet

Comments:
Docket Number: 13-31828-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS

Phone: (860) 418-7001 Fax: (860) 418-7053

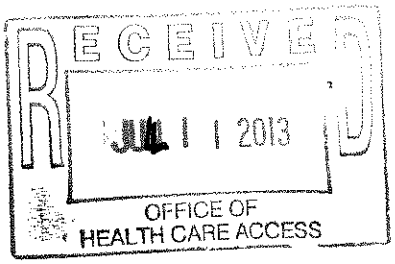
SHIPMAN & GOODWIN LLP®

COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

July 11, 2013

Lisa A. Davis
Deputy Commissioner, OHCA
410 Capitol Avenue, MS # 13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308



Re: Public Hearing Request
13-31828-CON
NR Connecticut, LLC-d/b/a Retreat at South Connecticut
Establishment of a 105 bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut

Dear Deputy Commissioner Davis:

I am writing on behalf of Rushford Center, Inc., High Watch Recovery Center, Inc., CHR, Inc., MCCA, Inc., and Recovery Network of Programs, Inc. (collectively, the "Interested Parties") to request that the Office of Health Care Access hold a public hearing with respect to the above-referenced Certificate of Need application.

Pursuant to Connecticut General Statute § 19a-639a, the Interested Parties hereby request that a public hearing be held on the proposal by Retreat at South Connecticut to establish a residential substance abuse treatment facility in New Haven.

Thank you in advance for your consideration.

Very truly yours,

Joan W. Feldman, Esq.

2890682v1

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

July 17, 2013

Peter Schorr
NR Connecticut, LLC – d/b/a Retreat at South Connecticut
12 New City Street
Essex, CT 06426

RE: Certificate of Need Application, Docket Number 13-31828-CON
NR Connecticut, LLC – d/b/a Retreat at South Connecticut
Establishment of a 105 Bed Residential Substance Abuse Treatment Facility

Dear Mr. Schorr,

With the receipt of the completed Certificate of Need ("CON") application information submitted by NR Connecticut, LLC – d/b/a Retreat at South Connecticut ("Applicant") on July 8, 2013, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicant:	NR Connecticut, LLC – d/b/a Retreat at South Connecticut
Docket Number:	13-31828-CON
Proposal:	Establishment of a 105 Bed Residential Substance Abuse Treatment Facility with an associated capital expenditure of $7.5 million dollars

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: August 14, 2013

Time: 9:00 a.m.

Place: Department of Public Health, Office of Health Care Access
410 Capitol Avenue, Third Floor Hearing Room
Hartford, CT 06134

The Applicant is designated as party in this proceeding. Enclosed for your information is a copy of each hearing notice for the public hearing that will be published in the *New Haven Register* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM: LKG:AV:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

July 17, 2013 Requisition # 42607

New Haven Register
40 Sargent Street
New Haven, CT 06531-0715

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Friday, July 19, 2013.** Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:LKG:AV:lmg

New Haven Register **July 17, 2013**
Notice of Public Hearing, Docket Number 13-31828-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-639
Applicant:	NR Connecticut, LLC – d/b/a Retreat at South Connecticut
Town:	New Haven
Docket Number:	13-31828-CON
Proposal:	Establishment of a 105 Bed Residential Substance Abuse Treatment Facility with an associated capital expenditure of $7.5 million dollars
Date:	August 14, 2013
Time:	9:00 a.m.
Place:	Department of Public Health, Office of Health Care Access 410 Capitol Avenue, Third Floor Hearing Room Hartford, CT 06134

Any person who wishes to request status in the above listed public hearing may file a written petition no later than August 9, 2013 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3581
RECIPIENT ADDRESS	98607670456
DESTINATION ID	
ST. TIME	07/17 13:55
TIME USE	00'52
PAGES SENT	5
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: PETER SCHORR

FAX: (860) 767-0456

AGENCY: NR CONNECTICUT, LLC – D/B/A RETREAT AT SOUTH CT

FROM: OHCA

DATE: 7/17/13 **TIME:**

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: DN: 13-31828-CON Notice of Public Hearing

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Wednesday, July 17, 2013 1:13 PM
To: Greer, Leslie
Subject: Re: Hearing Notice 13-31828-CON

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

PLEASE NOTE: New Department of Labor guidelines allow web base advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

For only $349.00 The GRAYSTONE DIVERSITY COMBO provides placement online with both Diverse Issues & Hispanic Outlook. A savings of 25% ..... Let me know if you want to add the DIVERSITY COMBO to this job.

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Wednesday, July 17, 2013 1:07 PM
To: ads <ads@graystoneadv.com>
Cc: Dorothy Schreiner <DSchreiner@graystoneadv.com>
Subject: Hearing Notice 13-31828-CON

Please run the attached hearing notice in the New Haven Register by 7/19/13. For billing purposes refer to requisition 42607. In addition, please submit "proof of publication" for my records when available.

Thanks,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca
Please consider the environment before printing this message

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

TO: Kevin Hansted, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: July 19, 2013

RE: Certificate of Need Application; Docket Number: 13-31828-CON
NR Connecticut, LLC D/B/A Retreat at South Connecticut
Establishment of a 105 Bed Residential Substance Abuse Treatment Facility
to be Located in New Haven, Connecticut.

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

July 29, 2013

VIA FAX ONLY

Peter Schorr
President / CEO
NR Connecticut, LLC
12 New City Street
Essex, CT 06426

RE: Certificate of Need Application, Docket Number 13-31828-CON
NR Connecticut, LLC-d/b/a/Retreat at South Connecticut
Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut

Dear Mr. Schorr:

The Office of Health Care Access ("OHCA") will hold a public hearing on the above docket number on August 14, 2013. The hearing is at 9:00 a.m. in the Department of Public Health's third floor hearing room, 410 Capitol Avenue, Hartford. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29 (e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. OHCA requests that NR Connecticut, LLC –d/b/a/ Retreat at South Connecticut ("Applicant") submit prefiled testimony by 12:00 p.m. on August 9, 2013.

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find attached OHCA's Issues outlining the topics that will be discussed at the hearing.

Please contact Laurie Greci at (860) 418-7032, if you have any questions concerning this request.

Sincerely,

/Kevin Hansted
Hearing Officer

Attachment

C: William P. Beccaro, Esq.

Issues

Certificate of Need Application; Docket Number: 13-31828-CON

NR Connecticut, LLC D/B/A Retreat at South Connecticut

Establishment of a 105 Bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut.

Applicant should prepare to argue and present supporting evidence on the following issues to support the proposal identified above:

1. Clear public need, including the patient populations to be served.

2. The proposed number of beds in the facility, including the proposed number for each level of service.

3. The financial feasibility of the proposal, including documentation.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3613
RECIPIENT ADDRESS	98607670456
DESTINATION ID	
ST. TIME	07/29 10:57
TIME USE	00'36
PAGES SENT	3
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: William P. Beccard

FAX: 860 767 0456

AGENCY: Law Offices of William P. Beccard

FROM: Laurie Greci

DATE: 7/29/2013 **TIME:** 10:45 AM

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: Re: 13-31328-CON Retreat at South CT

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3612
RECIPIENT ADDRESS	98607670456
DESTINATION ID	
ST. TIME	07/29 10:52
TIME USE	00'36
PAGES SENT	3
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Peter Schorr, CEO

FAX: 860 767 0456

AGENCY: NR Connecticut, LLC - dba Retreat at South CT

FROM: Laurie Greci

DATE: 7/29/2013 **TIME:** 10:45 AM

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: Re: 13-31828-CON Retreat at South CT

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

GENERAL HELP WANTED

645 GENERAL HELP WANTED

645 GENERAL HELP WANTED

ANNOUNCEMENT

Help wanted advertisements in these columns have been accepted on the premise that jobs offered will be filled on the basis of merit. It is a violation of the Connecticut Fair Employment Practice Law to present or publish or cause to be published any notice or advertisement for employment which indicates preference or limitation based on sex, color, race, national ancestry or origin, religion, age, or physical disability. An exception exists if there is a bonafide occupational qualification for employment. All inquiries should be made to the Connecticut Commision on Human Rights and Opportunities, 50 Linden Street, Waterbury, Ct. 06702
Telephone (203)805-6530

CITY OF NEW HAVEN

Review new position announcements at **www.cityofnewhaven.com** or visit Dept. of HR, 200 Orange St, New Haven, CT 06510.
Minority applicants encouraged to apply.
EOE, M/F/D

Automotive

OFFICE MANAGER

Quality Hyundai seeks experienced Office Manager. Proficient in Reynolds & Reynolds. Please forward resume to: qualityhyundai@outlook.com

Construction

Immediate positions available for qualified individuals interested in working with an award winning restoration company. We are looking for individuals who have experience in the construction industry, specifically Carpenters and Glaziers, but all are welcome to apply. We offer a benefits package as well as competitive rates. Copy & paste your resume & professional references and email to: **restoration1949@gmail.com**

648 SALES & MARKETING

Salespeople - Roberts Chrysler Dodge seeks qualified sales pros to sell new & used cars. Auto sales exp pref'd, training provided. Salary plus comm, health plan, 401k. NO Sundays. Apply in person at: Robert's Chrysler Dodge, 120 South Broad St. (Rte 5), Meriden, Ct.

LEGALS

Invitation for Pre-Qualification

Dimeo Construction Company is the Construction Manager and is soliciting Pre-Qualifications for the University of Connecticut Health Center Finance Corporation Ambulatory Care Center (ACC) Fit-out Project Number 11-042. This is a 252,000 sf $65,000,000 project consisting of the interior fit-out of medical office suites. This project is located in Farmington, CT and is expected to start in September of 2013 with a substantial completion on December 2014. All bidders must complete and submit a prequalification package in order to bid this project. In addition to being prequalified by Dimeo all contractors bidding on packages over $500k are required to be DAS Certified. Prequalification packages can be found at www.dimeo.com under the Pre-Construction link. Prequalification packages are due to Dan O'Connell (contact info below) no later than Monday, August 5, 2013 by 2:00PM. A list of available bid packages and values are posted within the Prequalification package.

There will be a Prequalification Outreach Conference on Tuesday, July 23th 2013 from 5 PM to 7 PM at the Human Resource Training Room located at 16 Munson Road, Farmington, CT 06032. This meeting is not mandatory but highly recommended.

All prime contractors working on the project must utilize Small Business Enterprises (SBE) and Minority Business Enterprises (MBE) certified by the State of Connecticut DAS Supplier Diversity Program, to meet the goal of 30% allocation (25% of contract value, at a minimum) to SBE's, of which 10% (6.25% of the contract value, at a minimum) must be allocated to MBE's only.

If you have any questions, please contact Dan O'Connell at Dimeo Construction Company at 401-781-9800 or *doconnell@dimeo.com*.

DIMEO CONSTRUCTION COMPANY IS AN AFFIRMATIVE ACTION/ EQUAL OPPORTUNITY EMPLOYER.

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CALL 203-777-3278
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LEGALS

INVITATION TO BID

South Central Connecticut Regional Water Authority
New Haven, Connecticut

Sealed bid proposals will be received at South Central Connecticut Regional Water Authority, 90 Sargent Drive in New Haven, Connecticut until the time and date that is specified below, at which time they will be publicly opened and read aloud.

Copy of the bid proposal, including any specifications, may be obtained at the Purchasing Department of the South Central Connecticut Regional Water Authority at the address given above between the hours of 8:30 a.m. and 4:00 p.m.

A list of current Public Bids is also available on our Website: www.rwater.com

The South Central Connecticut Regional Water Authority reserves the right to reject any and all bid proposals and/or to waive any informalities in bidding if it be in the public interest to do so. South Central Connecticut Regional Water Authority reserves the right to award a contract as it deems in its best interest.

Curb & Sidewalk Repair & Replacement August 5, 2013 2:00 p.m.

South Central Connecticut
Regional Water Authority
Peter Bocciarelli
Purchasing Manager

July 19, 2013

NOTICE TO CREDITORS

ESTATE OF:
Mary-Susan Zinn

The Hon. Mark J. DeGennaro, Judge of the Court of Probate, West Haven Probate District, by decree dated July 11, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Gail G. Caroll, Clerk

The fiduciary is:

Harry J. Zinn, Jr., c/o Steven M. Reilly, Esq., 41 Oxford Road, Oxford, CT 06478
2552796

NOTICE TO CREDITORS

ESTATE OF:
Elizabeth Anastasio

The Hon. Michael R. Brandt, Judge of the Court of Probate, East Haven - North Haven Probate District, by decree dated June 26, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Mary-Beth Cronk,
Chief Clerk

The fiduciary is:

Robert A. Anastasio, Executrix, c/o
Christine J. Ciociola, Esq., 150 West Main Street, Branford, CT 06405
2551575

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LEGALS

Notice of Tentative Determination to Approve Structures, Dredging & Fill
Applicant:
City of New Haven
Application No. 201302175-KR
City/Town: New Haven

The Department of Energy and Environmental Protection ("DEEP") hereby gives notice that a tentative determination has been reached to approve the following application submitted under Section 22a-361 of the Connecticut General Statutes ("CGS") for a permit to conduct work waterward of the coastal jurisdictional line in tidal, coastal or navigable waters of the state for flood and erosion control. The Commissioner also gives notice that a hearing may be held on this application if the Commissioner determines that the public interest will best be served thereby.

Applicant's Name and Address:City of New Haven, 200 Orange Street, New Haven, CT 06510
Contact: Dewberry Engineers Inc., Peter Spang, 59 Elm Street, New Haven, CT 06510, pspang@dewberry.com <mailto:pspang@dewberry.com>, (203) 497-3697
Site Location: 70, 66, & 60 Townsend Avenue

PROPOSED ACTIVITY
The proposed activity incldes temporarily retaining jersey barriers and will affect coastal resources.

INFORMATION REQUESTS/ PUBLIC COMMENT
Interested persons may obtain a copy of the application from the above contacts or by sending a request for an electronic copy to DEEP at Krista.Romero@ct.gov <mailto:Krista.Romero@ct.gov>.
The application is available for inspection at the DEEP Office of Long Island Sound Programs, 79 Elm Street, Hartford, from 8:30 - 4:30 Monday through Friday. Additional surveys, plans or other materials may be available with the original application file at DEEP. All interested parties are invited to express their views on the tentative determination concerning this application. Written comments on the application should be directed to Krista Romero, DEEP Office of Long Island Sound Programs, 79 Elm Street, Hartford, CT 06106-5127, no later than August 18, 2013. Comments regarding this application may be submitted via electronic mail to: Krisat.Romero@ct.gov<mailto:Krisat.Romero@ct.gov>.

ADA PUBLICATION STATEMENT
The Connecticut Department of Energy and Environmental Protection is an Affirmative Action and Equal Opportunity Employer that is committed to complying with the Americans with Disabilities Act. To request an accommodation contact us at (860) 418-5910 or deep.accommodations@ct.gov <mailto:deep.accommodations@ct.gov>.
2553207

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1-866-KIDS-TODAY

LEGALS

NOTICE TO CREDITORS

ESTATE OF
Marjorie R. Hemingway

The Hon. Salvatore L. Digilio, Judge of the Court of Probate, Hamden - Bethany Probate District, by decree dated June 26, 2013, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Valerie A. Dondi, Clerk

The fiduciary is:

Banning Repplier, c/o Karen L. Clute, Esq., Wiggin & Dana, One Century Tower, P.O. Box 1832, New Haven, CT 06508-1832
2551099

STATE OF CONNECTICUT
Court of Probate, District of New Haven Regional Children's Probate Court

NOTICE TO: **Robert Camera,** a person whose last known residence was in the town of New Haven, Connecticut.

Pursuant to an order of Hon. Mark J. DeGennaro, Judge, a hearing will be held at New Haven Regional Children's Court, 873 State Street, New Haven, CT 06511 on July 30, 2013 at 2:00 PM on an application for Permanent Guardian concerning a certain minor child born on January 14, 1998. The Court's decision will affect your interest, if any, as in said application on file more fully appears.

RIGHT TO COUNSEL: If the above-named person wishes to have an attorney, but is unable to pay for one, the Court will provide an attorney upon proof of inability to pay. Any such request should be made immediately by contacting the court office where the hearing is to be held.

If a permanent guardian is appointed by the Court, you may not petition the Court for Reinstatement as Guardian or petition to terminate the permanent guardianship, except if the permanent guardian appointed by the Court becomes unable or unwilling to serve as permanent guardian.

By Order of the Court
F. Paul Kurmay, Judge

STATE OF CONNECTICUT
Court of Probate, District of New Haven Regional Children's Probate Court

NOTICE TO: **Juan Unknown,** a person whose last known residence was in the town of New Haven, Connecticut.

Pursuant to an order of Hon. Mark J. DeGennaro, Judge, a hearing will be held at New Haven Regional Children's Court, 873 State Street, New Haven, CT 06511 on July 30, 2013 at 1:00 PM on an application for Termination of Parental Rights concerning a certain minor child born on September 30, 2004 to Sonia Burgos. The Court's decision will affect your interest, if any, as in said application on file more fully appears.

RIGHT TO COUNSEL: If the above-named person wishes to have an attorney, but is unable to pay for one, the Court will provide an attorney upon proof of inability to pay. Any such request should be made immediately by contacting the court office where the hearing is to be held.

By Order of the Court
F. Paul Kurmay, Judge

LEGALS

STATE OF CONNECTICUT

DOCKET NO: AANCV1260088345 : SUPERIOR COURT
JP MORGAN CHASE BANK, NATIONAL ASSOCIATION : JUDICIAL DISTRICT OF ANSONIA/MILFORD
V. : AT MILFORD
MIGACZ, STANLEY ET AL : JUNE 4, 2013

ORDER

ORDER REGARDING: 05/20/2013 107.00 MOTION FOR ORDER OF NOTICE

The foregoing, having been considered by the Court, is hereby:

ORDER: GRANTED

The Plaintiff has named you as a defendant in the complaint brought to the above named court seeking Foreclosure. The complaint was returnable to the above named court on 2/7/2012 and is now pending therein.

The court finds that the defendant listed below has not appeared in this action, and, so far as the plaintiff knows, has not received actual notice of the institution or pendency of it; address is unkown.

Now, therefore, it is hereby ordered that further notice of the institution and pendency of this action be given to each such defendant by some proper officer (or person) by causing a true and attested copy of this order to be published in the New Haven Register once a week for two successive weeks, to be completed before 7/16/2013 and that return of such service be made to this court.

Judicial Notice (JDNO) was sent regarding this order.

403771
John W. Moran, Judge

A TRUE COPY ATTEST: JOHN T. FIORILLO
CT STATE MARSHAL, HARTFORD COUNTY

LEGALS

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT
IN ADMIRALTY

CASE NO.
3:13-CV-870 (JCH)
IN THE MATTER OF:
CARPE DIEM THREE, LLC, STEWART LEONARD, SR., & THOMAS P. LEONARD, as Owners of M/Y STEW'S SPECIAL, Hull Number DZNSL701E508, her tenders, gear, furniture, tackle, appurtenances, etc.
June 26, 2013
Petitioners.
_____x

PETITIONERS' NOTICE OF ACTION TO CLAIMANTS OF PETITION FOR EXONERATION FROM OR LIMITATION OF LIABILITY

COME NOW, the Petitioners CARPE DIEM THREE, LLC, STEWART LEONARD, SR. & THOMAS P. LEONARD, (the "Petitioners") as Owners of *M/Y STEW'S SPECIAL*, Hull Number DZNSL 701E 508, her tenders, gear, furniture, tackle, appurtenances, etc., (the "Vessel") by and through their undersigned counsel, and hereby give Notice of filing a Petition for Exoneration from or Limitation of Liability.

NOTICE is given that CARPE DIEM THREE, LLC, STEWART LEONARD, SR. & THOMAS P. LEONARD, as owners of the *M/Y STEW'S SPECIAL*, have filed a Petition in Admiralty in the United States District Court of Connecticut, In Admiralty, Case No: 3:13-cv-00870-JCH, pursuant to 28 U.S.C. § 1333 and Rule 9(h) of the Federal Rules of Civil Procedure, for exoneration from or limitation of liability for all claims for loss, damage or injury arising out of an alleged incident involving the operation the *M/Y STEW'S SPECIAL*, Hull Number DZNSL701 E508, her tenders, gear, furniture, tackle, appurtenances, etc., on or about August 15, 2011, upon the navigable waters of the British Virgin Islands, between the islands of St. Maarten and St. Thomas.

All persons having such claims must file their respective claims on or before August 15, 2013, with the Clerk of this Court at the United States Courthouse, District of Connecticut, and to serve on or mail to the attorneys for Petitioner copies thereof, as provided in Rule F of the Supplemental Rules for Admiralty and Maritime Claims of the Federal Rules of Civil Procedure.

Respectfully Submitted,
STEWART "STEW" LEONARD SR.,
THOMAS P. LEONARD
AND
CARPE DIEM THREE, LLC
By: _____ /s/
Charles E. Murphy
LENNON, MURPHY, CAULFIELD & PHILLIPS, LLC
Tide Mill Landing
2425 Post Road, Suite 302
Southport, CT 06824
(203) 256-8600 - telephone
(203) 256-8615 - fax
cem@lmcpleal.com
Richard G. Rumrell, Esquire
RUMRELL, BATE, MCLEOD & BROCK, P.A.
24 Cathedral Place, Suite 504
St. Augustine, FL 32084
(904) 996-1100 – phone
(904) 996-1120 – fax
rumrell@rumrelllaw.com

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NEW HAVEN REGISTER
NewHavenRegister.com

LEGALS

PUBLIC NOTICE

Office of Health Care Access Public Hearing

Statute Reference: 19a-639
Applicant: NR Connecticut, LLC - d/b/a Retreat at South Connecticut
Town: New Haven
Docket Number: 13-31828-CON
Proposal: Establishment of a 105 Bed Residential Substance Abuse Treatment Facility with an associated capital expenditure of $7.5 million dollars
Date: August 14, 2013
Time: 9:00 a.m.
Place: Department of Public Health, Office of Health Care Access, 410 Capitol Avenue, Third Floor Hearing Room, Hartford, CT 06134

Any person who wishes to request status in the above listed public hearing may file a written petition no later than August 9, 2013 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.
2553112

EAST HAVEN

INVITATION TO BID

Proposals are invited by the owners for rehabilitation work on the property specified below:

Project Address:
14 Eldred Drive
East Haven, CT 06512

Proposals will be received until Friday, August 2, 2013 @ 11:00 a.m. At which time they will be opened. Proposals will be delivered to:

Town of East Haven
Office of Urban Renewal
250 Main Street
East Haven, CT 06512

Project Specifications are available at the Town of East Haven, Office of Urban Renewal, Mon. – Fri., 9:00 a.m. - 4:00 p.m. or at the State of Conn. Dept. of Admin. Services (DAS) website, **www.das.ct.gov**, State Contracting Portal, Town of East Haven, Solicitation Number 044-157-H.

For more information, contact Peter Testa at phone: 203-573-1188 x213 or email: peter@lwagnerassociates.com.

A mandatory pre-bid conference will be held at the following location and time:

MANDATORY PRE-BID
Friday, July 26, 2013
9:00 a.m.
14 Eldred Drive
East Haven, CT 06512

The above work includes; the installation of an oil fired hot water boiler and indirect hot water heater in a single family residential home.

AN AFFIRMATIVE ACTION /EQUAL OPPORTUNITY EMPLOYER
MBE/ WBE/ SBE AND SECTION 3 DESIGNATED CONTRACTORS ARE ENCOURAGED TO APPLY

WEST HAVEN

The West Haven Inland Wetland Agency made the following decisions at a Regular meeting on Tuesday, July 16, 2013 in the City Council Chambers, City Hall, 355 Main Street, West Haven, CT at 7:30 p.m.

LOWER LAKE PHIPPS DAMS - Review of flooding of Main Street and Painter Drive and city actions to alleviate the flooding of private property....**CONTINUED**

499 Derby Ave: Application for a Timber Salvage Harvest at Maltby Lakes located in the wetland area; Owner: South Central Connecticut Regional Water Authority, c/o Edward O. Norris III; Applicant: South Central Connecticut Regional Water Authority, William R. Vandoren; File # I.W. 13-004. **APPROVED WITH CONDITIONS**

20 Industry Dr Application to allow applicant to fill approximately 36,450 sq.ft. of wetlands for a 25,030 sq.ft. expansion of an existing facility. Owner/Applicant: Twenty Industry Drive, LLC. File # I.W. 13-003.....

81 Platt St: Application to allow a 40x25 brick patio and 25x25 brick parking space located in a wetland area. Owner/Applicant: Mercy Vallejo; File # I.W. 13-006.....**APPROVED WITH CONDITIONS**

288 Washington Ave: Application to allow on site drainage improvements which will discharge into an existing watercourse. Owner: Dan Maffeo; Applicant: Brian Mantilia, A&A Enterprises; File # I.W. 13-007.....**WITHDRAWN**

660 Ocean Ave. Application to allow applicant to rebuild existing stone wall in wetland area. Owner/Applicant: Eva Curtin; File # I.W. 13-005.....**APPROVED WITH CONDITIONS**

William Kane, Chairman

CALL 203-777-3278 or (TOLL FREE) 1-877-872-3278 TO PLACE YOUR CLASSIFIED AD

BEHAVIORAL HEALTH CONSULTANTS, LLC

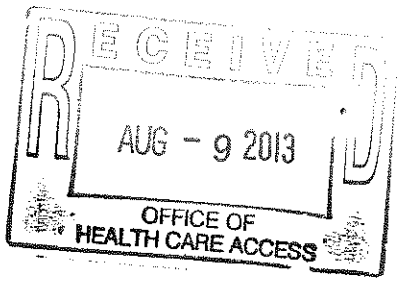
3018 Dixwell Avenue
Hamden, CT 06518
(203) 288-3554
Fax: (203) 281-0235

1591 Boston Post Road
Guilford, CT 06437
(203) 458-7160
Fax: (203) 458-2538

380 Boston Post Road
Orange, CT 06477
(203) 795-5322
Fax: (203) 795-5324

1305 Post Road
Fairfield, CT 06824
(203) 255-0374
Fax: (203) 255-0375

August 8, 2013



Ms. Kimberly Martone
State Department of Public Health
Office of Health Care Access
410 Capitol Avenue MS #13HCA
P.O. Box 340308
Hartford, CT 06134Y

From:
James N. Rascati, LCSW
Arnold D. Holzman, Ph.D.
Georgann Witte, Ph.D.
Mark J. Kirschner, Ph.D.
Behavioral Health Consultants, LLC

Re: Docket #13-31828, NR Connecticut, LLC-d/b/a Retreat at South Connecticut

We are a large group behavioral health practice writing to express our concerns about the aforementioned application and the entrance of the Retreat at South Connecticut into the greater New Haven area. We are deeply concerned about this for a number of reasons. First and foremost is that their intent is to only serve commercial insured clients and self payers. This "cherry-picking" of clients will have a deleterious impact on all the other providers of behavioral health services throughout Greater New Haven.

Should this CON be granted it will have a negative domino effect for those other community based organizations (CBO) who treat the Medicare, Medicaid and non-insured populations. Organizations such as the Cornell Scott Hill Health Center, Bridges, the APT Foundation, etc. who rely on the revenue from the commercial payers to help support their other treatment services for the uninsured or government funded clients.

It is estimated that 60 – 70% of substance abuse clients have a dual diagnosis and it seems to us that this population would not be properly served by the Retreat. It is not clear from their CON that they have the expertise to treat the dual diagnosed client. What will happen when as they get the substance abuse

disorder under control and the psychiatric problem remains? When that client becomes suicidal, psychotic or aggressive will they then be transferred to the community providers to treat?

It is ironic that the majority of residents who reside near the Boulevard or in Greater New Haven will not be eligible to receive treatment at the Retreat since 80% of them do not have commercial insurance and certainly do not have the ability for self-pay.

Our firm has been in business in Greater New Haven for more than twenty two years. In addition to our commercially insured clients we provide Employee Assistance Programs (EAP) for over 80 different businesses and organizations. Our EAP is responsible for approximately 20,000 employees represented by 50,000 lives. No one from our company participated in any discussion with representatives from the Retreat regarding determining if there was even such a need for such services.

When we have a need to admit one of our EAP or insured clients for substance abuse acute care we have not had an access problem. Often times we refer immediately to Silver Hill in New Canaan, the Rushford Center in Middletown or the Institute of Living partial hospital program in Hartford. From our perspective there is not an access problem for these services.

In summary, we encourage you to oppose accepting this CON application for the Retreat. Not only is there not a clear public need we are very concerned since the Retreat will **only** serve commercially insured and self-pay clients. The other community based treatment organizations rely on their limited commercially insured dollars to help support their other treatment serves for the uninsured and those on Medicare and Medicaid.

Sincerely yours,

James N. Rascati, LCSW
Director of Organizational Services

communiCARE
Community
Behavioral
Health System

CONFIDENTIAL

RECEIVED
AUG - 9 2013
OFFICE OF
HEALTH CARE ACCESS

To: Ms. Kimberly Martone
State Department of Public Health
Office of Health Care Access

Fax: (860) 418-7053 **Tel:**

Date: August 9, 2013

Subject: Docket #13-31828, NR Connecticut, LLC-d/b/a Retreat at South Connecticut

Number of page(s) including coversheet: 3

Ms. Martone:

Please see our response to the Retreat's application pertaining to the above noted docket.

Please contact Tony Corniello at (203) 483-2645, ext. 3231 or tcorniello@bhcare.org with any questions or if you require anything further.

Sincerely,

Marsha

Marsha M. Maldonado
Administrative Assistant
Tel (203) 483-2645, ext. 3227
mmaldonado@bhcare.org

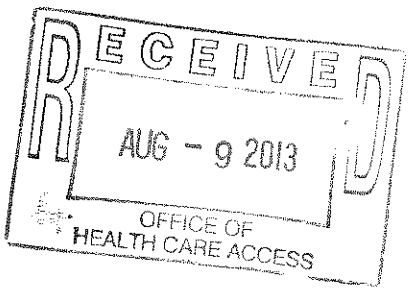
This transmission may contain confidential health information that is protected by special federal or state law or regulation. It is intended only for the use of the individual to which it has been addressed. Only the person named on this transmission is authorized to view any information contained herein. Re-disclosure without proper consent is strictly prohibited. Unauthorized use or disclosure or failure to maintain confidentiality may subject you to penalties under both federal and state law. If you have received this message in error, please contact the person noted above, or CommuniCare, Inc. at (203) 483-2630.

Partner Agencies:

Administrative Office:

communiCARE
Community
Behavioral
Health System

August 9, 2013



Ms. Kimberly Martone
State Department of Public Health
Office of Health Care Access
410 Capitol Avenue MS #13HCA
P.O. Box 340308
Hartford, CT 06134

Via Fax: (860) 418-7053

Re: Docket #13-31828, NR Connecticut, LLC-d/b/a Retreat at South Connecticut

Dear Ms. Martone:

As two Local Mental Health Authorities covering three catchment areas and more than 14 towns, we are writing to express our concerns about the application and the entrance of the Retreat at South Connecticut into the New Haven area. As providers of mental health, substance abuse and co-occurring disorders treatment for the uninsured and underinsured individuals, we are concerned that applicant's focus only includes services for those individuals who have commercial insurance or who have the financial capacity to pay "out of pocket". Our agencies, which include three locations (Branford, Milford and Ansonia) serve about 90% uninsured or underinsured individuals and about 10% of individuals with private insurance. We offer two of the services the Retreat plans to provide, outpatient and intensive outpatient services and provide those services to all individuals in need. We refer our clients to inpatient treatment facilities across the state.

The Retreat's application attempts to demonstrate "public need" for a substance abuse treatment facility. However, they did not break down that "need" by payer source, therefore they are not differentiating the need between the commercially insured and self-pay clients from those covered by Medicare, Medicaid or the uninsured who cannot afford the facility's fee. Our experience is that individuals with commercial insurance and those who can afford to pay "out of pocket" are the only individuals who are not experiencing difficulties accessing substance abuse services, especially inpatient rehabilitation treatment, therefore the Retreat failed to demonstrate "public need" for this type of facility.

Another concern includes our struggle with the high prevalence of dual diagnosed clients (about 60%) along with the high prevalence of co-morbid medical issues. These individuals are not best served by a place such as the Retreat. Many of these clients will be "screened out" due to the complexity of their issues. If they are accepted, during their stay they may require urgent care at the local emergency departments and inpatient hospitals due to the Retreat's lack of ability to manage their acute needs, creating more pressure on the existing system.

Partner Agencies:

Administrative Office:

In addition, although our services are provided in the towns surrounding New Haven, loss of clients who have commercial insurance to our outpatient and intensive outpatient services may have a negative impact on the financial viability of our clinics, and potentially reduce our ability to accept governmental payer clients.

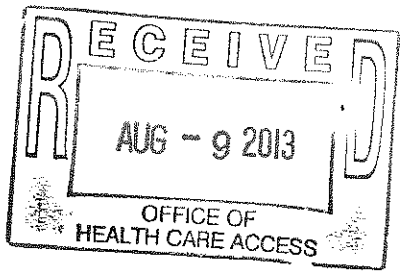
In our opinion, the Retreat has not addressed the true need of the population (uninsured, publically insured and clients with co-morbid mental health and medical needs). The Retreat's design will also draw the commercially insured clients and self-pay clients from the existing facilities and negatively impact their ability and ours to provide the services to the individuals who truly lack access to care. Due to the above stated concerns we oppose the application and the entrance of the Retreat at South Connecticut into the New Haven area.

Sincerely,

Roberta J. Cook
President and Chief Executive Officer
BHcare, Inc.

Barry Kasden
President and Chief Executive Officer
BRIDGES – A Community Support System

LESHKOWITZ & COMPANY, LLP
CERTIFIED PUBLIC ACCOUNTANTS
270 MADISON AVENUE
NEW YORK, N.Y. 10016
(212) 532-5550
FAX (212) 532-4007
E-MAIL: chl@leshkowitz.com



August 8, 2013

Ms. Lisa A. Davis
Deputy Commissioner
Office of Healthcare Access
Department of Public Health
410 Capitol Avenue, MS #13 HCA
Hartford, CT 06134

Re: Coal New Haven, LLC (CNH)
NR Connecticut, LLC - D/B/A Retreat at South Connecticut (Retreat)
Certificate of Need Application (CON)

Gentleman,

I am the Financial Presenter at the CON Public Hearing scheduled for August 14, 2013 at the office of the Connecticut Department of Health, in connection with the CON Application by Retreat. (The Project).

My presentation will focus on all financial aspects of the acquisition, build-out, furnishings and start-up of the proposed Project. It will also focus on the financial strength of the Project and its backers, and my view of the financial projections included as Attachment "K" to the Application.

First, a description of my professional background: I am a CPA since 1973 and an Attorney since 1977, admitted to practice both professions in New York. I am one of the two "Founding Fathers", together with my brother Joseph, of our CPA firm, Leshkowitz & Company, established in 1978. I am also a member of the Board of Trustees of Maimonides Medical Center (Maimonides), a large tertiary hospital facility in Brooklyn, NY. I have been the Vice Chairman of the Maimonides Board of Trustees since 2001 and I sit on its Finance Committee. Maimonides supports a large psychiatric program, including programs for drug and alcohol dependencies. As such, I am very familiar with the budget process, line item costing control, capacity utilization, and operating ratios of a large-scale medical provider.

Leshkowitz & Company is a regional CPA firm with over fifty professionals and support staff. We provide financial audit, tax compliance and planning, management services, and special forensic audit and litigation support to numerous clients. We have separate teams specializing in real estate and medical and dental related practices and facilities. We represent the Coal Group of companies owned and operated by David Silberstein, and we are therefore very familiar with his business operations and his personal net worth.

I evaluated the business model, financial projections, start-up period funding and working capital reserves needed by CNF and Retreat at South Connecticut, based on my diverse experience.

I intend for my presentation to the OCHA Board to comprise four main sections:

1. Presenter's Professional Background

I will describe my professional background and experience, as presented above, and how such experience is invaluable in evaluating budgets, cost projections and actual operating data of a medical related facility.

2. Funding Available

I will discuss the funding available to the Retreat and its ownership. I will describe the $7.5 million financing package already funded by Fulton Bank (see Exhibit "A" attached). Of this amount, approximately $3.2 million was used to close title on the property at 915 Ella T. Grasso Boulevard in New Haven. This amount is besides the $400,000 deposit separately funded by the principals at contract.

The balance of $ 4.3 million from Fulton Bank is intended to fund the following broad categories of cost:

$2.0 million	Additional "Turn Key" costs for renovation, equipment, furniture and fixtures
1.2 million	Start-up and pre-opening costs
$3.2 million	Total "Turn Key" costs projected – to be funded from Fulton Bank loan proceeds
1.1 million	Cash reserve remaining for working capital funding
$4.3 million	Total funding available after closing of title on building

Besides the $1.1 million that should be available to fund the ongoing working capital needs of Retreat, after the pre-opening and start-up costs are absorbed and funded, David Silberstein has the capacity to readily fund any reasonable additional working capital needs of Retreat from his other investment and personal sources. Furthermore, in order to obtain the full $7.5 million financing from Fulton Bank, David capitalized on Fulton Bank's excellent experience financing his Ephrata, Pennsylvania Retreat, but David also provided his unlimited personal guarantee plus additional collateral to better secure Fulton Bank.

3. Exceptional Management Team in Place

The principals and management team at the Pennsylvania facility have proven themselves to be capable and committed, working as a cohesive team to achieve exceptional financial results. Based on my review of their financials, this management team delivered an occupancy ratio and a revenue stream in year two what was first projected in year four, and then some. It is my understanding that the principals intend that Peter Schorr, and several of his key management lieutenants at the Ephrata facility will be transferred to the New Haven Retreat, so that its pre-opening and start-up period is managed the right way. They intend to remain in New Haven and assure that management and all other positions are properly filled and each employee is well trained and acclimated to the facility.

4. Adequacy and Reasonableness of Projections Submitted

As the outside accountants for David Silberstein, we have general oversight responsibility for the Ephrata facility. Although a local firm of CPA's actually signs off on the NR Pennsylvania Associates, LLC audited financial statements, we review all aspects of the financial statement prior to its release. Furthermore, several of our important observations and suggested revisions were incorporated in the final statements.

I reviewed the pro-forma financial projections included in the CON application under Attachment K. I reviewed the anticipated buildup of average occupancy over the four year period, as well as the expected revenue stream from inpatient and outpatient services. We also reviewed certain significant expense line items of expenses for reasonableness, as well performing an overall assessment of the comprehensiveness of the submission.

I concluded that the data contained in Attachment "K" is a comprehensive and complete budget of projected costs of the Retreat project. I also concluded that the income and expense projections, when viewed in the context of the actual annual history of the Ephrata Retreat, were prepared on a conservative basis and that they can be reasonably expected to be achieved.

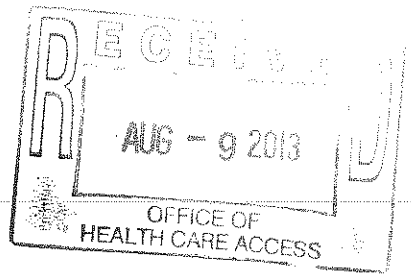
The aforementioned subject groupings will be further discussed at my presentation on August 14.

Respectfully submitted,

C.H. Leshkowitz

cc: William P. Beccaro, Esq.
Toni Fatone, Esq.
David Silberstein – Coal Capital Group
Peter Schorr – CEO, Retreat at South Connecticut
Joseph Leshkowitz, CPA

Retreat
at South Connecticut



State of Connecticut – Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

CON PUBLIC HEARING TESTIMONY OF KATHRYN HARASYM: testifying in support of NR Connecticut LLC, d/b/a Retreat at South Connecticut, Docket Number: 13-31828-CON

Growing up, I lived with both of my parents, as well as my two brothers. My parents provided everything we had ever needed to survive. I was very active in dance and in education. My parents considered me to be their "star child". This all changed when I picked up drugs and alcohol at the age of 12. Although I hated most of my family members for being alcoholics, I could not resist the temptation to live my life on the wild side. I wanted to escape from reality, which is what I did for the next 10 years. My first experience with Opiates took place when I was 14 years old and I immediately fell in love. As the years went on, opiates led me to turn into someone that I never imagined I'd become. Although I was able to graduate high school, as well as college, throughout my addiction, I had now become someone who stole, lied, and cheated. I was hurting everyone around me, as well as myself. Weighing 78 pounds by the end, my body was very close to shutting down. Luckily, I reached a bottom in my life where I decided that something needed to change. I knew that I could no longer live like this.

On January 10, 2012, I had made the decision to leave for rehab. After many attempts to get into different rehabs, I finally came across the Retreat at Lancaster County. I spent many hours on the phone with admissions, as they worked very hard to get me into treatment that day. I was relieved yet full of fear when I got the call that I had been approved and a driver would be coming to pick me up to take me to Retreat. Considering I had never been to rehab before, I had no idea what to expect. The driver spent the entire drive reassuring me that everything was going to be just fine. By the time I got to Retreat, I was beaten down and broken. Addiction had completely knocked me to my knees however; when I walked through the doors of the facility, I immediately felt "at home". Many staff members greeted me and promised me that things will get better.

I spent 28 days at Retreat and things did get better. For the first time in my life, I felt safe and cared for. Every staff member knew my name and many of them spent much time to help me. I learned how to laugh and smile during my stay at Retreat. I learned how to look in the mirror and be happy with my reflection. Most importantly, I learned how to accept the fact that I suffered from the disease of addiction; a concept that I could not grasp for quite some time. I had always been a quiet person, who kept all of my traumas and secrets locked up inside of me. Retreat helped me to cope with all that I felt inside, as I was encouraged to share about my feelings and experiences. It was explained to me how I can live life sober and happy, which is something I never thought was possible. During my 28 days at Retreat, I felt as though I had become a part of a big family, who loved me until I could learn to love myself.

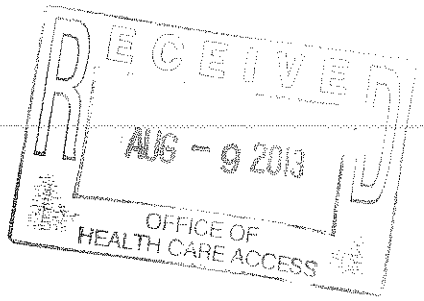
The person I am today is completely different from the person who had checked into Retreat on January 10, 2012. I am now living a life beyond my wildest dreams, just as Retreat promised me I would. I have my family in my life today, as well as loving friends. Today, I am able to show up when someone is in need of my help. I have been able to become reliable daughter, sister, aunt, and friend to those in my life today. If it had not been for the love, support, and education I received during my stay at Retreat, I don't know if I would have been able to become the person I am today. I have been given the honor of coming back to Retreat as an employee, to give back what was given to me. The Retreat at Lancaster County will always hold a special place in my heart.

Respectfully submitted,

Kathryn Harasym

Kathryn Harasym

Retreat
at South Connecticut



State of Connecticut – Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

SUMMARY OF CON PUBLIC HEARING TESTIMONY OF STEVEN G. KLOTZ, MD:
NR Connecticut LLC, d/b/a Retreat at South Connecticut,
Docket Number: 13-31828-CON

My name is Steven Klotz, and I am an addiction psychiatrist and medical director at Retreat. This is an outline of the testimony I expect to present at the public hearing on August 14, 2013. I would like to focus on the unique ways we serve our patient populations to give them *"best in class"* care.

Under my direction, Retreat's medical department creates a unique modality within the realm of substance abuse treatment. To provide this quality of care, Retreat employs its medical staff directly, rather than contracting on a part-time or per diem basis. This direct and daily medical oversight allows patients the ability to partake in the treatment process more quickly. Another distinguishing feature of this treatment and care modality is that Retreat's medical staff - which is on site and available 24 hours a day, 7 days a week - has the unique and tremendously beneficial opportunity to develop a more personal relationship with the patient. This pays tremendous dividends in quality of care, and impact of the program on the patient's future conduct. Additionally, if a medical issue presents itself, the medical team can respond immediately and efficiently, allowing the patient to re-join the treatment process as soon as possible.

Once the admission process is complete, a medical professional meets with the new patient to conduct a preliminary examination. A complete assessment, consisting of basic medical history, presenting symptoms, and vital signs, is preformed. If any acute medical issues present, they are assessed and treatment options are evaluated and discussed. Additionally, within 24 hours of admission, a history and physical is conducted with a physician, including labs tests (both urine and blood screen). A medical protocol, individually tailored to the unique needs of each patient and the substance abused, is assigned. Each protocol consists of the schedule of assessments, medications prescribed and education required.

In the event a medical or psychiatric condition not revealed in the pre-admission screening is discovered that is beyond the scope of Retreat's sub-acute means, a referral protocol is utilized to place the patient in an appropriate facility.

Concurrently as needed, a detoxification protocol begins with admission and continues until the medical team determines the patient can safely and appropriately "step-down" to a rehabilitation level of care. In the event a significant medical issue is present, treatment and education continues throughout the treatment process. For example, if a patient presents with a pre-cirrhotic condition, a proper medication regimen will begin as soon as medically appropriate, and continue through the rehabilitation stage of treatment. Individual aftercare planning specifically include recommendations for further treatment and referrals as necessary.

The medical team works closely with the clinical team, clinical specialists and specialty therapists. This allows the medical and clinical divisions to work as one, providing more harmonious and complete treatment to our patients. They conduct twice daily case conference reviews. These meetings include addressing specific needs and/or medical conditions a patient may present and how to address them within the clinical milieu. Additionally, it provides a unique platform where the clinical team can provide feedback to the medical team relevant to the overall treatment of each patient.

In keeping with our commitment to education in treatment, the medical director and nursing staff lead weekly group discussions with the patient community on the medical aspects of addiction. Common topics include: short-term physical and mental effects of addiction, post-acute withdrawal symptoms, psychopharmacology, side effects of commonly prescribed medications, long term health risks of addiction, and mental health/psychiatric issues in early recovery. Group topics are chosen based on the common needs of the population at the any given time, and are further tailored based on feedback provided by the clinical team during case conferences.

Another unique aspect of Retreat's programming is its Medical Professionals and First Responders track. We understand the unique needs of medical professionals who experience high levels of physical, emotional and psychological stress on a daily basis. This program is specifically designed to address the immediate and long-term challenges as well as the daily dangers of their careers, including Post Traumatic Stress Disorder and Critical Incidents.

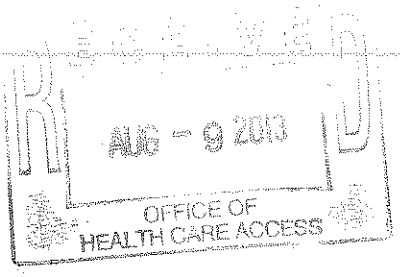
On personal level, having worked at many other facilities throughout my career, I can honestly say Retreat truly understands the impact addiction has on each person. Retreat not only is willing to, but insists on providing best in class medical care to its patients and provides the facility, staff and resources to do so. What makes Retreat particularly unique is its core understanding of the interdependence of all aspects of treatment: clinical, medical and otherwise, and a true commitment to treating the whole person - mind, body and spirit.

Respectfully submitted,

Steven G. Kulz M.D.

Retreat
at South Connecticut

State of Connecticut – Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134



SUMMARY OF CON PUBLIC HEARING TESTIMONY OF PETER SCHORR:
President and CEO, NR Connecticut LLC, d/b/a Retreat at South Connecticut,
Docket Number: 13-31828-CON

My name is Peter Schorr, and I am the President and CEO of Retreat at South Connecticut. The following is an outline of the testimony I expect to present at the public hearing on August 14, 2013.

I currently serve as President and CEO of Retreat at Lancaster County, located in Ephrata, Pennsylvania, a 120 bed facility with 30 detoxification and 90 rehabilitation beds. I have a long and extensive background at many levels in the field of addiction treatment. I opened Retreat at Lancaster County on August 15, 2011. Since that time we have treated approximately 2,500 individuals with the disease of addiction. The Ephrata property includes a main building of approximately 88,000 square feet and features state-of-the-art facilities and numerous amenities necessary to operate a high-end, inpatient drug and alcohol detoxification and rehabilitation center.

Retreat's approach is to create a peaceful setting which is both affordable and available to those with commercial insurance. Retreat has developed its programs around the differing needs of various patient populations across the entire continuum of care: detoxification, rehabilitation, partial hospitalization, intensive outpatient, general outpatient, continuing recovery oriented care, and community education. These programs are then further tailored to meet the individual's specific needs. We also offer specially focused programs for: first responders, veterans, healthcare workers, labor unions, and high-level professionals. Additionally, we have developed a highly successful and unique youth connection program in Ephrata, which we will also offer in New Haven. We expect young adults (under the age of 25) to compromise a significant percentage of our patient population.

To differentiate us from other facilities, we provide custom-tailored, highly individualized treatment plans which treat our patients holistically, treating not only addictions, but co-occurring disorders. We have found that our success has been in

treating the whole person, which is more effective and successful than just looking at one presenting issue. Continuity of care is another hallmark of the services we will provide. Our program is specifically designed to provide a seamless transition through all levels of care and treatment. This significantly increases the success rate of treatment, as patients need not be discharged and transferred to other facilities thought the entire detoxification and rehabilitation process.

As a long time Connecticut resident and father of a young adult, I have seen the need for quality substance abuse treatment become a growing crisis in my home state. As part of the research that led us to decide to establish a sister facility in Connecticut, we spoke with various inpatient facilities throughout the state on multiple occasions and a consistent message became clear: there was a lack of immediate access to treatment, a critical component of proper addiction care. The majority of facilities had waiting lists for treatment for all bed types that were often significant. We found this to be the case at different times of the day, week, and month. This is a critical shortfall, as when dealing with those suffering from the disease of addiction, it is essential to provide immediate access within the short window where the *"wall of resistance"* is broken - the time when the addict has agreed to attend treatment. Any delay can quite literally mean the difference between life and death. Knowing this, our Ephrata facility accepts patients 24 hours a day, 7 days a week and provides transportation as necessary; a practice we will repeat in New Haven.

We know from experience that a not insignificant percentage of our projected patients will be Connecticut residents currently forced to leave the state to access the type of treatment we intend to provide. When the patient is a distance from their home, it is much less likely that the family will be able to participate in the treatment process. Without the ability to treat the entire family, recidivism increases markedly, and the patient and family suffer further as the addiction cycle continues to manifest.

As part of our research associated with the decision to locate a second facility in Connecticut, we did an extensive analysis of the statistical data from SAMSHA, DMHAS, and other established, well-regarded sources. Even a quick perusal of this data clearly shows that there is a compelling, and growing public need for additional substance abuse treatment in the state of Connecticut. The State has a limited number of residential detoxification and rehabilitation and recovery beds, which cannot keep pace with the growing need. Access to these beds is problematic, as they are frequently oversubscribed. The result is that Connecticut's citizens wishing to seek care are often unable to obtain it when the most need it, or must do so outside of the state's borders. Connecticut has seen a 35% increase in the past 3 years in admissions to in-state substance abuse treatment facilities, while the total number of beds at these facilities has shrunk 37% in the last decade.

SAMSHA data concludes that more than 275,000 individuals in the State suffer from various forms of substance abuse addiction – yet less than 45,000 have received treatment from any rehabilitation facility. Connecticut remains above the national average in 2 key SAMSHA statistical measures – *"needing but not receiving treatment for alcohol use in the past year"*, and *"past year dependence on or abuse of illicit drugs"*. It unfortunately is one of the top 10 states in two other key measurement categories, *"past month illicit drug use"* and *"past month alcohol use"*. SAMSHA further found that

only 11.2% of people who needed treatment in a specialized facility for alcohol abuse or illicit drug use/abuse in the past year actually received treatment. Data produced since our initial submission confirms all this, and the popular media has within the last 2 weeks featured multiple articles (attached) about Connecticut's growing heroin addiction problem.

The Connecticut Department of Public Health reports that it licenses 44 facilities, but only 10 of these offer 3.7 levels of residential detoxification services. Furthermore, in September of 2011, state budget cuts forced Connecticut Valley Hospital in Middletown to eliminate 20 detoxification beds, further escalating demand, and creating additional pressure on an already overburdened system. The Connecticut Department of Mental Health and Addiction Services reports that for every person who seeks or receives treatment for addiction, there are six individuals with similar addictions who will not gain access or receive such care.

Our decision to locate the Connecticut facility in New Haven came about in a similar fashion as in Ephrata. An investor partner presented me with the opportunity to acquire the space formally occupied by a skilled nursing home facility. This structure is centrally located for easy access by our projected patient populations and their families, and the space is well-designed for our particular needs. Our renovations will provide the amenities necessary to operate a comprehensive, multi-dimensional, luxury level 3.7 residential drug and alcohol detoxification and rehabilitation center. While New Haven is the 2nd largest city in the state, and the 6th largest in the region, it presently is home to only 1 residential detoxification and rehabilitation and recovery facility with a capacity of 29 beds. Our proposed facilities geographic proximity to two major interstate highways and centralized location within the state means that it will provide Connecticut residents with a viable in-state option for care.

Retreat at South Connecticut will provide a total capacity of 105 beds: 26 detoxification and 79 rehabilitation - which will help fulfill a small part of the great unmet need that exists within the State. Although the proposed facility could allow for more beds, we deliberately limited capacity in keeping with our mission of providing state of the art, high-end treatment. We insist that our patients are comfortable, and have ample space for the therapeutic program. This limited capacity assures excellent staff to patient ratios, and ensures quality of care and treatment will not be compromised due to financial or capacity issues.

Retreat's staff will consist of experienced behavioral health professionals with extensive and proven backgrounds in the medical, clinical, and operational domains. The same team responsible for the opening, development, and growth of the Ephrata facility will transition to the New Haven facility, where they will replicate this successful treatment model.

Ultimately, my dream is to carry out our Mission Statement in my home state: *"To provide a compassionate and spiritual environment where those suffering from the disease of addiction can begin the journey to recovery by providing enlightenment and education to the individual and their families."*

Respectfully submitted,



Peter Schorr

MERITAS LAW FIRMS WORLDWIDE

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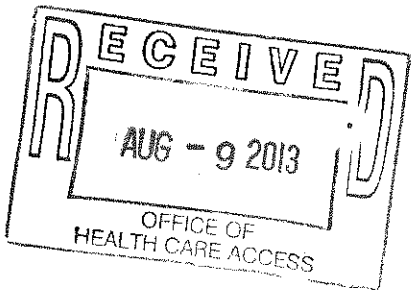
August 9, 2013

VIA HAND DELIVERY



Lisa A. Davis, M.B.A., B.S.N., R.N.
Deputy Commissioner
Office of Health Care Access
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: NR Connecticut, LLC d/b/a Retreat at South Connecticut
Establish a 105-Bed Residential Substance Abuse Treatment Facility in New Haven
Docket No. 13-31828-CON

Dear Deputy Commissioner Davis:

This office represents Cornell Scott-Hill Health Center in connection with the above-referenced docket. Enclosed are an original and four (4) copies of the following:

- Notice of Appearance of Updike, Kelly & Spellacy, P.C.
- Petition of Cornell Scott-Hill Health Center To Be Designated as an Intervenor With Full Rights Including Right of Cross-Examination
- Prefiled Testimony of Douglas Bruce, M.D.

These documents are being submitted in connection with the public hearing on the above matter, scheduled for August 14, 2013 at 9:00 a.m. Dr. Bruce will be present at the hearing to adopt his prefiled testimony under oath and for cross-examination.

Should you require anything further, please feel free to call me at (203) 786-8316.

Very truly yours,

Jennifer Groves Fusco

Enclosures

cc: Michael Taylor (*w/enc.*)

Updike, Kelly & Spellacy, P.C.
One Century Tower ▪ 265 Church Street ▪ New Haven, CT 06510 (t) 203.786.8300 (f) 203.772.2037 www.uks.com

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: CERTIFICATE OF NEED APPLICATION OF NR CONNECTICUT, LLC d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105 BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	)	DOCKET NO. 13-31828-CON
	)	AUGUST 9, 2013

NOTICE OF APPEARANCE

In accordance with Section 19a-9-28 of the Regulations of Connecticut State Agencies, please enter the appearance of Updike, Kelly & Spellacy, P.C. ("Firm") in the above-captioned proceeding on behalf of Cornell Scott-Hill Health Center ("CS-HHC"). The Firm will appear and represent CS-HHC at the public hearing on this matter, scheduled for August 14, 2013.

Respectfully Submitted,

CORNELL SCOTT-HILL HEALTH CENTER

By: _____

JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.
265 Church Street
One Century Tower
New Haven, CT 06510
Tel: (203) 786-8300
Fax (203) 772-2037

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 9th of August, 2013 to the following:

Peter Schorr
c/o Law Office of William P. Beccaro
12 New City Street
Essex, CT 06426
wbeccaro@snet.net

Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy, P.C.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: CERTIFICATE OF NEED APPLICATION OF NR CONNECTICUT, LLC d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	)	DOCKET NO. 13-31828-CON
	)	AUGUST 9, 2013

PETITION OF CORNELL SCOTT-HILL HEALTH CENTER TO BE DESIGNATED AS AN INTEVENOR WITH FULL RIGHTS INCLUDING THE RIGHT OF CROSS-EXAMINATION

In accordance with Section 4-177a of the Connecticut General Statutes and Section 19a-9-27 of the Regulations of Connecticut State Agencies, Cornell Scott-Hill Health Center ("CS-HHC"), located at 400 Columbus Avenue, New Haven, CT 06519, hereby petitions the Office of Health Care Access Division of the Department of Public Health ("OHCA") to be designated as an intervenor with full rights, including the right of cross-examination, in the Certificate of Need ("CON") proceeding designated as Docket No. 13-31828-CON. This proceeding concerns the request of NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Retreat") for permission to establish a 105-bed substance abuse treatment facility in New Haven. The facility would include residential detoxification and evaluation, intensive treatment (rehabilitation), partial hospital, intensive outpatient and outpatient services. CS-HHC provides many of the services being proposed by Retreat through the South Central Rehabilitation Center and Grant Street Partnership Program. CS-HHC accepts most commercial insurance, as well as Medicare and Medicaid, and provides services to the

uninsured. As detailed herein and in the accompanying testimony of Douglas Brown, M.D., CS-HHC would be adversely impacted by the approval of a facility for which there is no clear public need and which will serve commercially insured and self-pay patients only. This proposal will also have a deleterious effect on the healthcare system in New Haven, and in particular on the acute care providers who will be required to provide care and treatment to the individuals Retreat brings into New Haven. This will in turn impact CS-HHC and other non-profit providers within the system.

CS-HHC Programs & Services

CS-HHC is one of the more significant providers of residential detoxification and evaluation, partial hospital, intensive outpatient and outpatient services in metropolitan New Haven. As such, CS-HHC operates South Central Rehabilitation Center, a 29-bed residential detoxification facility, and Grant Street Partnership Program, a 44-bed partial hospital that is collocated with intensive outpatient and outpatient counseling services. These services are fully integrated with CS-HHC's primary and preventative medical services and accept all patients regardless of their source of payment. Approximately 10 percent of patients in these services are commercially insured, with the remainder being governmentally insured (i.e., Medicare or Medicaid) and uninsured patients.

As the oldest and one of the largest federally qualified health centers in Connecticut, CS-HHC has longstanding collaborative and referral relationships and transfer agreements with all area hospitals and other essential providers. CS-HHC is Joint Commission accredited and designated as a Patient-Centered Medical Home.

CS-HHC's Interests Will Be Adversely Affected by Approval of Retreat's CON Proposal

This CON proposal involves the establishment of a 105-bed residential substance abuse treatment facility in New Haven. If approved, this will be one of the largest freestanding facilities of its kind in the state. Retreat will offer an array of substance abuse services, including intensive treatment (rehabilitation) and the residential detoxification and evaluation, PHP/IOP and outpatient services offered by CS-HHC.

Retreat has not established a clear public need for a facility of this magnitude in Connecticut. Retreat bases need for the facility on the number of individuals in state who require, but do not seek substance abuse treatment services, as well as an informal survey that purports to show all other Level III.7 detoxification providers operating at capacity. Retreat's arguments are flawed. As CS-HHC will demonstrate in its testimony, there are many facilities in Connecticut that can accommodate patients without any wait, despite Retreat's assertions to the contrary. Where capacity may be lacking for a New Haven-based facility is in programs and services that are available to all patients, including Medicare and Medicaid recipients and the uninsured. This is not the model that Retreat is proposing. CS-HHC believes that OHCA should focus growth in behavioral health services on programs that are available to all individuals regardless of payer source, rather than approving exclusionary facilities that create two tiers of care and do not meet the needs of area and state residents.

In addition, Retreat has made no effort to coordinate with local providers, in particular acute care facilities, regarding the care and treatment of substance abuse patients who have co-occurring mental health disorders or medical complications. Retreat has not approached Yale-New Haven

Hospital ("YNHH") or any other hospital to the best of our knowledge, about the necessary transfer agreement for these types of services. If Retreat had spoken with YNHH, they would likely have been told that the hospital is operating at capacity for inpatient mental health services and that the influx of patients from Retreat will have a significant deleterious effect on an already overwhelmed system. This in turn will limit access to services for those who need them, including the many Medicaid recipients and indigent patients residing in and around New Haven.

Moreover, because Retreat has not shown a clear public need for the proposed facility, the patients required to meet its projections and to fill a significant number of detoxification and rehabilitation beds will have to come from existing providers, including CS-HHC. Retreat claims that it has a referral network in Connecticut and the surrounding states, and will share the referral network associated with its sister facility in Pennsylvania, which will generate sufficient patients to populate the Connecticut facility without impacting existing providers (CON Application, p. 669). However, Retreat has provided only a handful of letters of support for this proposal. None of these letters of support are from providers that are based in or proximate to New Haven. In addition, Retreat's submissions show that Connecticut residents (at whom this facility is presumably targeted) make up less than one percent (12 of 2,206) of admissions to Retreat's Pennsylvania facility.

In addition, Retreat has made it clear that it will accept commercially insured and self-pay patients only, and will not offer services to Medicare or Medicaid recipients (CON Application pp. 35 & 704). Retreat claims that it will generate higher revenues per bed than its competitors through an extensive referral program that focuses on high-end, private pay (i.e., non-Medicare and/or Medicaid) patients (CON Application, p. 527). This means that the patients diverted from CS-HHC and other

facilities will be those who generate the highest revenues, leaving existing providers to serve the most vulnerable patients, including Medicare and Medicaid recipients and the uninsured, with less money to cover the cost of providing services. The magnitude of payments from these private sources is substantially greater than payments from public sources (i.e., Medicare or Medicaid) for comparable services, and thus contributes significantly to the financial sustainability of these programs. Diminution of private sector payments would adversely impact CS-HHC's overall financial performance and ability to provide access for New Haven's most vulnerable populations.

Summary of Evidence to Be Presented, Manner of Participation and Relief Sought

CS-HHC will ask OHCA to deny Retreat's request for permission to establish a substance abuse treatment facility in New Haven. There is no clear public need for the services being proposed. Conn. Gen. Stat. §19a-639(3). This facility will result in the unnecessary duplication of services and it will adversely impact CS-HHC and other existing providers. Conn. Gen. Stat. §19a-639(9). This will be shown through the presentation of capacity and utilization data, as well as other relevant evidence. The proposal will also decrease the cost-effectiveness and financial feasibility of care by skimming those patients who generate the most revenue from existing providers. Conn. Gen. Stat. §§19a-639(4) & (5). This in turn could have an adverse impact on the quality and accessibility of care provided by CS-HHC and others. Conn. Gen. Stat. §19a-639(5).

In addition, CS-HHC will introduce evidence of Retreat's failure to engage in discussions with local providers regarding the coordination of care. Most notably, Retreat has failed to discuss options for acute care with YNHH or any hospital, or to make arrangements for a transfer agreement

for its patients. The inevitable consequences of this include adverse financial impact on these providers and impaired access to care.

Moreover, Retreat cannot show any reason why a facility that does nothing to enhance access for Medicaid patients, and in fact causes financial harm to those who care for these patients, should be approved. Approval of such a proposal would be contrary to the intent of soon-to-be-implemented changes to the CON statutory decision criteria aimed at improving Medicaid access. *See* P.A. 13-234. CS-HHC will present evidence in support of its payer mix and the impact that Retreat's proposal to attract commercially insured and self-pay patients would have on its bottom line.

If CS-HHC is granted status, it intends to present this and other evidence and legal arguments in support of its positions. CS-HHC respectfully requests that it be allowed to submit written testimony, present evidence and arguments at the August 14, 2013 public hearing on this matter, cross-examine witnesses, and inspect and copy records pertaining to the proceeding. CS-HHC's participation will furnish assistance to OHCA in determining whether there is a need for this proposal and what its impact will be on existing providers. CS-HHC has information directly relevant to Retreat's erroneous claims in this regard, which will be presented at the hearing. In addition, CS-HHC's participation is in the interest of justice and will not impair the orderly conduct of these proceedings.

WHEREFORE, for the foregoing reasons, CS-HHC respectfully requests its Petition to be Designated as an Intervenor With Full Rights be granted.

Respectfully Submitted,

CORNELL SCOTT-HILL HEALTH CENTER

By: _____

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CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 9th of August, 2013 to the following:

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: CERTIFICATE OF NEED APPLICATION OF NR CONNECTICUT, LLC d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	)	DOCKET NO. 13-31828-CON
	)	AUGUST 9, 2013

PREFILED TESTIMONY OF
DOUGLAS BRUCE, M.D.

Good morning Hearing Officer Hansted and members of the OHCA staff. My name is Douglas Bruce, M.D. and I am the Medical Director of the South Central Rehabilitation Center ("SCRC") operated by Cornell Scott-Hill Health Center ("CS-HHC"). Thank you for this opportunity to speak in opposition to the CON Application filed by NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Retreat") for permission to establish a 105-bed substance abuse treatment facility in New Haven. This facility is intended for the treatment of commercially insured and self-pay patients only, and will not be available to those individuals covered by Medicare and Medicaid, or to the uninsured who cannot afford the facility's self-pay rates. My remarks today will focus on the significant adverse impact that a facility of this type and size, for which there is no clear public need, will have on existing providers like CS-HHC and on the New Haven healthcare delivery system. The proposed facility will be of little benefit to New Haven residents, while at the same time taxing the resources of acute care providers who are already struggling to meet the area's behavioral

health and medical needs. For the reasons set forth in this testimony, CS-HHC urges OHCA to deny Retreat's CON request.

CS-HHC Programs & Services

CS-HHC is one of the more significant providers of residential detoxification and evaluation, intensive treatment (rehabilitation), partial hospital, intensive outpatient and outpatient services in metropolitan New Haven. As such, CS-HHC operates South Central Rehabilitation Center, a 29-bed residential detoxification facility, and Grant Street Partnership Program, a 44-bed partial hospital that is collocated with intensive outpatient and outpatient counseling services. These services are fully integrated with CS-HHC's primary and preventive medical services and accept all patients regardless of their source of payment. Approximately 10 percent of patients in these services are commercially insured, with the remainder being governmentally insured (i.e. Medicare or Medicaid) and uninsured patients.

As the oldest and one of the largest federally qualified health centers in Connecticut, CS-HHC has longstanding collaborative and referral relationships and transfer agreements with all area hospitals and other essential providers. CS-HHC is Joint Commission accredited and designated as a Patient-Centered Medical Home.

Nature of Retreat's Proposal

This CON proposal involves the establishment of a 105-bed residential substance abuse treatment facility in New Haven. If approved, this will be one of the largest freestanding facilities of its kind in the state (see Statewide Health Care Facilities & Services Plan, Table 20, attached as Exhibit A). Retreat at South Connecticut will offer an array of substance abuse services, including the Level III.7 residential detoxification and evaluation services ("RDE Services"), PHP/IOP and other outpatient services offered by CS-HHC.

The Retreat facility will be located in a former skilled nursing facility on Ella T. Grasso Boulevard in New Haven. Despite its urban placement, Retreat will cater to commercially insured and self-pay patients only. The facility will not admit Medicare, Medicaid or other governmentally insured patients, many of whom reside in and around major cities such as New Haven. Patients insured under Medicare, Medicaid, CHAMPUS and other federal programs, as well as the uninsured, account for nearly 80 percent of all inpatient/newborn discharges in New Haven for FY 2012. These same patients account for almost 90 percent of discharges in the 06519 ZIP code, which roughly covers the Dwight/West-River neighborhood where the Retreat facility will be located (see Exhibit B attached). Nor will the facility be affordable for the area's uninsured population, given that the full per diem rate for residential services is approximately $1,500 to $1,700 per day (CON Application, p. 656).

In addition, Retreat has made no effort to arrange for a transfer agreement with an acute care facility or to otherwise coordinate with local providers, a requirement of providers offering the level of services being proposed by the Retreat.

There Is No Clear Public Need for a Commercial Insurance/Self-Pay Only Substance Abuse Treatment Facility in New Haven

Retreat has not established a clear public need for a 105-bed "luxury" substance abuse treatment facility in New Haven that will serve commercially insured and self-pay patients only, to the exclusion of Medicare and Medicaid recipients and the uninsured.

There is Ample Available Residential Detoxification & Evaluation & Rehabilitation Capacity for New Haven Area Residents

Despite Retreat's claim that need for a residential facility of this magnitude in Connecticut is "firmly established," CS-HHC has available RDE capacity and neither our facility nor the physicians with whom we coordinate (some of whom have written letters in opposition to this CON proposal) have encountered difficulty in finding available RDE or intensive treatment ("Rehabilitation Services") beds for our commercially insured patients (as compared with Medicaid and low-income patients, who are difficult to place at both levels of service) (CON Application, p. 667).[1]

Examples of RDE/Rehabilitation facilities in our area that typically have same-day availability (subject to pre-admission screening) include APT Foundation in New Haven, Silver Hill in New Canaan and Rushford Center in Middletown. Other RDE/Rehabilitation providers located slightly farther from New Haven, several of which are represented in this room today, likely have capacity for commercially insured patients as well. We find that for residential substance abuse

[1] Note that most commercial insurers will not authorize Rehabilitation Services as a step-down from RDE, but rather authorize these patients for PHP/IOP stays initially. In the event that a Rehabilitation stay is authorized by a commercial insurer, it is typically for a dually diagnosed patient (which Retreat does not appear equipped to handle) and the stay authorized prior to transition to PHP/IOP is short (5-7 days). This does not support Retreat's projection that 100 percent of its RDE patients will step down to Rehabilitation for an extended stay (16.5 days) (CON Application, p. 682).

services, the fact that a facility is located some distance from a patient's home is not typically an impediment to placement. As Retreat points out, substance abuse treatment facilities in Connecticut draw patients from across the state and Northeast region (CON Application, p. 27). In fact, many patients prefer to receive these privacy sensitive services at locations outside of their communities (CON Application, p. 27).

An Addiction Residential Census Report from the Department of Mental Health and Addiction Services ("DMHAS") is attached as Exhibit C. The information for this report is provided by grant-funded facilities, as well as other providers who choose to report through the DMHAS portal. It is not a complete list of available beds due to the exclusion of providers who are not grant-funded and the fact that certain facilities do not report on a daily basis, or report after this document has been published. Therefore, in all likelihood it underestimates available capacity. Nevertheless, the report for August 6, 2013 shows that there were at least 9 Level III.7 RDE beds and 22 Rehabilitation beds available for patients. This contradicts Retreat's claim that there is no available capacity for these services in the state.

Also attached as Exhibit C are the results of an informal telephone survey conducted by Yale-New Haven Hospital ("YNHH") of the capacity of existing RDE and Rehabilitation providers. As you can see from this survey, RDE facilities including South Central Rehabilitation Center, Rushford Center, Stonington Institute, Trinity Glen, First Step, Hallbrook and Altruism Acute Care and Evaluation have no wait for beds. In addition, Mountainside Treatment Center recently received approval to establish 16 RDE beds. These beds are under construction and will be open within the

next 6 months. Similarly, there are Rehabilitation beds available with no wait at Stonington Institute and the Patrick F. McAuliffe Center.

Moreover, clear public need does not mean providing citizens with the option of choosing a local or regional "exclusionary" facility that excludes certain members of the population based on wealth or insurance coverage. In fact, OHCA has not historically considered citizens' preferences for a particular type of facility, including a "luxury" facility, in determining whether real need exists and hence a CON should be awarded. This is true notwithstanding the nature of the facility or services requested.

The Retreat Facility Will Not Meet the Needs of New Haven Area Residents or the Objectives of Recent OHCA Legislation

By locating its facility in New Haven, Retreat has implied a commitment to meet the needs of New Haven area residents. However, the need in New Haven is not for additional "luxury" substance abuse capacity for commercially insured and self-pay patients, as Retreat proposes. Rather, the New Haven community requires additional capacity to serve the substance abuse and mental health treatment needs of Medicaid recipients and indigent individuals in our community. According to CHIME data, approximately 80 percent of New Haven's residents, and approximately 90 percent of residents in the 06519 ZIP code (which includes the Dwight/West-River neighborhood where the proposed facility will be located), receive some form of governmental insurance or are uninsured (see Exhibit B attached). These estimates are conservative and will likely increase as a result of healthcare reform and enhanced access to Medicaid. Retreat has chosen to locate its "luxury" facility in an urban neighborhood that is home to many of these individuals who, due to the exclusionary

nature of the facility, will not be able to benefit from its services. In addition, the cost for self-pay services at Retreat makes it unavailable for all but the wealthiest individuals, which does not describe a majority of those in and around New Haven with substance abuse and mental health issues.

Even if there were a need for more residential substance abuse treatment capacity for commercially insured and wealthy individuals in New Haven (which is not the case), the recent focus on ensuring and expanding access for Medicaid and indigent patients means that any new facility should be inclusive of all patients, regardless of payer source. Retreat cannot show any reason why a facility that does nothing to enhance access for Medicaid recipients, and in fact causes financial harm to those who care for these individuals, should be approved.

Approval of such a proposal would be contrary to recent changes in the CON statutory decision criteria aimed at improving Medicaid access. Public Act No. 13-234, which takes effect October 1, 2013, amends Section 19a-639 of the Connecticut General Statutes to include a requirement that an applicant for a CON demonstrate (1) how the provision of, or any change in access to, services for Medicaid recipients and indigent persons improves the quality, accessibility and cost-effectiveness of healthcare in the region; (2) how the proposal will impact the cost-effectiveness of providing access to services under the Medicaid program; (3) an applicant's past and proposed provision of healthcare services to relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons; and (4) whether an applicant, who has failed to provide access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which may not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other healthcare payers (see Exhibit D attached).

Retreat has stated its intention to exclude Medicare and Medicaid patients from tits facility (CON Application, p. 704). It has shown no justification for this approach other than the fact that commercially insured and self-pay patients generate higher revenues, which will give Retreat an advantage over its competitors, who will continue to treat governmentally insured individuals regardless of the financial impact on their bottom lines (CON Application, p. 527). This proposal violates both the letter and the spirit of the new law.

Retreat Will Adversely Impact the New Haven Healthcare System & Existing Providers

This proposal will have an adverse impact on the New Haven healthcare system by taxing the area's already overwhelmed acute care providers with dually diagnosed and medically complicated patients from Retreat. This is true regardless of whether Retreat accepts Medicare and Medicaid patients, because it results from the number of patients that the facility will bring into New Haven, irrespective of payer source. The proposal will also adversely impact existing providers of the services being proposed by Retreat, by attracting the higher-paying commercial and self-pay patients whose revenues help to support our operations.

Impact on the New Haven Healthcare System

Retreat is proposing a facility that provides exclusively substance abuse treatment services and has failed to take into account the fact that approximately 60 to 70 percent of substance abuse patients also suffer from a co-occurring mental health disorder. Retreat is not equipped, and does not appear to have any plan for diagnosing and treating the mental health issues of the patients it brings into New Haven. While Retreat may claim that it will prescreen for mental health issues and refuse

these patients, this is not an effective approach because mental health issues often go unreported or undiagnosed until after a patient has completed detoxification. In addition, many RDE patients have medical complications that require treatment in an acute care setting. Again, there is nothing in the CON submissions that indicates how Retreat intends to handle medically complicated patients.

The reality is that substance abuse patients with co-occurring mental health disorders and medical complications often require follow-up care in an acute setting. Because Yale-New Haven Hospital ("YNHH") is the acute care hospital in New Haven, we must assume that this is where Retreat's patients will be directed. Despite this fact, our understanding is that Retreat has made no effort to contact YNHH and arrange for a transfer agreement (which would have to be in place prior to the commencement of services at Retreat) or otherwise discuss coordination of care. In fact, we are not aware of any conversations that Retreat has had with local providers regarding the proposed facility and the impact that it will have on the New Haven healthcare community. This is true notwithstanding the fact that Retreat has begun construction on the facility in anticipation of an approval and had meetings with some local elected officials to garner support for the proposal.

Transfer agreements and coordination of care are critical to the proper functioning of our healthcare system. Care must be managed such that patients receive the services they require without impacting the ability of others in the community to obtain the same services. If Retreat had reached out to YNHH, they would likely have been told that the hospital is operating at capacity for inpatient mental health services. We understand that all beds are full on a regular basis and patients are receiving services in the Emergency Department. YNHH has a finite amount of capacity and if patients are transferred from Retreat to YNHH or seek treatment at YNHH after discharge, we

believe they will overwhelm an already overburdened community behavioral health and medical services provider and reduce access to services for Medicaid recipients and the uninsured in the New Haven area, particularly urgent care services in the Emergency Department and aftercare services and residential housing post-treatment. Notably, these are patients who, but for receiving services at Retreat, would likely not be in the New Haven area and accessing services through the hospital.

This inevitable influx of patients will have a deleterious effect on local acute care providers not only from a resources perspective, but from a financial perspective as well. Commercial behavioral health benefits are typically very limited – meaning they authorize less services and shorter stays than most medical insurances. As a result, many of Retreat's patients may have exhausted their benefits by the time they present at YNHH and will be unable to pay for care. This in turn will result in financial harm to the hospital, which may further limit access to care for those individuals who live in and around New Haven, who have Medicaid or are uninsured, and who rely on the hospital for services. This type of negative impact on the strength of the New Haven healthcare system is contrary to the intention of the CON statutes.

Impact on Existing Providers

Retreat has not shown that it can fill 105 substance abuse treatment beds with commercially insured and self-pay patients without attracting patients from existing providers. The only referral network that Retreat has been able to demonstrate includes a handful of clinicians (from outside of the New Haven market) and several employee assistance programs (CON Application, pp. 670-674). By Retreat's own admission, clinicians are not a high-volume referral source for residential substance abuse facilities, accounting for only 2 percent of admissions to its Pennsylvania facility (CON

Application, p. 706). Retreat claims that it will draw 75 percent of its admissions from Connecticut however the lack of Connecticut referral sources makes this unlikely without impact to existing providers in the state (CON Application, p. 669). Retreat also claims that it will share the existing referral network of its sister facility in Lancaster, Pennsylvania (CON Application, p. 669). However, given that only 12 of Retreat at Lancaster County's 2,206 patients (.05%) in FY 2012 were Connecticut residents, it is difficult to imagine how this referral network will assist Retreat at South Connecticut in meeting its goal (CON Application, p. 686).[2] Retreat's projections are simply too ambitious to meet without an established referral network, and Retreat does not have an established referral network for Connecticut.

Because Retreat has not shown a clear public need for the proposed facility, the patients required to meet its projections and to fill a significant number of detoxification and rehabilitation beds will have to come from existing providers. In addition, Retreat has made it clear that it will accept commercially insured and self-pay patients only, and will not offer services to Medicare or Medicaid recipients (CON Application pp. 35 & 704). Retreat claims that it will generate higher revenues per bed than its competitors through an extensive referral program that focuses on high-end, private pay (i.e., non-Medicare and/or Medicaid) patients (CON Application, p. 527). This means that the patients diverted from existing providers will be those who generate the highest revenues,

[2] Retreat claims that there is a need for the proposed facility in New Haven so that patients from the area are not burdened by travel, which can increase the cost of care and preclude family members from actively participating in a patient's care (CON Application, p. 38). However, the statistics cited in this paragraph make it clear that Retreat sought out and treated patients from Connecticut at its Pennsylvania facility. These individuals likely traveled more than 4 hours to Lancaster County for services. If Retreat likewise intends to populate the Connecticut facility with out-of-state residents, then this proposal is not serving the needs of the residents of our state.

leaving existing providers to serve the most vulnerable patients, including Medicare and Medicaid recipients and the uninsured, with less money to cover the cost of providing services.

Approximately 90 percent of CS-HHC's RDE and PHP/IOP patients are governmentally insured or low-income uninsured. Only 10 percent are commercially insured or the self-pay clients being targeted by Retreat. However, the magnitude of payments from these private sources is substantially greater than payments from public sources (i.e., Medicare or Medicaid) for comparable services, and thus contributes significantly to the financial sustainability of these programs. Diminution of private sector payments would adversely impact CS-HHC's overall financial performance and our ability to provide access for New Haven's most vulnerable populations.

Conclusion

Retreat is proposing to establish one of the largest freestanding substance abuse treatment facilities in Connecticut. Retreat has not shown a clear public need for this facility, and in fact it will duplicate the services of many existing freestanding substance abuse treatment facilities. Conn. Gen. Stat. §§19a-639(3) & (9). Retreat's projections are flawed and it does not have the support or referral network necessary to populate a 105-bed facility without impacting existing providers. If this project is approved, Retreat will syphon the commercially insured and self-pay patients from existing facilities, which will have a significant adverse financial impact on these facilities. This could in turn affect the quality, accessibility and cost-effectiveness of healthcare in the New Haven community. Conn. Gen. Stat. §19a-639(5).

In addition, Retreat has made no effort to establish relationships with local providers including acute care providers, who will be required to treat the many dually diagnosed and medically complicated patients that Retreat brings into New Haven. Retreat does not have a transfer agreement in place and has not had any discussions about such an agreement with the acute care hospital in New Haven, YNHH. This proposal will inevitably place additional burdens on the YNHH and New Haven healthcare systems as a result of the treatment needs of Retreat's patients. This will adversely impact access to care and, ultimately, the financial strength of the healthcare system. Conn. Gen. Stat. §19a-639(4).

In this time of expanded access to healthcare for all, particularly Medicaid recipients and indigent persons, OHCA should not approve a facility that has no intention of treating these individuals and that will negatively impact the facilities that do. The proposal is also inconsistent with the aims of federal healthcare reform, including the goals of reducing costs and making services more widely available to larger segments of the population. Also, there is no community benefit to a substance abuse treatment facility in New Haven that cannot serve a large percentage of New Haven residents because of its exclusionary payment policies. The facility would be unavailable to those who need it most – the Medicaid recipients and indigent individuals who receive care at CS-HHC and other local non-profit providers.

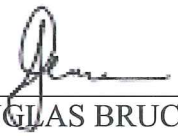
Even if Retreat were to change its model and accept all patients regardless of payer source, including Medicaid, this proposal still should not be approved due to several significant issues, including overburdening existing providers without assessing current capacity of the downstream services that will be required for Retreat's patients. Retreat's submissions simply do not establish

that the proposal is consistent with the statutory decision criteria for CONs set forth in Section 19a-639 of the General Statutes. This includes, most notably, the lack of clear public need for the Retreat at South Connecticut and Retreat's failure to implement an acute care transfer process to address the needs of the dually diagnosed and medically complicated individuals from out of town that Retreat will bring into New Haven. Nor will the proposal increase access to residential services for the New Haven community – instead access will be diminished through use of the finite resources of acute care providers. Retreat has also failed to investigate capacity for transitional care in the community (of which there is very little) for out-of-town patients who choose to stay with Retreat for outpatient care after their residential stays are complete. These problems exist no matter which payers Retreat agrees to accept, and they support denial of this CON application. And lastly, it would be easy for Retreat to agree to accept Medicaid, but then de facto exclude all but commercially insured and self-pay patients through its admissions process.

For these reasons, CS-HHC respectfully request that OHCA deny Retreat's CON request.

I thank you for your time and am available to answer any questions you may have.

Respectfully Submitted,



DOUGLAS BRUCE, M.D.
CORNELL SCOTT-HILL HEALTH CENTER

EXHIBIT A

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Access Center	APT Foundation, Inc.	1 Long Wharf	New Haven	06511	0	ACD, CMT, OT,
ADRC Outpatient Counseling Center	Alcohol and Drug Recovery Centers, Inc.	16 Coventry Street	Hartford	06112	0	OT
Adult Psychiatric Clinic/Child and Family Guidance Clinic	Cornell Scott-Hill Health Corporation	400 - 428 Columbus Avenue	New Haven	06519	0	OT
Altruism Acute Care and Evaluation	Southeastern Council on Alcoholism and Drug Dependency, Inc.	47 Coit Street	New London	06320	20 RDE	OT, RDE
Altruism House for Men	Southeastern Council on Alcoholism and Drug Dependency, Inc.	313 Main Street	Norwich	06360	13 ILTTR	ILTTR
Altruism House for Women	Southeastern Council on Alcoholism and Drug Dependency, Inc.	1000 Bank Street	New London	06320	10 ILTTR	ILTTR
Altruism House for Women	Southeastern Council on Alcoholism and Drug Dependency, Inc.	62-64 Coit Street	New London	06320	11 ILTTR	ILTTR
Angelus House	Wellspring Foundation, Inc.	158 Flanders Road	Bethlehem	06751	0	OT
Ansonia Counseling Services	Cornell Scott-Hill Health Corporation	121 Wakelee Avenue	Ansonia	06401	0	OT
APT Residential Services	APT Foundation, Inc.	425 Grant Street	Bridgeport	06608	125 ILTTR	ILTTR, OT
Behavioral Health Services at Hamden	Yale University	95 Circular Drive	Hamden	06514	0	OT
Bhcare Valley Outpatient Clinic	BHcare, Inc.	435 East Main Street	Ansonia	06401	0	OT
Bhcare, Inc.-Shoreline Clinic	BHcare, Inc.	14 Sycamore Way	Branford	06405	0	OT
Blue Sky Behavioral Health Clinic	Blue Sky Behavioral Health, LLC	52 Federal Road	Danbury	06810	0	CMT, DET, OT
Bridges ... A Community Support System, Inc.	Bridges ... A Community Support System, Inc.	949 Bridgeport Avenue	Milford	06460	0	OT
Bridges ... A Community Support System, Inc.	Bridges ... A Community Support System, Inc.	270 Center Street	West Haven	06516	0	OT
Carnes Weeks Center	McCall Foundation Inc.	58b High Street	Torrington	06790	20 IT	IT
Casa Eugenio Maria De Hostos	Chemical Abuse Services Agency, Inc.	690 Arctic Street	Bridgeport	06608	10 IT, 6 ILTTR	DET, ILTTR, IT, OT
Catholic Charities	Catholic Charities Diocese of Norwich, Inc.	28 Huntington Street	New London	06320	0	OT
Catholic Charities, Diocese of Norwich, Inc.	Catholic Charities Diocese of Norwich, Inc.	331 Main Street	Norwich	06360	0	OT
Catholic Charities, Diocese of Norwich, Inc.	Catholic Charities Diocese of Norwich, Inc.	151 Broad Street	Middletown	06457	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	90 Franklin Square	New Britain	06051	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	205 Wakelee Avenue	Ansonia	06401	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	203 High Street	Milford	06460	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	501 Lombard Street	New Haven	06513	0	OT

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	56 Church Street	Waterbury	06702	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	13 Wolcott Street	Waterbury	06705	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	132 Grove Street	Torrington	06790	0	OT
Center for Human Services	Recovery Network of Programs, Inc.	2 Research Drive	Stratford	06615	0	OT
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	164 - 166 Bartholomew Street	Hartford	06106	20 ILTTR	ILTTR
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	33 Center Street	Hartford	06106	15 ILTTR	ILTTR
Child and Family Agency of Southeastern Connecticut, Inc. Child Guidance Clinic Essex	Child and Family Agency of Southeastern Connecticut, Inc.	190 Westbrook Road	Essex	06426	0	OT
Child and Family Agency of Southeastern Connecticut, Inc. Groton/Mystic Campus	Child and Family Agency of Southeastern Connecticut, Inc.	591 Poquonnock Road	Groton	06340	0	OT
Child and Family Agency of Southeastern Connecticut, Inc. Smith Bent Children's Center	Child and Family Agency of Southeastern Connecticut, Inc.	7 Vauxhall Street	New London	06320	0	OT
Child and Family Guidance Center, Inc.	Child and Family Guidance Center, Inc.	180 Fairfield Avenue	Bridgeport	06604	0	OT
Child Guidance Clinic for Central Connecticut, Inc.	Child Guidance Clinic for Central Connecticut, Inc.	384 Pratt Street	Meriden	06451	0	OT
Children's Center of Hamden, Inc.	Children's Center of Hamden Inc.	1400 Whitney Avenue	Hamden	06517	0	OT
CHR Manchester	Community Health Resources	587 East Middle Turnpike	Manchester	06040	0	OT
Clayton House	Alcohol and Drug Recovery Centers, Inc.	203 Williams Street	Glastonbury	06033	15 ILTTR	ILTTR
Community Child Guidance Clinic, Inc.	Community Child Guidance Clinic, Inc.	317 North Main Street	Manchester	06042	0	OT
Community Health Center of Wherever You Are Friendship Services Center	Community Health Center, Inc.	241-249 Arch Street	New Britain	06051	0	OT
Community Health Center of Wherever You Are Master's Manna	Community Health Center, Inc.	46 North Plains Industrial Road	Wallingford	06492	0	OT
Community Health Center of Wherever You Are Prudence Crandall	Community Health Center, Inc.	594 Burritt Street	New Britain	06053	0	OT
Community Health Services, Inc.	Community Health Services Inc.	500 Albany Avenue	Hartford	06120	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	81 North Main Street	Bristol	06010	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	26 Russell Street	New Britain	06052	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	5 Hart Street	New Britain	06052	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	55 Winthrop Street	New Britain	06052	0	OT
Community Renewal Team Asian Family Services	Community Renewal Team	1921 Park Street	Hartford	06106	0	OT
Community Renewal Team, Inc. Behavioral Health Services	Community Renewal Team	90 Retreat Avenue	Hartford	06106	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

CSHH000028
08/09/13

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Community Renewal Team, Inc. Behavioral Health Services	Community Renewal Team	330 Market Street	Hartford	06120	0	OT, DET
Community Renewal Team, Inc. Behavioral Health Services	Community Renewal Team	35 Clark Street	Hartford	06120	0	OT, DET
Community Residences, Inc.	Community Residences, Inc.	205 Kelsey Street	Newington	06111	0	OT
Community Substance Abuse Center, Inc.	Community Substance Abuse Centers, Inc.	55 Fishfry Street	Hartford	06120	0	ACD, CMT, OT
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	4 Midland Road	Waterbury	06705	0	ACD, CMT, DET, OT
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	60 Beaver Brook Road	Danbury	06810	0	ACD, CMT, OT
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	20 North Main Street	Norwalk	06854	0	ACD, CMT, OT
Connecticut Junior Republic	Connecticut Junior Republic Association, Inc.	80 Prospect Street	Waterbury	06702	0	OT
Connecticut Junior Republic	Connecticut Junior Republic Association, Inc.	550 Goshen Road	Litchfield	06759	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	1120 Main Street	Bridgeport	06604	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	1 Lafayette Circle	Bridgeport	06604	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	115 Middle Street	Bridgeport	06604	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	17 High Street	Norwalk	06851	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	4 Byington Place	Norwalk	06852	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	141 Franklin Street	Stamford	06901	0	OT
Connection Counseling Center, The	Connection, Inc., The	178 State Street	Meriden	06450	0	OT
Connection Counseling Center, The	Connection, Inc., The	196 Court Street	Middletown	06457	0	OT
Connection Counseling Center, The	Connection, Inc., The	263 Main Street	Old Saybrook	06475	0	OT
Connection House	Connection, Inc., The	167 Liberty Street	Middletown	06457	14 ILTTR	ILTTR
Coventry House	Alcohol and Drug Recovery Centers, Inc.	46 Coventry Street	Hartford	06112	10 ILTTR	ILTTR
Crossroads, Inc.	Crossroads, Inc.	54 East Ramsdell Street	New Haven	06515	174 ILTTR	ILTTR
Crossroads, Inc.	Crossroads, Inc.	44 East Ramsdell Street	New Haven	06515	0	OT
CT Clinical Services, Inc.	CT Clinical Services, Inc.	139 Orange Street	New Haven	06510	0	OT
Detoxification Center	Alcohol and Drug Recovery Centers, Inc.	500 Blue Hills Avenue	Hartford	06112	28 IT, 10 ILTTR, 35 RDE	ILTTR, IT, RDE
Elm City Women and Children's Center and The Connection Counseling Center	Connection, Inc., The	48 Howe Street	New Haven	06511	15 ILTTR	ILTTR

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Fairfield Counseling Services, Inc.	Fairfield Counseling Services Inc.	125 Penfield Road	Fairfield	06824	0	OT
Families In Recovery Program	Liberation Programs, Inc.	141 Franklin Street	Stamford	06901	10 ILTTR	ILTTR
Family and Children's Agency, Inc.	Family and Children's Agency, Inc.	9 Mott Avenue	Norwalk	06850	0	OT
Family Intervention Center	Family Intervention Center, Inc.	22 Chase River Road	Waterbury	06704	0	DET, OT
Family Resource Associates, LLC	Family Resource Associates, LLC	3300 Main Street	Stratford	06614	0	OT
Farrell Treatment Center	Farrell Treatment Center, Inc.	586 Main Street	New Britain	06051	24 IT	IT, OT
First Step	Recovery Network of Programs, Inc.	425 Grant Street	Bridgeport	06610	19 RDE	RDE
Fresh Start	Community Renewal Team	17 Essex Street	Hartford	06120	21 ILTTR	ILTTR, OT
Grant Street Partnership	Cornell Scott-Hill Health Corporation	62 Grant Street	New Haven	06519	0	DET, OT
Greenwich Youth Options	Liberation Programs, Inc.	55 Old Field Point Road	Greenwich	06830	0	OT
Hallie House Women and Children's Center	Connection, Inc., The	99 Eastern Drive	Middletown	06457	8 ILTTR	ILTTR
Hartford Behavioral Health	Hartford Community Mental Health Center, Inc.	2550 Main Street	Hartford	06106	0	OT
Hartford Behavioral Health	Hartford Community Mental Health Center, Inc.	1 Main Street	Hartford	06106	0	OT
Hartford Dispensary - Norwich Clinic	Hartford Dispensary	772 West Thames Street	Norwich	06360	0	ACD, CMT
Hartford Dispensary Henderson/Johnson Clinic	Hartford Dispensary	12 - 14 Weston Street	Hartford	06103	0	ACD, CMT
Hartford Dispensary New Britain Clinic	Hartford Dispensary	70 Whiting Street	New Britain	06050	0	ACD, CMT
Hartford Dispensary/Doctors Clinic	Hartford Dispensary	345 Main Street	Hartford	06106	0	ACD, CMT
Hartford Dispensary/New London Clinic	Hartford Dispensary	931-939 Bank Street	New London	06320	0	ACD, CMT
Hartford Dispensary-16-18 Weston Street	Hartford Dispensary	16-18 Weston Street	Hartford	06120	0	ACD, CMT, OT
Hartford Dispensary-Bristol Clinic	Hartford Dispensary	1098 Farmington Avenue	Bristol	06010	0	ACD, CMT, OT
Hartford Dispensary-Manchester Clinic	Hartford Dispensary	335 Broad Street	Manchester	06040	0	ACD, CMT
Hartford Dispensary-Willimantic Clinic	Hartford Dispensary	54-56 Boston Post Road	Windham	06226	0	ACD, CMT
High Watch Recovery Center	High Watch Recovery Center, Inc.	62 Carter Road	Kent	06757	78 C&R	C&R, DET, OT
Hispanos Unidos, Inc.	Hispanos Unidos, Inc.	116 Sherman Avenue	New Haven	06511	0	OT
Hockanum Valley Community Council, Inc.	Hockanum Valley Community Council, Inc.	27 Naek Road	Vernon	06066	0	OT
Horizons	Recovery Network of Programs, Inc.	1635 Fairfield Avenue	Bridgeport	06605	15 IT	IT
Institute for the Hispanic Family	Catholic Charities, Inc. - Archdiocese of Hartford	45 Wadsworth Street	Hartford	06106	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Integrated Care Clinic	Optimus Health Care, Inc.	780 Summer Street	Stamford	06901	0	OT
Intercommunity, Inc.	Intercommunity, Inc.	287 Main Street	East Hartford	06118	0	OT
Intercommunity, Inc.	Intercommunity, Inc.	281 Main Street	East Hartford	06118	0	OT
Kinsella Treatment Center	Recovery Network of Programs, Inc.	1438 Park Avenue	Bridgeport	06604	0	ACD, CMT, OT
Lebanon Pines Long Term Care	Southeastern Council on Alcoholism and Drug Dependency, Inc.	37 Camp Mooween Road	Lebanon	06249	110 ILTTR	ILTTR
Legion Avenue Clinic	APT Foundation, Inc.	495 Congress Avenue	New Haven	06511	0	ACD, CMT, DET, CMT
Liberation Clinic	Liberation Programs, Inc.	125 Main Street	Stamford	06901	0	OT
Liberation House	Liberation Programs, Inc.	119 Main Street	Stamford	06901	67 ILTTR	ILTTR
Liberation Methadone Clinic (Bridgeport)	Liberation Programs, Inc.	399 Mill Hill Avenue	Bridgeport	06610	0	ACD, CMT, OT
Main Street Clinic	Liberation Programs, Inc.	117 Main Street	Stamford	06901	0	ACD, CMT
MCCA	Midwestern Connecticut Council on Alcoholism, Inc.	38 Old Ridgebury Road	Danbury	06810	20 IT, 10 RDE	ACD, CMT, DET, OT
MCCA/New Milford	Midwestern Connecticut Council on Alcoholism, Inc.	62 Bridge Street	New Milford	06776	0	DET, OT
MCCA/Ridgefield	Midwestern Connecticut Council on Alcoholism, Inc.	90 East Ridge Road	Ridgefield	06877	0	DET, OT
MCCA/Waterbury	Midwestern Connecticut Council on Alcoholism, Inc.	228 Meadow Street	Waterbury	06702	0	DET, OT
McCall Foundation	McCall Foundation, Inc.	58 High Street	Torrington	06790	0	DET, OT
McCall Foundation, Inc.-Winsted Satellite office	McCall Foundation, Inc.	115 Spencer Street	Winchester	06098	0	OT
McCall House	McCall Foundation, Inc.	127 Migeon Avenue	Torrington	06790	14 ILTTR	ILTTR
Milestone/New Life Center/Pathways	Community Health Resources	391 Pomfret Street	Putnam	06260	6 ILTTR, 18 IT	ACD, CMT, IT, ILTTR, RDE
Mother's Retreat and The Connection Counseling Center	Connection, Inc., The	542 Long Hill Road	Groton	06340	8 ILTTR	ILTTR, OT
Mountainside Treatment Center	MCI Healthcare LLC	187 South Canaan Road	Canaan	06018	62 ILTTR	ILTTR
Multicultural Ambulatory Addiction Services	Chemical Abuse Services Agency, Inc.	426 East Street	New Haven	06511	0	ACD, CMT, DET, OT
New Directions, Inc. of North Central Connecticut	New Directions, Inc. of North Central Connecticut	113 Elm Street	Enfield	06082	0	OT
New Era Rehabilitation Center, Inc.	New Era Rehabilitation Center, Inc.	311 East Street	New Haven	06511	0	ACD, CMT, DET, OT
New Era Rehabilitation Center, Inc.	New Era Rehabilitation Center, Inc.	3851 Main Street	Bridgeport	06606	0	ACD, CMT, DET, OT
New Hope Behavioral Health & Substance Abuse	New Hope Manor, Inc.	935 Main Street	Manchester	06040	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
New Perceptions/Right Turn	Perception Programs, Inc.	54 North Street	Windham	06226	0	OT
New Perceptions/Right Turn	Perception Programs, Inc.	13 Water Street	Killingly	06239	0	OT
New Prospects	Recovery Network of Programs, Inc.	392 Prospect Street	Bridgeport	06604	23 IT	IT
Newtown Youth and Family Services, Inc.	Newtown Youth and Family Services, Inc.	15 Berkshire Road	Newtown	06470	0	OT
North Central Counseling Services	Community Health Resources	693 Bloomfield Avenue	Bloomfield	06002	0	DET, OT
North Central Counseling Services	Community Health Resources	153 Hazard Avenue	Enfield	06082	0	DET, OT
North Haven Community Services	Town of North Haven	5 Linsley Street	North Haven	06473	0	OT
Northside Community Outpatient Services/Child and Family Guidance Clinic	Cornell Scott-Hill Health Corporation	226 Dixwell Avenue	New Haven	06511	0	OT
Northwest Center for Family Service & Mental Health	Community Mental Health Affiliates, Inc.	350 Main Street	Salisbury	06039	0	OT
Northwest Center for Family Service & Mental Health	Community Mental Health Affiliates, Inc.	100 Commercial Boulevard	Torrington	06790	0	OT
Orange Family Counseling	Bridges ... A Community Support System, Inc.	605-A Orange Center Rd	Orange	06477	0	OT
Orchard Hill Treatment Services	APT Foundation, Inc.	540 Ella T. Grasso Boulevard	New Haven	06519	0	ACD, CMT, OT
Outpatient Clinic	Connection, Inc., The	205-209 Orange Street	New Haven	06511	0	OT
Outpatient Treatment	Southeastern Council on Alcoholism and Drug Dependency, Inc.	321 Main Street	Norwich	06360	0	OT
Paces Counseling Associates, Inc.	Paces Counseling Associates, Inc.	991 Main Street	East Hartford	06108	0	OT
Park Street Inn	Connection, Inc., The	98 Park Street	New Haven	06511	0	OT
Patrick F. Mcauliffe Center	Connecticut Renaissance, Inc.	70 Central Avenue	Waterbury	06702	20 IT	IT
Perception House	Perception Programs, Inc.	134 Church Street	Windham	06226	20 ILTTR	ILTTR
Positive Directions - The Center for Prevention and Recovery, Inc.	Positive Directions-The Center for Prevention and Recovery, Inc.	420 Post Road West	Westport	06880	0	OT
Project Courage	Chemical Abuse Services Agency, Inc.	592 Kossuth Street	Bridgeport	06608	0	DET, OT
Recovery Adolescent Program	Recovery Network of Programs, Inc.	1549 Fairfield Avenue	Bridgeport	06605	0	OT
Recovery Counseling Services	Recovery Network of Programs, Inc.	480 Bond Street	Bridgeport	06610	0	OT
Renaissance East	Connecticut Renaissance, Inc.	31 Wolcott Street	Waterbury	06702	32 ILTTR	ILTTR
Renaissance West	Connecticut Renaissance, Inc.	466 West Main Street	Waterbury	06702	50 ILTTR	ILTTR
Reverend Edward M. Dempsey Drug Services	Central Naugatuck Valley HELP, Inc.	900 Watertown Avenue	Waterbury	06708	34 ILTTR	ILTTR

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

CSHH000032
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Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Rushford Center, Inc.	Rushford Center, Inc.	110 National Drive	Glastonbury	06033	0	OT
Rushford Center, Inc.	Rushford Center, Inc.	883 Paddock Avenue	Meriden	06450	0	ACD, OT
Rushford Center, Inc.	Rushford Center, Inc.	1250 Silver Street	Middletown	06457	16 RDE, 42 IT	ACD, DET, IT, OT, RDE
Rushford Center, Inc.	Rushford Center, Inc.	325 Main Street	Portland	06480	26 ILTTR	ILTTR
Sound Community Services, Inc.	Sound Community Services, Inc.	165 State Street	New London	06320	0	OT
South Central Rehabilitation Center	Cornell Scott-Hill Health Corporation	232 Cedar Street	New Haven	06519	29 RDE	ACD, CMT, RDE, OT
Southwest Community Health Center, Inc.	Southwest Community Health Center, Inc.	1046 Fairfield Avenue	Bridgeport	06604	0	OT
Southwest Community Health Center, Inc.	Southwest Community Health Center, Inc.	968 Fairfield Avenue	Bridgeport	06605	0	OT
Stafford Family Services	Town of Stafford	21 Hyde Park Road	Stafford	06076	0	OT
State Street Counseling Services	Cornell Scott-Hill Health Corporation	911-913 State Street	New Haven	06511	0	OT
Stonington Institute	Stonington Behavioral Health, Inc.	1353 Gold Star Highway	Groton	06340	0	DET, OT
Stonington Institute	Stonington Behavioral Health, Inc.	428 Long Hill Road	Groton	06340	0	DET, OT
Stonington Institute	Stonington Behavioral Health, Inc.	75 Swantown Hill Road	North Stonington	06359	45 IT, 18 RDE	ACD, DET, OT, IT, RDE
Transitions Outpatient Services	Community Health Resources	433 Valley Street	Windham	06226	0	OT
Transitions Outpatient Services	Community Health Resources	37 Commerce Avenue	Killingly	06239	0	OT
Transitions Outpatient Services/Thomas Murphy Center	Community Health Resources	1491 Main Street	Windham	06226	14 ILTTR	ILTTR
Travisano Network	Central Naugatuck Valley Help, Inc.	24 Shelter Rock Road	Danbury	06810	0	OT
Trinity Glen	Midwestern Connecticut Council on Alcoholism, Inc.	149 West Cornwall Road	Sharon	06069	50 C&R	C&R
United Community and Family Services, Inc.	United Community and Family Services, Inc.	400 Bayonet Street	New London	06320	0	OT
United Community and Family Services, Inc.	United Community and Family Services, Inc.	70 Main Street	Griswold	06351	0	OT
United Community and Family Services, Inc.	United Community and Family Services, Inc.	47 Town Street	Norwich	06360	0	OT
United Community and Family Services, Inc.	United Community and Family Services, Inc.	212 Upton Road	Colchester	06415	0	OT
United Services, Inc.	United Services, Inc.	132 Mansfield Avenue	Windham	06226	0	OT
United Services, Inc.	United Services, Inc.	233 Route 6	Columbia	06237	0	OT
United Services, Inc.	United Services, Inc.	1007 North Main Street	Killingly	06241	0	OT
United Services, Inc.	United Services, Inc.	303 Putnam Road	Plainfield	06387	0	OT
Viewpoint Recovery Program	CTE, Inc.	104 Richmond Hill Avenue	Stamford	06902	12 ILTTR	ILTTR

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Village for Families and Children, Inc.	Village for Families and Children, Inc.	1680 Albany Avenue	Hartford	06105	0	OT
Village for Families and Children, Inc.	Village for Families and Children, Inc.	105 Spring Street	Hartford	06105	0	OT
Village for Families and Children, Inc.	Village for Families and Children, Inc.	331 Wethersfield Avenue	Hartford	06114	0	OT
Waterbury Outpatient Services for CMHA	Community Mental Health Affiliates, Inc.	36 Sheffield Street	Waterbury	06704	0	OT
Watkins Network	Central Naugatuck Valley HELP, Inc.	257 Main Street	Torrington	06790	0	OT
Wellmore Behavioral Health	Wellmore, Inc.	402 East Main Street	Waterbury	06702	0	OT
Wellmore Behavioral Health, Inc.	Wellmore, Inc.	30 Controls Drive	Shelton	06484	0	OT
Wellmore, Inc. Therapeutic Shelter	Wellmore, Inc.	142 Griggs Street	Waterbury	06704	0	DET
Wellmore, Inc. Women and Children's Program	Wellmore, Inc.	79 Beacon Street	Waterbury	06704	8 ILTTR	ILTTR
West Haven Health Center Counseling Services	Cornell Scott-Hill Health Corporation	285 Main Street	West Haven	06516	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	36 Russell Street	New Britain	06052	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	75 North Mountain Road	New Britain	06053	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	91 North West Drive	Plainville	06062	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	645 Farmington Avenue	Hartford	06105	0	OT
Wherever You Are Eddy Center	Community Health Center, Inc.	1 Labella Circle	Middletown	06457	0	OT
Wherever You Are Shelter Now	Community Health Center, Inc.	43 Saint Casimir Drive	Meriden	06450	0	OT
Wherever You Are Shepherd Home	Community Health Center, Inc.	112 Bow Lane	Middletown	06457	0	OT
Youth Challenge Bible Training Center	Youth Challenge of Connecticut, Inc.	111 North Sterling Road	Plainfield	06354	9 ILTTR	ILTTR
Youth Challenge Mission for Women	Youth Challenge of Connecticut, Inc.	32 Atwood Street	Hartford	06105	8 ILTTR	ILTTR
Youth Challenge of Connecticut, Inc.-Men's Residential Center	Youth Challenge of Connecticut, Inc.	15-17-19 May Street	Hartford	06105	15 ILTTR	ILTTR
Total of 199 sites licensed and 1,512 beds broken out as follows: ILTTR beds total 972, IT beds total 265, RDE beds total 147 and C&R beds total 128						

Source: DPH licensure files and e-licensure database as of August 2012

[a]ABBREVIATION KEY:

ACD = Ambulatory Chemical Detoxification
CMT - Chemical Maintenance Treatment
C&R = Care and Rehabilitation
DET = Day or Evening Treatment
ILTTR = Intermediate and Long Term Treatment and Rehabilitation
IT = Intensive Treatment
OT = Outpatient Treatment
RDE = Residential Detoxification and Evaluation

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

CSHH000034
08/09/13

EXHIBIT B

Payer Mix for the City of New Haven, FY 2012

(INPATIENT,NEWBORN)
2012

Discharges	MEDICARE	PRIVATE	Total Medicaid	CHAMPUS	CHARTER OAK	OTHER FED PROG	WORKERS COMI	UNINSURED	Total
06511	2,390	1,709	3,814	8	0	13	21	103	**8,058**
06513	1,943	1,012	2,751	13	0	8	25	56	**5,808**
06510	116	125	219	2	0	3	1	7	**473**
06515	631	580	836	4	2	4	7	9	**2,073**
06519	957	342	1,847	3	0	12	14	38	**3,213**
06531	0	2	0	0	0	0	0	0	**2**
06501	0	2	4	0	0	0	0	0	**6**
06530	0	2	0	0	0	0	0	0	**2**
06532	1	5	2	0	0	1	0	0	**9**
06504	17	9	84	0	0	0	0	3	**113**
06506	0	1	1	0	0	1	0	0	**3**
06503	2	0	0	0	0	0	0	0	**2**
06540	1	1	1	0	0	0	0	4	**7**
06521	0	2	2	0	0	0	0	0	**4**
06520	0	26	4	0	0	0	0	1	**31**
06505	2	1	12	0	0	0	0	0	**15**
06502	7	1	2	0	0	0	0	0	**10**
06534	2	0	0	0	0	0	0	0	**2**
06509	0	1	1	0	0	0	0	0	**2**
06533	0	0	0	0	0	0	0	0	**0**
06536	0	0	2	0	0	0	0	0	**2**
06535	0	0	0	0	0	0	0	0	**0**
06507	0	0	0	0	0	0	0	0	**0**
06508	5	0	0	0	0	0	0	0	**5**
06537	0	0	0	0	0	0	0	0	**0**
06538	0	0	0	0	0	0	0	0	**0**
NEW HAVEN	**6,074**	**3,821**	**9,582**	**30**	**2**	**42**	**68**	**221**	**19,840**

% of Total	MEDICARE	PRIVATE	Total Medicaid	CHAMPUS	CHARTER OAK	OTHER FED PROG	WORKERS COMI	UNINSURED	Total
06511	29.7%	21.2%	47.3%	0.1%	0.0%	0.2%	0.3%	1.3%	100.0%
06513	33.5%	17.4%	47.4%	0.2%	0.0%	0.1%	0.4%	1.0%	100.0%
06510	24.5%	26.4%	46.3%	0.4%	0.0%	0.6%	0.2%	1.5%	100.0%
06515	30.4%	28.0%	40.3%	0.2%	0.1%	0.2%	0.3%	0.4%	100.0%
06519	29.8%	10.6%	57.5%	0.1%	0.0%	0.4%	0.4%	1.2%	100.0%

CSHH000036
08/09/13

All Patients (Inpatient Newborn)
Source: Chime Online

Payer Mix for the City of New Haven, FY 2012

Discharges	MEDICARE	PRIVATE	Total Medicaid	CHAMPUS	CHARTER OAK	OTHER FED PROG	WORKERS COMI	UNINSURED	Total
06531	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06501	0.0%	33.3%	66.7%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06530	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06532	11.1%	55.6%	22.2%	0.0%	0.0%	11.1%	0.0%	0.0%	100.0%
06504	15.0%	8.0%	74.3%	0.0%	0.0%	0.0%	0.0%	2.7%	100.0%
06506	0.0%	33.3%	33.3%	0.0%	0.0%	33.3%	0.0%	0.0%	100.0%
06503	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06540	14.3%	14.3%	14.3%	0.0%	0.0%	0.0%	0.0%	57.1%	100.0%
06521	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06520	0.0%	83.9%	12.9%	0.0%	0.0%	0.0%	0.0%	3.2%	100.0%
06505	13.3%	6.7%	80.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06502	70.0%	10.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06534	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06509	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06533									
06536	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06535									
06507									
06508	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06537									
06538									
NEW HAVEN	**30.6%**	**19.3%**	**48.3%**	**0.2%**	**0.0%**	**0.2%**	**0.3%**	**1.1%**	**####**

CSHH000037
08/09/13

All Patients (Inpatient Newborn)
Source: Chime Online

City-Data.com FORUM

New Haven, Connecticut (CT) Zip Code Map - Locations, Demographics

Jump to a detailed profile or search site with Google Custom Search
City, County or Zip Code Find

Business Search - 14 Million verified businesses
Search for: near: Find

Back to: New Haven, CT, All U.S. Cities.

VA Home Loan Benefits $0 Down and Low Monthly Payments. Pre-Qualify Now in Just 2 Minutes! www.VAMortgageCenter.com
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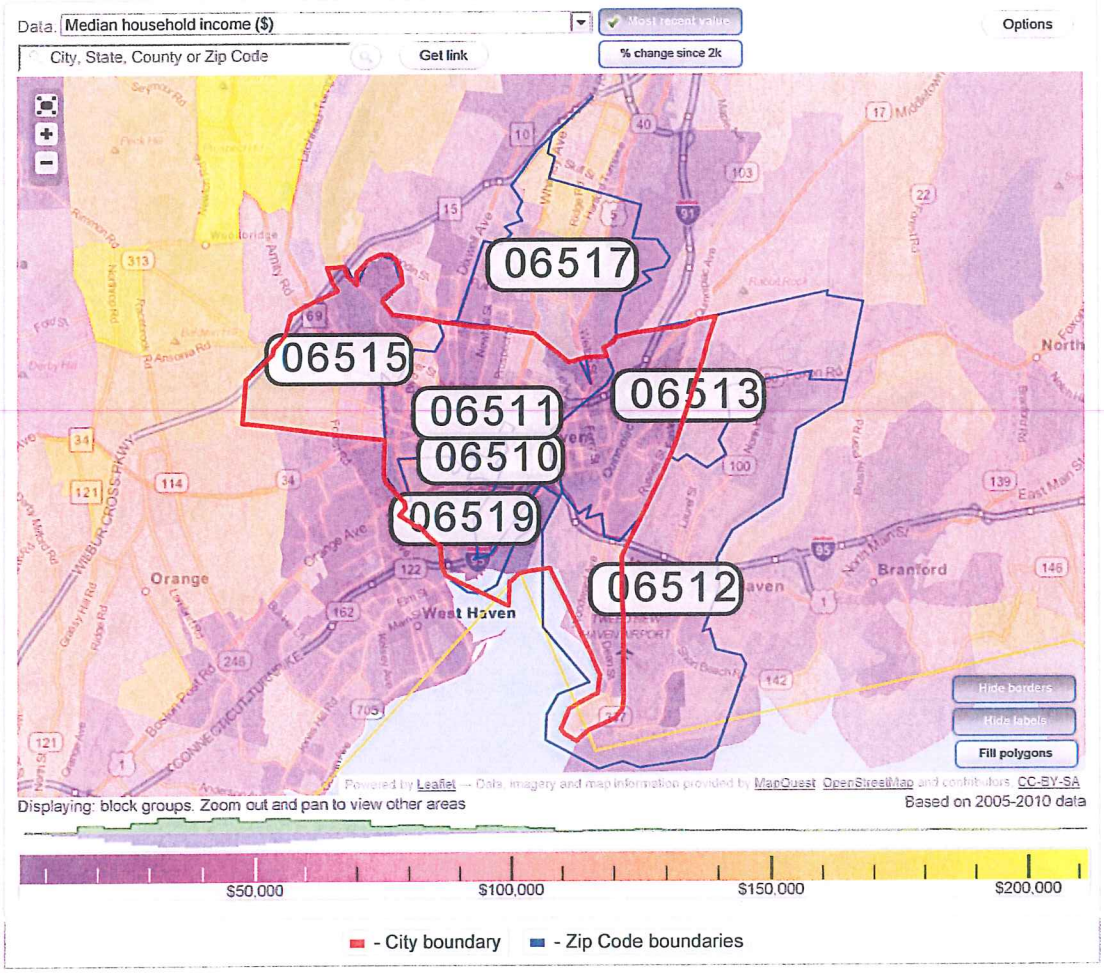

Zip codes: 06510, 06511, 06512, 06513, 06515, 06517, 06519.

Zip code 06510 statistics: (Find on map)

Estimated zip code population in 2010: 3,093

Land area: 0.3 sq. mi.
Water area: 0.0 sq. mi.
Population density: 10,692 people per square mile (high).

Males: 1,549 (50.1%)
Females: 1,542 (49.9%)

Zip code 06510 detailed profile

EXHIBIT C

Addiction Residential Census- August 6, 2013

Detox - 3.7													
	1	RNP	Bridgeport	Detox	Sara Smith	(203) 333-3518	-7	12	19	7	7		
	2	Cornell Sctt	New Haven	SCRC	Ben Metcalf	(203) 503-3300	6	26	19	2	1		
	2	Rushford	Middletown	Resid Detox	Tara Murphy	1-877-577-3233		16				No	16
	3	SCADD	New London	Resid Detox	Admiting Nurse	(860) 447-1717	2	20	15	4	1		
	3	Stonington	North Stoning	Resid Detox	Andrea Keeney	(860) 445-3000		16				No	16
	4	ADRC	Hartford	Resid Detox	Admitting Nurse	(860) 714-3700	8	35	27	7	7		
	5	MCCA	Danbury	Resid Detox	Ana Carvalho	(203) 792-4515X123	0	12	12	0	0		
							9	**137**	**92**				**32**
Intensive Res													
	1	CASA	Bridgeport	Intensive	Kremlin DeVissiere	(203) 339-4112	0	10	10	0	0		
	1	RNP	Bridgeport	Horizon	Sara Smith	(203) 333-3518	0	15	15	3	3		
	2	CVH	Middletown	Intens (Men)	Joann Chatfield	(800) 828-3396 x 5	10	60	51	2	3		
	2	CVH	Middletown	Intens (Women)	Joann Chatfield	(800) 828-3396 x 5	6	30	24	1	1		
	2	Rushford	Middletown	Intensive	Tara Murphy	1-877-577-3233		42				No	42
	3	CPAS	Putnam	Milestone	Michelle Blevin	(860) 928-1860		16				No	16
	4	ADRC	Hartford	SATEP ADRC	E. Navarro	(860) 714-3739	0	28	28	3	3		
	4	Blue Hills	Hartford	Intensive	Pat O'Brien	(860) 293-6415	4	21	14	4	1		
	4	Farrell	New Britain	Intensive	Ester Bryant	(860) 225-4641		24				No	24
	5	MCCA	Danbury	McDonough	Maureen Gorman	(203)792-4515	2	22	20	1	1		
	5	McCall	Torrington	Carnes Wks	Tracy Donahue	(860) 496-2107		20				No	20
							22	**288**	**162**				**102**

CSHH000040
08/09/13

CT Substance Abuse Facilities with Inpatient Beds*

FACILITY NAME	PROVIDER NAME	CITY	BEDS	BED DETAIL	WAIT TIME?**	ACCEPTS MEDICAID?**
LUXURY PROVIDERS						
High Watch Recovery Center	High Watch Recovery Center, Inc.	Kent	78	C&R	NO WAIT	NO
Silver Hill Hospital	Silver Hill Hospital	New Cannan	109	RDE, ILTTR	Few weeks	NO
Mountainside Treatment Center	MCI Healthcare LLC	Canaan	62+16****	RDE, ILTTR	NO WAIT	NO
OTHER 3.7 LEVEL PROVIDERS						
South Central Rehabilitation Center	Cornell Scott---Hill Health Corporation	New Haven	29	RDE, CMT, ACD	NO WAIT	YES
Rushford Center, Inc.	Rushford Center, Inc./Hartford Healthcare	Middletown	16	RDE, ILTTR	NO WAIT	YES
Stonington Institute ***	Stonington Behavioral Health, Inc.	North Stonington	16 RDE, 38 IT	RDE, IT	NO WAIT	YES
Connecticut Valley Hospital	Connecticut Valley Hospital	Middletown	110	RDE, ILTTR	Changes Daily	YES
Trinity Glen	Midwestern Connecticut Council on Alcoholism	Sharon	50	RDE, C&R	NO WAIT	YES
McDonough House	Midwestern Connecticut Council on Alcoholism, Inc.	Danbury	20	RDE, IT	Few weeks	YES
First Step	Recovery Network of Programs, Inc.	Bridgeport	19	RDE	NO WAIT	YES
Detoxification Center	Alcohol and Drug Recovery Centers, Inc.	Hartford	28	RDE, IT	Residential rehab one week; Detox beds are available	YES
Coventry House	Alcohol and Drug Recovery Centers, Inc.	Hartford	10	RDE, ILTTR	1 month	YES
Hallbrook	St. Vincent's Medical Center	Bridgeport	16	RDE	NO WAIT	YES
Community Health Resources	Community Health Resources	Putnam	6	RDE, ILTTR	2 months	YES
Altruism Acute Care and Evaluation	Dependency, Inc.	New London	20	RDE	NO WAIT	YES
Milestone/New Life Center/Pathways	Community Health Resources	Putnam	6	RDE, ILTTR	2 months	YES
OTHER INPATIENT SUBSTANCE ABUSE SERVICES						
Blue Sky Behavioral Health	Blue Sky Behavioral Health	Danbury	6	N/A	NO WAIT	NO
Clayton House	Alcohol and Drug Recovery Centers, Inc.	Glastonbury	15	ILTTR	60 days	YES
Horizons	Recovery Network of Programs, Inc.	Bridgeport	15	IT	Few days - few weeks	YES
Casa Eugenio Maria De Hostos	Chemical Abuse Services Agency, Inc.	Bridgeport	10	ILTTR	1-2 months, Spanish speaking only	YES
APT Residential Services	APT Foundation, Inc.	Bridgeport	125	ILTTR	N/A	YES
New Prospects	Recovery Network of Programs, Inc.	Bridgeport	23	IT	N/A	YES
Mother's Retreat and The Connection Counseling Center	Connection, Inc., The	Groton	8	ILTTR	2 months	N/A
Youth Challenge Mission for Women	Youth Challenge of Connecticut, Inc.	Hartford	8	ILTTR	N/A	N/A
Fresh Start	Community Renewal Team	Hartford	21	ILTTR	N/A	CSSD
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	Hartford	20	ILTTR	NO WAIT	YES
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	Hartford	15	ILTTR	NO WAIT	YES
Youth Challenge of Connecticut, Inc.---Men's Residential Center	Youth Challenge of Connecticut, Inc.	Hartford	15	ILTTR	NO WAIT	YSE
Lebanon Pines Long Term Care	Lebanon Pines Long Term Care	Lebanon	110	ILTTR	NO WAIT	YES
Hallie House Women and Children's Center	Connection, Inc., The	Middletown	8	ILTTR	N/A	N/A
Connection House	Connection, Inc., The	Middletown	14	ILTTR	N/A	YES
Farrell Treatment Center	Farrell Treatment Center, Inc.	New Britain	24	IT	2-3 weeks	YES
Crossroads, Inc.	Crossroads, Inc.	New Haven	174	ILTTR	2-3 weeks	YES
Elm City Women and Children's Center and The Connection Counseling Center	Connection, Inc., The	New Haven	15	ILTTR	A few months	CSSD
Altruism House for Women	Dependency, Inc.	New London	10	ILTTR	N/A	N/A
Altruism House for Women	Southeastern Council on Alcoholism and Drug	New London	11	ILTTR	NO WAIT	YES
Altruism House for Men	Dependency, Inc.	Norwich	13	ILTTR	One month	YES
Youth Challenge Bible Training Center	Youth Challenge of Connecticut, Inc.	Plainfield	9	ILTTR	NO WAIT	Yes
Liberation House	Liberation Programs, Inc.	Stamford	67	ILTTR	1 week	YES
Viewpoint Recovery Program	CTE, Inc.	Stamford	12	ILTTR	NO WAIT	YES
Families In Recovery Program	Liberation Programs, Inc.	Stamford	10	ILTTR	N/A	N/A
Carnes Weeks Center	McCall Foundation Inc.	Torrington	20	IT	1 week	YES
McCall House	McCall Foundation, Inc.	Torrington	14	ILTTR	N/A	YES
Renaissance East	Connecticut Renaissance, Inc.	Waterbury	32	ILTTR	1 months	YES
Renaissance West	Connecticut Renaissance, Inc.	Waterbury	50	ILTTR	N/A	N/A
Wellmore, Inc. Women and Children's Program	Wellmore, Inc.	Waterbury	8	ILTTR	NO WAIT	YES
Patrick F. Mcauliffe Center	Connecticut Renaissance, Inc.	Waterbury	20	IT	NO WAIT	YES
Reverend Edward M. Dempsey Drug Services	Central Naugatuck Valley HELP, Inc.	Waterbury	34	ILTTR	N/A	YES
Transitions Outpatient Services	Community Health Resources	Windham	14	ILTTR	Less than a week	YES
Perception House	Perception Programs, Inc.	Windham	20	ILTTR	CSSD- 3 months, but for Insurance 1.5 months	YES

*Source: Connecticut Statewide Health Care Facilities and Services Plan October 2012; page 280 .
**Information obtained via phone calls, and changes daily.
***Updated as of August 8, 2013.
****16 new detox beds per Docket No. 11-31734

CSHH000041
08/09/13

EXHIBIT D



House Bill No. 6705

Public Act No. 13-234

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HOUSING, HUMAN SERVICES AND PUBLIC HEALTH.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2013*) The Commissioner of Housing may appoint a Deputy Commissioner of Housing who shall be qualified by training and experience for the duties of the office of commissioner and shall, in the absence, disability or disqualification of the commissioner, perform all the functions and have all the powers and duties of said office. The position of the Deputy Commissioner of Housing shall be exempt from the classified service.

Sec. 2. (*Effective from passage*) (a) Wherever in sections 4-66h, 8-13m to 8-13s, inclusive, 8-13u to 8-13x, inclusive, and 12-170e of the general statutes the term "secretary" is used, the term "commissioner" shall be substituted in lieu thereof, and wherever the term "the Office of Policy and Management" is used, the term "Housing" shall be substituted in lieu thereof.

(b) Wherever the term "Economic and Community Development" is used in the following general statutes, the term "Housing" shall be substituted in lieu thereof: 4b-21, 7-392, 8-37v, 8-37w, 8-37y, 8-37aa, 8-

expenditures; (2) the process and factors to be used in determining each future year's assessment; and (3) the establishment of an appropriate notification process for the entities assessed under the account.

Sec. 144. Section 19a-639 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) In any deliberations involving a certificate of need application filed pursuant to section 19a-638, the office shall take into consideration and make written findings concerning each of the following guidelines and principles:

(1) Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;

(2) The relationship of the proposed project to the state-wide health care facilities and services plan;

(3) Whether there is a clear public need for the health care facility or services proposed by the applicant;

(4) Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;

(5) Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons, and (B) the impact upon the cost effectiveness of providing access to services provided under the Medicaid program;

(6) The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;

(7) Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;

(8) The utilization of existing health care facilities and health care services in the service area of the applicant; [and]

(9) Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities; and

(10) Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers.

(b) The office, as it deems necessary, may revise or supplement the guidelines and principles through regulation prescribed in subsection (a) of this section.

Sec. 145. Subsection (b) of section 19a-323 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(b) If death occurred in this state, the death certificate required by law shall be filed with the registrar of vital statistics for the town in which such person died, if known, or, if not known, for the town in which the body was found. The Chief Medical Examiner, Deputy Chief Medical Examiner, associate medical examiner, an authorized assistant

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 9th of August, 2013 to the following:

Peter Schorr
c/o Law Office of William P. Beccaro
12 New City Street
Essex, CT 06426
wbeccaro@snet.net

Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy, P.C.

MERITAS LAW FIRMS WORLDWIDE

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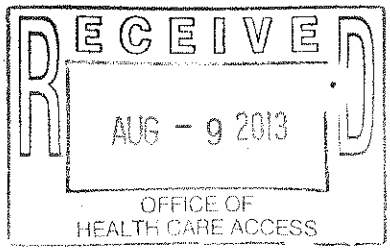
August 9, 2013



VIA HAND DELIVERY

Lisa A. Davis, M.B.A., B.S.N., R.N.
Deputy Commissioner
Office of Health Care Access
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: NR Connecticut, LLC d/b/a Retreat at South Connecticut
Establish a 105-Bed Residential Substance Abuse Treatment Facility in New Haven
Docket No. 13-31828-CON

Dear Deputy Commissioner Davis:

This office represents Yale-New Haven Hospital in connection with the above-referenced docket. Enclosed are an original and four (4) copies of the following:

- Notice of Appearance of Updike, Kelly & Spellacy, P.C.
- Petition of Yale-New Haven Hospital To Be Designated as an Intervenor With Full Rights Including Right of Cross-Examination
- Prefiled Testimony of William Sledge, M.D.

These documents are being submitted in connection with the public hearing on the above matter, scheduled for August 14, 2013 at 9:00 a.m. Dr. Sledge will be present at the hearing to adopt his prefiled testimony under oath and for cross-examination.

Should you require anything further, please feel free to call me at (203) 786-8316.

Very truly yours,

Jennifer Groves Fusco

Enclosures

cc: Nancy Rosenthal (*w/enc.*)
Stephen Merz (*w/enc.*)
William Sledge, M.D. (*w/enc.*)

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: CERTIFICATE OF NEED APPLICATION OF NR CONNECTICUT, LLC d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105 BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	)	DOCKET NO. 13-31828-CON
	)	AUGUST 9, 2013

NOTICE OF APPEARANCE

In accordance with Section 19a-9-28 of the Regulations of Connecticut State Agencies, please enter the appearance of Updike, Kelly & Spellacy, P.C. ("Firm") in the above-captioned proceeding on behalf of Yale-New Haven Hospital ("YNHH"). The Firm will appear and represent YNHH at the public hearing on this matter, scheduled for August 14, 2013.

Respectfully Submitted,

YALE-NEW HAVEN HOSPITAL

By: _____

JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.
265 Church Street
One Century Tower
New Haven, CT 06510
Tel: (203) 786-8300
Fax (203) 772-2037

CERTIFICATION

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Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy, P.C.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: CERTIFICATE OF NEED APPLICATION OF NR CONNECTICUT, LLC d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	)	DOCKET NO. 13-31828-CON
	)	AUGUST 9, 2013

PETITION OF YALE-NEW HAVEN HOSPITAL TO BE DESIGNATED AS AN INTEVENOR WITH FULL RIGHTS INCLUDING THE RIGHT OF CROSS-EXAMINATION

In accordance with Section 4-177a of the Connecticut General Statutes and Section 19a-9-27 of the Regulations of Connecticut State Agencies, Yale-New Haven Hospital ("YNHH"), located at 20 York Street, New Haven, CT 06510, hereby petitions the Office of Health Care Access Division of the Department of Public Health ("OHCA") to be designated as an intervenor with full rights, including the right of cross-examination, in the Certificate of Need ("CON") proceeding designated as Docket No. 13-31828-CON. This proceeding concerns the request of NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Retreat") for permission to establish a 105-bed substance abuse treatment facility in New Haven. The facility would include residential detoxification and evaluation, intensive treatment (rehabilitation), partial hospital, intensive outpatient and outpatient services. YNHH provides the PHP/IOP and other outpatient services being proposed by Retreat. YNHH will also serve as a downstream acute care provider for Retreat patients with mental health issues and medical complications. YNHH accepts most commercial insurance, as well as Medicare and

Medicaid, and provides services to the uninsured. As detailed herein and in the accompanying testimony of William Sledge, M.D., YNHH would be adversely impacted by the approval of a facility for which there is no clear public need and which will serve commercially insured and self-pay patients only. This proposal will also have a deleterious effect on the healthcare system in New Haven, and in particular on the acute care providers such as YNHH who will be required to provide care and treatment to the individuals Retreat brings into New Haven.

YNHH Programs & Services

YNHH is a 1,541 bed (including bassinets) teaching hospital with two integrated campuses in New Haven and a pediatric campus in Bridgeport. YNHH is affiliated with the Yale University School of Medicine, and includes the Yale-New Haven Psychiatric Hospital, the Yale-New Haven Children's Hospital, and the Smilow Cancer Hospital. YNHH is a member of the Yale-New Haven Health System. YNHH is the major provider of tertiary health services in the New Haven area, and serves as a major referral destination for acute inpatient psychiatric services, acute inpatient detoxification services, and outpatient psychiatric services.

YNHH has 118 inpatient beds dedicated to providing adult and adolescent psychiatric services, and between 60-70 percent of our patients that receive care have a dual diagnosis related to both a psychiatric issue and substance abuse. YNHH also has numerous general medicine beds that are used to provide acute detoxification services. The 118 psychiatric beds are typically full with no additional capacity. YNHH also provides psychiatric services in the emergency department, including a dedicated psychiatric crisis intervention unit at the York Street Campus and emergency

psychiatric consultation service offered at the Saint Raphael Campus. These services tend to run at capacity, and any additional acute care patients in need of urgent psychiatric services will likely strain the urgent care system. In the outpatient setting, YNHH provides Intensive Outpatient Program (IOP) and Partial Hospital Program (PHP) services for adults and adolescents at various locations within the greater New Haven area. These programs are effective and less costly alternatives to inpatient hospitalization and help patients recover and safely transition to the community. The adult PHP program has designated substance abuse tracks. Importantly, all of the IOP and PHP services have the capacity to serve additional patients, including substance abuse patients.

YNHH also provides outpatient psychiatric services, including group therapy and medication management, at the Continuing Care Clinic on the Saint Raphael Campus. Patients can step down from IOP and PHP by receiving outpatient services at the clinic in relapse prevention, psychotherapy, and group treatment for co-occurring disorders. There is capacity to provide these services to a greater number of patients.

The source of payment for these services includes Medicare, Medicaid, other governmental sources, commercial payers, and private-pay patients. Approximately 80 percent of the inpatient psychiatric services provided by YNHH are reimbursed by a governmental program. This figure also carries to the ambulatory psychiatric population, and the number of governmental payor patients will likely increase with the expansion of Medicaid and the exchanges under the Patient Protection and Affordable Care Act. YNHH provides psychiatry services to patients regardless of their ability to pay when patients enter the delivery system via the Emergency Department.

YNHH provides extensive benefits to the community including charity care, grants, scholarships, and educational services, and has partnered with several community organizations to ensure that patients transition successfully throughout the continuum of care. For example, YNHH is a member of the Community Services Network of Greater New Haven, a coordinating provider with the Local Mental Health Authority, and a partner agency to the South Central Consortium. YNHH is committed to working with its community partners to ensure access to care, including psychiatric services. YNHH is licensed as an acute care hospital by the Department of Public Health and accredited by the Joint Commission and is the largest provider of psychiatric services in Connecticut.

YNHH's Interests Will Be Adversely Affected by Approval of Retreat's CON Proposal

This CON proposal involves the establishment of a 105-bed residential substance abuse treatment facility in New Haven. If approved, this will be one of the largest freestanding facilities of its kind in the state. Retreat will offer an array of substance abuse services, including the PHP/IOP and outpatient services offered by YNHH. YNHH will also serve as a downstream acute care provider for Retreat patients with mental health issues and medical complications.

Retreat has not established a clear public need for a facility of this magnitude in Connecticut. Retreat bases need for the facility on the number of individuals in state who require, but do not seek substance abuse treatment services, as well as an informal survey that purports to show all other Level III.7 detoxification providers operating at capacity. Retreat's arguments are flawed. As YNHH will demonstrate in its testimony, there are many facilities in Connecticut that can accommodate patients without any wait, despite Retreat's assertions to the contrary. Where capacity

may be lacking for a New Haven-based facility is in programs and services that are available to all patients, including Medicare and Medicaid recipients and the uninsured. This is not the model that Retreat is proposing. YNHH believes that OHCA should focus growth in behavioral health services on programs that are available to all individuals regardless of payer source, rather than approving exclusionary facilities that create two tiers of care and do not meet the needs of area and state residents.

In addition, Retreat has made no effort to coordinate with local providers, in particular acute care facilities such as YNHH, regarding the care and treatment of substance abuse patients who have co-occurring mental health disorders or medical complications. Retreat has not approached YNHH or any other hospital to the best of our knowledge, about the necessary transfer agreement for these types of services. If Retreat had spoken with YNHH, they would likely have been told that the hospital is operating at capacity for inpatient mental health services and that the influx of patients from Retreat will have a significant deleterious effect on an already overwhelmed system. This in turn will limit access to services for those who need them, including the many Medicaid recipients and indigent patients residing in and around New Haven.

Moreover, because Retreat has not shown a clear public need for the proposed facility, the patients required to meet its projections will have to come from existing providers, including YNHH. Retreat claims that it has a referral network in Connecticut and the surrounding states, and will share the referral network associated with its sister facility in Pennsylvania, which will generate sufficient patients to populate the Connecticut facility without impacting existing providers (CON Application, p. 669). However, Retreat has provided only a handful of letters of support for this proposal. None

of these letters of support are from providers that are based in or proximate to New Haven. In addition, Retreat's submissions show that Connecticut residents (at whom this facility is presumably targeted) make up less than one percent (12 of 2,206) of admissions to Retreat's Pennsylvania facility.

In addition, Retreat has made it clear that it will accept commercially insured and self-pay patients only, and will not offer services to Medicare or Medicaid recipients (CON Application pp. 35 & 704). Retreat claims that it will generate higher revenues per bed than its competitors through an extensive referral program that focuses on high-end, private pay (i.e. non-Medicare and/or Medicaid) patients (CON Application, p. 527). This means that the patients diverted from YNHH and other facilities will be those who generate the highest revenues, leaving existing providers to serve the most vulnerable patients, including Medicare and Medicaid recipients and the uninsured, with less money to cover the cost of providing services. The magnitude of payments from these private sources is substantially greater than payments from public sources (i.e., Medicare or Medicaid) for comparable services, and thus contributes significantly to the financial sustainability of these programs. Diminution of private sector payments would adversely impact YNHH's overall financial performance and ability to provide access for New Haven's most vulnerable populations.

Summary of Evidence to Be Presented, Manner of Participation and Relief Sought

YNHH will ask OHCA to deny Retreat's request for permission to establish a substance abuse treatment facility in New Haven. There is no clear public need for the services being proposed. Conn. Gen. Stat. §19a-639(3). This facility will result in the unnecessary duplication of services and

it will adversely impact YNHH and other existing providers. Conn. Gen. Stat. §19a-639(9). This will be shown through the presentation of capacity and utilization data, as well as other relevant evidence. The proposal will also decrease the cost-effectiveness and financial feasibility of care by skimming those patients who generate the most revenue from existing providers. Conn. Gen. Stat. §§19a-639(4) & (5). This in turn could have an adverse impact on the quality and accessibility of care provided by YNHH and others. Conn. Gen. Stat. §19a-639(5).

In addition, YNHH will introduce evidence of Retreat's failure to engage in discussions with local providers regarding the coordination of care. Most notably, Retreat has failed to discuss options for acute care with YNHH or any hospital, or to make arrangements for a transfer agreement for its patients. The inevitable consequences of this include adverse financial impact on these providers and impaired access to care.

Moreover, Retreat cannot show any reason why a facility that does nothing to enhance access for Medicaid patients, and in fact causes financial harm to those who care for these patients, should be approved. Approval of such a proposal would be contrary to the intent of soon-to-be-implemented changes to the CON statutory decision criteria aimed at improving Medicaid access. *See* P.A. 13-234. YNHH will present evidence in support of its payer mix and the impact that Retreat's proposal to attract commercially insured and self-pay patients would have on its bottom line.

If YNHH is granted status, it intends to present this and other evidence and legal arguments in support of its positions. YNHH respectfully requests that it be allowed to submit written testimony, present evidence and arguments at the August 14, 2013 public hearing on this matter, cross-examine witnesses, and inspect and copy records pertaining to the proceeding. YNHH's participation will

furnish assistance to OHCA in determining whether there is a need for this proposal and what its impact will be on existing providers. YNHH has information directly relevant to Retreat's erroneous claims in this regard, which will be presented at the hearing. In addition, YNHH's participation is in the interest of justice and will not impair the orderly conduct of these proceedings.

WHEREFORE, for the foregoing reasons, YNHH respectfully requests its Petition to be Designated as an Intervenor With Full Rights be granted.

Respectfully Submitted,

YALE-NEW HAVEN HOSPITAL

By: _____

JENNIFER GROVES FUSCO, ESQ.
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: CERTIFICATE OF NEED APPLICATION OF NR CONNECTICUT, LLC d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	)	DOCKET NO. 13-31828-CON
	)	AUGUST 9, 2013

PREFILED TESTIMONY OF
WILLIAM SLEDGE, M.D.

Good morning Hearing Officer Hansted and members of the OHCA staff. My name is William Sledge, M.D. and I am the George and Esther Gross Professor of Psychiatry at the Yale University School of Medicine, and the Medical Director at the Yale-New Haven Psychiatric Hospital operated by the Yale-New Haven Hospital ("YNHH"). Thank you for this opportunity to speak in opposition to the CON Application filed by NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Retreat") for permission to establish a 105-bed substance abuse treatment facility in New Haven. This facility is intended for the treatment of commercially insured and self-pay patients only, and will not be available to those individuals covered by Medicare and Medicaid, or to the uninsured who cannot afford the facility's self-pay rates. My remarks today will focus on the significant adverse impact that a facility of this type and size, for which there is no clear public need, will have on existing providers like YNHH and on the healthcare delivery system in New Haven. The proposed facility will be of little benefit to New Haven residents, while at the same time taxing

the resources of acute care providers who are already struggling to meet the area's behavioral health and medical needs. For the reasons set forth in this testimony, YNHH urges OHCA to deny Retreat's CON request.

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Program (IOP) and Partial Hospital Program (PHP) services for adults and adolescents at various locations within the greater New Haven area. These programs are effective and less costly alternatives to inpatient hospitalization and help patients recover and safely transition to the community. The adult PHP program has designated substance abuse tracks. Importantly, all of the IOP and PHP services have the capacity to serve additional patients, including substance abuse patients.

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The source of payment for these services includes Medicare, Medicaid, other governmental sources, commercial payers, and private-pay patients. Approximately 80 percent of the inpatient psychiatric services provided by YNHH are reimbursed by a governmental program. This figure also carries to the ambulatory psychiatric population, and the number of governmental payor patients will likely increase with the expansion of Medicaid and the exchanges under the Patient Protection and Affordable Care Act. YNHH provides psychiatry services to patients regardless of their ability to pay when patients enter the delivery system via the Emergency Department.

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Nature of Retreat's Proposal

This CON proposal involves the establishment of a 105-bed residential substance abuse treatment facility in New Haven. If approved, this will be one of the largest freestanding facilities of its kind in the state (see Statewide Health Care Facilities & Services Plan, Table 20, attached as Exhibit A). Retreat will offer an array of substance abuse services, including the PHP/IOP and other outpatient services offered by YNHH.

The Retreat facility will be located in a former skilled nursing facility on Ella T. Grasso Boulevard in New Haven. Despite its urban placement, Retreat will cater to commercially insured and self-pay patients only. The facility will not admit Medicare, Medicaid or other governmentally insured patients, many of whom reside in and around major cities such as New Haven. Patients insured under Medicare, Medicaid, CHAMPUS and other federal programs, as well as the uninsured, account for nearly 80 percent of all inpatient/newborn discharges in New Haven for FY 2012. These same patients account for almost 90 percent of discharges in the 06519 ZIP code, which roughly covers the Dwight/West-River neighborhood where the Retreat facility will be located (see Exhibit B attached). Nor will the facility be affordable for the area's uninsured population, given that the full

per diem rate for residential services is approximately $1,500 to $1,700 per day (CON Application, p. 656).

In addition, Retreat has made no effort to arrange for a transfer agreement with an acute care facility or to otherwise coordinate with local providers, a requirement of providers offering the level of services proposed by the Retreat.

There Is No Clear Public Need for a Commercial Insurance/Self-Pay Only Substance Abuse Treatment Facility in New Haven

Retreat has not established a clear public need for a 105-bed "luxury" substance abuse treatment facility in New Haven that will serve commercially insured and self-pay patients only, to the exclusion of Medicare and Medicaid recipients and the uninsured.

There is Ample Available Residential Detoxification & Evaluation & Rehabilitation Capacity for New Haven Area Residents

Despite Retreat's claim that need for a residential facility of this magnitude in Connecticut is "firmly established," it is YNHH's understanding that there is RDE and Rehabilitation capacity in the state and neither our facility nor the physicians with whom we coordinate (some of whom have written letters in opposition to this CON proposal) have encountered difficulty in finding available RDE or Rehabilitation beds for our commercially insured patients (as compared with Medicaid and low-income patients, who are difficult to place at both levels of service) (CON Application, p. 667).[1]

[1] Note that most commercial insurers will not authorize Rehabilitation Services as a step-down from RDE, but rather authorize these patients for PHP/IOP stays initially. In the event that a Rehabilitation stay is authorized by a commercial insurer, it is typically for a dually diagnosed patient (which Retreat does not appear equipped to handle) and the stay authorized prior to transition to PHP/IOP is short (5-7 days). This does not support Retreat's projection that 100 percent of its RDE patients will step down to Rehabilitation for an extended stay (16.5 days) (CON Application, p. 682).

Examples of RDE/Rehabilitation facilities in our area that typically have same-day availability (subject to pre-admission screening) include APT Foundation in New Haven, Silver Hill in New Canaan and Rushford Center in Middletown. Other RDE/Rehabilitation providers located slightly farther from New Haven, several of which are represented in this room today, likely have capacity for commercially insured patients as well. We find that for residential substance abuse services, the fact that a facility is located some distance from a patient's home is not typically an impediment to placement. As Retreat points out, substance abuse treatment facilities in Connecticut draw patients from across the state and Northeast region (CON Application, p. 27). In fact, many patients prefer to receive these privacy sensitive services at locations outside of their communities (CON Application, p. 27).

An Addiction Residential Census Report from the Department of Mental Health and Addiction Services ("DMHAS") is attached as Exhibit C. The information for this report is provided by grant-funded facilities, as well as other providers who choose to report through the DMHAS portal. It is not a complete list of available beds due to the exclusion of providers who are not grant-funded and the fact that certain facilities do not report on a daily basis, or report after this document has been published. Therefore, in all likelihood it underestimates available capacity. Nevertheless, the report for August 6, 2013 shows that there were at least 9 Level III.7 RDE beds and 22 Rehabilitation beds available for patients. This contradicts Retreat's claim that there is no available capacity for these services in the state.

Also attached as Exhibit C are the results of an informal telephone survey conducted by YNHH of the capacity of existing RDE and Rehabilitation providers. As you can see from this

survey, RDE facilities including South Central Rehabilitation Center, Rushford Center, Stonington Institute, Trinity Glen, First Step, Hallbrook and Altruism Acute Care and Evaluation have no wait for beds. In addition, Mountainside Treatment Center recently received approval to establish 16 RDE beds. These beds are under construction and will be open within the next 6 months. Similarly, there are Rehabilitation beds available with no wait at Stonington Institute and the Patrick F. McAuliffe Center.

Moreover, clear public need does not mean providing citizens with the option of choosing a local or regional "exclusionary" facility that excludes certain members of the population based on wealth or insurance coverage. In fact, OHCA has not historically considered citizens' preferences for a particular type of facility, including a "luxury" facility, in determining whether real need exists and hence a CON should be awarded. This is true notwithstanding the nature of the facility or services requested.

The Retreat Facility Will Not Meet the Needs of New Haven Area Residents or the Objectives of Recent OHCA Legislation

By locating its facility in New Haven, Retreat has implied a commitment to meet the needs of New Haven area residents. However, the need in New Haven is not for additional "luxury" substance abuse capacity for commercially insured and self-pay patients, as Retreat proposes. Rather, the New Haven community requires additional capacity to serve the substance abuse and mental health treatment needs of Medicaid recipients and indigent individuals in our community. According to CHIME data, approximately 80 percent of New Haven's residents, and approximately 90 percent of residents in the 06519 ZIP code (which includes the Dwight/West-River neighborhood where the

proposed facility will be located), receive some form of governmental insurance or are uninsured (see Exhibit B attached). These estimates are conservative and will likely increase as a result of healthcare reform and enhanced access to Medicaid. Retreat has chosen to locate its "luxury" facility in an urban neighborhood that is home to many of these individuals who, due to the exclusionary nature of the facility, will not be able to benefit from its services. In addition, the cost for self-pay services at Retreat makes it unavailable for all but the wealthiest individuals, which does not describe a majority of those in and around New Haven with substance abuse and mental health issues.

Even if there were a need for more residential substance abuse treatment capacity for commercially insured and wealthy individuals in New Haven (which is not the case), the recent focus on ensuring and expanding access for Medicaid and indigent patients means that any new facility should be inclusive of all patients, regardless of payer source. Retreat cannot show any reason why a facility that does nothing to enhance access for Medicaid recipients, and in fact causes financial harm to those who care for these individuals, should be approved.

Approval of such a proposal would be contrary to recent changes in the CON statutory decision criteria aimed at improving Medicaid access. Public Act No. 13-234, which takes effect October 1, 2013, amends Section 19a-639 of the Connecticut General Statutes to include a requirement that an applicant for a CON demonstrate (1) how the provision of, or any change in access to, services for Medicaid recipients and indigent persons improves the quality, accessibility and cost-effectiveness of healthcare in the region; (2) how the proposal will impact the cost-effectiveness of providing access to services under the Medicaid program; (3) an applicant's past and proposed provision of healthcare services to relevant populations and payer mix, including access to

services by Medicaid recipients and indigent persons; and (4) whether an applicant, who has failed to provide access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which may not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other healthcare payers (see Exhibit D attached).

Retreat has stated its intention to exclude Medicare and Medicaid patients from its facility (CON Application, p. 704). It has shown no justification for this approach other than the fact that commercially insured and self-pay patients generate higher revenues, which will give Retreat an advantage over its competitors, who will continue to treat governmentally insured individuals regardless of the financial impact on their bottom lines (CON Application, p. 527). This proposal violates both the letter and the spirit of the new law.

Retreat Will Adversely Impact the New Haven Healthcare System & Existing Providers

This proposal will have an adverse impact on the New Haven healthcare system by taxing the area's already overwhelmed acute care providers with dually diagnosed and medically complicated patients from Retreat. This is true regardless of whether Retreat accepts Medicare and Medicaid patients, because it results from the number of patients that the facility will bring into New Haven, irrespective of payer source. It will also adversely impact existing providers of the services being proposed by Retreat, by attracting the higher-paying commercial and self-pay patients whose revenues help to support our operations.

Impact on the New Haven Healthcare System

Retreat is proposing a facility that provides exclusively substance abuse treatment services and has failed to take into account the fact that approximately 60 to 70 percent of substance abuse patients also suffer from a co-occurring mental health disorder. Retreat is not equipped, and does not appear to have any plan for diagnosing and treating the mental health issues of the patients it brings into New Haven. While Retreat may claim that it will prescreen for mental health issues and refuse these patients, this is not an effective approach because mental health issues often go unreported or undiagnosed until after a patient has completed detoxification. In addition, many RDE patients have medical complications that require treatment in an acute care setting. Again, there is nothing in the CON submissions that indicates how Retreat intends to handle medically complicated patients.

The reality is that substance abuse patients with co-occurring mental health disorders and medical complications often require follow-up care in an acute setting. Because YNHH is the acute care hospital in New Haven, we must assume that this is where Retreat's patients will be directed. Despite this fact, Retreat has made no effort to contact YNHH and arrange for a transfer agreement (which would have to be in place prior to the commencement of services at Retreat) or otherwise discuss coordination of care. In fact, we are not aware of any conversations that Retreat has had with local providers regarding the proposed facility and the impact that it will have on the New Haven healthcare community. This is true notwithstanding the fact that Retreat has begun construction on the facility in anticipation of an approval and had meetings with some local elected officials to garner support for the proposal.

Transfer agreements and coordination of care are critical to the proper functioning of our healthcare system. Care must be managed such that patients receive the services they require without impacting the ability of others in the community to obtain the same services. If Retreat had reached out to YNHH, they would likely have been told that the hospital is operating at capacity for inpatient mental health services. All beds are full on a regular basis and patients are receiving services in the Emergency Department. YNHH has a finite amount of capacity and if patients are transferred from Retreat to YNHH or seek treatment at YNHH after discharge, they will overwhelm an already overburdened community behavioral health and medical services provider and reduce access to services for Medicaid recipients and the uninsured in the New Haven area, particularly urgent care services in the Emergency Department and aftercare services and residential housing post-treatment. Notably, these are patients who, but for receiving services at Retreat, would likely not be in the New Haven area and accessing services through the hospital.

This inevitable influx of patients will have a deleterious effect on local acute care providers not only from a resources perspective, but from a financial perspective as well. Commercial behavioral health benefits are typically very limited – meaning they authorize less services and shorter stays than most medical insurances. As a result, many of Retreat's patients may have exhausted their benefits by the time they present at YNHH and will be unable to pay for care. This in turn will result in financial harm to the hospital, which may further limit access to care for those individuals who live in and around New Haven, who have Medicaid or are uninsured, and who rely on the hospital for services. This type of negative impact on the strength of the New Haven healthcare system is contrary to the intention of the CON statutes.

Impact on Existing Providers

Retreat has not shown that it can fill 105 substance abuse treatment beds with commercially insured and self-pay patients without attracting patients from existing providers. The only referral network that Retreat has been able to demonstrate includes a handful of clinicians (from outside of the New Haven market) and several employee assistance programs (CON Application, pp. 670-674). By Retreat's own admission, clinicians are not a high-volume referral source for residential substance abuse facilities, accounting for only 2 percent of admissions to its Pennsylvania facility (CON Application, p. 706). Retreat claims that it will draw 75 percent of its admissions from Connecticut however the lack of Connecticut referral sources makes this unlikely without impact to existing providers in the state (CON Application, p. 669). Retreat also claims that it will share the existing referral network of its sister facility in Lancaster, Pennsylvania (CON Application, p. 669). However, given that only 12 of Retreat at Lancaster County's 2,206 patients (.05%) in FY 2012 were Connecticut residents, it is difficult to imagine how this referral network will assist Retreat at South Connecticut in meeting its goal (CON Application, p. 686).[2] Retreat's projections are simply too ambitious to meet without an established referral network, and Retreat does not have an established referral network for Connecticut.

Because Retreat has not shown a clear public need for the proposed facility, the patients required to meet its projections and to fill a significant number of detoxification and rehabilitation

[2] Retreat claims that there is a need for the proposed facility in New Haven so that patients from the area are not burdened by travel, which can increase the cost of care and preclude family members from actively participating in a patient's care (CON Application, p. 38). However, the statistics cited in this paragraph make it clear that Retreat sought out and treated patients from Connecticut at its Pennsylvania facility. These individuals likely traveled more than 4 hours to Lancaster County for services. If Retreat likewise intends to populate the Connecticut facility with out-of-state residents, then this proposal is not serving the needs of the residents of our state.

beds will have to come from existing providers. In addition, Retreat has made it clear that it will accept commercially insured and self-pay patients only, and will not offer services to Medicare or Medicaid recipients (CON Application pp. 35 & 704). Retreat claims that it will generate higher revenues per bed than its competitors through an extensive referral program that focuses on high-end, private pay (i.e., non-Medicare and/or Medicaid) patients (CON Application, p. 527). This means that the patients diverted from existing providers will be those who generate the highest revenues, leaving existing providers to serve the most vulnerable patients, including Medicare and Medicaid recipients and the uninsured, with less money to cover the cost of providing services.

Approximately 80 percent of YNHH inpatient and PHP/IOP patients are governmentally insured or low-income uninsured. Only 20 percent are commercially insured or the self-pay clients being targeted by Retreat. However, the magnitude of payments from these private sources is substantially greater than payments from public sources (i.e., Medicare or Medicaid) for comparable services, and thus contributes significantly to the financial sustainability of these programs. Diminution of private sector payments would adversely impact YNHH's overall financial performance and our ability to provide access for New Haven's most vulnerable populations.

Conclusion

Retreat is proposing to establish one of the largest freestanding substance abuse treatment facilities in Connecticut. Retreat has not shown a clear public need for this facility, and in fact it will duplicate the services of many existing freestanding substance abuse treatment facilities. Conn. Gen. Stat. §§19a-639(3) & (9). Retreat's projections are flawed and it does not have the support or referral

network necessary to populate a 105-bed facility without impacting existing providers. If this project is approved, Retreat will syphon the commercially insured and self-pay patients from existing facilities, which will have a significant adverse financial impact on these facilities. This could in turn affect the quality, accessibility and cost-effectiveness of healthcare in the New Haven community. Conn. Gen. Stat. §19a-639(5).

In addition, Retreat has made no effort to establish relationships with local providers including acute care providers, who will be required to treat the many dually diagnosed and medically complicated patients that Retreat brings into New Haven. Retreat does not have a transfer agreement in place and has not had any discussions about such an agreement with the acute care hospital in New Haven, YNHH. This proposal will inevitably place additional burdens on the YNHH and New Haven healthcare systems as a result of the treatment needs of Retreat's patients. This will adversely impact access to care and, ultimately, the financial strength of the healthcare system. Conn. Gen. Stat. §19a-639(4).

In this time of expanded access to healthcare for all, particularly Medicaid recipients and indigent persons, OHCA should not approve a facility that has no intention of treating these individuals and that will negatively impact the facilities that do. The proposal is also inconsistent with the aims of federal healthcare reform, including the goals of reducing costs and making services more widely available to larger segments of the population. Also, there is no community benefit to a substance abuse treatment facility in New Haven that cannot serve a large percentage of New Haven residents because of its exclusionary payment policies. The facility would be unavailable to those

who need it most – the Medicaid recipients and indigent individuals who receive care at YNHH and other local non-profit providers.

Even if Retreat were to change its model and accept all patients regardless of payer source, including Medicaid, this proposal still should not be approved due to several significant issues, including overburdening existing providers without assessing current capacity of the downstream services that will be required for Retreat's patients. Retreat's submissions simply do not establish that the proposal is consistent with the statutory decision criteria for CONs set forth in Section 19a-639 of the General Statutes. This includes, most notably, the lack of clear public need for the Retreat at South Connecticut and Retreat's failure to implement an acute care transfer process to address the needs of the dually diagnosed and medically complicated individuals from out of town that Retreat will bring into New Haven. Nor will the proposal increase access to residential services for the New Haven community – instead access will be diminished through use of the finite resources of acute care providers. Retreat has also failed to investigate capacity for transitional care in the community (of which there is very little) for out-of-town patients who choose to stay with Retreat for outpatient care after their residential stays are complete. These problems exist no matter which payers Retreat agrees to accept, and they support denial of this CON application. And lastly, it would be easy for Retreat to agree to accept Medicaid, but then de facto exclude all but commercially insured and self-pay patients through its admissions process.

For these reasons, YNHH respectfully request that OHCA deny Retreat's CON request. I thank you for your time and am available to answer any questions you may have.

Respectfully Submitted,

WILLIAM SLEDGE, M.D.
YALE-NEW HAVEN HOSPITAL

EXHIBIT A

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Access Center	APT Foundation, Inc.	1 Long Wharf	New Haven	06511	0	ACD, CMT, OT,
ADRC Outpatient Counseling Center	Alcohol and Drug Recovery Centers, Inc.	16 Coventry Street	Hartford	06112	0	OT
Adult Psychiatric Clinic/Child and Family Guidance Clinic	Cornell Scott-Hill Health Corporation	400 - 428 Columbus Avenue	New Haven	06519	0	OT
Altruism Acute Care and Evaluation	Southeastern Council on Alcoholism and Drug Dependency, Inc.	47 Coit Street	New London	06320	20 RDE	OT, RDE
Altruism House for Men	Southeastern Council on Alcoholism and Drug Dependency, Inc.	313 Main Street	Norwich	06360	13 ILTTR	ILTTR
Altruism House for Women	Southeastern Council on Alcoholism and Drug Dependency, Inc.	1000 Bank Street	New London	06320	10 ILTTR	ILTTR
Altruism House for Women	Southeastern Council on Alcoholism and Drug Dependency, Inc.	62-64 Coit Street	New London	06320	11 ILTTR	ILTTR
Angelus House	Wellspring Foundation, Inc.	158 Flanders Road	Bethlehem	06751	0	OT
Ansonia Counseling Services	Cornell Scott-Hill Health Corporation	121 Wakelee Avenue	Ansonia	06401	0	OT
APT Residential Services	APT Foundation, Inc.	425 Grant Street	Bridgeport	06608	125 ILTTR	ILTTR, OT
Behavioral Health Services at Hamden	Yale University	95 Circular Drive	Hamden	06514	0	OT
Bhcare Valley Outpatient Clinic	BHcare, Inc.	435 East Main Street	Ansonia	06401	0	OT
Bhcare, Inc.-Shoreline Clinic	BHcare, Inc.	14 Sycamore Way	Branford	06405	0	OT
Blue Sky Behavioral Health Clinic	Blue Sky Behavioral Health, LLC	52 Federal Road	Danbury	06810	0	CMT, DET, OT
Bridges ... A Community Support System, Inc.	Bridges ... A Community Support System, Inc.	949 Bridgeport Avenue	Milford	06460	0	OT
Bridges ... A Community Support System, Inc.	Bridges ... A Community Support System, Inc.	270 Center Street	West Haven	06516	0	OT
Carnes Weeks Center	McCall Foundation Inc.	58b High Street	Torrington	06790	20 IT	IT
Casa Eugenio Maria De Hostos	Chemical Abuse Services Agency, Inc.	690 Arctic Street	Bridgeport	06608	10 IT, 6 ILTTR	DET, ILTTR, IT, OT
Catholic Charities	Catholic Charities Diocese of Norwich, Inc.	28 Huntington Street	New London	06320	0	OT
Catholic Charities, Diocese of Norwich, Inc.	Catholic Charities Diocese of Norwich, Inc.	331 Main Street	Norwich	06360	0	OT
Catholic Charities, Diocese of Norwich, Inc.	Catholic Charities Diocese of Norwich, Inc.	151 Broad Street	Middletown	06457	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	90 Franklin Square	New Britain	06051	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	205 Wakelee Avenue	Ansonia	06401	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	203 High Street	Milford	06460	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	501 Lombard Street	New Haven	06513	0	OT

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	56 Church Street	Waterbury	06702	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	13 Wolcott Street	Waterbury	06705	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	132 Grove Street	Torrington	06790	0	OT
Center for Human Services	Recovery Network of Programs, Inc.	2 Research Drive	Stratford	06615	0	OT
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	164 - 166 Bartholomew Street	Hartford	06106	20 ILTTR	ILTTR
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	33 Center Street	Hartford	06106	15 ILTTR	ILTTR
Child and Family Agency of Southeastern Connecticut, Inc. Child Guidance Clinic Essex	Child and Family Agency of Southeastern Connecticut, Inc.	190 Westbrook Road	Essex	06426	0	OT
Child and Family Agency of Southeastern Connecticut, Inc. Groton/Mystic Campus	Child and Family Agency of Southeastern Connecticut, Inc.	591 Poquonnock Road	Groton	06340	0	OT
Child and Family Agency of Southeastern Connecticut, Inc. Smith Bent Children's Center	Child and Family Agency of Southeastern Connecticut, Inc.	7 Vauxhall Street	New London	06320	0	OT
Child and Family Guidance Center, Inc.	Child and Family Guidance Center, Inc.	180 Fairfield Avenue	Bridgeport	06604	0	OT
Child Guidance Clinic for Central Connecticut, Inc.	Child Guidance Clinic for Central Connecticut, Inc.	384 Pratt Street	Meriden	06451	0	OT
Children's Center of Hamden, Inc.	Children's Center of Hamden Inc.	1400 Whitney Avenue	Hamden	06517	0	OT
CHR Manchester	Community Health Resources	587 East Middle Turnpike	Manchester	06040	0	OT
Clayton House	Alcohol and Drug Recovery Centers, Inc.	203 Williams Street	Glastonbury	06033	15 ILTTR	ILTTR
Community Child Guidance Clinic, Inc.	Community Child Guidance Clinic, Inc.	317 North Main Street	Manchester	06042	0	OT
Community Health Center of Wherever You Are Friendship Services Center	Community Health Center, Inc.	241-249 Arch Street	New Britain	06051	0	OT
Community Health Center of Wherever You Are Master's Manna	Community Health Center, Inc.	46 North Plains Industrial Road	Wallingford	06492	0	OT
Community Health Center of Wherever You Are Prudence Crandall	Community Health Center, Inc.	594 Burritt Street	New Britain	06053	0	OT
Community Health Services, Inc.	Community Health Services Inc.	500 Albany Avenue	Hartford	06120	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	81 North Main Street	Bristol	06010	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	26 Russell Street	New Britain	06052	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	5 Hart Street	New Britain	06052	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	55 Winthrop Street	New Britain	06052	0	OT
Community Renewal Team Asian Family Services	Community Renewal Team	1921 Park Street	Hartford	06106	0	OT
Community Renewal Team, Inc. Behavioral Health Services	Community Renewal Team	90 Retreat Avenue	Hartford	06106	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Community Renewal Team, Inc. Behavioral Health Services	Community Renewal Team	330 Market Street	Hartford	06120	0	OT, DET
Community Renewal Team, Inc. Behavioral Health Services	Community Renewal Team	35 Clark Street	Hartford	06120	0	OT, DET
Community Residences, Inc.	Community Residences, Inc.	205 Kelsey Street	Newington	06111	0	OT
Community Substance Abuse Center, Inc.	Community Substance Abuse Centers, Inc.	55 Fishfry Street	Hartford	06120	0	ACD, CMT, OT
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	4 Midland Road	Waterbury	06705	0	ACD, CMT, DET, OT
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	60 Beaver Brook Road	Danbury	06810	0	ACD, CMT, OT
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	20 North Main Street	Norwalk	06854	0	ACD, CMT, OT
Connecticut Junior Republic	Connecticut Junior Republic Association, Inc.	80 Prospect Street	Waterbury	06702	0	OT
Connecticut Junior Republic	Connecticut Junior Republic Association, Inc.	550 Goshen Road	Litchfield	06759	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	1120 Main Street	Bridgeport	06604	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	1 Lafayette Circle	Bridgeport	06604	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	115 Middle Street	Bridgeport	06604	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	17 High Street	Norwalk	06851	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	4 Byington Place	Norwalk	06852	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	141 Franklin Street	Stamford	06901	0	OT
Connection Counseling Center, The	Connection, Inc., The	178 State Street	Meriden	06450	0	OT
Connection Counseling Center, The	Connection, Inc., The	196 Court Street	Middletown	06457	0	OT
Connection Counseling Center, The	Connection, Inc., The	263 Main Street	Old Saybrook	06475	0	OT
Connection House	Connection, Inc., The	167 Liberty Street	Middletown	06457	14 ILTTR	ILTTR
Coventry House	Alcohol and Drug Recovery Centers, Inc.	46 Coventry Street	Hartford	06112	10 ILTTR	ILTTR
Crossroads, Inc.	Crossroads, Inc.	54 East Ramsdell Street	New Haven	06515	174 ILTTR	ILTTR
Crossroads, Inc.	Crossroads, Inc.	44 East Ramsdell Street	New Haven	06515	0	OT
CT Clinical Services, Inc.	CT Clinical Services, Inc.	139 Orange Street	New Haven	06510	0	OT
Detoxification Center	Alcohol and Drug Recovery Centers, Inc.	500 Blue Hills Avenue	Hartford	06112	28 IT, 10 ILTTR, 35 RDE	ILTTR, IT, RDE
Elm City Women and Children's Center and The Connection Counseling Center	Connection, Inc., The	48 Howe Street	New Haven	06511	15 ILTTR	ILTTR

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Fairfield Counseling Services, Inc.	Fairfield Counseling Services Inc.	125 Penfield Road	Fairfield	06824	0	OT
Families In Recovery Program	Liberation Programs, Inc.	141 Franklin Street	Stamford	06901	10 ILTTR	ILTTR
Family and Children's Agency, Inc.	Family and Children's Agency, Inc.	9 Mott Avenue	Norwalk	06850	0	OT
Family Intervention Center	Family Intervention Center, Inc.	22 Chase River Road	Waterbury	06704	0	DET, OT
Family Resource Associates, LLC	Family Resource Associates, LLC	3300 Main Street	Stratford	06614	0	OT
Farrell Treatment Center	Farrell Treatment Center, Inc.	586 Main Street	New Britain	06051	24 IT	IT, OT
First Step	Recovery Network of Programs, Inc.	425 Grant Street	Bridgeport	06610	19 RDE	RDE
Fresh Start	Community Renewal Team	17 Essex Street	Hartford	06120	21 ILTTR	ILTTR, OT
Grant Street Partnership	Cornell Scott-Hill Health Corporation	62 Grant Street	New Haven	06519	0	DET, OT
Greenwich Youth Options	Liberation Programs, Inc.	55 Old Field Point Road	Greenwich	06830	0	OT
Hallie House Women and Children's Center	Connection, Inc., The	99 Eastern Drive	Middletown	06457	8 ILTTR	ILTTR
Hartford Behavioral Health	Hartford Community Mental Health Center, Inc.	2550 Main Street	Hartford	06106	0	OT
Hartford Behavioral Health	Hartford Community Mental Health Center, Inc.	1 Main Street	Hartford	06106	0	OT
Hartford Dispensary - Norwich Clinic	Hartford Dispensary	772 West Thames Street	Norwich	06360	0	ACD, CMT
Hartford Dispensary Henderson/Johnson Clinic	Hartford Dispensary	12 - 14 Weston Street	Hartford	06103	0	ACD, CMT
Hartford Dispensary New Britain Clinic	Hartford Dispensary	70 Whiting Street	New Britain	06050	0	ACD, CMT
Hartford Dispensary/Doctors Clinic	Hartford Dispensary	345 Main Street	Hartford	06106	0	ACD, CMT
Hartford Dispensary/New London Clinic	Hartford Dispensary	931-939 Bank Street	New London	06320	0	ACD, CMT
Hartford Dispensary-16-18 Weston Street	Hartford Dispensary	16-18 Weston Street	Hartford	06120	0	ACD, CMT, OT
Hartford Dispensary-Bristol Clinic	Hartford Dispensary	1098 Farmington Avenue	Bristol	06010	0	ACD, CMT, OT
Hartford Dispensary-Manchester Clinic	Hartford Dispensary	335 Broad Street	Manchester	06040	0	ACD, CMT
Hartford Dispensary-Willimantic Clinic	Hartford Dispensary	54-56 Boston Post Road	Windham	06226	0	ACD, CMT
High Watch Recovery Center	High Watch Recovery Center, Inc.	62 Carter Road	Kent	06757	78 C&R	C&R, DET, OT
Hispanos Unidos, Inc.	Hispanos Unidos, Inc.	116 Sherman Avenue	New Haven	06511	0	OT
Hockanum Valley Community Council, Inc.	Hockanum Valley Community Council, Inc.	27 Naek Road	Vernon	06066	0	OT
Horizons	Recovery Network of Programs, Inc.	1635 Fairfield Avenue	Bridgeport	06605	15 IT	IT
Institute for the Hispanic Family	Catholic Charities, Inc. - Archdiocese of Hartford	45 Wadsworth Street	Hartford	06106	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Integrated Care Clinic	Optimus Health Care, Inc.	780 Summer Street	Stamford	06901	0	OT
Intercommunity, Inc.	Intercommunity, Inc.	287 Main Street	East Hartford	06118	0	OT
Intercommunity, Inc.	Intercommunity, Inc.	281 Main Street	East Hartford	06118	0	OT
Kinsella Treatment Center	Recovery Network of Programs, Inc.	1438 Park Avenue	Bridgeport	06604	0	ACD, CMT, OT
Lebanon Pines Long Term Care	Southeastern Council on Alcoholism and Drug Dependency, Inc.	37 Camp Mooween Road	Lebanon	06249	110 ILTTR	ILTTR
Legion Avenue Clinic	APT Foundation, Inc.	495 Congress Avenue	New Haven	06511	0	ACD, CMT, DET, CMT
Liberation Clinic	Liberation Programs, Inc.	125 Main Street	Stamford	06901	0	OT
Liberation House	Liberation Programs, Inc.	119 Main Street	Stamford	06901	67 ILTTR	ILTTR
Liberation Methadone Clinic (Bridgeport)	Liberation Programs, Inc.	399 Mill Hill Avenue	Bridgeport	06610	0	ACD, CMT, OT
Main Street Clinic	Liberation Programs, Inc.	117 Main Street	Stamford	06901	0	ACD, CMT
MCCA	Midwestern Connecticut Council on Alcoholism, Inc.	38 Old Ridgebury Road	Danbury	06810	20 IT, 10 RDE	ACD, CMT, DET, OT
MCCA/New Milford	Midwestern Connecticut Council on Alcoholism, Inc.	62 Bridge Street	New Milford	06776	0	DET, OT
MCCA/Ridgefield	Midwestern Connecticut Council on Alcoholism, Inc.	90 East Ridge Road	Ridgefield	06877	0	DET, OT
MCCA/Waterbury	Midwestern Connecticut Council on Alcoholism, Inc.	228 Meadow Street	Waterbury	06702	0	DET, OT
McCall Foundation	McCall Foundation, Inc.	58 High Street	Torrington	06790	0	DET, OT
McCall Foundation, Inc.-Winsted Satellite office	McCall Foundation, Inc.	115 Spencer Street	Winchester	06098	0	OT
McCall House	McCall Foundation, Inc.	127 Migeon Avenue	Torrington	06790	14 ILTTR	ILTTR
Milestone/New Life Center/Pathways	Community Health Resources	391 Pomfret Street	Putnam	06260	6 ILTTR, 18 IT	ACD, CMT, IT, ILTTR, RDE
Mother's Retreat and The Connection Counseling Center	Connection, Inc., The	542 Long Hill Road	Groton	06340	8 ILTTR	ILTTR, OT
Mountainside Treatment Center	MCI Healthcare LLC	187 South Canaan Road	Canaan	06018	62 ILTTR	ILTTR
Multicultural Ambulatory Addiction Services	Chemical Abuse Services Agency, Inc.	426 East Street	New Haven	06511	0	ACD, CMT, DET, OT
New Directions, Inc. of North Central Connecticut	New Directions, Inc. of North Central Connecticut	113 Elm Street	Enfield	06082	0	OT
New Era Rehabilitation Center, Inc.	New Era Rehabilitation Center, Inc.	311 East Street	New Haven	06511	0	ACD, CMT, DET, OT
New Era Rehabilitation Center, Inc.	New Era Rehabilitation Center, Inc.	3851 Main Street	Bridgeport	06606	0	ACD, CMT, DET, OT
New Hope Behavioral Health & Substance Abuse	New Hope Manor, Inc.	935 Main Street	Manchester	06040	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
New Perceptions/Right Turn	Perception Programs, Inc.	54 North Street	Windham	06226	0	OT
New Perceptions/Right Turn	Perception Programs, Inc.	13 Water Street	Killingly	06239	0	OT
New Prospects	Recovery Network of Programs, Inc.	392 Prospect Street	Bridgeport	06604	23 IT	IT
Newtown Youth and Family Services, Inc.	Newtown Youth and Family Services, Inc.	15 Berkshire Road	Newtown	06470	0	OT
North Central Counseling Services	Community Health Resources	693 Bloomfield Avenue	Bloomfield	06002	0	DET, OT
North Central Counseling Services	Community Health Resources	153 Hazard Avenue	Enfield	06082	0	DET, OT
North Haven Community Services	Town of North Haven	5 Linsley Street	North Haven	06473	0	OT
Northside Community Outpatient Services/Child and Family Guidance Clinic	Cornell Scott-Hill Health Corporation	226 Dixwell Avenue	New Haven	06511	0	OT
Northwest Center for Family Service & Mental Health	Community Mental Health Affiliates, Inc.	350 Main Street	Salisbury	06039	0	OT
Northwest Center for Family Service & Mental Health	Community Mental Health Affiliates, Inc.	100 Commercial Boulevard	Torrington	06790	0	OT
Orange Family Counseling	Bridges ... A Community Support System, Inc.	605-A Orange Center Rd	Orange	06477	0	OT
Orchard Hill Treatment Services	APT Foundation, Inc.	540 Ella T. Grasso Boulevard	New Haven	06519	0	ACD, CMT, OT
Outpatient Clinic	Connection, Inc., The	205-209 Orange Street	New Haven	06511	0	OT
Outpatient Treatment	Southeastern Council on Alcoholism and Drug Dependency, Inc.	321 Main Street	Norwich	06360	0	OT
Paces Counseling Associates, Inc.	Paces Counseling Associates, Inc.	991 Main Street	East Hartford	06108	0	OT
Park Street Inn	Connection, Inc., The	98 Park Street	New Haven	06511	0	OT
Patrick F. Mcauliffe Center	Connecticut Renaissance, Inc.	70 Central Avenue	Waterbury	06702	20 IT	IT
Perception House	Perception Programs, Inc.	134 Church Street	Windham	06226	20 ILTTR	ILTTR
Positive Directions - The Center for Prevention and Recovery, Inc.	Positive Directions-The Center for Prevention and Recovery, Inc.	420 Post Road West	Westport	06880	0	OT
Project Courage	Chemical Abuse Services Agency, Inc.	592 Kossuth Street	Bridgeport	06608	0	DET, OT
Recovery Adolescent Program	Recovery Network of Programs, Inc.	1549 Fairfield Avenue	Bridgeport	06605	0	OT
Recovery Counseling Services	Recovery Network of Programs, Inc.	480 Bond Street	Bridgeport	06610	0	OT
Renaissance East	Connecticut Renaissance, Inc.	31 Wolcott Street	Waterbury	06702	32 ILTTR	ILTTR
Renaissance West	Connecticut Renaissance, Inc.	466 West Main Street	Waterbury	06702	50 ILTTR	ILTTR
Reverend Edward M. Dempsey Drug Services	Central Naugatuck Valley HELP, Inc.	900 Watertown Avenue	Waterbury	06708	34 ILTTR	ILTTR

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Rushford Center, Inc.	Rushford Center, Inc.	110 National Drive	Glastonbury	06033	0	OT
Rushford Center, Inc.	Rushford Center, Inc.	883 Paddock Avenue	Meriden	06450	0	ACD, OT
Rushford Center, Inc.	Rushford Center, Inc.	1250 Silver Street	Middletown	06457	16 RDE, 42 IT	ACD, DET, IT, OT, RDE
Rushford Center, Inc.	Rushford Center, Inc.	325 Main Street	Portland	06480	26 ILTTR	ILTTR
Sound Community Services, Inc.	Sound Community Services, Inc.	165 State Street	New London	06320	0	OT
South Central Rehabilitation Center	Cornell Scott-Hill Health Corporation	232 Cedar Street	New Haven	06519	29 RDE	ACD, CMT, RDE, OT
Southwest Community Health Center, Inc.	Southwest Community Health Center, Inc.	1046 Fairfield Avenue	Bridgeport	06604	0	OT
Southwest Community Health Center, Inc.	Southwest Community Health Center, Inc.	968 Fairfield Avenue	Bridgeport	06605	0	OT
Stafford Family Services	Town of Stafford	21 Hyde Park Road	Stafford	06076	0	OT
State Street Counseling Services	Cornell Scott-Hill Health Corporation	911-913 State Street	New Haven	06511	0	OT
Stonington Institute	Stonington Behavioral Health, Inc.	1353 Gold Star Highway	Groton	06340	0	DET, OT
Stonington Institute	Stonington Behavioral Health, Inc.	428 Long Hill Road	Groton	06340	0	DET, OT
Stonington Institute	Stonington Behavioral Health, Inc.	75 Swantown Hill Road	North Stonington	06359	45 IT, 18 RDE	ACD, DET, OT, IT, RDE
Transitions Outpatient Services	Community Health Resources	433 Valley Street	Windham	06226	0	OT
Transitions Outpatient Services	Community Health Resources	37 Commerce Avenue	Killingly	06239	0	OT
Transitions Outpatient Services/Thomas Murphy Center	Community Health Resources	1491 Main Street	Windham	06226	14 ILTTR	ILTTR
Travisano Network	Central Naugatuck Valley Help, Inc.	24 Shelter Rock Road	Danbury	06810	0	OT
Trinity Glen	Midwestern Connecticut Council on Alcoholism, Inc.	149 West Cornwall Road	Sharon	06069	50 C&R	C&R
United Community and Family Services, Inc.	United Community and Family Services, Inc.	400 Bayonet Street	New London	06320	0	OT
United Community and Family Services, Inc.	United Community and Family Services, Inc.	70 Main Street	Griswold	06351	0	OT
United Community and Family Services, Inc.	United Community and Family Services, Inc.	47 Town Street	Norwich	06360	0	OT
United Community and Family Services, Inc.	United Community and Family Services, Inc.	212 Upton Road	Colchester	06415	0	OT
United Services, Inc.	United Services, Inc.	132 Mansfield Avenue	Windham	06226	0	OT
United Services, Inc.	United Services, Inc.	233 Route 6	Columbia	06237	0	OT
United Services, Inc.	United Services, Inc.	1007 North Main Street	Killingly	06241	0	OT
United Services, Inc.	United Services, Inc.	303 Putnam Road	Plainfield	06387	0	OT
Viewpoint Recovery Program	CTE, Inc.	104 Richmond Hill Avenue	Stamford	06902	12 ILTTR	ILTTR

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

YNNH000035
08/09/13

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Village for Families and Children, Inc.	Village for Families and Children, Inc.	1680 Albany Avenue	Hartford	06105	0	OT
Village for Families and Children, Inc.	Village for Families and Children, Inc.	105 Spring Street	Hartford	06105	0	OT
Village for Families and Children, Inc.	Village for Families and Children, Inc.	331 Wethersfield Avenue	Hartford	06114	0	OT
Waterbury Outpatient Services for CMHA	Community Mental Health Affiliates, Inc.	36 Sheffield Street	Waterbury	06704	0	OT
Watkins Network	Central Naugatuck Valley HELP, Inc.	257 Main Street	Torrington	06790	0	OT
Wellmore Behavioral Health	Wellmore, Inc.	402 East Main Street	Waterbury	06702	0	OT
Wellmore Behavioral Health, Inc.	Wellmore, Inc.	30 Controls Drive	Shelton	06484	0	OT
Wellmore, Inc. Therapeutic Shelter	Wellmore, Inc.	142 Griggs Street	Waterbury	06704	0	DET
Wellmore, Inc. Women and Children's Program	Wellmore, Inc.	79 Beacon Street	Waterbury	06704	8 ILTTR	ILTTR
West Haven Health Center Counseling Services	Cornell Scott-Hill Health Corporation	285 Main Street	West Haven	06516	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	36 Russell Street	New Britain	06052	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	75 North Mountain Road	New Britain	06053	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	91 North West Drive	Plainville	06062	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	645 Farmington Avenue	Hartford	06105	0	OT
Wherever You Are Eddy Center	Community Health Center, Inc.	1 Labella Circle	Middletown	06457	0	OT
Wherever You Are Shelter Now	Community Health Center, Inc.	43 Saint Casimir Drive	Meriden	06450	0	OT
Wherever You Are Shepherd Home	Community Health Center, Inc.	112 Bow Lane	Middletown	06457	0	OT
Youth Challenge Bible Training Center	Youth Challenge of Connecticut, Inc.	111 North Sterling Road	Plainfield	06354	9 ILTTR	ILTTR
Youth Challenge Mission for Women	Youth Challenge of Connecticut, Inc.	32 Atwood Street	Hartford	06105	8 ILTTR	ILTTR
Youth Challenge of Connecticut, Inc.-Men's Residential Center	Youth Challenge of Connecticut, Inc.	15-17-19 May Street	Hartford	06105	15 ILTTR	ILTTR
Total of 199 sites licensed and 1,512 beds broken out as follows: ILTTR beds total 972, IT beds total 265, RDE beds total 147 and C&R beds total 128						

Source: DPH licensure files and e-licensure database as of August 2012

[a]ABBREVIATION KEY:

ACD = Ambulatory Chemical Detoxification

CMT - Chemical Maintenance Treatment

C&R = Care and Rehabilitation

DET = Day or Evening Treatment

ILTTR = Intermediate and Long Term Treatment and Rehabilitation

IT = Intensive Treatment

OT = Outpatient Treatment

RDE = Residential Detoxification and Evaluation

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

EXHIBIT B

Payer Mix for the City of New Haven, FY 2012

(INPATIENT,NEWBORN)

2012

Discharges	MEDICARE	PRIVATE	Total Medicaid	CHAMPUS	CHARTER OAK	OTHER FED PROG	WORKERS COMI	UNINSURED	Total
06511	2,390	1,709	3,814	8	0	13	21	103	**8,058**
06513	1,943	1,012	2,751	13	0	8	25	56	**5,808**
06510	116	125	219	2	0	3	1	7	**473**
06515	631	580	836	4	2	4	7	9	**2,073**
06519	957	342	1,847	3	0	12	14	38	**3,213**
06531	0	2	0	0	0	0	0	0	**2**
06501	0	2	4	0	0	0	0	0	**6**
06530	0	2	0	0	0	0	0	0	**2**
06532	1	5	2	0	0	1	0	0	**9**
06504	17	9	84	0	0	0	0	3	**113**
06506	0	1	1	0	0	1	0	0	**3**
06503	2	0	0	0	0	0	0	0	**2**
06540	1	1	1	0	0	0	0	4	**7**
06521	0	2	2	0	0	0	0	0	**4**
06520	0	26	4	0	0	0	0	1	**31**
06505	2	1	12	0	0	0	0	0	**15**
06502	7	1	2	0	0	0	0	0	**10**
06534	2	0	0	0	0	0	0	0	**2**
06509	0	1	1	0	0	0	0	0	**2**
06533	0	0	0	0	0	0	0	0	**0**
06536	0	0	2	0	0	0	0	0	**2**
06535	0	0	0	0	0	0	0	0	**0**
06507	0	0	0	0	0	0	0	0	**0**
06508	5	0	0	0	0	0	0	0	**5**
06537	0	0	0	0	0	0	0	0	**0**
06538	0	0	0	0	0	0	0	0	**0**
NEW HAVEN	**6,074**	**3,821**	**9,582**	**30**	**2**	**42**	**68**	**221**	**19,840**

Aug 5, 2013

% of Total	MEDICARE	PRIVATE	Total Medicaid	CHAMPUS	CHARTER OAK	OTHER FED PROG	WORKERS COMI	UNINSURED	Total
06511	29.7%	21.2%	47.3%	0.1%	0.0%	0.2%	0.3%	1.3%	100.0%
06513	33.5%	17.4%	47.4%	0.2%	0.0%	0.1%	0.4%	1.0%	100.0%
06510	24.5%	26.4%	46.3%	0.4%	0.0%	0.6%	0.2%	1.5%	100.0%
06515	30.4%	28.0%	40.3%	0.2%	0.1%	0.2%	0.3%	0.4%	100.0%
06519	29.8%	10.6%	57.5%	0.1%	0.0%	0.4%	0.4%	1.2%	100.0%

All Patients (Inpatient Newborn)
Source: Chime Online

Payer Mix for the City of New Haven, FY 2012

Discharges	MEDICARE	PRIVATE	Total Medicaid	CHAMPUS	CHARTER OAK	OTHER FED PROG	WORKERS COMI	UNINSURED	Total
06531	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06501	0.0%	33.3%	66.7%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06530	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06532	11.1%	55.6%	22.2%	0.0%	0.0%	11.1%	0.0%	0.0%	100.0%
06504	15.0%	8.0%	74.3%	0.0%	0.0%	0.0%	0.0%	2.7%	100.0%
06506	0.0%	33.3%	33.3%	0.0%	0.0%	33.3%	0.0%	0.0%	100.0%
06503	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06540	14.3%	14.3%	14.3%	0.0%	0.0%	0.0%	0.0%	57.1%	100.0%
06521	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06520	0.0%	83.9%	12.9%	0.0%	0.0%	0.0%	0.0%	3.2%	100.0%
06505	13.3%	6.7%	80.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06502	70.0%	10.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06534	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06509	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06533									
06536	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06535									
06507									
06508	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06537									
06538									
NEW HAVEN	**30.6%**	**19.3%**	**48.3%**	**0.2%**	**0.0%**	**0.2%**	**0.3%**	**1.1%**	**####**

YNNH000039
08/09/13

All Patients (Inpatient Newborn)
Source: Chime Online

City-Data.com FORUM

New Haven, Connecticut (CT) Zip Code Map - Locations, Demographics

Jump to a detailed profile or search site with Google Custom Search
City, County or Zip Code Find
Business Search - 14 Million verified businesses
Search for: near: Find

Back to: New Haven, CT, All U.S. Cities.

VA Home Loan Benefits $0 Down and Low Monthly Payments. Pre-Qualify Now in Just 2 Minutes! www.VAMortgageCenter.com
Heating Oil from Auto TLC If you live in CT we offer oil delivery for $3.09 per gallon! www.AutomaticTLC.com/Save
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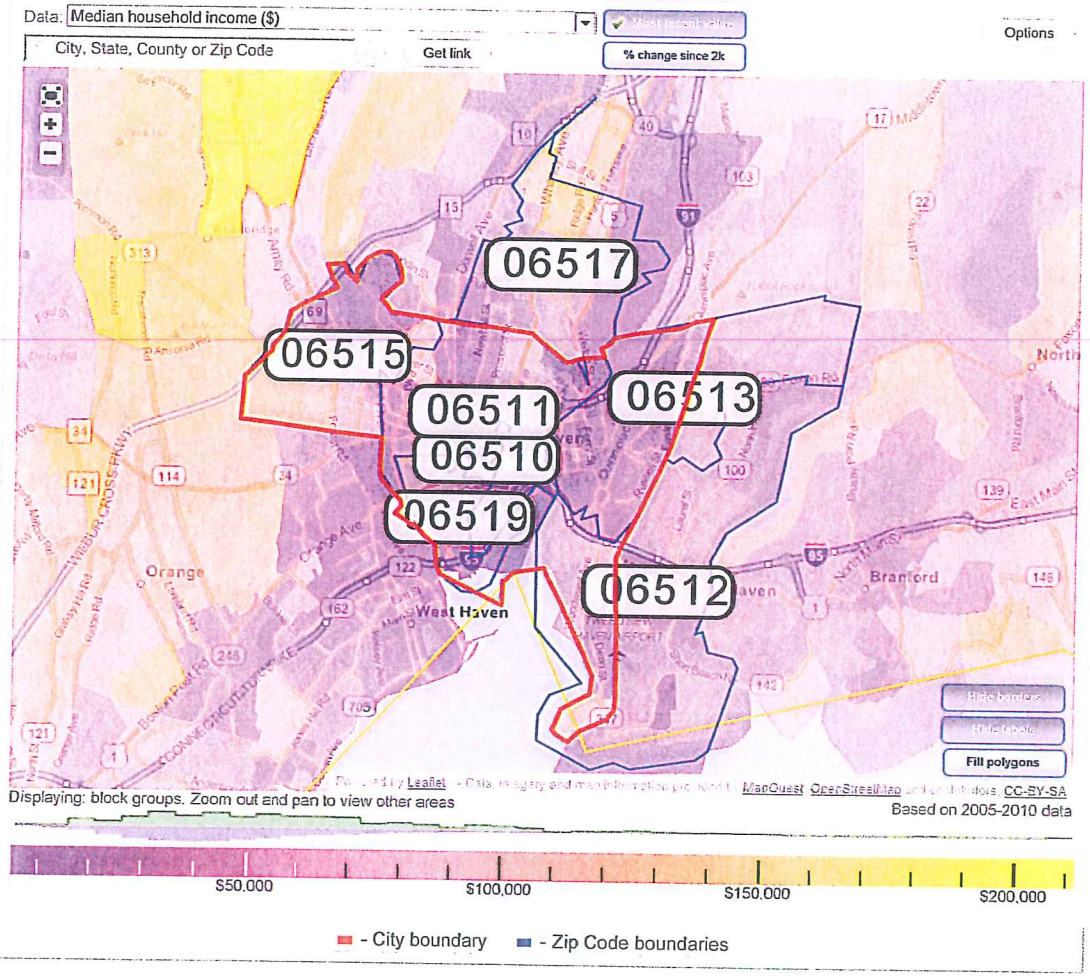
High Speed Internet High Speed plans start at $14.95/mo No contract or credit card required www.digitallanding.com AdChoices



Zip codes: 06510, 06511, 06512, 06513, 06515, 06517, 06519.

Zip code 06510 statistics: (Find on map)

Estimated zip code population in 2010: 3,093

Land area: 0.3 sq. mi.
Water area: 0.0 sq. mi.
Population density: 10,692 people per square mile (high).

Males: 1,549 (50.1%)
Females: 1,542 (49.9%)

Zip code 06510 detailed profile

EXHIBIT C

Addiction Residential Census- August 6, 2013

Detox - 3.7													
	1	RNP	Bridgeport	Detox	Sara Smith	(203) 333-3518	-7	12	19	7	7		
	2	Cornell Sctt	New Haven	SCRC	Ben Metcalf	(203) 503-3300	6	26	19	2	1		
	2	Rushford	Middletown	Resid Detox	Tara Murphy	1-877-577-3233		16				No	16
	3	SCADD	New London	Resid Detox	Admiting Nurse	(860) 447-1717	2	20	15	4	1		
	3	Stonington	North Stoning	Resid Detox	Andrea Keeney	(860) 445-3000		16				No	16
	4	ADRC	Hartford	Resid Detox	Admitting Nurse	(860) 714-3700	8	35	27	7	7		
	5	MCCA	Danbury	Resid Detox	Ana Carvalho	(203) 792-4515X123	0	12	12	0	0		
							9	**137**	**92**				**32**
Intensive Res													
	1	CASA	Bridgeport	Intensive	Kremlin DeVissiere	(203) 339-4112	0	10	10	0	0		
	1	RNP	Bridgeport	Horizon	Sara Smith	(203) 333-3518	0	15	15	3	3		
	2	CVH	Middletown	Intens (Men)	Joann Chatfield	(800) 828-3396 x 5	10	60	51	2	3		
	2	CVH	Middletown	Intens (Women)	Joann Chatfield	(800) 828-3396 x 5	6	30	24	1	1		
	2	Rushford	Middletown	Intensive	Tara Murphy	1-877-577-3233		42				No	42
	3	CPAS	Putnam	Milestone	Michelle Blevin	(860) 928-1860		16				No	16
	4	ADRC	Hartford	SATEP ADRC	E. Navarro	(860) 714-3739	0	28	28	3	3		
	4	Blue Hills	Hartford	Intensive	Pat O'Brien	(860) 293-6415	4	21	14	4	1		
	4	Farrell	New Britain	Intensive	Ester Bryant	(860) 225-4641		24				No	24
	5	MCCA	Danbury	McDonough	Maureen Gorman	(203)792-4515	2	22	20	1	1		
	5	McCall	Torrington	Carnes Wks	Tracy Donahue	(860) 496-2107		20				No	20
							22	**288**	**162**				**102**

YNNH000042
08/09/13

CT Substance Abuse Facilities with Inpatient Beds*

FACILITY NAME	PROVIDER NAME	CITY	BEDS	BED DETAIL	WAIT TIME?**	ACCEPTS MEDICAID?**
LUXURY PROVIDERS						
High Watch Recovery Center	High Watch Recovery Center, Inc.	Kent	78	C&R	NO WAIT	NO
Silver Hill Hospital	Silver Hill Hospital	New Cannan	109	RDE, ILTTR	Few weeks	NO
Mountainside Treatment Center	MCI Healthcare LLC	Canaan	62+16****	RDE, ILTTR	NO WAIT	NO
OTHER 3.7 LEVEL PROVIDERS						
South Central Rehabilitation Center	Cornell Scott---Hill Health Corporation	New Haven	29	RDE, CMT, ACD	NO WAIT	YES
Rushford Center, Inc.	Rushford Center, Inc./Hartford Healthcare	Middletown	16	RDE, ILTTR	NO WAIT	YES
Stonington Institute ***	Stonington Behavioral Health, Inc.	North Stonington	16 RDE, 38 IT	RDE, IT	NO WAIT	YES
Connecticut Valley Hospital	Connecticut Valley Hospital	Middletown	110	RDE, ILTTR	Changes Daily	YES
Trinity Glen	Midwestern Connecticut Council on Alcoholism	Sharon	50	RDE, C&R	NO WAIT	YES
McDonough House	Midwestern Connecticut Council on Alcoholism, Inc.	Danbury	20	RDE, IT	Few weeks	YES
First Step	Recovery Network of Programs, Inc.	Bridgeport	19	RDE	NO WAIT	YES
Detoxification Center	Alcohol and Drug Recovery Centers, Inc.	Hartford	28	RDE, IT	Residential rehab one week; Detox beds are available	YES
Coventry House	Alcohol and Drug Recovery Centers, Inc.	Hartford	10	RDE, ILTTR	1 month	YES
Halibrook	St. Vincent's Medical Center	Bridgeport	16	RDE	NO WAIT	YES
Community Health Resources	Community Health Resources	Putnam	6	RDE, ILTTR	2 months	YES
Altruism Acute Care and Evaluation	Dependency, Inc.	New London	20	RDE	NO WAIT	YES
Milestone/New Life Center/Pathways	Community Health Resources	Putnam	6	RDE, ILTTR	2 months	YES
OTHER INPATIENT SUBSTANCE ABUSE SERVICES						
Blue Sky Behavioral Health	Blue Sky Behavioral Health	Danbury	6	N/A	NO WAIT	NO
Clayton House	Alcohol and Drug Recovery Centers, Inc.	Glastonbury	15	ILTTR	60 days	YES
Horizons	Recovery Network of Programs, Inc.	Bridgeport	15	IT	Few days - few weeks	YES
Casa Eugenio Maria De Hostos	Chemical Abuse Services Agency, Inc.	Bridgeport	10	ILTTR	1-2 months, Spanish speaking only	YES
APT Residential Services	APT Foundation, Inc.	Bridgeport	125	ILTTR	N/A	YES
New Prospects	Recovery Network of Programs, Inc.	Bridgeport	23	IT	N/A	YES
Mother's Retreat and The Connection Counseling Center	Connection, Inc., The	Groton	8	ILTTR	2 months	N/A
Youth Challenge Mission for Women	Youth Challenge of Connecticut, Inc.	Hartford	8	ILTTR	N/A	N/A
Fresh Start	Community Renewal Team	Hartford	21	ILTTR	N/A	CSSD
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	Hartford	20	ILTTR	NO WAIT	YES
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	Hartford	15	ILTTR	NO WAIT	YES
Youth Challenge of Connecticut, Inc.---Men's Residential Center	Youth Challenge of Connecticut, Inc.	Hartford	15	ILTTR	NO WAIT	YSE
Lebanon Pines Long Term Care	Lebanon Pines Long Term Care	Lebanon	110	ILTTR	NO WAIT	YES
Hallie House Women and Children's Center	Connection, Inc., The	Middletown	8	ILTTR	N/A	N/A
Connection House	Connection, Inc., The	Middletown	14	ILTTR	N/A	YES
Farrell Treatment Center	Farrell Treatment Center, Inc.	New Britain	24	IT	2-3 weeks	YES
Crossroads, Inc.	Crossroads, Inc.	New Haven	174	ILTTR	2-3 weeks	YES
Elm City Women and Children's Center and The Connection Counseling Center	Connection, Inc., The	New Haven	15	ILTTR	A few months	CSSD
Altruism House for Women	Dependency, Inc.	New London	10	ILTTR	N/A	N/A
Altruism House for Women	Southeastern Council on Alcoholism and Drug	New London	11	ILTTR	NO WAIT	YES
Altruism House for Men	Dependency, Inc.	Norwich	13	ILTTR	One month	YES
Youth Challenge Bible Training Center	Youth Challenge of Connecticut, Inc.	Plainfield	9	ILTTR	NO WAIT	Yes
Liberation House	Liberation Programs, Inc.	Stamford	67	ILTTR	1 week	YES
Viewpoint Recovery Program	CTE, Inc.	Stamford	12	ILTTR	NO WAIT	YES
Families In Recovery Program	Liberation Programs, Inc.	Stamford	10	ILTTR	N/A	N/A
Carnes Weeks Center	McCall Foundation Inc.	Torrington	20	IT	1 week	YES
McCall House	McCall Foundation, Inc.	Torrington	14	ILTTR	N/A	YES
Renaissance East	Connecticut Renaissance, Inc.	Waterbury	32	ILTTR	1 months	YES
Renaissance West	Connecticut Renaissance, Inc.	Waterbury	50	ILTTR	N/A	N/A
Wellmore, Inc. Women and Children's Program	Wellmore, Inc.	Waterbury	8	ILTTR	NO WAIT	YES
Patrick F. Mcauliffe Center	Connecticut Renaissance, Inc.	Waterbury	20	IT	NO WAIT	YES
Reverend Edward M. Dempsey Drug Services	Central Naugatuck Valley HELP, Inc.	Waterbury	34	ILTTR	N/A	YES
Transitions Outpatient Services	Community Health Resources	Windham	14	ILTTR	Less than a week	YES
Perception House	Perception Programs, Inc.	Windham	20	ILTTR	CSSD- 3 months, but for Insurance 1.5 months	YES

*Source: Connecticut Statewide Health Care Facilities and Services Plan October 2012; page 280 .
**Information obtained via phone calls, and changes daily.
***Updated as of August 8, 2013.
****16 new detox beds per Docket No. 11-31734

YNNH000043
08/09/13

EXHIBIT D

STATE OF CONNECTICUT

QUI TRANSTULIT SUSTINET

House Bill No. 6705

Public Act No. 13-234

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HOUSING, HUMAN SERVICES AND PUBLIC HEALTH.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2013*) The Commissioner of Housing may appoint a Deputy Commissioner of Housing who shall be qualified by training and experience for the duties of the office of commissioner and shall, in the absence, disability or disqualification of the commissioner, perform all the functions and have all the powers and duties of said office. The position of the Deputy Commissioner of Housing shall be exempt from the classified service.

Sec. 2. (*Effective from passage*) (a) Wherever in sections 4-66h, 8-13m to 8-13s, inclusive, 8-13u to 8-13x, inclusive, and 12-170e of the general statutes the term "secretary" is used, the term "commissioner" shall be substituted in lieu thereof, and wherever the term "the Office of Policy and Management" is used, the term "Housing" shall be substituted in lieu thereof.

(b) Wherever the term "Economic and Community Development" is used in the following general statutes, the term "Housing" shall be substituted in lieu thereof: 4b-21, 7-392, 8-37v, 8-37w, 8-37y, 8-37aa, 8-

expenditures; (2) the process and factors to be used in determining each future year's assessment; and (3) the establishment of an appropriate notification process for the entities assessed under the account.

Sec. 144. Section 19a-639 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) In any deliberations involving a certificate of need application filed pursuant to section 19a-638, the office shall take into consideration and make written findings concerning each of the following guidelines and principles:

(1) Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;

(2) The relationship of the proposed project to the state-wide health care facilities and services plan;

(3) Whether there is a clear public need for the health care facility or services proposed by the applicant;

(4) Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;

(5) Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons, and (B) the impact upon the cost effectiveness of providing access to services provided under the Medicaid program;

(6) The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;

(7) Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;

(8) The utilization of existing health care facilities and health care services in the service area of the applicant; [and]

(9) Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities; and

(10) Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers.

(b) The office, as it deems necessary, may revise or supplement the guidelines and principles through regulation prescribed in subsection (a) of this section.

Sec. 145. Subsection (b) of section 19a-323 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(b) If death occurred in this state, the death certificate required by law shall be filed with the registrar of vital statistics for the town in which such person died, if known, or, if not known, for the town in which the body was found. The Chief Medical Examiner, Deputy Chief Medical Examiner, associate medical examiner, an authorized assistant

YNNH000047
08/09/13

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 9th of August, 2013 to the following:

Peter Schorr
c/o Law Office of William P. Beccaro
12 New City Street
Essex, CT 06426
wbeccaro@snet.net

Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy, P.C.

MERITAS LAW FIRMS WORLDWIDE

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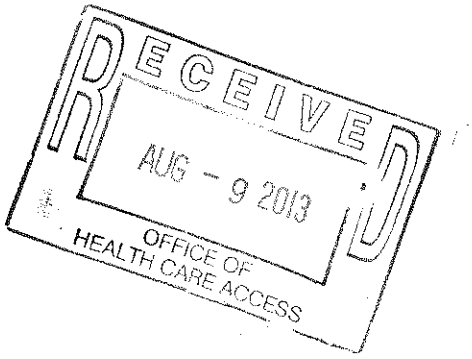
August 9, 2013



VIA HAND DELIVERY

Lisa A. Davis, M.B.A., B.S.N., R.N.
Deputy Commissioner
Office of Health Care Access
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: NR Connecticut, LLC d/b/a Retreat at South Connecticut
Establish a 105-Bed Residential Substance Abuse Treatment Facility in New Haven
Docket No. 13-31828-CON

Dear Deputy Commissioner Davis:

This office represents Stonington Behavioral Health, Inc. d/b/a Stonington Institute in connection with the above-referenced docket. Enclosed are an original and four (4) copies of the following:

- Notice of Appearance of Updike, Kelly & Spellacy, P.C.
- Petition of Stonington Behavioral Health, Inc. d/b/a Stonington Institute To Be Designated as an Intervenor With Full Rights Including Right of Cross-Examination
- Prefiled Testimony of William A. Aniskovich, CEO

These documents are being submitted in connection with the public hearing on the above matter, scheduled for August 14, 2013 at 9:00 a.m. Mr. Aniskovich will be present at the hearing to adopt his prefiled testimony under oath and for cross-examination.

Should you require anything further, please feel free to call me at (203) 786-8316.

Very truly yours,

Jennifer Groves Fusco

Enclosures

cc: William A. Aniskovich (*w/enc.*)

Updike, Kelly & Spellacy, P.C.
One Century Tower ▪ 265 Church Street ▪ New Haven, CT 06510 (t) 203.786.8300 (f) 203.772.2037 www.uks.com

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: CERTIFICATE OF NEED APPLICATION OF NR CONNECTICUT, LLC d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	)	DOCKET NO. 13-31828-CON
	)	AUGUST 9, 2013

NOTICE OF APPEARANCE

In accordance with Section 19a-9-28 of the Regulations of Connecticut State Agencies, please enter the appearance of Updike, Kelly & Spellacy, P.C. ("Firm") in the above-captioned proceeding on behalf of Stonington Behavioral Health, Inc. d/b/a Stonington Institute ("Stonington"). The Firm will appear and represent Stonington at the public hearing on this matter, scheduled for August 14, 2013.

Respectfully Submitted,

STONINGTON BEHAVIORAL HEALTH, INC. d/b/a
STONINGTON INSTITUTE

By: _____

JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.
265 Church Street
One Century Tower
New Haven, CT 06510
Tel: (203) 786-8300
Fax (203) 772-2037

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 9th of August, 2013 to the following:

Peter Schorr
c/o Law Office of William P. Beccaro
12 New City Street
Essex, CT 06426
wbeccaro@snet.net

Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy, P.C.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: CERTIFICATE OF NEED APPLICATION OF NR CONNECTICUT, LLC d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	)	DOCKET NO. 13-31828-CON
	)	AUGUST 9, 2013

PETITION OF STONINGTON BEHAVIORAL HEALTH, INC. d/b/a STONINGTON INSTITUTE TO BE DESIGNATED AS AN INTEVENOR WITH FULL RIGHTS INCLUDING THE RIGHT OF CROSS-EXAMINATION

In accordance with Section 4-177a of the Connecticut General Statutes and Section 19a-9-27 of the Regulations of Connecticut State Agencies, Stonington Behavioral Health, Inc. d/b/a Stonington Institute ("Stonington"), located at 75 Swantown Hill Road, North Stonington, CT 06359, hereby petitions the Office of Health Care Access Division of the Department of Public Health ("OHCA") to be designated as an intervenor with full rights, including the right of cross-examination, in the Certificate of Need ("CON") proceeding designated as Docket No. 13-31828-CON. This proceeding concerns the request of NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Retreat") for permission to establish a 105-bed substance abuse treatment facility in New Haven. The facility would include residential detoxification and evaluation, intensive treatment (rehabilitation), partial hospital, intensive outpatient and outpatient services. Stonington provides all of the services being proposed by Retreat. As detailed herein and in the accompanying testimony of William A. Aniskovich, CEO, Stonington would be adversely impacted by the approval of a facility

for which there is no clear public need and which will serve commercially insured and self-pay clients only.

Stonington Institute Programs & Services

Established in 1957, Stonington is a 58-bed substance abuse treatment facility located in Southeastern Connecticut. Stonington is licensed by the Department of Public Health as a Facility for the Care and Treatment of Substance Abusive or Dependent Persons, accredited by The Joint Commission ("TJC") and offers a full continuum of services to adults with substance abuse and co-occurring mental health issues. Stonington also provides services to adolescents with developmental disabilities. Stonington accepts clients from Connecticut and across the country into its residential and outpatient programs, which operate out of North Stonington and Groton, respectively.

Stonington offers residential detoxification and evaluation services ("RDE Services") for adults in a 16-bed unit at its North Stonington campus. RDE Services at Stonington are designated as American Society of Addiction Medicine Level III.7, which allows for the admission of individuals who have a history of heavy and/or prolonged use of alcohol and/or other drugs and are in need of detoxification in a voluntary, medically-monitored detoxification setting. RDE Services clients often have a secondary mental health diagnosis as well.

Stonington also has 38 licensed beds for the provision of intensive treatment/residential rehabilitation services ("Rehabilitation Services") for active duty military personnel and veterans. Rehabilitation Services are offered at the North Stonington campus. Clients in Stonington's "Starlight Program" suffer from substance abuse disorders, post-traumatic stress disorder and mental

health issues, and the rehabilitation program is tailored to meet the unique needs of, and challenges faced by, these individuals and their families.[1]

In addition to its residential programs, Stonington operates partial hospital and intensive outpatient programs ("PHP/IOP Services") for adults with co-occurring substance abuse and mental health disorders. These services are offered at clinics in Groton in both day and evening formats. PHP Services are provided 4-6 hours per day, 6 days per week. IOP Services are provided 3 nights per week, for 3 hours per session. Stonington has 190 total slots available for PHP/IOP clients.

Stonington is Medicaid certified and recently received hospital accreditation with deemed Medicare status from TJC, and will begin accepting Medicare clients as soon as it receives a provider number from the Centers for Medicare & Medicaid Services ("CMS"). In addition to its participation with these governmental programs, Stonington accepts every major commercial health plan network in Connecticut.

Stonington's Interests Will Be Adversely Affected by Approval of Retreat's CON Proposal

This CON proposal involves the establishment of a 105-bed residential substance abuse treatment facility in New Haven. If approved, this will be one of the largest freestanding facilities of its kind in the state. Retreat at South Connecticut will offer an array of substance abuse services, including the Level III.7 residential detoxification and evaluation services, intensive

---

[1] Although not directly relevant to this proposal, Stonington also operates a 10-bed intensive treatment/residential rehabilitation program for adolescent boys with developmental disabilities at the North Stonington campus. Stonington also operates a 4-bed inpatient psychiatric unit, which is open to clients with commercial insurance. Once Stonington receives its Medicare provider number from CMS (see discussion above), this unit will be open to both Medicare and Medicaid recipients as well.

treatment/residential rehabilitation services, PHP/IOP and other outpatient services offered by Stonington.

Retreat has not made even a basic showing of clear public need for a facility of this magnitude in Connecticut. Retreat bases the need for this facility on the number of individuals in the state who require, but do not seek substance abuse treatment services, as well as an informal survey that purports to shows all other Level III.7 detoxification providers operating at capacity. Retreat's arguments are flawed in several respects. They do not take into consideration the many reasons why substance abusers choose not to seek treatment, but instead assume, incorrectly, that failure to seek treatment equates to a lack of capacity. Nor does Retreat's informal survey of existing providers in the state establish a lack of capacity. As Stonington will demonstrate in its supporting testimony, it has adequate capacity in all of its programs to accommodate most clients without any wait, despite Retreat's assertions to the contrary.

Because Retreat has not shown a clear public need for the proposed facility, the clients needed to meet its projections and to fill a significant number of detoxification and rehabilitation beds will have to come from existing providers, including Stonington.[2] Retreat claims that it has a referral network in Connecticut and in surrounding states, and will share the referral network associated with its sister facility in Pennsylvania, which will generate sufficient clients to populate the Connecticut facility without impacting existing providers (CON Application, p. 669). However, Retreat has

[2] Retreat has not provided a breakdown of beds by level of service. However, its projections do not support a total of 105 combined detoxification and residential beds no matter what the complement. Retreat claims it only needs to fill 34 beds per day (32.7% occupancy) to break even (CON Application, p. 659), but it is requesting 105 beds because this is the "optimum" number of beds for a facility of this type (CON Application, p. 667). Stonington disputes the latter, but maintains that if 105 beds are approved, Retreat will strive to maximize patient days and profits at the expense of existing providers.

submitted only a handful of letters of support for this proposal from referring providers and its submissions show that Connecticut residents (at whom this facility is presumably targeted) make up less than one percent (12 of 2,206) of admissions to its Pennsylvania facility.

In addition, Retreat has made it clear that it will accept commercially insured and self-pay clients only, and will not offer services to Medicare or Medicaid recipients (CON Application pp. 35 & 704). Retreat claims that it will generate higher revenues per bed than its competitors through an extensive referral program that focuses on high-end, private pay (i.e., non-Medicare and/or Medicaid) clients (CON Application, p. 527). This means that the clients diverted from Stonington and others will be those who generate the highest revenues, leaving existing providers to serve the most vulnerable clients, including Medicare and Medicaid recipients and the uninsured, with less money to cover the cost of providing services. This will have a significant adverse financial impact on Stonington, which may ultimately affect the quality, accessibility and cost-effectiveness of the care it provides.

Summary of Evidence to Be Presented, Manner of Participation and Relief Sought

Stonington will ask OHCA to deny Retreat's request for permission to establish a substance abuse treatment facility in New Haven. There is no clear public need for the services being proposed. Conn. Gen. Stat. §19a-639(3). This facility will result in the unnecessary duplication of services and it will adversely impact Stonington and other existing providers. Conn. Gen. Stat. §19a-639(9). This will be shown through the presentation of capacity and historical utilization data, as well as other relevant evidence. The proposal will also decrease the cost-effectiveness of care by skimming those clients that generate the most revenue from existing providers. Conn. Gen. Stat. §§19a-639(4) & (5).

This in turn could have an adverse impact on the quality and accessibility of care provided by Stonington and others. Conn. Gen. Stat. §19a-639(5).

Moreover, Retreat cannot show any reason why a facility that does nothing to enhance access for Medicaid clients, and in fact causes financial harm to those who care for these clients, should be approved. Approval of such a proposal would be contrary to the intent of soon-to-be-implemented changes to the CON statutory decision criteria aimed at improving Medicaid access. *See* P.A 13-234. Stonington will present evidence in support of its payer mix and the impact that Retreat's proposal to attract commercially insured and self-pay clients would have on its bottom line.

If Stonington is granted intervenor status, it intends to present this and other evidence and legal arguments in support of its positions. Stonington respectfully requests that it be allowed to submit written testimony, present evidence and arguments at the August 14, 2013 public hearing on this matter, cross-examine witnesses, and inspect and copy records pertaining to the proceeding. Stonington's participation will furnish assistance to OHCA in determining whether there is a need for this proposal and what its impact will be on existing providers. Stonington has information directly relevant to Retreat's erroneous claims in this regard, which will be presented at the hearing. In addition, Stonington's participation is in the interest of justice and will not impair the orderly conduct of these proceedings.

WHEREFORE, for the foregoing reasons, Stonington respectfully requests that its Petition to be Designated as an Intervenor With Full Rights be granted.

Respectfully Submitted,

STONINGTON BEHAVIORAL HEALTH, INC. d/b/a
STONINGTON INSTITUTE

By: _____

JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.
265 Church Street
One Century Tower
New Haven, CT 06510
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Fax (203) 772-2037

CERTIFICATION

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Peter Schorr
c/o Law Office of William P. Beccaro
12 New City Street
Essex, CT 06426
wbeccaro@snet.net

Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy, P.C.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: CERTIFICATE OF NEED APPLICATION OF NR CONNECTICUT, LLC d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	)	DOCKET NO. 13-31828-CON
	)	AUGUST 9, 2013

PREFILED TESTIMONY OF WILLIAM A. ANISKOVICH, CEO

Good morning Hearing Officer Hansted and members of the OHCA staff. My name is William Aniskovich and I am the CEO of Stonington Institute ("Stonington"). Thank you for this opportunity to speak in opposition to the CON Application filed by NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Retreat") for permission to establish a 105-bed substance abuse treatment facility in New Haven. This facility is intended for the treatment of commercially insured and self-pay clients only, and will not be available to those individuals covered by Medicare and Medicaid. My remarks today will focus on the significant adverse impact that a facility of this type and size, for which there is no clear public need, will have on existing providers like Stonington.

Stonington Institute Programs & Services

Established in 1957, Stonington is a 58-bed substance abuse treatment facility located in Southeastern Connecticut. Stonington is licensed by the Department of Public Health as a Facility for the Care and Treatment of Substance Abusive or Dependent Persons, accredited by The Joint Commission ("TJC") and offers a full continuum of services to adults with substance abuse and co-

occurring mental health disorders. Stonington also provides services to adolescents with developmental disabilities. Stonington accepts clients from Connecticut and across the country into its residential and outpatient programs, which operate out of North Stonington and Groton, respectively.

Stonington offers residential detoxification and evaluation services ("RDE Services") for adults in a 16-bed unit at its North Stonington campus. RDE Services at Stonington are designated as American Society of Addiction Medicine Level III.7, which allows for the admission of individuals who have a history of heavy and/or prolonged use of alcohol and/or other drugs and are in need of detoxification in a voluntary, medically-monitored detoxification setting. RDE Services clients often have a secondary mental health diagnosis as well.

Stonington also has 38 licensed beds for the provision of intensive treatment/residential rehabilitation services ("Rehabilitation Services") for active duty military personnel and veterans. Rehabilitation Services are offered at the North Stonington campus. Clients in Stonington's "Starlight Program" suffer from substance abuse disorders, post-traumatic stress disorder and mental health issues, and the rehabilitation program is tailored to meet the unique needs of, and challenges faced by, these individuals and their families.[1]

In addition to its residential programs, Stonington operates partial hospital and intensive outpatient programs ("PHP/IOP Services") for adults with co-occurring substance abuse and mental

[1] Although not directly relevant to this proposal, Stonington operates a 10-bed intensive treatment/residential rehabilitation program for adolescent boys with developmental disabilities at the North Stonington campus. Stonington also operates a 4-bed inpatient psychiatric unit, which is open to clients with commercial insurance. Once Stonington receives its Medicare provider number from CMS (see discussion below), this unit will be open to both Medicare and Medicaid recipients as well.

health disorders. These services are offered at clinics in Groton in both day and evening formats. PHP Services are provided 4 to 6 hours per day, 6 days per week. IOP Services are provided 3 nights per week, for 3 hours per session. Stonington has 190 total slots available for PHP/IOP clients.

Stonington is Medicaid certified and recently received hospital accreditation with deemed Medicare status from TJC, and will begin accepting Medicare clients as soon as it receives a provider number from the Centers for Medicare & Medicaid Services ("CMS"). In addition to its participation with these governmental programs, Stonington accepts clients from every major commercial health plan network in Connecticut.

Nature of Retreat's Proposal

This CON proposal involves the establishment of a 105-bed residential substance abuse treatment facility in New Haven. If approved, this will be one of the largest freestanding facilities of its kind in the state.[2] Retreat will offer an array of substance abuse services, including the Level III.7 residential detoxification and evaluation services, intensive treatment/residential rehabilitation services, PHP/IOP and other outpatient services offered by Stonington. Retreat has not broken down the proposed beds by level of service, but rather simply claims that 105 beds is within the "optimum" range of beds for the "Retreat modality" (CON Application, p. 667).[3] The so called "Retreat modality" refers to the programs and services offered at a sister facility in Pennsylvania, Retreat at Lancaster County, which serves as a model for Retreat at South Connecticut. Retreat, however,

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[2] The only licensed freestanding substance abuse facilities with a greater total number of beds are APT Residential Services and Lebanon Pines Long Term Care, which are listed in the Statewide Health Care Facilities & Services Plan (Table 20) as having 125 and 110 Intermediate and Long Term Treatment and Rehabilitation beds, respectively (see Exhibit A attached).

[3] Incidentally, this is the exact bed capacity of the existing facility being used for Retreat at South Connecticut.

offers no evidence of how the "experience" of its Pennsylvania facility supports this claim of optimality, nor is there a single piece of reliable clinical research extant that supports such a claim.

The Retreat facility will be located in a former skilled nursing facility on Ella T. Grasso Boulevard in New Haven. Despite its urban placement, Retreat will cater to commercially insured and private-pay clients only. The facility will not admit Medicare and Medicaid recipients, many of whom reside in and around major cities such as New Haven.

There Is No Clear Public Need for Retreat at South Connecticut

A threshold issue in every CON application is whether there is a "clear public need" for the facility, service, acquisition or transaction being proposed. Conn. Gen. Stat. §19a-639(3). Despite Retreat's claim that the need for a 105-bed substance abuse treatment facility in Connecticut is "firmly established," it has not made even a basic showing of clear public need for a facility of this magnitude (CON Application, p. 667). As previously mentioned, the proposed facility would be the third largest freestanding substance abuse treatment facility in the state (Statewide Health Care Facilities & Services Plan, Table 20, attached as Exhibit A).

Retreat's claim that there is a clear public need for this facility is based primarily on literature indicating a high incidence of substance abuse in Connecticut and a significant percentage of individuals with substance abuse disorders who do not seek treatment.[4] These types of statistics are often used to support the need for additional substance abuse beds and services. However, they are not in and of themselves determinative of a lack of adequate substance abuse treatment capacity in

[4] Retreat also states that "proprietary research" supports its claim that there is a tremendous unmet and growing need for private-pay and private insurance inpatient substance abuse services in Connecticut (CON Application, p. 667). However, Retreat has not shared any of this "proprietary research" with OHCA or the public and it should not form the basis of a finding of clear public need.

Connecticut. Retreat fails to account for the myriad of reasons why people do not seek treatment for substance abuse disorders. For some, it is that they do not have the appropriate insurance coverage or the financial means to obtain treatment. Others do not believe that their issues require treatment. The fact that substance abusers do not seek treatment does not necessarily indicate a lack of capacity within the system. Even if there was unlimited access to services, it is still likely that many people would continue to avoid treatment for a variety of reasons.

Stonington Institute's Capacity & Utilization

Retreat has attempted to analyze the capacity and utilization of existing substance abuse providers, however, the results of its informal survey are incomplete and misleading. First, they focus only on the providers that offer the Level III.7 RDE Services proposed by Retreat. For purposes of establishing clear public need, Retreat must consider the need for each service individually and analyze utilization and capacity for all providers offering residential rehabilitation and/or PHP/IOP services, regardless of whether they provide Level III.7 residential detoxification and evaluation services. If Retreat had considered these providers, the overall capacity of the system would likely have been far greater (Statewide Health Care Facilities & Services Plan, Table 20, attached as Exhibit A).

Moreover, the results of Retreat's survey are inaccurate. Retreat suggests that Stonington has zero beds available out of its 63 (now 58) licensed beds (CON Application, p. 76). In reality, Stonington has unused capacity in each of its residential and outpatient programs and no backlog or wait list for services. While Stonington's 16-bed RDE Service runs close to capacity, the short average length of stay for these clients (3-5 days) means that anywhere from 3 to 8 clients are being

discharged on any given day. For this reason, there are almost always one or more beds available on the same day for individuals requesting admission for RDE Services. The only limitation on same-day availability is the gender mix of clients, and whether a bed in a shared room is immediately available for a female or male client seeking services. Note also that Stonington's RDE volume declined by approximately 12 percent between 2011 and 2012 (6,205 days to 5,475 days), further indication that there is unused RDE capacity in the state.

Stonington's Rehabilitation Services are currently operating at around 60 percent capacity, with 22 of 38 beds occupied and 16 beds available for new admissions on any given day. Stonington recently converted its Rehabilitation Service to a program focused on active duty military personnel and veterans. This change was driven by Stonington's decision to terminate its DCF-funded adolescent program and the fact that managed care virtually eliminated demand for these types of beds for commercially insured clients. Commercial insurers will typically authorize the less expensive PHP level of service in lieu of a residential rehabilitation stay. Retreat has offered no letters from commercial payers indicating a willingness to support any intensive treatment beds, let alone a 105-bed facility. The current demand for Rehabilitation Services in this state can be accommodated easily by existing providers, including Stonington, which can service active duty military personnel and veterans.[5]

Stonington also provides PHP/IOP Services and has ample additional capacity for any current unmet need identified by Retreat. Stonington has 190 slots available for these services and is presently operating at approximately 90 percent capacity. Consider this along with other PHP/IOP

[5] Retreat lists veterans as one of its target client groups (CON Application, p. 19). However, Retreat will not accept TRICARE or Medicaid, which cover services for most veterans.

services provided by hospitals and freestanding facilities that do not provide RDE Services (and were therefore not listed as existing providers by Retreat) and there is no clear public need for the addition of PHP/IOP capacity in the state at this time. Note also that Stonington's PHP/IOP volume declined by approximately 6 percent between 2011 and 2012 (47,060 days to 44,200 days), further indication that there is unused PHP/IOP capacity in the state.

Retreat's Volume Projections Are Flawed

Retreat's projected volumes, as detailed on page 677 of the CON Application, are not achievable and do not support the number of beds it has requested. With respect to RDE Services, Retreat is projecting between 5,280 and 7,920 client days in the first 4 years of operation (CON Application, pp. 30 & 677). It appears the projected average length of stay ("ALOS") for this service is 5.5 days (CON Application, p. 682).[6] Therefore, Retreat is projecting between 18 admissions (5,280 ÷ 5.5 ÷ 52) and 28 admissions (7,920 ÷ 5.5 ÷ 52) per week. Stonington currently admits approximately 35 clients per week to its 16-bed RDE Service and is operating near capacity. Using this same measure of capacity, even if Retreat can achieve 18 to 28 admissions per week, it will only be enough to fill between 8 and 13 RDE beds.

Based on the foregoing, Retreat must be anticipating that at least 90 of its beds will be used for Rehabilitation Services. Retreat has projected between 15,840 and 23,760 client days in the first 4 years of operation (CON Application, pp. 30 & 677). Assuming a 16.5 day ALOS (CON Application, p. 682), this equates to between 18 admissions (15,840 ÷ 16.5 ÷ 52) and 28 admissions (23,760 ÷ 16.5 ÷ 52) per week. As previously mentioned, this volume of admissions (which assumes

[6] Based on Stonington's experience, this ALOS for commercially insured RDE Services is long. These payers typically approve 3-day stays on average.

that 100% of RDE clients will transition to Rehabilitation) will be impossible to achieve given the position of most commercial payers on referrals for Rehabilitation Services. Stonington operates a nationally recognized rehabilitation program for active duty military personnel and veterans and still admits only 250 clients per year, or approximately 5 per week. With these admissions, Stonington fills less than 25 beds on average at any given time. Stonington also has a step-down rate from RDE to PHP/IOP of approximately 40 percent, which belies Retreat's assumption that all RDE clients will step down to its Rehabilitation beds.

It is clear that Retreat chose the number of beds at the proposed facility not based on need for those beds, but rather on the size of the facility and the "optimum number" of beds for the "Retreat modality" (CON Application, p. 667). As a threshold matter, a facility this large is not considered "optimum" for therapeutic purposes. The residential program model depends on establishing and maintaining a therapeutic milieu. Residential treatment tends to be less effective the larger, more institutional and structured a facility becomes. Clients typically do better in the less structured and restrictive environments found in smaller residential programs.

Notwithstanding the foregoing, Retreat simply cannot fill the beds it is proposing given payment constraints, the impact of these constraints on demand and Retreat's lack of access to referral sources. Retreat was asked whether it has relationships with providers who will refer to the facility, and in response provided only 5 letters. Three were from LCSWs and an addiction counselor, all of whom are based in Fairfield County, not New Haven County where the facility will be located (CON Application, pp. 670-674). By Retreat's own admission, referrals from independent

therapists/doctors account for only 2 percent of admissions to its Pennsylvania facility, therefore it is unclear how these letters show an ability to fill 105 beds (CON Application, p. 706).

The remaining letters were from the Metro-North Railroad and Canel Lodge No. 700 Employee Assistance Programs (CON Application, pp. 672-673). Jerry Marcil of Canel Lodge No. 700, located in New London County, claims to have difficulty finding substance abuse treatment beds that take commercial insurance. Stonington is located in New London County, takes commercial insurance and has bed availability. Bruce Pollack of Metro-North Railroad claims that detoxification beds are scarce, and that there are no outpatient detoxification services in Connecticut. This is untrue. Stonington offers outpatient detoxification services, and licenses for Ambulatory Chemical Detoxification are held by numerous other providers (see Exhibit A attached). Regardless, there is no indication that the payers who insure the Canel Lodge No. 700 and Metro-North Railroad members and employees would authorize detoxification and/or rehabilitation stays at Retreat or any other facility.

Retreat further claims that it will draw 75 percent of its admissions from Connecticut, however the lack of Connecticut referral sources makes this unlikely without Retreat cannibalizing clients from existing providers in the state (CON Application, p. 669). Retreat also claims that it will share the existing referral network of its sister facility in Lancaster, Pennsylvania (CON Application, p. 669). However, given that only 12 of Retreat at Lancaster County's 2,206 clients (.05%) in FY 2012 were Connecticut residents, it is difficult to imagine how this referral network will assist Retreat in meeting its goal (CON Application, p. 686). Retreat's projections are simply too ambitious to

meet without an established referral network, and Retreat does not have an established referral network for Connecticut.[7]

The Proposal Will Result in the Unnecessary Duplication of Services and Will Have a Significant Adverse Impact on Stonington Institute and the Connecticut Healthcare System

Because Retreat has not shown a clear public need for the proposed facility, the clients required to meet its projections and to fill a significant number of detoxification and rehabilitation beds will have to come from existing providers, including Stonington. This means the unnecessary duplication of substance abuse services in Connecticut. Conn. Gen. Stat. §19a-639(9). In addition, Retreat has made it clear that it will accept commercially insured and self-pay clients only, and will not offer services to Medicare or Medicaid recipients (CON Application pp. 35 & 704). Retreat claims that it will generate higher revenues per bed than its competitors through an extensive referral program that focuses on high-end, private pay (i.e., non-Medicare and/or Medicaid) clients (CON Application, p. 527). This means that the clients diverted from Stonington and others will be those who generate the highest revenues, leaving existing providers to serve the most vulnerable clients, including Medicare and Medicaid recipients and the uninsured, with less money to cover the cost of providing services.

Retreat claims that it only needs to fill 33 percent of the requested beds to break even, likely because of higher rates of reimbursement for the commercially insured and self-pay clients who will occupy those beds (CON Application, p. 659). Compare this with Stonington, which requires 95

[7] Retreat also states that "proprietary research" supports its projections and the comparability of the Connecticut and Pennsylvania markets (CON Application, p. 706). However, Retreat has not shared any of this "proprietary research" with OHCA or the public and it should not form the basis of a finding that Retreat's projections are reasonable and achievable.

percent occupancy to break even. Currently, 68 percent of Stonington's RDE client days, and 77 percent of its PHP/IOP client days are Medicaid. Stonington's overall payer mix is 73 percent governmental payers and charity care, and only 27 percent commercial insurance and self-pay. However this small percentage of commercially insured and self-pay clients, which generates the highest rates, helps to support the significant percentage of governmentally insured clients at Stonington. Stonington could not break even if it lost any appreciable amount of its commercial/self-pay revenue. The loss of this revenue would have a significant adverse financial impact on Stonington, which could in turn compromise the quality, accessibility and cost-effectiveness of the care that we provide and weaken the healthcare system in Connecticut. Conn. Gen. Stat. §§19a-639(4) & (5).

Retreat cannot show any reason why a facility that does nothing to enhance access for Medicaid recipients, and in fact causes financial harm to those who care for these individuals, should be approved. Approval of such a proposal would be contrary to recent changes in the CON statutory decision criteria aimed at improving Medicaid access. Public Act No. 13-234, which takes effect October 1, 2013, amends Section 19a-639 of the Connecticut General Statutes to include a requirement that an applicant for a CON demonstrate (1) how the provision of, or any change in access to, services for Medicaid recipients and indigent persons improves the quality, accessibility and cost-effectiveness of healthcare in the region; (2) how the proposal will impact the cost-effectiveness of providing access to services under the Medicaid program; (3) an applicant's past and proposed provision of healthcare services to relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons; and (4) whether an applicant, who has failed to

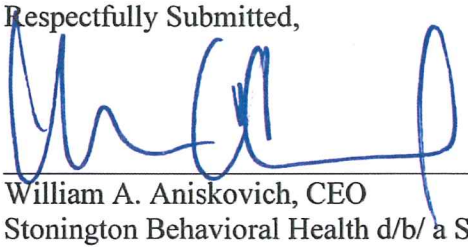
provide access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which may not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other healthcare payers (see Exhibit B attached). Retreat has clearly stated its intention to exclude Medicare and Medicaid clients from its facility (CON Application, p. 704). Retreat has shown no justification for this approach other than the fact that commercially insured and self-pay clients generate higher revenues, which will give Retreat an advantage over its competitors, including Stonington and others who treat and will continue to treat governmentally insured individuals regardless of the financial impact on their bottom lines.

Conclusion

Retreat is proposing to establish one of the largest freestanding substance abuse treatment facilities in Connecticut. It has not shown a clear public need for this facility, and in fact it will duplicate the services of many freestanding facilities, including Stonington, which have ample capacity to meet the current needs of Connecticut residents. Retreat's projections are flawed and it does not have the support or referral network necessary to populate a 105-bed facility without impacting existing providers. If this proposal is approved, Retreat will syphon the commercially insured and self-pay client from Stonington and other facilities. This will have a significant adverse financial impact on Stonington, which could in turn affect the quality, accessibility and cost-effectiveness of the care that we provide. In this time of expanded access to healthcare for all, particularly Medicaid recipients and indigent persons, OHCA should not approve a facility that has no intention of treating these individuals and that will negatively impact the facilities that do.

For these reasons, Stonington respectfully request that OHCA deny Retreat's CON request. I thank you for your time and am available to answer any questions you may have.

Respectfully Submitted,



William A. Aniskovich, CEO
Stonington Behavioral Health d/b/ a Stonington Institute

EXHIBIT A

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Access Center	APT Foundation, Inc.	1 Long Wharf	New Haven	06511	0	ACD, CMT, OT,
ADRC Outpatient Counseling Center	Alcohol and Drug Recovery Centers, Inc.	16 Coventry Street	Hartford	06112	0	OT
Adult Psychiatric Clinic/Child and Family Guidance Clinic	Cornell Scott-Hill Health Corporation	400 - 428 Columbus Avenue	New Haven	06519	0	OT
Altruism Acute Care and Evaluation	Southeastern Council on Alcoholism and Drug Dependency, Inc.	47 Coit Street	New London	06320	20 RDE	OT, RDE
Altruism House for Men	Southeastern Council on Alcoholism and Drug Dependency, Inc.	313 Main Street	Norwich	06360	13 ILTTR	ILTTR
Altruism House for Women	Southeastern Council on Alcoholism and Drug Dependency, Inc.	1000 Bank Street	New London	06320	10 ILTTR	ILTTR
Altruism House for Women	Southeastern Council on Alcoholism and Drug Dependency, Inc.	62-64 Coit Street	New London	06320	11 ILTTR	ILTTR
Angelus House	Wellspring Foundation, Inc.	158 Flanders Road	Bethlehem	06751	0	OT
Ansonia Counseling Services	Cornell Scott-Hill Health Corporation	121 Wakelee Avenue	Ansonia	06401	0	OT
APT Residential Services	APT Foundation, Inc.	425 Grant Street	Bridgeport	06608	125 ILTTR	ILTTR, OT
Behavioral Health Services at Hamden	Yale University	95 Circular Drive	Hamden	06514	0	OT
Bhcare Valley Outpatient Clinic	BHcare, Inc.	435 East Main Street	Ansonia	06401	0	OT
Bhcare, Inc.-Shoreline Clinic	BHcare, Inc.	14 Sycamore Way	Branford	06405	0	OT
Blue Sky Behavioral Health Clinic	Blue Sky Behavioral Health, LLC	52 Federal Road	Danbury	06810	0	CMT, DET, OT
Bridges ... A Community Support System, Inc.	Bridges ... A Community Support System, Inc.	949 Bridgeport Avenue	Milford	06460	0	OT
Bridges ... A Community Support System, Inc.	Bridges ... A Community Support System, Inc.	270 Center Street	West Haven	06516	0	OT
Carnes Weeks Center	McCall Foundation Inc.	58b High Street	Torrington	06790	20 IT	IT
Casa Eugenio Maria De Hostos	Chemical Abuse Services Agency, Inc.	690 Arctic Street	Bridgeport	06608	10 IT, 6 ILTTR	DET, ILTTR, IT, OT
Catholic Charities	Catholic Charities Diocese of Norwich, Inc.	28 Huntington Street	New London	06320	0	OT
Catholic Charities, Diocese of Norwich, Inc.	Catholic Charities Diocese of Norwich, Inc.	331 Main Street	Norwich	06360	0	OT
Catholic Charities, Diocese of Norwich, Inc.	Catholic Charities Diocese of Norwich, Inc.	151 Broad Street	Middletown	06457	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	90 Franklin Square	New Britain	06051	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	205 Wakelee Avenue	Ansonia	06401	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	203 High Street	Milford	06460	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	501 Lombard Street	New Haven	06513	0	OT

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	56 Church Street	Waterbury	06702	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	13 Wolcott Street	Waterbury	06705	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	132 Grove Street	Torrington	06790	0	OT
Center for Human Services	Recovery Network of Programs, Inc.	2 Research Drive	Stratford	06615	0	OT
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	164 - 166 Bartholomew Street	Hartford	06106	20 ILTTR	ILTTR
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	33 Center Street	Hartford	06106	15 ILTTR	ILTTR
Child and Family Agency of Southeastern Connecticut, Inc. Child Guidance Clinic Essex	Child and Family Agency of Southeastern Connecticut, Inc.	190 Westbrook Road	Essex	06426	0	OT
Child and Family Agency of Southeastern Connecticut, Inc. Groton/Mystic Campus	Child and Family Agency of Southeastern Connecticut, Inc.	591 Poquonnock Road	Groton	06340	0	OT
Child and Family Agency of Southeastern Connecticut, Inc. Smith Bent Children's Center	Child and Family Agency of Southeastern Connecticut, Inc.	7 Vauxhall Street	New London	06320	0	OT
Child and Family Guidance Center, Inc.	Child and Family Guidance Center, Inc.	180 Fairfield Avenue	Bridgeport	06604	0	OT
Child Guidance Clinic for Central Connecticut, Inc.	Child Guidance Clinic for Central Connecticut, Inc.	384 Pratt Street	Meriden	06451	0	OT
Children's Center of Hamden, Inc.	Children's Center of Hamden Inc.	1400 Whitney Avenue	Hamden	06517	0	OT
CHR Manchester	Community Health Resources	587 East Middle Turnpike	Manchester	06040	0	OT
Clayton House	Alcohol and Drug Recovery Centers, Inc.	203 Williams Street	Glastonbury	06033	15 ILTTR	ILTTR
Community Child Guidance Clinic, Inc.	Community Child Guidance Clinic, Inc.	317 North Main Street	Manchester	06042	0	OT
Community Health Center of Wherever You Are Friendship Services Center	Community Health Center, Inc.	241-249 Arch Street	New Britain	06051	0	OT
Community Health Center of Wherever You Are Master's Manna	Community Health Center, Inc.	46 North Plains Industrial Road	Wallingford	06492	0	OT
Community Health Center of Wherever You Are Prudence Crandall	Community Health Center, Inc.	594 Burritt Street	New Britain	06053	0	OT
Community Health Services, Inc.	Community Health Services Inc.	500 Albany Avenue	Hartford	06120	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	81 North Main Street	Bristol	06010	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	26 Russell Street	New Britain	06052	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	5 Hart Street	New Britain	06052	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	55 Winthrop Street	New Britain	06052	0	OT
Community Renewal Team Asian Family Services	Community Renewal Team	1921 Park Street	Hartford	06106	0	OT
Community Renewal Team, Inc. Behavioral Health Services	Community Renewal Team	90 Retreat Avenue	Hartford	06106	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Community Renewal Team, Inc. Behavioral Health Services	Community Renewal Team	330 Market Street	Hartford	06120	0	OT, DET
Community Renewal Team, Inc. Behavioral Health Services	Community Renewal Team	35 Clark Street	Hartford	06120	0	OT, DET
Community Residences, Inc.	Community Residences, Inc.	205 Kelsey Street	Newington	06111	0	OT
Community Substance Abuse Center, Inc.	Community Substance Abuse Centers, Inc.	55 Fishfry Street	Hartford	06120	0	ACD, CMT, OT
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	4 Midland Road	Waterbury	06705	0	ACD, CMT, DET, OT
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	60 Beaver Brook Road	Danbury	06810	0	ACD, CMT, OT
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	20 North Main Street	Norwalk	06854	0	ACD, CMT, OT
Connecticut Junior Republic	Connecticut Junior Republic Association, Inc.	80 Prospect Street	Waterbury	06702	0	OT
Connecticut Junior Republic	Connecticut Junior Republic Association, Inc.	550 Goshen Road	Litchfield	06759	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	1120 Main Street	Bridgeport	06604	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	1 Lafayette Circle	Bridgeport	06604	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	115 Middle Street	Bridgeport	06604	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	17 High Street	Norwalk	06851	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	4 Byington Place	Norwalk	06852	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	141 Franklin Street	Stamford	06901	0	OT
Connection Counseling Center, The	Connection, Inc., The	178 State Street	Meriden	06450	0	OT
Connection Counseling Center, The	Connection, Inc., The	196 Court Street	Middletown	06457	0	OT
Connection Counseling Center, The	Connection, Inc., The	263 Main Street	Old Saybrook	06475	0	OT
Connection House	Connection, Inc., The	167 Liberty Street	Middletown	06457	14 ILTTR	ILTTR
Coventry House	Alcohol and Drug Recovery Centers, Inc.	46 Coventry Street	Hartford	06112	10 ILTTR	ILTTR
Crossroads, Inc.	Crossroads, Inc.	54 East Ramsdell Street	New Haven	06515	174 ILTTR	ILTTR
Crossroads, Inc.	Crossroads, Inc.	44 East Ramsdell Street	New Haven	06515	0	OT
CT Clinical Services, Inc.	CT Clinical Services, Inc.	139 Orange Street	New Haven	06510	0	OT
Detoxification Center	Alcohol and Drug Recovery Centers, Inc.	500 Blue Hills Avenue	Hartford	06112	28 IT, 10 ILTTR, 35 RDE	ILTTR, IT, RDE
Elm City Women and Children's Center and The Connection Counseling Center	Connection, Inc., The	48 Howe Street	New Haven	06511	15 ILTTR	ILTTR

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Fairfield Counseling Services, Inc.	Fairfield Counseling Services Inc.	125 Penfield Road	Fairfield	06824	0	OT
Families In Recovery Program	Liberation Programs, Inc.	141 Franklin Street	Stamford	06901	10 ILTTR	ILTTR
Family and Children's Agency, Inc.	Family and Children's Agency, Inc.	9 Mott Avenue	Norwalk	06850	0	OT
Family Intervention Center	Family Intervention Center, Inc.	22 Chase River Road	Waterbury	06704	0	DET, OT
Family Resource Associates, LLC	Family Resource Associates, LLC	3300 Main Street	Stratford	06614	0	OT
Farrell Treatment Center	Farrell Treatment Center, Inc.	586 Main Street	New Britain	06051	24 IT	IT, OT
First Step	Recovery Network of Programs, Inc.	425 Grant Street	Bridgeport	06610	19 RDE	RDE
Fresh Start	Community Renewal Team	17 Essex Street	Hartford	06120	21 ILTTR	ILTTR, OT
Grant Street Partnership	Cornell Scott-Hill Health Corporation	62 Grant Street	New Haven	06519	0	DET, OT
Greenwich Youth Options	Liberation Programs, Inc.	55 Old Field Point Road	Greenwich	06830	0	OT
Hallie House Women and Children's Center	Connection, Inc., The	99 Eastern Drive	Middletown	06457	8 ILTTR	ILTTR
Hartford Behavioral Health	Hartford Community Mental Health Center, Inc.	2550 Main Street	Hartford	06106	0	OT
Hartford Behavioral Health	Hartford Community Mental Health Center, Inc.	1 Main Street	Hartford	06106	0	OT
Hartford Dispensary - Norwich Clinic	Hartford Dispensary	772 West Thames Street	Norwich	06360	0	ACD, CMT
Hartford Dispensary Henderson/Johnson Clinic	Hartford Dispensary	12 - 14 Weston Street	Hartford	06103	0	ACD, CMT
Hartford Dispensary New Britain Clinic	Hartford Dispensary	70 Whiting Street	New Britain	06050	0	ACD, CMT
Hartford Dispensary/Doctors Clinic	Hartford Dispensary	345 Main Street	Hartford	06106	0	ACD, CMT
Hartford Dispensary/New London Clinic	Hartford Dispensary	931-939 Bank Street	New London	06320	0	ACD, CMT
Hartford Dispensary-16-18 Weston Street	Hartford Dispensary	16-18 Weston Street	Hartford	06120	0	ACD, CMT, OT
Hartford Dispensary-Bristol Clinic	Hartford Dispensary	1098 Farmington Avenue	Bristol	06010	0	ACD, CMT, OT
Hartford Dispensary-Manchester Clinic	Hartford Dispensary	335 Broad Street	Manchester	06040	0	ACD, CMT
Hartford Dispensary-Willimantic Clinic	Hartford Dispensary	54-56 Boston Post Road	Windham	06226	0	ACD, CMT
High Watch Recovery Center	High Watch Recovery Center, Inc.	62 Carter Road	Kent	06757	78 C&R	C&R, DET, OT
Hispanos Unidos, Inc.	Hispanos Unidos, Inc.	116 Sherman Avenue	New Haven	06511	0	OT
Hockanum Valley Community Council, Inc.	Hockanum Valley Community Council, Inc.	27 Naek Road	Vernon	06066	0	OT
Horizons	Recovery Network of Programs, Inc.	1635 Fairfield Avenue	Bridgeport	06605	15 IT	IT
Institute for the Hispanic Family	Catholic Charities, Inc. - Archdiocese of Hartford	45 Wadsworth Street	Hartford	06106	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Integrated Care Clinic	Optimus Health Care, Inc.	780 Summer Street	Stamford	06901	0	OT
Intercommunity, Inc.	Intercommunity, Inc.	287 Main Street	East Hartford	06118	0	OT
Intercommunity, Inc.	Intercommunity, Inc.	281 Main Street	East Hartford	06118	0	OT
Kinsella Treatment Center	Recovery Network of Programs, Inc.	1438 Park Avenue	Bridgeport	06604	0	ACD, CMT, OT
Lebanon Pines Long Term Care	Southeastern Council on Alcoholism and Drug Dependency, Inc.	37 Camp Mooween Road	Lebanon	06249	110 ILTTR	ILTTR
Legion Avenue Clinic	APT Foundation, Inc.	495 Congress Avenue	New Haven	06511	0	ACD, CMT, DET, CMT
Liberation Clinic	Liberation Programs, Inc.	125 Main Street	Stamford	06901	0	OT
Liberation House	Liberation Programs, Inc.	119 Main Street	Stamford	06901	67 ILTTR	ILTTR
Liberation Methadone Clinic (Bridgeport)	Liberation Programs, Inc.	399 Mill Hill Avenue	Bridgeport	06610	0	ACD, CMT, OT
Main Street Clinic	Liberation Programs, Inc.	117 Main Street	Stamford	06901	0	ACD, CMT
MCCA	Midwestern Connecticut Council on Alcoholism, Inc.	38 Old Ridgebury Road	Danbury	06810	20 IT, 10 RDE	ACD, CMT, DET, OT
MCCA/New Milford	Midwestern Connecticut Council on Alcoholism, Inc.	62 Bridge Street	New Milford	06776	0	DET, OT
MCCA/Ridgefield	Midwestern Connecticut Council on Alcoholism, Inc.	90 East Ridge Road	Ridgefield	06877	0	DET, OT
MCCA/Waterbury	Midwestern Connecticut Council on Alcoholism, Inc.	228 Meadow Street	Waterbury	06702	0	DET, OT
McCall Foundation	McCall Foundation, Inc.	58 High Street	Torrington	06790	0	DET, OT
McCall Foundation, Inc.-Winsted Satellite office	McCall Foundation, Inc.	115 Spencer Street	Winchester	06098	0	OT
McCall House	McCall Foundation, Inc.	127 Migeon Avenue	Torrington	06790	14 ILTTR	ILTTR
Milestone/New Life Center/Pathways	Community Health Resources	391 Pomfret Street	Putnam	06260	6 ILTTR, 18 IT	ACD, CMT, IT, ILTTR, RDE
Mother's Retreat and The Connection Counseling Center	Connection, Inc., The	542 Long Hill Road	Groton	06340	8 ILTTR	ILTTR, OT
Mountainside Treatment Center	MCI Healthcare LLC	187 South Canaan Road	Canaan	06018	62 ILTTR	ILTTR
Multicultural Ambulatory Addiction Services	Chemical Abuse Services Agency, Inc.	426 East Street	New Haven	06511	0	ACD, CMT, DET, OT
New Directions, Inc. of North Central Connecticut	New Directions, Inc. of North Central Connecticut	113 Elm Street	Enfield	06082	0	OT
New Era Rehabilitation Center, Inc.	New Era Rehabilitation Center, Inc.	311 East Street	New Haven	06511	0	ACD, CMT, DET, OT
New Era Rehabilitation Center, Inc.	New Era Rehabilitation Center, Inc.	3851 Main Street	Bridgeport	06606	0	ACD, CMT, DET, OT
New Hope Behavioral Health & Substance Abuse	New Hope Manor, Inc.	935 Main Street	Manchester	06040	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

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Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
New Perceptions/Right Turn	Perception Programs, Inc.	54 North Street	Windham	06226	0	OT
New Perceptions/Right Turn	Perception Programs, Inc.	13 Water Street	Killingly	06239	0	OT
New Prospects	Recovery Network of Programs, Inc.	392 Prospect Street	Bridgeport	06604	23 IT	IT
Newtown Youth and Family Services, Inc.	Newtown Youth and Family Services, Inc.	15 Berkshire Road	Newtown	06470	0	OT
North Central Counseling Services	Community Health Resources	693 Bloomfield Avenue	Bloomfield	06002	0	DET, OT
North Central Counseling Services	Community Health Resources	153 Hazard Avenue	Enfield	06082	0	DET, OT
North Haven Community Services	Town of North Haven	5 Linsley Street	North Haven	06473	0	OT
Northside Community Outpatient Services/Child and Family Guidance Clinic	Cornell Scott-Hill Health Corporation	226 Dixwell Avenue	New Haven	06511	0	OT
Northwest Center for Family Service & Mental Health	Community Mental Health Affiliates, Inc.	350 Main Street	Salisbury	06039	0	OT
Northwest Center for Family Service & Mental Health	Community Mental Health Affiliates, Inc.	100 Commercial Boulevard	Torrington	06790	0	OT
Orange Family Counseling	Bridges ... A Community Support System, Inc.	605-A Orange Center Rd	Orange	06477	0	OT
Orchard Hill Treatment Services	APT Foundation, Inc.	540 Ella T. Grasso Boulevard	New Haven	06519	0	ACD, CMT, OT
Outpatient Clinic	Connection, Inc., The	205-209 Orange Street	New Haven	06511	0	OT
Outpatient Treatment	Southeastern Council on Alcoholism and Drug Dependency, Inc.	321 Main Street	Norwich	06360	0	OT
Paces Counseling Associates, Inc.	Paces Counseling Associates, Inc.	991 Main Street	East Hartford	06108	0	OT
Park Street Inn	Connection, Inc., The	98 Park Street	New Haven	06511	0	OT
Patrick F. Mcauliffe Center	Connecticut Renaissance, Inc.	70 Central Avenue	Waterbury	06702	20 IT	IT
Perception House	Perception Programs, Inc.	134 Church Street	Windham	06226	20 ILTTR	ILTTR
Positive Directions - The Center for Prevention and Recovery, Inc.	Positive Directions-The Center for Prevention and Recovery, Inc.	420 Post Road West	Westport	06880	0	OT
Project Courage	Chemical Abuse Services Agency, Inc.	592 Kossuth Street	Bridgeport	06608	0	DET, OT
Recovery Adolescent Program	Recovery Network of Programs, Inc.	1549 Fairfield Avenue	Bridgeport	06605	0	OT
Recovery Counseling Services	Recovery Network of Programs, Inc.	480 Bond Street	Bridgeport	06610	0	OT
Renaissance East	Connecticut Renaissance, Inc.	31 Wolcott Street	Waterbury	06702	32 ILTTR	ILTTR
Renaissance West	Connecticut Renaissance, Inc.	466 West Main Street	Waterbury	06702	50 ILTTR	ILTTR
Reverend Edward M. Dempsey Drug Services	Central Naugatuck Valley HELP, Inc.	900 Watertown Avenue	Waterbury	06708	34 ILTTR	ILTTR

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Rushford Center, Inc.	Rushford Center, Inc.	110 National Drive	Glastonbury	06033	0	OT
Rushford Center, Inc.	Rushford Center, Inc.	883 Paddock Avenue	Meriden	06450	0	ACD, OT
Rushford Center, Inc.	Rushford Center, Inc.	1250 Silver Street	Middletown	06457	16 RDE, 42 IT	ACD, DET, IT, OT, RDE
Rushford Center, Inc.	Rushford Center, Inc.	325 Main Street	Portland	06480	26 ILTTR	ILTTR
Sound Community Services, Inc.	Sound Community Services, Inc.	165 State Street	New London	06320	0	OT
South Central Rehabilitation Center	Cornell Scott-Hill Health Corporation	232 Cedar Street	New Haven	06519	29 RDE	ACD, CMT, RDE, OT
Southwest Community Health Center, Inc.	Southwest Community Health Center, Inc.	1046 Fairfield Avenue	Bridgeport	06604	0	OT
Southwest Community Health Center, Inc.	Southwest Community Health Center, Inc.	968 Fairfield Avenue	Bridgeport	06605	0	OT
Stafford Family Services	Town of Stafford	21 Hyde Park Road	Stafford	06076	0	OT
State Street Counseling Services	Cornell Scott-Hill Health Corporation	911-913 State Street	New Haven	06511	0	OT
Stonington Institute	Stonington Behavioral Health, Inc.	1353 Gold Star Highway	Groton	06340	0	DET, OT
Stonington Institute	Stonington Behavioral Health, Inc.	428 Long Hill Road	Groton	06340	0	DET, OT
Stonington Institute	Stonington Behavioral Health, Inc.	75 Swantown Hill Road	North Stonington	06359	45 IT, 18 RDE	ACD, DET, OT, IT, RDE
Transitions Outpatient Services	Community Health Resources	433 Valley Street	Windham	06226	0	OT
Transitions Outpatient Services	Community Health Resources	37 Commerce Avenue	Killingly	06239	0	OT
Transitions Outpatient Services/Thomas Murphy Center	Community Health Resources	1491 Main Street	Windham	06226	14 ILTTR	ILTTR
Travisano Network	Central Naugatuck Valley Help, Inc.	24 Shelter Rock Road	Danbury	06810	0	OT
Trinity Glen	Midwestern Connecticut Council on Alcoholism, Inc.	149 West Cornwall Road	Sharon	06069	50 C&R	C&R
United Community and Family Services, Inc.	United Community and Family Services, Inc.	400 Bayonet Street	New London	06320	0	OT
United Community and Family Services, Inc.	United Community and Family Services, Inc.	70 Main Street	Griswold	06351	0	OT
United Community and Family Services, Inc.	United Community and Family Services, Inc.	47 Town Street	Norwich	06360	0	OT
United Community and Family Services, Inc.	United Community and Family Services, Inc.	212 Upton Road	Colchester	06415	0	OT
United Services, Inc.	United Services, Inc.	132 Mansfield Avenue	Windham	06226	0	OT
United Services, Inc.	United Services, Inc.	233 Route 6	Columbia	06237	0	OT
United Services, Inc.	United Services, Inc.	1007 North Main Street	Killingly	06241	0	OT
United Services, Inc.	United Services, Inc.	303 Putnam Road	Plainfield	06387	0	OT
Viewpoint Recovery Program	CTE, Inc.	104 Richmond Hill Avenue	Stamford	06902	12 ILTTR	ILTTR

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Village for Families and Children, Inc.	Village for Families and Children, Inc.	1680 Albany Avenue	Hartford	06105	0	OT
Village for Families and Children, Inc.	Village for Families and Children, Inc.	105 Spring Street	Hartford	06105	0	OT
Village for Families and Children, Inc.	Village for Families and Children, Inc.	331 Wethersfield Avenue	Hartford	06114	0	OT
Waterbury Outpatient Services for CMHA	Community Mental Health Affiliates, Inc.	36 Sheffield Street	Waterbury	06704	0	OT
Watkins Network	Central Naugatuck Valley HELP, Inc.	257 Main Street	Torrington	06790	0	OT
Wellmore Behavioral Health	Wellmore, Inc.	402 East Main Street	Waterbury	06702	0	OT
Wellmore Behavioral Health, Inc.	Wellmore, Inc.	30 Controls Drive	Shelton	06484	0	OT
Wellmore, Inc. Therapeutic Shelter	Wellmore, Inc.	142 Griggs Street	Waterbury	06704	0	DET
Wellmore, Inc. Women and Children's Program	Wellmore, Inc.	79 Beacon Street	Waterbury	06704	8 ILTTR	ILTTR
West Haven Health Center Counseling Services	Cornell Scott-Hill Health Corporation	285 Main Street	West Haven	06516	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	36 Russell Street	New Britain	06052	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	75 North Mountain Road	New Britain	06053	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	91 North West Drive	Plainville	06062	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	645 Farmington Avenue	Hartford	06105	0	OT
Wherever You Are Eddy Center	Community Health Center, Inc.	1 Labella Circle	Middletown	06457	0	OT
Wherever You Are Shelter Now	Community Health Center, Inc.	43 Saint Casimir Drive	Meriden	06450	0	OT
Wherever You Are Shepherd Home	Community Health Center, Inc.	112 Bow Lane	Middletown	06457	0	OT
Youth Challenge Bible Training Center	Youth Challenge of Connecticut, Inc.	111 North Sterling Road	Plainfield	06354	9 ILTTR	ILTTR
Youth Challenge Mission for Women	Youth Challenge of Connecticut, Inc.	32 Atwood Street	Hartford	06105	8 ILTTR	ILTTR
Youth Challenge of Connecticut, Inc.-Men's Residential Center	Youth Challenge of Connecticut, Inc.	15-17-19 May Street	Hartford	06105	15 ILTTR	ILTTR
Total of 199 sites licensed and 1,512 beds broken out as follows: ILTTR beds total 972, IT beds total 265, RDE beds total 147 and C&R beds total 128						

Source: DPH licensure files and e-licensure database as of August 2012

[a]ABBREVIATION KEY:

ACD = Ambulatory Chemical Detoxification

CMT - Chemical Maintenance Treatment

C&R = Care and Rehabilitation

DET = Day or Evening Treatment

ILTTR = Intermediate and Long Term Treatment and Rehabilitation

IT = Intensive Treatment

OT = Outpatient Treatment

RDE = Residential Detoxification and Evaluation

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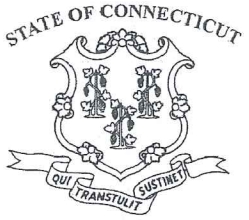
Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

EXHIBIT B



House Bill No. 6705

Public Act No. 13-234

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HOUSING, HUMAN SERVICES AND PUBLIC HEALTH.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2013*) The Commissioner of Housing may appoint a Deputy Commissioner of Housing who shall be qualified by training and experience for the duties of the office of commissioner and shall, in the absence, disability or disqualification of the commissioner, perform all the functions and have all the powers and duties of said office. The position of the Deputy Commissioner of Housing shall be exempt from the classified service.

Sec. 2. (*Effective from passage*) (a) Wherever in sections 4-66h, 8-13m to 8-13s, inclusive, 8-13u to 8-13x, inclusive, and 12-170e of the general statutes the term "secretary" is used, the term "commissioner" shall be substituted in lieu thereof, and wherever the term "the Office of Policy and Management" is used, the term "Housing" shall be substituted in lieu thereof.

(b) Wherever the term "Economic and Community Development" is used in the following general statutes, the term "Housing" shall be substituted in lieu thereof: 4b-21, 7-392, 8-37v, 8-37w, 8-37y, 8-37aa, 8-

expenditures; (2) the process and factors to be used in determining each future year's assessment; and (3) the establishment of an appropriate notification process for the entities assessed under the account.

Sec. 144. Section 19a-639 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) In any deliberations involving a certificate of need application filed pursuant to section 19a-638, the office shall take into consideration and make written findings concerning each of the following guidelines and principles:

(1) Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;

(2) The relationship of the proposed project to the state-wide health care facilities and services plan;

(3) Whether there is a clear public need for the health care facility or services proposed by the applicant;

(4) Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;

(5) Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons, and (B) the impact upon the cost effectiveness of providing access to services provided under the Medicaid program;

(6) The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;

(7) Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;

(8) The utilization of existing health care facilities and health care services in the service area of the applicant; [and]

(9) Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities; and

(10) Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers.

(b) The office, as it deems necessary, may revise or supplement the guidelines and principles through regulation prescribed in subsection (a) of this section.

Sec. 145. Subsection (b) of section 19a-323 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(b) If death occurred in this state, the death certificate required by law shall be filed with the registrar of vital statistics for the town in which such person died, if known, or, if not known, for the town in which the body was found. The Chief Medical Examiner, Deputy Chief Medical Examiner, associate medical examiner, an authorized assistant

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 9th of August, 2013 to the following:

Peter Schorr
c/o Law Office of William P. Beccaro
12 New City Street
Essex, CT 06426
wbeccaro@snet.net

Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy, P.C.

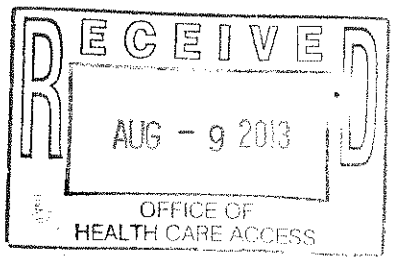
MERITAS LAW FIRMS WORLDWIDE

Jennifer Groves Fusco
(t) 203.786.8316
(f) 203.772.2037
jfusco@uks.com

August 9, 2013

VIA HAND DELIVERY

Lisa A. Davis, M.B.A., B.S.N., R.N.
Deputy Commissioner
Office of Health Care Access
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308



Re: NR Connecticut, LLC d/b/a Retreat at South Connecticut
Establish a 105-Bed Residential Substance Abuse Treatment Facility in New Haven
Docket No. 13-31828-CON

Dear Deputy Commissioner Davis:

This office represents APT Foundation, Inc. in connection with the above-referenced docket. Enclosed are an original and four (4) copies of the following:

- Notice of Appearance of Updike, Kelly & Spellacy, P.C.
- Petition of APT Foundation, Inc. To Be Designated as an Intervenor With Full Rights Including Right of Cross-Examination
- Prefiled Testimony of Robert Freeman

These documents are being submitted in connection with the public hearing on the above matter, scheduled for August 14, 2013 at 9:00 a.m. Mr. Freeman will be present at the hearing to adopt his prefiled testimony under oath and for cross-examination.

Should you require anything further, please feel free to call me at (203) 786-8316.

Very truly yours,

Jennifer Groves Fusco

Enclosures

cc: Robert Freeman (*w/enc.*)

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: CERTIFICATE OF NEED APPLICATION OF NR CONNECTICUT, LLC d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105 BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	)	DOCKET NO. 13-31828-CON
	)	AUGUST 9, 2013

NOTICE OF APPEARANCE

In accordance with Section 19a-9-28 of the Regulations of Connecticut State Agencies, please enter the appearance of Updike, Kelly & Spellacy, P.C. ("Firm") in the above-captioned proceeding on behalf of APT Foundation, Inc. ("APT"). The Firm will appear and represent APT at the public hearing on this matter, scheduled for August 14, 2013.

Respectfully Submitted,

APT FOUNDATION, INC.

By: _____

JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.
265 Church Street
One Century Tower
New Haven, CT 06510
Tel: (203) 786-8300
Fax (203) 772-2037

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 9th of August, 2013 to the following:

Peter Schorr
c/o Law Office of William P. Beccaro
12 New City Street
Essex, CT 06426
wbeccaro@snet.net

Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy, P.C.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: CERTIFICATE OF NEED APPLICATION OF NR CONNECTICUT, LLC d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	)	DOCKET NO. 13-31828-CON
	)	AUGUST 9, 2013

PETITION OF APT FOUNDATION, INC. TO BE DESIGNATED AS AN INTEVENOR WITH FULL RIGHTS INCLUDING THE RIGHT OF CROSS-EXAMINATION

In accordance with Section 4-177a of the Connecticut General Statutes and Section 19a-9-27 of the Regulations of Connecticut State Agencies, APT Foundation, Inc.("APT"), located at 1 Long Wharf Drive, New Haven, CT, 06511, hereby petitions the Office of Health Care Access Division of the Department of Public Health ("OHCA") to be designated as an intervenor with full rights, including the right of cross-examination, in the Certificate of Need ("CON") proceeding designated as Docket No. 13-31828-CON. This proceeding concerns the request of NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Retreat") for permission to establish a 105-bed substance abuse treatment facility in New Haven. The facility would include residential detoxification and evaluation, intensive treatment (rehabilitation), partial hospital, intensive outpatient and outpatient services. APT provides intermediate treatment (rehabilitation) as well as the IOP and outpatient services being proposed by Retreat. APT accepts most commercial insurance, as well as Medicare and Medicaid, and provides services to the uninsured. As detailed herein and in the accompanying testimony of

Robert Freeman, APT would be adversely impacted by the approval of a facility for which there is no clear public need and which will serve commercially insured and self-pay patients only. This proposal will also have a deleterious effect on the healthcare system in New Haven, and in particular on the acute care providers who will be required to provide care and treatment to the individuals Retreat brings into New Haven. This will in turn impact APT and other non-profit providers within the system.

APT Programs & Services

APT was established in 1970 as a non-profit, community-based organization to meet the behavioral health needs of the New Haven community. APT provides outpatient and residential substance abuse, outpatient mental health and primary care services, as well as educational and vocational services, at locations in New Haven, North Haven and Bridgeport. These services include intermediate treatment/residential rehabilitation and the intensive outpatient and outpatient services being proposed by Retreat. Notably, APT has 125 rehabilitation beds located at 425 Grant Street in Bridgeport, with an average of 20 available beds on any given day. There is also no wait time for IOP or outpatient services.

During the past 7 years, APT has made considerable changes to its operations and offerings to permit same-day access to treatment services such as comprehensive evaluation; outpatient; intensive outpatient; methadone maintenance; suboxone; and primary care. APT has been successful in meeting the needs of the community and has been able to expand and enhance services as increased demand dictates.

APT is partially funded by the State of Connecticut Department of Mental Health and Addiction Services ("DMHAS") and accepts self-pay, Medicaid and commercial insurance covering behavioral health services. Only 5 percent of APT's residential rehabilitation patients are self-pay, with the remainder being DMHAS/GA and Court Support Services Division – Department of Corrections ("CSSD-DOC") patients. IOP and outpatient services are 60 percent Medicaid and 40 percent commercial insurance and self-pay. APT also offers free care. In fact, during FY 2013, APT provided nearly $1.8 million in free care to patients without a means to cover the cost of treatment. At the same time, APT was able to assist many of these individuals in obtaining healthcare benefits.

APT's Interests Will Be Adversely Affected by Approval of Retreat's CON Proposal

This CON proposal involves the establishment of a 105-bed residential substance abuse treatment facility in New Haven. If approved, this will be one of the largest freestanding facilities of its kind in the state. Retreat will offer an array of substance abuse services, including residential rehabilitation and the IOP and outpatient services offered by APT.

Retreat has not established a clear public need for a facility of this magnitude in Connecticut. Retreat bases need for the facility on the number of individuals in state who require, but do not seek substance abuse treatment services, as well as an informal survey that purports to show all other Level III.7 detoxification providers operating at capacity. Retreat's arguments are flawed. As APT will demonstrate in its testimony, there are many facilities in Connecticut that can accommodate patients without any wait, despite Retreat's assertions to the contrary. Where capacity may be lacking for a New Haven-based facility is in programs and services that are available to all patients,

including Medicare and Medicaid recipients and the uninsured. This is not the model that Retreat is proposing. APT believes that OHCA should focus growth in behavioral health services on programs that are available to all individuals regardless of payer source, rather than approving exclusionary facilities that create two tiers of care and do not meet the needs or area and state residents.

In addition, Retreat has made no effort to coordinate with local providers, in particular acute care facilities, regarding the care and treatment of substance abuse patients who have co-occurring mental health disorders or medical complications. Retreat has not approached Yale-New Haven Hospital ("YNHH") or any other hospital to the best of our knowledge, about the necessary transfer agreement for these types of services. If Retreat had spoken with YNHH, they would likely have been told that the hospital is operating at capacity for inpatient mental health services and that the influx of patients from Retreat will have a significant deleterious effect on an already overwhelmed system. This in turn will limit access to services for those who need them, including the many Medicaid recipients and indigent patients residing in and around New Haven.

Moreover, because Retreat has not shown a clear public need for the proposed facility, the patients required to meet its projections and to fill a significant number of detoxification and rehabilitation beds will have to come from existing providers, including APT. Retreat claims that it has a referral network in Connecticut and the surrounding states, and will share the referral network associated with its sister facility in Pennsylvania, which will generate sufficient patients to populate the Connecticut facility without impacting existing providers (CON Application, p. 669). However, Retreat has provided only a handful of letters of support for this proposal. None of these letters of support are from providers that are based in or proximate to New Haven. In addition, Retreat's

submissions show that Connecticut residents (at whom this facility is presumably targeted) make up less than one percent (12 of 2,206) of admissions to Retreat's Pennsylvania facility.

In addition, Retreat has made it clear that it will accept commercially insured and self-pay patients only, and will not offer services to Medicare or Medicaid recipients (CON Application pp. 35 & 704). Retreat claims that it will generate higher revenues per bed than its competitors through an extensive referral program that focuses on high-end, private pay (i.e., non-Medicare and/or Medicaid) patients (CON Application, p. 527). This means that the patients diverted from APT and other facilities will be those who generate the highest revenues, leaving existing providers to serve the most vulnerable patients, including Medicare and Medicaid recipients and the uninsured, with less money to cover the cost of providing services. The magnitude of payments from these private sources is substantially greater than payments from public sources (i.e., Medicaid) for comparable services, and thus contributes significantly to the financial sustainability of these programs. Diminution of private sector payments would adversely impact APT's overall financial performance and ability to provide access for New Haven's most vulnerable populations.

Summary of Evidence to Be Presented, Manner of Participation and Relief Sought

APT will ask OHCA to deny Retreat's request for permission to establish a substance abuse treatment facility in New Haven. There is no clear public need for the services being proposed. Conn. Gen. Stat. §19a-639(3). This facility will result in the unnecessary duplication of services and it will adversely impact APT and other existing providers. Conn. Gen. Stat. §19a-639(9). This will be shown through the presentation of capacity and utilization data, as well as other relevant evidence.

The proposal will also decrease the cost-effectiveness and financial feasibility of care by skimming those patients who generate the most revenue from existing providers. Conn. Gen. Stat. §§19a-639(4) & (5). This in turn could have an adverse impact on the quality and accessibility of care provided by APT and others. Conn. Gen. Stat. §19a-639(5).

In addition, APT will introduce evidence of Retreat's failure to engage in discussions with local providers regarding the coordination of care. Most notably, Retreat has failed to discuss options for acute care with YNHH or any hospital, or to make arrangements for a transfer agreement for its patients. The inevitable consequences of this include adverse financial impact on these providers and impaired access to care.

Moreover, Retreat cannot show any reason why a facility that does nothing to enhance access for Medicaid patients, and in fact causes financial harm to those who care for these patients, should be approved. Approval of such a proposal would be contrary to the intent of soon-to-be-implemented changes to the CON statutory decision criteria aimed at improving Medicaid access. *See* P.A. 13-234. APT will present evidence in support of its payer mix and the impact that Retreat's proposal to attract commercially insured and self-pay patients would have on its bottom line.

If APT is granted status, it intends to present this and other evidence and legal arguments in support of its positions. APT respectfully requests that it be allowed to submit written testimony, present evidence and arguments at the August 14, 2013 public hearing on this matter, cross-examine witnesses, and inspect and copy records pertaining to the proceeding. APT's participation will furnish assistance to OHCA in determining whether there is a need for this proposal and what its impact will be on existing providers. APT has information directly relevant to Retreat's erroneous

claims in this regard, which will be presented at the hearing. In addition, APT's participation is in the interest of justice and will not impair the orderly conduct of these proceedings.

WHEREFORE, for the foregoing reasons, APT respectfully requests its Petition to be Designated as an Intervenor With Full Rights be granted.

Respectfully Submitted,

APT FOUNDATION, INC.

By: _____

JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.
265 Church Street
One Century Tower
New Haven, CT 06510
Tel: (203) 786-8300
Fax (203) 772-2037

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 9th of August, 2013 to the following:

Peter Schorr
c/o Law Office of William P. Beccaro
12 New City Street
Essex, CT 06426
wbeccaro@snet.net

Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy, P.C.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: CERTIFICATE OF NEED APPLICATION OF NR CONNECTICUT, LLC d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	)	DOCKET NO. 13-31828-CON
	)	AUGUST 9, 2013

PREFILED TESTIMONY OF
ROBERT FREEMAN

Good morning Hearing Officer Hansted and members of the OHCA staff. My name is Robert Freeman and I am the Director of Clinical Operations of APT Foundation, Inc. ("APT"). Thank you for this opportunity to speak in opposition to the CON Application filed by NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Retreat") for permission to establish a 105-bed substance abuse treatment facility in New Haven. This facility is intended for the treatment of commercially insured and self-pay patients only, and will not be available to those individuals covered by Medicare and Medicaid, or to the uninsured who cannot afford the facility's self-pay rates. My remarks today will focus on the significant adverse impact that a facility of this type and size, for which there is no clear public need, will have on existing providers like APT and on the healthcare delivery system in New Haven. The proposed facility will be of little benefit to New Haven residents, while at the same time taxing the resources of acute care providers who are already struggling to meet the area's behavioral

health and medical needs. For the reasons set forth in this testimony, APT urges OHCA to deny Retreat's CON request.

APT Programs & Services

APT was established in 1970 as a non-profit, community-based organization to meet the behavioral health needs of the New Haven community. APT provides outpatient and residential substance abuse, outpatient mental health and primary care services, as well as educational and vocational services, at locations in New Haven, North Haven and Bridgeport. These include intermediate treatment/residential rehabilitation and the intensive outpatient and outpatient services being proposed by Retreat. Notably, APT has 125 rehabilitation beds located at 425 Grant Street in Bridgeport, with an average of 20 available beds on any given day. There is also no wait time for IOP or outpatient services.

During the past 7 years, APT has made considerable changes to its operations and offerings to permit same-day access to treatment services such as comprehensive evaluation; outpatient; intensive outpatient; methadone maintenance; suboxone; and primary care. We have been successful in meeting the needs of the community and have been able to expand and enhance our services as increased demand dictates.

APT is partially funded by the State of Connecticut Department of Mental Health and Addiction Services ("DMHAS") and accepts self-pay, Medicaid and commercial insurance covering behavioral health services. Only 5 percent of APT's residential rehabilitation patients are self-pay, with the remainder being DMHAS/GA and Court Support Services Division – Department of

Corrections ("CSSD-DOC") patients. IOP and outpatient services are 60 percent Medicaid and 40 percent commercial insurance and self-pay. APT also offers free care. In fact, during FY 2013, APT provided nearly $1.8 million in free care to patients without a means to cover the cost of treatment. At the same time, APT was able to assist many of these individuals in obtaining healthcare benefits.

Nature of Retreat's Proposal

This CON proposal involves the establishment of a 105-bed residential substance abuse treatment facility in New Haven. If approved, this will be one of the largest freestanding facilities of its kind in the state (see Statewide Health Care Facilities & Services Plan, Table 20, attached as Exhibit A). Retreat will offer an array of substance abuse services, including intensive treatment/residential rehabilitation services ("Rehabilitation Services") and the IOP and other outpatient services offered by APT.

The Retreat facility will be located in a former skilled nursing facility on Ella T. Grasso Boulevard in New Haven. Despite its urban placement, Retreat will cater to commercially insured and self-pay patients only. The facility will not admit Medicare, Medicaid or other governmentally insured patients, many of whom reside in and around major cities such as New Haven. Patients insured under Medicare, Medicaid, CHAMPUS and other federal programs, as well as the uninsured, account for nearly 80 percent of all inpatient/newborn discharges in New Haven for FY 2012. These same patients account for almost 90 percent of discharges in the 06519 ZIP code, which roughly covers the Dwight/West-River neighborhood where the Retreat facility will be located (see Exhibit B attached). Nor will the facility be affordable for the area's uninsured population, given that the full

per diem rate for residential services is approximately $1,500 to $1,700 per day (CON Application, p. 656).

In addition, Retreat has made no effort to arrange for a transfer agreement with an acute care facility or to otherwise coordinate with local providers, a requirement of providers offering the level of services proposed by the Retreat.

There Is No Clear Public Need for a Commercial Insurance/Self-Pay Only Substance Abuse Treatment Facility in New Haven

Retreat has not established a clear public need for a 105-bed "luxury" substance abuse treatment facility in New Haven that will serve commercially insured and self-pay patients only, to the exclusion of Medicare and Medicaid recipients and the uninsured.

There is Ample Available Residential Detoxification & Evaluation & Rehabilitation Capacity for New Haven Area Residents

Despite Retreat's claim that need for a residential facility of this magnitude in Connecticut is "firmly established," neither our facility nor the physicians with whom we coordinate (some of whom have written letters in opposition to this CON proposal) have encountered difficulty in finding available RDE or Rehabilitation beds for our commercially insured patients (as compared with Medicaid and low-income patients, who are difficult to place at both levels of service) (CON Application, p. 667).[1]

[1] Note that most commercial insurers will not authorize Rehabilitation Services as a step-down from RDE, but rather authorize these patients for PHP/IOP stays initially. In the event that a Rehabilitation stay is authorized by a commercial insurer, it is typically for a dually diagnosed patient (which Retreat does not appear equipped to handle) and the stay authorized prior to transition to PHP/IOP is short (5-7 days). This does not support Retreat's projection that 100 percent of its RDE patients will step down to Rehabilitation for an extended stay (16.5 days) (CON Application, p. 682).

Examples of RDE/Rehabilitation facilities in our area that typically have same-day availability (subject to pre-admission screening) include APT Foundation in New Haven, Silver Hill in New Canaan and Rushford Center in Middletown. Other RDE/Rehabilitation providers located slightly farther from New Haven, several of which are represented in this room today, likely have capacity for commercially insured patients as well. We find that for residential substance abuse services, the fact that a facility is located some distance from a patient's home is not typically an impediment to placement. As Retreat points out, substance abuse treatment facilities in Connecticut draw patients from across the state and Northeast region (CON Application, p. 27). In fact, many patients prefer to receive these privacy sensitive services at locations outside of their communities (CON Application, p. 27).

An Addiction Residential Census Report from the DMHAS is attached as Exhibit C. The information for this report is provided by grant-funded facilities, as well as other providers who choose to report through the DMHAS portal. It is not a complete list of available beds due to the exclusion of providers who are not grant-funded and the fact that certain facilities do not report on a daily basis, or report after this document has been published. Therefore, in all likelihood it underestimates available capacity. Nevertheless, the report for August 6, 2013 shows that there were at least 9 Level III.7 RDE beds and 22 Rehabilitation beds available for patients. This contradicts Retreat's claim that there is no available capacity for these services in the state.

Also attached as Exhibit C are the results of an informal telephone survey conducted by Yale-New Haven Hospital ("YNHH") of the capacity of existing RDE and Rehabilitation providers. As you can see from this survey, RDE facilities including South Central Rehabilitation Center, Rushford

Center, Stonington Institute, Trinity Glen, First Step, Hallbrook and Altruism Acute Care and Evaluation have no wait for beds. In addition, Mountainside Treatment Center recently received approval to establish 16 RDE beds. These beds are under construction and will be open within the next 6 months. Similarly, there are Rehabilitation beds available with no wait at Stonington Institute and the Patrick F. McAuliffe Center.

Moreover, clear public need does not mean providing citizens with the option of choosing a local or regional "exclusionary" facility that excludes certain members of the population based on wealth or insurance coverage. In fact, OHCA has not historically considered citizens' preferences for a particular type of facility, including a "luxury" facility, in determining whether real need exists and hence a CON should be awarded. This is true notwithstanding the nature of the facility or services requested.

The Retreat Facility Will Not Meet the Needs of New Haven Area Residents or the Objectives of Recent OHCA Legislation

By locating its facility in New Haven, Retreat has implied a commitment to meet the needs of New Haven area residents. However, the need in New Haven is not for additional "luxury" substance abuse capacity for commercially insured and self-pay patients, as Retreat proposes. Rather, the New Haven community requires additional capacity to serve the substance abuse and mental health treatment needs of Medicaid recipients and indigent individuals in our community. According to CHIME data, approximately 80 percent of New Haven's residents, and approximately 90 percent of residents in the 06519 ZIP code (which includes the Dwight/West-River neighborhood where the proposed facility will be located), receive some form of governmental insurance or are uninsured (see

Exhibit B attached). These estimates are conservative and will likely increase as a result of healthcare reform and enhanced access to Medicaid. Retreat has chosen to locate its "luxury" facility in an urban neighborhood that is home to many of these individuals who, due to the exclusionary nature of the facility, will not be able to benefit from its services. In addition, the cost for self-pay services at Retreat makes it unavailable for all but the wealthiest individuals, which does not describe a majority of those in and around New Haven with substance abuse and mental health issues.

Even if there were a need for more residential substance abuse treatment capacity for commercially insured and wealthy individuals in New Haven (which is not the case), the recent focus on ensuring and expanding access for Medicaid and indigent patients means that any new facility should be inclusive of all patients, regardless of payer source. Retreat cannot show any reason why a facility that does nothing to enhance access for Medicaid recipients, and in fact causes financial harm to those who care for these individuals, should be approved.

Approval of such a proposal would be contrary to recent changes in the CON statutory decision criteria aimed at improving Medicaid access. Public Act No. 13-234, which takes effect October 1, 2013, amends Section 19a-639 of the Connecticut General Statutes to include a requirement that an applicant for a CON demonstrate (1) how the provision of, or any change in access to, services for Medicaid recipients and indigent persons improves the quality, accessibility and cost-effectiveness of healthcare in the region; (2) how the proposal will impact the cost-effectiveness of providing access to services under the Medicaid program; (3) an applicant's past and proposed provision of healthcare services to relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons; and (4) whether an applicant, who has failed to

provide access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which may not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other healthcare payers (see Exhibit D attached).

Retreat has stated its intention to exclude Medicare and Medicaid patients from its facility (CON Application, p. 704). It has shown no justification for this approach other than the fact that commercially insured and self-pay patients generate higher revenues, which will give Retreat an advantage over its competitors, who will continue to treat governmentally insured individuals regardless of the financial impact on their bottom lines (CON Application, p. 527). This proposal violates both the letter and the spirit of the new law.

Retreat Will Adversely Impact the New Haven Healthcare System & Existing Providers

This proposal will have an adverse impact on the New Haven healthcare system by taxing the area's already overwhelmed acute care providers with dually diagnosed and medically complicated patients from Retreat. This is true regardless of whether Retreat accepts Medicare and Medicaid patients, because it is a result of the number of patients that the facility will bring into New Haven, irrespective of payer source. It will also adversely impact existing providers of the services being proposed by Retreat, by attracting the higher-paying commercial and self-pay patients whose revenues help to support our operations.

Impact on the New Haven Healthcare System

Retreat is proposing a facility that provides exclusively substance abuse treatment services and has failed to take into account the fact that approximately 60 to 70 percent of substance abuse

patients also suffer from a co-occurring mental health disorder. Retreat is not equipped, and does not appear to have any plan for diagnosing and treating the mental health issues of the patients it brings into New Haven. While Retreat may claim that it will prescreen for mental health issues and refuse these patients, this is not an effective approach because mental health issues often go unreported or undiagnosed until after a patient has completed detoxification. In addition, many RDE patients have medical complications that require treatment in an acute care setting. Again, there is nothing in the CON submissions that indicates how Retreat intends to handle medically complicated patients.

The reality is that substance abuse patients with co-occurring mental health disorders and medical complications often require follow-up care in an acute setting. Because YNHH is the acute care hospital in New Haven, we must assume that this is where Retreat's patients will be directed. Despite this fact, our understanding is that Retreat has made no effort to contact YNHH and arrange for a transfer agreement (which would have to be in place prior to the commencement of services at Retreat) or otherwise discuss coordination of care. In fact, we are not aware of any conversations that Retreat has had with local providers regarding the proposed facility and the impact that it will have on the New Haven healthcare community. This is true notwithstanding the fact that Retreat has begun construction on the facility in anticipation of an approval and had meetings with some local elected officials to garner support for the proposal.

Transfer agreements and coordination of care are critical to the proper functioning of our healthcare system. Care must be managed such that patients receive the services they require without impacting the ability of others in the community to obtain the same services. If Retreat had reached out to YNHH, they would likely have been told that the hospital is operating at capacity for inpatient

mental health services. We understand that all beds are full on a regular basis and patients are receiving services in the Emergency Department. YNHH has a finite amount of capacity and if patients are transferred from Retreat to YNHH or seek treatment at YNHH after discharge, we believe they will overwhelm an already overburdened community behavioral health and medical services provider and reduce access to services for Medicaid recipients and the uninsured in the New Haven area, particularly urgent care services in the Emergency Department and aftercare services and residential housing post-treatment. Notably, these are patients who, but for receiving services at Retreat, would likely not be in the New Haven area and accessing services through the hospital.

This inevitable influx of patients will have a deleterious effect on local acute care providers not only from a resources perspective, but from a financial perspective as well. Commercial behavioral health benefits are typically very limited – meaning they authorize less services and shorter stays than most medical insurances. As a result, many of Retreat's patients may have exhausted their benefits by the time they present at YNHH and will be unable to pay for care. This in turn will result in financial harm to the hospital, which may further limit access to care for those individuals who live in and around New Haven, who have Medicaid or are uninsured, and who rely on the hospital for services. This type of negative impact on the strength of the New Haven healthcare system is contrary to the intention of the CON statutes.

Impact on Existing Providers

Retreat has not shown that it can fill 105 substance abuse treatment beds with commercially insured and self-pay patients without attracting patients from existing providers. The only referral network that Retreat has been able to demonstrate includes a handful of clinicians (from outside of

the New Haven market) and several employee assistance programs (CON Application, pp. 670-674). By Retreat's own admission, clinicians are not a high-volume referral source for residential substance abuse facilities, accounting for only 2 percent of admissions to its Pennsylvania facility (CON Application, p. 706). Retreat claims that it will draw 75 percent of its admissions from Connecticut however the lack of Connecticut referral sources makes this unlikely without impact to existing providers in the state (CON Application, p. 669). Retreat also claims that it will share the existing referral network of its sister facility in Lancaster, Pennsylvania (CON Application, p. 669). However, given that only 12 of Retreat at Lancaster County's 2,206 patients (.05%) in FY 2012 were Connecticut residents, it is difficult to imagine how this referral network will assist Retreat at South Connecticut in meeting its goal (CON Application, p. 686).[2] Retreat's projections are simply too ambitious to meet without an established referral network, and Retreat does not have an established referral network for Connecticut.

Because Retreat has not shown a clear public need for the proposed facility, the patients required to meet its projections and to fill a significant number of detoxification and rehabilitation beds will have to come from existing providers. In addition, Retreat has made it clear that it will accept commercially insured and self-pay patients only, and will not offer services to Medicare or Medicaid recipients (CON Application pp. 35 & 704). Retreat claims that it will generate higher revenues per bed than its competitors through an extensive referral program that focuses on high-end,

[2] Retreat claims that there is a need for the proposed facility in New Haven so that patients from the area are not burdened by travel, which can increase the cost of care and preclude family members from actively participating in a patient's care (CON Application, p. 38). However, the statistics cited in this paragraph make it clear that Retreat sought out and treated patients from Connecticut at its Pennsylvania facility. These individuals likely traveled more than 4 hours to Lancaster County for services. If Retreat likewise intends to populate the Connecticut facility with out-of-state residents, then this proposal is not serving the needs of the residents of our state.

private pay (i.e. non-Medicare and/or Medicaid) patients (CON Application, p. 527). This means that the patients diverted from existing providers will be those who generate the highest revenues, leaving existing providers to serve the most vulnerable patients, including Medicare and Medicaid recipients and the uninsured, with less money to cover the cost of providing services.

Approximately 60 percent of APT's IOP and outpatients are governmentally insured or low-income uninsured. Only 40 percent of outpatients are commercially insured or the self-pay clients being targeted by Retreat and only 5 percent of Rehabilitation Services are non-government-funded. However, the magnitude of payments from these private sources is substantially greater than payments from public sources (i.e. Medicaid) for comparable services, and thus contributes significantly to the financial sustainability of these programs. Diminution of private sector payments would adversely impact APT's overall financial performance and our ability to provide access for New Haven's most vulnerable populations.

Conclusion

Retreat is proposing to establish one of the largest freestanding substance abuse treatment facilities in Connecticut. Retreat has not shown a clear public need for this facility, and in fact it will duplicate the services of many existing freestanding substance abuse treatment facilities. Conn. Gen. Stat. §§19a-639(3) & (9). Retreat's projections are flawed and it does not have the support or referral network necessary to populate a 105-bed facility without impacting existing providers. If this project is approved, Retreat will syphon the commercially insured and self-pay patients from existing facilities, which will have a significant adverse financial impact on these facilities. This could in turn

affect the quality, accessibility and cost-effectiveness of healthcare in the New Haven community. Conn. Gen. Stat. §19a-639(5).

In addition, Retreat has made no effort to establish relationships with local providers including acute care providers, who will be required to treat the many dually diagnosed and medically complicated patients that Retreat brings into New Haven. Retreat does not have a transfer agreement in place and has not had any discussions about such an agreement with the acute care hospital in New Haven, YNHH. This proposal will inevitably place additional burdens on the YNHH and New Haven healthcare systems as a result of the treatment needs of Retreat's patients. This will adversely impact access to care and, ultimately, the financial strength of the healthcare system. Conn. Gen. Stat. §19a-639(4).

In this time of expanded access to healthcare for all, particularly Medicaid recipients and indigent persons, OHCA should not approve a facility that has no intention of treating these individuals and that will negatively impact the facilities that do. The proposal is also inconsistent with the aims of federal healthcare reform, including the goals of reducing costs and making services more widely available to larger segments of the population. Also, there is no community benefit to a substance abuse treatment facility in New Haven that cannot serve a large percentage of New Haven residents because of its exclusionary payment policies. The facility would be unavailable to those who need it most – the Medicaid recipients and indigent individuals who receive care at APT and other local non-profit providers.

Even if Retreat were to change its model and accept all patients regardless of payer source, including Medicaid, this proposal still should not be approved due to several significant issues,

including overburdening existing providers without assessing current capacity of the downstream services that will be required for Retreat's patients. Retreat's submissions simply do not establish that the proposal is consistent with the statutory decision criteria for CONs set forth in Section 19a-639 of the General Statutes. This includes, most notably, the lack of clear public need for the Retreat at South Connecticut and Retreat's failure to implement an acute care transfer process to address the needs of the dually diagnosed and medically complicated individuals from out of town that Retreat will bring into the New Haven. Nor will the proposal increase access to residential services for the New Haven community – instead access will be diminished through use of the finite resources of acute care providers. Retreat has also failed to investigate capacity for transitional care in the community (of which there is very little) for out-of-town patients who choose to stay with Retreat for outpatient care after their residential stays are complete. These problems exist no matter which payers Retreat agrees to accept, and they support denial of this CON application. And lastly, it would be easy for Retreat to agree to accept Medicaid, but then de facto exclude all but commercially insured and self-pay patients through its admissions process.

For these reasons, APT respectfully request that OHCA deny Retreat's CON request. I thank you for your time and am available to answer any questions you may have.

Respectfully Submitted,

ROBERT FREEMAN
APT FOUNDATION, INC.

EXHIBIT A

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Access Center	APT Foundation, Inc.	1 Long Wharf	New Haven	06511	0	ACD, CMT, OT,
ADRC Outpatient Counseling Center	Alcohol and Drug Recovery Centers, Inc.	16 Coventry Street	Hartford	06112	0	OT
Adult Psychiatric Clinic/Child and Family Guidance Clinic	Cornell Scott-Hill Health Corporation	400 - 428 Columbus Avenue	New Haven	06519	0	OT
Altruism Acute Care and Evaluation	Southeastern Council on Alcoholism and Drug Dependency, Inc.	47 Coit Street	New London	06320	20 RDE	OT, RDE
Altruism House for Men	Southeastern Council on Alcoholism and Drug Dependency, Inc.	313 Main Street	Norwich	06360	13 ILTTR	ILTTR
Altruism House for Women	Southeastern Council on Alcoholism and Drug Dependency, Inc.	1000 Bank Street	New London	06320	10 ILTTR	ILTTR
Altruism House for Women	Southeastern Council on Alcoholism and Drug Dependency, Inc.	62-64 Coit Street	New London	06320	11 ILTTR	ILTTR
Angelus House	Wellspring Foundation, Inc.	158 Flanders Road	Bethlehem	06751	0	OT
Ansonia Counseling Services	Cornell Scott-Hill Health Corporation	121 Wakelee Avenue	Ansonia	06401	0	OT
APT Residential Services	APT Foundation, Inc.	425 Grant Street	Bridgeport	06608	125 ILTTR	ILTTR, OT
Behavioral Health Services at Hamden	Yale University	95 Circular Drive	Hamden	06514	0	OT
Bhcare Valley Outpatient Clinic	BHcare, Inc.	435 East Main Street	Ansonia	06401	0	OT
Bhcare, Inc.-Shoreline Clinic	BHcare, Inc.	14 Sycamore Way	Branford	06405	0	OT
Blue Sky Behavioral Health Clinic	Blue Sky Behavioral Health, LLC	52 Federal Road	Danbury	06810	0	CMT, DET, OT
Bridges ... A Community Support System, Inc.	Bridges ... A Community Support System, Inc.	949 Bridgeport Avenue	Milford	06460	0	OT
Bridges ... A Community Support System, Inc.	Bridges ... A Community Support System, Inc.	270 Center Street	West Haven	06516	0	OT
Carnes Weeks Center	McCall Foundation Inc.	58b High Street	Torrington	06790	20 IT	IT
Casa Eugenio Maria De Hostos	Chemical Abuse Services Agency, Inc.	690 Arctic Street	Bridgeport	06608	10 IT, 6 ILTTR	DET, ILTTR, IT, OT
Catholic Charities	Catholic Charities Diocese of Norwich, Inc.	28 Huntington Street	New London	06320	0	OT
Catholic Charities, Diocese of Norwich, Inc.	Catholic Charities Diocese of Norwich, Inc.	331 Main Street	Norwich	06360	0	OT
Catholic Charities, Diocese of Norwich, Inc.	Catholic Charities Diocese of Norwich, Inc.	151 Broad Street	Middletown	06457	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	90 Franklin Square	New Britain	06051	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	205 Wakelee Avenue	Ansonia	06401	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	203 High Street	Milford	06460	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	501 Lombard Street	New Haven	06513	0	OT

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	56 Church Street	Waterbury	06702	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	13 Wolcott Street	Waterbury	06705	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	132 Grove Street	Torrington	06790	0	OT
Center for Human Services	Recovery Network of Programs, Inc.	2 Research Drive	Stratford	06615	0	OT
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	164 - 166 Bartholomew Street	Hartford	06106	20 ILTTR	ILTTR
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	33 Center Street	Hartford	06106	15 ILTTR	ILTTR
Child and Family Agency of Southeastern Connecticut, Inc. Child Guidance Clinic Essex	Child and Family Agency of Southeastern Connecticut, Inc.	190 Westbrook Road	Essex	06426	0	OT
Child and Family Agency of Southeastern Connecticut, Inc. Groton/Mystic Campus	Child and Family Agency of Southeastern Connecticut, Inc.	591 Poquonnock Road	Groton	06340	0	OT
Child and Family Agency of Southeastern Connecticut, Inc. Smith Bent Children's Center	Child and Family Agency of Southeastern Connecticut, Inc.	7 Vauxhall Street	New London	06320	0	OT
Child and Family Guidance Center, Inc.	Child and Family Guidance Center, Inc.	180 Fairfield Avenue	Bridgeport	06604	0	OT
Child Guidance Clinic for Central Connecticut, Inc.	Child Guidance Clinic for Central Connecticut, Inc.	384 Pratt Street	Meriden	06451	0	OT
Children's Center of Hamden, Inc.	Children's Center of Hamden Inc.	1400 Whitney Avenue	Hamden	06517	0	OT
CHR Manchester	Community Health Resources	587 East Middle Turnpike	Manchester	06040	0	OT
Clayton House	Alcohol and Drug Recovery Centers, Inc.	203 Williams Street	Glastonbury	06033	15 ILTTR	ILTTR
Community Child Guidance Clinic, Inc.	Community Child Guidance Clinic, Inc.	317 North Main Street	Manchester	06042	0	OT
Community Health Center of Wherever You Are Friendship Services Center	Community Health Center, Inc.	241-249 Arch Street	New Britain	06051	0	OT
Community Health Center of Wherever You Are Master's Manna	Community Health Center, Inc.	46 North Plains Industrial Road	Wallingford	06492	0	OT
Community Health Center of Wherever You Are Prudence Crandall	Community Health Center, Inc.	594 Burritt Street	New Britain	06053	0	OT
Community Health Services, Inc.	Community Health Services Inc.	500 Albany Avenue	Hartford	06120	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	81 North Main Street	Bristol	06010	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	26 Russell Street	New Britain	06052	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	5 Hart Street	New Britain	06052	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	55 Winthrop Street	New Britain	06052	0	OT
Community Renewal Team Asian Family Services	Community Renewal Team	1921 Park Street	Hartford	06106	0	OT
Community Renewal Team, Inc. Behavioral Health Services	Community Renewal Team	90 Retreat Avenue	Hartford	06106	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Community Renewal Team, Inc. Behavioral Health Services	Community Renewal Team	330 Market Street	Hartford	06120	0	OT, DET
Community Renewal Team, Inc. Behavioral Health Services	Community Renewal Team	35 Clark Street	Hartford	06120	0	OT, DET
Community Residences, Inc.	Community Residences, Inc.	205 Kelsey Street	Newington	06111	0	OT
Community Substance Abuse Center, Inc.	Community Substance Abuse Centers, Inc.	55 Fishfry Street	Hartford	06120	0	ACD, CMT, OT
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	4 Midland Road	Waterbury	06705	0	ACD, CMT, DET, OT
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	60 Beaver Brook Road	Danbury	06810	0	ACD, CMT, OT
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	20 North Main Street	Norwalk	06854	0	ACD, CMT, OT
Connecticut Junior Republic	Connecticut Junior Republic Association, Inc.	80 Prospect Street	Waterbury	06702	0	OT
Connecticut Junior Republic	Connecticut Junior Republic Association, Inc.	550 Goshen Road	Litchfield	06759	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	1120 Main Street	Bridgeport	06604	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	1 Lafayette Circle	Bridgeport	06604	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	115 Middle Street	Bridgeport	06604	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	17 High Street	Norwalk	06851	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	4 Byington Place	Norwalk	06852	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	141 Franklin Street	Stamford	06901	0	OT
Connection Counseling Center, The	Connection, Inc., The	178 State Street	Meriden	06450	0	OT
Connection Counseling Center, The	Connection, Inc., The	196 Court Street	Middletown	06457	0	OT
Connection Counseling Center, The	Connection, Inc., The	263 Main Street	Old Saybrook	06475	0	OT
Connection House	Connection, Inc., The	167 Liberty Street	Middletown	06457	14 ILTTR	ILTTR
Coventry House	Alcohol and Drug Recovery Centers, Inc.	46 Coventry Street	Hartford	06112	10 ILTTR	ILTTR
Crossroads, Inc.	Crossroads, Inc.	54 East Ramsdell Street	New Haven	06515	174 ILTTR	ILTTR
Crossroads, Inc.	Crossroads, Inc.	44 East Ramsdell Street	New Haven	06515	0	OT
CT Clinical Services, Inc.	CT Clinical Services, Inc.	139 Orange Street	New Haven	06510	0	OT
Detoxification Center	Alcohol and Drug Recovery Centers, Inc.	500 Blue Hills Avenue	Hartford	06112	28 IT, 10 ILTTR, 35 RDE	ILTTR, IT, RDE
Elm City Women and Children's Center and The Connection Counseling Center	Connection, Inc., The	48 Howe Street	New Haven	06511	15 ILTTR	ILTTR

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Fairfield Counseling Services, Inc.	Fairfield Counseling Services Inc.	125 Penfield Road	Fairfield	06824	0	OT
Families In Recovery Program	Liberation Programs, Inc.	141 Franklin Street	Stamford	06901	10 ILTTR	ILTTR
Family and Children's Agency, Inc.	Family and Children's Agency, Inc.	9 Mott Avenue	Norwalk	06850	0	OT
Family Intervention Center	Family Intervention Center, Inc.	22 Chase River Road	Waterbury	06704	0	DET, OT
Family Resource Associates, LLC	Family Resource Associates, LLC	3300 Main Street	Stratford	06614	0	OT
Farrell Treatment Center	Farrell Treatment Center, Inc.	586 Main Street	New Britain	06051	24 IT	IT, OT
First Step	Recovery Network of Programs, Inc.	425 Grant Street	Bridgeport	06610	19 RDE	RDE
Fresh Start	Community Renewal Team	17 Essex Street	Hartford	06120	21 ILTTR	ILTTR, OT
Grant Street Partnership	Cornell Scott-Hill Health Corporation	62 Grant Street	New Haven	06519	0	DET, OT
Greenwich Youth Options	Liberation Programs, Inc.	55 Old Field Point Road	Greenwich	06830	0	OT
Hallie House Women and Children's Center	Connection, Inc., The	99 Eastern Drive	Middletown	06457	8 ILTTR	ILTTR
Hartford Behavioral Health	Hartford Community Mental Health Center, Inc.	2550 Main Street	Hartford	06106	0	OT
Hartford Behavioral Health	Hartford Community Mental Health Center, Inc.	1 Main Street	Hartford	06106	0	OT
Hartford Dispensary - Norwich Clinic	Hartford Dispensary	772 West Thames Street	Norwich	06360	0	ACD, CMT
Hartford Dispensary Henderson/Johnson Clinic	Hartford Dispensary	12 - 14 Weston Street	Hartford	06103	0	ACD, CMT
Hartford Dispensary New Britain Clinic	Hartford Dispensary	70 Whiting Street	New Britain	06050	0	ACD, CMT
Hartford Dispensary/Doctors Clinic	Hartford Dispensary	345 Main Street	Hartford	06106	0	ACD, CMT
Hartford Dispensary/New London Clinic	Hartford Dispensary	931-939 Bank Street	New London	06320	0	ACD, CMT
Hartford Dispensary-16-18 Weston Street	Hartford Dispensary	16-18 Weston Street	Hartford	06120	0	ACD, CMT, OT
Hartford Dispensary-Bristol Clinic	Hartford Dispensary	1098 Farmington Avenue	Bristol	06010	0	ACD, CMT, OT
Hartford Dispensary-Manchester Clinic	Hartford Dispensary	335 Broad Street	Manchester	06040	0	ACD, CMT
Hartford Dispensary-Willimantic Clinic	Hartford Dispensary	54-56 Boston Post Road	Windham	06226	0	ACD, CMT
High Watch Recovery Center	High Watch Recovery Center, Inc.	62 Carter Road	Kent	06757	78 C&R	C&R, DET, OT
Hispanos Unidos, Inc.	Hispanos Unidos, Inc.	116 Sherman Avenue	New Haven	06511	0	OT
Hockanum Valley Community Council, Inc.	Hockanum Valley Community Council, Inc.	27 Naek Road	Vernon	06066	0	OT
Horizons	Recovery Network of Programs, Inc.	1635 Fairfield Avenue	Bridgeport	06605	15 IT	IT
Institute for the Hispanic Family	Catholic Charities, Inc. - Archdiocese of Hartford	45 Wadsworth Street	Hartford	06106	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Integrated Care Clinic	Optimus Health Care, Inc.	780 Summer Street	Stamford	06901	0	OT
Intercommunity, Inc.	Intercommunity, Inc.	287 Main Street	East Hartford	06118	0	OT
Intercommunity, Inc.	Intercommunity, Inc.	281 Main Street	East Hartford	06118	0	OT
Kinsella Treatment Center	Recovery Network of Programs, Inc.	1438 Park Avenue	Bridgeport	06604	0	ACD, CMT, OT
Lebanon Pines Long Term Care	Southeastern Council on Alcoholism and Drug Dependency, Inc.	37 Camp Mooween Road	Lebanon	06249	110 ILTTR	ILTTR
Legion Avenue Clinic	APT Foundation, Inc.	495 Congress Avenue	New Haven	06511	0	ACD, CMT, DET, CMT
Liberation Clinic	Liberation Programs, Inc.	125 Main Street	Stamford	06901	0	OT
Liberation House	Liberation Programs, Inc.	119 Main Street	Stamford	06901	67 ILTTR	ILTTR
Liberation Methadone Clinic (Bridgeport)	Liberation Programs, Inc.	399 Mill Hill Avenue	Bridgeport	06610	0	ACD, CMT, OT
Main Street Clinic	Liberation Programs, Inc.	117 Main Street	Stamford	06901	0	ACD, CMT
MCCA	Midwestern Connecticut Council on Alcoholism, Inc.	38 Old Ridgebury Road	Danbury	06810	20 IT, 10 RDE	ACD, CMT, DET, OT
MCCA/New Milford	Midwestern Connecticut Council on Alcoholism, Inc.	62 Bridge Street	New Milford	06776	0	DET, OT
MCCA/Ridgefield	Midwestern Connecticut Council on Alcoholism, Inc.	90 East Ridge Road	Ridgefield	06877	0	DET, OT
MCCA/Waterbury	Midwestern Connecticut Council on Alcoholism, Inc.	228 Meadow Street	Waterbury	06702	0	DET, OT
McCall Foundation	McCall Foundation, Inc.	58 High Street	Torrington	06790	0	DET, OT
McCall Foundation, Inc.-Winsted Satellite office	McCall Foundation, Inc.	115 Spencer Street	Winchester	06098	0	OT
McCall House	McCall Foundation, Inc.	127 Migeon Avenue	Torrington	06790	14 ILTTR	ILTTR
Milestone/New Life Center/Pathways	Community Health Resources	391 Pomfret Street	Putnam	06260	6 ILTTR, 18 IT	ACD, CMT, IT, ILTTR, RDE
Mother's Retreat and The Connection Counseling Center	Connection, Inc., The	542 Long Hill Road	Groton	06340	8 ILTTR	ILTTR, OT
Mountainside Treatment Center	MCI Healthcare LLC	187 South Canaan Road	Canaan	06018	62 ILTTR	ILTTR
Multicultural Ambulatory Addiction Services	Chemical Abuse Services Agency, Inc.	426 East Street	New Haven	06511	0	ACD, CMT, DET, OT
New Directions, Inc. of North Central Connecticut	New Directions, Inc. of North Central Connecticut	113 Elm Street	Enfield	06082	0	OT
New Era Rehabilitation Center, Inc.	New Era Rehabilitation Center, Inc.	311 East Street	New Haven	06511	0	ACD, CMT, DET, OT
New Era Rehabilitation Center, Inc.	New Era Rehabilitation Center, Inc.	3851 Main Street	Bridgeport	06606	0	ACD, CMT, DET, OT
New Hope Behavioral Health & Substance Abuse	New Hope Manor, Inc.	935 Main Street	Manchester	06040	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
New Perceptions/Right Turn	Perception Programs, Inc.	54 North Street	Windham	06226	0	OT
New Perceptions/Right Turn	Perception Programs, Inc.	13 Water Street	Killingly	06239	0	OT
New Prospects	Recovery Network of Programs, Inc.	392 Prospect Street	Bridgeport	06604	23 IT	IT
Newtown Youth and Family Services, Inc.	Newtown Youth and Family Services, Inc.	15 Berkshire Road	Newtown	06470	0	OT
North Central Counseling Services	Community Health Resources	693 Bloomfield Avenue	Bloomfield	06002	0	DET, OT
North Central Counseling Services	Community Health Resources	153 Hazard Avenue	Enfield	06082	0	DET, OT
North Haven Community Services	Town of North Haven	5 Linsley Street	North Haven	06473	0	OT
Northside Community Outpatient Services/Child and Family Guidance Clinic	Cornell Scott-Hill Health Corporation	226 Dixwell Avenue	New Haven	06511	0	OT
Northwest Center for Family Service & Mental Health	Community Mental Health Affiliates, Inc.	350 Main Street	Salisbury	06039	0	OT
Northwest Center for Family Service & Mental Health	Community Mental Health Affiliates, Inc.	100 Commercial Boulevard	Torrington	06790	0	OT
Orange Family Counseling	Bridges ... A Community Support System, Inc.	605-A Orange Center Rd	Orange	06477	0	OT
Orchard Hill Treatment Services	APT Foundation, Inc.	540 Ella T. Grasso Boulevard	New Haven	06519	0	ACD, CMT, OT
Outpatient Clinic	Connection, Inc., The	205-209 Orange Street	New Haven	06511	0	OT
Outpatient Treatment	Southeastern Council on Alcoholism and Drug Dependency, Inc.	321 Main Street	Norwich	06360	0	OT
Paces Counseling Associates, Inc.	Paces Counseling Associates, Inc.	991 Main Street	East Hartford	06108	0	OT
Park Street Inn	Connection, Inc., The	98 Park Street	New Haven	06511	0	OT
Patrick F. Mcauliffe Center	Connecticut Renaissance, Inc.	70 Central Avenue	Waterbury	06702	20 IT	IT
Perception House	Perception Programs, Inc.	134 Church Street	Windham	06226	20 ILTTR	ILTTR
Positive Directions - The Center for Prevention and Recovery, Inc.	Positive Directions-The Center for Prevention and Recovery, Inc.	420 Post Road West	Westport	06880	0	OT
Project Courage	Chemical Abuse Services Agency, Inc.	592 Kossuth Street	Bridgeport	06608	0	DET, OT
Recovery Adolescent Program	Recovery Network of Programs, Inc.	1549 Fairfield Avenue	Bridgeport	06605	0	OT
Recovery Counseling Services	Recovery Network of Programs, Inc.	480 Bond Street	Bridgeport	06610	0	OT
Renaissance East	Connecticut Renaissance, Inc.	31 Wolcott Street	Waterbury	06702	32 ILTTR	ILTTR
Renaissance West	Connecticut Renaissance, Inc.	466 West Main Street	Waterbury	06702	50 ILTTR	ILTTR
Reverend Edward M. Dempsey Drug Services	Central Naugatuck Valley HELP, Inc.	900 Watertown Avenue	Waterbury	06708	34 ILTTR	ILTTR

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Rushford Center, Inc.	Rushford Center, Inc.	110 National Drive	Glastonbury	06033	0	OT
Rushford Center, Inc.	Rushford Center, Inc.	883 Paddock Avenue	Meriden	06450	0	ACD, OT
Rushford Center, Inc.	Rushford Center, Inc.	1250 Silver Street	Middletown	06457	16 RDE, 42 IT	ACD, DET, IT, OT, RDE
Sound Community Services, Inc.	Sound Community Services, Inc.	325 Main Street	Portland	06480	26 ILTTR	ILTTR
South Central Rehabilitation Center	Cornell Scott-Hill Health Corporation	165 State Street	New London	06320	0	OT
Southwest Community Health Center, Inc.	Southwest Community Health Center, Inc.	232 Cedar Street	New Haven	06519	29 RDE	ACD, CMT, RDE, OT
Southwest Community Health Center, Inc.	Southwest Community Health Center, Inc.	1046 Fairfield Avenue	Bridgeport	06604	0	OT
Stafford Family Services	Town of Stafford	968 Fairfield Avenue	Bridgeport	06605	0	OT
State Street Counseling Services	Cornell Scott-Hill Health Corporation	21 Hyde Park Road	Stafford	06076	0	OT
Stonington Institute	Stonington Behavioral Health, Inc.	911-913 State Street	New Haven	06511	0	OT
Stonington Institute	Stonington Behavioral Health, Inc.	1353 Gold Star Highway	Groton	06340	0	DET, OT
Stonington Institute	Stonington Behavioral Health, Inc.	428 Long Hill Road	Groton	06340	0	DET, OT
Transitions Outpatient Services	Community Health Resources	75 Swantown Hill Road	North Stonington	06359	45 IT, 18 RDE	ACD, DET, OT, IT, RDE
Transitions Outpatient Services	Community Health Resources	433 Valley Street	Windham	06226	0	OT
Transitions Outpatient Services/Thomas Murphy Center	Community Health Resources	37 Commerce Avenue	Killingly	06239	0	OT
Travisano Network	Central Naugatuck Valley Help, Inc.	1491 Main Street	Windham	06226	14 ILTTR	ILTTR
Trinity Glen	Midwestern Connecticut Council on Alcoholism, Inc.	24 Shelter Rock Road	Danbury	06810	0	OT
United Community and Family Services, Inc.	United Community and Family Services, Inc.	149 West Cornwall Road	Sharon	06069	50 C&R	C&R
United Community and Family Services, Inc.	United Community and Family Services, Inc.	400 Bayonet Street	New London	06320	0	OT
United Community and Family Services, Inc.	United Community and Family Services, Inc.	70 Main Street	Griswold	06351	0	OT
United Community and Family Services, Inc.	United Community and Family Services, Inc.	47 Town Street	Norwich	06360	0	OT
United Services, Inc.	United Services, Inc.	212 Upton Road	Colchester	06415	0	OT
United Services, Inc.	United Services, Inc.	132 Mansfield Avenue	Windham	06226	0	OT
United Services, Inc.	United Services, Inc.	233 Route 6	Columbia	06237	0	OT
United Services, Inc.	United Services, Inc.	1007 North Main Street	Killingly	06241	0	OT
Viewpoint Recovery Program	CTE, Inc.	303 Putnam Road	Plainfield	06387	0	OT
		104 Richmond Hill Avenue	Stamford	06902	12 ILTTR	ILTTR

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Village for Families and Children, Inc.	Village for Families and Children, Inc.	1680 Albany Avenue	Hartford	06105	0	OT
Village for Families and Children, Inc.	Village for Families and Children, Inc.	105 Spring Street	Hartford	06105	0	OT
Village for Families and Children, Inc.	Village for Families and Children, Inc.	331 Wethersfield Avenue	Hartford	06114	0	OT
Waterbury Outpatient Services for CMHA	Community Mental Health Affiliates, Inc.	36 Sheffield Street	Waterbury	06704	0	OT
Watkins Network	Central Naugatuck Valley HELP, Inc.	257 Main Street	Torrington	06790	0	OT
Wellmore Behavioral Health	Wellmore, Inc.	402 East Main Street	Waterbury	06702	0	OT
Wellmore Behavioral Health, Inc.	Wellmore, Inc.	30 Controls Drive	Shelton	06484	0	OT
Wellmore, Inc. Therapeutic Shelter	Wellmore, Inc.	142 Griggs Street	Waterbury	06704	0	DET
Wellmore, Inc. Women and Children's Program	Wellmore, Inc.	79 Beacon Street	Waterbury	06704	8 ILTTR	ILTTR
West Haven Health Center Counseling Services	Cornell Scott-Hill Health Corporation	285 Main Street	West Haven	06516	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	36 Russell Street	New Britain	06052	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	75 North Mountain Road	New Britain	06053	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	91 North West Drive	Plainville	06062	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	645 Farmington Avenue	Hartford	06105	0	OT
Wherever You Are Eddy Center	Community Health Center, Inc.	1 Labella Circle	Middletown	06457	0	OT
Wherever You Are Shelter Now	Community Health Center, Inc.	43 Saint Casimir Drive	Meriden	06450	0	OT
Wherever You Are Shepherd Home	Community Health Center, Inc.	112 Bow Lane	Middletown	06457	0	OT
Youth Challenge Bible Training Center	Youth Challenge of Connecticut, Inc.	111 North Sterling Road	Plainfield	06354	9 ILTTR	ILTTR
Youth Challenge Mission for Women	Youth Challenge of Connecticut, Inc.	32 Atwood Street	Hartford	06105	8 ILTTR	ILTTR
Youth Challenge of Connecticut, Inc.-Men's Residential Center	Youth Challenge of Connecticut, Inc.	15-17-19 May Street	Hartford	06105	15 ILTTR	ILTTR
Total of 199 sites licensed and 1,512 beds broken out as follows: ILTTR beds total 972, IT beds total 265, RDE beds total 147 and C&R beds total 128						

Source: DPH licensure files and e-licensure database as of August 2012

[a]ABBREVIATION KEY:

ACD = Ambulatory Chemical Detoxification

CMT - Chemical Maintenance Treatment

C&R = Care and Rehabilitation

DET = Day or Evening Treatment

ILTTR = Intermediate and Long Term Treatment and Rehabilitation

IT = Intensive Treatment

OT = Outpatient Treatment

RDE = Residential Detoxification and Evaluation

APT000034
08/09/2013

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

EXHIBIT B

Payer Mix for the City of New Haven, FY 2012

(INPATIENT,NEWBORN)
2012

Discharges	MEDICARE	PRIVATE	Total Medicaid	CHAMPUS	CHARTER OAK	OTHER FED PROG	WORKERS COM	UNINSURED	Total
06511	2,390	1,709	3,814	8	0	13	21	103	**8,058**
06513	1,943	1,012	2,751	13	0	8	25	56	**5,808**
06510	116	125	219	2	0	3	1	7	**473**
06515	631	580	836	4	2	4	7	9	**2,073**
06519	957	342	1,847	3	0	12	14	38	**3,213**
06531	0	2	0	0	0	0	0	0	**2**
06501	0	2	4	0	0	0	0	0	**6**
06530	0	2	0	0	0	0	0	0	**2**
06532	1	5	2	0	0	1	0	0	**9**
06504	17	9	84	0	0	0	0	3	**113**
06506	0	1	1	0	0	1	0	0	**3**
06503	2	0	0	0	0	0	0	0	**2**
06540	1	1	1	0	0	0	0	4	**7**
06521	0	2	2	0	0	0	0	0	**4**
06520	0	26	4	0	0	0	0	1	**31**
06505	2	1	12	0	0	0	0	0	**15**
06502	7	1	2	0	0	0	0	0	**10**
06534	2	0	0	0	0	0	0	0	**2**
06509	0	1	1	0	0	0	0	0	**2**
06533	0	0	0	0	0	0	0	0	**0**
06536	0	0	2	0	0	0	0	0	**2**
06535	0	0	0	0	0	0	0	0	**0**
06507	0	0	0	0	0	0	0	0	**0**
06508	5	0	0	0	0	0	0	0	**5**
06537	0	0	0	0	0	0	0	0	**0**
06538	0	0	0	0	0	0	0	0	**0**
NEW HAVEN	**6,074**	**3,821**	**9,582**	**30**	**2**	**42**	**68**	**221**	**19,840**

Aug 5, 2013

% of Total	MEDICARE	PRIVATE	Total Medicaid	CHAMPUS	CHARTER OAK	OTHER FED PROG	WORKERS COM	UNINSURED	Total
06511	29.7%	21.2%	47.3%	0.1%	0.0%	0.2%	0.3%	1.3%	100.0%
06513	33.5%	17.4%	47.4%	0.2%	0.0%	0.1%	0.4%	1.0%	100.0%
06510	24.5%	26.4%	46.3%	0.4%	0.0%	0.6%	0.2%	1.5%	100.0%
06515	30.4%	28.0%	40.3%	0.2%	0.1%	0.2%	0.3%	0.4%	100.0%
06519	29.8%	10.6%	57.5%	0.1%	0.0%	0.4%	0.4%	1.2%	100.0%

All Patients (Inpatient Newborn)
Source: Chime Online

APP000036
08/09/2013

Payer Mix for the City of New Haven, FY 2012

Discharges	MEDICARE	PRIVATE	Total Medicaid	CHAMPUS	CHARTER OAK	OTHER FED PROG	WORKERS COMI	UNINSURED	Total
06531	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06501	0.0%	33.3%	66.7%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06530	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06532	11.1%	55.6%	22.2%	0.0%	0.0%	11.1%	0.0%	0.0%	100.0%
06504	15.0%	8.0%	74.3%	0.0%	0.0%	0.0%	0.0%	2.7%	100.0%
06506	0.0%	33.3%	33.3%	0.0%	0.0%	33.3%	0.0%	0.0%	100.0%
06503	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06540	14.3%	14.3%	14.3%	0.0%	0.0%	0.0%	0.0%	57.1%	100.0%
06521	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06520	0.0%	83.9%	12.9%	0.0%	0.0%	0.0%	0.0%	3.2%	100.0%
06505	13.3%	6.7%	80.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06502	70.0%	10.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06534	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06509	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06533									
06536	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06535									
06507									
06508	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
06537									
06538									
NEW HAVEN	**30.6%**	**19.3%**	**48.3%**	**0.2%**	**0.0%**	**0.2%**	**0.3%**	**1.1%**	**####**

APT000037
08/09/2013

All Patients (Inpatient Newborn)
Source: Chime Online

City-Data.com FORUM

New Haven, Connecticut (CT) Zip Code Map - Locations, Demographics

Jump to a detailed profile or search site with Google Custom Search
City, County or Zip Code Find

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Search for: near: Find

Back to: New Haven, CT, All U.S. Cities.

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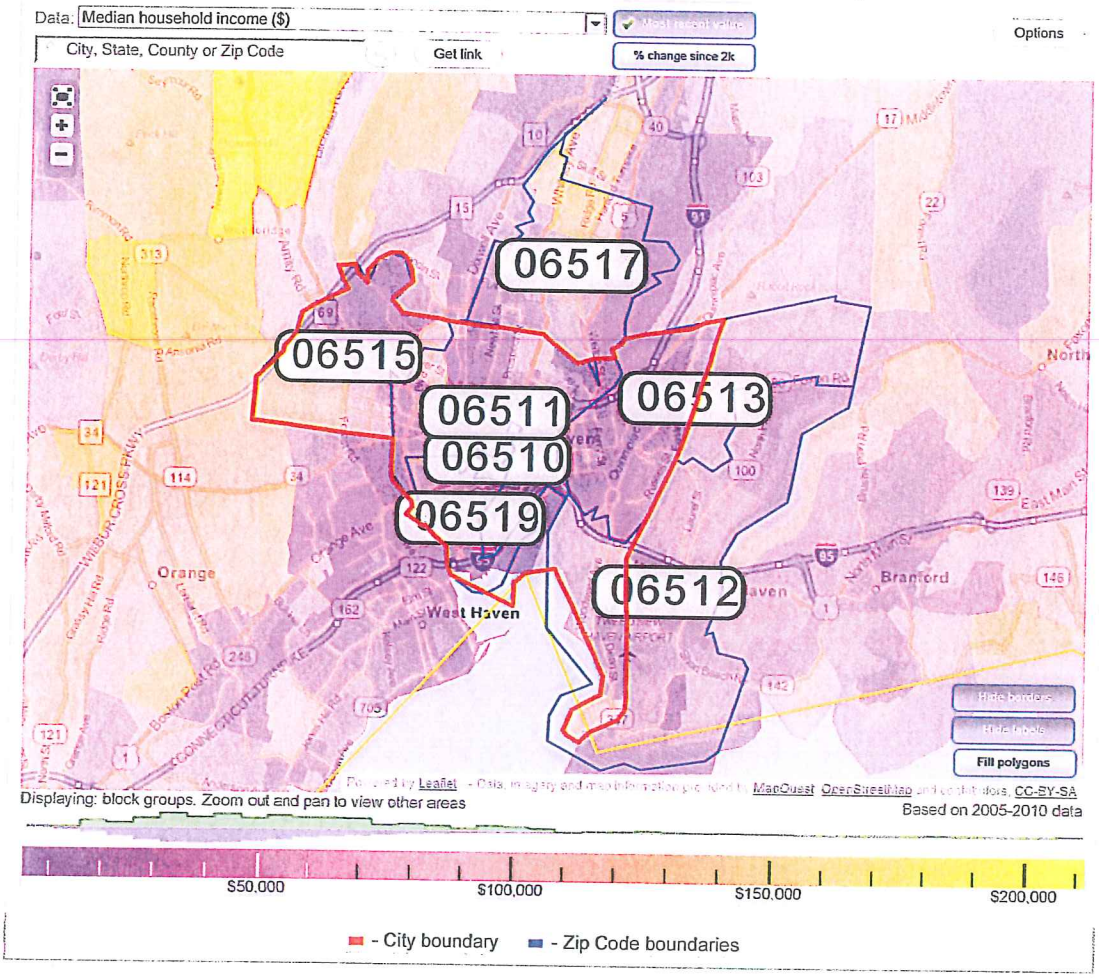

Zip codes: 06510, 06511, 06512, 06513, 06515, 06517, 06519.

Zip code 06510 statistics: (Find on map)

Estimated zip code population in 2010: 3,093

Land area: 0.3 sq. mi.
Water area: 0.0 sq. mi.
Population density: 10,692 people per square mile (high).

Males: 1,549 (50.1%)
Females: 1,542 (49.9%)

Zip code 06510 detailed profile

EXHIBIT C

Addiction Residential Census- August 6, 2013

Detox - 3.7													
	1	RNP	Bridgeport	Detox	Sara Smith	(203) 333-3518	-7	12	19	7	7		
	2	Cornell Sctt	New Haven	SCRC	Ben Metcalf	(203) 503-3300	6	26	19	2	1		
	2	Rushford	Middletown	Resid Detox	Tara Murphy	1-877-577-3233		16				No	16
	3	SCADD	New London	Resid Detox	Admiting Nurse	(860) 447-1717	2	20	15	4	1		
	3	Stonington	North Stoning	Resid Detox	Andrea Keeney	(860) 445-3000		16				No	16
	4	ADRC	Hartford	Resid Detox	Admitting Nurse	(860) 714-3700	8	35	27	7	7		
	5	MCCA	Danbury	Resid Detox	Ana Carvalho	(203) 792-4515X123	0	12	12	0	0		
							9	**137**	**92**				**32**
Intensive Res													
	1	CASA	Bridgeport	Intensive	Kremlin DeVissiere	(203) 339-4112	0	10	10	0	0		
	1	RNP	Bridgeport	Horizon	Sara Smith	(203) 333-3518	0	15	15	3	3		
	2	CVH	Middletown	Intens (Men)	Joann Chatfield	(800) 828-3396 x 5	10	60	51	2	3		
	2	CVH	Middletown	Intens (Women)	Joann Chatfield	(800) 828-3396 x 5	6	30	24	1	1		
	2	Rushford	Middletown	Intensive	Tara Murphy	1-877-577-3233		42				No	42
	3	CPAS	Putnam	Milestone	Michelle Blevin	(860) 928-1860		16				No	16
	4	ADRC	Hartford	SATEP ADRC	E. Navarro	(860) 714-3739	0	28	28	3	3		
	4	Blue Hills	Hartford	Intensive	Pat O'Brien	(860) 293-6415	4	21	14	4	1		
	4	Farrell	New Britain	Intensive	Ester Bryant	(860) 225-4641		24				No	24
	5	MCCA	Danbury	McDonough	Maureen Gorman	(203)792-4515	2	22	20	1	1		
	5	McCall	Torrington	Carnes Wks	Tracy Donahue	(860) 496-2107		20				No	20
							22	**288**	**162**				**102**

CT Substance Abuse Facilities with Inpatient Beds*

FACILITY NAME	PROVIDER NAME	CITY	BEDS	BED DETAIL	WAIT TIME?**	ACCEPTS MEDICAID?**
LUXURY PROVIDERS						
High Watch Recovery Center	High Watch Recovery Center, Inc.	Kent	78	C&R	NO WAIT	NO
Silver Hill Hospital	Silver Hill Hospital	New Cannan	109	RDE, ILTTR	Few weeks	NO
Mountainside Treatment Center	MCI Healthcare LLC	Canaan	62+16****	RDE, ILTTR	NO WAIT	NO
OTHER 3.7 LEVEL PROVIDERS						
South Central Rehabilitation Center	Cornell Scott---Hill Health Corporation	New Haven	29	RDE, CMT, ACD	NO WAIT	YES
Rushford Center, Inc.	Rushford Center, Inc./Hartford Healthcare	Middletown	16	RDE, ILTTR	NO WAIT	YES
Stonington Institute ***	Stonington Behavioral Health, Inc.	North Stonington	16 RDE, 38 IT	RDE, IT	NO WAIT	YES
Connecticut Valley Hospital	Connecticut Valley Hospital	Middletown	110	RDE, ILTTR	Changes Daily	YES
Trinity Glen	Midwestern Connecticut Council on Alcoholism	Sharon	50	RDE, C&R	NO WAIT	YES
McDonough House	Midwestern Connecticut Council on Alcoholism, Inc.	Danbury	20	RDE, IT	Few weeks	YES
First Step	Recovery Network of Programs, Inc.	Bridgeport	19	RDE	NO WAIT	YES
Detoxification Center	Alcohol and Drug Recovery Centers, Inc.	Hartford	28	RDE, IT	Residential rehab one week; Detox beds are available	YES
Coventry House	Alcohol and Drug Recovery Centers, Inc.	Hartford	10	RDE, ILTTR	1 month	YES
Hallbrook	St. Vincent's Medical Center	Bridgeport	16	RDE	NO WAIT	YES
Community Health Resources	Community Health Resources	Putnam	6	RDE, ILTTR	2 months	YES
Altruism Acute Care and Evaluation	Dependency, Inc.	New London	20	RDE	NO WAIT	YES
Milestone/New Life Center/Pathways	Community Health Resources	Putnam	6	RDE, ILTTR	2 months	YES
OTHER INPATIENT SUBSTANCE ABUSE SERVICES						
Blue Sky Behavioral Health	Blue Sky Behavioral Health	Danbury	6	N/A	NO WAIT	NO
Clayton House	Alcohol and Drug Recovery Centers, Inc.	Glastonbury	15	ILTTR	60 days	YES
Horizons	Recovery Network of Programs, Inc.	Bridgeport	15	IT	Few days - few weeks	YES
Casa Eugenio Maria De Hostos	Chemical Abuse Services Agency, Inc.	Bridgeport	10	ILTTR	1-2 months, Spanish speaking only	YES
APT Residential Services	APT Foundation, Inc.	Bridgeport	125	ILTTR	N/A	YES
New Prospects	Recovery Network of Programs, Inc.	Bridgeport	23	IT	N/A	YES
Mother's Retreat and The Connection Counseling Center	Connection, Inc., The	Groton	8	ILTTR	2 months	N/A
Youth Challenge Mission for Women	Youth Challenge of Connecticut, Inc.	Hartford	8	ILTTR	N/A	N/A
Fresh Start	Community Renewal Team	Hartford	21	ILTTR	N/A	CSSD
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	Hartford	20	ILTTR	NO WAIT	YES
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	Hartford	15	ILTTR	NO WAIT	YES
Youth Challenge of Connecticut, Inc.---Men's Residential Center	Youth Challenge of Connecticut, Inc.	Hartford	15	ILTTR	NO WAIT	YSE
Lebanon Pines Long Term Care	Lebanon Pines Long Term Care	Lebanon	110	ILTTR	NO WAIT	YES
Hallie House Women and Children's Center	Connection, Inc., The	Middletown	8	ILTTR	N/A	N/A
Connection House	Connection, Inc., The	Middletown	14	ILTTR	N/A	YES
Farrell Treatment Center	Farrell Treatment Center, Inc.	New Britain	24	IT	2-3 weeks	YES
Crossroads, Inc.	Crossroads, Inc.	New Haven	174	ILTTR	2-3 weeks	YES
Elm City Women and Children's Center and The Connection Counseling Center	Connection, Inc., The	New Haven	15	ILTTR	A few months	CSSD
Altruism House for Women	Dependency, Inc.	New London	10	ILTTR	N/A	N/A
Altruism House for Women	Southeastern Council on Alcoholism and Drug	New London	11	ILTTR	NO WAIT	YES
Altruism House for Men	Dependency, Inc.	Norwich	13	ILTTR	One month	YES
Youth Challenge Bible Training Center	Youth Challenge of Connecticut, Inc.	Plainfield	9	ILTTR	NO WAIT	Yes
Liberation House	Liberation Programs, Inc.	Stamford	67	ILTTR	1 week	YES
Viewpoint Recovery Program	CTE, Inc.	Stamford	12	ILTTR	NO WAIT	YES
Families In Recovery Program	Liberation Programs, Inc.	Stamford	10	ILTTR	N/A	N/A
Carnes Weeks Center	McCall Foundation Inc.	Torrington	20	IT	1 week	YES
McCall House	McCall Foundation, Inc.	Torrington	14	ILTTR	N/A	YES
Renaissance East	Connecticut Renaissance, Inc.	Waterbury	32	ILTTR	1 months	YES
Renaissance West	Connecticut Renaissance, Inc.	Waterbury	50	ILTTR	N/A	N/A
Wellmore, Inc. Women and Children's Program	Wellmore, Inc.	Waterbury	8	ILTTR	NO WAIT	YES
Patrick F. Mcauliffe Center	Connecticut Renaissance, Inc.	Waterbury	20	IT	NO WAIT	YES
Reverend Edward M. Dempsey Drug Services	Central Naugatuck Valley HELP, Inc.	Waterbury	34	ILTTR	N/A	YES
Transitions Outpatient Services	Community Health Resources	Windham	14	ILTTR	Less than a week	YES
Perception House	Perception Programs, Inc.	Windham	20	ILTTR	CSSD- 3 months, but for Insurance 1.5 months	YES

*Source: Connecticut Statewide Health Care Facilities and Services Plan October 2012; page 280 .
**Information obtained via phone calls, and changes daily.
***Updated as of August 8, 2013.
****16 new detox beds per Docket No. 11-31734

APT000041
08/09/2013

EXHIBIT D

STATE OF CONNECTICUT

QUI TRANSTULIT SUSTINET

House Bill No. 6705

Public Act No. 13-234

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HOUSING, HUMAN SERVICES AND PUBLIC HEALTH.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2013*) The Commissioner of Housing may appoint a Deputy Commissioner of Housing who shall be qualified by training and experience for the duties of the office of commissioner and shall, in the absence, disability or disqualification of the commissioner, perform all the functions and have all the powers and duties of said office. The position of the Deputy Commissioner of Housing shall be exempt from the classified service.

Sec. 2. (*Effective from passage*) (a) Wherever in sections 4-66h, 8-13m to 8-13s, inclusive, 8-13u to 8-13x, inclusive, and 12-170e of the general statutes the term "secretary" is used, the term "commissioner" shall be substituted in lieu thereof, and wherever the term "the Office of Policy and Management" is used, the term "Housing" shall be substituted in lieu thereof.

(b) Wherever the term "Economic and Community Development" is used in the following general statutes, the term "Housing" shall be substituted in lieu thereof: 4b-21, 7-392, 8-37v, 8-37w, 8-37y, 8-37aa, 8-

expenditures; (2) the process and factors to be used in determining each future year's assessment; and (3) the establishment of an appropriate notification process for the entities assessed under the account.

Sec. 144. Section 19a-639 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) In any deliberations involving a certificate of need application filed pursuant to section 19a-638, the office shall take into consideration and make written findings concerning each of the following guidelines and principles:

(1) Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;

(2) The relationship of the proposed project to the state-wide health care facilities and services plan;

(3) Whether there is a clear public need for the health care facility or services proposed by the applicant;

(4) Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;

(5) Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons, and (B) the impact upon the cost effectiveness of providing access to services provided under the Medicaid program;

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08/09/2013

(6) The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;

(7) Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;

(8) The utilization of existing health care facilities and health care services in the service area of the applicant; [and]

(9) Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities; and

(10) Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers.

(b) The office, as it deems necessary, may revise or supplement the guidelines and principles through regulation prescribed in subsection (a) of this section.

Sec. 145. Subsection (b) of section 19a-323 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(b) If death occurred in this state, the death certificate required by law shall be filed with the registrar of vital statistics for the town in which such person died, if known, or, if not known, for the town in which the body was found. The Chief Medical Examiner, Deputy Chief Medical Examiner, associate medical examiner, an authorized assistant

APT000045
08/09/2013

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 9th of August, 2013 to the following:

Peter Schorr
c/o Law Office of William P. Beccaro
12 New City Street
Essex, CT 06426
wbeccaro@snet.net

Jennifer Groves Fusco, Esq.
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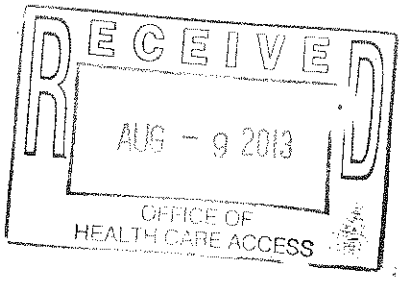

August 9, 2013

Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Post Office Box 340308
Hartford, CT 06134-0308
Attn: Kimberly Martone
Director of Operations

RE: Intervenor Request
Docket Number 13-31828-CON
NR Connecticut, LLC-d/b/a Retreat of South Connecticut
Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut

Dear Ms. Martone:

By this letter and enclosed pre-filed testimony, and on behalf of Rushford Center, Inc. located at 1250 Silver Street, Middletown, Connecticut 06457 (the "Intervenor"), I respectfully petition the Office of Health Care Access ("OHCA"), pursuant to Connecticut General Statutes Section 4-177a (b) and Section 19a-9-27 of the Regulations of Connecticut State Agencies, for the Intervenor to receive intervenor status, with full procedural rights, so that the Intervenor may present its opposition to the above-referenced Certificate of Need Application to establish a 105 Bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut (the "105-Bed Facility") that is to be heard at the public hearing scheduled to commence on August 14, 2013 at 9:00 a.m. The Intervenor operates a detoxification and intensive residential rehabilitation substance use treatment facility in the State of Connecticut and receives referrals from the State-wide region, including but not limited to, the proposed service area.

The Intervenor opposes the 105-Bed Facility because: (i) the Applicant has failed to demonstrate a clear public need for the proposed 105-Bed Facility; (ii) if approved, the proposed 105-Bed Facility will significantly and adversely affect the Intervenor's

financial well-being; and (iii) the expenditure of approximately $7,500,000 by the Applicant for the proposed 105 Bed-Facility will not be cost-effective and thus, will be a disservice to patients, employers and third-party-payers alike and will not be in the best interests of the State-wide health care delivery system.

The Intervenor proposes to participate in the hearing and to present oral and written testimony and evidence establishing grounds for denial of the above-referenced Application. The Intervenor will provide testimony as to why there is no need for the 105-Bed Facility and, to the extent there is any incremental need in the future, the Intervenor and other established and existing providers currently operating in the State of Connecticut can more effectively address those needs. The Intervenor's participation in the hearing with full procedural rights will assist OHCA in resolving the issues of the pending contested case, will be in the interest of justice, and will not impair the orderly conduct of the proceedings.

In addition, the Intervenor respectfully petitions and seeks the right to cross-examine the Applicant and any of its witnesses, experts or other persons submitting oral or written testimony in support of the above-referenced Application at the hearing to commence on August 14, 2013. As you know, this is a disputed Application, such that cross-examination will help clarify the pertinent issues and will assist in bringing out all the facts so as to provide for a fully informed decision on the Application.

Finally, the Intervenor wants OHCA to be informed that the Intervenor had initially planned on filing this petition jointly with High Watch Recovery Center, Inc., CHR, Inc., MCCA, Inc., and Recovery Network of Programs, Inc. ("Supporters of Intervenor"), but because of OHCA rules, could not do so. Each of the foregoing entities will be present at the August 14, 2013 hearing and will state their position in opposition to the Application at the public testimony portion of the hearing. In addition, by way of the attached letter, the Supporters of Intervenor endorse this petition in its entirety.

The undersigned will serve as the contact person for the Intervenor with respect to this matter and can be contacted at (860) 251-5104, jfeldman@goodwin.com, or One Constitution Plaza, Hartford CT, 06103-1919.

Respectfully Submitted,

Joan Feldman

Joan Feldman, Esq.

Enc.

August 9, 2013

Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Post Office Box 340308
Hartford, CT 06134-0308
Attn: Kimberly Martone
Director of Operations

RE: Intervenor Request
Docket Number 13-31828-CON
NR Connecticut, LLC-d/b/a Retreat of South Connecticut
Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut

Dear Ms. Martone:

High Watch Recovery Center, Inc., CHR, Inc., MCCA, Inc., and Recovery Network of Programs, Inc. write to inform you that we collectively support Rushford Center, Inc.'s opposition to the above-referenced Certificate of Need Application to establish a 105 Bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut (the "105-Bed Facility"). We have reviewed Rushford Center Inc.'s petition for Intervenor status and we fully support the submission.

Our facilities operate residential substance use treatment facilities in the State of Connecticut and receive referrals from the State-wide region, including but not limited to the proposed service area. We oppose this Application because there is no need for an additional 105 substance use treatment beds in the State of Connecticut, if approved, the proposed 105-Bed Facility will significantly and adversely affect our financial well-being and the stability of the treatment programs we operate, and to the extent there is any incremental need in the future, our facilities and other established and existing providers currently operating in the State of Connecticut can more effectively address those needs.

A representative from each of our facilities will be present at the hearing to be held on August 14. 2013 who will be ready, willing and able to answer any of OHCA's questions

or assist with clarifying any pertinent issues relevant for OHCA to make a fully informed decision on the Application.

We look forward to the hearing and providing OHCA with any assistance it may need in connection to this Application.

Respectfully Submitted,

High Watch Recovery Center, Inc.,

Name: Janina J. Hearn, APRN BC
Title: President/CEO

CHR, Inc.

Name: Sabrina Trocchi, MPA
Title: Senior V.P. of Health Care + System Operations

MCCA, Inc.

Name: Joseph J. Sullivan
Title: President

Recovery Network of Programs, Inc.

Name: John Hamilton
Title: CEO

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

IN RE: NR CONNECTICUT, LLC D/B/A RETREAT AT SOUTH CONNECTICUT- ESTABLISH A 105 BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	:	**DOCKET NO. 13-31828-CON**
	:	**August 9, 2013**

PRE-FILED TESTIMONY OF JEFFREY WALTER ON BEHALF OF THE INTERVENOR, IN OPPOSITION TO THE ABOVE-CAPTIONED APPLICATION

Good day, Attorney Hansted and staff of the Office of Health Care Access ("OHCA"). My name is Jeffrey Walter and I am the President and Chief Executive Officer of Rushford Center, Inc. (the "Intervenor"). I am here today to oppose the Applicant's proposal to establish a 105 Bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut (the "105-Bed Facility" or the "Application"). In my pre-filed testimony, I will set forth the specific reasons why: (I) the Applicant has failed to establish a clear public need for the 105-Bed Facility; (II) the proposed 105-Bed Facility will have a significant and detrimental impact on the Intervenor and other existing residential substance use treatment facilities located in Connecticut; and (III) the proposed Application will not be in the best interests of the State-wide health care delivery system.

I. THE APPLICANT HAS FAILED TO DEMONSTRATE A CLEAR PUBLIC NEED FOR THE 105-BED FACILITY.

Currently, there are approximately one hundred and ninety-nine (199) non-state operated facilities in the State of Connecticut (the "State" or "Connecticut") that provide a range of services regarding the "care or treatment of substance abusive or dependent persons."

See Table 20[1] of OHCA's Statewide Health Care Facilities and Services Plan (October 2012). Of these one hundred and ninety-nine (199) facilities, seventeen (17) of them provide a 3.7 level of residential detoxification and/or intensive residential rehabilitation treatment for persons who seek treatment for substance use in the State (collectively, the "Existing Residential Treatment Facilities"). Specifically, the Existing Residential Treatment Facilities have approximately 147 residential detoxification beds and 488 intensive residential rehabilitation beds for a total of 635 beds dedicated to residential substance use treatment. See Table 1 below.

Table 1

Facility	# of Beds for Residential Detoxification Treatment	# of Beds for Intensive Residential Rehabilitation Treatment	Total # of Beds
Southeastern Council on Alcoholism and Drug Dependency, Inc. (a/k/a Altruism Acute Care and Evaluation)	20	0	20
McCall Foundation Inc. (a/k/a Carnes Weeks Center)	0	20	20
Alcohol and Drug Recovery Centers, Inc. (a/k/a Detoxification Center)	35	28	63
Farrell Treatment Center, Inc.	0	24	24
Recovery Network of Programs, Inc. (3 separate facilities/locations known as First Step, Horizons, and New Prospects)	19	38	57
High Watch Recovery Center, Inc.	0	78	78
Midwestern Connecticut Council on Alcoholism, Inc. (a/k/a MCCA)	12	22	34
MCI Healthcare LLC (a/k/a Mountainside Treatment Center)	0	62	62
Connecticut Renaissance, Inc. (a/k/a Patrick F. Mcauliffe Center)	0	20	20

[1] According to OHCA, the data for Table 20 is current as of August 2012.

Rushford Center, Inc.	16	42	58
Cornell Scott-Hill Health Corporation (a/k/a South Central Rehabilitation Center)	29	0	29
Stonington Behavioral Health, Inc. (a/k/a Stonington Institute	16	38	54
Turning Point	0	90	90
Community Health Resources Milestone Program	0[2]	16	22
Chemical Abuse Services Agency, Inc. (a/k/a Casa Eugenio Maria De Hostos)	0	10	10
Grand Total:	**147**	**488**	**635**

Please note that Table 1 does not account for or include the sixteen (16) additional residential detoxification beds or the twenty-eight (28) residential rehabilitation beds approved by OHCA for MCI Healthcare LLC (d/b/a Mountainside Treatment Center) in May of 2012, and Litchfield Hills Retreat, LLC in May of 2010, respectively.[3] See Docket Number 11-31734-CON for Mountainside Treatment Center and Docket Number: 09-31500-CON for Litchfield Hills Retreat. Please also note that the Connecticut Department of Mental Health and Addiction Services ("DMHAS") operates Connecticut Valley Hospital (d/b/a "Merritt Hall" and "Blue Hills Hospital") and has an additional one hundred and fifty-two (152) beds, forty-one (41) of which are level 4.2 inpatient detoxification beds, and one hundred and eleven (111) of which are intensive residential rehabilitation beds.[4] Moreover, and as noted in OHCA's 2012 Statewide Health Care Facilities and Services Plan, Natchaug Hospital[5] and Silver Hill

[2] CHR previously had six (6) residential detoxification beds for which DMHAS approved closure because of underutilization.

[3] The Mountainside Treatment Center and Litchfield Hills Retreat, LLC beds are not yet in operation.

[4] While 4.2. level residential treatment beds indicate inpatient care in the hospital setting, such beds are used for providing detoxification and rehabilitation services for persons in need of substance use treatment.

[5] Natchaug has thirty-three (33) adult beds and an average daily census of five (5) detoxification patients.

Hospital[6] both have 4.2 level beds for substance use treatment and recovery services. See Section 8.5.2.2.2., page 100.

Historically speaking, it is also worth noting that increases in residential bed capacity for the Existing Residential Treatment Facilities have generally been incremental in number and decentralized across the State.[7] However, despite: (a) the large number of residential treatment beds operated by the Existing Residential Treatment Facilities; (b) OHCA's approval of an additional sixteen (16) residential detoxification beds for Mountainside Treatment Center, and twenty-eight (28) residential rehabilitation beds for Litchfield Hills Retreat, LLC; and (c) the number of beds at Connecticut Valley Hospital, Natchaug Hospital and Silver Hill Hospital, the Applicant states that there is an unmet and clear public need for an additional 105 beds to be located in New Haven, Connecticut.

The Intervenor will demonstrate that the Applicant's claim of a clear public need for an additional 105 residential treatment beds is self-serving and without merit for the following reasons:

a. The Applicant Fails to Prove that Any Increase In the Incidence of Substance Use Among Certain Populations in the State Is Directly Related to an Increased Demand for More Residential Treatment Beds In the State.

The Applicant populates its Application with large amounts of irrelevant data that fails to demonstrate that there is a clear public need for an additional 105 residential treatment beds in Connecticut. In particular, the Applicant claims that there is "a growing need for addiction services in Connecticut" and bases this statement upon the incidence of various types of substance use problems within certain sectors of the population within the State. Simply put,

---

[6] Silver Hill Hospital operates approximately thirty four (34) residential detoxification beds and thirty-eight (38) residential rehabilitation beds.

[7] Currently, the average number of residential treatment beds for each Existing Residential Treatment Facility listed in Table 1 is thirty seven (37) beds.

by stating that Connecticut has more individuals with substance use problems than perhaps some other states, the Applicant concludes that there is a clear public need for an additional 105 residential treatment beds to be located in New Haven, Connecticut.[8] The Intervenor believes that the incidence of substance use within certain populations and/or age groups does not in of itself translate to an increased demand or need for residential treatment beds, and certainly does not establish a clear public need for 105 additional residential treatment beds in the State (i.e. a 16.5% increase in residential treatment beds in the State as compared to the total amount of beds currently operated by the Existing Residential Treatment Facilities).

The Applicant also concludes that because there has been an increase in the number of heroin treatment admissions for individuals between the ages of 18-24, despite the fact that admissions for heroin use in the State have decreased overall, this is justification for more residential treatment beds. Specifically, the Applicant states that,

> the Connecticut Department of Mental Health and Addiction Services reports in the most recent Biennial Report that while the incidence of treatment admissions due to heroin use has begun to decrease overall, it has increased 18% since 2006 for those aged 18-24.

See CON Application at page 24. The Applicant's assertion that a shift in demographics demonstrates a clear public need for a 105 additional residential treatment beds for substance use in Connecticut is again without merit and unsubstantiated.

The Applicant also erroneously concludes that the low demand for residential substance use treatment in Connecticut is attributable to a shortage of facilities to service these patients. The Applicant states that,

> According to the most recent data from the Center for Behavioral Health Statistics and Quality (formerly Office of Applied Studies of the Federal Substance Abuse and

[8] Interestingly, the Applicant proposes a facility that happens to be approximately the same size as their facility in Lancaster, Pennsylvania. Is this a business model or is the proposed facility size based upon actual need?

> Mental Health Administration - SAMSHA) more than 257,000 individuals in the State of Connecticut suffer from various forms of substance abuse addiction, but less than 45,000 have received treatment from any rehabilitation facility. The Retreat at South Connecticut will be in a strategic position to serve as a resource to alleviate the unmet need.

See CON Application at page 23. Whether intentional or not, the Applicant fails to provide any meaningful or relevant evidence to demonstrate that the incidence of substance use disorders in Connecticut is related to the demand for residential treatment beds, or that the low demand for residential treatment beds in Connecticut is related to the number of residential treatment beds in the State. Nevertheless, the Applicant continues to state throughout its application that the reason why only 11.2% of the population seeks treatment in Connecticut is because of inadequate access to residential treatment beds. Specifically, as stated by the Applicant,

> Connecticut has seen a growing problem with binge drinking and general alcohol abuse among college students, increasing admissions due to heroin addiction in young adults, and an across the age spectrum increase in non-medical abuse of prescription opiates. Despite this, SAMHSA statistics indicate that the problem is not being adequately addressed - as only 11.2% of the people who needed treatment in a specialized facility for alcohol abuse or illicit drug use/abuse in the past year actually received treatment. Expanded and prompt access to all levels of addiction services located within the State of Connecticut is critical for the state [sic] to be able to addresses [sic] its citizens substance abuse issues. This project (Retreat at South Connecticut) is an important step in addressing that need.

See CON Application at page 23. By simply concluding that there is such a causal connection between the number of beds and the percentage of individuals seeking treatment, the Applicant fails to prove that more individuals would seek treatment if there were more residential detoxification and/or intensive residential rehabilitation treatment beds. In fact, because there is additional bed capacity in the State, the Applicant's argument becomes completely speculative and thus, totally unpersuasive in substantiating a clear public need. Clearly, the

Applicant's entire argument is premised on nothing more than the adage "if they build it, they will come".

The Applicant further claims that during the period of 2009-2011, "Connecticut saw a 35% increase" in admissions while the number of beds decreased between 2002 and 2010 by 37% resulting in an alleged "burden on State-run facilities". See CON Application at page 25. This statement is at odds with DMHAS data. Specifically, according to DMHAS, the number of admissions to level 3.7 residential detoxification programs between 2009 and 2011 increased by 13% and with respect to intensive residential rehabilitation programs, admissions increased by 4.6% between 2009 and 2011. See Exhibit A attached hereto for DMHAS admission data. More importantly, the Applicant in proffering this data fails to: (a) identify the specific facilities it is referring to; (b) cite or point to the specific sources for these claims; and (c) distinguish between adult and adolescent beds. Second, we can find no independent support, citations, details or sources for the Applicant's statement that the number of beds decreased between 2002 and 2010 by 37%. Finally, the Applicant's historical references are irrelevant because the issue at hand is whether there is existing capacity and whether there is a clear public need for an additional 105 beds today.[9]

It is also worth noting that the Applicant offers the aforementioned information as evidence that their program will assist DMHAS with program/bed decompression. It is, however, disingenuous for the Applicant to argue that any alleged "burden on State run facilities" would be diminished by its facility simply because: (a) DMHAS has very few self-

[9] In addition, it should also be noted that starting in 2010, DMHAS invested in new community-based residential detoxification and treatment beds, including the development of two (2) specialty residential treatment programs for individuals with co-occurring substance use and mental health disorders (20 beds at Connecticut Renaissance in Waterbury; 20 beds at Recovery Network of Programs in Bridgeport) and the development of a 19-bed residential detoxification program in Bridgeport (Recovery Network of Programs).

funded patients who can pay for their own services; and (b) the Applicant has no intention of taking or providing services to Medicaid or Medicare patients. See Applicant's Responses to OHCA's Completeness Questions at page 704. Therefore, the Intervenor does not believe that the proposed 105-Bed Facility will alleviate any alleged burden on State-run facilities or any other facilities that could potentially experience a demand from uninsured and underinsured patients for residential treatment beds.

The Applicant also argues that the fact that some patients are choosing to seek treatment out of the State is further proof of a clear public need for 105 residential treatment beds. As stated by the Applicant,

> Connecticut has a limited number of residential detoxification and rehabilitation and recovery beds, which cannot keep pace with the increasing need. Access to these beds is problematic, and there are often significant waiting lists at the facilities that presently offer the service. The result is that many individuals wishing to seek care are either unable to obtain it, or are often forced to do so outside of Connecticut.

See CON Application at pages 20-21.

However, the Applicant provides no evidence for the reasons why residents choose programs out of State and fails to recognize that many individuals may choose programs outside of Connecticut because a specific program appeals to their specific treatment needs. Nor does the Applicant have any evidence that if their program was approved by OHCA that those same individuals seeking programs outside of the State would forgo such out-of-State programs to choose the Applicant's program or facility. As you can see from the Applicant's responses to the Completeness Questions, nearly one-third of the Applicant's admissions to its facility in Lancaster, Pennsylvania are from out-of-state patients. If the Applicant believes that seeking treatment outside your state is detrimental to the patient, why does Applicant plan on offering services to out-of-state patients?

b. The Applicant's Claim That There Is Not Ready Access for Patients to Residential Treatment Beds In the Existing Residential Facilities Is Erroneous.

The Applicant relies upon two (2) phone surveys that it allegedly conducted to claim that the ten (10) facilities that provide a 3.7 level of care are operating at or close to 100% capacity with a "long" waitlist for a bed.[10] [11] The Intervenor is of the opinion that these surveys are statistically unreliable and do not represent the actual residential treatment bed capacity in the State and thus, do not demonstrate a clear public need or an access issue.

Accordingly, the Intervenor conducted its own survey relating to residential treatment bed capacity.[12] See the tables attached hereto as Exhibit B for the survey results and a summary of the survey data. Based upon the responses received from the level 3.7 residential detoxification and intensive residential rehabilitation providers surveyed, the surveyed providers are operating, on average, at seventy-nine (79%) capacity.[13] Moreover, based upon the survey results, only one surveyed provider reports having a waitlist. In contrast, the Applicant claims that their survey results indicate that eight (8) out of the eleven (11) facilities "surveyed" were at 100% capacity during the "2nd Survey". Thus, the Applicant's survey results are at direct odds with the Intervenor's survey results. See Exhibit C attached hereto for a copy of the Intervenor's survey.

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[10] Intervenor has no recollection of being surveyed. The Applicant incorrectly states that there are only ten (10) facilities in the State that offer a 3.7 level of residential detoxification and/or intensive residential rehabilitation service when in fact there are seventeen (17). See CON Application at page 21 and Table 1.

[11] In addition and as also noted above, the Applicant fails to mention OHCA's approval of forty-four (44) additional beds for Mountainside Treatment Center and Litchfield Hills Retreat, LLC which have been approved by OHCA but not yet in operation, and the number of beds at Connecticut Valley Hospital (operated by DMHAS), Natchaug Hospital and Silver Hill Hospital.

[12] Intervenor sent surveys to all the level 3.7 providers listed on Table 1 herein. Nine (9) of the facilities responded.

[13] Based on actual patient bed days utilized for the period of July 1, 2012-June 30, 2013 as reflected in Exhibit B.

In addition, please see Table 2 below for a summary analysis of the currently available, approved, and proposed residential detoxification and intensive residential rehabilitation bed capacity in the State and the impact on such capacity if the Application were to be approved.

Table 2
Summary of Current, Approved and Proposed Capacity

(Table Data)		(Table Explanations)
Current Capacity:		**Current Capacity:** The total number of beds from Table 1 herein is 635. We multiplied 635 by 365 (i.e. the number of days in the year that each of these beds is available), which resulted in a total of 231,775 available bed days. Applying the FY 2012-2013 utilization percentage of 79% from Exhibit B herein to the total number of available bed days (i.e. 231,775), resulted in the utilization of 183102 bed days.
Totals Beds	635	
Total Available Bed Days	231775	
Application of Current Utilization % from Ex. B.	79%	
Total Available Bed Days Utilized	183102	
Additional OHCA Approved Beds:		**Additional OHCA Approved Beds:** Once the 44 OHCA approved beds are put into operation, this will add 16,060 more available bed days (i.e. 44 multiplied by 365 days per year) to the current bed days capacity of 231,775 bed days.
MCI HealthCare, LLC	16	
Litchfield Hills Retreat	28	
Total Additional Beds Approved	44	
Total Additional Bed Days Approved	16060	
Proposed Beds:		**Proposed Beds:** The Applicant's proposed addition of 105 beds will further add another 38,325 more available bed days (i.e. 105 multiplied by 365 days per year) to the current bed days capacity of 231,775 bed days.
Retreat at South Connecticut - Beds	105	
Proposed Bed Days	38325	
Total Bed Days Capacity:		**Total Bed Days Capacity:** Adding the current available bed days (i.e. 231,775) to the bed days that will be available when the OHCA approved beds start operating (i.e. 16,060) plus the bed days that will be available if the Applicant's beds were to be approved (i.e. 38, 325) would result in a total of 286,160 available bed days.
Current	231775	
Approved	16060	
Proposed	38325	
Total	286160	
Impact:		**Impact:** Applying the utilization percentage of 79% from Exhibit B herein to the grand total number of available bed days (i.e. 286,160) would result in only the utilization of 226,066 beds days out of the 286,160 total available bed days. In other words, this would give the State an excess capacity of 60,094 bed days (i.e. 286,160 minus 226,066) or 165 extra or unutilized beds (i.e. 60,094 divided by 365 days per year). This would result in a dilution of the current percent utilization of beds from 79% to 64% (i.e. 183,102 divided by 286,160).
Application of 79% Utilization	226066	
Excess Capacity- Bed days	60094	
Excess Capacity - Beds	165	
Utilization Dilution %	64%	

As reflected in Table 2 above, there currently exists excess capacity without the addition of the 105 beds proposed by the Applicant. If Approved, and the Applicant's beds were added to the

overall number of residential detoxification and intensive residential rehabilitation beds in the State of Connecticut, the Applicant predicts that the operating capacity for the Existing Residential Treatment Facilities would be reduced to sixty-four percent (64%) from seventy-nine percent (79%).[14]

Also, DMHAS, the State agency that monitors access and capacity needs relating to substance use treatment in the State, has not determined that there is a need for additional residential and detoxification treatment beds in the State. If it should determine that there is a need for additional residential capacity in the State, the Intervenor believes that such need would best be met through an incremental increase in beds regionally dispersed throughout the State, allowing greater client choice, access, and ability for families to be involved in treatment.

II. THE PROPOSED 105-BED RESIDENTIAL FACILITY WILL HAVE A SIGNIFICANT AND DETRIMENTAL IMPACT ON EXISTING RESIDENTIAL SUBSTANCE USE TREATMENT FACILITIES LOCATED IN CONNECTICUT.

The Applicant does not propose to provide services to patients who are beneficiaries of governmental payer programs. Rather, the Applicant proposes to target patients who have either commercial insurance or the means to pay out-of-pocket for their treatment. It is generally well known by those working in the healthcare industry that government payers typically pay providers significantly less than commercial payers.[15] Many of the substance use residential treatment providers in the State provide services to patients with both commercial and government payer insurance. From a financial perspective, having a payer mix that includes commercial insurance is critical to a provider's financial wellbeing because the

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[14] This projection is based on the modeling described in Exhibit B and is not intended to be a definitive statistic.
[15] See the Medicare Payment Advisory Commission March 2010 Report to the Congress Medicare Payment Policy at http://www.medpac.gov/documents/Mar10_EntireReport.pdf.

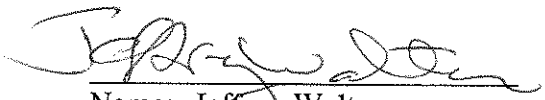
commercial payers help offset a provider's losses from government payer programs. If those providers, such as the Intervenor, who currently accept patients with both commercial insurance and/or governmental payer insurance (i.e. Medicare, Medicaid and DMHAS funded) experience a change in payer mix as a result of a migration of patients with commercial insurance away from them to the Applicant, their financial stability will be significantly and negatively impacted. Given that the providers in this State that care for beneficiaries of government-funded programs already operate on very small operating margins, it will not take a significant shift in commercial payer mix to upset the delicate balance maintained by the Intervenor and the other Existing Residential Treatment Facilities and push these providers either over the fiscal edge or away from accepting patients with government payer insurance. With respect to those substance use providers in the State who only accept patients with commercial insurance, according to our survey, these providers already have additional capacity and the shift of more patients with commercial insurance away from them will definitely have a significant impact on the financial viability of some or all of those programs.

III. The Proposed Application Will Not Be in the Best Interests of the State-Wide Health Care Delivery System.

The proposed Application if approved will have a deleterious impact on the Existing Residential Treatment Facilities in the State for the following reasons: (1) the Applicant failed to prove that there is a clear public need for 105 additional residential treatment beds; (2) a significant portion of commercial paying patients would need to shift from Existing Residential Treatment Facilities to the Applicant in order for the Applicant to sustain itself. If this were to occur, it would be at the detriment of existing providers including, the Intervenor; (3) because of a shift of commercial paying patients, some of the providers will have to curtail or

discontinue their service to patients with government payer insurance or worse yet, terminate their services entirely. None of these outcomes are in the best interest of the State-wide healthcare delivery system. The Intervenor strongly believes that if there is proven to be a need for any additional beds that those beds should be decentralized and incrementally added to existing providers across the State. Moreover, by having more programs and services that are decentralized, there will be more choices for patients with a greater potential for families to be supportive and involved in the patient's recovery program.

I adopt the foregoing pre-filed testimony as my own.



Name: Jeffrey Walter
Title: President & CEO

EXHIBIT A

DMHAS
ADMISSION DATA

Substance Admissions to Medically Monitored Detox and Intensive Residential Rehabilitation 3.7
Funded and Non-Funded Programs
August 5, 2013

Medically Monitored Detox 3.7d

Fiscal Year	**# of Admissions**
FY 09	9,267
FY 10	8,708
FY 11	10,463
FY 12	11,035
FY 13	11,078 *

* Due to data entry issues, FY 13 data may not be complete.

SA Intensive Residential Rehabilitation 3.7

Fiscal Year	**# of Admissions**
FY 09	2,906
FY 10	2,907
FY 11	3,040
FY 12	2,877
FY 13	2,566 *

* Due to data entry issues, FY 13 data may not be complete.

EXHIBIT B

Survey Results
&
Summary

HHC Behavioral Health Network

The Reateat at South Connecticut - Intervenor Petition Survey Data

Provider Survey Summary Schedule

Provider	Licensed Beds: Residential Detox	Licensed Beds: Intensive Residential	July 1, 2012 to June 30, 2013 Payer Mix	July 1, 2011 to June 30, 2012 Payer Mix	July 1, 2012 to June 30, 2013 Patient Days Residential Detox	July 1, 2011 to June 30, 2012 Patient Days Residential Detox	July 1, 2012 to June 30, 2013 Patient Days Intensive Residential	July 1, 2011 to June 30, 2012 Patient Days Intensive Residential	Wait List: Yes/ No	Days with Full Beds July 1, 2012 - June 30, 2013	100% % occupied	Days with Full Beds July 1, 2011 - June 30, 2012	100% % occupied	Is there a need for a new 105 Bed Facility?
CASA, Inc	0	10	% Commercial: 85% %Public/Government: 15%	% Commercial: 80% %Public/Government: 20%	0	0	3,520	3,580	Yes 5-7 Days	352	96%	358	98%	No
Farrell Treatment Center, Inc.	0	24	% Commercial: 5% %Public/Government: 85%	% Commercial: 5% %Public/Government: 85%	0	0	6,000	5,400	No	85	23%	75	21%	No
High Watch Recovery Center, Inc.	0	78	% Commercial: 0 %Public/Government: 0	% Commercial: 0 %Public/Government: 0	0	0	21,805	21,510	No	0	0%	0	0%	No
Recovery Network of Programs, Inc.	19	38	% Commercial: 9% %Public/Government: 85%	% Commercial: 4% %Public/Government: 89%	6,588	6,554	13,176	13,044	No	347	48%	343	94%	No
Midwestern Connecticut Council on Alocholism, Inc.	12	22	% Commercial: 1% %Public/Government: 71%	% Commercial: 1% %Public/Government: 64%	3,788	3,564	6,961	7,305	No	347	48%	3,564	29%	No
Connecticut Renaissance, Inc.	0	20	% Commercial: %Public/Government: 100%	% Commercial: %Public/Government: 100%	0	0	6,272	6,353	No	63	17%	84	23%	No
Rushford Center Inc.	16	42	% Commercial: 18% %Public/Government: 81%	% Commercial: 20% %Public/Government: 79%	4,949	4,872	14,035	14,101	No	22	6%	30	8%	No
Stonington Behavioral Health, Inc.	16	38	% Commercial: 25% %Public/Government: 70%	% Commercial: 25% %Public/Government: 70%	5,475	6,205	5,110	6,935	No	0	0%	0	0%	No
Milestone/New Life Ctr/Pathways CHR	0	16	% Commercial: 5% %Public/Government: 80%	% Commercial: 2% %Public/Government: 85%	0	1,480	4,062	4,872	No	180	49%	185	51%	No
	63	288			20800	22675	80941	83100						

Provider Utilization
Provider Survey - Data Summary

July 1, 2012 to June 30, 2013:

Totals Beds/ Patient Days	351
Total Available Bed Days	128,115
Actual Patient Days July 1, 2012 to June 30, 2013	101,741
Utilization %	79%

July 1, 2011 to June 30, 2012:

Totals Beds/ Patient Days	357
Total Available Bed Days	130,305
Actual Patient Days July 1, 2011 to June 30, 2012	105,775
Utilization %	81%

EXHIBIT C

SURVEY

CT Substance Abuse Treatment Provider Survey 2013

*1. Please provide the following information about your organization:

Name:

Title

Company:

Address:

City/Town:

State: -- select state --

ZIP:

Country:

Email Address:

Phone Number:

*2. Can we contact you with possible follow up questions regarding this survey?

- Yes
- No

*3. How many Connecticut licensed beds do you have for:

Residential Detox and Evaluation

Intensive Residential Treatment

*4. For the period of July 1, 2012 - June 30, 2013, please provide information on your payer mix for:

% Commercial Insurance

% Private Pay

% Public/ Government Sources

% Charity Care

***5. For the previous year, July 1, 2011 - June 30, 2012, please provide information on your payer mix for:**

% Commercial Insurance	
% Private Pay	
% Public/ Government Sources	
% Charity Care	

***6. Please indicate the number of patient days provided for the following periods and services:**

Residential Detox and Evaluation: July 1, 2012 - June 30, 2013	
Residential Detox and Evaluation: July 1, 2011 - June 30, 2012	
Intensive Residential Treatment: July 1, 2012 - June 30, 2013	
Intensive Residential Treatment: July 1, 2011 - June 30, 2012	

***7. Do you maintain a wait list?**

- Yes
- No

If yes, what is the average number of days on the wait list before being admitted?

***8. During the following periods, how many days were your beds full?**

July 1, 2012 - June 30, 2013

July 1, 2011 - June 30, 2012

***9. Do you believe there is a need for a new 105 bed substance abuse residential treatment center in the greater New Haven area for residential detox/evaluation and intensive residential treatment?**

- Yes
- No

Please explain

***10. Do you believe a new 105 bed substance abuse residential treatment center for residential detox/evaluation and intensive residential treatment, accepting only commercially-insured and private pay patients would have a detrimental effect on your facility?**

- Yes
- No

Please explain

Done

Powered by SurveyMonkey
Check out our sample surveys and create your own now!

Certificate of Service

I hereby certify that a true and correct copy of the foregoing request for intervenor status was sent via facsimile and first class United States Mail the 9th day of August 2013 to:

William P. Beccaro, Esq.
Law Offices of Peter P. Beccaro
12 New City Street
Essex, CT 06426

Tel: (860) 767-8632
Fax: (860) 767-0456
wbeccaro@snet.net

Joan Feldman

Joan Feldman, Esq.

2916460v14

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

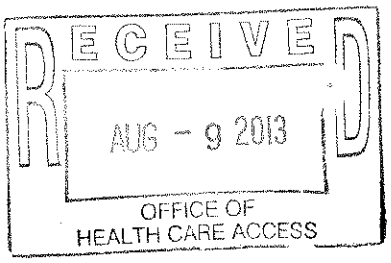
IN RE: NR CONNECTICUT, LLC D/B/A RETREAT AT SOUTH CONNECTICUT- ESTABLISH A 105 BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	:	**DOCKET NO. 13-31828-CON**
	:	
	:	
	:	
	:	
	:	**August 9, 2013**

NOTICE OF APPEARANCE

In accordance with Section 19a-9-28 of the Regulations of Connecticut State Agencies, please enter the appearance of Shipman & Goodwin LLP ("Firm") in the above-captioned proceeding on behalf of Rushford Center, Inc. ("Rushford"). The Firm will appear and represent Rushford at the public hearing on this matter, scheduled for August 14, 2013.

Respectfully Submitted,

RUSHFORD CENTER, INC.



By: Joan Feldman

Joan W. Feldman
Shipman & Goodwin LLP
jfeldman@goodwin.com
One Constitution Plaza
Hartford, CT 06103-1919
Tel: 860-251-5104
Fax: 860-251-5311
Its Attorney

Certificate of Service

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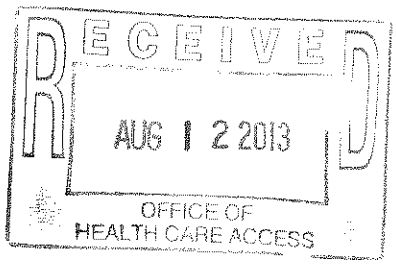


State of Connecticut – Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

RESPONSE BY APPLICANT, NR CONNECTICUT LLC, D/B/A RETREAT AT SOUTH CONNECTICUT, DOCKET NUMBER: 13-31828-CON TO REQUESTS BY VARIOUS PARTIES FOR INTERVENER STATUS WITH FULL PROCEDURAL RIGHTS

Applicant is in receipt of copies of several writings by various parties seeking to petition the Office of Health Care Access (hereinafter OCHA) pursuant to Connecticut General Statues Section 4-177a (b) and Section 19a-9-27 of the Regulations of Connecticut State Agencies for these entities to receive intervener status, with full procedural rights, so they may present opposition to the above-referenced Certificate of Need Application at the public hearing to be held on August 14, 2013.

As a threshold matter, while Applicant has no objection or issues with these entities participating in the hearing to present oral and written testimony, Applicant strongly disagrees with the petitioner's contention that they be granted full procedural rights, as this in fact will not assist OCHA in resolving the issues in this case, nor will it be in the interests of justice - and will certainly extend the scope, time, cost and likely impair the orderly conduct of the proceedings. Allowing these parties to present oral and written testimony will protect and preserve all affected rights and interests, without unnecessary complication, cost and delay, and will be in the best interest of the state-wide health care delivery system.

Applicant strongly disagrees with the various parties' contention that it has failed to demonstrate a clear public need for its facility. Quite to the contrary, applicant contends, and will demonstrate in some detail at the public hearing, the overwhelming need for additional treatment beds. Furthermore, applicant's facility design and treatment modality are unique and distinctive from those of existing providers. Applicant feels strongly, and can and will demonstrate (with independent statistical evidence) that it will be able to achieve a robust continuing census at its facility without interfering in any statistically significant manner with existing providers.

Applicant further disagrees with the various parties contentions that its surveys of bed availability at existing facilities were flawed. Again, applicant will demonstrate in detail at the hearing the specifics of the surveys and other independent evidence that will clearly and irrefutably show the unmet need for the type and scope of services applicant proposes to provide.

Additionally, applicant does not agree with the various parties contention that establishment of applicant's facility will do violence to the governmental payer insurance (i.e. Medicare, Medicaid, and DMHAS funded) patient population. In the public hearing, applicant will elaborate on how the establishment of their proposed facility will assist in bed decompression for these individuals.

Finally, applicant will show in detail how the establishment of the proposed facility will be of vital additional benefits not presently being addressed by the other facilities, i.e. addressing unmet need, extending and expanding treatment options to various population groups who are presently woefully underserved), providing an attractive option for an equally great unmet need in the surrounding states, and providing a robust economic engine to the local community desperately in need of good quality, well-paying jobs, as well as an increase in the tax base and related incremental revenues.

For the foregoing reasons, applicant respectfully requests that the various parties petition to receive intervener status, with full procedural rights be denied, and that these entities participation be limited to presenting oral and written testimony at the public hearing.

Respectfully submitted,

BY: William Beccaro

William Beccaro
Retreat at South Connecticut
12 New City Street
Essex, CT
It's Attorney

Hidden America: Heroin Use Has Doubled, Spreading to Suburbs

Jul 31, 2013 6:58pm

ABC News

ABC News' Byron Pitts reports:

Cory Monteith, the clean-cut star of the hit TV show "Glee," shocked fans earlier this month when he was found dead in Vancouver of an overdose involving heroin and alcohol - but he has quickly become the new face of the next generation of users of the highly addictive drug.

Though this growing group can be found all over the country – a government study shows 620,000 people admitted to using heroin in 2011, twice the number in 2003 – it's mostly being seen in, of all places, suburbia.

"Every part of Bergen County is touched in some way, shape or form by the heroin epidemic," said Lt. Thomas Dombroski of the Bergen County, N.J., Prosecutor's Office as he drove through the leafy suburbs west of New York City.

Bergen County reported 28 overdoses last year, up from previous years. Most of the victims were younger than 22.

Dombroski said that most parents might not know that, often, the gateway drug could already be in their medicine cabinet.

"Prescription medication is a pathway," he said.

That was the case for Dylan Young, 23, who first spoke with ABC News three years ago when he was still using.

"I started using prescription painkillers that my father had," he said then. "And it went from that."

At 13, Young was smoking pot and drinking. Then he started stealing pills from his parents. Eventually, he moved on to heroin. The hold the drug had on him was so strong that he ended up in rehab six times.

"A lot of us are missing something and then end up filling that void with drugs," Young said. "It can really happen to anyone and it also depends on the choices you make, the people you hang out with. And I just think if you are not staying

busy, you might end up using. ... When you are in that situation, you usually don't see hope of a life ahead of you. You just see your next fix."

Dombroski said heroin was cheaper than prescription medication, going for $4 a bag compared to $30 for just one 30-milligram oxycodone pill.

Most experts agree that intervention and treatment are key but the irony is that, like Monteith, many heroin addicts die when they start using again right after leaving treatment.

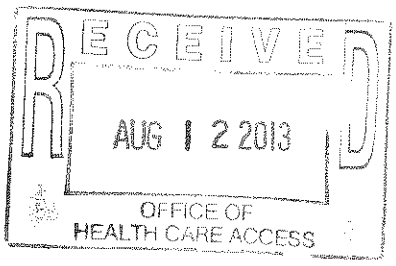
Monteith told Parade magazine in 2011, that, at 19, he'd gone to rehab. And in April, his rep confirmed that he'd entered treatment once again for addiction.

"Most of the overdose deaths that we're getting are people who come back from rehab," Dombroski said. "They get high for the first time since rehab and that high is what kills them."

Young has been clean for three years.

"I just focus on life itself rather than waking up in the morning and thinking about how I am going to get high for the day," he said.

Retreat
at South Connecticut



State of Connecticut – Department of Public Health
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Heroin making a comeback in state, Northeast

John Nickerson
Updated 9:15 pm, Saturday, July 27, 2013

Heroin is making a comeback.

Purer and cheaper -- it can be snorted rather than injected -- heroin is drawing users away from illicit prescription drugs that have become more expensive and harder to obtain.

In the last week alone, police in Stamford have made five significant busts seizing nearly 900 bags of heroin and arresting nine people, including a couple who hid their cache in their 4-year-old daughter's Hello Kitty backpack.

Police also arrested three people, including a Bridgeport man and an Ansonia woman, July 18 in front of Sacred Heart Church in Stamford after finding 350 bags of "True Religion" heroin in the trunk of their car. The heroin had a street value of $7,000, police said.

Heroin seizures by authorities throughout the Northeast have been running nearly twice the U.S. average for the past five years, and in 2012, in which final data is still pending, it was projected to spike sharply, according to data collected by the federal Drug Enforcement Agency.

"There are a couple of reasons for the increase," said Pam Mautte, director of the Valley Substance Abuse Action Council, whose group monitors drug trends and offers drug education in Shelton, Derby, Ansonia, Seymour and Oxford. "It is less costly than other street drugs and it is also fairly easy to get."

She said heroin users may have been addicted to opiate-based prescription drugs, but then find they can't afford them and go on to heroin because it's less expensive.

Mautte said there are trends in drug use, and right now, heroin seems to be the popular drug.

"Every few years, the trend changes, but it seems that heroin is hanging on," she said, adding that the Valley isn't the only area in the state to see an increase in its use.

Mautte said heroin use is up "across the board" and includes all demographics.

She cited a study conducted by her group in 2011 that found a small percentage of Valley students in grades 9 to 11 use the drug. The study found that over 12 months, about 1.2 percent of ninth-graders in the Valley used the drug.

While that is a "tiny number of students," there are still serious concerns that they are starting to use the drug at such a young age, Mautte said.

She said the VSAAC, which is based in Ansonia, offers programs for students to educate them about the danger of drugs.

"We tailor our programs to meet the needs in the community," she said.

In Stamford, police have found the appetite for drugs is "ever evolving," said Assistant Chief Timothy Shaw in a recent interview.

In his three years commanding Stamford's Narcotics and Organized Crime squad before taking over as the department's assistant chief, Shaw said he has seen more people selling and buying marijuana as well as prescription narcotics making a big presence on the street-dealing scene.

And, he said, prescription drugs -- or more precisely, the lack of them from time to time -- may be fueling the use of heroin.

"Heroin is a major problem and I think it is based on the pills," Shaw said. "Once they cannot get the prescription drugs, what's next? It seems like with that addiction (to pills), heroin is the filler and that is something that is causing an uptick in heroin addictions."

A number of recent Stamford drug busts have highlighted the trend.

On Wednesday afternoon, police arrested a 61-year-old woman getting ready to do a drug deal in a pet store parking lot on West Avenue. When they searched her they found 81 folds of heroin and 112 methadone pills.

Early Wednesday morning, police were called to Fairfield Avenue where a man and his son were threatening another man with a gun because someone blocked their driveway. When the dust settled they found the father and son in possession of 300 bags of heroin, over an ounce of pot and a semiautomatic pistol.

On Tuesday, police found a city couple carrying 72 small bags of heroin in their 4-year-old daughter's Hello Kitty backpack.

Later that night police chased down a man downtown near Latham Park and found 83 folds of heroin marked "Awesome" and "Plan B."

A routine traffic stop Thursday night led to the arrest of three people after a drug sniffing dog found a secret trunk compartment containing 350 bags of heroin.

A month earlier, police trying to intercept a drug dealer at the Stamford train station were attacked by the man's young pit bull. Police took 37 bags of heroin from the man, who they said swallowed an unknown quantity before they got his hands in cuffs.

Capt. Richard Conklin, who oversees the NOC squad, says the amount of heroin police have been seeing in the city has been growing for the past year.

"But recently, and it could just be our good luck," Conklin said. "This is the most activity we have had with heroin in quite some time at this level -- in years."

Conklin said he sees the link between prescription drugs and heroin, too. Because the highs from prescription drugs and heroin are very comparable, a shortage for either will create a demand for the other, he said.

Conklin said the common denominator with mid-level heroin dealers his officers have arrested lately is that they are all going to New York City on a daily or weekly basis to purchase prepackaged and reshaped heroin.

In New York City a fold of heroin -- with its NYC brand stamps declaring "True Religion," "914," "Awesome," or "Plan B" will cost $9 to $10 and without having to cut it with anything or repackage it, the folds will sell for about $20 apiece in Stamford.

Many of the dealers themselves are addicted, and selling heroin is a way to cut the expense of a very expensive habit, Conklin said.

"They don't have to touch it, really. It is prepackaged and reshaped. They can buy quantities. Bundles are 10 bags, bricks are 100 bags, so they will go down and buy a number of bundles or a couple bricks and bring them back and sell it. They don't touch it at all," he said.

The big change in heroin, Conklin says, is that it has been boosted way up in purity. Years ago, it was only six- to eight-percent pure and as a result, one had to shoot it up to get a good high.

"Now it is being sold at a level where it is 80-plus percent pure and it is conducive to being snorted like cocaine and that certainly appeals to a much wider cross section of the population," he said.

Jessica Macho, a social worker in the Public Defender's Office at state Superior Court in Stamford, agrees that the use of heroin is on the rise across all demographics.

"I had noticed that a lot of young people (19-24) had been using in the past few years," Macho said. "It now seems to be hitting all ages, races and socio-economic statuses."

Staff writer Anne M. Amato contributed to this report.

EXHIBIT "A"

Fulton Bank

LISTENING IS JUST THE BEGINNING.

August 6, 2013

Mr. David Silberstein, Coal New Haven, LLC
Mr. Peter Schorr, NR Connecticut, LLC
1377 East 4th Street, 4th Floor
Brooklyn, NY 11230

RE: 915 Ella T Grasso Blvd, New Haven, CT

Dear Messrs. Silberstein and Schorr,

Please accept this letter as follow up to my letter provided on October 24, 2012 regarding the financing package provided to Coal New Haven, LLC ("CNH"). Fulton Bank has provided a $7,500,000 financing package for the development of the property located at 915 Ella T Grasso Blvd, New Haven, CT. On August 23, 2012, CNH and Fulton Bank executed loan documents for the entire $7,500,000 transaction. As of August 6, 2013, CNH maintains the balance of these funds with Fulton Bank which are readily available to fund the additional costs associated with this project including but not limited to, the renovation of the property and for furniture, equipment and startup costs of CNH's tenant, NR Connecticut, LLC.

If you have any questions regarding the above structure, please do not hesitate to contact me directly at (717) 291-2657.

Sincerely,

J. Whit Buckwalter
Vice President

FAX

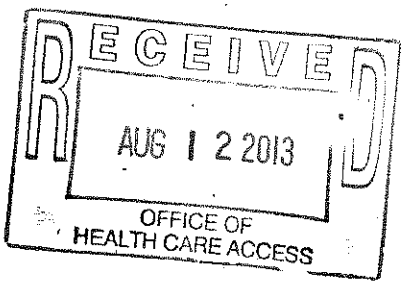
COVER SHEET

From: SPECTRUM PSYCHIATRIC GROUP PC
Address: 60 WASHINGTON AVE, SUITE 304
City: HAMDEN State: CT Zip: 06518
Phone: (203)281-2890 Fax: (203)281-2896

To: MS Kimberly Mastone Date: 8/12/13 Time: _____
Company: State Dept of Public Health
Phone: _____ Fax: 1-860-418-7053
Subject: Docket #13-31828
Pages: 3 including cover sheet Sent By: CM

Comments:

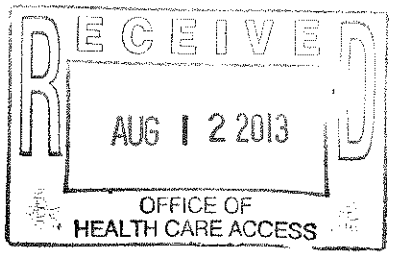
Letter Enclosed



THE INFORMATION CONTAINED IN THIS FAX MESSAGE IS INTENDED ONLY FOR THE PERSONAL AND CONFIDENTIAL USE OF THE RECIPIENT NAMED ABOVE. THE CONFIDENTIALITY OF THIS RECORD IS REQUIRED UNDER CHAPTER 889 OF THE GENERAL STATUTES. THIS MATERIAL SHALL NOT BE TRANSMITTED TO ANYONE WITHOUT WRITTEN CONSENT OR OTHER AUTHORIZATION AS PROVIDED IN THE AFOREMENTIONED STATUTES. THIS MESSAGE MAY BE A DOCTOR-PATIENT COMMUNICATION AND AS SUCH IS PRIVILEGED AND CONFIDENTIAL. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT OR AN AUTHORIZED AGENT, YOU ARE HEREBY NOTIFIED THAT YOU HAVE RECEIVED THIS FAX IN ERROR AND THAT REVIEW, DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS MESSAGE IS STRICTLY PROHIBITED. IF YOU RECEIVED THIS FAX IN ERROR, PLEASE NOTIFY THIS OFFICE IMMEDIATELY BY TELEPHONE AND RETURN THE ORIGINAL TRANSMISSION TO THIS OFFICE BY MAIL. THANK YOU

SPECTRUM PSYCHIATRIC GROUP, P.C.

August 8, 2013



Ms. Kimberly Martone
State Department of Public Health
Office of Health Care Access
410 Capitol Avenue MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Fax: 860-418-7053.

Re: Docket #13-31828, NR Connecticut, LLC-d/b/a Retreat at South Connecticut

Dear Ms. Martone,

Our practice is writing to express our concerns about the aforementioned application and the entrance of the Retreat at South Connecticut into the New Haven area. Having served both the private and public sector of the greater New Haven area for the last twenty years we are greatly concerned about a new service aimed solely at treating insured patients who have only a substance abuse problem.

I. Dual diagnosed needs in the population are not best served by a place such as the Retreat. 35% percent of our clients present with either a co-morbid medical and/or psychiatric diagnosis with symptoms requiring medical and/or psychiatric treatment including ongoing evaluation and medication titration.
   a. Concern – The Retreat capacity and expertise in evaluating and treating
      i. Ongoing medical concerns
      ii. Ongoing psychiatric concerns continuous evaluation, psychiatric intervention, and medication titration
   b. What are The Retreat's
      i. Evaluative process?
      ii. Admission/extended stay/discharge criteria
         1. What happens when a patient becomes actively suicidal, hyperactive/vigilant, psychotic, and or aggressive?
         2. What happens when a patient has active and or ongoing significant medical concerns?
      iii. Connection to community-based medical and psychiatric providers
         1. Expectation for community providers to accept referrals for medically or psychiatrically compromised patients?

II. 50% percent of clients seen within our private practice are:
   a. Commercially insured
   b. Have a substance diagnosis
   c. Receive ongoing psychiatric care/medication

60 Washington Avenue
Suite 304
Hamden, CT 06518
T (203) 281-2890
F (203) 281-2896

d. Do not experience delay in OP treatment

III. Loss of these clients will
   a. Have negative impact on financial viability of the practice, and
   b. Reduce ability to accept governmental payer patients.

IV. Currently, there is no wait time placing commercially insured patients
   a. Patients with commercial insurance can access medically appropriate care, psychiatrically appropriate care in already existing services both at our practice and the large network of community providers.

V. Our practice currently treats commercially insured patients but also patients with public insurance. We work out of Yale New Haven hospital and share the hospitals commitment to treat patients who are not commercially covered. The Retreat will essentially provide a service that is not needed to a population that is already well-served. The net effect will be to siphon off commercially insured patients from the existing service that serve the entire population.

We unequivocally oppose the Retreat's CON.

Very truly yours,

Robert Ostroff, M.D.

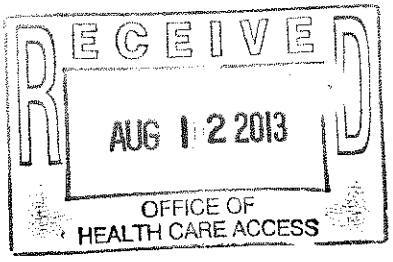
Robert B. Ostroff, MD

Managing Partner, Spectrum Psychiatric Group, PC

Greenwood-Gilbert-George-Orchard-Blockwatch #311
c/o 153 Greenwood St., New Haven CT 06511, 203-376-7189

August 12, 2013

Office of Health Care Access
Attn: Kim Martone
410 Capitol Avenue
Hartford, CT 06134
Faxed to 860-418-7053
Re: Docket No. 13-31828-CON



Dear Ms. Martone:

On behalf of Greenwood-Gilbert-George-Orchard-Blockwatch (New Haven Police Department #311), I am writing to oppose the Certificate of Need Application filed by The Retreat at Southern Connecticut, Docket No. 13-31828-CON ("The Retreat"). It is our understanding that "The Retreat" wants to open a substance abuse rehabilitation facility in our West River neighborhood. As a person who began his professional career as a drug abuse prevention educator and counselor, I am deeply concerned with the prospect of this facility entering our community. As a long-time resident and active member of this community I feel it is important that you take into account my opinion and the opinions of members of Blockwatch # 311.

Based on statements from representatives of "The Retreat", the organization will not accept patients unless they have private health insurance or the ability to pay out of pocket. In reality, New Haven has a large number of low-income families, as well as many seniors. In this city, more than 48 percent of the adult inpatients served in this community rely on Medicaid, and over 30 percent rely on Medicare as their insurance. In effect, nearly 80 percent of New Haven residents would be excluded by "The Retreat" if they needed such treatments. "The Retreat", under this plan would not serve the needs of the New Haven community.

Furthermore, we believe that "The Retreat" poses a risk of overburdening current New Haven safety net providers because they intend to bring additional patients from outside the community to New Haven for services. We already have an inadequate number of mental health professionals in our community serving individuals who need substance abuse treatment and who have Medicaid or no insurance. In the event that "The Retreat" detoxification patients require mental health assistance, this would create an additional burden on the safety net facilities that are already experiencing heavy traffic.

Based on the above mentioned concerns Blockwatch #311 does not support the application of "The Retreat" to open a substance abuse rehabilitation facility in New Haven, and we urge you to oppose the Certificate of Need. Thank you for your time and consideration.

Sincerely,

Prof James E. Jones (Manhattanville College)
Co-Chair Blockwatch #311

Greer, Leslie

From: Greci, Laurie
Sent: Tuesday, August 13, 2013 10:37 AM
To: wbeccaro@snet.net
Cc: Greer, Leslie; Veyberman, Alla; Hansted, Kevin; Riggott, Kaila
Subject: Letters concerning 13-31828-CON Received by OHCA
Attachments: 13-31828-CON Letters received by OHCA.pdf

Importance: Low

Dear Atty. Beccaro,

I have attached a .pdf file of letters received by OHCA that have been added to the above docket. If you have any problems reading the letters or receiving the file, please let me know.

Regards,
Laurie

Laurie K. Greci
Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

TO: Marianne Horn, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: August 13, 2013

RE: Certificate of Need Application; Docket Number: 13-31828-CON
NR Connecticut, LLC D/B/A Retreat at South Connecticut
Establishment of a 105 Bed Residential Substance Abuse Treatment Facility
to be Located in New Haven, Connecticut.

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing. This designation supersedes the previous designation to Kevin Hansted, which is hereby revoked.

Connecticut Department
of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

August 13, 2013

VIA FAX ONLY

Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy, P.C
265 Church Street
One Centure Tower
New Haven, CT 06510

RE: Certificate of Need Application, Docket Number 13-31828-CON
NR Connecticut, LLC-d/b/a/Retreat at South Connecticut
Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut

Dear Atty. Groves Fusco:

Enclosed are the rulings by the Department Public Health's Office of Health Care Access on the petition for party or intervenor status filed by you on behalf of Yale-New Haven Hospital, APT Foundation, Inc., Cornell Scott- Hill Health Center and Stonington Behavioral Health d/b/a Stonington Institute regarding the public hearing to be held in the matter identified above on August 14, 2013. These rulings will be entered as an exhibit in the Table of the Record in this case for the Certificate of Need application filed under Docket Number 13-31828-CON.

If you have any questions concerning this matter, please contact Laurie Greci at (860) 418-7032.

Sincerely,

Marianne Horn
Hearing Officer

KH:LG;AV

Copy: Atty. William Beccaro
Atty. Joan W. Feldman, Shipman & Goodwin, LLC

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

IN THE MATTER OF:

A Certificate of Need Application by
NR Connecticut, LLC d/b/a Retreat at South Connecticut
Notice to Petitioner re: Request for Status

Docket Number: 13-31828-CON
August 13, 2013

**RULING ON A PETITION FILED BY
YALE-NEW HAVEN HOSPITAL
TO BE DESIGNATED AS AN INTERVENOR WITH FULL PROCEDURAL RIGHTS**

By petition dated August 9, 2013, Yale-New Haven Hospital ("Petitioner") requested Intervenor status with full right of cross-examination in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") application of NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Applicant") filed under Docket Number: 13-31828-CON.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with full rights of cross-examination at the hearing scheduled for August 14, 2013, 9:00 a.m., at the Legislative Office Building, Room 2D, 300 Capitol Avenue, Hartford, Connecticut. As an Intervenor with full rights of cross-examination, the Petitioner is allowed to participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 13-31828-CON and will be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicant until the issuance of a final decision by OHCA. As an Intervenor with full rights of cross-examination, the Petitioner may be cross-examined by the Applicant and the Petitioner has the right to cross-examine the Applicant.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

August 13, 2013
Date

Marianne Horn
Marianne Horn
Hearing Officer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

IN THE MATTER OF:

A Certificate of Need Application by
NR Connecticut, LLC d/b/a Retreat at South Connecticut
Notice to Petitioner re: Request for Status

Docket Number: 13-31828-CON
August 13, 2013

RULING ON A PETITION FILED BY
APT FOUNDATION, INC.
TO BE DESIGNATED AS AN INTERVENOR WITH FULL PROCEDURAL RIGHTS

By petition dated August 9, 2013, APT Foundation, Inc. ("Petitioner") requested Intervenor status with full right of cross-examination in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") application of NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Applicant") filed under Docket Number: 13-31828-CON.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with full rights of cross-examination at the hearing scheduled for August 14, 2013, 9:00 a.m., at the Legislative Office Building, Room 2D, 300 Capitol Avenue, Hartford, Connecticut. As an Intervenor with full rights of cross-examination, the Petitioner is allowed to participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 13-31828-CON and will be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicant until the issuance of a final decision by OHCA. As an Intervenor with full rights of cross-examination, the Petitioner may be cross-examined by the Applicant and the Petitioner has the right to cross-examine the Applicant.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

August 13, 2013
Date

Marianne Horn
Hearing Officer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

IN THE MATTER OF:

A Certificate of Need Application by
NR Connecticut, LLC d/b/a Retreat at South Connecticut
Notice to Petitioner re: Request for Status

Docket Number: 13-31828-CON
August 13, 2013

RULING ON A PETITION FILED BY STONINGTON BEHAVIORAL HEALTH, INC. d/b/a STONINGTON INSTITUTE TO BE DESIGNATED AS AN INTERVENOR WITH FULL PROCEDURAL RIGHTS

By petition dated August 9, 2013, Stonington Behavioral Health, Inc. d/b/a Stonington Institute ("Petitioner") requested Intervenor status with full right of cross-examination in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") application of NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Applicant") filed under Docket Number: 13-31828-CON.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with full rights of cross-examination at the hearing scheduled for August 14, 2013, 9:00 a.m., at the Legislative Office Building, Room 2D, 300 Capitol Avenue, Hartford, Connecticut. As an Intervenor with full rights of cross-examination, the Petitioner is allowed to participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 13-31828-CON and will be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicant until the issuance of a final decision by OHCA. As an Intervenor with full rights of cross-examination, the Petitioner may be cross-examined by the Applicant and the Petitioner has the right to cross-examine the Applicant.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

August 13, 2013
Date

Marianne Horn
Marianne Horn
Hearing Officer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

IN THE MATTER OF:

A Certificate of Need Application by
NR Connecticut, LLC d/b/a Retreat at South Connecticut
Notice to Petitioner re: Request for Status

Docket Number: 13-31828-CON
August 13, 2013

**RULING ON A PETITION FILED BY
CORNELL SCOTT-HILL HEALTH CENTER
TO BE DESIGNATED AS AN INTERVENOR WITH FULL PROCEDURAL RIGHTS**

By petition dated August 9, 2013, Cornell Scott-Hill Health Center ("Petitioner") requested Intervenor status with full right of cross-examination in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") application of NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Applicant") filed under Docket Number: 13-31828-CON.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with full rights of cross-examination at the hearing scheduled for August 14, 2013, 9:00 a.m., at the Legislative Office Building, Room 2D, 300 Capitol Avenue, Hartford, Connecticut. As an Intervenor with full rights of cross-examination, the Petitioner is allowed to participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 13-31828-CON and will be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicant until the issuance of a final decision by OHCA. As an Intervenor with full rights of cross-examination, the Petitioner may be cross-examined by the Applicant and the Petitioner has the right to cross-examine the Applicant.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

August 13, 2013
Date

Marianne Horn
Marianne Horn
Hearing Officer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

August 13, 2013

VIA FAX ONLY

Joan W. Feldman, Esq.
Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103-1919

RE: Certificate of Need Application, Docket Number 13-31828-CON
NR Connecticut, LLC-d/b/a/Retreat at South Connecticut
Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut

Dear Atty. Feldman:

Enclosed is the ruling by the Department Public Health's Office of Health Care Access on the petition for party or intervenor status filed by you on behalf of Rushford Center, Inc. regarding the public hearing to be held in the matter identified above on August 14, 2013. This ruling will be entered as an exhibit in the Table of the Record in this case for the Certificate of Need application filed under Docket Number 13-31828-CON.

If you have any questions concerning this matter, please contact Laurie Greci at (860) 418-7032.

Sincerely,

Marianne Horn
Hearing Officer

KH:LG;AV

Copy: Atty. William Beccaro
Atty. Jennifer Groves Fusco, Updike, Kelley and Spellacy, PC

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

IN THE MATTER OF:

A Certificate of Need Application by
NR Connecticut, LLC d/b/a Retreat at South Connecticut
Notice to Petitioner re: Request for Status

Docket Number: 13-31828-CON
August 13, 2013

RULING ON A PETITION FILED BY
RUSHFORD CENTER, INC.
TO BE DESIGNATED AS AN INTERVENOR WITH FULL PROCEDURAL RIGHTS

By petition dated August 9, 2013, Rushford Center, Inc. ("Petitioner") requested Intervenor status with full right of cross-examination in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") application of NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Applicant") filed under Docket Number: 13-31828-CON.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with full rights of cross-examination at the hearing scheduled for August 14, 2013, 9:00 a.m., at the Legislative Office Building, Room 2D, 300 Capitol Avenue, Hartford, Connecticut. As an Intervenor with full rights of cross-examination, the Petitioner is allowed to participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 13-31828-CON and will be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicant until the issuance of a final decision by OHCA. As an Intervenor with full rights of cross-examination, the Petitioner may be cross-examined by the Applicant and the Petitioner has the right to cross-examine the Applicant.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

August 13, 2013
Date

Marianne Horn
Marianne Horn
Hearing Officer

Updike, Kelly & Spellacy, P.C. Counselors at Law

Jennifer L. Groves
(203) 786-8316
(203) 772-2037 FAX

One Century Tower
265 Church Street
New Haven, Connecticut 06510

FACSIMILE TRANSMITTAL SHEET

TO: **Office of Health Care Access**
ATTN: Laurie Greci

FACSIMILE: (860) 418-7053

DATE: **August 13, 2013**

Re: ***NR Connecticut, LLC d/b/a Retreat at South Connecticut***
Establish a 105-Bed Residential Substance Abuse Treatment Facility in New Haven
Docket No. 13-31828-CON

TOTAL NUMBER OF PAGES (INCLUDING THIS SHEET): 32

MESSAGE

IF YOU HAVE ANY PROBLEMS WITH RECEIPT OF THIS TRANSMITTAL, PLEASE CALL DEB ALEXA AT (203) 786-8300, EXTENSION 3353. THANK YOU.

UPDIKE, KELLY & SPELLACY, P.C., PRACTICES LAW IN THE AREAS OF:
Administrative Law, Appellate Law, Bankruptcy/Workout Law, Business Law, Commercial Lending and Banking, Commercial Litigation, Design/Construction Law, Environmental Law, Labor and Employment Law, Legislative Representation, Personal Law, Product Liability Law, Public Finance/Public Law, Real Estate Law, Professional Defense Law, Taxation, Financial and Estate Planning and Pensions, and Probate Law
A member firm of Meritas, with member firms worldwide

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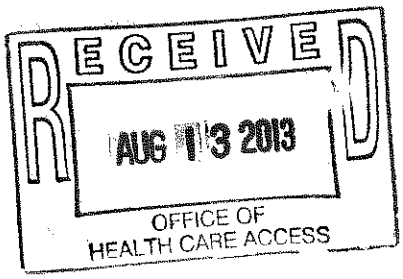

MERITAS LAW FIRMS WORLDWIDE

Jennifer Groves Fusco
(t) 203.786.8316
(f) 203.772.2037
jfusco@uks.com

August 13, 2013

VIA ELECTRONIC &
FACSIMILE (860-418-7053)

Lisa A. Davis, M.B.A., B.S.N., R.N.
Deputy Commissioner
Office of Health Care Access
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: NR Connecticut, LLC d/b/a Retreat at South Connecticut
Establish a 105-Bed Residential Substance Abuse Treatment Facility in New Haven
Docket No. 13-31828-CON

Dear Deputy Commissioner Davis:

This office represents Stonington Behavioral Health, Inc. d/b/a Stonington Institute ("Stonington") in connection with the above-referenced docket. On Friday, August 9, 2013, Stonington submitted testimony on behalf of William A. Aniskovich, CEO for purposes of the hearing on this matter, scheduled for August 14, 2013. Mr. Aniskovich intended to be at the hearing tomorrow to adopt his testimony and be available for cross-examination. However, earlier this morning, the Department of Public Health arrived at Stonington for a two-day unannounced licensure inspection. Unfortunately, Mr. Aniskovich must be at Stonington tomorrow during the inspection given that other senior management staff is out of the country on scheduled vacations.

Accordingly, Stonington respectfully requests that it be allowed to send a substitute witness in lieu of Mr. Aniskovich to testify at tomorrow's hearing. Per my discussion with Attorney Kevin Hansted, enclosed please find the prefiled testimony of Georganna Koppermann, Director of Buisness Development and Military Affairs at Stonington, which is substantially similar to our prior filing on behalf of Stoington. This prefiled testimony has also been sent via email to counsel for the Applicant, NR Connecticut, LLC d/b/a Retreat at South Connecticut, as well as counsel for the other potential intervenors.

Thank you in advance for your consideration of this request. Should you require anything further, please feel free to call me at (203) 786-8316.

Very truly yours,

Jennifer Groves Fusco

/jgf

Enclosures
cc: Georganna Koppermann (*w/enc.*)
William A. Aniskovich (*w/enc.*)

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: CERTIFICATE OF NEED APPLICATION OF NR CONNECTICUT, LLC d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	)	DOCKET NO. 13-31828-CON
	)	AUGUST 13, 2013

PREFILED TESTIMONY OF GEORGANNA KOPPERMANN, DIRECTOR OF BUSINESS DEVELOPMENT AND MILITARY AFFAIRS

Good morning Hearing Officer Horn and members of the OHCA staff. My name is Georganna Koppermann and I am the Director of Business Development and Military Affairs at Stonington Institute ("Stonington"), with extensive experience in behavioral health marketing and business development at both substance abuse and psychiatric hospitals across the country. Thank you for this opportunity to speak in opposition to the CON Application filed by NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Retreat") for permission to establish a 105-bed substance abuse treatment facility in New Haven. This facility is intended for the treatment of commercially insured and self-pay clients only, and will not be available to those individuals covered by Medicare and Medicaid. My remarks today will focus on the significant adverse impact that a facility of this type and size, for which there is no clear public need, will have on existing providers like Stonington.

Stonington Institute Programs & Services

Established in 1957, Stonington is a 58-bed substance abuse treatment facility located in Southeastern Connecticut. Stonington is licensed by the Department of Public Health as a Facility for the Care and Treatment of Substance Abusive or Dependent Persons, accredited by The Joint Commission ("TJC") and offers a full continuum of services to adults with substance abuse and co-occurring mental health disorders. Stonington also provides services to adolescents with developmental disabilities. Stonington accepts clients from Connecticut and across the country into its residential and outpatient programs, which operate out of North Stonington and Groton, respectively.

Stonington offers residential detoxification and evaluation services ("RDE Services") for adults in a 16-bed unit at its North Stonington campus. RDE Services at Stonington are designated as American Society of Addiction Medicine Level III.7, which allows for the admission of individuals who have a history of heavy and/or prolonged use of alcohol and/or other drugs and are in need of detoxification in a voluntary, medically-monitored detoxification setting. RDE Services clients often have a secondary mental health diagnosis as well.

Stonington also has 38 licensed beds for the provision of intensive treatment/residential rehabilitation services ("Rehabilitation Services") for active duty military personnel and veterans. Rehabilitation Services are offered at the North Stonington campus. Clients in Stonington's "Starlight Program" suffer from substance abuse disorders, post-traumatic stress disorder and mental health issues, and the rehabilitation program is tailored to meet the unique needs of, and challenges

faced by, these individuals and their families.[1] I am primarily responsible for compliance with military protocols and TRICARE standards and am the first point of contact for inquiries, admissions and referrals to the Starlight Program.

In addition to its residential programs, Stonington operates partial hospital and intensive outpatient programs ("PHP/IOP Services") for adults with co-occurring substance abuse and mental health disorders. These services are offered at clinics in Groton in both day and evening formats. PHP Services are provided 4 to 6 hours per day, 6 days per week. IOP Services are provided 3 nights per week, for 3 hours per session. Stonington has 190 total slots available for PHP/IOP clients.

Stonington is Medicaid certified and recently received hospital accreditation with deemed Medicare status from TJC, and will begin accepting Medicare clients as soon as it receives a provider number from the Centers for Medicare & Medicaid Services ("CMS"). In addition to its participation with these governmental programs, Stonington accepts clients from every major commercial health plan network in Connecticut.

Nature of Retreat's Proposal

This CON proposal involves the establishment of a 105-bed residential substance abuse treatment facility in New Haven. If approved, this will be one of the largest freestanding facilities of

[1] Although not directly relevant to this proposal, Stonington operates a 10-bed intensive treatment/residential rehabilitation program for adolescent boys with developmental disabilities at the North Stonington campus. Stonington also operates a 4-bed inpatient psychiatric unit, which is open to clients with commercial insurance. Once Stonington receives its Medicare provider number from CMS (see discussion below), this unit will be open to both Medicare and Medicaid recipients as well.

its kind in the state.[2] Retreat will offer an array of substance abuse services, including the Level III.7 residential detoxification and evaluation services, intensive treatment/residential rehabilitation services, PHP/IOP and other outpatient services offered by Stonington. Retreat has not broken down the proposed beds by level of service, but rather simply claims that 105 beds is within the "optimum" range of beds for the "Retreat modality" (CON Application, p. 667).[3] The so called "Retreat modality" refers to the programs and services offered at a sister facility in Pennsylvania, Retreat at Lancaster County, which serves as a model for Retreat at South Connecticut. Retreat, however, offers no evidence of how the "experience" of its Pennsylvania facility supports this claim of optimality, nor is there a single piece of reliable clinical research extant that supports such a claim.

The Retreat facility will be located in a former skilled nursing facility on Ella T. Grasso Boulevard in New Haven. Despite its urban placement, Retreat will cater to commercially insured and private-pay clients only. The facility will not admit Medicare and Medicaid recipients, many of whom reside in and around major cities such as New Haven.

There Is No Clear Public Need for Retreat at South Connecticut

A threshold issue in every CON application is whether there is a "clear public need" for the facility, service, acquisition or transaction being proposed. Conn. Gen. Stat. §19a-639(3). Despite Retreat's claim that the need for a 105-bed substance abuse treatment facility in Connecticut is "firmly established," it has not made even a basic showing of clear public need for a facility of this

[2] The only licensed freestanding substance abuse facilities with a greater total number of beds are APT Residential Services and Lebanon Pines Long Term Care, which are listed in the Statewide Health Care Facilities & Services Plan (Table 20) as having 125 and 110 Intermediate and Long Term Treatment and Rehabilitation beds, respectively (see Exhibit A attached). This is a different level of service than Retreat is requesting.

[3] Incidentally, this is the exact bed capacity of the existing facility being used for Retreat at South Connecticut.

magnitude (CON Application, p. 667). As previously mentioned, the proposed facility would be the third largest freestanding substance abuse treatment facility in the state (Statewide Health Care Facilities & Services Plan, Table 20, attached as Exhibit A).

Retreat's claim that there is a clear public need for this facility is based primarily on literature indicating a high incidence of substance abuse in Connecticut and a significant percentage of individuals with substance abuse disorders who do not seek treatment.[4] These types of statistics are often used to support the need for additional substance abuse beds and services. However, they are not in and of themselves determinative of a lack of adequate substance abuse treatment capacity in Connecticut. Retreat fails to account for the myriad of reasons why people do not seek treatment for substance abuse disorders. For some, it is that they do not have the appropriate insurance coverage or the financial means to obtain treatment. Others do not believe that their issues require treatment. The fact that substance abusers do not seek treatment does not necessarily indicate a lack of capacity within the system. Even if there was unlimited access to services, it is still likely that many people would continue to avoid treatment for a variety of reasons.

Stonington Institute's Capacity & Utilization

Retreat has attempted to analyze the capacity and utilization of existing substance abuse providers, however, the results of its informal survey are incomplete and misleading. First, they focus only on the providers that offer the Level III.7 RDE Services proposed by Retreat. For purposes of establishing clear public need, Retreat must consider the need for each service

[4] Retreat also states that "proprietary research" supports its claim that there is a tremendous unmet and growing need for private-pay and private insurance inpatient substance abuse services in Connecticut (CON Application, p. 667). However, Retreat has not shared any of this "proprietary research" with OHCA or the public and it should not form the basis of a finding of clear public need.

individually and analyze utilization and capacity for all providers offering residential rehabilitation and/or PHP/IOP services, regardless of whether they provide Level III.7 residential detoxification and evaluation services. If Retreat had considered these providers, the overall capacity of the system would likely have been far greater (Statewide Health Care Facilities & Services Plan, Table 20, attached as Exhibit A).

Moreover, the results of Retreat's survey are inaccurate. Retreat suggests that Stonington has zero beds available out of its 63 (now 58) licensed beds (CON Application, p. 76). In reality, Stonington has unused capacity in each of its residential and outpatient programs and no backlog or wait list for services. While Stonington's 16-bed RDE Service runs close to capacity, the short average length of stay for these clients (3-5 days) means that anywhere from 3 to 8 clients are being discharged on any given day. For this reason, there are almost always one or more beds available on the same day for individuals requesting admission for RDE Services. The only limitation on same-day availability is the gender mix of clients, and whether a bed in a shared room is immediately available for a female or male client seeking services. Note also that Stonington's RDE volume declined by approximately 12 percent between 2011 and 2012 (6,205 days to 5,475 days), further indication that there is unused RDE capacity in the state.

Stonington's Rehabilitation Services are currently operating at around 60 percent capacity, with 22 of 38 beds occupied and 16 beds available for new admissions on any given day. Stonington recently converted its Rehabilitation Service to a program focused on active duty military personnel and veterans. This change was driven by Stonington's decision to terminate its DCF-funded adolescent program and the fact that managed care virtually eliminated demand for these types of

beds for commercially insured clients. Commercial insurers will typically authorize the less expensive PHP level of service in lieu of a residential rehabilitation stay. Retreat has offered no letters from commercial payers indicating a willingness to support any intensive treatment beds, let alone a 105-bed facility. The current demand for Rehabilitation Services in this state can be accommodated easily by existing providers, including Stonington, which can service active duty military personnel and veterans.[5]

Stonington also provides PHP/IOP Services and has ample additional capacity for any current unmet need identified by Retreat. Stonington has 190 slots available for these services and is presently operating at approximately 90 percent capacity. Consider this along with other PHP/IOP services provided by hospitals and freestanding facilities that do not provide RDE Services (and were therefore not listed as existing providers by Retreat) and there is no clear public need for the addition of PHP/IOP capacity in the state at this time. Note also that Stonington's PHP/IOP volume declined by approximately 6 percent between 2011 and 2012 (47,060 days to 44,200 days), further indication that there is unused PHP/IOP capacity in the state.

Retreat's Volume Projections Are Flawed

Retreat's projected volumes, as detailed on page 677 of the CON Application, are not achievable and do not support the number of beds it has requested. With respect to RDE Services, Retreat is projecting between 5,280 and 7,920 client days in the first 4 years of operation (CON Application, pp. 30 & 677). It appears the projected average length of stay ("ALOS") for this service

[5] Retreat lists veterans as one of its target client groups (CON Application, p. 19). However, Retreat will not accept TRICARE or Medicaid, which cover services for most veterans.

is 5.5 days (CON Application, p. 682).[6] Therefore, Retreat is projecting between 18 admissions (5,280 ÷ 5.5 ÷ 52) and 28 admissions (7,920 ÷ 5.5 ÷ 52) per week. Stonington currently admits approximately 35 clients per week to its 16-bed RDE Service and is operating near capacity. Using this same measure of capacity, even if Retreat can achieve 18 to 28 admissions per week, it will only be enough to fill between 8 and 13 RDE beds.

Based on the foregoing, Retreat must be anticipating that at least 90 of its beds will be used for Rehabilitation Services. Retreat has projected between 15,840 and 23,760 client days in the first 4 years of operation (CON Application, pp. 30 & 677). Assuming a 16.5 day ALOS (CON Application, p. 682), this equates to between 18 admissions (15,840 ÷ 16.5 ÷ 52) and 28 admissions (23,760 ÷ 16.5 ÷ 52) per week. As previously mentioned, this volume of admissions (which assumes that 100% of RDE clients will transition to Rehabilitation) will be impossible to achieve given the position of most commercial payers on referrals for Rehabilitation Services. Stonington operates a nationally recognized rehabilitation program for active duty military personnel and veterans and still admits only 250 clients per year, or approximately 5 per week. With these admissions, Stonington fills less than 25 beds on average at any given time. Stonington also has a step-down rate from RDE to PHP/IOP of approximately 40 percent, which belies Retreat's assumption that all RDE clients will step down to its Rehabilitation beds.

It is clear that Retreat chose the number of beds at the proposed facility not based on need for those beds, but rather on the size of the facility and the "optimum number" of beds for the "Retreat modality" (CON Application, p. 667). As a threshold matter, a facility this large is not considered

[6] Based on Stonington's experience, this ALOS for commercially insured RDE Services is long. These payers typically approve 3-day stays on average.

"optimum" for therapeutic purposes. The residential program model depends on establishing and maintaining a therapeutic milieu. Residential treatment tends to be less effective the larger, more institutional and structured a facility becomes. Clients typically do better in the less structured and restrictive environments found in smaller residential programs.

Notwithstanding the foregoing, Retreat simply cannot fill the beds it is proposing given payment constraints, the impact of these constraints on demand and Retreat's lack of access to referral sources. Retreat was asked whether it has relationships with providers who will refer to the facility, and in response provided only 5 letters. Three were from LCSWs and an addiction counselor, all of whom are based in Fairfield County, not New Haven County where the facility will be located (CON Application, pp. 670-674). By Retreat's own admission, referrals from independent therapists/doctors account for only 2 percent of admissions to its Pennsylvania facility, therefore it is unclear how these letters show an ability to fill 105 beds (CON Application, p. 706).

The remaining letters were from the Metro-North Railroad and Canel Lodge No. 700 Employee Assistance Programs (CON Application, pp. 672-673). Jerry Marcil of Canel Lodge No. 700, located in New London County, claims to have difficulty finding substance abuse treatment beds that take commercial insurance. Stonington is located in New London County, takes commercial insurance and has bed availability. Bruce Pollack of Metro-North Railroad claims that detoxification beds are scarce, and that there are no outpatient detoxification services in Connecticut. This is untrue. Stonington offers outpatient detoxification services, and licenses for Ambulatory Chemical Detoxification are held by numerous other providers (see Exhibit A attached). Regardless, there is no indication that the payers who insure the Canel Lodge No. 700 and Metro-North Railroad members

and employees would authorize detoxification and/or rehabilitation stays at Retreat or any other facility.

Retreat further claims that it will draw 75 percent of its admissions from Connecticut, however the lack of Connecticut referral sources makes this unlikely without Retreat cannibalizing clients from existing providers in the state (CON Application, p. 669). Retreat also claims that it will share the existing referral network of its sister facility in Lancaster, Pennsylvania (CON Application, p. 669). However, given that only 12 of Retreat at Lancaster County's 2,206 clients (.05%) in FY 2012 were Connecticut residents, it is difficult to imagine how this referral network will assist Retreat in meeting its goal (CON Application, p. 686). Retreat's projections are simply too ambitious to meet without an established referral network, and Retreat does not have an established referral network for Connecticut.[7]

The Proposal Will Result in the Unnecessary Duplication of Services and Will Have a Significant Adverse Impact on Stonington Institute and the Connecticut Healthcare System

Because Retreat has not shown a clear public need for the proposed facility, the clients required to meet its projections and to fill a significant number of detoxification and rehabilitation beds will have to come from existing providers, including Stonington. This means the unnecessary duplication of substance abuse services in Connecticut. Conn. Gen. Stat. §19a-639(9). In addition, Retreat has made it clear that it will accept commercially insured and self-pay clients only, and will not offer services to Medicare or Medicaid recipients (CON Application pp. 35 & 704). Retreat

[7] Retreat also states that "proprietary research" supports its projections and the comparability of the Connecticut and Pennsylvania markets (CON Application, p. 706). However, Retreat has not shared any of this "proprietary research" with OHCA or the public and it should not form the basis of a finding that Retreat's projections are reasonable and achievable.

claims that it will generate higher revenues per bed than its competitors through an extensive referral program that focuses on high-end, private pay (i.e., non-Medicare and/or Medicaid) clients (CON Application, p. 527). This means that the clients diverted from Stonington and others will be those who generate the highest revenues, leaving existing providers to serve the most vulnerable clients, including Medicare and Medicaid recipients and the uninsured, with less money to cover the cost of providing services.

Retreat claims that it only needs to fill 33 percent of the requested beds to break even, likely because of higher rates of reimbursement for the commercially insured and self-pay clients who will occupy those beds (CON Application, p. 659). Compare this with Stonington, which requires 95 percent occupancy to break even. Currently, 68 percent of Stonington's RDE client days, and 77 percent of its PHP/IOP client days are Medicaid. Stonington's overall payer mix is 73 percent governmental payers and charity care, and only 27 percent commercial insurance and self-pay. However this small percentage of commercially insured and self-pay clients, which generates the highest rates, helps to support the significant percentage of governmentally insured clients at Stonington. Stonington could not break even if it lost any appreciable amount of its commercial/self-pay revenue. The loss of this revenue would have a significant adverse financial impact on Stonington, which could in turn compromise the quality, accessibility and cost-effectiveness of the care that we provide and weaken the healthcare system in Connecticut. Conn. Gen. Stat. §§19a-639(4) & (5).

Retreat cannot show any reason why a facility that does nothing to enhance access for Medicaid recipients, and in fact causes financial harm to those who care for these individuals, should

be approved. Approval of such a proposal would be contrary to recent changes in the CON statutory decision criteria aimed at improving Medicaid access. Public Act No. 13-234, which takes effect October 1, 2013, amends Section 19a-639 of the Connecticut General Statutes to include a requirement that an applicant for a CON demonstrate (1) how the provision of, or any change in access to, services for Medicaid recipients and indigent persons improves the quality, accessibility and cost-effectiveness of healthcare in the region; (2) how the proposal will impact the cost-effectiveness of providing access to services under the Medicaid program; (3) an applicant's past and proposed provision of healthcare services to relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons; and (4) whether an applicant, who has failed to provide access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which may not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other healthcare payers (see Exhibit B attached). Retreat has clearly stated its intention to exclude Medicare and Medicaid clients from its facility (CON Application, p. 704). Retreat has shown no justification for this approach other than the fact that commercially insured and self-pay clients generate higher revenues, which will give Retreat an advantage over its competitors, including Stonington and others who treat and will continue to treat governmentally insured individuals regardless of the financial impact on their bottom lines.

Conclusion

Retreat is proposing to establish one of the largest freestanding substance abuse treatment facilities in Connecticut. It has not shown a clear public need for this facility, and in fact it will duplicate the services of many freestanding facilities, including Stonington, which have ample

capacity to meet the current needs of Connecticut residents. Retreat's projections are flawed and it does not have the support or referral network necessary to populate a 105-bed facility without impacting existing providers. If this proposal is approved, Retreat will syphon the commercially insured and self-pay client from Stonington and other facilities. This will have a significant adverse financial impact on Stonington, which could in turn affect the quality, accessibility and cost-effectiveness of the care that we provide. In this time of expanded access to healthcare for all, particularly Medicaid recipients and indigent persons, OHCA should not approve a facility that has no intention of treating these individuals and that will negatively impact the facilities that do.

For these reasons, Stonington respectfully request that OHCA deny Retreat's CON request. I thank you for your time and am available to answer any questions you may have.

Respectfully Submitted,

Georganna Koppermann

Georganna Koppermann,
Director of Business Development & Military Affairs
Stonington Behavioral Health d/b/a Stonington Institute

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 13th of August, 2013 to the following:

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EXHIBIT A

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[b]
Access Center	APT Foundation, Inc.	1 Long Wharf	New Haven	06511	0	ACD, CMT, OT,
ADRC Outpatient Counseling Center	Alcohol and Drug Recovery Centers, Inc.	16 Coventry Street	Hartford	06112	0	OT
Adult Psychiatric Clinic/Child and Family Guidance Clinic	Cornell Scott-Hill Health Corporation	400 - 428 Columbus Avenue	New Haven	06519	0	OT
Altruism Acute Care and Evaluation	Southeastern Council on Alcoholism and Drug Dependency, Inc.	47 Colt Street	New London	06320	20 RDE	OT, RDE
Altruism House for Men	Southeastern Council on Alcoholism and Drug Dependency, Inc.	513 Main Street	Norwich	06360	13 ILTTR	ILTTR
Altruism House for Women	Southeastern Council on Alcoholism and Drug Dependency, Inc.	1000 Bank Street	New London	06320	10 ILTTR	ILTTR
Altruism House for Women	Southeastern Council on Alcoholism and Drug Dependency, Inc.	62-64 Colt Street	New London	06320	21 ILTTR	ILTTR
Angelus House	Wellspring Foundation, Inc.	158 Flanders Road	Bethlehem	06751	0	OT
Ansonia Counseling Services	Cornell Scott-Hill Health Corporation	121 Wakelee Avenue	Ansonia	06401	0	OT
APT Residential Services	APT Foundation, Inc.	425 Grant Street	Bridgeport	06608	125 ILTTR	ILTTR, OT
Behavioral Health Services at Hamden	Yale University	95 Circular Drive	Hamden	06514	0	OT
Bhcare Valley Outpatient Clinic	BHcare, Inc.	435 East Main Street	Ansonia	06401	0	OT
Bhcare, Inc.-Shoreline Clinic	BHcare, Inc.	14 Sycamore Way	Branford	06405	0	OT
Blue Sky Behavioral Health Clinic	Blue Sky Behavioral Health, LLC	52 Federal Road	Danbury	06810	0	CMT, DET, OT
Bridges ... A Community Support System, Inc.	Bridges ... A Community Support System, Inc.	949 Bridgeport Avenue	Milford	06460	0	OT
Bridges ... A Community Support System, Inc.	Bridges ... A Community Support System, Inc.	370 Center Street	West Haven	06516	0	OT
Carnes Weeks Center	McCall Foundation Inc.	58b High Street	Torrington	06790	20 IT	IT
Casa Eugenio Maria De Hostos	Chemical Abuse Services Agency, Inc.	690 Arctic Street	Bridgeport	06608	10 IT, 6 ILTTR	DET, ILTTR, IT, OT
Catholic Charities	Catholic Charities Diocese of Norwich, Inc.	28 Huntington Street	New London	06320	0	OT
Catholic Charities, Diocese of Norwich, Inc.	Catholic Charities Diocese of Norwich, Inc.	881 Main Street	Norwich	06360	0	OT
Catholic Charities, Diocese of Norwich, Inc.	Catholic Charities Diocese of Norwich, Inc.	151 Broad Street	Middletown	06457	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	80 Franklin Square	New Britain	06051	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	205 Wakelee Avenue	Ansonia	06401	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	209 High Street	Milford	06460	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	501 Lombard Street	New Haven	06513	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

STON000026
09/13/2013

13/08 2013 14:43 FAX 019/031

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[c]	Services on License[d]
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	56 Church Street	Waterbury	06702	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	13 Wolcott Street	Waterbury	06705	0	OT
Catholic Charities, Inc.	Catholic Charities Inc. - Archdiocese of Hartford	132 Grove Street	Torrington	06790	0	OT
Center for Human Services	Recovery Network of Programs, Inc.	2 Research Drive	Stratford	06615	0	OT
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	164 - 166 Bartholomew Street	Hartford	06106	20 ILTTR	ILTTR
Centro Renacer of CT, Inc.	Centro Renacer of CT, Inc.	83 Center Street	Hartford	06106	15 ILTTR	ILTTR
Child and Family Agency of Southeastern Connecticut, Inc. Child Guidance Clinic Essex	Child and Family Agency of Southeastern Connecticut, Inc.	190 Westbrook Road	Essex	06426	0	OT
Child and Family Agency of Southeastern Connecticut, Inc. Groton/Mystic Campus	Child and Family Agency of Southeastern Connecticut, Inc.	591 Poquonnock Road	Groton	06340	0	OT
Child and Family Agency of Southeastern Connecticut, Inc. Smith Bent Children's Center	Child and Family Agency of Southeastern Connecticut, Inc.	7 Vauxhall Street	New London	06320	0	OT
Child and Family Guidance Center, Inc.	Child and Family Guidance Center, Inc.	160 Fairfield Avenue	Bridgeport	06604	0	OT
Child Guidance Clinic for Central Connecticut, Inc.	Child Guidance Clinic for Central Connecticut, Inc.	384 Pratt Street	Meriden	06451	0	OT
Children's Center of Hamden, Inc.	Children's Center of Hamden Inc.	1400 Whitney Avenue	Hamden	06517	0	OT
CHR Manchester	Community Health Resources	587 East Middle Turnpike	Manchester	06040	0	OT
Clayton House	Alcohol and Drug Recovery Centers, Inc.	203 Williams Street	Glastonbury	06033	15 ILTTR	ILTTR
Community Child Guidance Clinic, Inc.	Community Child Guidance Clinic, Inc.	317 North Main Street	Manchester	06042	0	OT
Community Health Center of Wherever You Are Friendship Services Center	Community Health Center, Inc.	241-249 Arch Street	New Britain	06051	0	OT
Community Health Center of Wherever You Are Master's Manna	Community Health Center, Inc.	46 North Plains Industrial Road	Wallingford	06492	0	OT
Community Health Center of Wherever You Are Prudence Crandall	Community Health Center, Inc.	594 Burritt Street	New Britain	06053	0	OT
Community Health Services, Inc.	Community Health Services Inc.	500 Albany Avenue	Hartford	06120	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	81 North Main Street	Bristol	06010	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	26 Russell Street	New Britain	06052	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	5 Hart Street	New Britain	06052	0	OT
Community Mental Health Affiliates, Inc.	Community Mental Health Affiliates, Inc.	55 Winthrop Street	New Britain	06052	0	OT
Community Renewal Team Asian Family Services	Community Renewal Team	1214 Park Street	Hartford	06106	0	OT
Community Renewal Team, Inc. Behavioral Health Services	Community Renewal Team	90 Retreat Avenue	Hartford	06106	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

STONI000027
08/13/2013

13/08 2013 14:43 FAX 020/031

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[b]
Community Renewal Team, Inc. Behavioral Health Services	Community Renewal Team	990 Market Street	Hartford	06120	0	OT, DET
Community Renewal Team, Inc. Behavioral Health Services	Community Renewal Team	35 Clark Street	Hartford	06120	0	OT, DET
Community Residences, Inc.	Community Residences, Inc.	205 Kelsey Street	Newington	06111	0	OT
Community Substance Abuse Center, Inc.	Community Substance Abuse Centers, Inc.	55 Fishfry Street	Hartford	06120	0	ACD, CMT, OT
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc	4 Midland Road	Waterbury	06705	0	ACD, CMT, DET, OT
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	60 Beaver Brook Road	Danbury	06810	0	ACD, CMT, OT
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	20 North Main Street	Norwalk	06854	0	ACD, CMT, OT
Connecticut Junior Republic	Connecticut Junior Republic Association, Inc.	80 Prospect Street	Waterbury	06702	0	OT
Connecticut Junior Republic	Connecticut Junior Republic Association, Inc.	550 Goshen Road	Litchfield	06759	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	1120 Main Street	Bridgeport	06604	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	1 Lafayette Circle	Bridgeport	06604	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	115 Middle Street	Bridgeport	06604	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	17 High Street	Norwalk	06851	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	4 Bylington Place	Norwalk	06852	0	OT
Connecticut Renaissance, Inc.	Connecticut Renaissance, Inc.	141 Franklin Street	Stamford	06901	0	OT
Connection Counseling Center, The	Connection, Inc., The	178 State Street	Meriden	06450	0	OT
Connection Counseling Center, The	Connection, Inc., The	196 Court Street	Middletown	06457	0	OT
Connection Counseling Center, The	Connection, Inc., The	269 Main Street	Old Saybrook	06475	0	OT
Connection House	Connection, Inc., The	167 Liberty Street	Middletown	06457	14 ILTTR	ILTTR
Coventry House	Alcohol and Drug Recovery Centers, Inc.	46 Coventry Street	Hartford	06112	10 ILTTR	ILTTR
Crossroads, Inc.	Crossroads, Inc.	54 East Ramsdell Street	New Haven	06515	174 ILTTR	ILTTR
Crossroads, Inc.	Crossroads, Inc.	44 East Ramsdell Street	New Haven	06515	0	OT
CT Clinical Services, Inc.	CT Clinical Services, Inc.	199 Orange Street	New Haven	06510	0	OT
Detoxification Center	Alcohol and Drug Recovery Centers, Inc.	500 Blue Hills Avenue	Hartford	06112	28 IT, 10 ILTTR, 35 RDE	ILTTR, IT, RDE
Elm City Women and Children's Center and The Connection Counseling Center	Connection, Inc., The	48 Howe Street	New Haven	06511	15 ILTTR	ILTTR

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

13/08 2013 14:43 FAX 021/031

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[3]	Services on License[4]
Fairfield Counseling Services, Inc.	Fairfield Counseling Services Inc.	125 Penfield Road	Fairfield	06824	0	OT
Families in Recovery Program	Liberation Programs, Inc.	141 Franklin Street	Stamford	06901	10 ILTTR	ILTTR
Family and Children's Agency, Inc.	Family and Children's Agency, Inc.	9 Mott Avenue	Norwalk	06850	0	OT
Family Intervention Center	Family Intervention Center, Inc.	22 Chase River Road	Waterbury	06704	0	DET, OT
Family Resource Associates, LLC	Family Resource Associates, LLC	3300 Main Street	Stratford	06614	0	OT
Farrell Treatment Center	Farrell Treatment Center, Inc.	585 Main Street	New Britain	06051	24 IT	IT, OT
First Step	Recovery Network of Programs, Inc.	425 Grant Street	Bridgeport	06610	19 RDE	RDE
Fresh Start	Community Renewal Team	17 Essex Street	Hartford	06120	22 ILTTR	ILTTR, OT
Grant Street Partnership	Cornell Scott-Hill Health Corporation	62 Grant Street	New Haven	06519	0	DET, OT
Greenwich Youth Options	Liberation Programs, Inc.	55 Old Field Point Road	Greenwich	06830	0	OT
Hallie House Women and Children's Center	Connection, Inc., The	99 Eastern Drive	Middletown	06457	8 ILTTR	ILTTR
Hartford Behavioral Health	Hartford Community Mental Health Center, Inc.	2550 Main Street	Hartford	06106	0	OT
Hartford Behavioral Health	Hartford Community Mental Health Center, Inc.	1 Main Street	Hartford	06106	0	OT
Hartford Dispensary - Norwich Clinic	Hartford Dispensary	772 West Thames Street	Norwich	06360	0	ACD, CMT
Hartford Dispensary Henderson/Johnson Clinic	Hartford Dispensary	12 - 14 Weston Street	Hartford	06103	0	ACD, CMT
Hartford Dispensary New Britain Clinic	Hartford Dispensary	70 Whiting Street	New Britain	06050	0	ACD, CMT
Hartford Dispensary/Doctors Clinic	Hartford Dispensary	345 Main Street	Hartford	06106	0	ACD, CMT
Hartford Dispensary/New London Clinic	Hartford Dispensary	931-939 Bank Street	New London	06320	0	ACD, CMT
Hartford Dispensary-16-18 Weston Street	Hartford Dispensary	16-18 Weston Street	Hartford	06120	0	ACD, CMT, OT
Hartford Dispensary-Bristol Clinic	Hartford Dispensary	1098 Farmington Avenue	Bristol	06010	0	ACD, CMT, OT
Hartford Dispensary-Manchester Clinic	Hartford Dispensary	335 Broad Street	Manchester	06040	0	ACD, CMT
Hartford Dispensary-Willimantic Clinic	Hartford Dispensary	54-56 Boston Post Road	Windham	06226	0	ACD, CMT
High Watch Recovery Center	High Watch Recovery Center, Inc.	62 Carter Road	Kent	06757	78 C&R	C&R, DET, OT
Hispanos Unidos, Inc.	Hispanos Unidos, Inc.	116 Sherman Avenue	New Haven	06511	0	OT
Hockanum Valley Community Council, Inc.	Hockanum Valley Community Council, Inc.	27 Nash Road	Vernon	06066	0	OT
Horizons	Recovery Network of Programs, Inc.	1635 Fairfield Avenue	Bridgeport	06605	15 IT	IT
Institute for the Hispanic Family	Catholic Charities, Inc. - Archdiocese of Hartford	45 Wadsworth Street	Hartford	06106	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

STDN000029
08/13/2013

13/08 2013 14:43 FAX 022/031

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
Integrated Care Clinic	Optimus Health Care, Inc.	780 Summer Street	Stamford	06901	0	OT
Intercommunity, Inc.	Intercommunity, Inc.	287 Main Street	East Hartford	06118	0	OT
Intercommunity, Inc.	Intercommunity, Inc.	281 Main Street	East Hartford	06118	0	OT
Kinsella Treatment Center	Recovery Network of Programs, Inc.	1438 Park Avenue	Bridgeport	06604	0	ACD, CMT, OT
Lebanon Pines Long Term Care	Southeastern Council on Alcoholism and Drug Dependency, Inc.	97 Camp Meerween Road	Lebanon	06249	110 ILTTR	ILTTR
Legion Avenue Clinic	APT Foundation, Inc.	495 Congress Avenue	New Haven	06511	0	ACD, CMT, DET, CMT
Liberation Clinic	Liberation Programs, Inc.	125 Main Street	Stamford	06901	0	OT
Liberation House	Liberation Programs, Inc.	119 Main Street	Stamford	06901	67 ILTTR	ILTTR
Liberation Methadone Clinic (Bridgeport)	Liberation Programs, Inc.	399 Mill Hill Avenue	Bridgeport	06610	0	ACD, CMT, OT
Main Street Clinic	Liberation Programs, Inc.	117 Main Street	Stamford	06901	0	ACD, CMT
MCCA	Midwestern Connecticut Council on Alcoholism, Inc.	38 Old Ridgebury Road	Danbury	06810	20 IT, 10 RDE	ACD, CMT, DET, OT
MCCA/New Milford	Midwestern Connecticut Council on Alcoholism, Inc.	62 Bridge Street	New Milford	06776	0	DET, OT
MCCA/Ridgefield	Midwestern Connecticut Council on Alcoholism, Inc.	90 East Ridge Road	Ridgefield	06877	0	DET, OT
MCCA/Waterbury	Midwestern Connecticut Council on Alcoholism, Inc.	228 Meadow Street	Waterbury	06702	0	DET, OT
McCall Foundation	McCall Foundation, Inc.	58 High Street	Torrington	06790	0	DET, OT
McCall Foundation, Inc.-Winsted Satellite office	McCall Foundation, Inc.	115 Spencer Street	Winchester	06098	0	OT
McCall House	McCall Foundation, Inc.	127 Migeon Avenue	Torrington	06790	14 ILTTR	ILTTR
Milestone/New Life Center/Pathways	Community Health Resources	391 Pomfret Street	Putnam	06260	6 ILTTR, 18 IT	ACD, CMT, IT, ILTTR, RDE
Mother's Retreat and The Connection Counseling Center	Connection, Inc., The	542 Long Hill Road	Groton	06340	8 ILTTR	ILTTR, OT
Mountainside Treatment Center	MCI Healthcare LLC	187 South Canaan Road	Canaan	06018	62 ILTTR	ILTTR
Multicultural Ambulatory Addiction Services	Chemical Abuse Services Agency, Inc.	426 East Street	New Haven	06511	0	ACD, CMT, DET, OT
New Directions, Inc. of North Central Connecticut	New Directions, Inc. of North Central Connecticut	113 Elm Street	Enfield	06082	0	OT
New Era Rehabilitation Center, Inc.	New Era Rehabilitation Center, Inc.	311 East Street	New Haven	06511	0	ACD, CMT, DET, OT
New Era Rehabilitation Center, Inc.	New Era Rehabilitation Center, Inc.	3851 Main Street	Bridgeport	06606	0	ACD, CMT, DET, OT
New Hope Behavioral Health & Substance Abuse	New Hope Manor, Inc.	935 Main Street	Manchester	06040	0	OT

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

13/08 2013 14:43 FAX 023/031

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[a]	Services on License[a]
New Perceptions/Right Turn	Perception Programs, Inc.	54 North Street	Windham	06226	0	OT
New Perceptions/Right Turn	Perception Programs, Inc.	13 Water Street	Killingly	06239	0	OT
New Prospects	Recovery Network of Programs, Inc.	392 Prospect Street	Bridgeport	06604	23 IT	IT
Newtown Youth and Family Services, Inc.	Newtown Youth and Family Services, Inc.	15 Berkshire Road	Newtown	06470	0	OT
North Central Counseling Services	Community Health Resources	699 Bloomfield Avenue	Bloomfield	06002	0	DET, OT
North Central Counseling Services	Community Health Resources -	153 Hazard Avenue	Enfield	06082	0	DET, OT
North Haven Community Services	Town of North Haven	5 Linsley Street	North Haven	06473	0	OT
Northside Community Outpatient Services/Child and Family Guidance Clinic	Cornell Scott-Hill Health Corporation	226 Dbwell Avenue	New Haven	06511	0	OT
Northwest Center for Family Service & Mental Health	Community Mental Health Affiliates, Inc.	350 Main Street	Salisbury	06039	0	OT
Northwest Center for Family Service & Mental Health	Community Mental Health Affiliates, Inc.	100 Commercial Boulevard	Torrington	06790	0	OT
Orange Family Counseling	Bridges ... A Community Support System, Inc.	605-A Orange Center Rd	Orange	06477	0	OT
Orchard Hill Treatment Services	APT Foundation, Inc.	540 Ella T. Grasso Boulevard	New Haven	06519	0	ACD, CMT, OT
Outpatient Clinic	Connection, Inc., The	205-209 Orange Street	New Haven	06511	0	OT
Outpatient Treatment	Southeastern Council on Alcoholism and Drug Dependency, Inc.	321 Main Street	Norwich	06360	0	OT
Paces Counseling Associates, Inc.	Paces Counseling Associates, Inc.	991 Main Street	East Hartford	06108	0	OT
Park Street Inn	Connection, Inc., The	98 Park Street	New Haven	06511	0	OT
Patrick F. Mcauliffe Center	Connecticut Renaissance, Inc.	70 Central Avenue	Waterbury	06702	20 IT	IT
Perception House	Perception Programs, Inc.	134 Church Street	Windham	06226	20 ILTTR	ILTTR
Positive Directions - The Center for Prevention and Recovery, Inc.	Positive Directions-The Center for Prevention and Recovery, Inc.	420 Post Road West	Westport	06880	0	OT
Project Courage	Chemical Abuse Services Agency, Inc.	592 Kossuth Street	Bridgeport	06608	0	DET, OT
Recovery Adolescent Program	Recovery Network of Programs, Inc.	1549 Fairfield Avenue	Bridgeport	06605	0	OT
Recovery Counseling Services	Recovery Network of Programs, Inc.	480 Bond Street	Bridgeport	06610	0	OT
Renaissance East	Connecticut Renaissance, Inc.	31 Wolcott Street	Waterbury	06702	32 ILTTR	ILTTR
Renaissance West	Connecticut Renaissance, Inc.	466 West Main Street	Waterbury	06702	50 ILTTR	ILTTR
Reverend Edward M. Dempsey Drug Services	Central Naugatuck Valley HELP, Inc.	900 Watertown Avenue	Waterbury	06708	34 ILTTR	ILTTR

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

STON000091
08/13/2013

13/08 2013 14:44 FAX 024/031

Facility Name	Provider Name	Facility Address	City	Zip code	Beds[1]	Services on License[2]
Rushford Center, Inc.	Rushford Center, Inc.	210 National Drive	Glastonbury	06033	0	OT
Rushford Center, Inc.	Rushford Center, Inc.	888 Paddock Avenue	Meriden	06450	0	ACD, OT
Rushford Center, Inc.	Rushford Center, Inc.	1250 Silver Street	Middletown	06457	16 RDE, 42 IT	ACD, DET, IT, OT, RDE
Rushford Center, Inc.	Rushford Center, Inc.	525 Main Street	Portland	06480	26 ILTTR	ILTTR
Sound Community Services, Inc.	Sound Community Services, Inc.	165 State Street	New London	06320	0	OT
South Central Rehabilitation Center	Cornell Scott-Hill Health Corporation	232 Cedar Street	New Haven	06519	29 RDE	ACD, CMT, RDE, OT
Southwest Community Health Center, Inc.	Southwest Community Health Center, Inc.	1046 Fairfield Avenue	Bridgeport	06604	0	OT
Southwest Community Health Center, Inc.	Southwest Community Health Center, Inc.	968 Fairfield Avenue	Bridgeport	06605	0	OT
Stafford Family Services	Town of Stafford	21 Hyde Park Road	Stafford	06076	0	OT
State Street Counseling Services	Cornell Scott-Hill Health Corporation	911-913 State Street	New Haven	06511	0	OT
Stonington Institute	Stonington Behavioral Health, Inc.	1353 Gold Star Highway	Groton	06340	0	DET, OT
Stonington Institute	Stonington Behavioral Health, Inc.	428 Long Hill Road	Groton	06340	0	DET, OT
Stonington Institute	Stonington Behavioral Health, Inc.	75 Swantown Hill Road	North Stonington	06359	45 IT, 18 RDE	ACD, DET, OT, IT, RDE
Transitions Outpatient Services	Community Health Resources	433 Valley Street	Windham	06226	0	OT
Transitions Outpatient Services	Community Health Resources	37 Commerce Avenue	Killingly	06239	0	OT
Transitions Outpatient Services/Thomas Murphy Center	Community Health Resources	1491 Main Street	Windham	06226	14 ILTTR	ILTTR
Travisano Network	Central Naugatuck Valley Help, Inc.	24 Shelter Rock Road	Danbury	06810	0	OT
Trinity Glen	Midwestern Connecticut Council on Alcoholism, Inc.	149 West Cornwall Road	Sharon	06069	50 C&R	C&R
United Community and Family Services, Inc.	United Community and Family Services, Inc.	400 Bayonet Street	New London	06320	0	OT
United Community and Family Services, Inc.	United Community and Family Services, Inc.	70 Main Street	Griswold	06351	0	OT
United Community and Family Services, Inc.	United Community and Family Services, Inc.	47 Town Street	Norwich	06360	0	OT
United Community and Family Services, Inc.	United Community and Family Services, Inc.	212 Upton Road	Colchester	06415	0	OT
United Services, Inc.	United Services, Inc.	132 Mansfield Avenue	Windham	06226	0	OT
United Services, Inc.	United Services, Inc.	239 Route 6	Columbia	06237	0	OT
United Services, Inc.	United Services, Inc.	1007 North Main Street	Killingly	06241	0	OT
United Services, Inc.	United Services, Inc.	303 Putnam Road	Plainfield	06367	0	OT
Viewpoint Recovery Program	CTE, Inc.	104 Richmond Hill Avenue	Stamford	06902	12 ILTTR	ILTTR

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

13/08 2013 14:44 FAX 025/031

Facility Name	Provider Name	Facility Address	City	Zip code	Beds*	Services on License*
Village for Families and Children, Inc.	Village for Families and Children, Inc.	1680 Albany Avenue	Hartford	06105	0	OT
Village for Families and Children, Inc.	Village for Families and Children, Inc.	105 Spring Street	Hartford	06105	0	OT
Village for Families and Children, Inc.	Village for Families and Children, Inc.	331 Wethersfield Avenue	Hartford	06114	0	OT
Waterbury Outpatient Services for CMHA	Community Mental Health Affiliates, Inc.	36 Sheffield Street	Waterbury	06704	0	OT
Watkins Network	Central Naugatuck Valley HELP, Inc.	257 Main Street	Torrington	06790	0	OT
Wellmore Behavioral Health	Wellmore, Inc.	402 East Main Street	Waterbury	06702	0	OT
Wellmore Behavioral Health, Inc.	Wellmore, Inc.	30 Controls Drive	Shelton	06484	0	OT
Wellmore, Inc. Therapeutic Shelter	Wellmore, Inc.	142 Griggs Street	Waterbury	06704	0	DET
Wellmore, Inc. Women and Children's Program	Wellmore, Inc.	79 Beacon Street	Waterbury	06704	8 ILTTR	ILTTR
West Haven Health Center Counseling Services	Cornell Scott-Hill Health Corporation	265 Main Street	West Haven	06516	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	36 Russell Street	New Britain	06052	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	75 North Mountain Road	New Britain	06053	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	91 North West Drive	Plainville	06062	0	OT
Wheeler Clinic, Inc., The	Wheeler Clinic, Inc.	645 Farmington Avenue	Hartford	06105	0	OT
Wherever You Are Eddy Center	Community Health Center, Inc.	1 Labelle Circle	Middletown	06457	0	OT
Wherever You Are Shelter Now	Community Health Center, Inc.	43 Saint Casimir Drive	Meriden	06450	0	OT
Wherever You Are Shepherd Home	Community Health Center, Inc.	112 Bow Lane	Middletown	06457	0	OT
Youth Challenge Bible Training Center	Youth Challenge of Connecticut, Inc.	111 North Sterling Road	Plainfield	06354	9 ILTTR	ILTTR
Youth Challenge Mission for Women	Youth Challenge of Connecticut, Inc.	32 Atwood Street	Hartford	06105	8 ILTTR	ILTTR
Youth Challenge of Connecticut, Inc.-Men's Residential Center	Youth Challenge of Connecticut, Inc.	15-17-19 May Street	Hartford	06105	15 ILTTR	ILTTR
Total of 193 sites licensed and 1,512 beds broken out as follows: ILTTR beds total 972, IT beds total 269, RDE beds total 147 and C&R beds total 128						

Source: DPH licensure files and e-licensure database as of August 2012

*ABBREVIATION KEY:

ACD = Ambulatory Chemical Detoxification

CMT - Chemical Maintenance Treatment

C&R = Care and Rehabilitation

DET = Day or Evening Treatment

ILTTR = Intermediate and Long Term Treatment and Rehabilitation

IT = Intensive Treatment

OT = Outpatient Treatment

RDE = Residential Detoxification and Evaluation

STON000033
06/13/2013

Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons

EXHIBIT B



House Bill No. 6705

Public Act No. 13-234

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HOUSING, HUMAN SERVICES AND PUBLIC HEALTH.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2013*) The Commissioner of Housing may appoint a Deputy Commissioner of Housing who shall be qualified by training and experience for the duties of the office of commissioner and shall, in the absence, disability or disqualification of the commissioner, perform all the functions and have all the powers and duties of said office. The position of the Deputy Commissioner of Housing shall be exempt from the classified service.

Sec. 2. (*Effective from passage*) (a) Wherever in sections 4-66h, 8-13m to 8-13s, inclusive, 8-13u to 8-13x, inclusive, and 12-170e of the general statutes the term "secretary" is used, the term "commissioner" shall be substituted in lieu thereof, and wherever the term "the Office of Policy and Management" is used, the term "Housing" shall be substituted in lieu thereof.

(b) Wherever the term "Economic and Community Development" is used in the following general statutes, the term "Housing" shall be substituted in lieu thereof: 4b-21, 7-392, 8-37v, 8-37w, 8-37y, 8-37aa, 8-

expenditures; (2) the process and factors to be used in determining each future year's assessment; and (3) the establishment of an appropriate notification process for the entities assessed under the account.

Sec. 144. Section 19a-639 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) In any deliberations involving a certificate of need application filed pursuant to section 19a-638, the office shall take into consideration and make written findings concerning each of the following guidelines and principles:

(1) Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;

(2) The relationship of the proposed project to the state-wide health care facilities and services plan;

(3) Whether there is a clear public need for the health care facility or services proposed by the applicant;

(4) Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;

(5) Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons, and (B) the impact upon the cost effectiveness of providing access to services provided under the Medicaid program;

(6) The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;

(7) Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;

(8) The utilization of existing health care facilities and health care services in the service area of the applicant; [and]

(9) Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities; and

(10) Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers.

(b) The office, as it deems necessary, may revise or supplement the guidelines and principles through regulation prescribed in subsection (a) of this section.

Sec. 145. Subsection (b) of section 19a-323 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

(b) If death occurred in this state, the death certificate required by law shall be filed with the registrar of vital statistics for the town in which such person died, if known, or, if not known, for the town in which the body was found. The Chief Medical Examiner, Deputy Chief Medical Examiner, associate medical examiner, an authorized assistant

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 9th of August, 2013 to the following:

Peter Schorr
c/o Law Office of William P. Beccaro
12 New City Street
Essex, CT 06426
wbeccaro@snet.net

Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy, P.C.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TENTATIVE AGENDA

PUBLIC HEARING

Docket Number: 13-31828-CON

NR Connecticut, LLC D/B/A Retreat at South Connecticut

Establishment of a 105 Bed Residential Substance Abuse Treatment Facility to be Located in New Haven, Connecticut.

August 14, 2013, at 9:00 a.m.

I. **Convening of the Public Hearing**

II. **Applicant's Direct Testimony (10 minutes)**

III. **Intervenors' Direct Testimony (10 minutes each) / Cross Examination**

IV. **Applicant's Cross Examination**

V. **OHCA's Questions**

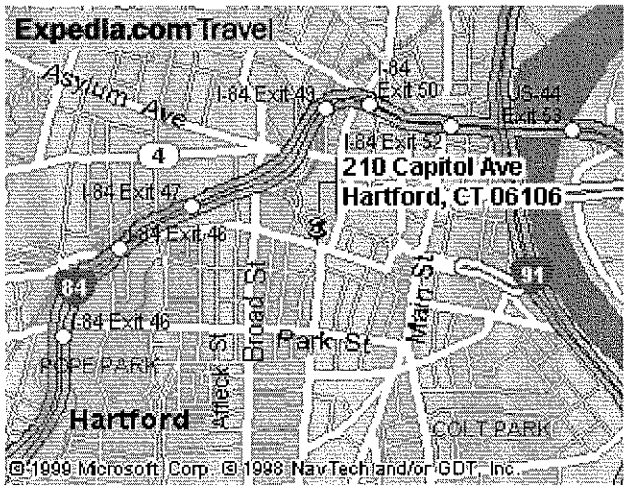
VI. **Public Comment**

VII. **Closing Remarks**

V. **Public Hearing Adjourned**

An Equal Opportunity Provider
(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

Directions to the State Capitol
(210 Capitol Avenue, Hartford, CT)
and Legislative Office Building
(300 Capitol Avenue, Hartford, CT)



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Going West on I-84: Take the Asylum Street Exit 48. Turn right at the light, then immediately take the left fork, which is Farmington Avenue. Turn left at the next light onto Broad Street. After one light and the State Armory, turn left into the Legislative Office Building driveway and continue left to the LOB Garage. To park at the Capitol, which has very limited space, turn left at the second light onto Capitol Avenue, from Broad Street turn left onto Trinity Street at the third light, and left onto the Capitol Grounds.

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The Capitol and the Legislative Office Building (LOB) are on the right.

Parking: Limited free parking is available in the Legislative Office Building parking garage (weekdays only) accessible from both Capitol Avenue and Broad Street and on the north Capitol grounds off Trinity Street.

On-street metered parking and commercial parking lots are also nearby.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **NR Connecticut, LLC D/B/A Retreat at South Connecticut**

DOCKET NUMBER: **13-31828-CON**

PUBLIC HEARING: **August 14, 2013 at 9:00 a.m.**

PLACE: **Legislative Office Building Room 2D**
Hartford, Connecticut

EXHIBIT	DESCRIPTION
A	Letter from the Applicant dated march 25, 2013 enclosing the CON application for NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Applicant") to establish a 105 Bed Residential Substance Abuse Treatment Facility to be Located in New Haven, Connecticut under Docket Number 13-31828, received by OHCA on March 25, 2013. (663 page)
B	OHCA's letter to the Applicant dated April 24, 2013 requesting additional information and/or clarification in the matter of the CON application under Docket Number 13-31828. (4 pages)
C	OHCA's email to the Applicant dated May 28, 2013 regarding obtaining information from the Department of Mental Health and Addiction Services in the matter of the CON application under Docket Number 13-31828. (2 pages)
D	Applicant's responses to OHCA's letter of April 24, 2013, dated June 17, 2013, in the matter of the CON application under Docket Number 13-31828, received by OHCA on June 18, 2013. (300 pages)
E	Designation letter dated July 19, 2013 for Hearing Officer in the matter of the CON application under Docket Number 13-31828. (1 page)
F	OHCA's letter to the Applicant dated July 8, 2013 deeming the application complete as of July 8, 2013 in the matter of the CON application under Docket Number 13-31828. (1 page)
G	Letter from Shipman & Goodwin LLP on behalf of Rushford Center, Inc, High Watch Recovery Center, Inc. CHR, Inc., MCCA, Inc. and Recovery Network Programs, Inc. (collectively, the "Interested Parties") dated July 11, 2013 requesting a hearing in the matter of the CON application under Docket Number 13-31828, received by OHCA on July 11, 2013.(1 page)

H	OHCA's request for legal notification in the *New Haven Register* and OHCA's Notice to the Applicant of the public hearing scheduled for August 14, 2013 in the matter of the CON application under Docket Number 13-31828, dated July 17, 2013. (4 pages)
I	OHCA's letter to the Applicant dated July 29, 2013 requesting prefile testimony and enclosing issues outlining topics to be discussed at the hearing in the matter of the CON application under Docket Number 13-31828. (2 pages)
J	Letter from the Applicant enclosing prefile testimony dated August 8, 2013 in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013.(11 pages)
K	Petition of Cornell Scott-Hill Health Center dated Augut 9, 2013, requesting intervenor status and enclosing notice of appearance of Updike, Kelly & Spellacy, P.C.and prefile testimony in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013.(46 pages)
L	Petition of Stonington Behavioral Health dated Augut 9, 2013, requesting intervenor status and enclosing notice of appearance of Updike, Kelly & Spellacy, P.C. and prefile testimony in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (37 pages)
M	Petition of Yale New Haven Hospital dated Augut 9, 2013, requesting intervenor status and enclosing notice of appearance of Updike, Kelly & Spellacy, P.C. and prefile testimony in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (48 pages)
N	Petition of APT Foundation dated Augut 9, 2013, requesting intervenor status and enclosing notice of appearance of Updike, Kelly & Spellacy, P.C. and prefile testimony in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (46 pages)
O	Petition of the Rushford Center dated Augut 9, 2013, requesting intervenor status and enclosing notice of appearance of Shipman & Goodwin, LLP and prefile testimony in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (28 pages)
P	Letter to OHCA from Behavioral Health Consultant, LLC dated August 8, 2013 in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (2 pages)

Q	Letter to OHCA from CommuniCare dated August 9, 2013 in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (2 pages)
R	Letter from the Applicant to OHCA undated responding to intervenors requests from various parties in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 12, 2013. (8 pages)
S	Letter to OHCA from Spectrum Psychiatric Group. P.C. dated August 8, 2013 in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 12, 2013. (2 pages)
T	Letter to OHCA from Greenwood-Gilbert-George-Orchard-Blockwatch #311. dated August 12, 2013 in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 12, 2013. (1 page)
U	Designation letter dated August 13, 2013 designating Marianne Horn as hearing officer and revoking Kevin Hansted as hearing officer in the matter of the CON application under Docket Number 13-31828. (1 page)
V	OHCA's Ruling on the Petition of Yale New Haven Hospital, Cornell Scott-Hill Health Center, APT Foundation and Stonington Behavioral Health to be granted intervenor status in the matter of the CON application under Docket Number 13-31828, dated August 13, 2013. (5 pages)
W	OHCA's Ruling on the Petition of Rushford Center to be granted intervenor status in the matter of the CON application under Docket Number 13-31828, dated August 13, 2013.(2 pages)
X	Email from OHCA to the Applicant dated August 13, 2013 enclosing letters received in the matter of the CON application under Docket Number 13-31828. (1 page)
Y	Facsimilie from Updike, Kelly and Spellacy to OHCA dated August 13, 2013 regarding substitute from Stonington Institute in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 13, 2013. (31 pages)

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*** TX REPORT ***
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Joan Feldman

FAX: (860) 251-5311

AGENCY: Shipman & Goodwin LLP

FROM: Lauren Greci

DATE: 8/13/2013 **TIME:**

NUMBER OF PAGES:
(including transmittal sheet

Comments: Docket FB-31828-CON
Please deliver promptly.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Joan Feldman

FAX: (860) 251-5311

AGENCY: Shipman & Goodwin LLP

FROM: Laura Greci

DATE: 8/13/2013 TIME: _____

NUMBER OF PAGES: _____
(including transmittal sheet

Comments: Docket 13-31828-CON
Please deliver promptly.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 *Fax: (860) 418-7053*

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3637
RECIPIENT ADDRESS	918607670456
DESTINATION ID	
ST. TIME	08/13 15:28
TIME USE	09'40
PAGES SENT	45
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: William Beccard

FAX: (861) 767-0456

AGENCY:

FROM: Laurie Greci

DATE: 8/13/2013 **TIME:**

NUMBER OF PAGES:
(including transmittal sheet)

Comments: Re: 13-31828-CON

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TRANSMISSION OK

TX/RX NO	3638
RECIPIENT ADDRESS	912037722037
DESTINATION ID	
ST. TIME	08/13 15:38
TIME USE	07'55
PAGES SENT	45
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Jennife- Groves Fusco

FAX: (203) 772-2037

AGENCY: Updike, Kelly and Spellacy, PC

FROM: Laure Grech

DATE: 8/14/2013 TIME:

NUMBER OF PAGES: (including transmittal sheet)

Comments: Docket 13-31828-CON Please delivery promptly

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Jennifer Groves Fusco

FAX: (203) 772-2037

AGENCY: Updike, Kelly and Spellacy, PC

FROM: Laura Grech

DATE: 8/14/2013 TIME: _____

NUMBER OF PAGES: _____
(including transmittal sheet

Comments: Docket 13-31828-CON Please deliver promptly

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 *Fax: (860) 418-7053*

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

Greer, Leslie

From: Veyberman, Alla
Sent: Tuesday, August 13, 2013 4:49 PM
To: wbeccaro@snet.net
Cc: Greer, Leslie; Hansted, Kevin; Riggott, Kaila; Greci, Laurie
Subject: RE: Letters concerning 13-31828-CON Received by OHCA
Attachments: 31828fax received.pdf

Dear Atty. Beccaro,

I have attached a letter received by OHCA that have been added to the above docket. If you have any receiving the file, please let me know.

Thank you,

Alla

Alla Veyberman
CT Department of Public Health
Office of Health Care Access (OHCA)
Phone: 860.418.7007
Fax: 860.418.7053
Email: Alla.Veyberman@ct.gov

FAX

Yale New Haven Health System
Community & Government Relations
789 Howard Ave.
New Haven, CT 06519

Date 8/13/13

Number of pages including cover sheet 2

To: Kim Martone, OHCA

Phone

Fax Phone 860 418 7053

CC:

Re:

From:

Phone **203-688-2503**

Fax Phone **203-688-3863**

REMARKS:

☒ Urgent ☐ For your review ☐ Reply ASAP ☐ Please comment

Re: Docket No. 13-31838-CON

RECEIVED
AUG 13 2013
OFFICE OF

Office of Health Care Access
Attn: Kim Martone
410 Capitol Avenue
Hartford, CT 06134

Re: Docket No. 13-31828-CON
Dear Ms. Martone:

I am the President of the West River Neighborhood Services Corporation (WRNSC) a 501(c)3 nonprofit organization located in the West River section of the City of New Haven. The WRNSC has the mission of building community through engagement and events that address public safety, economic development, ownership, and revitalization. We have a thirty year history in the City of New Haven, and the only community that has a standing Neighborhood Revitalization Committee (NRZ) consisting of community partners, businesses, residents, and staff members of various city departments, such as; planning, economic development, parking authority, Livable Cities Initiative (LCI), and others.

We're very concerned about the proposed Retreat facility opening in our New Haven community, and am writing in opposition to the Certificate Of Need Application filed by The Retreat at of a community Southern Connecticut, Docket No. 13-31828-CON (The Retreat). Our community is home to numerous nonprofit treatment facilities that barely have a visible footprint, and numerous other halfway and sober houses that are deterrents to community building and engagement because of their transient population. The WRNSC hopes that you'll take into consideration the opinion of this organization and its members.

The proposed Retreat facility is a for profit and one that will not benefit our residents who don't have medical insurance or the means to pay for substance abuse treatment. This in my opinion is another destabilizing blow to our community that knows firsthand the drug crisis and upon the family unit. Throughout the process where public meetings were held it was heralded that this group had another facility in Lancaster, Pennsylvania that was well received by the community. Yet, I must state loud and clear that there is a strong contrast between the rural community of Lancaster and the urban community of New Haven., and that not enough forethought had been considered in the contrast to the two communities.

We as a community are on the verge of redevelopment and creating change, but we're mindful before we effect change, we first must stabilize our current social issues. The WRNSC has some immediate concerns and opposition to the proposed Retreat facility in our New Haven community. We're asking that you oppose the Certificate of Need. It will not benefit our community, or those that are in desperate need of its assistance. Please, consider our opinion and not allow it to open here in New Haven.

Sincerely,

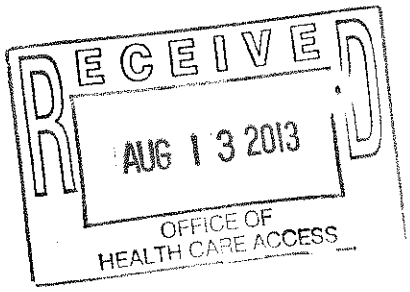
Stacy Spell

RECEIVED
AUG 13 2013
OFFICE OF
HEALTH CARE ACCESS

YALE-NEW HAVEN HOSPITAL

August 13, 2013

Via Fax: 860-418-7053



Ms. Laurie Greci
Department of Public Health
Office of Health Care Access Division

Re: Notice of Appearance – Docket No. 13-31828-CON

Dear Ms. Greci:

Attached please find a Notice of Appearance on behalf of Yale-New Haven Hospital in the above referenced action. I have also sent this notice to your attention via e-mail at laurie.greci@ct.gov.

Please feel free to contact me directly should you have any questions.

Sincerely,

Lynn M. Walsh
Paralegal

789 Howard Avenue, CB 230
New Haven, CT 06519
203-688-2291
Lynn.Walsh@ynhh.org

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: CERTIFICATE OF NEED APPLICATION OF NR CONNECTICUT, LLC d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105 BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY IN NEW HAVEN, CONNECTICUT	)	DOCKET NO. 13-31828-CON
	)	AUGUST 13, 2013

NOTICE OF APPEARANCE

In accordance with Section 19a-9-28 of the Regulations of Connecticut State Agencies, please enter the appearance of Jennifer Willcox, Legal and Risk Services Department, Yale New Haven Health System ("Counsel") in the above-captioned proceeding on behalf of Yale-New Haven Hospital ("YNHH"). Counsel will appear and represent YNHH at the public hearing on this matter, scheduled for August 14, 2013.

Respectfully Submitted,

YALE-NEW HAVEN HOSPITAL

By: _____
JENNIFER WILLCOX, ESQ.
Yale New Haven Health System
Legal & Risk Services Department
789 Howard Avenue, CB 230
New Haven, CT 06519
Tel: (203) 688-2291
Fax (203) 772-2037

668270

CERTIFICATION

I hereby certify that a copy of the foregoing has been sent via United States mail, postage prepaid, and electronic mail, this 9th of August, 2013 to the following:

Peter Schorr
c/o Law Office of William P. Beccaro
12 New City Street
Essex, CT 06426
wbeccaro@snet.net

Jennifer Willcox, Esq.
Yale New Haven Health System

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE JUAN CANDELARIA
NINETY-FIFTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 1804
HARTFORD, CONNECTICUT 06106

CAPITOL: 860-240-8585
TOLL FREE: 1-800-842-8267
FAX: 860-240-0206
E-MAIL: Juan.Candelaria@cga.ct.gov

RECEIVED
AUG 15 2013
OFFICE OF
HEALTH CARE ACCESS

DEPUTY MAJORITY LEADER

MEMBER
APPROPRIATIONS COMMITTEE
COMMITTEE ON CHILDREN
HIGHER EDUCATION & EMPLOYMENT ADVANCEMENT COMMITTEE
JOINT COMMITTEE ON LEGISLATIVE MANAGEMENT

August 12, 2013

Office of Health Care Access
Attn: Kim Martone
410 Capitol Avenue
Hartford, CT 06134

Re: Docket No. 13-31828-CON

Dear Ms. Martone:

I am writing in opposition to the Certificate Of Need Application filed by The Retreat at Southern Connecticut, Docket No. 13-31828-CON (The Retreat), which seeks to open a substance abuse rehabilitation facility in New Haven. While I am in no way against improving access to those who need substance abuse services in our community, I am deeply concerned with the prospect of this facility entering our community based on what I know from the application. As a long-time resident and active member of a very vibrant community I feel it is important that you take into account my opinions on this important matter.

Based on statements that representatives from The Retreat have made, the organization will not accept patients unless they have private health insurance or the ability to pay out of pocket. Despite this being one of the wealthiest states in the U.S., New Haven has a large number of low-income families, as well as many seniors. In New Haven, more than 48 percent of the adult inpatients served in this community rely on Medicaid, and over 30 percent rely on Medicare, as their insurance. This means that nearly 80 percent of New Haven residents would be excluded by The Retreat if they needed such treatments. The Retreat therefore does not serve the needs of the New Haven community.

Furthermore, I believe The Retreat poses a risk on overburdening the current safety net providers that serve New Haven because they intend to bring additional patients from outside the community to New Haven for services. We already have an inadequate number of mental health professionals in our community serving individuals who need substance abuse treatment and who have Medicaid or no insurance. In the event their detoxification patients require mental health assistance, this would create an additional burden on the safety net facilities that are already experiencing heavy traffic.

It is because of the above mentioned concerns that I do not support the application of The Retreat to open a substance abuse rehabilitation facility in New Haven, and I urge you to oppose the Certificate Of Need. This proposed facility will not benefit many of New Haven's residents and therefore should not be permitted to open here. Thank you for your time and consideration.

Sincerely,

Juan Candelaria
State Representative
95th Assembly District

****
*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3641
RECIPIENT ADDRESS	98602515311
DESTINATION ID	
ST. TIME	08/13 16:39
TIME USE	04'15
PAGES SENT	12
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Joan Feldman

FAX: (860) 251-5311

AGENCY: Shipman & Goodwin LLP

FROM: Lauire Greci

DATE: 8/13/2013 **TIME:**

NUMBER OF PAGES: *(including transmittal sheet*

Comments: Docket FB-31828-CON Exhibit R + Exhibit X Please deliver promptly. this is in addition to last email sent

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3640
RECIPIENT ADDRESS	912037722037
DESTINATION ID	
ST. TIME	08/13 16:36
TIME USE	02'03
PAGES SENT	12
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Jennife - Groves Fusco

FAX: (203) 772-2037

AGENCY: Updike, Kelly and Spellacy, PC

FROM: Laurie Greci

DATE: 8/14/2013 **TIME:**

NUMBER OF PAGES: *(including transmittal sheet*

Comments: Docket 13-31828-CON Please delivery promptly

Exhibit R + Exhibit X in addition to last email

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Jennifer Groves Fusco

FAX: (203) 772-2037

AGENCY: Updike, Kelly and Spellacy, PC

FROM: Laura Greci

DATE: 8/14/2013 **TIME:** _____

NUMBER OF PAGES: _____
(including transmittal sheet

Comments: Docket 13-31828-CON Please delivery promptly

Exhibit R + Exhibit X in addition to last email

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 *Fax: (860) 418-7053*

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Joan Feldman

FAX: (860) 251-5311

AGENCY: Shipman & Goodwin LLP

FROM: Laura Grech

DATE: 8/13/2013 TIME: _____

NUMBER OF PAGES: _____
(including transmittal sheet

Comments: Docket #13-31828-CON Exhibit R + Exhibit X
Please deliver promptly.
this is in addition to last email sent

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 *Fax: (860) 418-7053*

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

PUBLIC HEARING
APPLICANT
SIGN UP SHEET

August 14, 2013
9:00 a.m.

Docket Number: 13-31828-CON
NR Connecticut, LLC D/B/A Retreat at South Connecticut
Establishment of a 105 Bed Residential Substance Abuse Treatment Facility to be Located in New Haven, Connecticut

PRINT NAME	Phone	Fax	Representing Organization
Peter Schorr	717 859-8000	717 859-6330	Retreat at South CT
Steven KLOTZ, MD	717 859-8000	717 859-6330	Retreat at South CT
Kathryn Harasym	717 859-8000	717 859-6330	Retreat at South CT
Chaim Herbert Loshkowitz	212-532-5550	212 532-4007	Retreat at South Ct.

PUBLIC HEARING
INTERVENOR
SIGN UP SHEET

August 14, 2013
9:00 a.m.

Docket Number: 13-31828-CON
NR Connecticut, LLC D/B/A Retreat at South Connecticut
Establishment of a 105 Bed Residential Substance Abuse Treatment Facility to be Located in New Haven, Connecticut

PRINT NAME	Phone	Fax	Representing Organization
Jennifer Fusco	(203) 786 8316	(203) 752-2599	YNHH, APT, Stonington, CSHHC
Stephen Menz	203-688-2185	203-688-5629	YNHH
Rob Rioux	203-503-3276		Cornell Scott-Hill Health Center
William Sledge	203-214-3002		YNHH
Lindsey Greene-Upshaw	281-841-~~7725~~		YNHH

NR Connecticut, LLC D/B/A Retreat at South Connecticut

PRINT NAME	Phone	Fax	Representing Organization
Matt McKennan	(203)907-9558		YNHH
Kyle Ballon	203-688-2603		YNHH
Nancy Rosenthal	203-863-3908		YNHH
Georganna Koppermann	860-235-5570		Stonington Institute
Douglas Brill	203-503-3300		Cornell Scott - Hill Health Center
BS Freeman	203-781-4600		APT Foundation
Jennifer Wilcox	203-687-229[illegible]		YNHH
Joan Feldman	860 251-5704		Chipman & Goodwin for Rushford Center
Jeffrey Walters	203-238-~~860~~ 6803		Rushford Center, Inc.

PUBLIC HEARING
GENERAL PUBLIC
SIGN UP SHEET

August 14, 2013
9:00 a.m.

Docket Number: 13-31828-CON
NR Connecticut, LLC D/B/A Retreat at South Connecticut
Establishment of a 105 Bed Residential Substance Abuse Treatment Facility to be Located in New Haven, Connecticut

PRINT NAME	Representing Organization
Janina Kean Pres/CEO	High Watch Recovery Center
Joe Sullivan Pres/CEO	ICCA Inc.
Jill Benson VP System Operations	Community Health Resources (CHR)
~~Georgiana Kopperman~~	Stonington Institute
~~Douglas Rose~~	Cornell Scott-Hill Health Center

NR Connecticut, LLC D/B/A Retreat at South Connecticut

PRINT NAME	Representing Organization
Robert Freeman	APT Foundation
John Hamilton	Recovery Network of Programs
Heather Porter	Silver Hill Hospital

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

AGENDA

PUBLIC HEARING

Docket Number: 13-31828-CON

NR Connecticut, LLC D/B/A Retreat at South Connecticut

Establishment of a 105 Bed Residential Substance Abuse Treatment Facility to be Located in New Haven, Connecticut.

August 14, 2013, at 9:00 a.m.

I. **Convening of the Public Hearing**

II. **Applicant's Direct Testimony (10 minutes)**

III. **Intervenors' Direct Testimony (10 minutes each) / Cross Examination**

IV. **Applicant's Cross Examination**

V. **OHCA's Questions**

VI. **Public Comment**

VII. **Closing Remarks**

V. **Public Hearing Adjourned**

An Equal Opportunity Provider
(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **NR Connecticut, LLC D/B/A Retreat at South Connecticut**

DOCKET NUMBER: **13-31828-CON**

PUBLIC HEARING: **August 14, 2013 at 9:00 a.m.**

PLACE: **Legislative Office Building Room 2D**
Hartford, Connecticut

EXHIBIT	DESCRIPTION
A	Letter from the Applicant dated march 25, 2013 enclosing the CON application for NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Applicant") to establish a 105 Bed Residential Substance Abuse Treatment Facility to be Located in New Haven, Connecticut under Docket Number 13-31828, received by OHCA on March 25, 2013. (663 page)
B	OHCA's letter to the Applicant dated April 24, 2013 requesting additional information and/or clarification in the matter of the CON application under Docket Number 13-31828. (4 pages)
C	OHCA's email to the Applicant dated May 28, 2013 regarding obtaining information from the Department of Mental Health and Addiction Services in the matter of the CON application under Docket Number 13-31828. (2 pages)
D	Applicant's responses to OHCA's letter of April 24, 2013, dated June 17, 2013, in the matter of the CON application under Docket Number 13-31828, received by OHCA on June 18, 2013. (300 pages)
E	Designation letter dated July 19, 2013 for Hearing Officer in the matter of the CON application under Docket Number 13-31828. (1 page)
F	OHCA's letter to the Applicant dated July 8, 2013 deeming the application complete as of July 8, 2013 in the matter of the CON application under Docket Number 13-31828. (1 page)
G	Letter from Shipman & Goodwin LLP on behalf of Rushford Center, Inc, High Watch Recovery Center, Inc. CHR, Inc., MCCA, Inc. and Recovery Network Programs, Inc. (collectively, the "Interested Parties") dated July 11, 2013 requesting a hearing in the matter of the CON application under Docket Number 13-31828, received by OHCA on July 11, 2013.(1 page)

H	OHCA's request for legal notification in the *New Haven Register* and OHCA's Notice to the Applicant of the public hearing scheduled for August 14, 2013 in the matter of the CON application under Docket Number 13-31828, dated July 17, 2013. (4 pages)
I	OHCA's letter to the Applicant dated July 29, 2013 requesting prefile testimony and enclosing issues outlining topics to be discussed at the hearing in the matter of the CON application under Docket Number 13-31828. (2 pages)
J	Letter from the Applicant enclosing prefile testimony dated August 8, 2013 in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013.(11 pages)
K	Petition of Cornell Scott-Hill Health Center dated Augut 9, 2013, requesting intervenor status and enclosing notice of appearance of Updike, Kelly & Spellacy, P.C.and prefile testimony in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013.(46 pages)
L	Petition of Stonington Behavioral Health dated Augut 9, 2013, requesting intervenor status and enclosing notice of appearance of Updike, Kelly & Spellacy, P.C. and prefile testimony in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (37 pages)
M	Petition of Yale New Haven Hospital dated Augut 9, 2013, requesting intervenor status and enclosing notice of appearance of Updike, Kelly & Spellacy, P.C. and prefile testimony in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (48 pages)
N	Petition of APT Foundation dated Augut 9, 2013, requesting intervenor status and enclosing notice of appearance of Updike, Kelly & Spellacy, P.C. and prefile testimony in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (46 pages)
O	Petition of the Rushford Center dated Augut 9, 2013, requesting intervenor status and enclosing notice of appearance of Shipman & Goodwin, LLP and prefile testimony in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (28 pages)
P	Letter to OHCA from Behavioral Health Consultant, LLC dated August 8, 2013 in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (2 pages)

Q	Letter to OHCA from CommuniCare dated August 9, 2013 in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (2 pages)
R	Letter from the Applicant to OHCA undated responding to intervenors requests from various parties in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 12, 2013. (8 pages)
S	Letter to OHCA from Spectrum Psychiatric Group. P.C. dated August 8, 2013 in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 12, 2013. (2 pages)
T	Letter to OHCA from Greenwood-Gilbert-George-Orchard-Blockwatch #311 dated August 12, 2013 in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 12, 2013. (1 page)
U	Designation letter dated August 13, 2013 designating Marianne Horn as hearing officer and revoking Kevin Hansted as hearing officer in the matter of the CON application under Docket Number 13-31828. (1 page)
V	OHCA's Ruling on the Petition of Yale New Haven Hospital, Cornell Scott-Hill Health Center, APT Foundation and Stonington Behavioral Health to be granted intervenor status in the matter of the CON application under Docket Number 13-31828, dated August 13, 2013. (5 pages)
W	OHCA's Ruling on the Petition of Rushford Center to be granted intervenor status in the matter of the CON application under Docket Number 13-31828, dated August 13, 2013.(2 pages)
X	Email from OHCA to the Applicant dated August 13, 2013 enclosing letters received in the matter of the CON application under Docket Number 13-31828. (1 page)
Y	Facsimilie from Updike, Kelly and Spellacy to OHCA dated August 13, 2013 regarding substitute from Stonington Institute in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 13, 2013. (31 pages)
Z	Facsimilie fromWest River Neighborhood Services Corporation to OHCA undated in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 13, 2013.(1page)
AA	Facsimilie received from Yale-New Haven to OHCA dated August 13, 2013 enclosing a Notice of Appearance in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 13, 2013. (2 pages)

OHCA HEARINGS - EXHIBIT AND LATE FILE FORM

Applicants: NR Connecticut, LLC d/b/a Retreat at South Connecticut

DN: 13-31828-CON

Hearing Date: August 14, 2013

Time: 9:00 a.m.

Proposal: Establishment of a 105 Bed Residential Substance Abuse Treatment Facility to be Located in New Haven, Connecticut.

OHCA Exhibit #	Description
1	
2	
3	
4	
5	

Applicant Exhibit #	Description
1	
2	
3	
4	
5	

Intervenor Late file
~~Exhibit~~ # Description

1	DMHAS State ~~Vacancy Report~~ Beds Exh A - Jeffrey Watten by Aug 23
2	DMHAS Bed Vacancy by Aug 23
3	
4	
5	
6	
7	

Administrative Notice

Informal Exhibit #	Description
1	DMHAS Bed Vacancy Reports starting July 1, 2013 (SFY 2014)
2	
3	
4	
5	
6	
7	

Applicant Late File #	Description	Due Date	Rec'd
1	Revised FA II	8/23	
2			
3			
4			
5			
6			

Intervenor Late File #	Description	Due Date	Rec'd
1			
2			
3			
4			
5			
6			

Notes:

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

August 20, 2013

The Honorable Juan Candelaria
Representative – 95th Assembly District
State of Connecticut
Legislative Office Building, Room 1804
Hartford, CT 06106-1591

Re: Certificate of Need, Docket Number: 13-31828-CON
NR Connecticut, LLC d/b/a/Retreat at South Connecticut
Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven

Dear Representative Candelaria:

On August 15, 2013, the Department of Public Health ("DPH"), Office of Health Care Access received your letter concerning the Certificate of Need ("CON") for the proposal by NR Connecticut, LLC d/b/a Retreat at South Connecticut to establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of OHCA's formal record of the CON application docket. Please be advised, once a decision has been rendered it will be posted and available on OHCA's website at http://www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone at (860) 418-7029.

Sincerely,

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

LAD:KRM:bko

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
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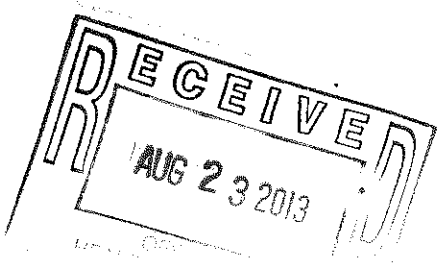

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TO: **Office of Health Care Access**
ATTN: Laurie Greci

FACSIMILE: (860) 418-7053

From: Jennifer Groves Fusco, Esq.

Number of Pages: 9 (Including Cover Sheet)

Subject: Retreat at South Connecticut, Docket No. 13-31828-CON

Message: Late File attached.

Please contact Deb Alexa at (203) 786-8322 to report transmittal difficulties. Thank you.

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Jennifer Groves Fusco
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August 23, 2013

VIA FACSIMILE & REGULAR MAIL

Lisa A. Davis, M.B.A., B.S.N., R.N.
Deputy Commissioner
Office of Health Care Access
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: NR Connecticut, LLC d/b/a Retreat at South Connecticut
Establish a 105-Bed Residential Substance Abuse Treatment Facility in New Haven
Docket No. 13-31828-CON

Dear Deputy Commissioner Davis:

This office represents Yale-New Haven Hospital, Cornell Scott – Hill Health Center and APT Foundation, Inc. (collectively "Intervernors") in connection with the above-referenced docket. Enclosed please find copies of the Department of Mental Health and Addiction Services ("DMHAS") Daily Addiction Residential Census reports for August 13 through August 21, 2013. At the Hearing Officer's request, Intervenors are submitting these documents as late file testimony in the hearing on this matter, which took place on August 14, 2013.

The attached reports show available bed capacity for Level III.7 Residential Detoxification and Evaluation ("RDE") and Intensive Treatment/Residential Rehabilitation ("IT") services. DMHAS reporting is required only of grant-funded providers, and certain providers on the list have not reported, so the number of available beds may be understated. As you can see from the attached, however, even with these limitations, there have been anywhere from 3 to 17 RDE beds and 14 to 35 IT beds available on a daily basis.

Should you require anything further, please feel free to call me at (203) 786-8316.

Very truly yours,

Jennifer Groves Fusco

Enclosures
cc: William Beccaro, Esq.
Joan Feldman, Esq.

Addiction Residential Census- August 13, 2013

LOC	Reg	Agency	Town	Location	Name	Phone	Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
Detox - 3.7													
	1	RNP	Bridgeport	Detox	Sara Smith	(203) 333-3518	-8	12	19	7	6		
	2	Cornell Scti	New Haven	SCRC	Ben Metcalf	(203) 503-3300	3	26	21	5	3		
	2	Rushford	Middletown	Resid Detox	Tara Murphy	1-877-577-3233	1	16	13	4	2		
	3	SCADD	New London	Resid Detox	Admitting Nurse	(860) 447-1717	6	20	13	4	3		
	3	Stonington	North Stoning	Resid Detox	Andrea Keeney	(860) 445-3000		16				No	16
	4	ADRC	Hartford	Resid Detox	Admitting Nurse	(860) 714-3700	4	35	29	8	8		
	5	MCCA	Danbury	Resid Detox	Ana Carvalho	(203) 792-4515X123	0	12	12	3	3		
							6	137	107				16
Intensive Res													
	1	CASA	Bridgeport	Intensive	Kremlin DeVissiere	(203) 339-4112	0	10	10	0	0		
	1	RNP	Bridgeport	Horizon	Sara Smith	(203) 333-3518	0	15	15	0	0		
	2	CVH	Middletown	Intens (Men)	Joann Chatfield	(800) 828-3396 x 5	4	60	56	2	2		
	2	CVH	Middletown	Intens (Women)	Joann Chatfield	(800) 828-3396 x 5	4	30	27	1	2		
	2	Rushford	Middletown	Intensive	Tara Murphy	1-877-577-3233	2	42	38	3	1		
	3	CPAS	Putnam	Milestone	Michelle Blevin	(860) 928-1880	11	16	5	0	0		
	4	ADRC	Hartford	SATEP ADRC	E. Navarro	(860) 714-3739	2	28	25	2	1		
	4	Blue Hills	Hartford	Intensive	Pat O'Brien	(860) 293-6415	0	21	19	2	0		
	4	Farrell	New Britain	Intensive	Ester Bryant	(860) 225-4641	1	24	22	1	0		
	5	MCCA	Danbury	McDonough	Maureen Gorman	(203)792-4515	0	22	22	3	3		
	5	McCall	Torrington	Cames Wks	Tracy Donahue	(860) 496-2107		20				No	20
							24	288	239				20

LOC	Reg	Agency	Town	Location	Name	Phone	Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
Detox - 3.7													
	1	RNP	Bridgeport	Detox	Sara Smith	(203) 333-3518	-7	12	19	1	1		
	2	Comell Scit	New Haven	SCRC	Ben Metcalf	(203) 503-3300	6	28	22	2	4		
	2	Rushford	Middletown	Resid Detox	Tara Murphy	1-877-577-3233	-1	16	16	5	4		
	3	SCADD	New London	Resid Detox	Admitting Nurse	(860) 447-1717	6	20	14	3	3		
	3	Stonington	North Stoning	Resid Detox	Andrea Keeney	(860) 445-3000		16				No	16
	4	ADRC	Hartford	Resid Detox	Admitting Nurse	(860) 714-3700	-1	35	31	8	3		
	5	MCCA	Danbury	Resid Detox	Ana Carvalho	(203) 792-4515X123	0	12	12	3	3		
							3	137	114				16
Intensive Res													
	1	CASA	Bridgeport	Intensive	Kremlin DeVissiere	(203) 339-4112	0	10	10	0	0		
	1	RNP	Bridgeport	Horizon	Sara Smith	(203) 333-3518	2	15	14	1	2		
	2	CVH	Middletown	Intens (Men)	Joann Chatfield	(800) 828-3396 X 5	4	60	54	2	0		
	2	CVH	Middletown	Intens (Women)	Joann Chatfield	(800) 828-3396 X 5	1	30	29	1	1		
	2	Rushford	Middletown	Intensive	Tara Murphy	1-877-577-3233	1	42	41	2	2		
	3	CPAS	Putnam	Milestone	Michelle Blevin	(860) 928-1860	11	16	5	0	0		
	4	ADRC	Hartford	SATEP ADRC	E. Navarro	(860) 714-3739	2	28	24	3	1		
	4	Blue Hills	Hartford	Intensive	Pat O'Brien	(860) 293-8415	4	21	15	2	0		
	4	Farrell	New Britain	Intensive	Ester Bryant	(860) 225-4841		24				No	24
	5	MCCA	Danbury	McDonough	Maureen Gorman	(203)792-4515	1	22	21	1	1		
	5	McCall	Torrington	Carnes Wks	Tracy Donahue	(860) 496-2107	-3	20	22	1	0		
							23	288	235				24

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004/009

LOC	Reg	Agency	Town	Location	Name	Phone	Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
Detox - 3.7													
	1	RNP	Bridgeport	Detox	Sara Smith	(203) 333-3516		12				No	12
	2	Cornell Scti	New Haven	SCRC	Ben Metcalf	(203) 503-3303		26				No	26
	2	Rushford	Middletown	Resid Detox	Tara Murphy	1-877-577-3233	2	16	15	1	2		
	3	SCADD	New London	Resid Detox	Admitting Nurse	(860) 447-1717	4	20	13	3	0		
	3	Stonington	North Stoning	Resid Detox	Andrea Keaney	(860) 445-3000		16				No	16
	4	ADRC	Hartford	Resid Detox	Admitting Nurse	(860) 714-3700	1	35	34	3	3		
	5	MCCA	Danbury	Resid Detox	Ana Carvalho	(203) 792-4515 X123	0	12	13	1	2		
							7	137	75				54
Intensive Res													
	1	CASA	Bridgeport	Intensive	Kremlin DeVissiere	(203) 339-4112	3	10	7	0	0		
	1	RNP	Bridgeport	Horizon	Sara Smith	(203) 333-3518		15				No	15
	2	CVH	Middletown	Intens (Men)	Joann Chatfield	(800) 828-3396 x 5	6	60	55	1	2		
	2	CVH	Middletown	Intens (Women)	Joann Chatfield	(800) 828-3396 x 5	2	30	29	2	3		
	2	Rushford	Middletown	Intensive	Tara Murphy	1-877-577-3233	2	42	41	1	2		
	3	CPAS	Putnam	Milestone	Michelle Blevin	(860) 928-1860		16				No	16
	4	ADRC	Hartford	SATEP ADRC	E. Navarro	(860) 714-3739	4	28	23	4	3		
	4	Blue Hills	Hartford	Intensive	Pat O'Brien	(860) 293-6415	4	21	17	0	0		
	4	Farrell	New Britain	Intensive	Ester Bryant	(860) 225-4641	2	24	23	1	2		
	5	MCCA	Danbury	McDonough	Maureen Gorman	(203)792-4515	3	22	20	0	1		
	5	McCall	Torrington	Carnes Wks	Tracy Donahue	(860) 496-2107		20				No	20
							26	268	215				51

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005/009

LOC	Reg	Agency	Town	Location	Name	Phone	Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
Detox - 3.7													
	1	RNP	Bridgeport	Detox	Sara Smith	(203) 333-3518	-5	12	18	3	4		
	2	Cornell Scti	New Haven	SCRC	Ben Metcalf	(203) 503-3300	10	28	19	2	5		
	2	Rushford	Middletown	Resid Detox	Tara Murphy	1-877-577-3233	0	16	15	6	5		
	3	SCADD	New London	Resid Detox	Admitting Nurse	(860) 447-1717	1	20	18	5	4		
	3	Stonington	North Stoning	Resid Detox	Andrea Keeney	(860) 445-3000		16				No	16
	4	ADRC	Hartford	Resid Detox	Admitting Nurse	(860) 714-3700	4	35	31	7	7		
	5	MCCA	Danbury	Resid Detox	Ana Carvalho	(203) 792-4515X123	0	12	12	3	3		
							10	137	113				16
Intensive Res													
	1	CASA	Bridgeport	Intensive	Kremlin DeVissiere	(203) 339-4112	1	10	9	0	0		
	1	RNP	Bridgeport	Horizon	Sara Smith	(203) 333-3518	0	15	15	1	1		
	2	CVH	Middletown	Intens (Men)	Joann Chatfield	(800) 628-3396 x 5	8	60	53	0	1		
	2	CVH	Middletown	Intens (Women)	Joann Chatfield	(800) 628-3396 x 5	4	30	28	0	2		
	2	Rushford	Middletown	Intensive	Tara Murphy	1-877-577-3233	2	42	41	0	1		
	3	CPAS	Putnam	Milestone	Michelle Blevin	(860) 928-1860	12	16	3	1	0		
	4	ADRC	Hartford	SATEP ADRC	E. Navarro	(860) 714-3739	1	28	22	5	0		
	4	Blue Hills	Hartford	Intensive	Pat O'Brien	(860) 293-8415	1	21	17	3	0		
	4	Farrell	New Britain	Intensive	Ester Bryant	(860) 225-4641	5	24	21	0	2		
	5	MCCA	Danbury	McDonough	Maureen Gorman	(203)792-4515	1	22	20	1	0		
	5	McCall	Torrington	Carnes Wks	Tracy Donahue	(860) 498-2107		20				No	20
							35	288	229				20

23/08 2013 11:54 FAX

006/009

LOC	Reg	Agency	Town	Location	Name	Phone		Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
Detox - 3.7														
	1	RNP	Bridgeport	Detox	Sara Smith	(203) 333-3515			12				No	12
	2	Cornell Scti	New Haven	SCRC	Ben Metcalf	(203) 503-3300		10	28	16	2	4		
	2	Rushford	Middletown	Resid Detox	Tara Murphy	1-877-577-3233		3	16	14	3	4		
	3	SCADD	New London	Resid Detox	Admitting Nurse	(860) 447-1717		3	20	17	3	3		
	3	Stonington	North Stoning	Resid Detox	Andrea Keeney	(860) 445-3000			16				No	16
	4	ADRC	Hartford	Resid Detox	Admitting Nurse	(860) 714-3700		0	35	34	8	5		
	5	MCCA	Danbury	Resid Detox	Ana Carvalho	(203) 792-4515X123		1	12	12	2	3		
								17	137	95				28
Intensive Res														
	1	CASA	Bridgeport	Intensive	Kremlin DeVissiere	(203) 338-4112		1	10	9	1	1		
	1	RNP	Bridgeport	Horizon	Sara Smith	(203) 333-3518			15				No	15
	2	CVH	Middletown	Intens (Men)	Joann Chatfield	(800) 828-3396 x 5		10	60	51	1	2		
	2	CVH	Middletown	Intens (Women)	Joann Chatfield	(800) 828-3396 x 5		1	30	28	1	0		
	2	Rushford	Middletown	Intensive	Tara Murphy	1-877-577-3233		4	42	41	1	4		
	3	CPAS	Putnam	Milestone	Michelle Blevin	(860) 928-1880		11	16	4	1	0		
	4	ADRC	Hartford	SATEP ADRC	E. Navarro	(860) 714-3739		1	28	25	2	0		
	4	Blue Hills	Hartford	Intensive	Pat O'Brien	(860) 293-6415		0	21	21	0	0		
	4	Farrell	New Britain	Intensive	Ester Bryant	(860) 225-4841		2	24	18	4	0		
	5	MCCA	Danbury	McDonough	Maureen Gorman	(203)792-4515		1	22	20	2	1		
	5	McCall	Torrington	Camea Wks	Tracy Donahue	(860) 496-2107			20				No	20
								31	288	217				35

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LOC	Reg	Agency	Town	Location	Name	Phone		Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
Detox - 3.7														
	1	RNP	Bridgeport	Detox	Sara Smith	(203) 333-3518		-8	12	19	7	6		
	2	Cornell Scti	New Haven	SCRC	Ben Metcalf	(203) 503-3300		9	26	21	1	5		
	2	Rushford	Middletown	Resid Detox	Tara Murphy	1-877-577-3233		1	16	15	2	2		
	3	SCADD	New London	Resid Detox	Admitting Nurse	(860) 447-1717		2	20	16	6	4		
	3	Stonington	North Stoning	Resid Detox	Andrea Keeney	(860) 445-3000			16				No	16
	4	ADRC	Hartford	Resid Detox	Admitting Nurse	(860) 714-3700		2	35	30	11	6		
	5	MCCA	Danbury	Resid Detox	Ana Carvalho	(203) 792-4515	X123	0	12	12	2	2		
								6	137	113				16
Intensive Res														
	1	CASA	Bridgeport	Intensive	Kremlin DeVissiere	(203) 339-4112		1	10	8	2	1		
	1	RNP	Bridgeport	Horizon	Sara Smith	(203) 333-3518		0	15	15	1	1		
	2	CVH	Middletown	Intens (Men)	Joann Chatfield	(800) 828-3396	x 5	2	60	51	8	1		
	2	CVH	Middletown	Intens (Women)	Joann Chatfield	(800) 828-3396	x 5	1	30	27	2	0		
	2	Rushford	Middletown	Intensive	Tara Murphy	1-877-577-3233		4	42	37	1	0		
	3	CPAS	Putnam	Milestone	Michelle Blevin	(860) 928-1880			16				No	16
	4	ADRC	Hartford	SATEP ADRC	E. Navarro	(860) 714-3739		1	28	26	2	1		
	4	Blue Hills	Hartford	Intensive	Pat O'Brien	(860) 293-8415		0	21	21	0	0		
	4	Farrell	New Britain	Intensive	Ester Bryant	(860) 225-4641		3	24	23	2	4		
	5	MCCA	Danbury	McDonough	Maureen Gorman	(203)792-4516		2	22	20	1	1		
	5	McCall	Torrington	Cames Wks	Tracy Donahue	(860) 496-2107			20				No	20
								14	288	228				36

23/08 2013 11:54 FAX

008/009

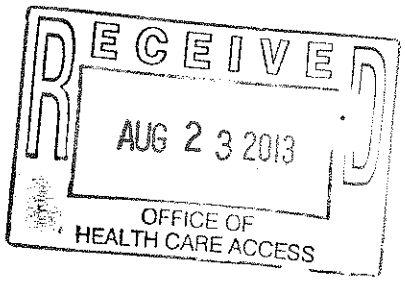
Addiction Residential Census- August 21, 2013

LOC	Reg	Agency	Town	Location	Name	Phone	Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
							1	41	39				
Detox - 3.7													
	1	RNP	Bridgeport	Detox	Sara Smith	(203) 333-3516	-7	12	19	2	2		
	2	Cornell Scti	New Haven	SCRC	Ben Metcalf	(203) 503-3300	7	26	21	1	3		
	2	Rushford	Middletown	Resid Detox	Tara Murphy	1-877-577-3233	0	16	13	6	3		
	3	SCADD	New London	Resid Detox	Admitting Nurse	(860) 447-1717	1	20	20	4	5		
	3	Stonington	North Stoning	Resid Detox	Andrea Keeney	(860) 445-3000		16				No	16
	4	ADRC	Hartford	Resid Detox	Admitting Nurse	(860) 714-3700	6	35	29	7	7		
	5	MCCA	Danbury	Resid Detox	Ana Carvalho	(203) 792-4515X123	0	12	12	2	2		
							7	137	114				16
Intensive Res													
	1	CASA	Bridgeport	Intensive	Kremlin DeVisslere	(203) 339-4112	0	10	8	2	0		
	1	RNP	Bridgeport	Horizon	Sara Smith	(203) 333-3516	0	15	15	0	0		
	2	CVH	Middletown	Intens (Men)	Joann Chatfield	(800) 828-3396 x 5	2	60	55	3	0		
	2	CVH	Middletown	Intens (Women)	Joann Chatfield	(800) 828-3396 x 5	1	30	29	0	0		
	2	Rushford	Middletown	Intensive	Tara Murphy	1-877-577-3233	3	42	39	1	1		
	3	CPAS	Putnam	Milestone	Michelle Blevin	(860) 928-1860	12	16	2	2	0		
	4	ADRC	Hartford	SATEP ADRC	E. Navarro	(860) 714-3739	2	28	26	3	3		
	4	Blue Hills	Hartford	Intensive	Pat O'Brien	(860) 293-6415	0	21	21	0	0		
	4	Farrell	New Britain	Intensive	Ester Bryant	(860) 225-4641	3	24	22	0	1		
	5	MCCA	Danbury	McDonough	Maureen Gorman	(203)792-4515	1	22	20	2	1		
	5	McCall	Torrington	Carnes Wks	Tracy Donahue	(860) 496-2107		20				No	20
							24	288	237				20

23/08 2013 11:54 FAX 009/009

Retreat
at South Connecticut

August 23, 2013



State of Connecticut – Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

APPLICANT'S LATE FILING # 1 - AS REQUESTED BY OCHA AT A PUBLIC HEARING ON AUGUST 14, 2013: NR Connecticut LLC, d/b/a Retreat at South Connecticut - Docket Number: 13-31828-CON

This submission is *Applicant's Late Filing # 1*, as requested by OCHA at the above-referenced Public Hearing. OCHA asked Applicant to provide them with a more detailed breakdown of Applicant's patient projections by category - specifically, *"In response to CON Application Question 7 - Financial Attachment II"*, at page 655, of Applicant's initial Certificate of Need Application dated March 25, 2013. The attached documents, along with this cover memorandum, constitute Applicant's response.

Applicant projects Inpatient utilization to be 22,880 Units in Year 1 and Outpatient utilization to be 5,288 Units. A Unit is calculated by taking the annual number of projected admissions (1,040), and multiplying it by an average estimated length of stay (22 days), for a total of 22,880 Inpatient Units in Year 1.

Applicant believes these numbers to be quite conservative in nature. Total Projected admissions of 1,040 in Year 1 was verified utilizing data from "*Table 8.2 – Substance Abuse Treatment Need and Demand Statewide and by Region*" which appears on page 99 of the Connecticut Department of Public Health Office of Healthcare Access's *"Statewide Health Care Facilities and Service Plan – October 2012"*. Applicant utilized an equally conservative methodology to arrive at a 22 day Length of Stay. A review of SAMSHA data for the last decade indicates an upward trend in LOS, and experience in our existing facility in Ephrata is consistent with the SAMSHA data.

As mentioned previously, to verify these numbers Applicant reviewed the data in Table 8.2 of the Statewide Healthcare Services Facilities and Services Plan. This table indicates that the *"Estimated Population Needing Treatment"* in Connecticut is 281,222 and the *"Estimated Population That Seek Treatment"* is 46,741, leaving an estimated population of 234,481 in Connecticut currently in need of treatment. Applicant then utilized a recent Kaiser Foundation study, cited in its initial Certificate of Need Application to determine the potential number of insured individuals in need of treatment. According to the study, an estimated 65% of Connecticut citizens have health insurance, for a total of 152,412. Of note, while there is data from a January 2011 Office of Health Care Access Fact Sheet which reported that percentage to be at 75%, Applicant deliberately chose the more conservative estimate.

Applicant needs to capture **only 0.68%** of the pool of Connecticut residents, who are insured, in need of treatment, but have not sought treatment in order to meet its projected estimate. It is important to note that this estimate does not contain even **one** individual that is currently being served by existing facilities. Finally, these admission projections are achieved utilizing only Connecticut residents, and do not take into account the inevitable out-of-state individuals who will seek out Applicant's facility and comprise part of the overall patient population mix.

Adding further credence to the projections provided are the results of multiple bed availability surveys Applicant has conducted. These surveys were conducted at differing days of the week and at various times of day. Applicant conducted these surveys in a "real-world, real-time" manner, duplicating what a typical individual or related family member in crisis would do – they would pick up the phone and call the facility directly to inquire about bed availability – and would not contact DHMAS for a copy of their Occupancy Study when seeking placement for services. The results of the initial surveys were included in the Applicant's initial Certificate of Need Application. Subsequent and more recent surveys are attached to this submission.

The results of the initial surveys clearly indicated that there were no readily available beds in any level 3.7 facilities - as facilities were full, some even had waiting lists, and in some cases they did not even answer the phone. Applicant's subsequent surveys continued to indicate virtually identical results. This trend continued, and as Applicant testified under oath in the hearing on August 14, 2013, in a survey conducted the day prior to, and again on the day of the public hearing, virtually every like licensed treatment center still had no beds available when contacted that very day. In several cases Applicant was informed that a waiting period of several days was to be expected before a bed would be free. (It is important to note that Applicant did not survey Outpatient beds that might be available because these beds are not relevant to our projections, as Applicant estimates that 90% of its admissions will come directly from its in-house detoxification unit). These surveys further support and confirm Applicant's ability to meet its projected admission levels and clearly confirm the existence of an acute public need for additional substance abuse treatment services which the Applicant will help to alleviate.

An editorial highlighting the urgent need for additional addiction treatment services in Connecticut appeared in the August 18th edition of the Hartford Courant. Applicant has attached a copy of this editorial as a courtesy to OHCA.

Should OCHA have any additional questions, or if OHCA would like the data provided to be formatted in a different manner, please do not hesitate to contact the Applicant. We would be happy to supply any additional information you may require.

Respectfully submitted,
Retreat at South Connecticut

BY: 
William Beccaro
It's Attorney

Retreat

In Response to CON Application Question 7 - Financial attachement II

12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description: Substance Abue,
Type of Unit Description: Inpatient
# of Months in Operation: 0

FY 2013
FY Projected Incremental
Total Incremental Expenses:

(1)	(2) Rate*	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:									
Medicare			$0				$0	$0	$0
Medicaid	$0		$0				$0	$0	$0
CHAMPUS/TriCare	$0		$0				$0	$0	$0
Total Governmental		0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers	$1,363	22,880	$28,028,000.00	$16,536,520	$0	$574,574	$10,916,906	$9,090,305	$1,826,601
Uninsured	$0		$0				$0	$0	$0
Total NonGovernment	$0		$28,028,000	$16,536,520	$0	$574,574	$10,916,906	$9,090,305	$1,826,601
Total All Payers	$0	0	$28,028,000	$16,536,520	$0	$574,574	$10,916,906	$9,090,305	$1,826,601

FY 2014
FY Projected Incremental
Total Incremental Expenses:

(1)	(2) Rate*	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:									
Medicare			$0				$0	$0	$0
Medicaid	$0		$0				$0	$0	$0
CHAMPUS/TriCare	$0		$0				$0	$0	$0
Total Governmental		0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers	$1,450	29,040	$35,574,000.00	$20,277,180	$0	$764,841	$14,531,979	$10,557,488	$3,974,491
Uninsured	$0		$0				$0	$0	$0
Total NonGovernment	$0		$35,574,000	$20,277,180	$0	$764,841	$14,531,979	$10,557,488	$3,974,491
Total All Payers	$0	0	$35,574,000	$20,277,180	$0	$764,841	$14,531,979	$10,557,488	$3,974,491

FY 2015
FY Projected Incremental
Total Incremental Expenses:

(1)	(2) Rate*	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Total Facility by Payer Category:									
Medicare			$0				$0	$0	$0
Medicaid	$0		$0				$0	$0	$0
CHAMPUS/TriCare	$0		$0				$0	$0	$0
Total Governmental		0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers	$1,445	31,680	$38,808,000.00	$21,344,400	$0	$873,180	$16,590,420	$11,110,299	$5,480,121
Uninsured	$0		$0				$0	$0	$0
Total NonGovernment	$0		$38,808,000	$21,344,400	$0	$873,180	$16,590,420	$11,110,299	$5,480,121
Total All Payers	$0	0	$38,808,000	$21,344,400	$0	$873,180	$16,590,420	$11,110,299	$5,480,121

* Rate is average of gross rate of all services

Retreat

In Response to CON Application Question 7 - Financial attachement II

12.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description: Substance Abue.
Type of Unit Description: Outpatient
# of Months in Operation: 0

FY 2013
FY Projected Incremental
Total Incremental Expenses:

Total Facility by Payer Category:	(1)	(2) Rate*	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$597	5,288	$3,154,875.00	$2,050,140	$0	$55,237	$1,049,498	$873,898	$175,600
Uninsured		$0		$0				$0	$0	$0
Total NonGovernment		$0		$3,154,875	$2,050,140	$0	$55,237	$1,049,498	$873,898	$175,600
Total All Payers		$0	0	$3,154,875	$2,050,140	$0	$55,237	$1,049,498	$873,898	$175,600

FY 2014
FY Projected Incremental
Total Incremental Expenses:

Total Facility by Payer Category:	(1)	(2) Rate*	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$597	10,950	$6,533,500.00	$4,129,610	$0	$120,195	$2,283,695	$1,659,106	$624,589
Uninsured		$0		$0				$0	$0	$0
Total NonGovernment		$0		$6,533,500	$4,129,610	$0	$120,195	$2,283,695	$1,659,106	$624,589
Total All Payers		$0	0	$6,533,500	$4,129,610	$0	$120,195	$2,283,695	$1,659,106	$624,589

FY 2015
FY Projected Incremental
Total Incremental Expenses:

Total Facility by Payer Category:	(1)	(2) Rate*	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$1,445	11,700	$6,981,000.00	$4,412,460	$0	$128,427	$2,440,113	$1,634,099	$806,014
Uninsured		$0		$0				$0	$0	$0
Total NonGovernment		$0		$6,981,000	$4,412,460	$0	$128,427	$2,440,113	$1,634,099	$806,014
Total All Payers		$0	0	$6,981,000	$4,412,460	$0	$128,427	$2,440,113	$1,634,099	$806,014

* Rate is average of gross rate of all services

List of substance abuse facilities in Connecticut currently providing level 3.7 residential detoxification and rehabilitation and recovery services

Name of Facility	Address	Town	County	Telephone	Facility total beds	Available Beds Survey - 08/13	Available Beds Survey - 8/14
South Central Rehabilitation Center [SCRC]	232 Cedar Street	New Haven	New Haven	203-503-3300	29	2:40 PM: I called and tried every option to get a "live" person on the phone. 5 minutes later all I could do was leave a message. 4:00 PM: Sue answered and told me there were no beds available today and maybe they would have beds tomorrow.	10:30 AM: per Tanza in admission, no beds available
First Step	425 Grant Street	Bridgeport	Fairfield	203-416-1915	19	No beds available till the 22nd or 23rd per Donna...	
Connecticut Valley Hospital [Merritt Hall]	Tynan Circle	Middletown	Middlesex	860-262-6333	~	3:02 PM: I was transferred to their admissions dept. It rang for 2 straight minutes before I hung up. There was no chance to leave a VM 4:20 PM: It rang for 2 straight minutes before I hung up again. NO ANSWER	
Rushford Center	1250 Silver Street	Middletown	Middlesex	860-346-0300	58	Detox is full until AT LEAST Thursday per Nicole in the admissions dept	8:30 AM: no beds available, per Nicole in admissions, verified by 2nd call at 10:30 AM
Detoxification Center [Blue Hills and ADRC]	500 Blue Hills Avenue	Hartford	Hartford	860-714-3700	73	2:55 PM: the guy who answered the phone said I have to call back in 15 minutes because they are switching shifts, after I asked if they are any beds available. I then asked for his name but he hung up on me already. 3:15 PM: The phone rang for 2 straight minutes before I hung up.... There was no chance to leave a VM	
Silver Hill Hospital	208 Valley Road	New Cannan	Fairfield	203-966-3561	92	Per Trish, No beds available. "It's possible to have a bed open tomorrow or Thursday."	
MCCA	30 Old Ridgeberry Road	Danbury	Fairfield	203-792-4515	30	2:45 PM: Finally got transferred to admissions and it went right to VM. The VM said her name was Courtney with the admissions dept and she is available from 8:30am to 5pm Tuesday thru Saturday. I left a message 4:20 PM: had to leave another VM	
Stonington Institute	75 Swantown Hill Road	North Stonington	New London	800-832-1022	63	3:05 PM: Went straight to VM after being transferred to admissions, left VM, the VM said they will call back in longer than one hour. 4:00 PM: Jessica called back. Only have detox and PHP for 3 to 6 weeks after that. Rooming is off campus for PHP. Detox currently has a couple day wait. 5:45 PM: To clarify some information, The women told me they to in-house detox and then there "Rehab" afterwards. BUT the program is 5 or 6 days a week, 9am-2pm a day (the women wasn't positive about either of those 2 statements, Then there is offsite housing, with a house manager.	8:30 AM: Message left.. 1 hr call back 9:05 AM: Heard back from Stonington- Spoke to Jessica they have no beds available today. She stated that they get a list at 9:30 of other facilities that have beds available. She stated it could be a couple of days til something opens up but they wont know until they check insurance. I asked her to call me back once she gets that list and she stated that when I call in to give intake and insurance info that she would be more then willing to give us other facility names., verified by 3rd call at 10:30AM
Southeastern Council on Alcohol an d Drug Sependence [SCADD]	37 Camp Mooween Road	Lebanon	New London	860-447-1717	~	No beds available today. MAYBE tomorrow per Joann in admissions	
Community Prevention and Addiction Services [CPAS]	1491 West Main Street	Willimantic	Windham	860-456-3215	~	No detox program anymore per Jose. Only rehab	
Mountainside Treatment Center	187 South Cannan Road	Cannan	Litchfield	800-762-5433	78	Per Jessica in admissions, they do NOT do detox, they just do rehab	

EDITORIAL

Addiction: State's Overdose Problem Requires A Sense Of Urgency

The Hartford Courant

7:26 PM EDT, August 16, 2013

Connecticut is not doing enough to keep people from becoming addicted to alcohol and drugs and dying of drug overdoses.

Only a fraction of those who need help with the chronic, relapsing disease of addiction get that help here, mirroring statistics nationwide.

Drug and alcohol overdoses are killing kids, parents and siblings. They are the leading cause of injury deaths here, exceeding the number of deaths from motor vehicle accidents.

Between 1997 and 2007, 2,900 people died from overdoses in our state, according to Dr. Traci Green, a Brown University epidemiologist who did extensive research on drug use in Connecticut. Three-quarters of the overdose deaths involved opioids such as heroin and prescription drugs, she said.

More Narcan

The state needs to take action to save lives. It should:

•**Ramp up efforts to broadly distribute Naloxone,** commonly called Narcan, a lifesaving drug that can keep overdoses from progressing.

•**Restart the Alcohol and Drug Policy Council**, which is supposed to coordinate addiction treatment across multiple state agencies. This cobweb-covered committee hasn't met in more than a year.

•**Pass a law mandating that 75 percent** of state-funded addiction treatment be based on scientific evidence of effectiveness.

•**Force private insurers to provide the addiction** and mental health treatment that policyholders already pay for — without the unconscionable delays and restrictions that now exist. The federal government has not provided regulations on this issue. The state should take the lead.

Our state has two laws that should help save lives. In 2011, Connecticut became one of just a handful of states to enact a "Good Samaritan" law, which grants immunity from prosecution to those who intervene to save someone who is overdosing.

Warning Signs In Your Wallet

Connecticut also passed a law last year allowing health care professionals to hand out Narcan, generally given in the form of a nasal spray. But the law is not enough: The state Department of Mental Health and Addiction Services should train people in its use and broadly distribute the drug. Massachusetts, which has a less-restrictive law, has since 2006 been giving Narcan to addicts, friends of addicts, family members, police and firefighters. The two-dose kits have saved nearly 2,000 lives in the Bay State as a result.

Connecticut also needs to publicize the signs of an overdose. Many who die of drug overdoses do so in the presence of those who love them. They think addicts are just in a deep sleep when their shallow breathing and blue lips or fingertips indicate they may be dying. DMHAS has a good video on the signs of overdoses and use of Narcan, but it's buried deep in its website when it should be highlighted on the first page. Better yet, emulate Massachusetts, which takes steps to publicize the warning signs of an overdose through wallet cards and other steps.

DMHAS doesn't require its contractors to do proven, effective, evidence-based treatment, although the agency "encourages" them to do so. Not requiring treatment based on solid research studies is a disservice to addicts and an invitation to waste taxpayers' money. The General Assembly must mandate that within five years, 75 percent of treatment services should be based in proven effectiveness. Oregon passed such a law six years ago.

Finally, Connecticut should reconsider its priorities. Addiction services are scattered through nine state agencies, with nearly all the money earmarked to help adults. Most of the money comes from the DMHAS, which sets aside a quarter of its budget for addiction.

Addiction services for adolescents are obtained through the Department of Children and Families, which spends $23 million of its $818 million budget on addiction. The young are getting short shrift.

Addiction has not been a priority for Connecticut. Yet, as the overdose problem makes clear, the state cannot afford the grievously high cost of its denial.

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SHIPMAN & GOODWIN LLP®
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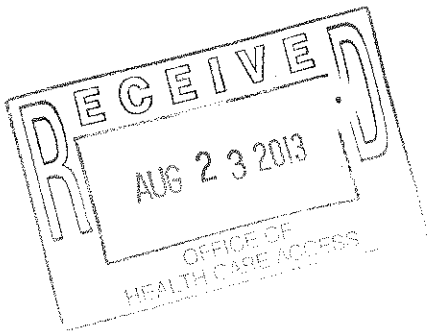
jfeldman@goodwin.com

August 23, 2013

VIA HAND DELIVERY

Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Post Office Box 340308
Hartford, CT 06134-0308
Attn: Kimberly Martone
Director of Operations



RE: Late-File
Docket Number 13-31828-CON
NR Connecticut, LLC-d/b/a Retreat of South Connecticut
Establish a 105 Bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut

Dear Ms. Martone:

On behalf of Rushford Center, Inc. ("Rushford") and as requested by the Office of Health Care Access at the public hearing held on August 14, 2013, enclosed please find a revised version of Exhibit A ("DMHAS Admission Data") from Rushford's previously submitted Pre-Filed Testimony. As requested, the admissions data for Fiscal Year ("FY") 2013 was provided and updated by the Department of Mental Health & Addiction Services ("DMHAS") as of August 22, 2013 and a third column was added by DMHAS to each of the respective tables to reflect the number of beds used as the basis for the number of admissions data reported by DMHAS.

Please note that there is some discrepancy between the DMHAS data and the data that Rushford provided in its pre-filed testimony. Specifically, as it relates to detoxification beds, Rushford did not include the six (6) beds at Community Prevention and Addiction Services ("CPAS") because those beds were closed in September 2012. However, DMHAS did include the six (6) CPAS beds because the FY for funding purposes was 2012 through 2013. With respect to intensive residential rehabilitation providers, DMHAS' list did not include providers that have a higher or comparable level of residential rehabilitation care, such as Stonington Institute, Mountainside Treatment Center, Turning Point, High Watch Recovery Center and one of Recovery Network of Programs locations.

We hope that this is sufficiently responsive to your inquiry.

Respectfully Submitted,

Joan Feldman

Joan Feldman, Esq.

Enc.

EXHIBIT A

DMHAS
ADMISSION DATA

Substance Admissions to Medically Monitored Detoxification and Intensive Residential Rehabilitation 3.7
Funded and Non-Funded Programs
22-Aug-13

Medically Monitored Detox 3.7d

Fiscal Year	# of Admissions	# of Beds
FY09	9267	126
FY10	8709	131
FY11	10463	143
FY12	11035	153
FY13	11091	153

SA Intensive Residential Rehabilitation 3.7

Fiscal Year	# of Admissions	# of Beds
FY09	2906	206
FY10	2907	206
FY11	3040	193
FY12	2877	193
FY13	2571	197

Certificate of Service

I hereby certify that a true and correct copy of the foregoing late-file was sent via email and first class United States Mail the 23rd day of August 2013 to:

1. **William P. Beccaro, Esq.**
   Law Offices of Peter P. Beccaro
   12 New City Street
   Essex, CT 06426

   Tel: (860) 767-8632
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   wbeccaro@snet.net

2. **Jennifer Groves Fusco, Esq.**
   Updike, Kelly & Spellacy, P.C.
   265 Church Street
   One Century Tower
   New Haven, CT 06510
   Tel: (203) 786-8300
   Fax: (203) 772-2037
   jfusco@uks.com

Joan Feldman, Esq.

Greer, Leslie

From: Greci, Laurie
Sent: Monday, August 26, 2013 1:49 PM
To: Greer, Leslie
Cc: Hansted, Kevin; Horn, Marianne; Veyberman, Alla
Subject: FW: Retreat at South Connecticut -- Docket No. 13-31828-CON (Late File)
Attachments: Certificate of Service.pdf

Leslie,
Will you please add this email and the attached file to the docket for this CON?
Thank you,
Laurie

From: William P. Beccaro [mailto:wbeccaro@snet.net]
Sent: Monday, August 26, 2013 11:25 AM
To: Greci, Laurie
Subject: Retreat at South Connecticut -- Docket No. 13-31828-CON (Late File)

Good morning:

Apparently, this Certificate of Service was not attached to the documents your received Friday. It was part of the documents that were mailed to the interveners.

Please feel free to contact me if you have any questions. Thank you.

WILLIAM P. BECCARO
on behalf of Retreat at South Connecticut
Attorney at Law
12 New City Street
Essex, CT 06426
860-767-8632 (office)
860-767-0456 (facsimile)
860-227-9477 (cellular)
wbeccaro@snet.net (email)

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Certificate of Service

I hereby certify that a true and correct copy of the foregoing Applicant's Late Filing # 1 was sent via electronic mail, and first Class United States Mail the 23rd day of August to:

1) Jennifer Groves Fusco, Esq.
   Updike, Kelly & Spellacy, P.C.
   265 Church Street
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   New Haven, CT 06510
   jfusco@uks.com

2) Joan Feldman, Esq.
   Shipman & Goodwin, LLP
   One Constitution Plaza
   Hartford, CT 06103
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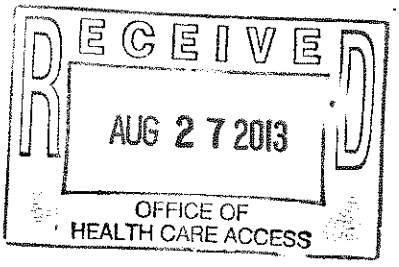
William P. Beccaro

William P. Beccaro, Esq.



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FACSIMILE COMMUNICATION

Sender's Direct Fax Number:
(203) 772-2037

TO: Lisa A. Davis, M.B.A., B.S.N., R.N. FACSIMILE: (860) 418-7053

From: Jennifer Groves Fuseo, Esq. Number of Pages: 4 (Including Cover Sheet)

Subject: **Retreat at South Connecticut, Docket No. 13-31828-CON**

Message:

Please contact Deb Alexa at (203) 786-8322 to report transmittal difficulties. Thank you.

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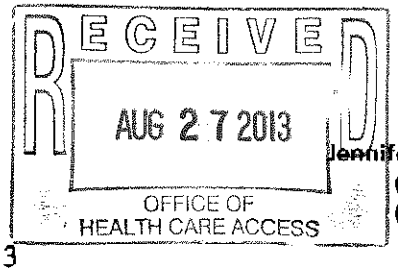

Jennifer Groves Fusco
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August 27, 2013

VIA FACSIMILE & REGULAR MAIL

Lisa A. Davis, M.B.A., B.S.N., R.N.
Deputy Commissioner
Office of Health Care Access
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: NR Connecticut, LLC d/b/a Retreat at South Connecticut
Establish a 105-Bed Residential Substance Abuse Treatment Facility in New Haven
Docket No. 13-31828-CON

Dear Deputy Commissioner Davis:

This office represents Yale-New Haven Hospital, Cornell Scott – Hill Health Center and APT Foundation, Inc. (collectively "Intervernors") in connection with the above-referenced docket. We are in receipt of the late-file testimony of NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Retreat"), dated August 23, 2013, and are providing this submission in rebuttal.

Retreat was asked to provide OHCA with revised versions of Financial Attachment II, which separate out the levels of service being proposed. Retreat has provided revised Financial Attachments II for inpatient and outpatient services, along with a cover memorandum that re-argues points from the hearing, the results of its informal "survey" of bed capacity at existing providers, and an editorial from the Hartford Courant. This late-file testimony is not responsive to OHCA's request. Nevertheless, should OHCA choose to accept this additional information into the record, Intervenors offer the following points in rebuttal:

- The breakdown of units by inpatient/outpatient, as set forth in the cover memorandum and revised Financial Attachments II, is inconsistent with the projected volume in Retreat's initial CON submissions. Specifically, the number of inpatient days for FY 2013 is reported as 22,880 in the cover memorandum and revised Financial Attachment II. However, in the CON Application (pages 30 & 677), inpatient days for FY 2013 are reported as 21,120 (5,280 RDE and 15,840 IT). The 22,880 figure appears to come from the original Financial Attachment II (page 655) where this was reported as the <u>total</u> number of inpatient and outpatient units. Accordingly, the revised Financial Attachment II for inpatient units appears to be incorrect and the volume overstated.

- The projected inpatient volume of 22,880 units results in an average daily census of 63 in FY 2013. This amounts to an occupancy rate of only 60 percent of the proposed 105 beds. The projected volume then increases by 8,800 units (38 percent) over the first three years of operation, reaching 31,680 units in FY 2015. If you use a FY 2013 figure of 21,120 (per the original CON), the volume increases by 10,560 units or 50 percent by FY 2015. Applicants have offered no explanation or justification for this significant projected volume growth.

- Retreat again argues that there is a "need" for a 105-bed substance abuse treatment facility in New Haven because of the estimated number of individuals in Connecticut who require, but do not seek, treatment. However, Retreat fails to account for several important facts. First, individuals with substance abuse disorders choose not to seek treatment for a variety of reasons having nothing to do with lack of capacity in the system. Retreat has offered no evidence that a new facility will motivate these individuals (who have not taken advantage of the many existing facilities in this state, which have ample capacity and the ability to treat their disorders) to seek treatment.

  Retreat also assumes, without offering any supporting evidence, that the percentage of commercially insured individuals among those who fail to seek treatment for substance abuse disorders is the same as the percentage of commercially insured individuals in the general population. Likely, a significant percentage of individuals who have substance abuse disorders and fail to seek treatment are <u>not</u> commercially insured and/or wealthy and, therefore, would <u>not</u> be eligible for admission to the Retreat facility. In this regard, Retreat's proposal fails to meet the needs of <u>all</u> Connecticut residents.

  Lastly, the statistics that Retreat cites from the Statewide Health Care Facilities and Services Plan speak to substance abuse treatment services generally, but do not specify which, if any, services in the state (i.e. inpatient, PHP, IOP) lack capacity. It is possible that a significant percentage of those patients who fail to seek treatment could be effectively treated in less-costly outpatient programs, as opposed to the inpatient/residential programs proposed by Retreat. Again, this presumes that patients are willing to seek treatment, which is not always the case.

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Thank you for your consideration of this rebuttal information. Should you require anything further, please feel free to call me at (203) 786-8316.

Very truly yours,



Jennifer Groves Fusco

cc: William Beccaro, Esq.
Joan Feldman, Esq.

Greer, Leslie

From: Veyberman, Alla
Sent: Friday, September 06, 2013 10:48 AM
To: wbeccaro@snet.net
Cc: Greer, Leslie
Subject: FW: NR CT, LLC d/b/a Retreat at South Connecticut
Attachments: 31828-12.pdf

Good morning,
Just want to make sure that you received a copy of this filing.

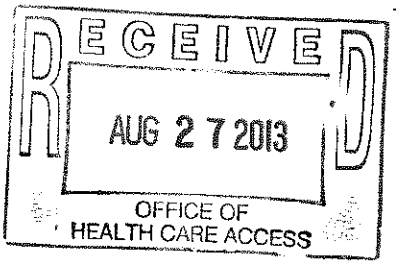
Thank you.

Alla Veyberman
CT Department of Public Health
Office of Health Care Access (OHCA)
Phone: 860.418.7007
Fax: 860.418.7053
Email: Alla.Veyberman@ct.gov

From: Greer, Leslie
Sent: Tuesday, August 27, 2013 1:15 PM
To: Greci, Laurie; Veyberman, Alla; Riggott, Kaila; Hansted, Kevin; Martone, Kim
Subject: NR CT, LLC d/b/a Retreat at South Connecticut

Attached is correspondence received for NR Connecticut, LLC d/b/a Retreat at South Connecticut.

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca



MERITAS LAW FIRMS WORLDWIDE

Sender's Direct Dial Number:
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FACSIMILE COMMUNICATION

Sender's Direct Fax Number:
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TO: Lisa A. Davis, M.B.A., B.S.N., R.N. FACSIMILE: (860) 418-7053

From: Jennifer Groves Fuseo, Esq. Number of Pages: 4 (Including Cover Sheet)

Subject: **Retreat at South Connecticut, Docket No. 13-31828-CON**

Message:

Please contact Deb Alexa at (203) 786-8322 to report transmittal difficulties. Thank you.

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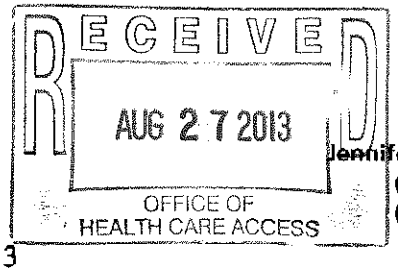

Jennifer Groves Fusco
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jfusco@uks.com

August 27, 2013

VIA FACSIMILE & REGULAR MAIL

Lisa A. Davis, M.B.A., B.S.N., R.N.
Deputy Commissioner
Office of Health Care Access
410 Capitol Avenue
Post Office Box 340308
Hartford, CT 06134-0308

Re: NR Connecticut, LLC d/b/a Retreat at South Connecticut
Establish a 105-Bed Residential Substance Abuse Treatment Facility in New Haven
Docket No. 13-31828-CON

Dear Deputy Commissioner Davis:

This office represents Yale-New Haven Hospital, Cornell Scott – Hill Health Center and APT Foundation, Inc. (collectively "Intervernors") in connection with the above-referenced docket. We are in receipt of the late-file testimony of NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Retreat"), dated August 23, 2013, and are providing this submission in rebuttal.

Retreat was asked to provide OHCA with revised versions of Financial Attachment II, which separate out the levels of service being proposed. Retreat has provided revised Financial Attachments II for inpatient and outpatient services, along with a cover memorandum that re-argues points from the hearing, the results of its informal "survey" of bed capacity at existing providers, and an editorial from the Hartford Courant. This late-file testimony is not responsive to OHCA's request. Nevertheless, should OHCA choose to accept this additional information into the record, Intervenors offer the following points in rebuttal:

- The breakdown of units by inpatient/outpatient, as set forth in the cover memorandum and revised Financial Attachments II, is inconsistent with the projected volume in Retreat's initial CON submissions. Specifically, the number of inpatient days for FY 2013 is reported as 22,880 in the cover memorandum and revised Financial Attachment II. However, in the CON Application (pages 30 & 677), inpatient days for FY 2013 are reported as 21,120 (5,280 RDE and 15,840 IT). The 22,880 figure appears to come from the original Financial Attachment II (page 655) where this was reported as the <u>total</u> number of inpatient and outpatient units. Accordingly, the revised Financial Attachment II for inpatient units appears to be incorrect and the volume overstated.

- The projected inpatient volume of 22,880 units results in an average daily census of 63 in FY 2013. This amounts to an occupancy rate of only 60 percent of the proposed 105 beds. The projected volume then increases by 8,800 units (38 percent) over the first three years of operation, reaching 31,680 units in FY 2015. If you use a FY 2013 figure of 21,120 (per the original CON), the volume increases by 10,560 units or 50 percent by FY 2015. Applicants have offered no explanation or justification for this significant projected volume growth.

- Retreat again argues that there is a "need" for a 105-bed substance abuse treatment facility in New Haven because of the estimated number of individuals in Connecticut who require, but do not seek, treatment. However, Retreat fails to account for several important facts. First, individuals with substance abuse disorders choose not to seek treatment for a variety of reasons having nothing to do with lack of capacity in the system. Retreat has offered no evidence that a new facility will motivate these individuals (who have not taken advantage of the many existing facilities in this state, which have ample capacity and the ability to treat their disorders) to seek treatment.

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Very truly yours,



Jennifer Groves Fusco

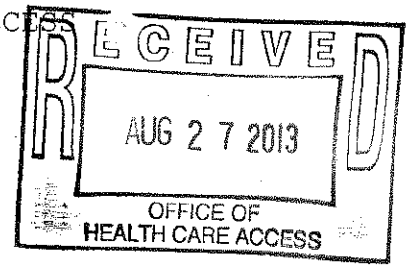
cc: William Beccaro, Esq.
Joan Feldman, Esq.

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS



NR CONNECTICUT, LLC
D/B/A RETREAT AT SOUTH CONNECTICUT

ESTABLISHMENT OF A 105 BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY TO BE LOCATED IN NEW HAVEN, CONNECTICUT

DOCKET NO. 13-31828-CON

AUGUST 14, 2013

9:00 A.M.

300 CAPITOL AVENUE
HARTFORD, CONNECTICUT

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

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of NR Connecticut, LLC, D/B/A Retreat at South Connecticut, Establishment of a 105 Bed Residential Substance Abuse Treatment Facility to be located in New Haven, Connecticut, held at 300 Capitol Avenue, Hartford, Connecticut, on August 14, 2013 at 9:11 a.m. . . .

HEARING OFFICER MARIANNE HORN: Good morning. We're going to go on the record now. This public hearing before the Office of Health Care Access is identified by Docket No. 13-31828-CON. It's being held on August 14, 2013 to consider NR Connecticut, LLC, D/B/A Retreat at South Connecticut's application to establish a 105-bed residential substance abuse treatment facility to be located in New Haven, Connecticut.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General

Statutes.

My name is Marianne Horn. I'm an attorney from the Department of Public Health, and I've been designated by Commissioner Jewel Mullen of the Department of Public Health to serve as the Hearing Officer for this matter.

The staff members assigned to assist me in this case are Kaila Riggott to my right, Laurie Greci and Alla Veyberman. Kim Martone, the Director of OHCA, is also providing assistance this morning. The hearing is being recorded by Post Reporting Services. You'll need to turn your microphone on and off after you testify.

In making its decision, OHCA will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes, and following the hearing a proposed final decision will be issued, in accordance with Connecticut General Statutes, Section 4-179.

The Applicant, NR Connecticut, LLC, D/B/A Retreat at South Connecticut, has been designated as a party in this proceeding.

At this time, I will ask staff to read into the record those documents already appearing in OHCA's Table of the Record in this case. All documents

have been identified in the Table of the Record for reference purposes. Ms. Veyberman?

MS. ALLA VEYBERMAN: Good morning. Alla Veyberman, OHCA staff. I would like to enter into the record Exhibits A through AA. Thank you.

HEARING OFFICER HORN: Are there any objections to the exhibits?

MS. VEYBERMAN: Not at the moment. Thank you.

HEARING OFFICER HORN: Any objections from any of the parties, Intervenors? Hearing none. The way we'll proceed with the hearing today is, first, to hear from the Applicant for a brief 10-minute overview of the project, followed by each Intervenor with full rights of participation.

Each Intervenor will have 10 minutes to provide testimony, and then each Intervenor may Cross-Examine the Applicant. Following that, the Applicant may Cross-Examine all of the Intervenors.

During the public comment section of this hearing, out of deference to Legislators and Municipal Officials, we will call them first, and then we will go to the public section of the sign-up sheets. Do we have any Legislators or Municipal Officers in the audience

yet? Okay, thank you.

Each person, who wishes to speak, should write their name on the sign-up sheets, which have been provided, and please turn off all cell phones and electronic devices, so that the person speaking will not be interrupted.

At this time, I would like all of the individuals, who are going to testify, to stand, raise your right hand, and to be sworn in by the court reporter.

(Whereupon, the parties were sworn.)

HEARING OFFICER HORN: Okay. At this time, I would ask the Applicant to proceed with his testimony.

MR. PETER SCHORR: Good morning. My name is Peter Schorr. I am the CEO of Retreat at Lancaster County and the proposed Applicant for Retreat of South Connecticut. I want to thank the Office of Health Care Access for this opportunity to express in person what we're trying to achieve.

Two years ago, I opened Retreat at Lancaster County, a 120-bed facility, catering to private pay and commercial insurance.

In my 30 years of experience in this

field, one of the things I've noticed, time and time again, that it's very hard to get people to be engaged in treatment. I've ran facilities. I've started, you know, my first job in this industry was a pee collector at a methadone clinic, so I've worked my way up to where, in 1995, where I was actually fortunate enough to own my own facility and been doing that since.

And over the years and my experience is that, you know, it's a battle, as is, when we're dealing with addictions. We have a small window of opportunity to get people to be invested in treatment, and the last thing I want to do is have them to be uncomfortable and concentrate on everything, other than what they're there for.

What they're there for is for us to help them get better, so I want to make a facility that's comfortable, the food is good, the beds are comfortable, they have amenities, that that's all taken out of the equation, and now let's concentrate while you're here.

In the two years since I opened Retreat at Lancaster County, we've serviced over 2,500 individuals with many successes. I judge success by how people are doing after two years. I have one person, who is going to testify. Probably the most important testimony you're

going to hear today is someone, who went through the facility and is successful today, and that's what matters.

People ask me why Connecticut? I'm a nine-year resident of the State of Connecticut. I'm a parent to a young adult. I see, personally, many kids, many adults, who suffer from addiction.

Down in Pennsylvania, I get many people from Connecticut coming to my facility, because there's just a lack of whatever it is at the time treatment, and we have, like I said before, we have a small window of opportunity to treat people.

When someone is ready for treatment, you know, it's not days. You've got minutes and hours sometimes. We're dealing with some very dangerous drugs these days.

So I saw a need. An opportunity came to me at this nursing home in New Haven, Connecticut. One of my financial partners said to me would you be interested in something up in New Haven, and I said let me take a look at it. Let me see if it fits our needs.

Previously, it was a nursing home, and one of the things I wanted to do is see if I can duplicate what I did in Lancaster County, because it was important,

like I said before, to have something, where people can go and feel like they're getting care, and they feel like they're getting treatment, and they concentrate on that.

So I looked at it, and I had contractors come in. We looked at all different ways to renovate it, and things to add, what we can do, and not make it look like an institution, and I think we came up with a plan for that.

And then we had to find out is there a need in the State of Connecticut for beds? Talking to the State, some people in the State, they said there is.

A report came out last year. Obviously, a lot of people in this room, who are against this, are part of that report, stating that there's a very big need for beds in this state, and that even if people, like myself, who are not looking for public funding and are willing to put their own funds up and build a facility, if they didn't have that, maybe they should start looking at public funds to find where we can get more beds.

Someone said to me we are doing this, because, you know, if we build a facility, people will come. We're building a facility, because people are here.

Two days ago, I got a call from the EAP of

the State Health Care Workers, asking me can we treat their patients down in Pennsylvania, and I said yes. I mean I said one of the things we're working on now is opening a facility in Connecticut, and, alleluia, we need that.

One of the reasons my population -- and, look, I believe in treatment, and I believe everybody deserves treatment, and I believe all these facilities that are here do a great job, and it's all needed, because there's so many people.

And in the report that your office prepared, only 17 percent of the people that suffer from addiction in the State of Connecticut are getting treatment. That's a mistake. We've got to rectify that. That's teamwork. I'm not their enemy. I'm their friend.

When I come here, when people say you're coming here, are you building something, you're hoping people are going to come? No. I'm coming here, because they are here.

There are plenty of people in the State of Connecticut that suffer from addiction that are not getting treatment. This is why we decided this is the place for us. Not only do I live in the state, but the place has a need.

Again, I'm in this field for 30 years. I suffer from my own problems with addiction 30 years ago, and I know what it's like not to be able to find a facility that will take me, not to be able to find a facility that takes my insurance.

I know people are upset that we're going to take all the commercial insurance, and all the Medicaid people will be left out in the dust, and they have to take them, and they won't be able to afford it.

First of all, 80 percent of the population of the State of Connecticut has commercial insurance, and we're only taking -- and 17 percent are being treated. Where are the rest going? There's enough for all of us.

I think, you know, my accountant is going to testify, because not only is he my accountant, he's also on the Board of a major hospital in New York, and he knows how the system works, and he can explain that.

We have different programs at our facility. We treat impaired professionals. We treat first responders. We treat all these different things that may not be, you know, these other facilities may not have, or, for whatever reason, they choose not to do, and, addiction, it's a family disease.

Unfortunately, when people have to leave

the state and go to Florida or Pennsylvania, the family can't participate in that, and we give them the opportunity in the State of Connecticut for our residents in the State of Connecticut to participate in the recovery, because it's important. We've seen that time and time again.

Another thing, we feel that it's very important that people are saying, well, our constituents in New Haven won't be able to participate in our facility.

I just want to say we're not a New Haven facility. That's where our facility is. We're here for the State of Connecticut and anyone, who is looking for treatment.

What we do bring to the City of New Haven is 100-something jobs, which is important. I know it's not an issue for OHCA to look at, but, you know, as a community, you know, we're bringing 100 really good jobs to the community.

When we came to Ephrata Pennsylvania, you know, I thought we were going to have 100 employees. Today, I have 170 full-time employees, so we do bring something else, besides just a treatment center.

You know, 170 people work for me that have

a passion for treatment that is second to none. Sitting behind me is my Director of Operations, and he's the one -- that's my Executive Director, the woman sitting there, Chrissy Gariano, who is totally deaf, has worked her way through college, Master's degree in Psychology, and runs, you know, as an Executive Director, my facility, second to none. Second to none.

My staff is dedicated. My staff is, besides dealing with addiction, we go a step further. We deal with the co-occurring disorders. And besides primary therapists, we have what we call clinical specialists that handle the mental health aspect of a patient.

We're not a dual diagnosis center, we're not a psychiatric hospital, and that's not what we're going for. We're going for a drug and alcohol, but we go a step further and treat co-occurring disorders, and we find that's very important, by treating the patient as a whole and seeing that not only their addiction, but what caused it, what's part of the whole process.

So, again, that's what we do at Retreat, and that's what we want to replicate at Retreat at South Connecticut.

Now, again, listening and reading all this

opposition, saying, well, you know, the emergency rooms. You know, you guys came out with a report last year, all right? That report answers every single question that was put to you from the opponents, every single one, and the sad thing is they all participated in it.

Every single one of them participated in this report, saying that we need more beds. We need treatment. And now people are saying, well, give us the beds. We'll do it.

The report says we need treatment. Our treatment keeps people out of emergency rooms. You know, people always say, well, downstream it's going to go back to the hospitals. No. We're downstream. The hospitals send to us, and we're going to help them and rectify their emergency room problem.

And we have a full medical staff. We try to keep people out of the emergency room. 1.7 percent of our population has used our local hospital of 2,500 patients. It's not a lot. I don't think that's going to put a burden on Yale-New Haven.

Again, a lot of opposition is we don't need beds, we don't need beds. I think it's proven by your own agency, by the own opponents here, that we need beds. There's not enough beds in this state. There's

not enough beds anywhere, let alone in just Connecticut.

We're not looking to poach patients from people. We're looking -- you know, how we do business is, when we set up marketers, you know, we go to different places, and we explain what our program is, our specialty programs, what we have to offer, and, hopefully, you know, they have patients that need what our services are.

If not, we also are a big referral source to other facilities. When we first came to Pennsylvania, you know, a lot of the local facilities were nervous about us, because, you know, there's another new facility in the town, but, again, we became partners with everybody, and we all work together.

We all refer to other places, because we can't take everybody. We don't take every single insurance. We don't do that.

So we came to New Haven, and we chose to build a 105-bed facility, where we can put the facility. I think, when it was a nursing home, it had 140-something beds, and we can put more beds in there, but, as a conscious decision, we decided, you know, our infrastructure would be comfortable if we had 105 beds.

We chose to have 26 detox beds and 79

rehab beds. Being with the rule of thumb, it usually is three to one, and try to have that ratio as close as possible, so when our patients graduate from detox, they have a rehab bed waiting for them.

Unfortunately for us, if there's only 26 detox beds, we may have to send patients to other places, because, once that's full, we can't take anymore admissions. It doesn't matter how many people we have in the house.

So that's how we chose 105. We wanted the infrastructure to handle that and be comfortable as our philosophy is. We want patients to concentrate on treatment and not on all the outside external stressors that go along with it.

HEARING OFFICER HORN: Thank you. If I could just have you adopt your pre-filed testimony, please?

MR. SCHORR: You want me to adopt it?

HEARING OFFICER HORN: Yes, please.

MR. SCHORR: How do I do that?

HEARING OFFICER HORN: You just say I hereby adopt my pre-filed testimony.

MR. SCHORR: I hereby adopt it.

HEARING OFFICER HORN: Thank you. And I

would ask the other witnesses, who have filed pre-filed, to do that before they testify. Thank you.

DR. STEVEN KLOTZ: I am Dr. Steven Klotz, and I adopt my pre-filed testimony.

MR. HERBERT LESHKOWITZ: I am Herbert Leshkowitz, and I hereby adopt my prior testimony.

HEARING OFFICER HORN: Your pre-filed testimony?

MR. LESHKOWITZ: My pre-filed testimony, yes.

HEARING OFFICER HORN: Very good. Anything further from the Applicant?

MR. SCHORR: I'm going to defer now to our Medical Director, Dr. Steven Klotz.

DR. KLOTZ: Good morning. Thank you, all, for attending. I'd like to thank the Office of Health Care Access for allowing me the opportunity to specifically address the clear public need, including the patient population to be served.

A lot has been said and a lot more has been written about selection of patients, about access to care. Statistics have been drawn up and offered, and I've often noticed that statistics can be made to make anybody look and say what they would like to say.

Public need is not a number demonstrated by a statistic. Public need is a patient on a waiting list to get into treatment that may save their life.

Public need is a patient being discharged back to the street, or back to a home that is unsafe and unhealthy and continues their stressors and their addictive behaviors.

Public need are patients, who, because of a lack of substance abuse care in a timely manner, are funneled into medical units, surgical units, and intensive care units, and, later, to funeral homes.

These have a huge public cost not only to the immediate family, but to the community and to the State. In an attempt to address this in a unique fashion, Mr. Schorr has allowed me to participate and help direct a comprehensive and unique medical approach to treating patients with chemical dependency and co-morbid or co-occurring disorders.

A great deal of fear mongering has been offered that we will not be able to handle our population and burden the State and other local providers by selecting only patients that are healthy.

Retreats Medical Department differs. We have a unique multi-modal approach and a comprehensive

substance abuse and dependency treatment. Our model has been proven to work in two years of operation, excuse me, just under two years of operation at our Lancaster Ephrata facility.

Our quality exceeds local and national standards as offered by other substance abuse providers. We employ our health care providers. We employ more than one health care provider. There is always a physician on call 24 hours a day, seven days a week, 365 days a year. We employ a group of varied specialists and subspecialists.

I, as the Medical Director, am quadruple Board-eligible, covering a wide range of psychiatric and medical areas, including addiction medicine.

We prefer to address and treat our patients immediately upon their entrance into our facility, not to send them out to local places.

I have a team of doctors, who are experts in cardiology, endocrinology and other varied fields. Our patients, if they suffer from a medical complication, we address it on-site, we manage it on-site, and we only seek outside assistance in the exact same circumstances that any community provider would seek an outside assistance.

For instance, an acutely-threatening patient, or perhaps a patient undergoing an acute myocardial infarction. We do not burden the local health care system with other medical issues.

Our health care providers are available and provide immediate response. I personally take call most nights of the week, and I answer my phone in under two rings. My colleagues are equally efficient.

At Retreat, our medical doctors are a member of a roundtable team. We interact directly both with the personal therapists, the group therapists, the clinical assistants, and our mental health care specialists.

When an issue, such as a co-occurring disorder, such as PTSD, or perhaps depression, or anxiety, which are often co-morbid, they are seen by the psychiatrist, a treatment option and plan is discussed and implemented.

The team is made aware of screening tools that they can use to monitor, and the patient is followed up with a physician. He is not left to follow-up outside.

At time of discharge, arrangements are made for follow-up care, and a patient is provided with

continued prescriptions, so as not to become an immediate burden to the community facilities.

The staff dines with and works with the patients in the community, so that my observations and my colleagues' observations are not limited to a limited interview in a medical office.

When I have a patient that is presenting with symptoms or not presenting with symptoms, our unique model and our 24-hour employed staff sees the patient in the community and can raise concerns and share it with the full treatment team.

Any person on this treatment team can refer either to another level, or back and forth. We hold routine case conferences, such that our care is wraparound.

We have medical outreach. We have direct medical and psychiatric patient education as part of the comprehensive medical and psychiatric programming on site.

Our patients attend lectures on the medical and mental components of substance abuse, on the physiology and psychopharmacology. They receive specialized training on their medications that are offered, what works, what doesn't work, what risks and

benefits there are in the outpatient world.

We set them up, or do our best to set them up with after-care that is consistent with the model that they have seen.

When we talk about a clear public need and we talk about the absolute co-occurring and co-morbid disorders, we have a lot of need out there.

On the morning of September 11, 2001, I was on the ground to the Northport Veteran's Hospital in Long Island, just a few short miles across the Sound.

I was listening to the radio when the planes decimated the lives of 3,000-plus individuals. My heart bled the morning I heard about the local shootings in Connecticut.

Emergency services were provided to the first care responders and to the families. Having published on the long-term outcomes of the families and the communities of the victims of 9-11, I know we will be facing a greater burden in the years to come with the community in Connecticut, not just the direct families, but the health care providers and the people, who witnessed the repeating news events.

Many of those people will be at risk for using substances to assuage and calm their nerves. They

will develop pathologic behaviors, some of which will reach clinical severity. We offer at Retreat and we hope to offer at Retreat of South Connecticut the opportunity to introduce a new standard of medical care.

HEARING OFFICER HORN: Thank you. I'm going to ask you to wrap it up.

DR. KLOTZ: Okay.

HEARING OFFICER HORN: Thank you.

DR. KLOTZ: When we talk about clear public need, including patient population to be served, my office staff has called all of the rehabilitation and detox facilities available in the State of Connecticut.

This was done a couple of weeks ago, it was done yesterday, and it was done at 8:32 a.m. No beds are available to anybody. There is a minimum wait, if we have a discharge, of 72 hours.

Several facilities didn't answer their phones. Several facilities answered their phones, saying we will try to get back to you.

If ever there was a message that there's a clear public need, it is the fact that Connecticut cannot treat the people, who are in the E.R. waiting for appropriate placement. Thank you, all.

HEARING OFFICER HORN: Thank you. Your

testimony is in the record, so if there's anything you'd like to highlight on that, but we prefer you not go through it verbatim. Thank you.

MR. LESHKOWITZ: You're talking to me?

HEARING OFFICER HORN: Yes.

MR. LESHKOWITZ: Yes. All right. I would just like to thank the Commission, the Office of Health Care Access, for allowing me this opportunity.

I did do, I think, a fairly comprehensive written statement in preparation for my talk this morning, so I'm not going to repeat everything that I've said in the written statement, but, rather, highlight my own opinion, as to the financial efficacy and the financial likelihood of success, on the one hand, and the financial backing that I have personal knowledge of, on the other hand.

Just quick by way of background for the audience assembled here, I am a CPA for the last 40 years. I'm an attorney. I practice in New York State. I'm managing partner of Leshkowitz and Company, Certified Public Accountants.

We have a professional and other staff and support staff of about 50 people, and many of our clients are in the health care field.

I am also, in my community life, the vice-Chairman of the Board of Trustees of Maimonides Medical Center, which is a 720-bed tertiary care facility in South Brooklyn, so I sit on the Finance Committee. I have intimate knowledge of the budgets of the hospital, its various departments, including a very large psychiatric department and drug treatment center within that psychiatric department.

We review the budgets. We compare the actual performance to the budgets on a regular basis, so I think that I have perhaps a better than passing knowledge of the financial aspects.

What I would just like to focus on is the fact that the funding for this facility is more than adequate in my opinion. It is available today. It is in-hand. We have a seven and a half million dollar credit facility already funded from Fulton Bank.

Fulton Bank has an excellent work experience with this team, with the ownership team and the management team in the Ephrata facility in Pennsylvania, and they have provided, as I indicated, a seven and a half million dollar credit facility to fund the acquisition, the startup, as well as all of the other working capital needs of this new facility in New Haven.

We have, as we speak, approximately 4.3 million dollars still available in order to accomplish the renovation, the equipment, the furnishings, the startup, and all of the pre-opening costs.

Besides the availability, the very strong availability to support the startups cash flow through the startup and pre-opening period, which I might add to the Board is rather unique, especially in this economic climate that we are coming off of and that we are still in, to have this kind of committed financing and for me to be able to independently say that if we need more financing, which is not likely under the projections, but it could very well happen that we would need additional financing, it is readily available. I think that's rather unique in general financing, especially in new health care type facilities.

In addition, in terms of my analysis of the projections, I have reviewed the financial projections of the New Haven facility that were submitted to this Board for a four-year period.

I dealt with the efficacy and the likelihood of occurrence of the occupancy, how management projected that the occupancy would build in the facility. I looked at the revenue stream. I looked at each line

item of the operating costs, including the major cost for payroll, management and so on, and I found that the preparers of this projection did a very credible job in highlighting and estimating with great consideration the likely cost of this facility.

But, as I indicated, a projection is only that. You hope that you meet those projections. Sometimes it takes longer to meet the projection for a new operation. Sometimes it's accelerated.

I draw tremendous comfort and support from the fact that I also reviewed the original projections in the Ephrata in the Pennsylvania facility, and I found that those projections, in actuality, were far exceeded.

In other words, this management team, which will be the same management team here in New Haven, they will bring in the full support. They'll hire. They will train. They will be on the ground until this facility is functioning on its own with its own management staff, and then the senior people, including Mr. Schorr, will have general oversight over this facility, but I found that those projections are conservative and likely of occurrence.

The final point that I'd like to make, and then I'll be glad to answer whatever questions and maybe

come in under the 10-minute allotment, is a word about the management team.

We are the accountants for the principals of this enterprise. We're the accountants for it's the same principals as the Ephrata facility, so we know their backgrounds. We have observed them over the last several years, that we have represented the main players on this financial and management team.

We have seen them in operation, and we have seen their performance. We have analyzed financial statements, actual financial statements, actual performance of the Ephrata facility, and that's what I used to evaluate the projections for this new facility, because, under its mission, under its objectives, it should be I don't want to use the word clone, but it should be a very, very similar type of operation, and, therefore, the costs associated with that operation, beyond the startup and the setup and all that, should be approximately the same.

I can tell you that, in the Pennsylvania facility, we have this management team. Not we. I come in after the fact to review, but this management team has achieved a level of occupancy, a level of performance that was first projected in year number four. They've

already achieved it in year number two, therefore, with this management team, with the financial support in place and readily available, it's my considered opinion that this facility has a very strong likelihood of success. Thank you.

HEARING OFFICER HORN: Thank you. Anything further from the Applicant?

MS. KATHRYN HARASYM: Good morning. I'm Katie Harasym. I'm a recovering drug addict and alcoholic, and I'm actually living proof of everything that Peter Schorr and his team does on a daily basis.

I grew up with two, you know, loving parents, two brothers. We lived in Staten Island, New York. I was the only girl, the middle child. I was a star child. I had straight As, competitive dancer, was everything that my parents wanted me to be.

I was never very comfortable at home, I was never comfortable in my own skin, so, by the time I was 12 years old, I decided that I wanted to try alcohol, and I started drinking and smoking at the age of 12 years old.

I hated everybody in my family that drank, because I have a line of alcoholics, but, for some reason, I couldn't resist the temptation to do that. I

immediately felt relief. I immediately felt like I had found what I had been looking for my whole life. I felt comfortable. I thought I could look people in the eye. I felt like I was good enough to be around other people.

But, with that, I stopped dancing, my grades went down really quick, I couldn't stand my family. I was just a completely different person. All I wanted to do was drink. All I wanted to do was get high.

That's what I fell in love with, so, by the time I was 14, I had went to a new high school. We had moved to New Jersey, and I found opiates by the age of 14, and there was no turning back after that.

I had found that I had completely fallen in love with opiates, and I was only 14 years old, so they weren't as easy to get as, you know, other substances, but I would do what I had to do to get them.

I turned into like a little guinea pig for people. I would just ask like is it going to get me high? And if they said yes, I'd take it. I had no idea what I was doing, I had no idea what I was taking, but anything to take me out of me worked for me.

I got through high school. My grades were all right. I didn't dance anymore. I tried to go back into it numerous times, and I just chose drinking and

drugging over all of that. I decided to go to college. That didn't work out too well. After a couple of months, I came home, and it wasn't because, you know, I didn't do good in school, because I'm a good student, but it was because I couldn't sit with myself, and I didn't have my solution out there. I didn't have the drugs and alcohol out there, so I came home.

I went to community college, finished that. I went to Rutgers in Camden, New Jersey, and I, through active addiction, completed that, which is a miracle, but, through the years, I turned into somebody that I had never ever wanted to be.

I stole from everybody. I lied. I cheated. I became a shell of a human being. There was nothing left to me. I hated who I was. I hated that I was a slave to drugs.

I would manipulate everybody. I would tell my family like, you know, it's just I'm stressed out. I made them believe that there was nothing wrong.

Towards the end of my active addiction, I had dreamed of going to rehab, but I didn't know how to ask for the help. I didn't know that rehab like was an option for me. I didn't think I could get the help.

I waited until I completed college, and I

made the decision that I wanted to change my life, because the last five days of my using were five days from hell.

I mean I had been through traumatic experiences. I had hurt everybody around me within those last five days, and, on my last day using, which was January 9th of 2012, I had hit a rock bottom.

Now I didn't lose everything materialistically. I still had a home to live in, I had a car, I had a college degree, I had two jobs, but, inside, I lost everything.

I didn't even know who I was anymore. I felt like I had nothing to live for. All of that stuff materialistically that I still had meant nothing to me, because, inside, I had nothing.

I had made the decision that if I couldn't get help, I was going to end everything on my own terms, and, luckily, you know, my parents had come home early on January 9, 2012 and had approached me about some things they had found out, and, so, rather than me taking my own life, I was able to get the opportunity to go into rehab.

My parents had asked me like what I was doing, and I told them, you know, I'm a drug addict. I had tried to get clean before on my own, and it just

didn't work, and this runaround brought me to all new places, I mean to areas that I should not have been in, around people, who I should not have been around.

I spent all of January 10th looking to get into rehab, and nobody would take me. My insurance wasn't good enough. I, you know, I hadn't tried inpatient before, so people wanted me to try outpatient.

I had called a friend, who I knew was in recovery down in Florida, and I asked her how she got into rehab, because it really wasn't working for me, and she had her uncle call me, and he had given me different names.

This is a man I've never met before in my life. I still have no idea what he looks like. I have no idea who he is, but he knew somebody that worked for the Retreat at Lancaster County, and he got me on the phone with them, and the Admissions Department spent the entire day on the phone with me, trying to get me in, trying to get me cleared to come in.

And, luckily, after a lot of fight, you know, a lot of phone calls with my mom, with me, for insurance purposes, I was able to go in.

Within an hour and a half after being okayed, I had a driver waiting outside for me to come

pick me up to come to Retreat. And being that this was my first inpatient treatment center, I had absolutely no idea what to expect.

I was scared. I was broken. I was lost. All I did was cry the whole way there. I didn't know what I was getting myself into, but I knew I didn't want to live like that anymore.

I knew I didn't want to be a slave to drugs anymore. I didn't want to be a slave to alcohol anymore. I just could not do it.

The whole ride he reassured me it was going to be okay, like this is a great facility. By the time I got there and I walked into the lobby, I had numerous staff members greeting me, numerous staff members just hugging me, asking me my name, telling me it was going to be okay, because they could just see it in me, that I was petrified.

I spent 28 days at the Retreat at Lancaster County, and those were a very good 28 days. For the first time in my life, I felt safe in my surroundings. For the first time in my life, I felt the love. I felt cared for. People knew my name. People asked me how I was doing.

People addressed issues that I had that

came along with my drug addiction. I learned how to smile. I learned how to laugh. I learned how to look in the mirror and be okay with what I saw, rather than look in the mirror and cry, or not be able to look at all.

I'm so grateful to have had the experience there. I felt like I became a part of a family. Rather than just going to a treatment center, it was like I had become part of a family, and that is something I love so much about this facility.

After I left, I did go to after-care through the Retreat at Lancaster County. I did the PHP program, an IOP. I lived in a recovery house. I got a job. I waited until I had over a year sober and applied to actually go back to Retreat to work, and that is what I do today.

I am able to give back to the patients what was given to me. I come in with a smile. You know, when I was a patient there, people had to beg me to smile. People had to beg me to laugh, beg me to talk, and now, today, the patients come to me, and I have nicknames, like smiley and sunshine, and they tell me that I light up their day every morning.

It really means so much to me. To see where I was over a year and a half ago compared to now,

I'm a completely different person. I didn't get my old life back. I got a completely new one, and I thank Peter and his staff and the facility for that, because, without feeling that when I was there, I don't know if I would have made it. I don't know if I would have even tried.

So thank you for letting me share that with you.

HEARING OFFICER HORN: Thank you. And if I could just ask you to adopt your pre-filed testimony? I forgot to get that at the front end of your testimony.

MS. HARASYM: Okay. I adopt my pre-trial testimony.

HEARING OFFICER HORN: Pre-filed.

MS. HARASYM: Pre-filed testimony.

HEARING OFFICER HORN: Very good. Thank you.

COURT REPORTER: One moment, please.

HEARING OFFICER HORN: Okay. Let me just clarify that the Applicant was to have 10 minutes total, so if there's anything else that you feel that you need to add to what has already been filed, I would ask you to keep it very brief, otherwise, we'll move onto the Intervenors.

Okay, then, I would ask the representative

for the Intervenor, Rushford Center, to make a brief statement and then proceed to Cross-Examine the Applicant.

MR. JEFFREY WALTER: My name is Jeffrey Walter. I'm President and CEO of Rushford Center, and I adopt my pre-filed testimony.

HEARING OFFICER HORN: Thank you.

MR. WALTER: Rushford provides a full range of addiction treatment services. We have 16 detox beds, 42 intensive treatment or rehab beds, 26 intermediate treatment beds, and we have 28 beds, and those are for adults, and we have 28 residential beds for adolescents.

In addition, we provide partial hospital intensive outpatient and outpatient services in three locations.

I'm here representing five providers; Community Health Resources, MidState Council, Regional Network of Programs, High Watch and Rushford.

Together, we are regionally disbursed throughout Connecticut, and each of our organizations have between 30 and 70 years of experience in Connecticut providing addiction services.

We oppose the Applicant's proposal on

three bases that are outlined in our petition; the lack of a demonstration of need, the adverse impact on existing providers, and the adverse impact on the service delivery system in general.

As to the demonstration of need, we would refute the Applicant's assertion, that there is no capacity in the current system.

We have made attempts to gain more of what I would call credible information about the current capacity within the system by conducting our own survey of all of the providers of residential detoxification and intensive rehabilitation programs in Connecticut.

We had nine respondents to our questionnaire. The petition provides the data, the results of that survey, as well as the survey instrument, itself, and we found that there was at least a 21 percent excess of capacity in the nine respondents, and we went about extrapolating to all of the providers trying to use statistically-credible methodology.

And we also found in our survey that, most days in the year, there are beds available in each of these facilities.

At Rushford in the 12 months, most recent 12 months that were surveyed, there were 30 days out of

365 days where Rushford had no beds.

Only one of the providers that responded kept a waiting list, and what we found was that there are admissions to each of these facilities every day. Rushford has admissions every day. We have beds today.

We found, through our survey and through our extrapolation, that when we added in the 105 beds, if the application was approved, that would dilute the current system and provide for about a 36 percent excess of capacity, based on the existing service delivery system.

We also refute the data that attempts to establish the need for 105 beds. We do not agree with the assertion, that there has been an increase in demand and a decrease in beds over the last four years, and we have gone through data, both from the Department of Mental Health and Addiction Services, as well as the report, the OHCA report, and have not found anything in those documents, in those data, that would support the need for 105 beds at this time.

I'd like to just take a moment to speak about the OHCA statewide facilities' report, because I served on the Behavioral Subcommittee for a period of about 18 months, and that report establishes, I think is

the best document we have in Connecticut right now that establishes what the service delivery system looks like today, or at least in 2012, when the report was done.

It does not make -- it does not identify need for any particular new services or additional services, and our subcommittee spent some amount of time discussing that fact, that we could not, based on the data that we had at our disposal, make any kind of prediction about what the bed need would be in the future, or even at the time that we wrote the report.

The Department of Mental Health and Addiction Services, DMHAS, was very involved with OHCA in producing the behavioral health chapter of that report, and they did not, at that time, take a position on the need for additional beds, and, so, there's nothing in that report that speaks to that.

I'd like to move onto our second concern, which is the impact on the existing providers. I guess it's unusual for providers to really come out and say that there isn't a need for another facility.

We are a system of, a group of providers that are involved in helping people in recovery, as Mr. Schorr said, and, so, it took a lot of soul searching for myself and I think the other members of our Intervenor

group to decide that we were going to come out and oppose this particular application, and it's because of the impact that we really believe this will have on not only the providers, but the clients that we serve.

So we outline, in some detail in our petition, what our concerns are based on, and I would just state, I would just summarize that part of our petition by saying that we have a very -- we have a system that is really precarious at this time financially and in terms of the viability to sustain the wonderful services we have in Connecticut today for people that are seeking recovery from addiction.

And, so, the existing providers, including Rushford, depend on a payer mix that is a struggle to attain and to maintain, and we believe that the entry of the Retreat with 105 beds that are exclusively for people, who have private insurance, is going to have a destabilizing effect on all of the providers, certainly our group of five providers at Rushford, in particular.

Even a five percent swing in payer mix is going to have a devastating effect on our ability to continue to provide the quality of care that we really have to provide and that the community is expecting us to provide.

There's no way that private non-profits, Rushford, can compete with the Retreat, in terms of marketing, for the private pay commercial part of the community.

The Retreat has already been out marketing in Connecticut and asserting that they're going to be open by the end of the month. There's just no way that Rushford can come up with the resources to compete, in terms of marketing.

As far as the impact on the delivery system as a whole, the delivery system is the providers, the existing providers, the ones that have been established for all these years and have really worked hard to keep the doors open for the entire community, for all segments of the community. They're not for any one particular segment.

The development of new and expanded services, we believe, need to be based on local need and the community's desire to have those services. And, yes, residential services do tend to draw from a statewide, you know, have a statewide reach, but they're based in a community, and the continuum of care is community-based.

When people move from residential to an ambulatory level of care and then go into a recovery

house while they're in outpatient treatment, they're living in the community. They're living in a new community often, and, so, that community has to support any facility. It has to support any additional services that the facility thinks is needed. That has to be supported by the community, and, so, community connections are really important.

And it's also important that the Department of Mental Health and Addiction Services supports these additional beds when they're deemed to be necessary, and, so, our position is that, to the extent that there is any need for additional beds, they should be incremental, they should be community-based, they should be based on support from the community that the facility is located in.

And we don't believe that the Applicant has shown that they can really -- I don't think they're persuasive that they represent that kind of development of services.

I think that one of the reasons that we believe that is because there really hasn't been a demonstration that the Applicant's facility in New Haven is going to be integrated into a wider health care delivery system.

There isn't a sign of collaboration with other providers, both within the addiction field, but, more importantly, within the wider health care system and the human service system.

All the different organizations that Rushford and the other organizations that I represent today are involved with every single day, and there isn't support necessarily from the community, even though they're going to be drawing from a wide -- from Connecticut.

As facilities, we still need to have support from local hospitals and all these various components of the community, and we don't see that, signs of that in the application.

And, so, for all these reasons, we are asking OHCA to deny the application. Thank you.

HEARING OFFICER HORN: Thank you. Anything further from Rushford?

MS. JOAN FELDMAN: We do have Cross.

HEARING OFFICER HORN: Yes.

MS. FELDMAN: Okay.

HEARING OFFICER HORN: Please proceed.

MS. FELDMAN: Thank you. My name is Joan Feldman, and I'm an attorney with Shipman & Goodwin, and

I represent Rushford Center, Inc. I have a couple of questions for Mr. Schorr. Mr. Schorr, in your testimony this morning, you mentioned that you have spoken with people at the State that said that there was a need for your facility. Can you tell us who you spoke with?

MR. SCHORR: No.

MS. FELDMAN: Why is that?

MR. SCHORR: I don't know the name. It was two years ago when I started this. I just don't remember that person's name, but, again, this report is public, and it was published. It's from almost a year and a half ago, and it just demonstrates, and listening to testimony, demonstrates exactly why we're here, because all the hospitals said there's a need, including Rushford, that there's a need for more beds in the State.

You want me to give a name is going to justify your question. It's not, but this report does.

MS. FELDMAN: As you know, there are many State agencies in Connecticut, and could you at least narrow it down for us? I don't know whether you spoke with someone at a toll booth.

MR. SCHORR: Department of Health.

MS. FELDMAN: The Department of Health?

MR. SCHORR: Right. When we first started

this process, we were involved, before we even discussed what OHCA -- the whole process, how it worked, and before we went forward, we wanted to know, you know, would this application be, you know, accepted freely, or there would be opposition, and speaking with OHCA representatives told us the process and how it went, and we were told then that there was a need for beds.

MS. FELDMAN: Okay, so, did you know that the agency that oversees substance use programs and behavioral health programs in Connecticut is not the Department of Public Health?

MR. SCHORR: I did not know that at the time, no.

MS. FELDMAN: Okay. You just mentioned the report the second this morning, and I'm assuming, again, you're reporting to the -- you're referring to the OHCA report that you referred to earlier in your testimony?

MR. SCHORR: I am.

MS. FELDMAN: Okay and you said earlier this morning that, in the report, there's a statement that there's a need for more substance use beds, is that correct?

MR. SCHORR: Yes. There's quote on page

168 saying that from several hospitals.

MS. FELDMAN: Do you have the report with you?

MR. SCHORR: I do.

MS. FELDMAN: Okay.

MR. SCHORR: It's this report.

MS. FELDMAN: Yeah. Okay.

MR. SCHORR: Page 168 says that, specifically.

MS. FELDMAN: Says that there's a need for more substance use beds?

MR. SCHORR: Yes. Specifically, page 168. Do you want me to show it to you? It says it, specifically.

MS. FELDMAN: Yes, please.

MR. SCHORR: Okay. I can read it. It says, "Limited access capacity for inpatient adults or residential adolescent services. Most hospitals represented in the focus groups noted the shortage of inpatient beds for both adults and children needing psychiatric or substance use treatment services," I quote.

MS. FELDMAN: Okay. Was that reference to behavioral health services or substance use services?

MR. SCHORR: I'm sorry. Say that again?

MS. FELDMAN: Was that reference to inpatient behavioral health services or need for detox and rehab beds?

MR. SCHORR: For both it says. I mean it says for inpatient substance abuse services, treatment.

MS. FELDMAN: Okay. Are you familiar with DMHAS's 2010 report, where the Commissioner, Commissioner Rehmer, states that DMHAS has not made that determination, and they will study that issue and report back to the legislators?

MR. SCHORR: No, that's 2010. This supersedes it. It's 2012.

MS. FELDMAN: Correct.

MR. SCHORR: So I don't even understand.

MS. FELDMAN: And that report is prepared by what agency?

MR. SCHORR: Which one, this one?

MS. FELDMAN: The one you're referring to.

MR. SCHORR: This is prepared by Department of Health, Public Health.

MS. FELDMAN: Okay and the agency that has oversight for substance use and behavioral health problems in the state is what agency?

MR. SCHORR: It's all under the Department of Public Health.

MS. FELDMAN: I believe that --

MR. SCHORR: It's all under the Department of Health.

MS. FELDMAN: The agency that is responsible for oversight of programs in this state for individuals with behavioral health and substance use problems is what agency? You're saying the Department of Public Health?

MR. SCHORR: The Department of Public Health oversees that.

MS. FELDMAN: Okay, that's fine. We don't have the full report with us. Okay. Mr. Schorr, in your pre-filed testimony that you submitted to the Office of Health Care Access I believe on Friday afternoon, on page three of your pre-filed testimony, in the third paragraph you state that State budget cuts force the Connecticut Valley Hospital in Middletown to eliminate 20 detoxification beds, and, as I read that testimony that you provided on Friday and, also, on page I believe it was 25 of your application, you're implying that there's a reduction in beds for the treatment of individuals with co-occurring disorders, or substance use disorders.

Isn't it true that those beds were not eliminated by the Department of Mental Health and Addiction Services, that, in fact, they were converted to beds for individuals with co-occurring disorders? Mr. Schorr?

MR. SCHORR: Yeah. The reality is that there's fewer beds than there were before.

MS. FELDMAN: Well you said that, but I'm asking you --

MR. SCHORR: The reality is that they took away beds, and there's fewer beds than there were before. You keep mentioning co-occurring disorders. When you're dealing with substance abuse, most patients do have co-occurring disorders.

MS. FELDMAN: Correct.

MR. SCHORR: And that's something that we specialize in. We're dealing with that.

MS. FELDMAN: Okay.

MR. SCHORR: I don't want you to mix up psychiatric and co-occurring, because they're totally separate.

MS. FELDMAN: I understand that.

MR. SCHORR: We specialize in treating patients not only for addiction, but for their co-

occurring disorders, also.

MS. FELDMAN: So, in terms of making a statement, that 20 beds were eliminated by the State, because of budget cuts, when those beds, in fact, were converted to beds for the treatment of individuals with co-occurring disorders, including substance use disorders, in fact, there is not an elimination of 20 beds.

MR. SCHORR: I'm going to refer back to, again, to page 168, where they specifically say that participants, including Rushford, have stated that there is an overall decline in State-operated beds for adults.

MS. FELDMAN: Okay, so, this is not -- I'm referring to the citation that you are using as a basis for your conclusion that the State has taken the position that there's a need for additional beds, where we find no evidence of that fact.

This statement is not a definitive statement. As I read it, it was a group of hospitals that were represented in focus groups, and it included both psychiatric hospitals and hospitals that provided services to individuals with substance use.

It did not include all the community providers in that focus group.

Okay. Mr. Schorr, I have one last question for you. Also in your pre-filed testimony on Friday, you stated on page two, quote, "To differentiate us from other facilities, we provide custom-tailored, highly-individualized treatment plans, which treat our patients holistically, treating not only addictions, but co-occurring disorders," what we were just referring to.

And isn't it also true that the Commonwealth of Pennsylvania, Department of Public Health, has surveyed your facility in Lancaster, Pennsylvania in 2011, 2012, and, most recently, in April of 2003(sic), and cited you for failure to have individualized treatment plans in more than 50 percent of the records that they reviewed?

MR. SCHORR: I don't believe that to be true at all.

MS. FELDMAN: Okay, well, I have the report here.

MR. SCHORR: I don't believe it to be true, that it's 50 percent. That's not true at all, and you know that's not true.

MS. FELDMAN: Fifty percent of the records that they reviewed.

MR. SCHORR: We get a full licensure every

year. We're considered one of the best facilities in the State of Pennsylvania, and we put our record up against any other facility.

Look at every facility's survey done by the State, and you'll see that we're one of the best.

MS. FELDMAN: I absolutely agree that it's not, Mr. Schorr, that many facilities have citations, but I think I'm referring to the fact that you're, in your statement, differentiating yourself from all other facilities by stating that you provide individualized, highly individualized treatment plans, when, in fact, those were the basis of the citations in these surveys.

I have no further questions.

MR. SCHORR: I just want to say that's not what it says, and she's reading it to something that's not there. We do do individualized planning, which has nothing to do with co-occurring disorders, what she's saying. She's taking something totally out of context, but I'm going to have my Medical Director.

MS. FELDMAN: I'm happy to provide the surveys, if OHCA would like copies.

HEARING OFFICER HORN: I don't think we're looking for them at this point.

MS. FELDMAN: Okay.

HEARING OFFICER HORN: Thank you.

DR. KLOTZ: May I answer to the same question, as some of it falls within my bailiwick?

HEARING OFFICER HORN: We're going to look to your representative. Yes, you have some time for Redirect.

MR. SCHORR: We don't need to answer that. It's taken totally out of context.

DR. KLOTZ: We do just want to offer the following, and I do not want to use persons' names, as they're employees of people who are here, and I don't think it's socially responsible to out someone, but, as of this morning, again, a second follow-up set of calls to Rushford has no beds for 96 hours.

Now when we hear testimony that people are admitted, I'm sure they are. There are waiting lists, but the person, who is about to go into acute withdrawal with delirium tremens, or at risk of a heart attack, seizure and death, needs immediate admission, not to go home and figure it out on their own.

We have survey dates from November 2012, December 2012, and multiple months across this. Stonington still is not answering their phones at all.

MS. JENNIFER FUSCO: Excuse me. I'm going

to object to this. I mean I think Attorney Feldman was Cross-Examining, a question was asked, the question was answered, and now testimony is being given again, not in relation to Rushford.

DR. KLOTZ: Okay, we apologize.

HEARING OFFICER HORN: We do have an order here.

DR. KLOTZ: I apologize.

HEARING OFFICER HORN: We've had Cross-Exam. Is there any Redirect? Okay, then, I'm assuming there's no Recross. We'll move onto the next Intervenor, which is Stonington Behavioral Health, Doing Business As Stonington Institute, and ask them to give a brief statement and then proceed to Cross-Examine the Applicant.

MS. FUSCO: Hearing Officer Horn, my name is Jennifer Fusco. I'm actually counsel for Stonington Institute, Yale-New Haven Hospital, the Cornell Scott Hill Health Center and APT Foundation.

We thought it would easier, if this works for you, if we have each of the four give a presentation, and then I just have a few Cross-Examination questions, or I'm happy to ask them whenever you think, but they're not specific to any Intervenor. They're general

questions, so I didn't know if waiting until the end of the presentations made more sense. Whatever works.

HEARING OFFICER HORN: That sounds fine.

MS. FUSCO: Okay.

HEARING OFFICER HORN: And, again, I would encourage you, we do have your pre-filed testimony, if there are highlights of that, but we don't need you to go through it in great detail.

MS. FUSCO: Absolutely.

HEARING OFFICER HORN: Thank you.

MS. GEORGANNA KOPPERMANN: Good morning, Hearing Officer Horn and members of OHCA staff. My name is Georganna Koppermann, and I'm the Director of Business Development and Military Affairs at Stonington Institute, a residential substance abuse facility located in North Stonington, Connecticut. I hereby adopt my pre-filed testimony.

Thank you for this opportunity to speak in opposition of the CON application for the establishment of the Retreat in Southern Connecticut, a 105-bed substance abuse facility for commercially-insured and self-pay patients only, to be located in Downtown New Haven.

The facility will not accept any

governmental-insured patients, including Medicare and Medicaid recipients. As my testimony demonstrates, there's no clear public need for the facility proposed by Retreat, and, if allowed to open, it will have a significant adverse impact on existing providers, such as Stonington.

The Retreat facility will offer services, including a level 3.7 residential detox and evaluation, intensive treatment residential rehab, PHP, IOP, and other outpatient services.

Stonington provides all of these services and, despite Retreat's assertations to the contrary, assertions to the contrary, has ample capacity to meet the needs of the commercially-insured and self-pay patients, who are the target of the Retreat's proposal.

Our residential detox and evaluation services are provided in a 16-bed unit on the North Stonington campus. They are available to men and women, to commercially-insured and self-pay patients and to Medicaid patients.

Stonington is recently going through the approval process to provide services to Medicare patients, as well, and plans to begin treating Medicare patients as soon as we receive our provider number from

CMS.

While our detox service operates close to capacity, the short length of stay, three to five days on average, mean that multiple patients are discharged each day.

This results in same-day availability almost every day, therefore, Retreat's claim, that Stonington is at capacity and has no beds available for detox patients, is incorrect.

Our rehabilitation service, which caters to active duty military service members and veterans, consists of 38-bed unit, which operates around 60 percent capacity, with approximately 22 beds filled at any given time.

We also have a PHP, IOP program right out of our Groton offices, which can accommodate 190 individuals and operates around 90 percent capacity.

Stonington's programs are available to patients with co-occurring substance abuse and mental health disorders. Stonington also has a four-bed inpatient psych unit available on its main campus to treat the acute needs of patients.

Retreat bases the supposed need for its 105-bed facility on several factors. First, they focus

on the fact that there is a high incidence of substance abuse in Connecticut and a significant percentage of patients, who do not seek treatment.

As I mentioned in my testimony, there are many reasons why patients with substance abuse disorders do not seek treatment that have nothing to do with the lack of capacity in our system.

These include financial considerations and refusal to acknowledge the need of treatment. Retreat also bases its claim of need on its survey of existing providers.

They consider only those providers, who offer level 3.7 detox services, and conclude that there's no capacity available at those providers.

As I mentioned, the survey was wrong about Stonington's capacity, and I suspect it is wrong about the capacity of other providers, as well.

In addition, the survey does not consider available capacity for rehab or outpatient services, both which are part of their proposal.

Retreat also offers no basis for its selection of 105 beds, other than the fact that this is the optimum number of beds for the Retreat modality.

There is no evidence to support this

claim, and Retreat's projections certainly do not support this number of beds. In fact, as laid out in my testimony, the projected detox visits support 13 beds, at most. This leaves 90-plus beds for residential rehab and the same number of patients presumed to use those beds.

I can tell you, based on research conducted by Stonington around our rehabilitation services, there is a very small market for rehab beds for commercially-insured patients in Connecticut.

Commercial insurers are far more likely to authorize partial hospitalization as a step down to detox, therefore, the assumption, that 100 percent of the Retreat's detox patients will transition to rehab, is completely unfounded.

None of the foregoing supports a 105-bed facility, which would be one of the largest substance abuse facilities in the State, and there is no indication that Retreat would be able to meet its projections.

When asked for its referral sources, Retreat provided letters from a few clinicians in Fairfield County and several employee assistance programs.

By their own admission, clinicians make up only a small percentage of referrals for residential

services, and there is no indication that payers will support referrals to Retreat's programs.

In addition, Retreat claims that it will share a referral network with its sister facility in Lancaster, Pennsylvania, but with only 12 clients from Connecticut admitted to the Pennsylvania facility last year, it is unclear how this referral network will be able to populate 75 percent of the Retreat at the South Connecticut facility with Connecticut residents, as Retreat claims.

Because Retreat has not shown a clear public need for the proposed facility, they will need to attract patients from existing providers, like Stonington, in order to fill their beds and programs.

Retreat has made it clear that they will not accept Medicare or Medicaid patients as a mean of gaining an advantage over its competitors.

This means that the patients siphoned from other facilities will be those, who generate the highest revenues, the commercially-insured and the self-paid patients.

Given our heavily-weighted governmentally-insured charity care patient population, 73 percent, we require 95 percent capacity to break even. In a business

with a small operating margin, the loss of commercial self-pay revenue will have a significant adverse impact on our bottom line.

Retreat cannot show any reason why a facility that does nothing to advance access for Medicaid recipients and, in fact, causes financial harm to those who care for these individuals, should be approved.

Approval of such a proposal would be contrary to recent changes in the CON statutory decision criteria, which takes effect this fall, aimed at improving Medicaid access.

In conclusion, Retreat's proposal is flawed at many levels, in terms of the factors that OHCA must consider in evaluating a CON proposal. Retreat has failed to establish a clear public need for a 105-bed residential facility for substance abuse.

They have failed to propose at this proposal -- they have failed to show that this proposal will not result in any unnecessary duplication of services, and that it will improve, rather than impair, the quality, accessibility and cost-effectiveness of health care in our State.

In fact, the proposal will serve to weaken the health care system by adversely effecting existing

providers by Stonington, who care for all patients, regardless of payer source and the impact on our bottom lines.

For these reasons, I urge you to deny Retreat's CON request. Thank you.

HEARING OFFICER HORN: Thank you.

MS. FUSCO: That concludes Stonington's presentation.

HEARING OFFICER HORN: That was Stonington, APT?

MS. FUSCO: That was just Stonington.

HEARING OFFICER HORN: Okay.

MS. FUSCO: We have a witness for each Intervenor. I don't know if you have a preference of order. Dr. Sledge is up here, and he's with Yale-New Haven Hospital.

HEARING OFFICER HORN: I was planning to go APT next.

MS. FUSCO: That's fine.

HEARING OFFICER HORN: And, again, if you would please adopt your pre-filed testimony?

MR. ROBERT FREEMAN: Good morning, Hearing Officer Horn and members of the OHCA committee.

HEARING OFFICER HORN: Good morning.

MR. FREEMAN: I'm Bob Freeman. I'm the Director of Clinical Operations for the APT Foundation, based in New Haven, and I'm requesting to adopt my pre-filed testimony.

The APT Foundation was founded in 1970, based in New Haven. We were, you know, a group of people that were concerned about substance abuse treatment needs of the people that live in the City of New Haven.

Today, we serve not only the City of New Haven, but New Haven County. We go as far east as New London. We have patients that come from Fairfield, and we serve up to Hartford.

We do that, because we really specialize in access to care and making sure that people are able to receive treatment on demand.

We maintain two sites in New Haven. We have one, a new site in North Haven. We also have a residential facility in Bridgeport.

Our services, in addition to the residential program, we will offer IOP-level services. We also offer outpatient services. We have Methadone maintenance, and we have Suboxone. In total, we serve about 4,000 people at any given time in the community.

We work as a Behavioral Health Center. We

have primary care physicians. We have psychiatrists. We have Advanced Practice Registered Nurses, licensed clinicians, all available on demand at our intake unit to see every person that walks into the facility for a comprehensive treatment plan.

We believe that these services are really critical to, you know, the well-being and developing a comprehensive treatment plan for the persons that we serve.

So the APT Foundation does not maintain a waiting list. I'm happy to report today, when I checked with our residential facility in Bridgeport, that we did have 12 beds available.

We accept commercial insurance, we accept private pay insurance, we accept self-pay, with a sliding fee scale that goes down to zero, and, during the last fiscal year, we provided 1.8 million dollars' worth of free care for individuals that live in the communities that don't have health care insurance, and we work on helping those people get health insurance.

So the APT Foundation is in opposition to Retreat's request to open their facility in New Haven. There really isn't a clear public need to this proposal to go into New Haven and into Connecticut.

Again, the APT Foundation does have 125 residential rehab beds. We have our outpatient services. We have our intensive outpatient services. There may be a need for beds, but, again, with the Medicaid population, there may be problems with getting those persons served.

The facility is not really tailored to serve the people of the New Haven community. As an example, 80 percent of the people that live within the City of New Haven are on governmental payers or uninsured.

Within the neighborhood, the Dwight and West River neighborhoods in New Haven, that number is 90 percent, and those are the people that we're currently serving that we are providing free care to, that we are helping get the health insurance, you know, that those persons need to be successful in their recovery.

It's really important that the APT Foundation is able to maintain that financial equilibrium, as has been referenced in several other testimonies, that we need to maintain our payer mix.

If we see, you know, a drop in commercially-insured persons, which tend to pay better, we will have less money available to the community to

provide free care for the persons in the City of New Haven.

So, in conclusion, there really is no clear public need for the additional substance abuse treatment beds. To the extent that the additional beds are needed, they should be added at facilities that are providing to the Medicaid recipients and uninsured persons.

Any additional beds should be focused on the needs of Connecticut residents, and New Haven should meet the needs of New Haven residents, most of whom have governmental insurance or are uninsured.

For these reasons, we urge OHCA to deny the Retreat's request for a Certificate of Need request. Thank you.

(Off the record)

HEARING OFFICER HORN: Next on my list would be Yale-New Haven, Yale-New Haven Hospital.

MS. FUSCO: Dr. Sledge is here to give the presentation for Yale-New Haven.

DR. WILLIAM SLEDGE: Good morning, Hearing Officer Horn --

HEARING OFFICER HORN: Good morning.

DR. SLEDGE: -- Commissioner Martone,

staff members of OHCA, others present. My name is William Sledge. I'm the Medical Director of the Yale-New Haven Psychiatric Hospital. I'm also the George D. and Esther S. Gross Professor of Psychiatry at Yale University, and I have been involved in Yale-New Hospital services for 17 years in the psychiatric side of things, and I've watched it grow or been a part of its growth over that time.

I want to make three main points, but some side points, as well. I also should say that part of my academic work is I'm a health care systems investigator. I study cost effectiveness of health care systems, and I look for ways to improve the quality of care and to make it more cost effective.

And, over time, I've been interested in alternatives to hospitalization, and that has been one of the areas that I've developed some important findings about.

This proposal has three major problems for us, in terms of our system of care. The first has been obvious, which is it excludes the great majority of patients, who need the care that they are proposing to offer.

The number of low insured and uninsured

patients in our system is about 65 percent, and we do not turn away anybody for any reason. We take all comers, and we provide them with the same level of care as everyone.

And, so, this system, which proposes to take those, who have the resources to pay for the services that they are proposing, will not so much hurt us as they will hurt the people that we depend on, which are the private non-profits in the New Haven area.

It's been pointed out very articulately, I think, by the previous speaker the margin that the private non-profits work under is dependent on a certain number of revenue from people, who have commercial insurance, and that may be 10 percent or so of their business, and it's not necessarily the major majority of it, but the margin provided by that is critical to their health and prosperity and which is critical to ours.

Connecticut is going through a transition in its insurance and its reimbursement. We are looking at exciting times, where more people will be insured, but the way they will be insured is clear that it will be at a lower level than what we've had before.

That is the only way to really make the Accountable Care Act make sense and work, and, so,

everyone has to function at a higher level of efficiency, everyone has to do more, and there cannot be this segmentation of population by payer capacity. That is going to be a big problem for the whole system, and it certainly will be a problem for substance abuse services in our region, in our area.

The second point I want to make is the impact on us. We're running at capacity, in terms of our inpatient services. I just got a telephone call from the emergency room about the number of people waiting to be admitted to the hospital, and we go through this almost every day.

We run at over 100 percent capacity, in terms of our mental health services. We have a dual diagnosis unit, and it is fair to say that 80 percent of our patients admitted to the hospital have a co-occurring substance abuse problem, and I'm not quite sure where the co-occurring dual diagnosis confusion comes from.

Co-occurring means co-occurring, to have them together, mental illness and substance abuse problems. We treat those. We do not treat primary substance abusing patients, but we are very familiar with the complications of substance abuse of all sorts, and we treat that as we treat these other conditions.

The removal from us of the ability to refer people to rehab by the failure of any of the private non-profits, who operate on a shoestring, would be very difficult. Length of stay is an important issue for us to manage. That is the only way we can really accommodate the demand.

So we also are concerned about the new patients, who you might bring into our system, that are not people, who are native to the Greater New Haven area and the demand on that. That's hard to estimate what that would be from this particular proposal.

The third point I'd like to make is there's been no collaboration, whatsoever. There's been no reaching out to us, no attempt to coordinate with us, no attempt to figure out these things in a collaborative way.

This is in quite contrast to everyone else, who comes into New Haven with a new system or a new program. Recently, MCCA came to New Haven with a proposal for opening up an increased substance abuse detox and rehab, and they sat down with us, talked to us, we worked it out, it was all very easy and comfortable. We were happy with that, and that's just an example of the difference.

So I'd urge that this proposal be rejected by your group, and I would also say that I would like to comment about Ms. Harasym's account, which I found very touching and I thought was very moving, and I would say we should have that as a standard for everyone, not just people, who can pay, not just people with commercial insurance.

That should be the experience that we want for all the citizens of Connecticut, and that's the way this would be in the public good, if we were taking that perspective. Everyone in Connecticut should have that access, not just people, who can pay.

I don't think this is a good idea. I urge you to reject it. Thank you.

HEARING OFFICER HORN: Thank you.

MS. FUSCO: That concludes Yale-New Haven's presentation. I think we have Cornell Scott Hill Health Center next.

DR. DOUGLAS BRUCE: Good morning. Good morning, Officer.

HEARING OFFICER HORN: Good morning.

DR. BRUCE: Officer Horn.

HEARING OFFICER HORN: Hearing Officer, yes. That's fine.

DR. BRUCE: Hearing Officer. Sorry. All these terms are very confusing to me. Thank you for the opportunity to speak this morning on behalf of the Cornell Scott Hill Health Center.

My name is Douglas Bruce. I'm the Medical Director of South Central Rehabilitation Center at the Cornell Scott Hill Health Center, and I adopt my pre-filed testimony.

HEARING OFFICER HORN: Very good. Thank you.

DR. BRUCE: So because much is said in the pre-filed testimony and much has already been commented on this morning, I will limit my comments to three areas, and first is concerning the Retreat's proposal, second concerning the lack of a clear public need for the Retreat's proposal, and, thirdly, the adverse impact on the Cornell Scott Hill Health Center.

The Cornell Scott Hill Health Center is a federally-qualified health care center in New Haven, providing primary health care, psychiatric services, and addiction treatment to the large urban population of New Haven, in the Greater New Haven area, that suffers with these issues.

The South Central Behavioral

Rehabilitation Center is a 29-bed detoxification center. I would like to respectfully disagree with the census reports this morning.

Yesterday, DMHAS reported that we did have open beds, and, this morning, we had seven open beds, two people in triage, and we're holding one bed in reserve, which we often do, for Yale-New Haven Hospital, should there be a transferred need.

We work very diligently to prevent patients from being discharged from the unit for any reason, except unless they actually need a hospitalized level of care.

As a medical physician, my other job, as Dr. Sledge, I'm on the faculty of Yale University and work with people with infectious diseases, and, so, we've worked very hard to take care of patients with end-stage liver disease and cirrhosis, pancreatitis and other medical issues in the detoxification center to prevent an ongoing movement of people to the hospital, because, again, the hospital is operating at capacity and don't need any additional burdens at this time.

So that's a little bit about what we're doing. I'm not here to contest the Retreat's ability to provide a boutique service for a certain niche of the

population or its ability to provide quality services, but I do have concerns regarding the claim that there's only 17 percent of people with an addictive disorder in the state, who are getting services, and my concern is that that is a misunderstanding of need and want.

There are many people that need addiction treatment, but not as many people that necessarily want it. And we did hear this morning, and I agree with Dr. Sledge, a very moving testimony of one person's journey in recovery, and one thing that we heard in that journey was that there wasn't, at the moment of understanding, a drug and alcohol problem, an immediate understanding of a desire to get into treatment.

And, so, I think we have to be very careful when we say that there are hundreds of thousands of people in the State of Connecticut with a problem. That does not mean that there are hundreds of thousands of people in the State of Connecticut knocking on the door for detoxification services.

And the very town in which the Retreat proposes to open services, again, there are seven beds available today.

I think it's somewhat like a cancer diagnosis. People, who are diagnosed with cancer,

immediately want treatment. Patients with an addictive disorder aren't necessarily immediately seeking treatment. And one of the things that we need to do, and I know that Dr. Sledge is doing at the hospital, is working with people to try and help them understand a need for treatment, and then referring them to appropriate services.

Regarding the clear public need or lack thereof, I've already commented on the fact that there are beds available. We don't have a waiting list. People come, first come, first served. Our facility is open 24 hours a day, seven days a week, and we've been providing services for over two decades.

As has already been mentioned, one of the concerns that we have as an organization is the adverse impact that the Retreat's proposal would have upon our bottom line.

We do take care of everyone that walks in the door; people, as already mentioned, who have alcohol withdrawal or benzodiazepine withdrawal, those ones in withdrawal that are life threatening.

When people walk in the front door and they need assistance, we provide that assistance. Whether they have private insurance, whether they don't

have insurance, or they're Medicaid recipients, we're going to treat all individuals, but, as has been mentioned by others, we operate on a very, very small margin.

The commercial insurance does pay at a higher rate than Medicaid. We're providing free care to individuals. If we are to lose that commercial margin, it will put us into the red, and that will compromise our ability to continue to provide services to the largely Medicaid population in our community, as well as to people, who are undocumented or do not have an ability to have insurance or afford care.

I would like to respectfully disagree with Dr. Klotz. He said that public need is not a number. I think public need is a number.

The Retreat sounds like it's done a fantastic job in Pennsylvania and in several years has seen over 2,500 people. We see over 2,000 people a year in New Haven and providing services to people in the Greater New Haven area, and I think that we see that we are providing a service, and we're providing that service adequately.

And as we see, from the fact that there are open beds available yesterday, as DMHAS has reported

today, as well, that we're actually meeting the demand. The issue is not a lack of access to beds. The issue is about a large group of people, who may have addictive disorders, that are not actually treatment seeking, and that's not something that more beds will fix at all.

If the Retreat's proposal were approved and they were to pull the commercial payers out of the New Haven mix, that would adversely impact our ability to provide services.

So, lastly, just a comment about coordination of care and the importance of dual diagnoses. As Dr. Sledge mentioned, they're providing care to people with dual diagnoses, and we are, as well.

Dual diagnosis is something that we all know in the addiction world is a serious issue, and it's something that requires coordinated services, and the hospital system provides all of the inpatient psychiatric services in the Greater New Haven area, and the Cornell Scott Hill Health Center provides the largest outpatient psychiatric services in the community, and we also have not been in discussion with Retreat about the ongoing need of outpatient psychiatric services, which patients would need once they finish any kind of dual diagnosis program.

So, again, coordination of care is very important. How does that impact the services that we're providing to our community, as well, and the largely Medicaid population that we serve?

Sorry. I'm looking at my unfortunately poor physician handwriting to make sure that I have not missed any important comments.

I would just like to conclude that the Retreat should not misunderstand or misconstrue my presence here or the presence of my colleagues here, which is in any way to claim that clinical services that they might provide are inadequate or inappropriate for our patient population.

My presence here is in regarding the need, which is what this hearing is all about, and we don't think that there is a need, not for what is being claimed, but that their presence would adversely impact our ability to provide critical clinical services to a population that needs those services.

And, so, ironically, although the Retreat would want us to believe that their presence would improve care in the community, we really firmly believe that their presence would actually adversely impact the care of a population that needs those clinical services.

Thank you very much.

HEARING OFFICER HORN: Thank you. That concludes the Intervenor's Direct testimony. I'm going to suggest we take a 10-minute break.

MS. FUSCO: I actually have very few Cross-Examination questions, if you'd like to just do those?

HEARING OFFICER HORN: Okay.

MS. FUSCO: I probably don't have more than 10 minutes.

HEARING OFFICER HORN: Okay, very good.

MS. FUSCO: If we can do that?

HEARING OFFICER HORN: We can do that. Thank you.

MS. FUSCO: Thank you. I have a few questions. Mr. Schorr, my name, again, is Jennifer Fusco. I'm an attorney for some of the Intervenors in this matter.

There's been a lot of discussion back and forth today about the availability of detox beds and the availability of detox beds on a daily basis and, in particular, today, August 14, 2013.

Are you familiar with, or have you ever requested copies of the Department of Mental Health and

Addiction Services daily addiction residential census report?

MR. SCHORR: We did it the old fashioned way. We actually called the facilities, and what was testified --

MS. FUSCO: I want to ask some questions, in particular, about this report. So you're not familiar with this report? You haven't seen --

MR. SCHORR: No. We did it the old fashioned way. We called.

MS. FUSCO: -- copies of this report? You didn't request it of the agency?

MR. SCHORR: No. Like I said, we called.

MS. FUSCO: Okay, but I'm asking. No inquiries were made of the agency that's in charge of tracking availability of these beds?

MR. SCHORR: Again, personnel, who made the phone calls, is here in attendance and can testify about, under oath, making those calls.

MS. FUSCO: Okay, well, I don't have any questions about --

MR. SCHORR: I answered your question. I did not go that way. We did it the old fashioned way, just picking up a phone and asking. We called as an

individual, not as Yale University, not as anyone else. We called as just a person looking for a bed for detox.

MS. FUSCO: I understand. So you've never seen this report. It's a report that's published by the Department of Mental Health and Addiction Services. Would you be surprised to know that that report, the most recent one I've seen was issued yesterday, I haven't seen today's report, but it shows a level 3.7 detox bed availability in this state of six beds, including one bed at Rushford, three at Cornell Scott, six at SCAD, and four at ADRC, so there is, in fact, as of yesterday, and there's probably a similar report today, because the one I attached from last week showed nine, level 3.7 detox bed availability.

MR. SCHORR: I'd be very surprised, because the phone calls we made and the testimony we heard, that there's beds available, is not true, because we just called two minutes ago.

MS. FUSCO: Well --

MR. SCHORR: Again, you're asking me if I spoke to an agency reporting how many beds. Now I told you we picked up the phone and asked if there's any beds available. That's the only way I know. I don't have any other answer.

MS. FUSCO: Sir, I understand. You answered my question. And, certainly, if OHCA would like us to update with the most recent DMHAS daily report, we can certainly do that in a late file with yesterday's report, if you'd like.

HEARING OFFICER HORN: Yes, we would like that in a late file. That will be marked Intervenor 1.

MS. FUSCO: In your presentation from first thing this morning, you made the statement that many people from Connecticut are seeking treatment at your facility in Pennsylvania, because there are no services here, there are no beds available here, is that correct?

MR. SCHORR: No. I'm stating that many people in the State of Connecticut are seeking treatment elsewhere, mine being just one of the facilities. I mentioned Florida, other facilities in --

MS. FUSCO: But you did mention that people from, that many people from Connecticut are using your facility?

MR. SCHORR: No, I did not say that. I'm saying that many people from the State of Connecticut are seeking treatment elsewhere, period.

MS. FUSCO: Okay, because it is true,

based upon your CON filings, that you only treated 12 residents of the State of Connecticut.

MR. SCHORR: Again, I'm not saying they're coming to me alone.

MS. FUSCO: Okay and do you agree, and I believe you said in your CON submissions, that, often times, people, who are going out of state for treatment, are going out of state, because they appreciate the privacy of being treated somewhere, other than their local community or their home state?

MR. SCHORR: Again, I'm not going to testify on why certain individuals go out of state. What I've been told from EAPs, which are an important aspect of our referrals, is that the programming for this specific population is not available in the State of Connecticut.

MS. FUSCO: But you're not answering my question, and I'll phrase --

MR. SCHORR: I can't answer for every individual. There are times, when people do leave the state, because they want to leave the state. I agree with you.

MS. FUSCO: Okay.

HEARING OFFICER HORN: I would ask just

one person to speak at a time, so the record is clear and that the question be answered.

MS. FUSCO: You also mentioned in your testimony this morning you were talking about a report, and I assume it's the copy of the statewide Health Care Facilities and Services and Plan that you've shown. Did you say that that report shows that only 70 percent of people, who need treatment, are getting treatment?

MR. SCHORR: I said 17 percent.

MS. FUSCO: Seventeen percent, okay. Now are those statistics you've cited, or is that document something that you've included in the record of this hearing in your CON submissions or pre-file, or is that something you brought today to quote from?

MR. SCHORR: Again, when we did our initial application, we did it based on SAMHSA. Now this report became available to us since our application, and it really, you know, I hate to use the word a smoking gun, but everybody in this room has participated in it and said there's a need for more beds. There's a need for more services.

What they're not saying is a need for more Medicaid beds. They're not saying more commercial beds. They're saying more beds. They also --

MS. FUSCO: Okay --

MR. SCHORR: May I answer one more thing?

MS. FUSCO: You've answered my question. You had your opportunity to testify.

MR. SCHORR: Okay.

MS. FUSCO: You filed your CON application in this matter around March of 2013, correct?

MR. SCHORR: Correct.

MS. FUSCO: So that means that report, which I believe was published in October of 2012, is that --

MR. SCHORR: That's the date on it, yes.

MS. FUSCO: So that was available to you at the time you filed your CON, but you didn't consult it or use it for filing your CON, is that correct?

MR. SCHORR: I believe it's not our job to tell OHCA what they already know. This is their report.

MS. FUSCO: Understood, but it is your job to establish your case in chief for a need for a facility, but you didn't choose to use the statewide health plan in doing that?

MR. SCHORR: What I'm saying is this is OHCA's report. They know by reading it there is a need for beds, hopefully, and now, when I'm coming to a public

hearing and people are stating that there's not a need for beds, my job is to say, well, just look at the report that you participated in, and it says -- I'm not directing this to OHCA. They have the report. They know this. I'm directing it to the people that are saying we don't need any beds.

MS. FUSCO: Understood.

MR. SCHORR: And all I'm saying is just look at the report. You say we need beds. We believe we needed beds before this report. This is just confirming what we said.

MS. FUSCO: Okay. You've answered my question. Now, along the same lines, you know, you, throughout your CON application and your pre-filed testimony, you cite statistics regarding the number of individuals in Connecticut, who suffer from substance abuse disorders and who don't seek treatment for those disorders. Fair to say you cited that a bunch of times?

MR. SCHORR: I don't know if we gave a percentage, as is in this book, but we reported from SAMHSA data what we believed to be true.

MS. FUSCO: Okay.

MR. SCHORR: And then reported today, just saying that only 17 percent, just from this, not anything

to do with our application. Our application, we did everything from SAMHSA data.

MS. FUSCO: Okay. You haven't produced any evidence in these CON submissions to support a direct link between this failure of residents of the State of Connecticut to seek substance abuse treatment and the lack of bed capacity in the State.

You haven't submitted any kind of evidence that shows a direct link between the failure of Connecticut residents to seek substance abuse treatment and a lack of capacity for beds, meaning that the lack of capacity is driving the failure to seek treatment.

My question is very specific. I don't want you to tell me why you think that's the case. I want to know if you have submitted --

MR. SCHORR: One of the exercises we did, and we've done it five times since we did this application, was to actually call facilities and see what kind of capacity was available, and each time we did that there was a full capacity, there was waiting lists, and that's why we presented what we did.

That's one of how the information we got, and then SAMHSA surveys information that states that Connecticut is under, you know, people are not seeking

treatment, and I think it was testified before about that, so we'll talk about that.

MS. FUSCO: Well, understand. I mean the SAMHSA surveys certainly do say that people are not seeking treatment, but the SAMHSA surveys don't say that people aren't seeking treatment, because there aren't enough beds, do they?

MR. SCHORR: Again, as an intelligent analysis, when we call places and they say they're full and if people are saying people are not seeking treatment, what's going to happen when they all seek treatment?

We had to make an intelligent analysis, and our analysis was --

HEARING OFFICER HORN: Excuse me. I'm going to break in here. She's asking a question on Cross-Examination, and it's a yes or no answer, basically.

MS. FUSCO: You've answered my question. I'm not asking for an alternate answer. Would you acknowledge that there are reasons why people don't seek substance abuse treatment, other than there being no bed available when they need it?

MR. SCHORR: Of course.

MS. FUSCO: Okay and, in fact, if you look at your CON application, page 253, do you have it with you?

MR. SCHORR: I'll get it.

MS. FUSCO: And, on that page, Figure 7.10, there's a chart, and that chart shows, in fact, and this is the section that talks about, you know, people, who need it, but don't make an effort, who make an effort and don't receive it, but this chart shows, and I think it's kind of staggering, that 95.3 percent of the people in this national survey didn't receive treatment, because they didn't feel they needed treatment.

MR. SCHORR: Correct.

MS. FUSCO: Is that consistent with your understanding?

MR. SCHORR: Correct.

MS. FUSCO: People, who aren't seeking, think they don't need it.

MR. SCHORR: Correct.

MS. FUSCO: And if you flip to page 255, Figure 7.11, I believe these are people, who sought out and made an effort to get treatment, but didn't ultimately receive it.

In this case it shows, does it not, that a

large percentage of those didn't receive treatment, because they had no health coverage, or couldn't afford the cost of the care, is that correct?

MR. SCHORR: Correct.

MS. FUSCO: And, then, again, another large percentage not ready to stop using.

MR. SCHORR: Correct.

MS. FUSCO: -- on the job and things like that. And none of that has anything to do with the availability of beds, but, rather, people's circumstances and attitudes, correct?

MR. SCHORR: Correct.

MS. FUSCO: Okay, now, in your pre-filed testimony, and I think this is something you cite in the CON, as well, but it may be easier to reference it in your pre-file, you reference some SAMHSA data that I believe says that there are about 275,000 individuals with substance abuse issues in Connecticut and only 45,000 seek treatment. Does that sound right?

MR. SCHORR: I mean that's a national statistic, where it's actually more. They're saying that 10 percent of the population suffer from addiction.

MS. FUSCO: Okay, understood. Is there anything in your submissions, any evidence that points to

-- so let's say there are 230,000 people in Connecticut, let's use that number, who are not seeking treatment. Anything in your submission that speaks to what percentage or what number of those individuals are commercially insured or could afford the rates?

MR. SCHORR: Well 80 percent of Connecticut has commercial insurance, so just take 80 percent of that number.

MS. FUSCO: Well, I mean, what's your justification for saying that the rate of commercial insurance in the general population is the same in the substance abuse population or in the substance abuse population that's not seeking treatment?

I mean do you have evidence that proves that those numbers are the same, that you can carry that same percentage down?

MR. SCHORR: Well it's national statistics. I mean it's not something that I'm creating out of my head.

MS. FUSCO: But there's nothing specifically in your application that says those, who don't seek substance abuse treatment in Connecticut, are 80 percent commercially insured?

MR. SCHORR: I think it's a

generalization. You're asking me what are the percentages of people that are not seeking treatment have commercial insurance, and I'm saying the State is 80 percent. If you want a discount at 20 percent, it's still a lot.

MS. FUSCO: And would you acknowledge that there's probably a significant percentage of the people of those 230,000, who aren't seeking treatment, who are on governmental insurance, who have Medicaid or who are uninsured and couldn't afford your facility's self-pay rate?

MR. SCHORR: I'm sure there's a large percentage of that.

MS. FUSCO: And those people would be excluded from your facility, because you won't be taking Medicaid, correct?

MR. SCHORR: Well what I'm hearing here is that there are other places for them to go.

MS. FUSCO: I have no other questions. Thanks. Oh, I'm sorry. I might. One last question. Sorry, Mr. Schorr. Back to this daily bed availability issue. I'm sorry. Back to the daily bed availability issue.

You do understand, in terms of conducting

these surveys, that you can call in at any hour of the day, they can say they're full, because a patient hasn't been discharged yet, but that patient might be discharged in an hour or two, that depending upon the exact time of day you call, they could be full, but they could have multiple beds open within hours, and some individuals will keep calling back until the beds are open?

MR. SCHORR: I think I testified earlier you have a small window of opportunity a lot of times for people to go into treatment, and one of the things that you say here, it's part of this chart, about why people don't go into treatment, and people abusing and using certain drugs, they don't have that window of opportunity to wait until you have a bed.

MS. FUSCO: Okay, but we're not talking two to three weeks, or even two to three days. In some instances, it's an hour. You've answered the question. I have no further questions. Thanks.

HEARING OFFICER HORN: Okay. Would the Applicants like to do any Redirect before we take a break?

MR. WILLIAM BECCARO: For the record, Attorney William Beccaro for Retreat at South Connecticut. We'd be happy, given the time, I think in

respect for the Hearing Officer and the staff, it would just probably be better if we take a short break.

I don't expect to be lengthy at all in my Redirect.

HEARING OFFICER HORN: Okay and we can also move right into your Cross-Exam of the Intervenors, if that is a way you'd like to approach it.

MR. BECCARO: Whatever your pleasure is, Madam Hearing Officer.

HEARING OFFICER HORN: Okay. Thank you. We'll take a 10-minute break.

(Off the record)

HEARING OFFICER HORN: Okay. At this point, we are going to go back on the record and ask the Applicant if there is any Redirect Examination they would like to conduct, based on the Cross-Examination by the Intervenors.

MR. BECCARO: Thank you, Hearing Officer Horn. If I may, again, for the record, Attorney William Beccaro for Retreat at South Connecticut.

I have what I hope is blissfully brief Redirect for several of my members here, so if I may proceed? And thank you in advance to the Hearing Officer and the members of OHCA for their time and their efforts

this morning, and I thank all the interested parties for their attendance.

I'm happy to see that we have such a high level of interest in this facility. I think that underscores precisely the need that we are driving at this morning.

If I might start with Mr. Schorr and just ask him to comment and elaborate on we've had some substantial discussion this morning from various parties, regarding concern about a nexus between what I suspect everyone would agree is a large alcohol and drug abuse problem in the State of Connecticut, but, then, where there appears to be some concern is how one draws the line from that to an individual, who is, A, commercially insured, B, willing and able to enter treatment on fairly brief notice, and, most importantly for our Intervenor friends, C, is able to do so in a way that does not do any statistically-significant damage to their present population census.

So I would think an important issue for the Office of Health Care Access and the Department of Public Health is for us to be able to give them an assurance that if and when they give you your Certificate of Need and you open your facility, you do not do so at

the expense of the census of the current providers, so if you could give me a brief elaboration on that?

MR. SCHORR: It is our belief that we will not be going after the same patients as our opponents over here, and one of the things that was pointed out to me earlier is, come October, Obamacare goes into effect, and there's millions of more people that are going to be on insurance rolls.

I don't know the exact number for the State of Connecticut, but I'm sure it's pretty substantial.

Now these people need to go for treatment just as well as anyone else. Now if we're fighting over a small amount of beds and we're going to take all the commercial insurance, we're talking about 105 beds. We're not talking about 1,000 beds here.

I understand the concerns, and that concerns me, too, because, again, I believe that people need treatment, and I believe that all the people in this room provide quality care and something that's needed, but there's going to be a shortage of beds for everybody; Medicaid, commercial, whatever.

Now these people need to be treated. Come October, we're talking, and it's only two months away,

not even, you know, I don't think we're going to be competing for the same bed space, but I do believe that, you know, we are, you know, helpful. We get a lot of referrals that we can't take, commercial insurance included, that we will partner up with these people, that we will work closely with them with our Admissions Department.

Our Admissions Department runs 24 hours a day, seven days a week, and, again, not everyone is appropriate for our facility for whatever reason there is. Someone may have other services that we don't provide, and we want to be, as I say, a good neighbor.

Again, there's a lot of people. We have not really marketed Connecticut. We've put feelers out, you know, that we're coming, what can we expect, and a lot of people are looking forward to having this quality of care, and the patients that they're sending now are not being sent to these facilities, and this is what we're told.

MR. BECCARO: If I may, Madam Hearing Officer, just for the sake of brevity, because I asked the doctor to just elaborate briefly from a medical perspective on the same issue, so I'm just going to bounce from him and then back to Mr. Schorr again for the

sake of some clarity in our testimony, if I could.

HEARING OFFICER HORN: That's fine.

MR. BECCARO: Doctor, the question that I asked previously -- I'm sorry. My apologies. Doctor, the same question I asked previously of Mr. Schorr, regarding the understandable concern on the part of the sister and brother facilities here in the room and, obviously, the regulating agencies, about making sure that there's an orderly continuation of health care to all of Connecticut's citizens.

Can you talk a little bit about -- again, I want to allay fears, that somehow the establishment of this facility does not mean filling its beds at the expense of existing facilities and some details about why it is that OHCA and others can have a comfort level that one does not come at the expense of the other?

DR. KLOTZ: One, historically, the facility, while located in New Haven, serves all of Connecticut and, in fact, may attract patients from surrounding communities outside of Connecticut.

We have reached out and worked highly cooperatively with numerous hospitals to be a referral source for their emergency rooms and have entered into well-planned, well-established reciprocal agreements.

We expect to be able to do this once a C of N has been issued. I think it would be premature for us to approach the medical health care establishment and seek treatment agreements in advance of that.

I also think that, having a lot of experience in the New York Psychiatric Emergency Rooms, that when patients enter or seek to access treatment, there is a moment by which you need to operate.

New York State has a DMHAS-type equivalent that we used all the time. The accuracy is often not very good and it's delayed.

We often found that our medical and social work teams were calling hospitals directly to find out why. We have patients, who find out that their medical issues have reached a critical nature as a consequence of their alcoholism, not necessarily because they've lost their jobs.

Where people arrive at the need for detox and rehabilitation at an inpatient level is varied. It is not always the person there. It may be someone, who is involved in a driving accident. It may be somebody, whose employer refers them. It may be a nephrologist, a cardiologist, an orthopedist, who says you have all of these falls, a neurologist, you've hit your head so many

times.

People access for all reasons from all over the place. Our current numbers continue to demonstrate that there is a need to provide these people. These are not people, who are being accessed elsewhere, but they may come from a wide variety of locations throughout Connecticut.

MR. BECCARO: Thank you. And, finally, on the same subject to our friendly number counter, Mr. Leshkowitz, if you could also, because, again, continuing on the earlier voiced concerns about facilities, which handle all variety of patients and their sort of knife edge financial stability, instability, and their concern that, if any number of their full pay patients were removed from their system, it would lead to some real disastrous consequences to them.

MR. LESHKOWITZ: Yes. Let me comment, again, based on my own very direct experiences, being one of the -- being the Vice Chairman of the Board of the Maimonides Medical Center, which is a private, not-for-profit, as I said before, 720-bed facility in Southern Brooklyn.

We have a one-billion-dollar budget, which pales, I guess, compared to Columbia, Presbyterian, or

NYU, or Cornell, or those systems, but in the borough of Brooklyn, we are a very substantial operator, and because we operate in the borough of Brooklyn, our census is approximately 85 percent Medicaid/Medicare and only about 15 percent private insurance.

And, yet, unlike many, many of our competitors similarly situated, we have been profitable for years, while other operators, other hospitals are in trouble, other hospitals are on the verge of bankruptcy, other hospitals are on the verge of closing, and we have been brought in by the State of New York in several instances to be that white knight to assist in helping reorganize the management of those facilities, because those facilities are important in providing appropriate medical care to their constituencies, their neighborhoods that they draw on.

So what sets us apart? Why are we in Maimonides profitable, yet numerous other hospitals similarly situated are not, and the key answer is management.

We emphasize our management has been refined to a point where our budgets, our cost controls, are measuring every dollar. In a billion dollars, we measure every dollar of cost, and we do it in specific

ways, as well, that sets us apart.

Just several very quick examples. We maximize revenue by effective management. We promote within the community. We participate in graduate medical education, which provides us with a substantial amount of federal dollars.

We're in the forefront of computerizing medical records. It's commonly known Maimonides has been in the forefront for the last number of years in this national effort to avoid the poor handwriting, as one of the Intervenors mentioned, by computerizing the entire process.

We have to be lean and mean, because we have no endowments to fall back on at all, so we're profitable, because we're focused on optimizing the income from all sources and a strong cost control in line with good patient care.

So we're able to navigate a patient base, which is 85 percent public pay, not private pay, and, yet, we've been, historically, we have been successful at this.

The other point I would just like to emphasize here is, with regard to this proposed center, there's no government money here, therefore, there's no

government financial risk. The risk is all private.

The people, who are providing the -- the principals of the company, as I indicated in my Direct testimony, have deep pockets. Besides the seven and a half million dollar credit facility in place available today, we have other reserves that, if necessary, if necessary, I don't believe, based on my financial analysis that it will be necessary beyond the 7.5 million, but if it becomes necessary, the principals are committed to providing it and have the wherewithal to provide it. Thank you.

COURT REPORTER: One moment, please.

MR. BECCARO: Thank you very much, and let me shift to my second and hopefully next to last questions for several of the members.

Back to Mr. Schorr. There has been a large amount of discussion and sort of back and forth regarding facilities and bed availability, and lack of beds, excess beds, so on and so forth.

Could you comment in a little more detail what exactly and specifically you undertook to get to the numbers that you've submitted and you've reemphasized today that make you feel comfortable, that, in fact, there is a very tight availability of beds to an actual

shortage of beds in this state?

MR. SCHORR: I'm going to defer to my Marketing Director, Tom Garifolo, who I instructed. Before he even was involved in making these phone calls, part of our application was that we contacted ourselves and, no offense, but patients do not call DMHAS to ask if there's a bed available. They call facilities directly.

Our exercise was to actually call the facilities several times to make sure if there was bed availability, because I'm calling as a patient. I'm not calling as a hospital. I'm calling just as the average Joe patient, who wants treatment, so we did that part of our application several times, and then we did it yesterday and today, and Tommy will testify under oath, if needed, what he found.

HEARING OFFICER HORN: Yes. This is Redirect. It's based on the Cross-Examination that was done, which was based on the testimony that's already in the record.

MR. BECCARO: Madam Hearing Officer, I'm happy to have Mr. Schorr testify directly, since it is clearly within the scope of the questions that were asked. I will defer to your judgment on this.

If you want Mr. Schorr to testify, as to

what was discovered, that's fine. I thought perhaps it might be more effective for the individual, who actually made the telephone calls, but we'll do it whatever pleasure the Hearing Officer and the panel prefers.

MS. FUSCO: We would object to a new witness testifying. I mean if this witness --

MR. BECCARO: That's fine.

MS. FUSCO: -- had information, he should have been the one answering the questions on Cross-Examination to allow us to sort of explore his knowledge versus him bringing it out on Redirect without --

MR. BECCARO: I have no problem with that. I'm happy to let Mr. Schorr speak to it.

HEARING OFFICER HORN: Okay. Go ahead with Mr. Schorr. Thank you.

MR. SCHORR: Phone call made to Rushford. Spoke to Nicole in Admissions. Maybe a detox bed available Friday or Saturday.

MR. BECCARO: When was that, Mr. Schorr?

MR. SCHORR: This is today. Stonington called. No answer. APT Foundation, they did not offer detox beds. South Central Rehab, per Tanza(phonetic), no detox beds available for females. Maybe tomorrow.

MR. BECCARO: And, also, furthermore, were

similar calls made yesterday?

MR. SCHORR: Exact same calls were made yesterday.

MR. BECCARO: Okay and can you give me some information on those?

MR. SCHORR: Yes. Called Silver Hill, a similar facility. Per Trish, no beds available. If possible, could have a bed open tomorrow or Thursday. This was from yesterday. We called several facilities.

Mountainside, per Jessica in Admissions, they do not have detox rehab. Connecticut Valley Hospital, Merritt Hall, at 3:00 p.m., I was transferred to their Admissions Department. It rang for two straight minutes before I hung up. There was no chance to leave a voice message.

I called back at 4:20. It rang for two straight minutes before I hung up again. No answer. Rushford Detox is full at least until Thursday, per Nicole in the Admissions Department.

Stonington went straight into voicemail. Transit to Admissions, left voicemail at 3:05. The voicemail said they will get back in no longer than one hour.

Jessica called back at 4:00 p.m. Only

have detox and PHP for three to six weeks after that. Rooming is off campus for PHP. Detox currently has a couple of day wait. Called back at 5:45 to clarify some information. The woman told me they do in-house detox and rehab afterwards, but the program is five or six days a week, 9:00 a.m. to 2:00 p.m. a day, just explaining what the program was.

I think the gist of it is that and what I testified earlier was that our small window of opportunity calling these facilities did not pan out.

Someone testified earlier that they have open beds today, which, when we called up, they said they didn't.

It's a concern for us, you know, in this field, because, you know, that's why we have 24/7 admissions, is because we believe we have a small window of opportunity to get people in.

And some of the testimony and some of the surveys say that a lot of people fall through the wayside, because they may try, and they don't get in, they go back to whatever they're doing, and then rehab or whatever it is is forgotten about.

And that's something, you know, we're pretty strong about, that we want people to get in when

they make a decision to go to rehab, whether it's going to us or another facility, and that's part of what our Marketing Department does, also, because, like I said earlier, not everyone goes to us, but we make sure they go somewhere, and that's important, that small window of opportunity.

MR. BECCARO: Thank you. Dr. Klotz, you said you had some involvement in this survey, telephone conversations over the last two days. If you could just speak briefly to that?

DR. KLOTZ: To simply reiterate what Mr. Schorr has presented, I had my medical staff and my medical assistants also call from outside numbers and from home numbers. At each time, both Nicole and Jessica and other unnamed people told us that there was no availability on excess of 96 hours.

Now there may be a network availability, such as someone referred to, that we hold a bed for Yale, but we're looking to treat all the people of Connecticut, not someone, who is fortunate enough to be sent to a tertiary care medical education university medical center.

MR. BECCARO: Thank you. Finally, and I believe this will conclude my Redirect, there was also

some discussion this morning about outreach, both community outreach and, also, outreach to other providers, referral networks, back and forth between various medical facilities, so on and so forth.

I'm going to ask you, Mr. Schorr, and, also, Dr. Klotz, if you could comment briefly on the status of where that's at and efforts you have made to that extent.

MR. SCHORR: Part of the process, before we even applied for a CON, was we went out to -- I must have gone to 15 or 20 community meetings. The first community meeting I went to wasn't even the right community, and when we found what the right community was for this, where we sat, they were very supportive, and a lot of people in this room were at that meeting, including the doctor from Yale, a couple of them.

And what I did was invite a lot of community members down to Pennsylvania to see what we do, to see that, you know, touch the bricks and mortar, as they say, and participate in some groups and see that we make a difference in what we do.

They came back and reported, because I went to a meeting after that, that they were very impressed what we do, and they are in support of our

facility being open in Yale. These are the people, who live in the community.

Again, we're not a facility that's -- and I don't think this is where a need of beds for the State of Connecticut comes in, of a need of beds of New Haven. It's a need of beds for the State of Connecticut, and that's what we're doing.

We have our own --

MR. BECCARO: Mr. Schorr, if I could just interrupt for a minute, and forgive me, I'm sorry, I stepped away, so my apologies to you and the panel if you already answered this, but, in those meetings, did you not also have some interaction with a representative or representatives from Yale directly, not just community folks?

MR. SCHORR: Had direct meeting with them. This is a process we have to go through. We know -- I have experience in opening facilities. I know about transfer agreements, and I know about referral agreements, and I know everything that's important to have when you're opening a facility, but, again, I don't want to put the cart before the horse. I'm going through a CON application before I go through my application with licensing with the State.

I went through enough meetings to get community approval. The hardest thing, and I'm sure everyone here will understand, is for a community to embrace you and say, oh, it's okay to bring that kind of facility in, because, you know, it has a stigma of bringing people, who are using drugs and things like that.

You'll always have some opposition, because they don't understand what we're doing, but, you know, we got a lot of community support, and it was important, but, through all these meetings that we had, there was representatives from a lot of these, and I see some familiar faces here, and had some conversations with people, and it was supportive then.

I don't know what fell through the wayside in the meantime. I think I have an idea, but, you know, I went through meeting, after meeting, after meeting, and discussed what we're doing, what we're trying to accomplish there. No holds barred.

We exposed everything. We told them exactly what we did. We brought them down, showed them what we did, and everyone was pretty accepting of it.

MR. BECCARO: Thank you. And, Dr. Klotz, if you could, without repeating anything that Mr. Schorr

talked about, from a medical perspective and your perspective as the Medical Director, talk also a little bit about not so much the community outreach, but, obviously, the referral agreements, the back and forth between the various medical facilities, etcetera?

DR. KLOTZ: Prior to being the Medical Director at Retreat of Lancaster, I was the Chief Psychiatrist at an alternate substance dependency substance abuse residential treatment facility.

I have a lot of experience in working with the communities for the purposes of making sure that continuity of care is seamless.

We have, at Retreat, the opportunity to have multiple of our doctors discuss the current care that the patient is receiving and make sure that we are up to receiving that patient quickly and efficiently in continuing that, we have the ability for patients, who need an outpatient visit, to attend to those visits and return immediately, within hours, to the care that we're providing.

We have reached out to community hospitals, tertiary care facilities in Pennsylvania and secondary hospitals. We have a unique ability to call people directly and not overwhelm an emergency room, but,

rather, have a brief directed admission to a particular unit, address the problem that exceeds their needs, and have the patient return to us.

MR. BECCARO: And, Doctor, just in one sentence or less, so it would be your -- that's been your experience, and I don't want to put words in your mouth, but would you agree with me, that that would be, then, the plan you would follow at the appropriate time in this particular facility, and you have not yet done so, because that time is not yet ripe. Is that a fair statement?

DR. KLOTZ: The model we have is working wonderfully. We hope to duplicate it here.

MR. BECCARO: Thank you. And, last, and my apologies, and my final question for Mr. Schorr, we also heard some discussion this morning about after-care, community placement, step-downs, so on and so forth. Could you just briefly expound on that and how you do have, in fact, a plan in place?

MR. SCHORR: We are a big believer in continuity of care, and I don't think a 30-day stay in a rehab is curing anybody. I think it's a process that takes several months, at least, and then connect at some programs, AA or NA.

What we do is we do have, just for our patients that come into Retreat at Lancaster, we treat PHP and IOP programs, but what we do have is after-care coordinators that make sure patients going back into their community have the proper after-care set up with them, and one of the Intervenors was mentioning about what services they provide, which is a valuable service.

And since we're going to have commercial insurance patients, we would like to have the ability to send those patients for that kind of treatment, if needed.

As far as recovery houses and things like that, I'm well aware of the community in New Haven, and, again, we're not taking every single patient. We're not here to say, you know, everybody comes for treatment, that's it, and we're the only game in town.

We want to, you know, work closely with these places, especially with -- I mean psychiatric, like it was said before, is a big component of addiction, and we can only take it to a certain level.

We're not dealing with schizophrenic patients. We can take, you know, some co-occurring disorders up to a certain level, and then they need a higher level of care.

And ever after-care, once they go to there, they might need a higher level of care that we can provide. We refer these places in the State of Connecticut for our patients, who would be coming back to or first time, because a lot of people come to us first-time treatment.

So it's something that we're very conscious of, of continuity of care, and that's something that no patient ever leaves our facility without an after-care plan in effect.

MR. BECCARO: Thank you. And, Madam Hearing Officer and representatives of OHCA and other interested members, I thank you. That concludes our presentation. We certainly appreciate your time and attention this morning.

HEARING OFFICER HORN: You had no Cross, then, for the Intervenors?

MR. BECCARO: We do not.

HEARING OFFICER HORN: Thank you. I was approached at the break. There was a member of the public, who has a pressing engagement, and I am asking the folks around the table if you can indulge me for five minutes here and have him present his testimony before he has to leave for another meeting.

MR. BECCARO: We certainly have no objection.

HEARING OFFICER HORN: Okay, thank you.

MR. JOE SULLIVAN: My name is Joe Sullivan. Thank you so much for accommodating me on this, and it is a very pressing meeting I have to be at in Danbury.

My name is Joe Sullivan, and I'm President and CEO of MCCA, a sizeable, not-for-profit substance abuse treatment organization, with a detox and a residential treatment in Danbury and seven outpatient clinics in Western Connecticut, including one in Derby and one in New Haven.

I'm going to make a couple of points that haven't been made yet. We will run the risk of being negatively affected by this Applicant, if it's approved.

MR. BECCARO: Madam Hearing Officer, if I could just interject? I'm happy to hear what this gentleman has to say, but my understanding was he was coming in as a member of the public, and now we're having yet another presenting professional witness, and I would think that perhaps we could be shown the same courtesy that we were extending regarding one of our folks, who did not sign up to testify, so I'm a little troubled by

this at this late hour.

HEARING OFFICER HORN: My understanding was this gentleman was a member of the public, who is making public comment.

MS. FELDMAN: Yes. Yes.

HEARING OFFICER HORN: He's not been granted Intervenor status --

MS. FELDMAN: Correct.

HEARING OFFICER HORN: -- pre-filed.

MS. FELDMAN: Correct. He's making comments about his experience as a member of the public, which we understand to be totally appropriate. He is not a party to this proceeding.

MR. BECCARO: And I would only respond that I welcome his or any other public member's comment, positive or negative, but I heard the beginning of testimony, that this gentleman was speaking, both in his capacity and from his experience, as someone, who has a job and some expertise in the effected industry, and that puts him in a somewhat different category.

MS. FELDMAN: Hearing Officer, I think we're splitting hairs here. We did not object when the Applicant had close to an hour of testimony, when I understand you had allotted them 10 minutes.

Neither of the Intervenors uttered a word about that. This is a member of the public, this is a hearing that is open to the public, and I think it would be inappropriate to have such a chilling effect not to let this member speak.

I don't understand what purpose would be served, in terms of helping OHCA reach an informed decision.

HEARING OFFICER HORN: We're going to allow the testimony and give it whatever weight it is due.

MR. SULLIVAN: Okay, thank you. And I want to make a point, also. I am a Board member of the Connecticut Counselor Certification Board. In fact, it's Treasurer. So I want to speak to a couple of points that have not yet been made.

Through the Certification Board, I am aware that we have in the State of Connecticut a severe workforce shortage, and, so, one of the concerns about establishing a sizable operation in New Haven would be the impact on existing workforce, and it runs the risk of driving up cost by making salary competition quite vigorous, and that could further serve to destabilize the existing non-profits in the area.

Two other quick points. As we sit here, the Office of Health Care Advocate is preparing an application to the Center for Medicare and Medicaid innovation.

The application is for 30 to 45 million dollars that will be submitted next month and, if it's approved, will help Connecticut transition from a fee for service to value-based reimbursement over the next three to five years.

The project will include 80 percent of the covered lives in the State of Connecticut within five years. It will involve Medicare, Medicaid, and commercial insurance.

Clearly, the future will require integration of primary health care and behavioral health care. Most germane to this hearing here it will require health care and behavioral health care services that include all payers, not those that try to target patients covered by selective payers.

The future requires the maintenance of financially-stable programs that serve broad populations covered by multiple payers, public and private alike, and this is the new model under the Affordable Care Act that we're going to see a lot of innovation like this, which

leads me to my final point.

In the recently concluded budget session of the General Assembly, the DMHAS budget, first of all, the Governor's budget proposed severe decreases in State grants to the private non-profits, particularly those that provide detox services and outpatient behavioral health services.

Through a lot of efforts that a number of providers made here, we were able to get a number of those cuts restored, but not fully restored for the current fiscal year that just started July 1.

Those cuts were budgeted fully or actually increased for the next fiscal year, that is FY '15, all of that on the assumption that, under the Affordable Care Act, almost everybody is going to have insurance, so a lot of that will be through the Medicaid expansion, and I understand that the Applicant doesn't desire to serve Medicaid, but some of it will be under the Insurance Exchange.

Our agency has just been approved for funding these sisters to help through the Office of Health Care Advocate to help people enroll in insurance under the -- through the Exchange.

So, over time, despite all the intentions

may be well and good right now, but how is the future going to evolve, and with a high budget, deep pockets, as one of the Applicants said, they have deep pockets, what is that going to do to destabilize the non-profits that have been the heart of the service delivery substance abuse treatment of the State of Connecticut? What's that going to do to us over the next few years?

I think the Commission has to consider that and the destabilizing effect of this application. Thank you so much for hearing me, and thank you so much for accommodating me.

HEARING OFFICER HORN: Thank you very much. We're going to take a break. I think we'll take a one-hour break for lunch. We'll come back, and we will have some OHCA questions, and then proceed to the public part of the meeting. Thank you very much.

(Lunch recess)

HEARING OFFICER HORN: Okay, welcome back from lunch. We are going to go back on the record, and we are going to start with OHCA questions.

MS. LAURIE GRECI: Laurie Greci, OHCA staff. The first questions I have would be for Jeff Walters. Walter. Mr. Walter. During your testimony, you stated there were 30 days out of the last 365 days

there were no beds available through Rushford, is that correct?

MR. WALTER: Yes.

MS. GRECI: Okay. Do you know how long any one client that was inquiring about a bed had to wait, in order to obtain a bed, either through you or another provider?

MR. WALTER: How long any person, or on average, or the longest?

MS. GRECI: An average. You know, would those people have to wait a day to get into Rushford, or maybe they got admitted to a different facility right away, though it was not Rushford? Do you know any of that?

MR. WALTER: I don't have a number of days.

MS. GRECI: No, that's okay.

MR. WALTER: I don't have the data, but the process is that, if we can't accommodate someone, if somebody calls and requests an intake today and we can't accommodate them today, we'll give them several choices.

One is that we can book it for tomorrow, we take their phone number and say we get discharges all day and we can call you if we have a discharge before

tomorrow, and we can call to other facilities and help you get into another facility. Those are kind of the options.

MS. GRECI: Okay. In your testimony, you provided a table of funded and non-funded programs, the number of admissions by year?

MR. WALTER: Yes.

MS. GRECI: Is there any way that you could also provide the number of beds for each of those years that those admissions were reported on?

MS. FELDMAN: What page are you referring to?

MS. GRECI: I think it's Exhibit A.

MR. WALTER: Exhibit B has our survey results, which is the --

MS. GRECI: No. I'm speaking about Exhibit A.

MR. WALTER: Exhibit A is the DMHAS data.

MS. GRECI: Okay. It's included in your testimony?

MR. WALTER: Right.

MS. GRECI: Correct.

MS. FELDMAN: We got this directly from DMHAS.

MR. WALTER: You're asking if we could put the number of beds for those years?

MS. GRECI: Correct.

MR. WALTER: And what we would do, this is a table that we got directly from the Department, so what we could do is ask the Department to identify the number of beds.

MS. GRECI: Update it and provide the number of beds and resubmit it?

MR. WALTER: Yeah. I'm sure that data is available.

MS. GRECI: Okay, so, we would make that Late File 1. Intervenor Late File.

Do you have any idea how long do you think that that would take, how responsive they might be to your request?

MR. WALTER: I don't think anyone from the Department is here right now, but I think it would be a matter of days.

MS. GRECI: Okay.

MR. WALTER: I think they've got this information.

HEARING OFFICER HORN: Okay. As a general rule, as we're going through this afternoon, I'm going to

ask that late files be submitted by Friday, August 23rd. It should give people enough time to get things done.

MR. WALTER: That shouldn't be a problem.

MS. GRECI: Okay and, then, and, also, that same table for fiscal year '13, do you know through what date, the start and end date for those? I mean it would be October 1st.

MR. WALTER: July 1st.

MS. GRECI: July 1st.

MR. WALTER: These are state fiscal years.

MS. GRECI: Okay, July 1st.

MR. WALTER: For all of these data.

MS. GRECI: And what's the ending date?

MR. WALTER: June 30th.

MS. GRECI: Okay, it is, but that's why it's not up-to-date. Okay. Do you think that you could also ask at the time same if they have an update to that information when you ask for the number of beds for fiscal year '13?

MR. WALTER: I will ask.

MS. GRECI: Just ask.

MR. WALTER: I will tell you that we just got this chart, whatever, two weeks ago, but we'll ask, because it's possible, now that we're in August, they

might have.

MS. FELDMAN: It's August 5th.

MS. GRECI: All right. Let's see now. Where am I going? All right. You did start discussing about dual diagnosis. Just ballpark figure, what percent of persons that might be in a residential program, rehab program, would be dually diagnosed or co-morbidity?

MR. WALTER: Well I would have to --

MS. GRECI: By your experience at Rushford.

MR. WALTER: A ballpark is that the majority of clients have a co-occurring disorder, but, you know, that doesn't mean that they're all, they all have serious psychiatric co-occurring disorder, but that many of our clients, probably the majority of our clients, will have an identified secondary --

MS. GRECI: A psychiatric condition that might need to be treated by a psychiatrist or other health care professional?

MR. WALTER: Or other mental health.

MS. GRECI: Okay. The majority. Are you saying like over 50 percent? Seventy-five percent?

MR. WALTER: Over 50 percent.

MS. GRECI: Okay. That's fair. Okay.

Let's see. Do I have any other questions? I believe that's all I have for you, Mr. Walter. Thank you.

MS. VEYBERMAN: I have a question for the Applicant. Page 30 of your application, you provide a table one with projected volume, so I have a question about that table.

If you can please provide details on how to quantify the projected volume in that table, in terms of bed days, number of admissions, clinic visits, please?

MR. SCHORR: How we came to our statistics was using a similar model that we did in Pennsylvania. Our projections, obviously, you know, again, like we said before, are projections, but, you know, we've put feelers out. We know what to expect.

We feel that our numbers are conservative, but, through our marketing efforts and things like that, we thought they were achievable.

MS. VEYBERMAN: All right, but can you please specify for us, like, you know, for example, by service type, like each number what it represents? Number of admissions. Number of bed days. Number of counseling sessions.

MR. SCHORR: Those are bed days.

MS. VEYBERMAN: For each level?

MR. SCHORR: Each level.

MS. VEYBERMAN: Okay, thank you.

MR. SCHORR: And the partial are visits.

MS. VEYBERMAN: So partial --

MR. SCHORR: Partial is not bed days. Those are how many visits that we had.

MS. VEYBERMAN: Okay.

MR. SCHORR: For the year. The other ones are bed days.

MS. GRECI: Laurie Greci, OHCA staff. I'm going to start asking questions of the Applicant. Whoever responds, that's fine. Just say who you are before you respond to the question. It's up to you whoever.

Can you just give an overall relationship explanation of Cole(phonetic) New Haven and our Connecticut Retreat at Lancaster and Retreat at South Connecticut?

MR. SCHORR: I'm sorry. The question is? I'm Peter Schorr, the CEO. The question is what is the relationship between us?

MS. GRECI: Relationships between those company names. Cole New Haven is in the application with David Silverstein, and I'm just trying to get an

understanding of the information that was submitted.

MR. SCHORR: David Silverstein is one of my financial partners.

MS. GRECI: Financial partner, okay. That would be part of Cole New Haven?

MR. SCHORR: Yes.

MS. GRECI: And, NR Connecticut, are you the sole member of that?

MR. SCHORR: No. I'm 60 percent owner of that.

MS. GRECI: Sixty percent.

MR. SCHORR: And the Cole New Haven is the owner of the real estate.

MS. GRECI: So I'm looking at, when I was looking at your financial attachment number one for the -- actually, you're leasing the property back from Cole New Haven?

MR. SCHORR: Yes.

MS. GRECI: Okay and the leasehold improvements are the ones that are several million dollars?

MR. SCHORR: No, not just the leasehold. The leasehold improvements are approximately three million dollars, not including all the furniture and

equipment that's needed.

MS. GRECI: Correct. Okay. That explains that one. Just give me one second. There was not anything in the application concerning dual diagnosis of co-morbidity. The license that you're requesting is a facility for the care and treatment of substance abuse or addictive persons, but, yet, in the floor plan, you have two mental health rooms. Can you explain what the mental health rooms in the floor plan refer to?

MR. SCHORR: Yes, I can. Again, our first diagnosis of patients coming to us has to be substance abuse, but, in correlation with our treatment and like I said before, we have clinical specialists that handle the mental health aspect of it.

That's a service we provide. We don't get -- there's no separate billing or anything like that. That's just an added service that we provide.

MS. GRECI: Thank you. Can Dr. Klotz explain the difference between a 3.7 level of care versus a hospital, which is a higher level, 4.0, such as Yale-New Haven?

DR. KLOTZ: The hospital inpatient facility, such as tertiary care, 4.0, would be able to provide services, such as patients, who require IV

access, patients, who require daily laboratory monitoring, patients, who may need invasive or consistent medical monitoring.

The 3.7 level of care, which we provide, is not IV or invasive. It has supplemental labs, which we can receive on a daily basis, but are not on site.

These are for people, who are considered medically stable, meaning that there's no predictable imminent risk to their health or life, and the same, although separate in nomenclature, could be seen.

We are not seeking to treat the acutely-psychotic and imminently dangerous or suicidal patient, but we perform comprehensive psychiatric diagnosis, evaluation and ongoing treatment for all of those same patients, who would routinely be treated in a community or partial hospital type of setting in the outpatient.

MS. GRECI: Thank you. I wanted to go back to table one on page 30 that Alla had asked about, the volumes, and I just want to -- the partial hospitalization, intensive outpatient you say visits, so that would be a day, the three hours for intensive outpatient. Is that considered a visit?

MR. SCHORR: Yes.

MS. GRECI: Thank you. On page 702 of the

application, it talks about rack rate schedule. That's a term I've never heard before. I just would like if someone could explain what it means.

MR. SCHORR: It's our printed rate that we charge insurance companies, and then discount from there.

MS. GRECI: Thank you. Do you have an expected date, if you were able to open this facility, that you would begin operations?

MR. SCHORR: Tomorrow. Again, it's the process. As soon as, you know, we get our approval for our CON and our licensing, we have about a two to three-month renovation before we can open up.

MS. GRECI: I'm just redoing my notes, if you can bear with me for a minute.

MS. KAILA RIGGOTT: Kaila Riggott, OHCA staff. I have a general question of the Applicant. OHCA is charged with insuring access to services for all of Connecticut's residents. Can you address how your proposal insures access for all populations?

MR. SCHORR: In relation to your report of October 2012, I refer to Chart 8.2 on page 99, which, in your own study documents, say there's approximately 281,000 people, who need treatment in the State of Connecticut.

There are 46,000 that have seeked it and have had some form of treatment of addiction, so that leaves approximately 234,000.

And, also, according to your report of 2011, there are 75 percent of the people in the State of Connecticut that have commercial insurance. Obviously, in October, that number is going to go up.

One of the things we're looking to do is to capture about .04 percent of that population. If you look at our estimates and our numbers, that we need to sustain our projections.

How we get to that point is, you know, that's our job. I mean we're not looking for public assistance here. This money is coming from my pocket, and how it comes and what I have to do is I have to make sure that I know what I'm doing, because we're not talking about, you know, three dollars here.

We have a professional staff, and I've done this before, and we go out and market, and we're going to capture this .004 percent to fill up my beds and to also help the other facilities, because we're going to make all these facilities that are not using Connecticut now and put those in the pool, and they're going to be able to -- everyone is going to appreciate that and to be

part of it.

MS. RIGGOTT: Thank you.

MS. GRECI: I have another question. Actually, it's not really a question, as maybe perhaps a request for a late file.

On page 655, there's a response for our financial attachments two, where we ask for three years of incremental revenue expense, volume and statistics, using the type of service, the number of units, and the months of operation.

In the type of unit description at the top left, under the heading there, it says inpatient/outpatient. The purpose of this format is to separate the inpatient and outpatient, to specifically separate into the services, the level of service being provided, and I wonder if we could please get a revised pro forma financial attachment two by year, by service.

MR. SCHORR: Yes, of course.

MS. GRECI: Thank you. That would be Late File 2.

HEARING OFFICER HORN: Applicant 1 will be entered into the record. Can you also provide that by August 23rd, please?

MR. BECCARO: Certainly.

HEARING OFFICER HORN: Thank you. We have one other sort of housekeeping late file request, and we had discussed this earlier. It was, I believe, from Attorney Fusco, the DMHAS state bed vacancy report. If you could provide a copy of that to us, we would appreciate it.

MS. FUSCO: Yes, we could provide the copy for August 13th that we took a look at.

HEARING OFFICER HORN: Okay and, again, due August 23rd, and that will be marked Intervenor Late File Exhibit 2.

And I wanted folks to know that we will be taking administrative notice of DMHAS utilization and discharge reports from the start of fiscal year 2014, which we are in now, so back to July 1st.

MR. BECCARO: Also, if I may, just in keeping with the housekeeping of filings, we should have, I suspect, the record reflect that we've all made some extensive reference, and, by we, I mean the Hearing Officer, the Intervenors and the Applicant, of the statewide health care facilities and service plan of October 2012.

Is it sufficient for you to simply take judicial notice of that? Would you like it formally

entered in as a late file? What's your pleasure on that?

HEARING OFFICER HORN: We see it really as part of our file, but we don't need to take judicial notice. Is there any objection to that?

MS. FUSCO: No objection.

MR. BECCARO: I figured. Forgive me. I figured as much. I just wanted to be clear. I wanted to make sure that that, in fact, would be captured as part of the record. Thank you very much.

HEARING OFFICER HORN: Very good question. Thank you. And speaking of the plan.

MS. RIGGOTT: Just as a point of clarification with regard to the plan and some earlier testimony with respect to mention of a reduction in beds, the information from the plan that was quoted was from an appendix to the plan.

As part of OHCA's facility planning process, the acute care and behavioral health subcommittee agreed to co-sponsor focus groups with hospital ED staff, and that included ED docs, behavioral health and nurse directors.

The aim of these focus groups were to gain better insight on how well persons presenting with behavioral health needs, and that includes both mental

health and substance abuse, were receiving care, either in general hospitals or through community programs. I just wanted to make that point of clarification.

MR. BECCARO: Appreciate that. Thank you.

HEARING OFFICER HORN: Is there anything further from OHCA? No?

MS. FELDMAN: Question regarding your request for additional information by way of late files.

HEARING OFFICER HORN: Yes.

MS. FELDMAN: Ms. Greci, you had asked the Intervenor, Rushford Center, to request, through Freedom of Information to DMHAS, an update of that chart to include a column with respect to I believe you said the number of beds.

Are you talking about the number of beds in the State DMHAS-funded beds, or the beds that they used as a basis for determining the number of admissions?

MS. GRECI: That would definitely be for the number of admissions that were reported. Hopefully, it will be the same number of beds for the year, but if there's a variation, then you might want to note that, also.

MS. FELDMAN: Okay and one other question related to the administrative notice with respect to a

DMHAS document. I was unclear exactly what DMHAS document you were referring to and the time period, because I think you said 2014.

HEARING OFFICER HORN: For fiscal year 2014, so from July 1st of this year forward.

MS. FELDMAN: Okay. And the document, again, is?

MS. GRECI: It's the DMHAS bed vacancy report.

MS. FELDMAN: Okay. Is that the same report that you're asking Attorney Fusco to provide for August 13th, but just cumulatively?

MS. FUSCO: I think the report that I'm providing is actually the daily census broken down, as reported through the DMHAS portal by the grant funded providers that shows each day the bed availability for each provider. It might show total number of beds.

MS. FELDMAN: Okay.

MS. GRECI: The intention is to have more than one or two isolated reports, to have a trend, so that, if we need that data, we have it available.

MS. FELDMAN: Okay. Thank you.

MS. FUSCO: And we can certainly, if you need to update with, you know, if we're not submitting

this until the 23rd, if there are -- we can update next week, if you'd like to see sort of a weekly comparison, because I know we submitted one from last week, as well, if that would help.

MS. GRECI: That would be fine. Thank you.

HEARING OFFICER HORN: Okay. That brings us, then, to the public portion. We have a few people, who appear to be signed up to speak. Are there any legislators in the audience? Municipal leaders? Okay.

We'll be calling the names of those, who have signed up to speak, in the order of which they have signed up. We ask that everyone keep your comments to three minutes, and I'm serious this time.

I know that will be difficult, but it's important for us to move the proceedings along and to allow as many people to speak as possible.

For those of you, who do not wish to speak, keep in mind that you can submit written testimony. That written testimony becomes incorporated into the record. Anyone, who wishes to submit written testimony, will need to submit it by Friday, August 23, 2013.

The mailing address is on the

informational sheet provided. You don't have to identify your street address or telephone number when you're testifying today or if you send in written testimony.

Okay, we're now going to hear statements from the public, and Kim will call people off the list, or Kaila.

MS. RIGGOTT: Please forgive me if I'm mispronouncing your name. Janina Kean.

MS. JANINA KEAN: Thank you for the opportunity to speak to you. My name is Janina Jacqueline Kean, and I reside at 70 North Main Street in Sharon, Connecticut.

I'm also employed by High Watch Recovery Center as the Chief Executive Officer. I have had stewardship of that organization for the last 15 years.

We are a 78-bed, residential, dual diagnosis, substance abuse treatment facility, licensed by the Department of Public Health.

We have been in existence in the State of Connecticut for the last 73 years. We were started by the man who started Alcoholics Anonymous, Bill Wilson, and High Watch began in 1940.

We employ 64 full-time individuals, who are residents of the State of Connecticut. Our annual

operating budget is seven million dollars. We generate all of our revenue from our per diem bed rate. We are not contracted with any insurance company, and those we treat are self-pay.

Our rates are as follows. We charge $390 a day for the first 21 days, and then, thereafter, we charge $357 per day.

I wanted to make note on the rack rate, that the rack rate for the Retreat is $1,495 a day, yet I am providing the same level of care that they claim that they are providing.

We are a 501c3 company and feel strongly about giving back to the community that we serve, which is the State of Connecticut and the residents within the State.

For this reason, out of 78 licensed beds, only 69 are revenue-producing. Nine beds are used for free care, which translates to approximately 1.2 million dollars of free care a year on an operating budget of seven million.

The seven million we generate from the 69 beds supports the free care that we have been providing. Our nine free beds are filled 100 percent of the time, as you can imagine.

Our 69 revenue-producing beds have a 79 percent occupancy rate, which translates to an average of 14 unoccupied beds per day.

Had we been called yesterday, we have five available beds. Had we been called today, we have three available beds immediately.

I am a direct competitor for the Retreat. If they are allowed to open in the state, this will have a very negative impact on High Watch Recovery Center, by, number one --

MR. BECCARO: With all due respect, Madam Hearing Officer, once again, I'm going to restate, and this time in somewhat stronger terms, we allowed the latitude before, but this witness is testifying as High Watch Center, not as an individual.

I don't think that's appropriate for the public comment portion. She certainly had the opportunity, and we would have welcomed her to intervene, but that time has now passed, and I don't think it's at all fair to my client to allow her to come in at this point, without us having the benefit of the same sort of pre-file that all the other Intervenors had.

I don't think it's fair to the other Intervenors either, quite frankly.

MS. FELDMAN: The other Intervenors have no objection. In the spirit of informing OHCA and making sure that they have the appropriate information before them when they make this decision, we totally support this testimony from the public.

MR. BECCARO: With all due respect, this is, in fact, not general public testimony. It's not what the typical administrative hearing captures as public testimony.

And while it certainly is within the Hearing Officer's purview to accept this, I want to make sure that we're on record in opposition, not for the testimony in its abstract, but in the method in which it is being entered into the record.

HEARING OFFICER HORN: Thank you. I appreciate your objection. I am going to allow a brief statement from you. It is not sworn. It is not entered into the record, other than through your testimony, and it will be given whatever weight we deem it to be.

MS. KEAN: I'm almost done.

HEARING OFFICER HORN: Okay, thank you.

MS. KEAN: If they're allowed to open in the State of Connecticut, this will have a very negative impact on an organization that has resided in the state

for 74 years.

Number one, our occupancy rate for revenue-producing beds will decrease, and we will no longer be able to provide the level of free care that we have been providing to Connecticut residents.

Number two, if my occupancy rate decreases for my revenue-producing beds, I will need to lay off some of my Connecticut residents.

Three, I am greatly concerned on the viability of High Watch, which has been with us, again, as I said, for 74 years.

As CEO of a substance abuse treatment facility, as a Yale-trained psychiatric nurse practitioner, but, most importantly, as a woman, with 33 consecutive years of sobriety, it is egregious that there are individuals trying to profit from a very vulnerable population with chronic disease.

As health care providers, we have to have programs that deal with the chronicity of this disease. Many of our patients, as their disease progresses, become financially compromised.

How do we serve those individuals? How do we provide medical care for a medical problem that is not cost prohibitive? How do we protect our patients from

organizations, such as the Retreat, which are trying to profit from very sick, vulnerable patients, who suffer from an illness that, if left untreated, or you're unable to pay, may be fatal. Thank you.

I strongly oppose them coming into the State of Connecticut.

MS. RIGGOTT: Jill Benson.

HEARING OFFICER HORN: As you approach the podium, I would remind you that you are here testifying in the public portion as a member of the public and not as an Intervenor, and that is the weight that your testimony will be given.

MS. JILL BENSON: I understand that. Good afternoon. My name is Jill Benson. I need to identify who I am and who I work for. I'm Vice President of System Operations for Community Health Resources, also known as CHR, and I'm here to oppose the Applicant's application for a 105-bed residential substance abuse treatment facility.

CHR is a comprehensive, non-profit organization that delivers a full continuum of behavioral health treatment and recovery services, including residential substance abuse treatment services.

Our program receives referrals statewide

and serves a client payer mix that includes all payers, government, commercial insurance and out-of-pocket. From a financial perspective, as others have said, having a payer mix that is mixed is critical to the financial well-being of our program.

If approved, we fear that our commercial base will be eroded, and the margins are very small, but, more importantly, I think we're here to talk about the impact on the systems that are existing, and with the Affordable Care Act and the projection of 100,000 new Medicaid lives coming on board in January, if the non-profit system of care that serves that population is eroded, because of financial instability, a lot of people won't be able to be served.

If there is a proven need for additional services, I think that the existing providers are more than willing and capable to step up to the plate and expand the capacity to serve the need and, also, be able to serve everybody, regardless of their payer. Thank you.

HEARING OFFICER HORN: Thank you.

MR. BECCARO: Just for clarity in the record, Madam Hearing Officer, we'd note the same objection.

HEARING OFFICER HORN: Okay, it's noted. Thank you.

MS. RIGGOTT: John Hamilton.

HEARING OFFICER HORN: Once again, I note, as you come the podium, that you are here as a member of the public and not as an Intervenor, and your testimony will be given the weight that it is due.

MR. JOHN HAMILTON: Good afternoon. I'm John Hamilton. I'm a resident of Milford, Connecticut, and I'm also the CEO of Recovery Network of Programs, which is a large comprehensive mental health and addiction agency that serves the Greater Bridgeport area, and, as of an hour ago, we had three open detox beds, 3.7D, and one residential bed that was open.

I also, just by way of background, I serve as the Chairman of the Department of Mental Health and Addiction Services State Advisory Board.

I'm the permanent appointee of the NIDA, National Institute of Drug Abuse, Steering Committee, for the clinical trials network, and I sat on the ASAM, American Society of Addictive Medicine, Residential Treatment Task Force, that actually established the admission criteria for the 3.7 level of care that we actually are speaking of today.

I have to go on notice that there's always going to be a need for addiction treatment, however, as a field, I think we've done a -- we've not been successful in converting this need to a demand, or, as Dr. Bruce said in his earlier testimony, the want for treatment.

In fact, NIDA has done a study that suggests that only 15 percent of people that qualify for services, for addiction services, will actually seek those services out in a given year.

Residential treatment, though, continues to be a necessary treatment option for individuals, but a very specialized sub-population of individuals, who struggle with mental health issues, functional or cognitive deficits, or lack of supportive recovery environment.

Residential detox is also an essential treatment option for individuals that require detoxification, particularly with benzodiazepines and alcohol, as they can be life-threatening detoxification if not medically monitored.

And, yes, there is an increased rise in heroin and prescription drug use in Connecticut, however, the most effective evidence-based treatment for heroin addiction is medication-assisted treatment,

Buprenorphine, Methadone and Vivitrol. That is according to the scientific evidence, not residential treatment.

And with regards to detox, heroin and opiate detoxification, unlike alcohol and benzodiazepine detoxification, can be provided on an outpatient basis, because it is not a life-threatening detox.

We know there are different pathways to recovery. The field, though, has shown the greatest growth in the recovery field on recovery coaching and in the medication-assisted treatment field, particularly with the increased availability for prescriptive Suboxone and Buprenorphine from physician's office.

In my work over the last 10 years at the DMHAS Advisory Board and participating in every year's gap analysis, consistently, the greatest needs for bed in Connecticut is not residential 3.7 beds, but, in fact, transitional housing and recovery sober housing beds for those that live in Connecticut, which would not be brought to the Office of Health Care Access, by the way, because it falls outside of your purview, because it's not licensed beds.

Other states have actually started to reduce or defund residential beds and are creating virtual residentials for some individuals with recovery

supports, outpatient services, and wraparound services within their sober housing.

I believe this a direct impact from the understanding that residential addiction treatment was not included as an essential benefit in health care reform.

If my agency represents a snapshot of the addiction treatment world, it would be important to note that our detox and residential slots account for only 58 of the individuals that we're serving today out of the 1,905 individuals we have in treatment as of today.

Best practices in addiction treatment is to provide the least restrictive treatment available, no more or no less treatment than the individual needs and deserves.

So, to summarize, 3.7 detox and residential treatment are important treatment options for a small sub-group of individuals requiring treatment, however, this is not the need for residential treatment in Connecticut. Sober housing is. Thank you.

MR. BECCARO: And, again, with apologies, I'm going to be a broken record on this, same objections, just for the record, please.

HEARING OFFICER HORN: Yes, your objection

is noted. Thank you. Are there any other members of the public, who would wish to testify today? Seeing none, hearing none, thank you, all, for attending today.

Okay, we're having a discussion here about whether there's a need for closing remarks. Does anybody out there have a burning need to do closing remarks?

MS. FELDMAN: We'll pass.

MS. FUSCO: We'll pass, as well.

HEARING OFFICER HORN: The Applicant?

MR. BECCARO: Not unless the Hearing Officer and the panel feel the need.

HEARING OFFICER HORN: We were feeling very happy with the information that we received, and we thank you, all, very much for your time and for coming today. Thank you.

MR. BECCARO: Thank you very much for your time and attention.

(Whereupon, the hearing adjourned at 1:57 p.m.)

HEARING RE: NR CONNECTICUT, LLC
AUGUST 14, 2013

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CERTIFICATE

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

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

In witness whereof I have hereunto set my hand and do so attest to the above, this 23rd day of August, 2013.



Paul Landman
President

Post Reporting Service
1-800-262-4102

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

September 10, 2013

Via Fax Only

Peter Schorr
President / CEO
NR Connecticut, LLC
12 New City Street
Essex, CT 06426

RE: Certificate of Need Application, Docket Number 13-31828-CON
NR Connecticut, LLC-d/b/a/Retreat at South Connecticut
Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, CT
Closure of Public Hearing

Dear Mr. Schorr:

On August 27, 2013, the Office of Health Care Access ("OHCA") received the information requested by OHCA as a late file submission from the public hearing held in this matter on August 14, 2013. With the receipt of the late file submission, the hearing on the above application is hereby closed.

If you have any questions regarding this matter, please feel free to contact Laurie Greci at (860) 418-7032 or Alla Veyberman as (860) 418-7007.

Sincerely,

Marianne Horn
Hearing Officer

MH:amv

C: Joan W.Feldman, Shipman & Goodwin, LLP
Jennifer Groves Fusco, Updike, Kelly & Spellacy, P.C

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TO: PETER SCHOLER, JENNIFER GROVES FUSCO, JOAN FELDMAN

FAX: 860.767.0456, 203.772.2037, 860.251.5211,

AGENCY: RETREAT AT SOUTH CT

FROM: OHCA

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FAX SHEET

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

January 22, 2014

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:	Notice of Proposed Final Decision Office of Health Care Access Docket Number: 13-31828-CON
NR Connecticut, LLC, d/b/a/ Retreat at South Connecticut	**Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, CT**

To: Peter Schorr
President / CEO
NR Connecticut, LLC
12 New City Street
Essex, CT 06426

Dear Mr. Schorr:

Enclosed please find a copy of the Proposed Final Decision rendered by Hearing Officer Marianne Horn in the above-referenced case.

Pursuant to Connecticut General Statutes § 4-179, NR Connecticut, LLC-d/b/a Retreat at South Connecticut, the party in this matter, may request in writing the opportunity to file exceptions and a brief and a request to present an oral argument with the Deputy Commissioner of the Office of Health Care Access within twenty-one (21) days from the mailing of the decision, or by February 12, 2014. If no such request is received by this date, the Deputy Commissioner will take those rights to be waived and will render a Final Decision in this matter.

If you wish to expedite the process and avoid the necessity that the Deputy Commissioner await the expiration of the aforementioned twenty-one days, you may submit a written statement to the Deputy Commissioner affirmatively waiving those rights.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:av

Cc: Joan W.Feldman, Shipman & Goodwin, LLP
Jennifer Groves Fusco, Updike, Kelly & Spellacy, P.C

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Proposed Final Decision

Applicant: **NR Connecticut, LLC, d/b/a Retreat at South Connecticut**
915 Ella Grasso Boulevard, New Haven, CT

Docket Number: **13-31828-CON**

Project Title: **Establish a 105-Bed Residential Substance Abuse Treatment Facility**

Project Description: NR Connecticut, LLC, d/b/a Retreat at South Connecticut, ("Applicant" or "Retreat at South CT") seeks authorization to establish a 105 bed residential substance abuse treatment facility at 915 Ella Grasso Boulevard, New Haven, Connecticut.

Procedural History: The Applicant published notice of its intent to file the Certificate of Need ("CON") application in the *New Haven Register* on February 28, March 1 and 2, 2013. On March 25, 2013, the Office of Health Care Access ("OHCA") received the CON application from the Applicant for the above-referenced project. On July 8, 2013, OHCA deemed the CON application complete.

On July 17, 2013, OHCA notified the Applicant of the date, time and place of the public hearing. On July 19, 2013, a notice to the public announcing the hearing was published in the *New Haven Register.* Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a, a public hearing regarding the CON application was held on August 14, 2013.

Commissioner Jewel Mullen designated Attorney Marianne Horn as the hearing officer in this matter. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. § 19a-639a(f).

By petition dated August 9, 2013, APT Foundation, Inc. requested Intervenor status with full rights of cross-examination regarding the Applicant's CON application. The Hearing Officer designated APT Foundation, Inc. as an Intervenor with full rights of cross-examination.

By petition dated August 9, 2013, Cornell Scott-Hill Health Center requested Intervenor status with full rights of cross-examination regarding the Applicant's CON application. The Hearing Officer designated Cornell Scott-Hill Health Center as an Intervenor with full rights of cross-examination.

By petition dated August 9, 2013, Rushford Center, Inc. requested Intervenor status with full rights of cross-examination regarding the Applicant's CON application. The Hearing Officer designated Rushford Center, Inc. as an Intervenor with full rights of cross-examination.

By petition dated August 9, 2013, Stonington Behavioral Health, Inc., d/b/a Stonington Institute, requested Intervenor status with full rights of cross-examination regarding the Applicant's CON application. The Hearing Officer designated Stonington Institute as an Intervenor with full rights of cross-examination.

By petition dated August 9, 2013, Yale-New Haven Hospital requested Intervenor status with full rights of cross-examination regarding the Applicant's CON application. The Hearing Officer designated Yale New-Haven Hospital as an Intervenor with full rights of cross-examination.

The Hearing Officer heard testimony from witnesses for the Applicant and each of the Intervenors and, in rendering this decision, considered the entire record of the proceeding. The public hearing record was closed on September 10, 2013.

To the extent the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. *SAS Inst., Inc., v. S & H Computer Systems, Inc.,* 605 F.Supp. 816 (Md. Tenn. 1985).

Findings of Fact and Conclusions of Law

1. NR Connecticut, LLC ("Applicant") is a Connecticut limited liability company. Ex. A, p. 590

2. The Applicant proposes to establish the Retreat at South Connecticut ("Retreat at South CT"), a residential substance abuse treatment facility for adults aged 18 and older, at 915 Ella Grasso Boulevard, New Haven, Connecticut. Ex. A, pp.18, 27

3. The Applicant proposes to locate its residential substance abuse treatment facility in an existing 60,000 square foot two-story building in New Haven that will be renovated and upgraded to the same standards as its sister facility, Retreat at Lancaster County ("Lancaster facility"). Ex. A, p.18

4. The Lancaster facility is a 120-bed residential substance abuse treatment facility located on a 24 acre campus in Ephrata, Pennsylvania that has been operating since 2011. Ex. A, p. 44

5. The Applicant intends to provide the following levels of care[1,2] at the Retreat at South CT:
   a. Level 3.7[3] residential detoxification having continuous observation, monitoring and treatment under physician-approved procedures; and
   b. Residential rehabilitation, short-term (approximately 30 day stay).
   Ex. A, pp.18-19, 30

6. The Applicant proposes to have 26 Level 3.7 residential detoxification beds and 79 residential rehabilitation beds for a total number of 105 beds. Transcript of August 14, 2013, Public Hearing ("Tr.") Testimony of Mr. Peter Schorr, pp. 14-15

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[1] The American Society of Addiction Medicine defines the listed levels of care.

[2] Levels of care for substance abuse treatment licensed by the Connecticut Department of Public Health identify Level 3.7 residential detoxification as residential detoxification and evaluation and short-term residential rehabilitation as intensive treatment. Source: Statewide Health Care Facilities and Service Plan, October 2012, pp. 280-287

[3] The Substance Abuse and Mental Health Services Administration ("SAMHSA") characterizes short-term residential rehabilitation treatment as having a length of stay of 30 days or less.

7. As shown in Table 1 below, Connecticut has 8 private non-profit providers of Level 3.7 detox with a total of 156 licensed beds. There are 11 private non-profit providers of short-term residential rehabilitation with a total of 256 licensed beds.[4]

Table 1: Existing Providers of Level 3.7 Residential Detoxification and Evaluation and Residential Rehabilitation Treatment in Connecticut

Provider Name and Program Name	Town	Services*	Beds
Chemical Abuse Services Agency, Inc., Casa Eugenio Maria de Hostos	Bridgeport	IT	10
Recovery Network of Programs, Inc., First Step	Bridgeport	RDE	19
Recovery Network of Programs, Inc., Horizons	Bridgeport	IT	15
Recovery Network of Programs, Inc., New Prospects	Bridgeport	IT	23
Midwestern Connecticut Council on Alcoholism, Inc., McDonough House	Danbury	IT RDE	20 10
Alcohol and Drug Recovery Centers, Inc. – Detoxification Center	Hartford	IT RDE	28 35
Rushford Center	Middletown	RDE IT	16 42
Farrell Treatment Center	New Britain	IT	24
Cornell Scott-Hill Health Corporation, South Central Rehabilitation Center	New Haven	RDE	29
Southeastern Council on Alcoholism and Drug Dependence, Inc., Altruism Acute Care and Evaluation	New London	RDE	20
Stonington Behavioral Health Inc., Stonington Institute	North Stonington	RDE IT	18 45
Community Health Resources, Milestone/New Life Center/Pathways	Putnam	IT, RDE	9** 9**
McCall Foundation, Carnes Weeks Center	Torrington	IT	20
Connecticut Renaissance, Inc., Patrick F. McAuliffe Center	Waterbury	IT	20
		Total Number of Beds for RDE	**156**
		Total Number of Beds for IT	**256**

* Services Abbreviations: RDE – Level 3.7 Residential Detox and Evaluation; IT – Intensive Inpatient (Residential Rehabilitation Treatment up to 30 days)

** The 18 available beds are not specifically assigned to either level or care, therefore, an equal number were assigned to each.

Source: Statewide Health Care Facilities and Service Plan, October 2012, pp. 280-287

8. The State of Connecticut's Department of Mental Health and Addiction Services ("DMHAS") operates, funds and coordinates inpatient and community-based services for adults having substance use or psychiatric disorders, or co-occurring psychiatric and substance use disorders who are indigent or medically indigent. DMHAS' Addiction Services Division, located at Connecticut Valley Hospital in Middletown and Blue Hills Hospital in Hartford, has 152 beds for the provision of residential detoxification and evaluation and short-term residential treatment. The Greater Bridgeport Community Mental Health has 20

[4] The bed totals do not include those available at licensed general hospitals or licensed hospitals for the mentally ill.

beds for patients with co-occurring disorders. Statewide Health Care Facilities and Services Plan, October 2012, p. 96

9. All 30 of the short-term general or children's general hospitals had substance abuse treatment discharges from FY 2008 to FY 2010. Sixteen hospitals provide inpatient detox services[5] and twelve provide intensive inpatient treatment. Statewide Health Care Facilities and Services Plan, October 2012, pp. 99, 101

10. APT Foundation, Inc. ("APT"), a non-profit, community-based agency, provides ambulatory detoxification and outpatient treatment in New Haven and North Haven. APT accepts self-pay, Medicaid and commercial insurance. APT's payer mix is 60% Medicaid and 40% commercial insurance or self-pay. APT also offers free care. Ex. O, pp. 4, 5, 12

11. Cornell Scott-Hill Health Center ("CS-HHC"), a federally-qualified health center, is a provider of behavioral health services in New Haven. CS-HHC operates the South Central Rehabilitation Center, a 29-bed Level 3.7 residential detoxification facility, and the Grant Street Partnership Program, an outpatient treatment program. CS-HHC accepts all patients regardless of the source of payment. Ex. L, p. 12

12. Rushford Center, Inc. ("Rushford") provides inpatient and outpatient care for substance abuse. In Middletown, Rushford operates a 16-bed Level 3.7 unit and a 42-bed residential rehabilitation unit for adults. Rushford accepts patients with commercial insurance, Medicare and Medicaid. Ex. P, Prefiled Testimony of Jeffrey Walter, pp. 3, 12.

13. Stonington Behavioral Health, Inc. d/b/a Stonington Institute, Inc. ("Stonington") in Stonington, CT, offers a full continuum of services to adults with substance abuse and co-occurring disorders. Stonington has a 16-bed Level 3.7 residential detoxification unit for adults and a 38-bed unit for residential rehabilitation services for military personnel and veterans. Stonington is Medicare certified and accepts clients from every major commercial health plan network in Connecticut. Stonington's overall payer mix is 73% governmental payers and charity care and 27% commercial insurance and self-pay. Ex. Z, pp. 5, 6

[5] Hospital inpatient detoxification is Level 4.0 where patients are medically managed. Ex. A, p. 22

14. The "Addiction Residential Census Report" that is compiled daily (Monday to Friday) by DMHAS provides information on the number of available beds at facilities providing Level 3.7 detox and residential rehab that receive DMHAS grant funds, as well as other providers that choose to report through the DMHAS portal.

Table 2: DMHAS Beds Availability Statistics for Detoxification and Rehabilitation Level 3.7 Facilities

Service	Available Beds*						
	8/13/2013	8/14/2013	8/15/2013	8/16/2013	8/19/2013	8/20/2013	8/21/2013
Detox	6	3	7	10	17	6	7
Rehab	24	23	26	35	31	14	24
Total	30	26	33	45	48	20	31

* Not all facilities report availability of beds each day.
Ex. FF

15. The DMHAS data provided by Rushford show that between 2009 and 2013 the number of admissions to Level 3.7 residential detoxification programs and number of beds increased 19.7% and 21.4% respectively, while the intensive residential rehabilitation programs' admissions and beds decreased by 11.5% and 4.4%, respectively.

Table 3: DMHAS Admissions and Beds Statistics for Detoxification and Rehabilitation Level 3.7 Facilities by State Fiscal Year

State Fiscal Year*	Detoxification Admissions	Beds	Residential Rehabilitation Admissions	Beds
2009	9,267	126	2,906	206
2010	8,709	131	2,907	206
2011	10,463	143	3,040	193
2012	11,035	153	2,877	193
2013	11,091	153	2,571	197

* July 1 to June 30.
Ex. GG, p. 1

16. The Applicant projects that it will provide the following volumes of services by persons and bed days for the first years of operation:

Table 4: Projected Volume by Fiscal Year*

Service type	FY 2014		FY 2015		FY 2016	
	Persons	Bed Days	Persons	Bed Days	Persons	Bed Days
Detoxification	1,320	7,260	1,440	7,920	1,440	7,920
Rehabilitation	1,320	21,780	1,440	23,760	1,440	23,760
Total Persons and Bed Days	**2,640**	**29,040**	**2,880**	**31,680**	**2,880**	**31,680**

*Assumes Applicant's fiscal year is Jan 1 – Dec 30
Ex. A, pp. 30; Ex. E, p. 682

17. In the most recent fiscal year, the Applicant provided services to 2,206 people at its Lancaster facility, where twelve (less than 1% of the admitted clients) were from Connecticut. Ex. A, p. 686

18. The proposed payer mix is based on self-pay and commercial insurance. Retreat at South CT projects the following patient population payer mix:

Table 5: Projected Payer Mix by Fiscal Year *

Payers	FY 2013	FY 2014	FY 2015	FY 2016
Commercial Insurers	85%	85%	85%	85%
Self-Pay/Uninsured	15%	15%	15%	15%
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

*Assumes Applicant's fiscal year is Jan 1 – Dec 30
Ex. A, p.35

19. Given the high rate of individuals in New Haven who are governmentally-insured, the proposed facility would not benefit these individuals since it will not accept Medicaid patients. Tr. Testimony of Mr. Robert Freeman, pp. 63, 65

20. The payer mix in Fiscal Year 2012 shows that 79 % of the residents of the town of New Haven had government insurance and 20% had commercial insurance. Of New Haven County residents, 65% had government insurance and 33% had commercial insurance.

Table 6: Payer Mix for the Town of New Haven and New Haven County for Fiscal Year 2012*

Payer	Town of New Haven	Percent	New Haven County	Percent
Medicare	6,073	31%	50,319	40%
Medicaid	9,456	48%	30,807	24%
Other Government	72	0%	721	1%
Total	**15,601**	**79%**	**81,847**	**65%**
Commercial	4,009	20%	41,057	33%
Uninsured	221	1%	1,949	2%
Total	**4,230**	**21%**	**43,006**	**35%**
Total	**19,831**	**100%**	**124,853**	**100%**

*October 1 to September 30
Source: OHCA's Acute Care Hospital Inpatient Discharge Database

21. The existing providers of the service proposed by the Applicant have capacity to meet the needs of the commercially-insured and self-pay patients, who are the target of the Applicant's proposal. Tr. Testimony of Jeffrey Walter, President and Chief Executive Officer of Rushford Center, p. 37-38; Tr. Testimony of Georganna Koppermann, Director of Business Development and Military Affairs at Stonington Institute, pp.56-57

22. The current providers of the service proposed by the Applicant rely upon patients who are commercially-insured or self-pay to offset the lower reimbursement rate realized by serving the governmentally-insured charity care population. Tr. Testimony of Mr. Walter, p.40; Tr. Testimony of William Sledge, M.D., Medical Director of the Yale-New Haven Psychiatric Hospital, pp. 67-70; Tr. Testimony of Ms. Koppermann, pp.60-62; Tr. Testimony of Douglas Bruce, M.D., Medical Director of South Central Rehabilitation Center at the Cornell Scott-Hill Health Center , pp.74, 75

23. The total estimated cost of the proposal is $7,566,000, including capitalized financing costs. Ex. A, p. 34

24. The Applicant projects an incremental gain in revenue from operations before taxes of $2.0 million, $4.6 million and $6.3 million, respectively, in the first three full fiscal years of operations.

Table 7: Projected Incremental Revenues and Expenditures by Fiscal Year*

Account Description	FY 2013	FY 2014	FY 2015
Net Patient Revenue	$12,596,215	$17,700,710	$20,032,140
Salaries/Benefits	6,148,924	7,030,851	7,241,777
Professional Services	637,093	712,282	728,105
Bad Debts	629,811	885,036	1,001,607
Lease Expense	914,400	2,014,832	2,215,277
Other Operating Expense	2,263,785	2,458,628	2,559,238
Total Operating Expense	10,594,013	13,101,629	13,746,004
Income from Operations	**$ 2,002,202**	**$ 4,599,081**	**$ 6,286,136**

*Assumes Applicant's fiscal year is Jan 1 – Dec 30
Ex. A, p. 654

25. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations adopted by OHCA. (Conn .Gen. Stat. § 19a-639(a)(1))

26. This CON application is consistent with the State Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

27. The Applicant has not established that there is a clear public need for its proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

28. The Applicant has not satisfactorily demonstrated that the proposal will financially strengthen the health care system in the state. (Conn. Gen. Stat. § 19a-639(a)(4))

29. The Applicant has not satisfactorily demonstrated that its proposal would improve the accessibility of health care delivery in the region, and therefore no determination can be made as to the potential improvement in quality and cost effectiveness. (Conn. Gen. Stat. § 19a-639(a)(5))

30. The Applicant has shown that there will be an increase in access to the provision of health care services to the relevant populations and payer mix. (Conn. Gen. Stat. § 19a-639(a)(6))

31. The Applicant has not satisfactorily identified the population to be served by its proposal and has not satisfactorily demonstrated that this population has a need as proposed. (Conn. Gen. Stat. § 19a-639(a)(7))

32. The Applicant has not provided any historical utilization of behavioral health treatment services in the service area that would support this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

33. The utilization of existing health care facilities and services in the service area does not support this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

34. The Applicant has failed to satisfactorily demonstrate that the proposal will not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in General Statutes § 19a-639(a). The Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

NR Connecticut, LLC ("Applicant") is a Connecticut limited liability company. *FF 1* The Applicant proposes to establish a residential substance abuse treatment facility, The Retreat at South Connecticut in New Haven, Connecticut. *FF 2* The proposed facility will be established and operated similar to its sister facility, Retreat at Lancaster County, Pennsylvania. *FF 4* The proposed facility will offer Level 3.7 residential detoxification ("Level 3.7 detox") and rehabilitation and recovery ("residential rehab") services, as well as partial hospitalization, intensive outpatient treatment, continuing recovery-oriented care and community education services (collectively identified as "outpatient services"). *FF 5*

The Applicant proposes to have 26 Level 3.7 detox beds and 79 residential rehab beds for a total of 105 beds. *FF 6* The Applicant claims that based on the experience gained from operating the Lancaster facility, the optimum number of beds for the proposed facility is between 100 and 120 beds. Ex. A, p. 667 Peter Schorr, President and CEO of the proposed facility, stated that the projected number of beds for the proposed facility and the split of beds by service is based on the fact that "it was a nursing home…140-something beds, and we can put more beds in there, but we decided that… our infrastructure would be comfortable if we had 105 beds. We chose to have 26 detox beds and 79 rehab beds." Mr. Schorr stated that the rule of thumb is usually three rehab beds to one detox, and having that ratio will allow his clients to have a rehab bed available after graduating from detox." *Tr. Testimony of Mr. Peter Schorr, pp.14-15* The Applicant, however, provided no evidence that the bed ratio is appropriate for this type of facility. In addition, the Applicant provided no information concerning the percentage of clients that would be projected to enter a residential rehab program after completing inpatient detoxification.

The Applicant claims that Connecticut has a limited number of Level 3.7 detox and residential rehab beds that cannot keep pace with increasing demand. *Ex. A, p. 21* The Applicant also claims, through proprietary research and publicly available documentation, that it has identified the need in Connecticut for additional beds to provide these levels of service. *Ex. E, p. 667* Based on phone surveys conducted by the Applicant on two separate days, the Applicant claims that the Level 3.7 facilities are operating at, or close to, 100% capacity and many of them have a long waiting list for a bed. *Ex. A. p. 22*

Additionally, the Applicant asserts that there are waiting lists at Connecticut's facilities and that many residents leave the state to obtain treatment. *Ex. A, pp. 20-22* Mr. Schorr stated that one of the reasons for opening the proposed facility in Connecticut is that there are people from Connecticut coming to Retreat at Lancaster. *Tr. Testimony of Mr. Peter Schorr, p.7* The Applicant expects that 75% of its patients will come from Connecticut and the remaining 25% from surrounding states. *Ex. E, p. 669* The Applicant claims that the proposed facility will help to fulfill the unmet needs not just of New Haven County but the entire state. *Ex. A, p. 27* In the most recent

fiscal year, however, the Applicant provided services to 2,206 people at its Lancaster facility, where twelve, less than 1%, of the admitted clients were from Connecticut. *FF 17* The reported number of Connecticut clients served in Pennsylvania does not support the Applicant's statements or the need for the proposal.

Based on SAMHSA's 2012 National Survey on Drug Use and Health, the Applicant claims that 269,645 Connecticut residents aged 18 and older need, but have not received, treatment for some form of substance use disorder.

Table 8: Estimated Number of Persons that May Benefit from the Proposal

Description	18 to 25 yrs. of age	26 and Older	Total
Population, based on Census 2010 estimates	350,601	2,277,969	2,268,570
Needing Treatment for Alcohol Abuse, % *	18.46%	6.32%	
Number	64,721	143,968	208,689
Needing Treatment for Illicit Drug Use, %*	8.16%	1.42%	
Number	28,609	32,347	60,956
		Total	**269,645**

* Rates used by Applicant based on SAMHSA's National Survey on Drug Use and Health, 2009 and 2010
Ex. A, pp. 25, 37, 352

However, Douglas Bruce, M.D., Medical Director of South Central Rehabilitation Center at the Cornell Scott Hill Health Center, New Haven, stated that there are many people that need addiction treatment, but do not necessarily want it. Dr. Bruce further stated that the issue is not a lack of access to beds. The issue is that a large number of people with substance use disorders are not seeking treatment and more beds will not address that problem. *Tr. Testimony of Dr. Douglas Bruce, pp. 74, 77*

Based upon Dr. Bruce's testimony, the estimated number of persons that the Applicant claims need treatment is not necessarily an indication of the number that will seek treatment. Other than the Applicant's statements proclaiming need, there is insufficient documentation to support the clear public need for the proposed facility. Furthermore, there is no evidence supporting the number of beds proposed for the facility. None of the existing facilities offering the residential rehab level of care have more than 45 beds, as compared to the Applicant's proposed 79 beds. *FF 6*

Mr. Schorr stated that "there are not enough beds in this state. There are not enough beds anywhere, let alone in just Connecticut." *Tr. Testimony of Mr. Schorr, pp. 13-14* However, Connecticut has 8 private non-profit providers of Level 3.7 detox with a total of 156 licensed beds. *FF 7* This bed total does not include those available at DMHAS operated facilities, licensed general hospitals or licensed hospitals for the mentally ill. *FF 8, 9* There are 11 private providers of residential rehab with a licensed total of 274 beds. *FF 7* The Intervenors provided DMHAS reports that illustrated the availability of Level 3.7 detox and residential rehab beds at grant-funded facilities and other providers that choose to report their bed availability to DMHAS. From August 13 to 21, 2013, there were beds available at the two levels of care on each day

reported. *FF 14* Not all facilities in Connecticut with these levels of care report their bed availability, therefore, there may have been additional beds available on the reported days.

In addition, two facilities, Rushford and Stonington Institute, provided testimony that there are normally beds available at their facilities. Jeffrey Walter, President and Chief Executive Officer of Rushford Center, stated that, based on the responses received from the Level 3.7 residential detoxification and intensive residential rehabilitation providers to a survey conducted by Rushford, "there was at least a 21% excess of capacity in the nine [survey] respondents and that most days in the year, there are beds available in each of these [nine] facilities." Mr. Walter also stated that in the most recent 12 months there were only 30 days out of 365 days where Rushford had no beds. Tr. Testimony of Mr. Walter, pp. 37-38. Georganna Koppermann, Director of Business Development and Military Affairs at Stonington Institute, stated that Stonington Institute has ample capacity to meet the needs of the commercially-insured and self-pay patients who are the target of the Applicant's proposal. While Stonington's detox service operates close to capacity, due to the short length of stay, three to five days on average, several patients are discharged each day. The rehabilitation service, which caters to active duty military service members and veterans, consists of a 38-bed unit that operates at 60% capacity with approximately 22 beds filled at any given time. Tr. Testimony of Ms. Koppermann, pp. 56-57

In order to determine the need for the Applicant's services, the number of persons that may utilize the services must be determined. The Applicant utilized the rates of illicit drug and alcohol use reported from SAMHSA's National Survey on Drug Use and Health. *Ex. A, p. 25* These rates are for persons who need treatment, but did not receive treatment. The Applicant did not demonstrate that there are persons that have sought treatment but were unable to find it in Connecticut. Based on the availability of beds as evidenced by the DMHAS report and that the number of persons that are seeking treatment has not been determined, the Applicant has failed to demonstrate that there is a clear public need for the proposal.

The Applicant proposes to provide its services to persons who have commercial insurance or who are able to pay for their treatment out-of-pocket. *FF 18* Several private non-profit providers offered testimony that their agencies have the capacity to provide Level 3.7 detox and residential rehab for those who seek it. These agencies provide services to all persons regardless of their ability to pay. *FF 10, 11, 12, 13* Having clients with commercial insurance enables these agencies to continue providing services to all who need them. *FF 22*

The Applicant claims that the proposed facility should have little or no impact on existing providers because the existing providers are unable to meet the demand for projected services. *Ex. A, p. 29* The Applicant did not provide any evidence that its proposal would not have an economic impact on the behavioral health care system in Connecticut. With many of the existing providers of the proposed services relying on reimbursement from government payers, the potential loss of clients with commercial insurance to the proposed facility may decrease their ability to provide services to all of their clients regardless of payer. *FF 22* The Applicant's proposal with its potential impact on the reimbursement from commercial payers to the existing providers will have a negative impact on the financial strength of the behavioral health system in the state.

Mr. Walter stated that the proposal will "impact …not only the providers, but the clients that we serve. The existing providers, including Rushford, depend on a payer mix that is a struggle to attain and to maintain, and …the entry of Retreat with 105 beds that are exclusively for people who have private insurance, is going to have a destabilizing effect on all of the providers …even a five percent swing in payer mix is going to have a devastating effect on our ability to continue to provide the quality of care that we really have to provide and that the community is expecting us to provide." Tr. Testimony of Mr. Walter, p.40 Ms. Koppermann stated that "given the heavily-weighted governmentally-insured charity care population, 73%, we require 95% capacity to break even. In a business with a small operating margin, the loss of commercial and self-pay revenue will have a significant adverse impact on our bottom line…The proposal will serve to weaken the health care system by adversely affecting existing providers … who care for all patients, regardless of payer source and the impact on our bottom lines." Tr. Testimony of Ms. Koppermann, pp.60-62. Dr. Bruce stated that "we operate on a very, very small margin. The commercial insurance does pay at a higher rate than Medicaid. We're providing free care to individuals. If we are to lose that commercial margin, it will put us into the red, and that will compromise our ability to continue to provide services to the largely Medicaid population in our community, as well as to people who are undocumented or do not have an ability to have insurance or afford care." Tr. Testimony of Dr. Bruce, pp.74, 75

Since the Applicant was unable to establish the clear public need for the proposal and that this proposal would avoid a duplication of services in the area, the Applicant has failed to establish that its proposal would improve the accessibility, quality or cost effectiveness of health care delivery in the region.

Order

Based upon the foregoing Findings of Fact and Discussion, I respectfully recommend that the Certificate of Need application of NR Connecticut, LLC d/b/a Retreat at South Connecticut to establish a behavioral health treatment facility in New Haven, Connecticut, be **DENIED**.

Respectfully submitted,

January 22, 2014
Date

Marianne Horn
Hearing Officer

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3944
RECIPIENT ADDRESS	918602515211
DESTINATION ID	
ST. TIME	01/22 14:32
TIME USE	02'10
PAGES SENT	17
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: PETER SCHOER, JENNIFER GROVES FUSCO, JOAN FELDMAN

FAX: 860.767.0456, 203.772.2037, 860.251.5211,

AGENCY: RETREAT AT SOUTH CT

FROM: OHCA

DATE: 01/22/14 Time:

NUMBER OF PAGES: 17
(including transmittal sheet

Comments:
Docket Number: 13-31828-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS

****
*** TX REPORT ***
****

TRANSMISSION OK

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TIME USE	02'10
PAGES SENT	17
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

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PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS

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*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3942
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ST. TIME	01/22 14:25
TIME USE	03'11
PAGES SENT	17
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

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LAW OFFICES – WILLIAM P. BECCARO

12 NEW CITY STREET
ESSEX, CT 06426
860-767-8632 (telephone)
860-767-0456 (facsimile)

RECEIVED
FEB 11 2014
Office of
HEALTHCARE ACCESS

FACSIMILE TRANSMITTAL

DATE: **February 11, 2014**

TO: **Ms. Kimberly R. Martone, Director of Operations, OCHA**

FACSIMILE #: **860-418-7053**

SUBJECT: **Retreat at South Connecticut, OCHA Docket # 13-31828-CON**

NUMBER OF PAGES (including this cover page): **2**

Please see attached – thank you

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Retreat
at South Connecticut

February 11, 2014

Kimberly R. Martone, Director of Operations
Department of Public Health - Office of Health Care Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308
Via hand delivery, facsimile, and U.S.Mail

RECEIVED
FEB 11 2014
Office of
HEALTHCARE ACCESS

Re: NR Connecticut, LLC, d/b/a Retreat at South Connecticut, Establish a 105-Bed Residential Substance Abuse Treatment Facility, OHCA Docket No. 13-31828-CON

Dear Ms. Martone:

I am writing on behalf of NR Connecticut, LLC, d/b/a Retreat at South Connecticut ("Applicant") in response to your letter, dated January 22, 2014, regarding the above docket. Applicant respectfully requests that it be permitted to submit exceptions to the Proposed Final Decision, dated January 22, 2014, along with supporting memorandum, and that it have the opportunity to present an oral argument.

Additionally, Applicant respectfully requests sixty (60) days from the date of this letter, or April 14, 2014 (as April 12th falls on a Saturday), for filing its exceptions and supporting memorandum to the Proposed Final Decision. The reason for this request is that Applicant requires adequate time to fully respond to informal participant testimony offered at the public hearing, as well as data set forth in the Proposed Final Decision, which Applicant did not previously have the opportunity to address. Further, Applicant's senior management has numerous other conflicting commitments in February and March, including the opening of a new facility in Greenacres and Palm Springs, Florida, which necessitates the requested extension. As the public hearing in this matter was closed on September 10, 2013, and the Proposed Final Decision was only recently issued, the extension request will not prejudice the rights of any third parties and is in the interest of justice.

Thank you for your consideration of this request and please do not hesitate to contact me if you have any questions.

Sincerely yours,

William P. Beccaro
On behalf of Retreat at South Connecticut

Retreat

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William P. Beccaro
On behalf of Retreat at South Connecticut

Retreat
at South Connecticut

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Sincerely yours,

William P. Beccaro
On behalf of Retreat at South Connecticut

Greer, Leslie

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Friday, February 14, 2014 3:37 PM
To: Greci, Laurie
Cc: Riggott, Kaila; Veyberman, Alla; Greer, Leslie
Subject: RE: Retreat at South Connecticut

Thanks, Laurie!

From: Greci, Laurie [mailto:Laurie.Greci@ct.gov]
Sent: Friday, February 14, 2014 3:19 PM
To: Jennifer Groves Fusco
Cc: Riggott, Kaila; Veyberman, Alla; Greer, Leslie
Subject: RE: Retreat at South Connecticut

Hi Jennifer!

I have attached the document we received. There has not yet been any action taken on the request, mostly due to the weather-related closings of the office.

Regards,
Laurie

From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Friday, February 14, 2014 2:39 PM
To: Greci, Laurie
Subject: Retreat at South Connecticut

Hi, Laurie.

I understand that Retreat has requested the right to file exceptions and briefs and present oral argument on the Proposed Final Decision. They did not copy me on the letter ... unless it's stuck in the mail, which is entirely possible given this weather. Can you scan me a copy? And will you let me know when oral argument is scheduled?

Thanks and I hope you are keeping warm!

Jen

LEGAL NOTICE: Unless expressly stated otherwise, this message is confidential and may be privileged. It is intended for the addressee(s) only. If you are not an addressee, any disclosure, copying or use of the information in this e-mail is unauthorized and may be unlawful. If you are not an addressee, please inform the sender immediately and permanently delete and/or destroy the original and any copies or printouts of this message. Thank you. Updike, Kelly & Spellacy, P.C.

Greer, Leslie

From: Greci, Laurie
Sent: Tuesday, February 18, 2014 8:19 AM
To: jfeldman@goodwin.com
Cc: Riggott, Kaila; Veyberman, Alla; Greer, Leslie; Hansted, Kevin
Subject: CON 13-31828 Retreat at South Connecticut
Attachments: 31828-15 request for time extension oral argument letter.pdf

Dear Atty. Feldman,

The attached correspondence was received by OHCA. Please note that OHCA has not yet responded to the Applicant's request.

Regards,

Laurie Greci

Laurie K. Greci
Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

LAW OFFICES – WILLIAM P. BECCARO

12 NEW CITY STREET
ESSEX, CT 06426
860-767-8632 (telephone)
860-767-0456 (facsimile)

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NUMBER OF PAGES (including this cover page): **2**

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Retreat
at South Connecticut

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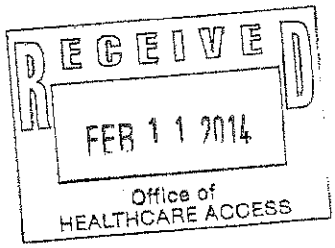

Re: NR Connecticut, LLC, d/b/a Retreat at South Connecticut, Establish a 105-Bed Residential Substance Abuse Treatment Facility, OHCA Docket No. 13-31828-CON

Dear Ms. Martone:

I am writing on behalf of NR Connecticut, LLC, d/b/a Retreat at South Connecticut ("Applicant") in response to your letter, dated January 22, 2014, regarding the above docket. Applicant respectfully requests that it be permitted to submit exceptions to the Proposed Final Decision, dated January 22, 2014, along with supporting memorandum, and that it have the opportunity to present an oral argument.

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Sincerely yours,

William P. Beccaro
On behalf of Retreat at South Connecticut

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

FINAL
TABLE OF THE RECORD

APPLICANT: **NR Connecticut, LLC D/B/A Retreat at South Connecticut**

DOCKET NUMBER: **13-31828-CON**

PUBLIC HEARING: **August 14, 2013 at 9:00 a.m.**

PLACE: **Legislative Office Building Room 2D**
Hartford, Connecticut

EXHIBIT	DESCRIPTION
A	Letter from the Applicant dated March 25, 2013, enclosing the CON application for NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Applicant") to establish a 105 Bed Residential Substance Abuse Treatment Facility to be Located in New Haven, Connecticut under Docket Numb 13-31828, received by OHCA on March 25, 2013. (663 page)
B	OHCA's letter to the Applicant dated April 24, 2013, requesting additional information and/or clarification in the matter of the CON application under Docket Number 13-31828. (4 pages)
C	OHCA's email to the Applicant dated May 28, 2013, regarding obtaining information from the Department of Mental Health and Addiction Services("DMHAS") in the matter of the CON application under Docket Number 13-31828. (2 pages)
D	OHCA's email to the Applicant dated June 3, 2013, regarding information concerning FOIA request to DMHAS
E	Applicant's responses to OHCA's letter of April 24, 2013, dated June 17, 2013, in the matter of the CON application under Docket Number 13-31828, received by OHCA on June 18, 2013. (300 pages)
F	Designation letter dated July 19, 2013 for Hearing Officer in the matter of the CON application under Docket Number 13-31828. (1 page)

G	OHCA's letter to the Applicant dated July 8, 2013, deeming the application complete as of July 8, 2013 in the matter of the CON application under Docket Number 13-31828. (1 page)
H	Letter from Shipman & Goodwin LLP on behalf of Rushford Center, Inc, High Watch Recovery Center, Inc. CHR, Inc., MCCA, Inc. and Recovery Network Programs, Inc. (collectively, the "Interested Parties") dated July 11, 2013, requesting a hearing in the matter of the CON application under Docket Number 13-31828, received by OHCA on July 11, 2013.(1 page)
I	OHCA's request for legal notification in the *New Haven Register* and OHCA's Notice to the Applicant of the public hearing scheduled for August 14, 2013 in the matter of the CON application under Docket Number 13-31828, dated July 17, 2013. (4 pages)
J	OHCA's letter to the Applicant dated July 29, 2013 requesting prefile testimony and enclosing issues outlining topics to be discussed at the hearing in the matter of the CON application under Docket Number 13-31828. (2 pages)
K	Letter from the Applicant enclosing prefile testimony dated August 8, 2013, in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013.(11 pages)
L	Petition of Cornell Scott-Hill Health Center dated Augut 9, 2013, requesting intervenor status and enclosing notice of appearance of Updike, Kelly & Spellacy, P.C.and prefile testimony in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013.(46 pages)
M	Petition of Stonington Behavioral Health, Inc., d/b/a Stonington Institute dated Augut 9, 2013, requesting intervenor status and enclosing notice of appearance of Updike, Kelly & Spellacy, P.C. and prefile testimony in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (37 pages)
N	Petition of Yale-New Haven Hospital dated Augut 9, 2013, requesting intervenor status and enclosing notice of appearance of Updike, Kelly & Spellacy, P.C. and prefile testimony in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (48 pages)
O	Petition of APT Foundation, Inc. dated Augut 9, 2013, requesting intervenor status and enclosing notice of appearance of Updike, Kelly & Spellacy, P.C. and prefile testimony in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (46 pages)
P	Petition of the Rushford Center, Inc. dated Augut 9, 2013, requesting intervenor status and enclosing notice of appearance of Shipman & Goodwin, LLP and prefile testimony in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (28 pages)
Q	Letter to OHCA from Behavioral Health Consultant, LLC dated August 8, 2013 in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 9, 2013. (2 pages)
R	Letter to OHCA from CommuniCare dated August 9, 2013 in the matter of the CON application under Docket Number 13-31828, received by OHCA on

	August 9, 2013. (2 pages)

S	Letter from the Applicant to OHCA undated responding to intervenors requests from various parties in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 12, 2013. (8 pages)
T	Letter to OHCA from Spectrum Psychiatric Group, P.C. dated August 8, 2013, in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 12, 2013. (2 pages)
U	Letter to OHCA from Greenwood-Gilbert-George-Orchard-Blockwatch #311 dated August 12, 2013, in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 12, 2013. (1 page)
V	Designation letter dated August 13, 2013, designating Marianne Horn as hearing officer and revoking Kevin Hansted as hearing officer in the matter of the CON application under Docket Number 13-31828. (1 page)
W	OHCA's Ruling on the Petition of Rushford Center, Inc. to be granted intervenor status in the matter of the CON application under Docket Number 13-31828, dated August 13, 2013.(2 pages)
X	OHCA's Ruling on the Petition of Yale-New Haven Hospital, Cornell Scott-Hill Health Center, APT Foundation, Inc. and Stonington Behavioral Health to be granted intervenor status in the matter of the CON application under Docket Number 13-31828, dated August 13, 2013. (5 pages)
Y	Email from OHCA to the Applicant dated August 13, 2013, enclosing letters received in the matter of the CON application under Docket Number 13-31828. (1 page)
Z	Facsimilie from Updike, Kelly and Spellacy to OHCA dated August 13, 2013, regarding substitute witness from Stonington Institute in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 13, 2013. (31 pages)
AA	Facsimilie fromWest River Neighborhood Services Corporation to OHCA undated in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 13, 2013.(1page)
BB	Facsimilie received from Yale-New Haven Hospital to OHCA dated August 13, 2013, enclosing a Notice of Appearance in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 13, 2013. (2 pages)
	The following came in during or after the hearing held on August 14, 2013
CC	Letter to OHCA from Representative Juan Candelaria to OHCA dated August 12, 2013, opposing the Applicant's request in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 15, 2013. (2 pages)
DD	OHCA's response dated August 20, 2013, to Representative Candelaria's letter dated August 12, 2013, in the matter of the CON application under Docket Number 13-31828. (1 page)
EE	Letter from the Applicant to OHCA dated August 23, 2013, enclosing late file in the matter of the CON application under Docket Number 13-31828, received by

	OHCA on August 23, 2013. (8 pages)
FF	Letter from Updike, Kelly & Spellacy, PC representing Yale-New Haven Hospital, Cornell Scott-Hill Health Center and APT Foundation, Inc. to OHCA dated August 23, 2013, enclosing late file in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 23, 2013. (8 pages)
GG	Letter from Shipman & Goodwin, LLP representing Rushford to OHCA dated August 23, 2013, enclosing late file in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 23, 2013. (5 pages)
HH	Letter to OHCA from Updike, Kelly & Spellacy, PC representing Yale-New Haven Hospital, Cornell Scott-Hill Health Center and APT Foundation, Inc. dated August 27, 2013, responding to the Applicant's late file in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 27, 2013. (3 pages) Hardcopy received on August 29, 2013.
II	Transcript of the hearing held on August 14, 2013, in the matter of the CON application under Docket Number 13-31828, received by OHCA on August 27, 2013 (170 pages)
JJ	Email to OHCA from the Applicant dated August 26, 2013, attaching the Certificate of Service in the matter of the CON application under Docket Number13-31828, received by OHCA on August 26, 2013. (2 pages)

At the hearing held on August 14, 2013 the following was added

Late Files requested of the Intervenor at the hearing held on August 14, 2013:
Late file due by August 23, 2013.

1. **DMHAS State Beds Exhibit A – Jeffrey Walter**

2. **DMHAS Bed Vacancy**

Late Files requested of the Applicant at the hearing held on August 14, 2013:
Late file due by August 23, 2013.

1. **Revised Financial Attachment II**

Administrative Notice is taken of the following item:

1. **DMHAS Bed Vacancy Reports Starting July 1, 2013 (SFY 2014)**

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

February 19, 2014

VIA FACSIMILE ONLY

William P. Beccaro, Esquire
12 New City Street
Essex, CT 06426

RE: Certificate of Need Application, Docket Number 13-31828-CON
NR Connecticut, LLC – d/b/a Retreat at South Connecticut
Establishment of a 105-bed Residential Substance Abuse Treatment Facility in New Haven, CT
Request for 60-day Extension of Presentation of Oral Argument

Dear Atty. Beccaro:

On February 11, 2014, the Office of Health Care Access ("OHCA") received your letter on behalf of the Applicant requesting a sixty day extension to submit exceptions to the Proposed Final Decision and present oral argument in the above-referenced matter.

OHCA hereby grants the Applicant's request to submit exceptions and to present oral argument. The Applicant's request for a sixty day extension until April 14, 2014 to submit exceptions is also granted.

If you have any questions concerning this matter, please feel free to contact Laurie Greci at (860) 418-7032.

Sincerely,

Marianne Horn
Hearing Officer

MH:lkg

C: Joan W. Feldman, Shipman & Goodwin, LLP
Jennifer Groves Fusco, Updike, Kelly & Spellacy, PC

* * * COMMUNICATION RESULT REPORT (FEB. 19. 2014 2:08PM) * * *

FAX HEADER:

TRANSMITTED/STORED : FEB. 19. 2014 2:08PM FILE MODE	OPTION	ADDRESS	RESULT	PAGE
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: WILLIAM P. BECCARO, ESQ.

FAX: (860) 767-0456

AGENCY: LAW OFFICES – WILLIAM P. BECCARO

FROM: LAURIE GRECI

DATE: FEB 19, 2014 **Time:** 2:15 PM

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Re: 13-31828-CON Request for Extension and Oral Argument

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

* * * COMMUNICATION RESULT REPORT (FEB. 19. 2014 2:09PM) * * *

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JENNIFER FUSCO, ESQ.

FAX: (203) 772-2037

AGENCY: UPDIKE, KELLY & SPELLACY

FROM: LAURIE GRECI

DATE: FEB 19, 2014 **Time:** 2:15 PM

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Re: 13-31828-CON Request for Extension and Oral Argument

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* * * COMMUNICATION RESULT REPORT (FEB. 19. 2014 2:10PM) * * *

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
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FAX SHEET

TO: JOAN FELDMAN, ESQ.

FAX: (860) 251-5211

AGENCY: SHIPMAN & GOODWIN

FROM: LAURIE GRECI

DATE: FEB 19, 2014 **Time:** 2:15 PM

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Re: 13-31828-CON Request for Extension and Oral Argument

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Hartford, CT 06134

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

March 4, 2014

Peter Schorr
President / CEO
NR Connecticut, LLC
12 New City Street
Essex, CT 06426

Certified Mail:7005 0390 00013506 9525

In RE: Certificate of Need Application, Docket Number 13-31828-CON
NR Connecticut, LLC-d/b/a/Retreat at South Connecticut
Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, CT

NOTICE OF ORAL ARGUMENT

Retreat at South Connecticut has requested an oral argument regarding the recommendation of Hearing Officer Marianne Horn, Esq. Pursuant to Section 4-179 C.G.S., Oral Argument for the above cited case has been scheduled as follows:

May 1, 2014 at 10:30 a.m.
Department of Public Health
3rd Floor, DPH Hearing Room
410 Capitol Avenue, Hartford, Connecticut

On May 1, 2014, you will have fifteen minutes to make your argument. If you wish to file briefs or exceptions, you must do so by April 26, 2014. Please call Barbara Olejarz at (860) 418-7005 if you have any questions.

Lisa Davis

Lisa Davis, MBA, BSN, RN
Deputy Commissioner

3/4/14
Date

C: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
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* * * COMMUNICATION RESULT REPORT (MAR. 4. 2014 2:38PM) * * *

FAX HEADER:

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STATE OF CONNECTICUT
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OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: PETER SCHORR

FAX: 860 767 0456

AGENCY: NR CONNECTICUT, LLC

FROM: OHCA

DATE: 3/4/14 **Time:**

NUMBER OF PAGES: *(including transmittal sheet*

Comments:

Notice of Oral Argument for Retreat of South Connecticut

PLEASE PHONE Barbara K. Olejarz IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

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* * * COMMUNICATION RESULT REPORT (MAR. 4. 2014 2:39PM) * * *

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: WILLIAM BECCARO

FAX: 860-767-0456

AGENCY: LAW OFFICE OF WILLIAM P. BECCARO

FROM: OHCA

DATE: 3/4/14 **Time:**

NUMBER OF PAGES:
(including transmittal sheet

Comments:

Notice of Oral Argument for Retreat of South Connecticut

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* * * COMMUNICATION RESULT REPORT (MAR. 4. 2014 2:40PM) * * *

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STATE OF CONNECTICUT
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OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JOAN FELDMAN

FAX: 860 251-5211

AGENCY: SHIPMAN & GOODWIN

FROM: OHCA

DATE: 3/4/14 **Time:**

NUMBER OF PAGES:
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Notice of Oral Argument for Retreat of South Connecticut

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Phone: (860) 418-7001 ***Fax: (860) 418-7053***

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* * * COMMUNICATION RESULT REPORT (MAR. 4. 2014 2:40PM) * * *

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
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FAX SHEET

TO: JENNIFER FUSCO

FAX: 203 772-2037

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FROM: OHCA

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P.O.Box 340308
Hartford, CT 06134

JUDA J. EPSTEIN
ATTORNEY AT LAW
3543 MAIN STREET
SECOND FLOOR
BRIDGEPORT, CT 06606
TELEPHONE NUMBER (203) 371-7007
FACSIMILE NUMBER (203) 371-6001
EMAIL ADDRESS: LAWOFFICESJJE@AOL.COM

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APR 11 2014
Office of
HEALTHCARE ACCESS

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TO:	FROM:
Kimberly Martone	Juda J. Epstein
COMPANY:	DATE:
Director of Operations, Department of Public Health Office of Health Care Access	4-11-2014
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
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PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
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RE:	YOUR REFERENCE NUMBER:
Appearance and Applicant's Exceptions to Proposed Final Decision	

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THE LAW OFFICE OF
JUDA J. EPSTEIN
WWW.LAWOFFICESJJE.COM

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April 11, 2014

Kimberly R. Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

VIA OVERNIGHT MAIL

RE: NR CONNECTICUT, LLC, D/B/A RETREAT AT SOUTH CONNECTICUT, ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY, OHCA DOCKET NO. 13-31828-CON

Dear Ms. Martone,

Enclosed herein please find my Appearance for the Applicant NR Connecticut, LLC, d/b/a Retreat at South Connecticut ("Applicant"). Also enclosed is an original and two copies of Applicant's Exceptions to Proposed Final Decision.

Please contact the undersigned should you or your staff have any questions.

Very truly yours,

Juda J. Epstein

cc: William P. Beccaro, Esq. (via U.S. mail with enclosures)
Joan W. Feldman, Esq. (via U.S. mail with enclosures)
Jennifer Groves Fusco, Esq. (via U.S. mail with enclosures)

Enc.
JJE/dv

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

BEFORE THE OFFICE OF HEALTH CARE ACCESS DIVISION OF THE DEPARTMENT OF PUBLIC HEALTH	:	Docket No. 12-31828-CON
IN RE APPLICATION OF NR RETREAT, LLC, d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACULITY IN NEW HAVEN, CT	:	April 11, 2014

NOTICE OF APPEARANCE

Please enter the appearance of the Law Offices of Juda J. Epstein on behalf of NR Retreat, LLC, d/b/a Retreat at South Connecticut in the above entitled proceeding.

Respectfully submitted,
NR RETREAT, LLC
d/b/a RETREAT AT SOUTH CONNECTICUT

By _____

Juda J. Epstein, Esq.
Law Offices of Juda J. Epstein
3543 Main Street, 2nd Floor
Bridgeport, CT 06606
(203) 371-7007 (tel)
(203) 257-8015 (fax)
Its Attorney

CERTIFICATE OF SERVICE

This is to certify that a true and accurate copy of the foregoing was sent by U.S. Mail this 11th day of April, 2014, to the following counsel of record:

William P. Beccaro, Esq.
12 New City Street
Essex, CT 06426

Joan W. Feldman, Esq.
Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103-1919

Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street, 10th Floor
New Haven, CT 06510

Juda J. Epstein

IN THE MATTER OF:

An Application for a Certificate of Need Filed Pursuant to Section 19a-638, C.G.S. by:	Office of Health Care Access Docket Number: 13-31828-CON
NR Connecticut, LLC, d/b/a Retreat at South Connecticut	**Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, CT**

APPLICANT'S EXCEPTIONS TO FINAL PROPOSED DECISION

Applicant NR Connecticut, LLC, d/b/a Retreat at South Connecticut ("Applicant" or "Retreat") respectfully submits the following exceptions to the Proposed Final Decision issued by the Office of Health Care Access ("OHCA") on January 22, 2014 (cited to hereafter as "Prop. Dec.") on Retreat's application to establish a 105-Bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut ("Application").

For the reasons set forth below, the Proposed Final Decision is arbitrary, capricious and contrary to law. *See* Connecticut General Statutes § 4-183(j); *Griffin Hospital v. Commission on Hospitals and Health Care*, 200 Conn. 489, appeal dismissed, 479 U.S. 1023, 107 S.Ct. 781, 93 L.Ed.2d 819 (1986); *Hospital of St. Raphael v. Commission on Hospitals & Health Care*, 182 Conn. 314, 318 (1980). The proposed factual findings are inaccurate or incomplete and disregard compelling evidence that there is a clear need for additional residential detoxification and rehabilitation services in Connecticut and that Applicant's comprehensive clinical programs and unique amenities differentiate it from other providers. These fatal omissions result in proposed conclusions which are contrary to the statutory "guidelines and principles" applicable to Certificate of Need applications pursuant to Connecticut General Statutes § 19a-639(a) and in abuse of OHCA's discretion.

I. The Proposed Final Decision Must Be Corrected To Include the Following Findings of Fact

Based upon the sworn testimony and evidence, and consistent with OHCA's previous findings of fact in other matters, the following facts have been established:

1. Connecticut is among the 10 states with the highest rates in the 18 to 25 age cohort for past month illicit drug use, past month marijuana use, past year marijuana use, and past month alcohol abuse, according to the National Survey on Drug Use and Health ("NSDUH"). The last category, past month alcohol abuse, also applies to the 26 and above age group. *See* Substance Abuse and Mental Health Services Administration ("SAMHSA") *States in Brief* ["Connecticut Report"], Application, Attachment D, p.116. Connecticut's rate of non-medical use of pain relievers is estimated by the most recent NSDUH findings to be 3.8% of the adult population. Department of Mental Health and

Addiction Services ("DMHAS") *Collection and Evaluation of Data related to Substance Use, Abuse, and Addiction Programs,* June 2011; Application, Attachment D, p. 99. For young adults age 18-25, the rate continues to be two and a half times the general adult population at 10.5%. *Id.* There is also evidence that many persons who become addicted to prescription pain relievers move to heroin as a cheaper and more readily available alternative. *Id.*

3. Connecticut's rates of unmet need for drug treatment have consistently exceeded the national average and are among the highest in the nation for individuals in the age group 18 to 25. Based upon SAMHSA's Connecticut Report, more than 208,689 Connecticut residents need, but have not received treatment for, some form of substance abuse dependence. Application, Attachment D, p. 119. DMHAS estimates that for every one person who seeks or receives behavioral health care for addiction, there are six individuals with similar conditions who will neither gain access to nor receive care. Application, Attachment F, p. 396; *See Final Decision, p.3, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012).*

4. According to OHCA's *Statewide Health Care Facilities and Services Plan* (pages 98-99), Connecticut has a population of 281,222 individuals needing substance abuse treatment, but only 46,741 receiving treatment. Overall, the Plan estimates that less than 17% of adults in need of substance use treatment seek such services in Connecticut.

5. Despite these alarming statistics, from 2002 to 2006, the National Survey of Substance Abuse Treatment Services (N-SSATS) reported that the number of substance abuse treatment facilities in Connecticut declined from 247 to 209. Application, Attachment D, p. 117. Based on data relied upon by OHCA, the number of Level 3.7 detox beds in Connecticut from 2012 to 2014 continued to decline. *Cf, Final Decision, FF 20, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012)* [finding that there were a total of 186 Detox beds in CT] and Prop. Dec., p. 4 [finding that there were a total of 156 Detox beds in CT]. In 2012, even prior to the latest decline of Level 3.7 detoxification beds in Connecticut, substance abuse treatment facilities such as Mountainside Treatment Center in Canaan were regularly referring individuals to facilities outside of the State (to New York, New Jersey and Massachusetts), primarily because of a lack of detoxification beds in Connecticut. *See Final Decision, FF 22, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, 11-31734-CON (May 11, 2012).*

6. Applicant submitted uncontroverted evidence that only 10 of 44 Connecticut facilities licensed by the Department of Public Health to treat substance abuse offer Level 3.7 residential detoxification. Application, Attachment C. Applicant surveyed these facilities on two different days and found that state-wide, only a handful of beds were available for detoxification. *Id.* The availability of a bed at the date/time that an

individual makes a decision to seek treatment is absolutely critical, as that window of opportunity may be lost while the individual's life continues to be imperiled by continued addiction and risk of overdose if residential treatment cannot be readily accessed. Application, p. 22; Testimony of Peter Schorr, Transcript, p. 107. Additionally, the unavailability of detoxification services at the 3.7 level places an unnecessary burden on hospital emergency rooms, resulting in a higher level of care (4.0) and substantially greater expense than is necessary. In New Haven, Yale-New Haven Psychiatric Hospital presently operates at capacity with regard to inpatient services and often has a waiting list of patients seeking to be admitted through its emergency room. Testimony of Dr. William Sledge, Transcript, p. 69.

7. DMHAS' three-year strategic substance abuse plan calls for improvement in access to substance abuse treatment. DMHAS 2010 Biennial Report, Application, Attachment D, p. 111. In its 2012 *Statewide Health Care Facilities and Services Plan*, OHCA cited NSDUH statistics showing that Connecticut's rate of unmet need for alcohol and/or illicit drug abuse or dependence has remained between 9% and 10% over the last seven years. *Id.*, p. 99.

8. Of the 199 facilities for the Care or Treatment of Substance Abuse of Dependent Persons listed in the 2012 *Statewide Health Care Facilities and Services Plan*, only seven (7) were listed as providing Residential Detoxification and Evaluation for a total of 147 such beds in the State while there were eleven (11) facilities with a total of 265 beds listed as providing Residential Rehabilitation Treatment. This data was current as of August, 2012. Connecticut Department of Public Health Office of Health Care Access *Statewide Health Care Facilities and Services Plan, October 2012*, pp. 280-287.

9. Retreat seeks approval for 26 Level 3.7 residential detoxification beds, as defined by the American Society of Addiction Medicine's five levels of detoxification care, and 79 beds to be available for continuing residential rehabilitation treatment. Application, p. 18. It will also provide partial hospitalization (PHP), intensive outpatient (IOP), general outpatient, continuing recovery oriented care, and continuing education with respect to addiction and substance abuse. Application, pp. 18-19 and Attachment B.

10. Detoxification and evaluation generally requires five to seven days to complete before an individual is ready to begin residential rehabilitation treatment, which typically continues for approximately 30 days. Application, pp. 18-19. Ensuring continuity of care has been one of the primary practice guidelines endorsed by DMHAS. Application, Attachment F, pp. 397-398, and Applicant's program is designed to provide a seamless transition for clients through the different levels of residential and outpatient programs

offered. Application, p. 19 and Attachment B (description of professional services and treatment philosophy).

11. The Retreat's holistic approach will treat each individual's physical, psychological, emotional and spiritual needs, utilizing motivational techniques, change theory and cognitive-behavioral therapy, to help him or her make the necessary changes to break the cycle of addiction. Applicant will utilize evidence-based methods of care, as well as specialized treatment plans targeted to the special needs of certain sectors of the population, such as health care workers, first responders, veterans and labor union members. In addition to providing comprehensive treatment for substance abuse and co-occurring disorders, Applicant's newly remodeled, state-of-the-art facility will offer a level of comfort and individualized attention not presently available in the New Haven area. Application, pp. 18-19; Pre-Filed Testimony of Peter Schorr, p. 2.

12. To provide the highest quality of care, Retreat employs its medical staff directly rather than on a part-time or per diem basis. Pre-Filed Testimony of Steven Klotz, M.D., pp. 1-2. The medical staff works closely with an interdisciplinary team of clinical specialists including nurse practitioners, clinical nurse specialists, substance abuse therapists, social workers, registered and licensed practice nurses, dietitians and aides. *Id*; Application, pp. 66-69. Another distinguishing feature of Retreat's services is access to specialized programs and treatment alternatives that encompass individual sessions where the patient is assessed by his or her primary therapist, daily community meetings and small group therapy sessions, and special treatment tracks focusing on co-dependency, relapse prevention, anger management and other coping skills necessary for successful recovery. Application, Exhibit B, pp. 63-65.

13. The combination of 26 Level 3.7 residential detoxification beds and 79 residential rehabilitation beds in the same facility will help to ensure that more drug-addicted and alcoholic individuals complete their treatment. Application, pp. 18-19. "Additionally, it will improve continuity of care and by improving access to detoxification care, will help to ensure that more individuals are entering into the first phase critical services at the same facility at which they will continue their rehabilitation to help them manage their addiction." *See Final Decision, FF 40, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012).*

14. Retreat will maintain the same high standards and provide the same individualized treatment as its existing sister facility, Retreat at Lancaster County ("Lancaster facility"), which is a 120-bed residential substance abuse facility located in Ephrata, Pennsylvania and operating since 2011. The Lancaster facility treated 2,206 individuals in the most recent fiscal year; 1,383 were from Pennsylvania and the

remainder were from other states, including 12 individuals from Connecticut. Applicant has found that the ratio of 30 detoxification beds to 90 residential rehabilitation beds to be optimal. It anticipates that the Connecticut facility will similarly attract individuals from Connecticut and surrounding states, and that most will transition from a detoxification program to a rehabilitation program. Application, pp. 19, 62-74; Testimony of Peter Schorr, Transcript, pp. 2-15.

15. The Applicant established through testimony and evidence that its proposed program is *unlikely* to have a substantial impact on existing providers because it will engage in targeted efforts to enroll individuals in need of treatment for drug or alcohol dependency who have not previously sought treatment. This will be aided by an initial marketing and advertising budget of $240,000 (Application, Attachment K, p. 656) and other community outreach efforts that will highlight the empirically validated treatment approaches, individualized care and amenities Retreat will offer. *See Final Decision, p.15, Employment Options, Inc. d/b/a Litchfield Hills Retreat, Docket 09-31500-CON (May 7, 2010)* [approving Litchfield Hills Retreat for the reason that it is a unique facility that will provide services in a setting with certain amenities that are not widely available within the State of Connecticut.]. Retreat's proposal meets an identified need in Connecticut for more residential treatment facilities that are in network and accept private insurance, including the plans offered by Access Health Connecticut and other health insurance exchanges. Application, pp. 21-22; Exhibit D, pp. 365-67.

16. In order to meet its first year projections, Applicant would need to admit less than 0.5 percent of the 208,689 Connecticut residents in need of treatment. *See* SAMHSA's Connecticut Report, Application, Attachment D, p. 117.

The foregoing proven, uncontroverted facts are relevant and material to the Application. OHCA has made findings of fact regarding the pervasive problem of drug addiction, the increasing need for substance abuse treatment and the decline in the number of programs and beds available in Connecticut. *See, e.g., Final Decision, Project Courage, LLC, Docket 13-31846-CON (January 18, 2014); Final Decision, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012); Final Decision, Blue Sky Behavioral Health, LLC, Docket 11-31687-CON (September 9, 2011): Final Decision, Employment Options, Inc. d/b/a Litchfield Hills Retreat, Docket 09-31500-CON (May 7, 2010);* and *Final Decision, Vista Partners, LLC, Docket 07-30927-CON (December 5, 2007).* In each of these decisions, OHCA considered whether the applicant's services were unique or different from other treatment providers and in every instance granted the application based upon the needs of a particular segment of the population. In stark contrast, the Proposed Final Decision makes no findings whatsoever regarding Applicant's vast array of individualized programs or unique amenities such as a full gymnasium and gourmet meals, which serve the needs of a segment of a patient

population who otherwise might be unlikely to seek treatment at existing residential treatment in Connecticut. These programs and services also serve to differentiate Retreat's proposal from the Intervenors' facilities. Especially given the fact that Applicant has a proven record of success at its Lancaster facility of admitting and treating a high volume of individuals who have private insurance or the ability to pay, the failure to make adequate findings regarding the proposed program and the population to be served is an unwarranted abuse of discretion and results in a Proposed Final Decision that is arbitrary, capricious and legally erroneous.

For all of these reasons, the Proposed Final Decision must be modified to fully incorporate the above corrected Findings of Fact 1 through 16.

II. The Proposed Final Decision Must Be Corrected to Omit or Revise the Following Irrelevant or Inaccurate Findings of Fact

The Proposed Decision is further flawed because it contains several findings of fact which are unsupported by the record evidence and are inaccurate or misleading. Accordingly, these findings of fact should either be corrected or omitted from final decision, as follows:

> *(9.) All 30 of the short-term general or children's general hospitals had substance abuse treatment discharges from FY 2008 to FY 2010. Sixteen hospitals provide detox services and twelve provide intensive inpatient treatment. Statewide Health Care Facilities and Services Plan, October 2012, pp. 99,101.*

To the extent the above might suggest that there is no need for Applicant's services because the detoxification services of existing substance abuse treatment facilities are supplemented by the services offered by hospitals in Connecticut, it is grossly misleading. As Applicant's testimony established, the more appropriate level of inpatient detoxification care for most individuals who do not suffer from acute symptomology and whose risks upon withdrawal can be medically monitored is Level 3.7, which Retreat proposes to offer, rather than the unnecessary, higher cost Level 4.0 treatment provided in a hospital setting. This fact is underscored by the hospital emergency department focus groups which participated in the preparation of OHCA's *Statewide Facility and Services Plan* and concluded that the emergency rooms of Connecticut hospitals were being inappropriately used by behavioral health patients for detoxification and other treatment. Physicians and hospital administrators were in agreement that these patients would be better treated in another setting, such as a substance abuse facility. *See Statewide Health Care Facilities and Services Plan, Appendix G, pp.166-168.*

In previous CON proceedings involving substance abuse providers, OHCA did not consider hospital data in evaluating the need for a substance abuse program. *See, e.g., Final Decision, Project Courage, LLC, Docket 13-31846-CON (January 18, 2014); Final Decision, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012); Final Decision, Employment Options, Inc. d/b/a Litchfield Hills Retreat, Docket 09-31500-CON (May 7, 2010);* and *Final Decision, Vista Partners, LLC, Docket 07-30927-CON*

(December 5, 2007). The Hearing Officer should not have departed from previous practice and considered hospital discharges for drug abuse treatment without permitting Applicant the opportunity to object or to offer rebuttal. Connecticut courts have held that OHCA may consider or use reports and data gathered by members of its own staff in CON proceedings, but it cannot properly base findings upon such reports or data without introducing them into evidence and affording Applicant an opportunity to object and to offer rebuttal. *See New England Rehabilitation Hospital of Hartford, Inc. v. Commission on Hospitals & Health Care,* 226 Conn. 105, 150 (1993); *See also, Parsons v. Board of Zoning Appeals,* 140 Conn. 290, 293 (1953).

For all the foregoing reasons, proposed Finding of Fact 9 should be stricken in its entirety. In the alternative, the hearing should be reopened to permit Applicant the opportunity to demonstrate that the hospital data actually supports, rather than diminishes, the public need for its facility in Connecticut because (i) its services are more effective and less expensive, and (ii) expanding the availability of detox and rehab programs will alleviate many of the challenges facing hospital emergency departments

> *(14.) The "Addiction Residential Census Report" that is compiled daily (Monday to Friday) by DMHAS provides information on the number of available beds at facilities providing Level 3.7 detox and residential rehab that receive DMHAS grant funds, as well as other providers that choose to report through the DMHAS portal. (The Proposed Final Decision then sets forth Table 2, reflecting that between 8/13/13 and 8/21/13, between 3 and 17 detox beds were available at a Connecticut facility).*

It is a misnomer to describe the DMHAS report as compiled "daily," when, in fact, data is not reported on Saturdays or Sundays when many individuals in crisis need immediate intervention. Similarly, data regarding the number of Level 3.7 detoxification beds reported by some providers to DMHAS as available is of limited utility absent testimony regarding whether such data accurately reflects the ability of a patient in crises to immediately access the bed.

Retreat's Application and testimony established that on two different days, telephone surveys reflected that only a handful of Level 3.7 beds were available at eleven facilities throughout Connecticut that offer residential detoxification. In previous CONs, OHCA has made findings of fact based upon an Applicant's survey of bed availability. *See, e.g., Final Decision, FF 19, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012).*

In the present case, the Hearing Officer appears to have ignored Applicant's survey evidence without any reason and instead permitted Intervenors to submit DMHAS bed census data by late file, which improperly denied Applicant the opportunity to object or to offer evidence or argument in rebuttal. *See New England Rehabilitation Hospital of Hartford, Inc. v. Commission on Hospitals & Health Care,* supra at 150; *Parsons v. Board of Zoning Appeals,* supra at 292- 293. The DMHAS census data is not accurate in ascertaining whether a

reasonable number of Level 3.7 beds are available to the general public in Connecticut. Additionally, the DMHAS census data does not reflect the time of day that the information is reported, whether the facility has a waiting list or how long the bed remained available before another patient filled the bed. Moreover, proposed Finding of Fact 9 is based only upon data for a one-week period in August, 2013, at the height of travel season, when patient census can be expected to be artificially low at all inpatient facilities.

It was an abuse of discretion to propose findings of fact based upon such unverified DMHAS census data, while ignoring the results of Applicant's surveys. Further, regardless of whether the number of Level 3.7 detoxification beds available state-wide is 3 (as confirmed for certain days by both DMHAS census data and Applicant's surveys) or as many 7 (the average according to this limited DMHAS census data), these small number of beds are grossly inadequate to meet the needs of the 208,689 Connecticut residents who suffer from drug or alcohol addiction, but are not undergoing treatment.

For all the foregoing reasons, proposed Finding of Fact 14 should be stricken in its entirety or the hearing should be reopened to permit Applicant the opportunity to counter the DMHAS census data with more accurate information reflecting the actual availability of detoxification beds in Connecticut.

(19.) Given the high rate of individuals in New Haven who are governmentally-insured, the proposed facility would not benefit these individuals since it will not accept Medicaid patients. Tr. Testimony of Robert Freeman, pp. 63, 65.

(20.) The payer mix in Fiscal Year 2012 shows that 79% of the residents of the town of New Haven had government insurance and 20% had commercial insurance. Of New Haven County residents, 65% had government insurance and 33% had commercial insurance. (The Proposed Finding then incorporates Table 6: Payer Mix for the Town of New Haven and New Haven County for Fiscal Year 2012: Source, OHCA's Acute Hospital Inpatient Discharge Database.)

The above proposed Findings of Fact 19 and 20, which focus upon the needs of individuals residing in the City or County of New Haven, are only minimally relevant since the populations Applicant seeks to serve are residents who live throughout Connecticut and in surrounding states. Indeed, the testimony of Mr. Freeman demonstrated that his own New Haven program served individuals from other areas of the State. Transcript, p. 63. Accordingly, and at a minimum, the proposed Findings of Fact should address the state-wide population Applicant intends to serve, rather than only New Haven residents.

In addition, proposed Finding of Fact 20 is inaccurate due to misplaced reliance upon the OHCA's Acute Hospital Inpatient Discharge Database in attempting to ascertain the percentage of New Haven residents who have commercial insurance. This data is skewed by the fact that a

far greater percentage of elderly Medicare-eligible patients obtain services at hospitals than would be the case at a substance abuse facility. Moreover, because many Medicaid patients do not have strong connections to primary care providers and are more apt to use emergency departments and other hospital facilities as their medical provider of first resort, the Medicaid data from OHCA's Acute Care Hospital Inpatient Discharge Database does not accurately reflect, nor is it relevant to, the population to be served by a substance abuse facility catering mainly to commercially insured patients.

Once again, OHCA considered information from its database without affording Applicant notice or affording it the opportunity to object or to offer rebuttal demonstrating that such data is inapplicable or misleading. *See New England Rehabilitation Hospital of Hartford, Inc. v. Commission on Hospitals & Health Care*, supra at 150; *Parsons v. Board of Zoning Appeals,* supra at 292- 293. If Applicant had been permitted the opportunity to respond regarding OHCA's consideration of the data set forth in the Proposed Final Decision at Table 6, it would have objected on the grounds that this data reflects only the percentage of patients from New Haven admitted to a Connecticut hospital during the relevant period who have commercial insurance. Further, Applicant would have demonstrated that the percentage of New Haven residents who have commercial insurance as reported by the United States Census Bureau data for 2008-12 is as follows: Town of New Haven, 54.9%; County of New Haven, 72.2%; and State of Connecticut, 74.9%. Additionally, these percentages will increase substantially in the coming years due to the passage of federal health care reform legislation and laws requiring parity between behavioral health and medical coverage in plans offered through the health insurance exchanges. The result will be that more people will be able to obtain policies that will cover some of the costs of substance abuse treatment services.

Based upon the foregoing, proposed Finding of Fact 19 should be stricken since it is not relevant and proposed Finding of Fact 20 should either be stricken or the hearing should be re-opened to permit Applicant the opportunity to demonstrate that the data OHCA considered is inaccurate and misleading and that United States Census Bureau data demonstrates that 74.9% of Connecticut residents are commercially insured.

> *(21) The existing providers of the service proposed by the Applicant have the capacity to meet the needs of the commercially-insured and self-pay patients, who are the target of the Applicant's proposal. Testimony of Jeffrey Walter, President and CEO of Rushford Center, pp. 37-28; Tr. Testimony of Georganna Kopperman, Director of Business Development and Military Affairs at Stonington Institute, pp. 56-57.*

This proposed finding of fact ignores the material fact that Applicant proposes to offer a comprehensive and clinically-proven treatment program in a new facility with a directly employed medical staff, low patient-to-staff ratios and numerous amenities which have proven attractive to individuals with commercial insurance coverage. The statistics provided in corrected Findings of Fact 1-4, above, demonstrate conclusively that there exists a vast pool of

patients who have either chosen to forego treatment at the existing facilities in the State or are seeking treatment outside of Connecticut.

Intervenors presented no testimony that their facilities offered comparable treatment programs on the scale of those offered by Retreat. Application, Attachment B, pp. 63-74. Nor was there testimony that any of the existing facilities can match Retreat in terms of the level of outreach and visibility it will give to its services or the physical plant and non-clinical amenities that Applicant will provide. Accordingly, Retreat has satisfactorily demonstrated that existing providers do not have the capacity to meet the needs of the population it presently serves in Pennsylvania and endeavors to serve in Connecticut.

OHCA has previously recognized that an applicant's individualized services or special amenities may differentiate it from other treatment providers and serve the need of a particular segment of the Connecticut population. *See, e.g., Final Decision, Employment Options, Inc. d/b/a Litchfield Hills Retreat, Docket 09-31500-CON (May 7, 2010).* Also, OHCA has recognized the benefits of a program, which similar to Applicant's, targeted Connecticut executives, physicians, and other professionals, acknowledging that these individuals often seek out private, discreet and individualized programs. *See Final Decision, FF 14, Vista Partners, LLC, Docket 07-30927-CON (December 5, 2007).* In 2007, the only facility offering such individualized treatment in the Northeast was the McLean Center at Fernside, located in Boston, Massachusetts, which has only 10 beds. *Id.* Accordingly, OHCA recognized that Vista's proposed program would serve the needs of a segment of the population and improve the quality and accessibility of substance and alcohol abuse/dependency patients in the region. *Id.* Here, the target market for Applicant's programs and services can be seen as equally unique because, as opposed to serving an elite population of patients, it seeks to provide affordable yet comprehensive services to the general population of insured adults in Connecticut.

It is also impossible to reconcile proposed Finding of Fact 21 with OHCA's previous findings that there was a shortage of Level 3.7 beds in Connecticut, given that the number of beds has seemingly declined while the number of addicted individuals has increased. *See Final Decision, FF 20, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012)* and corrected Findings of Fact 1 through 5, *infra*, pp. 1-2. While the Proposed Final Decision, page 11, states that CON applications are decided on a cases by case basis and do not lend themselves to general applicability due to the unique facts in each case, OHCA's findings regarding the same factual issues should be consistent from case to case.

Additionally, neither Mr. Walter nor Ms. Kopperman offered any statistical data or other evidence to demonstrate that there is excess capacity at their facilities with regard to detoxification beds. To the contrary, Mr. Walter testified that while beds are available "most days of the year" somewhere in the state, there were 30 days out of the year when Rushford had no beds available. Transcript, pp. 37-38. Ms. Kopperman testified that Stonington's

detoxification service operates "close to capacity," even though there are multiple discharges every day. Transcript, p. 57. The testimony of these individuals also ignores the undisputed fact that demand will grow as a result of many more Connecticut residents having insurance coverage for substance abuse services under the Affordable Care Act ("ACA").

It is simply unrealistic to expect that individuals in crisis (or their families), who are suffering from the devastating impairments which accompany addiction, will call around to all the facilities in the State which offer inpatient detoxification in order to locate an available bed. Until Level 3.7 detoxification beds are reasonably available and readily accessible to provide a continuum of care for patients across the State, it is unlikely that progress will be made in treating the 208,689 Connecticut residents who are afflicted by addiction but not receiving any services.

For all of the above reasons, proposed Finding of Fact 21 must be stricken.

(22) The current providers of the service proposed by the Applicant rely upon patients who are commercially-insured or self-pay to offset lower reimbursement rate realized by serving governmentally-insured charity care populations. Tr. Testimony of Mr. Walter, p.40; Tr. Testimony of William Sledge, M.D., Medical Director of the Yale-New Haven Psychiatric Hospital, pp. 67-70; Tr. Testimony of Ms. Kopperman, pp. 60-62; Tr. Testimony of Douglas Bruce, M.D., Medical Director of South Central Rehabilitation Center at the Cornell Scott-Hill Health Center, pp. 74, 75.

First, the testimony summarized above is irrelevant since all providers, including Applicant, must rely upon those individuals (or their insurance carriers) who pay in full for services to cover the shortfall resulting from those individuals who do not pay for services (or who pay less than the full cost of providing the service). While Applicant does not intend to participate in the Medicare or Medicaid programs, it will either refer the individual to an appropriate facility participating in Medicare or Medicaid or provide treatment without charge.

Second, the application cannot be denied solely because the Applicant does not intend to participate in Medicare and Medicaid. OHCA has previously approved numerous certificate of need applications of substance abuse treatment providers who do not participate in these programs. For example, OHCA approved Project Courage, LLC's application for establishment of an intensive outpatient behavioral health and substance abuse treatment facility to serve adolescents and young adults, which was entirely funded by commercial insurers (up to 100%) or by families out-of-pocket (up to 80%) with referral of those who do not have an insurance option or ability to self-pay to another provider. OHCA concluded that since the proposed program would permit Project Courage to receive out-of-network reimbursement for its services from third party payers, it would improve access for the targeted population and provide additional payment options for clients and their families. *Final Decision, pp. 2, 6, 10, Project*

Courage, LLC, *Docket 13-31846-CON (January 18, 2014).* Here, Applicant plans to be an in-network provider with most commercial insurance plans as is the case at the Lancaster facility.

Moreover, in 2011, OHCA approved MCI, Healthcare, LLC d/b/a Mountainside Treatment Center's application for 16 additional level 3.7 detoxification beds, with a patient mix of 80% commercial insurance and 20% self-pay. *Final Decision, FF 20, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012).* Also, in 2011, OHCA approved Blue Sky Behavioral Health, LLC's Application for a facility for treatment of substance abuse (as well as an outpatient psychiatric program) which would have a payer mix of 80% private pay and 20% commercial insurance. OHCA concluded that since the program would be entirely funded by self-pay and private insurance, it would have a positive impact on the financial strength of the health care system. *Final Decision, pp. 8-10, Blue Sky Behavioral Health, LLC, Docket 11-31687-CON (September 9, 2011).*

Finally, OHCA approved Vista Partners, LLC's application for an Alcohol and Drug Treatment Center in Sharon, Connecticut, which would be entirely patient funded, at an initial monthly rate of $50,000, without Medicare, Medicaid or commercial insurance participation. *Final Decision, p. 8, Vista Partners, LLC, Docket 07-30927-CON (December 5, 2007).*

In contrast, the Proposed Final Decision in this proceeding reflects that the Hearing Officer gave inappropriate consideration and weight to Intervenors' claims that the Applicant's program would negatively impact their bottom lines. First, Intervenors' claims are totally unsubstantiated, especially in light of the substantial population of commercially insured individuals who are in need of, but not receiving treatment, and to whom Applicant will market its program. This population will also continue to grow under the ACA. Second, to the extent the Proposed Final Decision gives greater consideration to the potential economic impact of the Application on Intervenors than the public need of individuals afflicted with addiction, it misapplies the statutory guidelines and principles set forth in Conn. Gen. Stat. § 19a-639(a).

For all of the foregoing reasons, proposed Finding of Fact 22 is irrelevant and must be stricken from the final decision.

III. The Proposed Final Decision Reaches Numerous Erroneous Conclusions which must be Corrected

Having made numerous erroneous factual findings, while neglecting to make findings based upon the material evidence submitted, it is not surprising that the Proposed Final Decision then misapplies the statutory guidelines and principles contained in Conn. Gen. Stat. §19a-639(a) to arrive at erroneous conclusions. The Proposed Final Decision should be corrected with regard to the following numbered conclusions of law:

(27) This conclusion should be corrected to reflect that the Applicant has established a clear public need for its proposal. Conn. Gen. Stat. § 19a-639(a)(3)

It is undisputed that there is a large segment of the Connecticut population (reported to be 208,689 individuals) who suffer from addiction and are in need of, but have not sought, treatment. The Proposed Final Decision, page 12, erroneously declines to consider the needs of this population, for the purported reason that the Applicant has not demonstrated that they have sought treatment in Connecticut or elsewhere. This conclusion is irrational and illogical because a clear public need for treatment exists, regardless of whether these individuals have sought treatment in the past. This large pool of patients in need of services also completely undermines the argument of Intervenors that approval of the Applicant's proposal will reduce the volume of commercially insured patients that they will serve as there is ample volume to support all existing providers, especially given the growth of the insured population under the ACA.

The Applicant presented ample evidence that it would serve the segment of the population who have not previously sought out treatment and who, in most cases, have insurance coverage to pay for the comprehensive care and individualized services that are built into Applicant's programs and cost structure. Further, the Applicant established that in the previous year, its Lancaster facility successfully enrolled 2,206 individuals from Pennsylvania and throughout the U.S. in similar programs. *See* corrected Finding of Fact 13, *infra.* The Proposed Final Decision utterly ignores this material evidence and fails to make any findings regarding the unique services and programs the Applicant proposes to offer or its past success in meeting the needs of individuals who had not previously sought treatment. Especially in view of OHCA's recent consideration of the specialized services offered by other Connecticut facilities, such as Mountainside, Litchfield Hills Retreat, and Vista, the failure to consider material evidence is an abuse of discretion.

(28) This conclusion should be corrected to reflect that the proposal will financially strengthen the health care system in the state or that the proposal is financially feasible for the Applicant. Conn. Gen. Stat. § 19a-639(a)(4)

In a glaring error of law, OHCA omitted from this proposed conclusion consideration of whether the proposal is financially feasible for Retreat. On this point, Retreat provided uncontroverted evidence the cost of the project is fully funded by $7.5 million in financing from its primary lender, Fulton Bank. Application, Attachment J, p. 652. It also provided financial attachments demonstrating that the project would be profitable in first year of operation and thereafter. *Id.*, Attachment K. In addition, Applicant does not intend to seek or accept any federal, state or local funds, grants, abatements or credits and will impose no fiscal burden whatsoever on Connecticut's healthcare system. Instead, its operations are fully funded and will subsidize the free care it renders to patients who cannot afford to pay while providing comprehensive and high quality drug treatment services to state residents. Accordingly,

Retreat's investment in the New Haven facility will necessarily strengthen Connecticut's health care system as well as the local economy.

In addition to the investment of capital and resources, Retreat's proposal will result in improved coordination of care, because individuals admitted to its New Haven facility for detoxification can seamlessly transition to a 30-day inpatient program, and then avail themselves of outpatient care. OHCA has previously recognized the benefits of this coordinated continuum of care approach. In granting Mountainside Treatment Center's application for an additional 16 level 3.7 detoxification beds in 2011, OHCA found that the combination of detoxification beds with Mountainside's existing residential rehabilitation beds will improve timely access to detoxification care, improve continuity of care due to the provision of detoxification and rehabilitation care at the same location and will have a positive impact on the quality of health care delivery in Connecticut while retaining residents who currently leave the state for treatment. *See Final Decision, p. 10, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012).* The same conclusion must follow in this case.

> *(29) This conclusion should be corrected to reflect that the proposal would improve the accessibility of health care delivery in the region and improve the quality and cost effectiveness of health care in Connecticut. Conn. Gen. Stat. § 19a-639(a)(5)*

Proposed conclusion 29 is totally contrary to the record evidence and clearly erroneous. It cannot be disputed that the additional 26 Level 3.7 detoxification beds and 79 residential rehabilitation beds along with Retreat's full spectrum of outpatient programs will improve accessibility to services. Moreover, Applicant has demonstrated through its successful Lancaster facility that the high quality programs and services it provides are also cost effective. There was no evidence to contrary. Accordingly, proposed conclusion 26 must be corrected.

> *(31) This conclusion should be corrected to reflect that the Applicant has satisfactorily identified the population to be served by its proposal and that this population has a need for the proposal. Conn. Gen. Stat. § 19a-639(a)(7)*

At page 27 of its Application, Retreat stated that "[t]he population to be served would be primarily Connecticut residents, aged 18 and older, in need of residential detoxification and recovery." Applicant also provided uncontroverted evidence that Connecticut: (i) is among the 10 states with the highest rates in the 18 to 25 age cohort for past month illicit drug use, past month marijuana use, past year marijuana use, and past month alcohol abuse; (ii) that its rate of non-medical use of pain relievers is estimated by the most recent NSDUH findings to be 3.8% of the adult population and that for young adults age 18-25, the rate continues to be two and a half times the general adult population at 10.5%; and (iii) that SAMHSA's latest estimates show that 208,689 Connecticut residents need, but have not received treatment for, some form of substance abuse dependence. In its 2012 *Statewide Health Care Facilities and Services Plan*, OHCA also stated that there are 281,222 Connecticut individuals needing substance abuse treatment, but only

46,741 receiving treatment. Applicant more than met its burden of identifying the population to be served and demonstrating the population's need for its proposal. The Hearing Officer's proposed conclusion misapplies both the facts and law, and must be corrected.

(32) This conclusion should be corrected to reflect that the Applicant has satisfactorily provided historical utilization data of behavioral health treatment services in the service area that would support the proposal. Conn. Gen. Stat. § 19a-639(a)(8)

The historical data is presented through statistical reports appended to the Application (Attachment D) as well as through OHCA's findings of facts and conclusions in other behavioral health applications since 2007, which OHCA may administratively notice. *See, e.g. Final Decision, Project Courage, LLC, Docket 13-31846-CON(January 18, 2014); Final Decision, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, 11-31734-CON (May 11, 2012); Final Decision, Blue Sky Behavioral Health, LLC, Docket 11-31687-CON (September 9, 2011): Final Decision, Employment Options, Inc. d/b/a Litchfield Hills Retreat, Docket 09-31500-CON (May 7, 2010);* and *Final Decision, Vista Partners, LLC, Docket 07-30927-CON (December 5, 2007).* All of the foregoing support the granting of the Application, and accordingly, proposed conclusion 32 should be corrected.

(33) This conclusion should be corrected to reflect that the Applicant has satisfactorily demonstrated that the utilization of existing health care facilities and services in the service area supports the proposal. Conn. Gen. Stat. § 19a-639(a)(8)

Based upon the survey data provided at Attachment C of the Application and the inconclusive nature of the DMHAS census reports regarding bed availability throughout the State, the record in this proceeding adequately demonstrates patient backlogs, treatment delays and other utilization patterns at existing health care facilities that support this proposal. Further, there is only one other provider of residential rehabilitation services in the City of New Haven and none in the State that offer the array of clinical programs and special amenities proposed by Applicant to the general public at affordable rates. Accordingly, proposed conclusion 33 must be corrected.

(34) This conclusion should be corrected to reflect that the Applicant has satisfactorily demonstrated that the proposal will not result in an unnecessary duplication of existing services in the area. Conn. Gen. Stat. § 19a-639(a)(9)

Once again, a duplication of services will not result because Applicant's services are specialized and unique, and will be offered to a segment of the population which needs, but is not currently receiving, treatment. Therefore, proposed conclusion 34 must be revised, consistent with the uncontroverted evidence presented.

IV. Conclusion

For all of the foregoing reasons, the Applicant respectfully requests that its exceptions be sustained and that the Proposed Final Decision be corrected and the Application for a Certificate of Need granted. In the alternative, the Applicant respectfully requests that the hearing be reopened in order to permit it to fully respond to data and other matter outside of the hearing record which were considered by the hearing officer.

RESPECTFULLY SUBMITTED,
THE APPLICANT
NR CONNECTICUT, LLC d/b/a
RETREAT AT SOUTH CONNECTICUT

By: _____

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Date: April 11, 2014

CERTIFICATE OF SERVICE

This is to certify that a true and accurate copy of the foregoing was sent by U.S. Mail this 11th day of April, 2014, to the following counsel of record:

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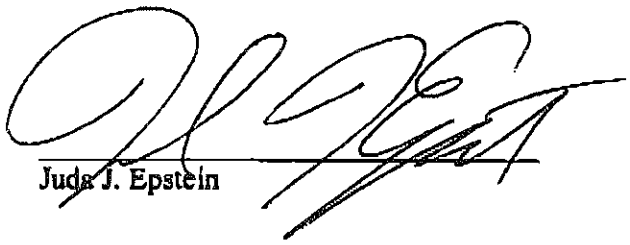

Juda J. Epstein

Docket Number: 13-31828-CON

Fax pages 22 – 55 were copies of 1 – 21 and have been removed from the record

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April 11, 2014

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VIA OVERNIGHT MAIL

RE: NR CONNECTICUT, LLC, D/B/A RETREAT AT SOUTH CONNECTICUT, ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY, OHCA DOCKET NO. 13-31828-CON

Dear Ms. Martone,

Enclosed herein please find my Appearance for the Applicant NR Connecticut, LLC, d/b/a Retreat at South Connecticut ("Applicant"). Also enclosed is an original and two copies of Applicant's Exceptions to Proposed Final Decision.

Please contact the undersigned should you or your staff have any questions.

Very truly yours,

Juda J. Epstein

cc: William P. Beccaro, Esq. (via U.S. mail with enclosures)
Joan W. Feldman, Esq. (via U.S. mail with enclosures)
Jennifer Groves Fusco, Esq. (via U.S. mail with enclosures)

Enc.
JJE/dv

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

BEFORE THE OFFICE OF HEALTH CARE ACCESS DIVISION OF THE DEPARTMENT OF PUBLIC HEALTH	:	Docket No. 12-31828-CON
IN RE APPLICATION OF NR RETREAT, LLC, d/b/a RETREAT AT SOUTH CONNECTICUT TO ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACULITY IN NEW HAVEN, CT	:	April 11, 2014

NOTICE OF APPEARANCE

Please enter the appearance of the Law Offices of Juda J. Epstein on behalf of NR Retreat, LLC, d/b/a Retreat at South Connecticut in the above entitled proceeding.

Respectfully submitted,
NR RETREAT, LLC
d/b/a RETREAT AT SOUTH CONNECTICUT

By _____

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CERTIFICATE OF SERVICE

This is to certify that a true and accurate copy of the foregoing was sent by U.S. Mail this 11th day of April, 2014, to the following counsel of record:

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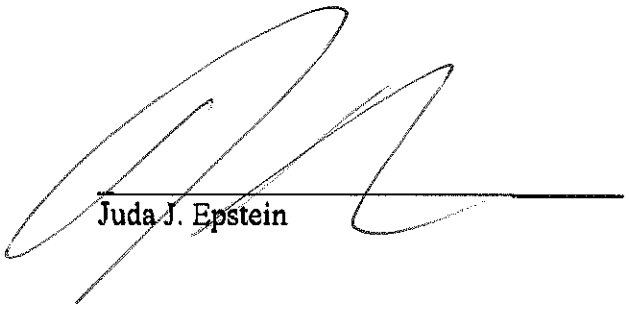

Juda J. Epstein

IN THE MATTER OF:

An Application for a Certificate of Need Filed Pursuant to Section 19a-638, C.G.S. by:	Office of Health Care Access Docket Number: 13-31828-CON
NR Connecticut, LLC, d/b/a Retreat at South Connecticut	**Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, CT**

APPLICANT'S EXCEPTIONS TO FINAL PROPOSED DECISION

Applicant NR Connecticut, LLC, d/b/a Retreat at South Connecticut ("Applicant" or "Retreat") respectfully submits the following exceptions to the Proposed Final Decision issued by the Office of Health Care Access ("OHCA") on January 22, 2014 (cited to hereafter as "Prop. Dec.") on Retreat's application to establish a 105-Bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut ("Application").

For the reasons set forth below, the Proposed Final Decision is arbitrary, capricious and contrary to law. *See* Connecticut General Statutes § 4-183(j); *Griffin Hospital v. Commission on Hospitals and Health Care,* 200 Conn. 489, appeal dismissed, 479 U.S. 1023, 107 S.Ct. 781, 93 L.Ed.2d 819 (1986); *Hospital of St. Raphael v. Commission on Hospitals & Health Care,* 182 Conn. 314, 318 (1980). The proposed factual findings are inaccurate or incomplete and disregard compelling evidence that there is a clear need for additional residential detoxification and rehabilitation services in Connecticut and that Applicant's comprehensive clinical programs and unique amenities differentiate it from other providers. These fatal omissions result in proposed conclusions which are contrary to the statutory "guidelines and principles" applicable to Certificate of Need applications pursuant to Connecticut General Statutes § 19a-639(a) and in abuse of OHCA's discretion.

I. The Proposed Final Decision Must Be Corrected To Include the Following Findings of Fact

Based upon the sworn testimony and evidence, and consistent with OHCA's previous findings of fact in other matters, the following facts have been established:

1. Connecticut is among the 10 states with the highest rates in the 18 to 25 age cohort for past month illicit drug use, past month marijuana use, past year marijuana use, and past month alcohol abuse, according to the National Survey on Drug Use and Health ("NSDUH"). The last category, past month alcohol abuse, also applies to the 26 and above age group. *See* Substance Abuse and Mental Health Services Administration ("SAMHSA") *States in Brief* ["Connecticut Report"], Application, Attachment D, p.116. Connecticut's rate of non-medical use of pain relievers is estimated by the most recent NSDUH findings to be 3.8% of the adult population. Department of Mental Health and

Addiction Services ("DMHAS") *Collection and Evaluation of Data related to Substance Use, Abuse, and Addiction Programs,* June 2011; Application, Attachment D, p. 99. For young adults age 18-25, the rate continues to be two and a half times the general adult population at 10.5%. *Id.* There is also evidence that many persons who become addicted to prescription pain relievers move to heroin as a cheaper and more readily available alternative. *Id.*

3. Connecticut's rates of unmet need for drug treatment have consistently exceeded the national average and are among the highest in the nation for individuals in the age group 18 to 25. Based upon SAMHSA's Connecticut Report, more than 208,689 Connecticut residents need, but have not received treatment for, some form of substance abuse dependence. Application, Attachment D, p. 119. DMHAS estimates that for every one person who seeks or receives behavioral health care for addiction, there are six individuals with similar conditions who will neither gain access to nor receive care. Application, Attachment F, p. 396; *See Final Decision, p.3, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012).*

4. According to OHCA's *Statewide Health Care Facilities and Services Plan* (pages 98-99), Connecticut has a population of 281,222 individuals needing substance abuse treatment, but only 46,741 receiving treatment. Overall, the Plan estimates that less than 17% of adults in need of substance use treatment seek such services in Connecticut.

5. Despite these alarming statistics, from 2002 to 2006, the National Survey of Substance Abuse Treatment Services (N-SSATS) reported that the number of substance abuse treatment facilities in Connecticut declined from 247 to 209. Application, Attachment D, p. 117. Based on data relied upon by OHCA, the number of Level 3.7 detox beds in Connecticut from 2012 to 2014 continued to decline. *Cf, Final Decision, FF 20, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012)* [finding that there were a total of 186 Detox beds in CT] and Prop. Dec., p. 4 [finding that there were a total of 156 Detox beds in CT]. In 2012, even prior to the latest decline of Level 3.7 detoxification beds in Connecticut, substance abuse treatment facilities such as Mountainside Treatment Center in Canaan were regularly referring individuals to facilities outside of the State (to New York, New Jersey and Massachusetts), primarily because of a lack of detoxification beds in Connecticut. *See Final Decision, FF 22, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, 11-31734-CON (May 11, 2012).*

6. Applicant submitted uncontroverted evidence that only 10 of 44 Connecticut facilities licensed by the Department of Public Health to treat substance abuse offer Level 3.7 residential detoxification. Application, Attachment C. Applicant surveyed these facilities on two different days and found that state-wide, only a handful of beds were available for detoxification. *Id.* The availability of a bed at the date/time that an

individual makes a decision to seek treatment is absolutely critical, as that window of opportunity may be lost while the individual's life continues to be imperiled by continued addiction and risk of overdose if residential treatment cannot be readily accessed. Application, p. 22; Testimony of Peter Schorr, Transcript, p. 107. Additionally, the unavailability of detoxification services at the 3.7 level places an unnecessary burden on hospital emergency rooms, resulting in a higher level of care (4.0) and substantially greater expense than is necessary. In New Haven, Yale-New Haven Psychiatric Hospital presently operates at capacity with regard to inpatient services and often has a waiting list of patients seeking to be admitted through its emergency room. Testimony of Dr. William Sledge, Transcript, p. 69.

7. DMHAS' three-year strategic substance abuse plan calls for improvement in access to substance abuse treatment. DMHAS 2010 Biennial Report, Application, Attachment D, p. 111. In its 2012 *Statewide Health Care Facilities and Services Plan*, OHCA cited NSDUH statistics showing that Connecticut's rate of unmet need for alcohol and/or illicit drug abuse or dependence has remained between 9% and 10% over the last seven years. *Id.*, p. 99.

8. Of the 199 facilities for the Care or Treatment of Substance Abuse of Dependent Persons listed in the 2012 *Statewide Health Care Facilities and Services Plan*, only seven (7) were listed as providing Residential Detoxification and Evaluation for a total of 147 such beds in the State while there were eleven (11) facilities with a total of 265 beds listed as providing Residential Rehabilitation Treatment. This data was current as of August, 2012. Connecticut Department of Public Health Office of Health Care Access *Statewide Health Care Facilities and Services Plan, October 2012,* pp. 280-287.

9. Retreat seeks approval for 26 Level 3.7 residential detoxification beds, as defined by the American Society of Addiction Medicine's five levels of detoxification care, and 79 beds to be available for continuing residential rehabilitation treatment. Application, p. 18. It will also provide partial hospitalization (PHP), intensive outpatient (IOP), general outpatient, continuing recovery oriented care, and continuing education with respect to addiction and substance abuse. Application, pp. 18-19 and Attachment B.

10. Detoxification and evaluation generally requires five to seven days to complete before an individual is ready to begin residential rehabilitation treatment, which typically continues for approximately 30 days. Application, pp. 18-19. Ensuring continuity of care has been one of the primary practice guidelines endorsed by DMHAS. Application, Attachment F, pp. 397-398, and Applicant's program is designed to provide a seamless transition for clients through the different levels of residential and outpatient programs

offered. Application, p. 19 and Attachment B (description of professional services and treatment philosophy).

11. The Retreat's holistic approach will treat each individual's physical, psychological, emotional and spiritual needs, utilizing motivational techniques, change theory and cognitive-behavioral therapy, to help him or her make the necessary changes to break the cycle of addiction. Applicant will utilize evidence-based methods of care, as well as specialized treatment plans targeted to the special needs of certain sectors of the population, such as health care workers, first responders, veterans and labor union members. In addition to providing comprehensive treatment for substance abuse and co-occurring disorders, Applicant's newly remodeled, state-of-the-art facility will offer a level of comfort and individualized attention not presently available in the New Haven area. Application, pp. 18-19; Pre-Filed Testimony of Peter Schorr, p. 2.

12. To provide the highest quality of care, Retreat employs its medical staff directly rather than on a part-time or per diem basis. Pre-Filed Testimony of Steven Klotz, M.D., pp. 1-2. The medical staff works closely with an interdisciplinary team of clinical specialists including nurse practitioners, clinical nurse specialists, substance abuse therapists, social workers, registered and licensed practice nurses, dietitians and aides. *Id*; Application, pp. 66-69. Another distinguishing feature of Retreat's services is access to specialized programs and treatment alternatives that encompass individual sessions where the patient is assessed by his or her primary therapist, daily community meetings and small group therapy sessions, and special treatment tracks focusing on co-dependency, relapse prevention, anger management and other coping skills necessary for successful recovery. Application, Exhibit B, pp. 63-65.

13. The combination of 26 Level 3.7 residential detoxification beds and 79 residential rehabilitation beds in the same facility will help to ensure that more drug-addicted and alcoholic individuals complete their treatment. Application, pp. 18-19. "Additionally, it will improve continuity of care and by improving access to detoxification care, will help to ensure that more individuals are entering into the first phase critical services at the same facility at which they will continue their rehabilitation to help them manage their addiction." *See Final Decision, FF 40, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012).*

14. Retreat will maintain the same high standards and provide the same individualized treatment as its existing sister facility, Retreat at Lancaster County ("Lancaster facility"), which is a 120-bed residential substance abuse facility located in Ephrata, Pennsylvania and operating since 2011. The Lancaster facility treated 2,206 individuals in the most recent fiscal year; 1,383 were from Pennsylvania and the

remainder were from other states, including 12 individuals from Connecticut. Applicant has found that the ratio of 30 detoxification beds to 90 residential rehabilitation beds to be optimal. It anticipates that the Connecticut facility will similarly attract individuals from Connecticut and surrounding states, and that most will transition from a detoxification program to a rehabilitation program. Application, pp. 19, 62-74; Testimony of Peter Schorr, Transcript, pp. 2-15.

15. The Applicant established through testimony and evidence that its proposed program is *unlikely* to have a substantial impact on existing providers because it will engage in targeted efforts to enroll individuals in need of treatment for drug or alcohol dependency who have not previously sought treatment. This will be aided by an initial marketing and advertising budget of $240,000 (Application, Attachment K, p. 656) and other community outreach efforts that will highlight the empirically validated treatment approaches, individualized care and amenities Retreat will offer. *See Final Decision, p.15, Employment Options, Inc. d/b/a Litchfield Hills Retreat, Docket 09-31500-CON (May 7, 2010)* [approving Litchfield Hills Retreat for the reason that it is a unique facility that will provide services in a setting with certain amenities that are not widely available within the State of Connecticut.]. Retreat's proposal meets an identified need in Connecticut for more residential treatment facilities that are in network and accept private insurance, including the plans offered by Access Health Connecticut and other health insurance exchanges. Application, pp. 21-22; Exhibit D, pp. 365-67.

16. In order to meet its first year projections, Applicant would need to admit less than 0.5 percent of the 208,689 Connecticut residents in need of treatment. *See* SAMHSA's Connecticut Report, Application, Attachment D, p. 117.

The foregoing proven, uncontroverted facts are relevant and material to the Application. OHCA has made findings of fact regarding the pervasive problem of drug addiction, the increasing need for substance abuse treatment and the decline in the number of programs and beds available in Connecticut. *See, e.g., Final Decision, Project Courage, LLC, Docket 13-31846-CON (January 18, 2014); Final Decision, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012); Final Decision, Blue Sky Behavioral Health, LLC, Docket 11-31687-CON (September 9, 2011): Final Decision, Employment Options, Inc. d/b/a Litchfield Hills Retreat, Docket 09-31500-CON (May 7, 2010);* and *Final Decision, Vista Partners, LLC, Docket 07-30927-CON (December 5, 2007).* In each of these decisions, OHCA considered whether the applicant's services were unique or different from other treatment providers and in every instance granted the application based upon the needs of a particular segment of the population. In stark contrast, the Proposed Final Decision makes no findings whatsoever regarding Applicant's vast array of individualized programs or unique amenities such as a full gymnasium and gourmet meals, which serve the needs of a segment of a patient

population who otherwise might be unlikely to seek treatment at existing residential treatment in Connecticut. These programs and services also serve to differentiate Retreat's proposal from the Intervenors' facilities. Especially given the fact that Applicant has a proven record of success at its Lancaster facility of admitting and treating a high volume of individuals who have private insurance or the ability to pay, the failure to make adequate findings regarding the proposed program and the population to be served is an unwarranted abuse of discretion and results in a Proposed Final Decision that is arbitrary, capricious and legally erroneous.

For all of these reasons, the Proposed Final Decision must be modified to fully incorporate the above corrected Findings of Fact 1 through 16.

II. The Proposed Final Decision Must Be Corrected to Omit or Revise the Following Irrelevant or Inaccurate Findings of Fact

The Proposed Decision is further flawed because it contains several findings of fact which are unsupported by the record evidence and are inaccurate or misleading. Accordingly, these findings of fact should either be corrected or omitted from final decision, as follows:

> *(9.) All 30 of the short-term general or children's general hospitals had substance abuse treatment discharges from FY 2008 to FY 2010. Sixteen hospitals provide detox services and twelve provide intensive inpatient treatment. Statewide Health Care Facilities and Services Plan, October 2012, pp. 99,101.*

To the extent the above might suggest that there is no need for Applicant's services because the detoxification services of existing substance abuse treatment facilities are supplemented by the services offered by hospitals in Connecticut, it is grossly misleading. As Applicant's testimony established, the more appropriate level of inpatient detoxification care for most individuals who do not suffer from acute symptomology and whose risks upon withdrawal can be medically monitored is Level 3.7, which Retreat proposes to offer, rather than the unnecessary, higher cost Level 4.0 treatment provided in a hospital setting. This fact is underscored by the hospital emergency department focus groups which participated in the preparation of OHCA's *Statewide Facility and Services Plan* and concluded that the emergency rooms of Connecticut hospitals were being inappropriately used by behavioral health patients for detoxification and other treatment. Physicians and hospital administrators were in agreement that these patients would be better treated in another setting, such as a substance abuse facility. *See Statewide Health Care Facilities and Services Plan, Appendix G, pp.166-168.*

In previous CON proceedings involving substance abuse providers, OHCA did not consider hospital data in evaluating the need for a substance abuse program. *See, e.g., Final Decision, Project Courage, LLC, Docket 13-31846-CON (January 18, 2014); Final Decision, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012); Final Decision, Employment Options, Inc. d/b/a Litchfield Hills Retreat, Docket 09-31500-CON (May 7, 2010);* and *Final Decision, Vista Partners, LLC, Docket 07-30927-CON*

(December 5, 2007). The Hearing Officer should not have departed from previous practice and considered hospital discharges for drug abuse treatment without permitting Applicant the opportunity to object or to offer rebuttal. Connecticut courts have held that OHCA may consider or use reports and data gathered by members of its own staff in CON proceedings, but it cannot properly base findings upon such reports or data without introducing them into evidence and affording Applicant an opportunity to object and to offer rebuttal. *See New England Rehabilitation Hospital of Hartford, Inc. v. Commission on Hospitals & Health Care,* 226 Conn. 105, 150 (1993); *See also, Parsons v. Board of Zoning Appeals*, 140 Conn. 290, 293 (1953).

For all the foregoing reasons, proposed Finding of Fact 9 should be stricken in its entirety. In the alternative, the hearing should be reopened to permit Applicant the opportunity to demonstrate that the hospital data actually supports, rather than diminishes, the public need for its facility in Connecticut because (i) its services are more effective and less expensive, and (ii) expanding the availability of detox and rehab programs will alleviate many of the challenges facing hospital emergency departments

> *(14.) The "Addiction Residential Census Report" that is compiled daily (Monday to Friday) by DMHAS provides information on the number of available beds at facilities providing Level 3.7 detox and residential rehab that receive DMHAS grant funds, as well as other providers that choose to report through the DMHAS portal. (The Proposed Final Decision then sets forth Table 2, reflecting that between 8/13/13 and 8/21/13, between 3 and 17 detox beds were available at a Connecticut facility).*

It is a misnomer to describe the DMHAS report as compiled "daily," when, in fact, data is not reported on Saturdays or Sundays when many individuals in crisis need immediate intervention. Similarly, data regarding the number of Level 3.7 detoxification beds reported by some providers to DMHAS as available is of limited utility absent testimony regarding whether such data accurately reflects the ability of a patient in crises to immediately access the bed.

Retreat's Application and testimony established that on two different days, telephone surveys reflected that only a handful of Level 3.7 beds were available at eleven facilities throughout Connecticut that offer residential detoxification. In previous CONs, OHCA has made findings of fact based upon an Applicant's survey of bed availability. *See, e.g., Final Decision, FF 19, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012).*

In the present case, the Hearing Officer appears to have ignored Applicant's survey evidence without any reason and instead permitted Intervenors to submit DMHAS bed census data by late file, which improperly denied Applicant the opportunity to object or to offer evidence or argument in rebuttal. *See New England Rehabilitation Hospital of Hartford, Inc. v. Commission on Hospitals & Health Care,* supra at 150; *Parsons v. Board of Zoning Appeals,* supra at 292- 293. The DMHAS census data is not accurate in ascertaining whether a

reasonable number of Level 3.7 beds are available to the general public in Connecticut. Additionally, the DMHAS census data does not reflect the time of day that the information is reported, whether the facility has a waiting list or how long the bed remained available before another patient filled the bed. Moreover, proposed Finding of Fact 9 is based only upon data for a one-week period in August, 2013, at the height of travel season, when patient census can be expected to be artificially low at all inpatient facilities.

It was an abuse of discretion to propose findings of fact based upon such unverified DMHAS census data, while ignoring the results of Applicant's surveys. Further, regardless of whether the number of Level 3.7 detoxification beds available state-wide is 3 (as confirmed for certain days by both DMHAS census data and Applicant's surveys) or as many 7 (the average according to this limited DMHAS census data), these small number of beds are grossly inadequate to meet the needs of the 208,689 Connecticut residents who suffer from drug or alcohol addiction, but are not undergoing treatment.

For all the foregoing reasons, proposed Finding of Fact 14 should be stricken in its entirety or the hearing should be reopened to permit Applicant the opportunity to counter the DMHAS census data with more accurate information reflecting the actual availability of detoxification beds in Connecticut.

> *(19.) Given the high rate of individuals in New Haven who are governmentally-insured, the proposed facility would not benefit these individuals since it will not accept Medicaid patients. Tr. Testimony of Robert Freeman, pp. 63, 65.*
>
> *(20.) The payer mix in Fiscal Year 2012 shows that 79% of the residents of the town of New Haven had government insurance and 20% had commercial insurance. Of New Haven County residents, 65% had government insurance and 33% had commercial insurance. (The Proposed Finding then incorporates Table 6: Payer Mix for the Town of New Haven and New Haven County for Fiscal Year 2012: Source, OHCA's Acute Hospital Inpatient Discharge Database.)*

The above proposed Findings of Fact 19 and 20, which focus upon the needs of individuals residing in the City or County of New Haven, are only minimally relevant since the populations Applicant seeks to serve are residents who live throughout Connecticut and in surrounding states. Indeed, the testimony of Mr. Freeman demonstrated that his own New Haven program served individuals from other areas of the State. Transcript, p. 63. Accordingly, and at a minimum, the proposed Findings of Fact should address the state-wide population Applicant intends to serve, rather than only New Haven residents.

In addition, proposed Finding of Fact 20 is inaccurate due to misplaced reliance upon the OHCA's Acute Hospital Inpatient Discharge Database in attempting to ascertain the percentage of New Haven residents who have commercial insurance. This data is skewed by the fact that a

far greater percentage of elderly Medicare-eligible patients obtain services at hospitals than would be the case at a substance abuse facility. Moreover, because many Medicaid patients do not have strong connections to primary care providers and are more apt to use emergency departments and other hospital facilities as their medical provider of first resort, the Medicaid data from OHCA's Acute Care Hospital Inpatient Discharge Database does not accurately reflect, nor is it relevant to, the population to be served by a substance abuse facility catering mainly to commercially insured patients.

Once again, OHCA considered information from its database without affording Applicant notice or affording it the opportunity to object or to offer rebuttal demonstrating that such data is inapplicable or misleading. *See New England Rehabilitation Hospital of Hartford, Inc. v. Commission on Hospitals & Health Care*, supra at 150; *Parsons v. Board of Zoning Appeals,* supra at 292- 293. If Applicant had been permitted the opportunity to respond regarding OHCA's consideration of the data set forth in the Proposed Final Decision at Table 6, it would have objected on the grounds that this data reflects only the percentage of patients from New Haven admitted to a Connecticut hospital during the relevant period who have commercial insurance. Further, Applicant would have demonstrated that the percentage of New Haven residents who have commercial insurance as reported by the United States Census Bureau data for 2008-12 is as follows: Town of New Haven, 54.9%; County of New Haven, 72.2%; and State of Connecticut, 74.9%. Additionally, these percentages will increase substantially in the coming years due to the passage of federal health care reform legislation and laws requiring parity between behavioral health and medical coverage in plans offered through the health insurance exchanges. The result will be that more people will be able to obtain policies that will cover some of the costs of substance abuse treatment services.

Based upon the foregoing, proposed Finding of Fact 19 should be stricken since it is not relevant and proposed Finding of Fact 20 should either be stricken or the hearing should be re-opened to permit Applicant the opportunity to demonstrate that the data OHCA considered is inaccurate and misleading and that United States Census Bureau data demonstrates that 74.9% of Connecticut residents are commercially insured.

> *(21) The existing providers of the service proposed by the Applicant have the capacity to meet the needs of the commercially-insured and self-pay patients, who are the target of the Applicant's proposal. Testimony of Jeffrey Walter, President and CEO of Rushford Center, pp. 37-28; Tr. Testimony of Georganna Kopperman, Director of Business Development and Military Affairs at Stonington Institute, pp. 56-57.*

This proposed finding of fact ignores the material fact that Applicant proposes to offer a comprehensive and clinically-proven treatment program in a new facility with a directly employed medical staff, low patient-to-staff ratios and numerous amenities which have proven attractive to individuals with commercial insurance coverage. The statistics provided in corrected Findings of Fact 1-4, above, demonstrate conclusively that there exists a vast pool of

patients who have either chosen to forego treatment at the existing facilities in the State or are seeking treatment outside of Connecticut.

Intervenors presented no testimony that their facilities offered comparable treatment programs on the scale of those offered by Retreat. Application, Attachment B, pp. 63-74. Nor was there testimony that any of the existing facilities can match Retreat in terms of the level of outreach and visibility it will give to its services or the physical plant and non-clinical amenities that Applicant will provide. Accordingly, Retreat has satisfactorily demonstrated that existing providers do not have the capacity to meet the needs of the population it presently serves in Pennsylvania and endeavors to serve in Connecticut.

OHCA has previously recognized that an applicant's individualized services or special amenities may differentiate it from other treatment providers and serve the need of a particular segment of the Connecticut population. *See, e.g., Final Decision, Employment Options, Inc. d/b/a Litchfield Hills Retreat, Docket 09-31500-CON (May 7, 2010).* Also, OHCA has recognized the benefits of a program, which similar to Applicant's, targeted Connecticut executives, physicians, and other professionals, acknowledging that these individuals often seek out private, discreet and individualized programs. *See Final Decision, FF 14, Vista Partners, LLC, Docket 07-30927-CON (December 5, 2007).* In 2007, the only facility offering such individualized treatment in the Northeast was the McLean Center at Fernside, located in Boston, Massachusetts, which has only 10 beds. *Id.* Accordingly, OHCA recognized that Vista's proposed program would serve the needs of a segment of the population and improve the quality and accessibility of substance and alcohol abuse/dependency patients in the region. *Id.* Here, the target market for Applicant's programs and services can be seen as equally unique because, as opposed to serving an elite population of patients, it seeks to provide affordable yet comprehensive services to the general population of insured adults in Connecticut.

It is also impossible to reconcile proposed Finding of Fact 21 with OHCA's previous findings that there was a shortage of Level 3.7 beds in Connecticut, given that the number of beds has seemingly declined while the number of addicted individuals has increased. *See Final Decision, FF 20, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012)* and corrected Findings of Fact 1 through 5, *infra*, pp. 1-2. While the Proposed Final Decision, page 11, states that CON applications are decided on a cases by case basis and do not lend themselves to general applicability due to the unique facts in each case, OHCA's findings regarding the same factual issues should be consistent from case to case.

Additionally, neither Mr. Walter nor Ms. Kopperman offered any statistical data or other evidence to demonstrate that there is excess capacity at their facilities with regard to detoxification beds. To the contrary, Mr. Walter testified that while beds are available "most days of the year" somewhere in the state, there were 30 days out of the year when Rushford had no beds available. Transcript, pp. 37-38. Ms. Kopperman testified that Stonington's

detoxification service operates "close to capacity," even though there are multiple discharges every day. Transcript, p. 57. The testimony of these individuals also ignores the undisputed fact that demand will grow as a result of many more Connecticut residents having insurance coverage for substance abuse services under the Affordable Care Act ("ACA").

It is simply unrealistic to expect that individuals in crisis (or their families), who are suffering from the devastating impairments which accompany addiction, will call around to all the facilities in the State which offer inpatient detoxification in order to locate an available bed. Until Level 3.7 detoxification beds are reasonably available and readily accessible to provide a continuum of care for patients across the State, it is unlikely that progress will be made in treating the 208,689 Connecticut residents who are afflicted by addiction but not receiving any services.

For all of the above reasons, proposed Finding of Fact 21 must be stricken.

(22) The current providers of the service proposed by the Applicant rely upon patients who are commercially-insured or self-pay to offset lower reimbursement rate realized by serving governmentally-insured charity care populations. Tr. Testimony of Mr. Walter, p.40; Tr. Testimony of William Sledge, M.D., Medical Director of the Yale-New Haven Psychiatric Hospital, pp. 67-70; Tr. Testimony of Ms. Kopperman, pp. 60-62; Tr. Testimony of Douglas Bruce, M.D., Medical Director of South Central Rehabilitation Center at the Cornell Scott-Hill Health Center, pp. 74, 75.

First, the testimony summarized above is irrelevant since all providers, including Applicant, must rely upon those individuals (or their insurance carriers) who pay in full for services to cover the shortfall resulting from those individuals who do not pay for services (or who pay less than the full cost of providing the service). While Applicant does not intend to participate in the Medicare or Medicaid programs, it will either refer the individual to an appropriate facility participating in Medicare or Medicaid or provide treatment without charge.

Second, the application cannot be denied solely because the Applicant does not intend to participate in Medicare and Medicaid. OHCA has previously approved numerous certificate of need applications of substance abuse treatment providers who do not participate in these programs. For example, OHCA approved Project Courage, LLC's application for establishment of an intensive outpatient behavioral health and substance abuse treatment facility to serve adolescents and young adults, which was entirely funded by commercial insurers (up to 100%) or by families out-of-pocket (up to 80%) with referral of those who do not have an insurance option or ability to self-pay to another provider. OHCA concluded that since the proposed program would permit Project Courage to receive out-of-network reimbursement for its services from third party payers, it would improve access for the targeted population and provide additional payment options for clients and their families. *Final Decision, pp. 2, 6, 10, Project*

Courage, LLC, *Docket 13-31846-CON (January 18, 2014).* Here, Applicant plans to be an in-network provider with most commercial insurance plans as is the case at the Lancaster facility.

Moreover, in 2011, OHCA approved MCI, Healthcare, LLC d/b/a Mountainside Treatment Center's application for 16 additional level 3.7 detoxification beds, with a patient mix of 80% commercial insurance and 20% self-pay. *Final Decision, FF 20, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012).* Also, in 2011, OHCA approved Blue Sky Behavioral Health, LLC's Application for a facility for treatment of substance abuse (as well as an outpatient psychiatric program) which would have a payer mix of 80% private pay and 20% commercial insurance. OHCA concluded that since the program would be entirely funded by self-pay and private insurance, it would have a positive impact on the financial strength of the health care system. *Final Decision, pp. 8-10, Blue Sky Behavioral Health, LLC, Docket 11-31687-CON (September 9, 2011).*

Finally, OHCA approved Vista Partners, LLC's application for an Alcohol and Drug Treatment Center in Sharon, Connecticut, which would be entirely patient funded, at an initial monthly rate of $50,000, without Medicare, Medicaid or commercial insurance participation. *Final Decision, p. 8, Vista Partners, LLC, Docket 07-30927-CON (December 5, 2007).*

In contrast, the Proposed Final Decision in this proceeding reflects that the Hearing Officer gave inappropriate consideration and weight to Intervenors' claims that the Applicant's program would negatively impact their bottom lines. First, Intervenors' claims are totally unsubstantiated, especially in light of the substantial population of commercially insured individuals who are in need of, but not receiving treatment, and to whom Applicant will market its program. This population will also continue to grow under the ACA. Second, to the extent the Proposed Final Decision gives greater consideration to the potential economic impact of the Application on Intervenors than the public need of individuals afflicted with addiction, it misapplies the statutory guidelines and principles set forth in Conn. Gen. Stat. § 19a-639(a).

For all of the foregoing reasons, proposed Finding of Fact 22 is irrelevant and must be stricken from the final decision.

III. The Proposed Final Decision Reaches Numerous Erroneous Conclusions which must be Corrected

Having made numerous erroneous factual findings, while neglecting to make findings based upon the material evidence submitted, it is not surprising that the Proposed Final Decision then misapplies the statutory guidelines and principles contained in Conn. Gen. Stat. §19a-639(a) to arrive at erroneous conclusions. The Proposed Final Decision should be corrected with regard to the following numbered conclusions of law:

(27) This conclusion should be corrected to reflect that the Applicant has established a clear public need for its proposal. Conn. Gen. Stat. § 19a-639(a)(3)

It is undisputed that there is a large segment of the Connecticut population (reported to be 208,689 individuals) who suffer from addiction and are in need of, but have not sought, treatment. The Proposed Final Decision, page 12, erroneously declines to consider the needs of this population, for the purported reason that the Applicant has not demonstrated that they have sought treatment in Connecticut or elsewhere. This conclusion is irrational and illogical because a clear public need for treatment exists, regardless of whether these individuals have sought treatment in the past. This large pool of patients in need of services also completely undermines the argument of Intervenors that approval of the Applicant's proposal will reduce the volume of commercially insured patients that they will serve as there is ample volume to support all existing providers, especially given the growth of the insured population under the ACA.

The Applicant presented ample evidence that it would serve the segment of the population who have not previously sought out treatment and who, in most cases, have insurance coverage to pay for the comprehensive care and individualized services that are built into Applicant's programs and cost structure. Further, the Applicant established that in the previous year, its Lancaster facility successfully enrolled 2,206 individuals from Pennsylvania and throughout the U.S. in similar programs. *See* corrected Finding of Fact 13, *infra.* The Proposed Final Decision utterly ignores this material evidence and fails to make any findings regarding the unique services and programs the Applicant proposes to offer or its past success in meeting the needs of individuals who had not previously sought treatment. Especially in view of OHCA's recent consideration of the specialized services offered by other Connecticut facilities, such as Mountainside, Litchfield Hills Retreat, and Vista, the failure to consider material evidence is an abuse of discretion.

(28) This conclusion should be corrected to reflect that the proposal will financially strengthen the health care system in the state or that the proposal is financially feasible for the Applicant. Conn. Gen. Stat. § 19a-639(a)(4)

In a glaring error of law, OHCA omitted from this proposed conclusion consideration of whether the proposal is financially feasible for Retreat. On this point, Retreat provided uncontroverted evidence the cost of the project is fully funded by $7.5 million in financing from its primary lender, Fulton Bank. Application, Attachment J, p. 652. It also provided financial attachments demonstrating that the project would be profitable in first year of operation and thereafter. *Id.,* Attachment K. In addition, Applicant does not intend to seek or accept any federal, state or local funds, grants, abatements or credits and will impose no fiscal burden whatsoever on Connecticut's healthcare system. Instead, its operations are fully funded and will subsidize the free care it renders to patients who cannot afford to pay while providing comprehensive and high quality drug treatment services to state residents. Accordingly,

Retreat's investment in the New Haven facility will necessarily strengthen Connecticut's health care system as well as the local economy.

In addition to the investment of capital and resources, Retreat's proposal will result in improved coordination of care, because individuals admitted to its New Haven facility for detoxification can seamlessly transition to a 30-day inpatient program, and then avail themselves of outpatient care. OHCA has previously recognized the benefits of this coordinated continuum of care approach. In granting Mountainside Treatment Center's application for an additional 16 level 3.7 detoxification beds in 2011, OHCA found that the combination of detoxification beds with Mountainside's existing residential rehabilitation beds will improve timely access to detoxification care, improve continuity of care due to the provision of detoxification and rehabilitation care at the same location and will have a positive impact on the quality of health care delivery in Connecticut while retaining residents who currently leave the state for treatment. *See Final Decision, p. 10, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012).* The same conclusion must follow in this case.

(29) This conclusion should be corrected to reflect that the proposal would improve the accessibility of health care delivery in the region and improve the quality and cost effectiveness of health care in Connecticut. Conn. Gen. Stat. § 19a-639(a)(5)

Proposed conclusion 29 is totally contrary to the record evidence and clearly erroneous. It cannot be disputed that the additional 26 Level 3.7 detoxification beds and 79 residential rehabilitation beds along with Retreat's full spectrum of outpatient programs will improve accessibility to services. Moreover, Applicant has demonstrated through its successful Lancaster facility that the high quality programs and services it provides are also cost effective. There was no evidence to contrary. Accordingly, proposed conclusion 26 must be corrected.

(31) This conclusion should be corrected to reflect that the Applicant has satisfactorily identified the population to be served by its proposal and that this population has a need for the proposal. Conn. Gen. Stat. § 19a-639(a)(7)

At page 27 of its Application, Retreat stated that "[t]he population to be served would be primarily Connecticut residents, aged 18 and older, in need of residential detoxification and recovery." Applicant also provided uncontroverted evidence that Connecticut: (i) is among the 10 states with the highest rates in the 18 to 25 age cohort for past month illicit drug use, past month marijuana use, past year marijuana use, and past month alcohol abuse; (ii) that its rate of non-medical use of pain relievers is estimated by the most recent NSDUH findings to be 3.8% of the adult population and that for young adults age 18-25, the rate continues to be two and a half times the general adult population at 10.5%; and (iii) that SAMHSA's latest estimates show that 208,689 Connecticut residents need, but have not received treatment for, some form of substance abuse dependence. In its 2012 *Statewide Health Care Facilities and Services Plan*, OHCA also stated that there are 281,222 Connecticut individuals needing substance abuse treatment, but only

46,741 receiving treatment. Applicant more than met its burden of identifying the population to be served and demonstrating the population's need for its proposal. The Hearing Officer's proposed conclusion misapplies both the facts and law, and must be corrected.

(32) This conclusion should be corrected to reflect that the Applicant has satisfactorily provided historical utilization data of behavioral health treatment services in the service area that would support the proposal. Conn. Gen. Stat. § 19a-639(a)(8)

The historical data is presented through statistical reports appended to the Application (Attachment D) as well as through OHCA's findings of facts and conclusions in other behavioral health applications since 2007, which OHCA may administratively notice. *See, e.g. Final Decision, Project Courage, LLC, Docket 13-31846-CON(January 18, 2014); Final Decision, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, 11-31734-CON (May 11, 2012); Final Decision, Blue Sky Behavioral Health, LLC, Docket 11-31687-CON (September 9, 2011): Final Decision, Employment Options, Inc. d/b/a Litchfield Hills Retreat, Docket 09-31500-CON (May 7, 2010);* and *Final Decision, Vista Partners, LLC, Docket 07-30927-CON (December 5, 2007).* All of the foregoing support the granting of the Application, and accordingly, proposed conclusion 32 should be corrected.

(33) This conclusion should be corrected to reflect that the Applicant has satisfactorily demonstrated that the utilization of existing health care facilities and services in the service area supports the proposal. Conn. Gen. Stat. § 19a-639(a)(8)

Based upon the survey data provided at Attachment C of the Application and the inconclusive nature of the DMHAS census reports regarding bed availability throughout the State, the record in this proceeding adequately demonstrates patient backlogs, treatment delays and other utilization patterns at existing health care facilities that support this proposal. Further, there is only one other provider of residential rehabilitation services in the City of New Haven and none in the State that offer the array of clinical programs and special amenities proposed by Applicant to the general public at affordable rates. Accordingly, proposed conclusion 33 must be corrected.

(34) This conclusion should be corrected to reflect that the Applicant has satisfactorily demonstrated that the proposal will not result in an unnecessary duplication of existing services in the area. Conn. Gen. Stat. § 19a-639(a)(9)

Once again, a duplication of services will not result because Applicant's services are specialized and unique, and will be offered to a segment of the population which needs, but is not currently receiving, treatment. Therefore, proposed conclusion 34 must be revised, consistent with the uncontroverted evidence presented.

IV. Conclusion

For all of the foregoing reasons, the Applicant respectfully requests that its exceptions be sustained and that the Proposed Final Decision be corrected and the Application for a Certificate of Need granted. In the alternative, the Applicant respectfully requests that the hearing be reopened in order to permit it to fully respond to data and other matter outside of the hearing record which were considered by the hearing officer.

RESPECTFULLY SUBMITTED,
THE APPLICANT
NR CONNECTICUT, LLC d/b/a
RETREAT AT SOUTH CONNECTICUT

By: _____

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Date: April 11, 2014

CERTIFICATE OF SERVICE

This is to certify that a true and accurate copy of the foregoing was sent by U.S. Mail this 11th day of April, 2014, to the following counsel of record:

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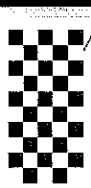
Juda J. Epstein



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(203) 772-2037

Date: April 24, 2014

FAX#: 860-418-7053

To: Lisa Davis

Company: Office of Health Care Access

From: Jennifer Groves Fusco, Esq.

Number of Pages 3 (Including Cover Sheet)

Subject: Docket No. 13-31828-CON

Message:

Please contact Deb Alexa at (203) 786-8322 to report transmittal difficulties. Thank you.

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April 24, 2014

VIA FACSIMILE & REGULAR MAIL

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Hartford, CT 06134-0308

RECEIVED
APR 24 2014
Office of
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Re: NR Connecticut, LLC d/b/a Retreat at South Connecticut
Establish a 105-Bed Residential Substance Abuse Treatment Facility in New Haven
Docket No. 13-31828-CON

Dear Deputy Commissioner Davis:

This office represents Yale-New Haven Hospital, Cornell Scott – Hill Health Center and APT Foundation, Inc. (collectively "Intervernors") in connection with the above-referenced docket. We are in receipt of the Exceptions to Proposed Final Decision, filed by NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Retreat") on April 11, 2014. Therein, Retreat requests that the Proposed Final Decision ("PFD") denying its request for permission to establish a 105-bed residential substance abuse treatment facility in New Haven be overturned. In the alternative, Retreat has asked that the record in this CON proceeding be reopened for the presentation of additional evidence.

Intervenors object to the record being reopened for the submission of any additional evidence. Retreat has had ample opportunity to make its case-in-chief for a CON and should not be allowed to submit additional information at this time. The Hearing Officer's findings were accurate and supported by evidence in the record and these findings warrant denial of Retreat's CON Application.

Retreat requests that the record be reopened so that it can submit evidence including prior OHCA CON decisions and findings in those decisions related to clear public need and other statutory decision criteria. Retreat also requests the opportunity to rebut certain data from the Statewide Healthcare Facilities & Services Plan ("SHP"), the Acute Care Hospital Inpatient Discharge Database ("ACHIDD") and Intervenors' Late File Testimony, each of which was cited in the PFD. Retreat claims that it did not have the opportunity to fully respond to this "data and other matters outside of the hearing record" considered by the Hearing Officer.

OHCA should deny Retreat's request to reopen the record and admit additional evidence for several reasons. First, the information that Retreat seeks to admit, specifically prior OHCA dockets and decisions, is irrelevant. OHCA decides each CON Application on its own merits. Findings in one proceeding do not necessarily translate to another proceeding, even if the subject matter of the CONs is similar. Moreover, this information existed prior to the close of evidence in this case. If Retreat deemed these decisions and their underlying dockets relevant to its CON Application, the information should have been introduced at or before the public hearing in August of 2013. Retreat bears the burden of establishing that the requirements for a CON have been met. They chose not to introduce this evidence as part of their case-in-chief and they should not be allowed to do so now once OHCA has determined, after a full and fair hearing, that Retreat failed to meet its evidentiary burden.

The same arguments can be made with respect to information contained within the SHP and the ACHIIDD. With respect to the SHP, which was published in October of 2012, Retreat itself introduced evidence from this document at the public hearing. OHCA's reference to this same document in its PFD is appropriate and within its discretion as an administrative agency.

With respect to the Late File Testimony, Retreat argues that the hearing should be reopened so that they have an opportunity to rebut the DMHAS reports submitted by Intervenors. However, Retreat could and should have submitted any rebuttal to the Late File Testimony before the hearing record was closed. OHCA has allowed rebuttal to Late File Testimony in CON proceedings in the past, without exception. Retreat chose not to respond to the Late File Testimony in August of 2013, and should not be allowed to do so now.

For the foregoing reasons, Intervenors urge OHCA not to reopen the record in this matter and to issue a Final Decision denying Retreat's CON request, consistent with the Hearing Officer's findings. To the extent that OHCA decides to allow additional evidence, whether administratively noticed or submitted by Retreat, all Intervenors should have an opportunity to participate in any further proceedings.

Should you require anything further, please feel free to call me at (203) 786-8316.

Very truly yours,

Jennifer Groves Fusco

Enclosures

cc: Juda J. Epstein, Esq.
Joan Feldman, Esq.

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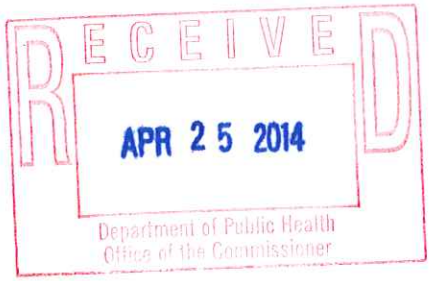
April 24, 2014



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Lisa A. Davis, M.B.A., B.S.N., R.N.
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Jennifer Groves Fusco

Enclosures

cc: Juda J. Epstein, Esq.
Joan Feldman, Esq.

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RE: **NR CONNECTICUT, LLC, D/B/A RETREAT AT SOUTH CONNECTICUT, ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY, OHCA DOCKET NO. 13-31828-CON**	YOUR REFERENCE NUMBER:

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April 30, 2014

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
Office of Health Care Access
Division of the Department of Public Health
410 Capitol Avenue
Hartford, CT 06134-0308

VIA FACSIMILE AND US MAIL

RE: NR CONNECTICUT, LLC, D/B/A RETREAT AT SOUTH CONNECTICUT, ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY, OHCA DOCKET NO. 13-31828-CON

Dear Deputy Commissioner Davis,

I am writing on behalf of NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Retreat") regarding Jennifer Groves Fusco's letter to you, dated April 24, 2014 ("letter brief") in which Intervenors Yale-New Haven Hospital, Cornell Scott-Hill Health Center and APT Foundation, Inc. object to the reopening of the above matter and oppose Applicant's Exceptions to Proposed Final Decision, dated April 11, 2014 ("Applicant's Exceptions"). For the reasons stated below, Attorney Fusco's letter brief is improper and must be disregarded.

Because Intervenors are not parties in the above docket, they lack standing to object or to oppose Applicant's Exceptions. Previous rulings in this docket clearly state that Intervenors' rights of participation are limited to inspecting and copying records, receiving copies of pleadings and correspondence, and cross-examining the Applicant. See Hearing Officer Marianne Horn's Rulings on Petitions Filed by Yale-New Haven Hospital, Cornell Scott-Hill Health Center, and APT Foundation, Inc., dated August 13, 2013. While the hearing officer specifically reserved the right to make additional rulings as to the extent of any further participation by Intervenors (*id.*), Attorney Fusco did not seek OHCA's permission to file a response to Applicant's Exceptions, nor did she file any objection or opposition memorandum on this docket.

Instead, Attorney Fusco communicated Intervenors' opposition to the Applicant's Exceptions in a letter brief which was sent via facsimile and mail to the decisional authority. This contravenes Connecticut General Statutes § 4-181(c), which prohibits an intervenor in a contested case from communicating with a hearing officer or member of an agency without notice and the opportunity for all parties to participate in the

communication. See *Martone v. Lensink*, 207 Conn. 296 (1988). As a result of this improper communication, the undersigned was deprived of the opportunity to object based upon Intervenors' lack of standing and to have Intervenors' opposition arguments stricken from the record.

Additionally, Intervenors' arguments are totally lacking in merit. With regard to OHCA's previously reported CON decisions which support Applicant's Exceptions to the proposed final decision, the agency may consider their precedential value without the need for a copy to be admitted into evidence. While OHCA decides each CON Application on its own merits, its findings of the same issues of fact and its application of the statutory criteria should be consistent from case to case. Intervenors' argument regarding the hearing officer's reliance upon the Statewide Healthcare Facilities & Services Plan and the Acute Care Hospital Inpatient Discharge Database is similarly unpersuasive because it ignores the controlling statute, Connecticut General Statutes § 4-178(7), which requires that parties be notified in a timely manner if any agency memoranda or data are judicially noticed by a hearing officer. In this instance, notice was not provided and a rehearing must be scheduled so as to afford Applicant an opportunity to offer rebuttal evidence.

Finally, with regard to Attorney Fusco's contention that Intervenors should have an opportunity to participate in any further proceedings, any such request should be properly filed with OHCA so as to allow Applicant an opportunity to respond and to permit the hearing officer to rule.

Very truly yours,

Juda J. Epstein

cc: William P. Beccaro, Esq. (via U.S. mail)
Jennifer Groves Fusco, Esq. (via U.S. mail)
Joan Feldman, Esq. (via U.S. mail)

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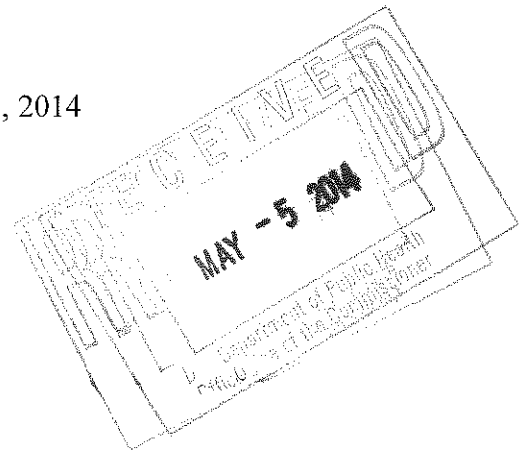
April 30, 2014



Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
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Division of the Department of Public Health
410 Capitol Avenue
Hartford, CT 06134-0308

VIA FACSIMILE AND US MAIL

RE: NR CONNECTICUT, LLC, D/B/A RETREAT AT SOUTH CONNECTICUT, ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY, OHCA DOCKET NO. 13-31828-CON

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Jennifer Groves Fusco, Esq. (via U.S. mail)
Joan Feldman, Esq. (via U.S. mail)

JJE/dv

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

May 9, 2014

VIA FAX ONLY

Peter Schorr
President / CEO
NR Connecticut, LLC
12 New City Street
Essex, CT 06426

RE: Certificate of Need Application, Docket Number 13-31828-CON
NR Connecticut, LLC-d/b/a/Retreat at South Connecticut
Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut

Dear Mr. Schorr:

Enclosed is an order by the Department Public Health's Office of Health Care Access opening the the above referenced matter in order to take further evidence. This order will be entered as an exhibit in the Table of the Record in this case for the Certificate of Need application filed under Docket Number 13-31828-CON.

Sincerely,

Kimberly Martone
Director of Operations

Enclosure

Copy: Jennifer Groves Fusco, Updike, Kelly & Spellacy, P.C.
Joan W. Feldman, Shipman & Goodwin, LLC

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

IN THE MATTER OF:

A Certificate of Need Application by Docket Number: 13-31828-CON
NR Connecticut, LLC d/b/a Retreat at South Connecticut

ORDER

On or about August 27, 2013, the Office of Health Care Access ("OHCA") closed the record in the above-referenced matter. On January 22, 2014, OHCA issued a Proposed Final Decision. On April 11, 2014, OHCA received Exceptions to its Proposed Final Decision dated January 22, 2014. Included in the Exceptions is a claim that the Applicant was not given advance notice of certain information as required by Connecticut General Statutes § 4-178 or the opportunity to respond to a late file submitted by the Intervenors. Specifically, the Applicant claims that it was prejudiced by not having an opportunity to respond to the following:

1. OHCA's use of hospital discharges for drug abuse treatment to evaluate the need for a substance abuse program. (Proposed Final Decision, FF9);
2. OHCA's use of DMHAS bed census data submitted as a late file by the Intervenors. (Proposed Final Decision, FF14); and
3. OHCA's use of data from the Acute Care Hospital Inpatient Discharge Database. (Proposed Final Decision, FF20)

Therefore, the record in the above-referenced matter is hereby opened for the limited purpose of allowing the Applicant to submit written evidence in rebuttal to the aforementioned findings of fact as stated in the Proposed Final Decision dated January 22, 2014. The Applicant shall file its written evidence on or before Friday, May 23, 2014. The Intervenors are not permitted to reply to the information submitted by the Applicant.

May 9, 2014
Date

Marianne Horn
Hearing Officer

* * * COMMUNICATION RESULT REPORT (MAY. 9. 2014 1:38PM) * * *

FAX HEADER:

TRANSMITTED/STORED : MAY. 9. 2014 1:37PM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
296	MEMORY TX		98607670456	OK	3/3

REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: PETER SCHORR

FAX: 860 767-0456

AGENCY: NR CONNECTICUT, LLC

FROM: OHCA

DATE: 5/9/14 **Time:**

NUMBER OF PAGES: 3
(including transmittal sheet

Comments:

Order regarding Retreat of South Connecticut
Docket Number: 13-31828

PLEASE PHONE Barbara K. Olejarz IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

* * * COMMUNICATION RESULT REPORT (MAY. 9. 2014 1:39PM) * * *

FAX HEADER:

TRANSMITTED/STORED : MAY. 9. 2014 1:38PM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
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REASON FOR ERROR
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E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JENNIFER FUSCO

FAX: 203 772-2037

AGENCY: UPDIKE, KELLY AND SPELLACY

FROM: OHCA

DATE: 5/9/14 **Time:**

NUMBER OF PAGES: 3
(including transmittal sheet

Comments:

Order regarding Retreat of South Connecticut
Docket Number: 13-31828

PLEASE PHONE Barbara K. Olejarz IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
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Hartford, CT 06134

* * * COMMUNICATION RESULT REPORT (MAY. 9. 2014 1:40PM) * * *

FAX HEADER:

TRANSMITTED/STORED : MAY. 9. 2014 1:38PM

FILE	MODE	OPTION	ADDRESS	RESULT	PAGE
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REASON FOR ERROR
E-1) HANG UP OR LINE FAIL
E-2) BUSY
E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JOAN FELDMAN

FAX: 860 251-5211

AGENCY: SHIPMAN & GOODWIN

FROM: OHCA

DATE: 5/9/14 **Time:**

NUMBER OF PAGES: 3
(including transmittal sheet

Comments:

Order regarding Retreat of South Connecticut
Docket Number: 13-31828

PLEASE PHONE Barbara K. Olejarz IF THERE ARE ANY TRANSMISSION PROBLEMS.

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THE LAW OFFICE OF
JUDA J. EPSTEIN

WWW.LAWOFFICESJJE.COM

May 23, 2014

RECEIVED
MAY 23 2014
Office of
HEALTHCARE ACCESS

Kimberly R. Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

VIA OVERNIGHT MAIL

RE: NR CONNECTICUT, LLC, D/B/A RETREAT AT SOUTH CONNECTICUT, ESTABLISH A 105-BED RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY, OHCA DOCKET NO. 13-31828-CON

Dear Ms. Martone,

Enclosed please find an original and two (2) copies of Applicant's response to Finding of Facts 9, 14 and 20 of the Proposed Final Decision in the above-referenced docket. Thank you for the opportunity to present this further evidence in support of Retreat at South Connecticut's CON Application.

Please contact the undersigned should you have any questions.

Very truly yours,

Juda J. Epstein

cc: William P. Beccaro, Esq. (via U.S. mail with enclosures)
Joan W. Feldman, Esq. (via U.S. mail with enclosures)
Jennifer Groves Fusco, Esq. (via U.S. mail with enclosures)

Enc.
JJE/dv

RECEIVED
MAY 23 2014
Office of
HEALTHCARE ACCESS

IN THE MATTER OF:

An Application for a Certificate of Need Filed Pursuant to Section 19a-638, C.G.S. by:	Office of Health Care Access Docket Number: 13-31828-CON
NR Connecticut, LLC, d/b/a Retreat at South Connecticut	**Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, CT**

APPLICANT'S RESPONSES TO FINDINGS OF FACT NOS. 9, 14 AND 20 IN PROPOSED FINAL DECISION DATED JANUARY 22, 2014

Pursuant to Section 4-177c(a) of the Connecticut General Statutes, Section 19a-9-6 of the Regulations of Connecticut State Agencies and the Order of the Office of Health Care Access dated May 9, 2014, Applicant NR Connecticut, LLC, d/b/a Retreat at South Connecticut ("Applicant" or "Retreat") hereby submits its response and rebuttal to the following Findings of Fact in OHCA's Proposed Final Decision in the above Docket:

Finding of Fact No. 9

All 30 of the short-term general or children's general hospitals had substance abuse treatment discharges from FY 2008 to FY 2010. Sixteen hospitals provide detox services and twelve provide intensive inpatient treatment. Statewide Health Care Facilities and Services Plan. October 2012, pp. 99, 101.

The inclusion of Finding of Fact #9 in the Proposed Final Decision is both misguided and misleading. By focusing on hospital-based services, OHCA seems to be suggesting that the Applicant's proposed 105-bed, state-of-the art facility in New Haven is not needed because the detoxification and intensive inpatient services of Connecticut's existing residential treatment centers are supplemented by these acute care providers. This finding ignores the important distinctions between Level 3.7 care (medically monitored inpatient treatment), which Applicant proposes to offer, and Level 4.0 (acute care inpatient treatment), which requires a hospital setting. As described in detail in the accompanying Affidavit provided by Retreat's Medical

Director, Dr. Joseph Troncale (attached at Tab 1), hospital detoxification and intensive inpatient services are geared toward a far more acute and smaller strata of patients than the population Retreat intends to serve at its New Haven facility. (Troncale Aff. ¶3).

Hospital-based programs offer what the American Society of Addiction Medicine ("ASAM") labels as Level 4 treatment, which is intended for those patients who cannot be managed in a non-hospital setting. (Troncale Aff. ¶4). Accordingly, these programs play a much different role in the delivery of health care to substance abuse patients than the residential services Retreat plans to offer since they are directed at a relatively small segment of individuals whose mental and substance-related problems are so severe that they require medical monitoring, IV medications, psychiatric hospitalization and/or other types of intensive hospital care. (*Id.*) The vast majority of substance abuse patients do not require these types of acute level services. (Troncale Aff. ¶8). As such, hospital providers should not be viewed as an existing or competing provider in evaluating the clear public need for a Level 3.7 facility such as the one Applicant proposes. (*Id.*)

The facility Retreat is proposing will provide Level 3.7 medically monitored inpatient treatment and will be staffed by a full complement of medical, addiction treatment and mental health personnel who will oversee a planned regimen of care in a 24-hour live-in setting. (Troncale Aff. ¶6). Level 3 as opposed to Level 4 treatment has proven to be ideal for most patients who need drug and alcohol detoxification and rehabilitation treatment as the majority of people who suffer with addiction are relatively young and are not medically compromised. (Troncale Aff. ¶7).

In addition, a treatment improvement protocol issued by the Substance Abuse and Mental Health Services Administration ("SAMHSA") also makes clear that most general hospitals are

incapable of providing the continuum of care necessary for effective substance abuse treatment. (Troncale Aff. ¶10 and Exhibit C). Specifically, the treatment protocol and other clinical literature indicates that the main portal through which most substance abuse patients access hospital services -- the Emergency Department – may actually result in the patient entering a treatment setting that adversely affects his or her chances for long-term recovery. (Troncale Aff. ¶¶ 9-11 and Exhibits C and D). Indeed, even the American Hospital Association has stated that "Boarding [in an ED] can adversely affect psychiatric patients by exacerbating their conditions as patients are held in typically loud, hectic environments not conducive to their recovery." (Troncale Aff.¶ 17 at Exhibit D). As noted by Dr. Troncale, substance abuse patients who are relegated to receiving their care from hospital EDs also tend to visit the ED repeatedly because they often fail to get the comprehensive services they require. (Troncale Aff. ¶9).

On the other hand, and in contrast to the ED triage and detoxification-focused services that most hospitals provide, Applicant's proposal would establish a state-of-the-art facility that will follow the patient from the inpatient to the outpatient setting and provide the integrated set of specialized services that are needed for full recovery. (Troncale Aff. ¶¶13-14). This comprehensive continuum of care approach is endorsed not only by national bodies like ASAM and SAMHSA, but by the Connecticut Department of Mental Health and Addiction Services ("DMHAS") as well. (*See* CON Application at Exhibit F, pps. 397-99).

Nonetheless, the letters of support for its proposals that Applicant has received from various professional associations in Connecticut -- the Connecticut College of Emergency Physicians ("CCEP"), the National Association of Social Workers/Connecticut Chapter ("NASW") and the Connecticut Psychological Association ("CPA") – demonstrate that the vast majority of patients who visit Connecticut hospitals with substance abuse issues still end up in

hospital ED's as a treatment setting of last resort because access to residential detoxification beds remains so limited. (*See* Letters at Tab 2). This unfortunate situation not only provides clear evidence of the need for Retreat's New Haven facility, it also propagates a disjointed and sub-optimal system of care for the hundreds of thousands of substance abuse patients in Connecticut who need effective and efficient care. For example, the NASW notes in its letter that "lacking beds for adequate in-patient addiction care, clinicians have no choice but to refer clients to the local hospitals Emergency Department." In fact, as the Connecticut Psychological Association writes in its letter, some clinicians and patients attempt to game the system by using local hospitals as a gateway to secure the scarce number of residential beds that may be available:

> *As a result of the shortage of substance use treatment beds, patients and practitioners have learned the best way to obtain one of the few available beds is through direct referral from a hospital inpatient unit. Accordingly, patients and practitioners have found that patients often need to present at an Emergency Department, so they can be admitted to an inpatient unit in order to obtain that direct referral for a bed.*

Likewise, the Connecticut College of Emergency Physicians notes in its letter of support that "emergency physicians hear on [a] daily basis from our health care colleagues that they are sending patients to the emergency department for medical treatment because they are unable to find an available bed for their client."

The fact of the matter is that hospitals serve as costly and inefficient platforms for delivering substance abuse services because the intensity of their treatment is not needed by most patients. (Troncale Aff. ¶8). It is also recognized that the inefficiencies caused by this situation also place a major burden on the hospitals themselves. According to the Statewide Health Care Facilities and Services Plan published by OHCA in October, 2012 (the "Statewide Health Plan"), while overall acute care hospital visits in the State declined by 1% from 2008 to 2011, substance abuse related admissions increased 26%. (*Id.* at p. 25). The Statewide Health Plan also reported on a variety of concerns raised by hospital physicians and administrators participating in a focus

group concerning Emergency Department services. This group cited the problems caused by "behavioral health patients presenting at EDs [when] other treatment settings would be more appropriate" as a contributing factor to increased ED utilization at hospitals throughout the State. (*Id.* at p. 34). This observation comported with data that OHCA included in the Statewide Health Plan, which showed that in FY 2010, 18% of all ED visits had a diagnosis related to behavioral health. (*Id.* at p. 33). Additionally, OHCA's Statewide Health Plan mentioned that ED focus group participants observed or commented on the following:

i) Inappropriate use of the ED by behavioral health patients competing with other patients for ED resources was affecting overall quality of care delivered in the ED. (*Id.* at p. 166).

ii) There was limited access to behavioral health services especially for those requiring inpatient (adults) or residential (youth) services as well as initiating services for new patients. (*Id.*)

iii) Most hospitals represented noted the shortage of inpatient beds for both adults and children needing psychiatric or substance use treatment services. (*Id.* at p. 168).

iv) Across hospitals represented in the focus groups, the average length of stay in the ED for those awaiting admission to behavioral health service ranged from twelve to thirty-two hours. (*Id.*)

v) Overall, all regions reported use of the ED as a clearinghouse, or entry point, for access to all services (group home, inpatient, outpatient substance abuse, etc.), leading to a back-up in the ED and inability to adequately care for those truly needing emergency service. For example, access to many detoxification facilities is only available upon referral from an ED. For opiate treatment, patients spend five to six hours in an ED for this referral. Others wait days for placement and are eventually stabilized and discharged from the ED before obtaining placement. (*Id.* at p. 169).

vi) The ED is essentially functioning as a short-term inpatient unit and detoxification facility for behavioral health clients who cannot access beds at appropriate facilities. All participants agreed that behavioral health patients are not getting an adequate quality of care in the emergency department and would be better served in other settings if resources were available. (*Id.*)

vii) Participants also noted, "The ED is not conducive to providing quality care" to behavioral health/substance abuse patients and these patients do not have positive outcomes in the ED setting. (Id.)

All of the comments and observations noted above evidence a severe shortage of residential detoxification and intensive inpatient beds in the State and the lack of coordination of care between hospital EDs and the existing community based providers. However, for Retreat's Pennsylvania facility, relieving overburdened EDs of substance abuse patients who can be better treated in a residential setting and coordinating care with hospital providers has been a major strength as is noted in the letters of support from WellSpan Health/York Hospital and Christiana Care Health Services attached to this Response at Tab 3.

Approval of Retreat's CON Application will help reduce overcrowding in emergency rooms throughout Connecticut and this, in turn, should also result in strengthening the financial performance of these institutions by cutting down on their use of costly and unnecessary resources to treat substance abuse patients. (Troncale Aff. ¶18). In support of this notion, a 2012 research study found that for an academic medical center ("AMC") ED, the boarding of psychiatric/substance abuse patients resulted in a direct loss of $1,198 per patient compared to the AMC's non-psychiatric admissions. (Troncale Aff. ¶18 and Exhibit E). Moreover, when reduced bed turnover resulting from the boarding of these same patients was factored in, the AMC's total losses climbed to $2,264 for each admission of a psychiatric/substance abuse patient. (*Id.*). The findings in the study are corroborated by the support letter Retreat has received from the Connecticut College of Emergency Physicians which states in pertinent part that, "Emergency physicians will and do care for all individuals that come to the emergency department but this care comes at the highest level and cost. If substance abuse patients were

given an alternative like The Retreat those unnecessary cost[s] to the health care system could be avoided."

Finally, Retreat notes that in the Statewide Health Plan, OHCA observed that "many behavioral health patients presenting [to Hospital EDs] do not need emergency room treatment and could be more effectively and less expensively managed in outpatient settings." (*Id.* at 34). This agency also noted that there is a need for an "around-the-clock" alternative to the ED. (*Id.*). Applicant's proposed New Haven facility can help OHCA fill these important voids in the delivery system and improve the quality of substance abuse services for the residents of Connecticut at a time when heroin addiction, among other types of opiate addiction, is at record levels in our cities, suburbs and rural communities. (*See* Tab 12 for recent newspaper articles highlighting the State's soaring heroin addiction and overdose rates).

Finding of Fact No. 14

The "Addiction Residential Census Report" that is compiled daily (Monday to Friday) by DMHAS provides information on the number of available beds at facilities providing Level 3.7 detox and residential rehab that receive DMHAS grant funds, as well as other providers that choose to report through the DMHAS portal. (The Proposed Final Decision then sets forth Table 2, reflecting that between 8/13/13/ and 8/21/13 between 3 and 17 detox beds were available at a Connecticut facility).

As part of its initial Application and testimony, Applicant established that on two different days, telephone surveys conducted by Retreat staff reflected that only a handful of Level 3.7 beds were available. The Applicant conducted an additional survey of bed availability during the week of May 15, 2014 through May 21, 2014 in preparation of this Response, and, disappointingly, found that the situation had not changed. A surveyed facility offered a reserved bed to our caller only once. On two occasions, one other facility encouraged our caller to come to the facility, but did not guarantee a bed when he arrived. The full results of these surveys have been provided at Tab 4. Largely, the survey reflected the frustration that an actual hospital

or family member looking to place a patient for treatment would experience – a maze of voicemail, unanswered telephones and waiting lists. These results are confirmed by the letters submitted by the CPA, NASW and CCEP. As such, Applicant believes that these surveys are the best evidence of the limited availability at the facilities in Connecticut that offer residential detoxification. While the Hearing Officer previously appears to have ignored Applicant's survey evidence without any stated reason or rationale, such surveys have been accepted in previous CON proposals and OHCA has made findings of fact and granted approval of the proposal based, at least in part, upon the applicant's survey of bed availability. *See, e.g., Final Decision, FF 19, MCI Healthcare, LLC d/b/a Mountainside Treatment Center, Docket 11-31734-CON (May 11, 2012).*

However, in this proceeding, the Hearing Officer chose to disregard this evidence and decided to rely exclusively upon the Addiction Residential Census Report that is compiled by DMHAS on Monday through Friday mornings. All data in the DMHAS report is voluntarily reported by the applicable facilities. In preparation of this Response, Applicant received three additional reports from DMHAS for May 19-21, 2014 as set forth at Tab 5. Those reports indicated 33, -4 and 8 beds available for detoxification and 10, 17 and 8 beds available for rehabilitation, being available on those respective dates. Taking this data at face value, the most recent reports show that at least on one date, no beds were available in the entire State in the event a patient sought treatment. Also, this data demonstrates that the bed availability numbers may experience a great deal of variance and volatility from day-to-day as a number of open slots were completely filled within 24 hours.

It is Retreat's position that the DMHAS Census Reports do not provide an adequate nor reliable gage for determining that there is a sufficient number of residential

detoxification and intensive inpatient beds in Connecticut. In the first instance, simple mathematics would tell you that when the State Health Plan (pages 98-99) estimates that there are 281,222 Connecticut residents who need substance abuse treatment, but less than 47,000 of the residents are receiving this care, having even 33 open detox beds -- the high count on the DMHAS Census Reports attached at Tab 5 -- is a grossly inadequate number to serve the needs of Connecticut residents. Also, as noted previously, the reports that providers make to DMHAS for purposes of conveying bed availability are delivered by the facilities in the morning, which is the time when there is the least acute need for admission to a detoxification facility. Additionally, no census data is provided on weekends when demand to detoxification beds would be expected to peak and the OHCA's Hearing Officer relied on census data from a one-week period in August when census rates would be expected to be at their lowest due to the summer travel season. Also, the DMHAS census data does not explain whether the facility has a waiting list, nor is there an indication that the facilities would necessarily report in a standardized way. For example, a facility with a long waiting list may not report at all (as was the case with Stonington during the three-day time period for which Retreat obtained survey results). Finally, and most importantly, the DMHAS data is not readily available to the public or providers so that a hospital or family member attempting to place a patient would not know which one or two of the seven listed facilities has indicated that it has an opening. While the data may be useful for DMHAS as a starting point for where to place a patient among its designated facilities, it is certainly not the best source of data for determining bed availability for the average health care consumer or determining the merits of this CON application.

It is also worthy of mention that DMHAS itself conducted a separate study to measure the availability of substance abuse services as part of its 2012 Report on Statement Priority

Services. This report is provided at Tab 6. In that study, 70% of providers of intensive residential and co-occurring residential services self-reported that they never or only sometimes had bed availability as opposed to often or always having bed availability (p. 20). Similarly, 60% of providers of residential substance abuse services reported that they never or only sometimes had bed availability. (*Id.* at p. 20).

These results are mirrored in the actual experience of patients and referring clinicians in Connecticut. In its letter of support for Retreat, the CCEP notes that "our health care colleagues … are unable to find an available bed for their client." The CPA states "For many years, psychologists and other mental health providers in Connecticut have experienced the greatest difficulty finding available beds for insured patients who present with an immediate need for inpatient substance use treatment." And the NASW reports that "[its] members who work with addictions tell us that there are an inadequate number of in-patient beds in greater New Haven." Likewise, in the narrative description of the focus groups conducted by DMHAS for the 2012 Report, the agency notes that "long wait times to access detox (and residential treatment) were commonly cited…[and] ….[f]amily members in particular were very concerned regarding the importance of accessing services promptly, as an individual could lose modification, thus missing an important 'window of opportunity.'" (Tab 6 at p. 24). These results led DMHAS to conclude that it should "conduct a comprehensive review of existing residential treatment bed capacity, at all levels, to assess the adequacy based upon current and future demand." (*Id.* at 30).

Applicant has proposed to construct a new facility in New Haven that will be built without any costs to taxpayers and without government subsidy of any kind that will alleviate the current stress on Connecticut's substance abuse detoxification and rehabilitation system and ensure that there is sufficient capacity moving forward. This opportunity to create more

accessible and affordable high quality care for substance abuse patients in this State should not be squandered.

Finding of Fact No. 20

The payer mix in Fiscal Year 2012 shows that 79% of the town of New Haven had government insurance and 20% had commercial insurance. Of New Haven County residents, 65% had government insurance and 33% had commercial insurance. (The Proposed Finding then incorporates Table 6: Payer Mix for the Town of New Haven and New Haven County for Fiscal Year 2012: Source, OHCA's Acute Hospital Inpatient Discharge Database.)

The above proposed Finding of Fact #20 focuses only on the needs of individuals residing in the City or County of New Haven, and consequently is only minimally relevant since the populations Applicant seeks to serve are residents who live throughout Connecticut and in surrounding states. As noted previously, the testimony of Mr. Freeman of the Cornell Scott-Hill Health Center demonstrated that his own New Haven-based program also served individuals from other areas of the State. *See* August 14, 2013 Public Hearing Transcript at p. 63. Accordingly, and at a minimum, the proposed Findings of Fact should address the state-wide population Applicant intends to serve, rather than only New Haven residents.

Further, proposed Finding of Fact #20 is inaccurate due to the misplaced reliance upon the OHCA's Acute Hospital Inpatient Discharge Database in attempting to ascertain the percentage of New Haven residents who have commercial insurance. This data is skewed by the fact that a far greater percentage of elderly Medicare-eligible patients obtain services at hospitals than would be the case at a substance abuse facility. In fact, according to the National Institute on Drug Abuse only 0.6% of patients admitted to publicly funded substance abuse treatment centers were 65 or older. (*See* Tab 7). Moreover, because many Medicaid patients do not have strong connections to primary care providers and are more apt to use emergency departments and other hospital facilities as their medical provider of first resort, the Medicaid data from OHCA's Acute Care Hospital Inpatient Discharge Database does not accurately

reflect, nor is it relevant to, the population to be served by a substance abuse facility catering mainly to commercially insured patients.

According to the United States Census Bureau American Community Survey the percentage of residents with commercial insurance are vastly higher than the payer mix data mistakenly relied upon in Finding of Fact 20. Specifically, the percentage of City of New Haven, County of New Haven and Connecticut residents generally for 2008-2012 who have commercial insurance as reported by the Census Bureau is 54.9%, 72.2% and 74.9%, respectively. (*See* Tab 8).

In addition, as a result of the Patient Protection and Affordable Care Act (the "ACA"), the number of individuals insured under commercial insurance is expected to rise dramatically. According to the Associated Press, as of April 17, 2014, at least 78,713 individuals purchased health insurance with private carriers through Connecticut's health insurance exchange – Access Health CT – through its first enrollment period. (*See* Tab 9). In addition, it is estimated that 23,000 additional individuals between 19 and 25 years old in Connecticut have gained coverage through their parents' coverage under the ACA. (*See* Tab 10). This large influx of insured residents is expected to further increase with the implementation of the employer mandate. According to an April 2014 Report of the Congressional Budget Office, the number of nonelderly individuals with health insurance is expected to rise from 80% in the absence of the ACA to about 84% in 2014 and to about 89% percent in 2016 and beyond. (*See* Tab 11). Retreat is committed to being an in-network provider with each of these plans and it will also provide free care through scholarship beds to those who are uninsured or otherwise qualify for the program.

Accordingly, and based on the above, Finding of Fact #20 should be amended to reflect that the United States Center Bureau data demonstrates that 74.9% of Connecticut residents are commercially insured and that the number is expected to rise significantly due to the effects of the ACA. The correct insurance data makes the need for Retreat's services self-evident:

i. The State Health Plan estimates that 281,222 Connecticut residents are in need of substance abuse treatment;

ii. It further estimates that 46,741 of these residents or only 17% are getting the help they need;

iii. That leaves an unmet need of 234,481 individuals who should be in treatment and 75% of those individuals – or an estimated population of 175,680 substance abusers – are insured; and

iv. This is not counting the growing ranks of the insured that will accompany the growing expansion of the ACA.

Retreat will not siphon away commercially insured patients from existing providers as the Intervenors fear because there exists an ample pool of insured patients to treat in its Connecticut facility without negatively impacting their residential detox and intensive inpatient programs. These providers can also expand their programs and services to meet this clear public need and reverse the current trend where less than 1 in five people who need substance abuse treatment in this State are receiving care. Retreat will also provide free care to those without the resources to pay. Based on the information provided in this Response and the record as a whole, the Applicant respectfully requests that OHCA modify its Proposed Final Decision to approve this CON Application.

Respectfully Submitted,

NR CONNECTICUT, LLC d/b/a
RETREAT AT SOUTH CONNECTICUT

By: _____

Juda J. Epstein, Esq.
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3543 Main Street, 2nd Floor
Bridgeport, CT 06606
(203) 371-7007 - telephone
(203) 257-8015 - facsimile
lawofficesjje@aol.com

Dated: May 23, 2014

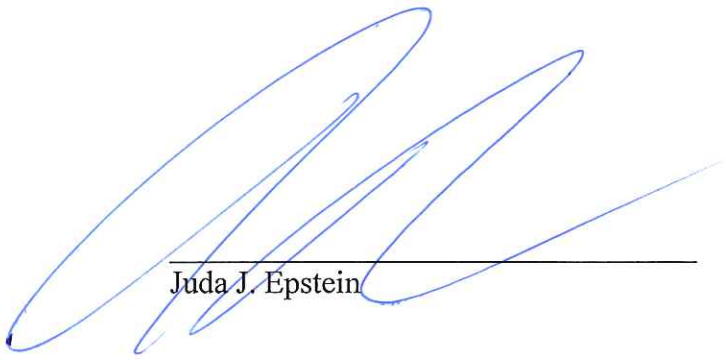
CERTIFICATE OF SERVICE

This is to certify that a true and accurate copy of the foregoing was sent by U.S. Mail this 23rd day of May, 2014, to the following counsel of record:

William P. Beccaro, Esq.
12 New City Street
Essex, CT 06426

Joan W. Feldman, Esq.
Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103-1919

Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street, 10th Floor
New Haven, CT 06510



Juda J. Epstein

IN THE MATTER OF:

An Application for a Certificate of Need Filed Pursuant to Section 19a-638, C.G.S. by:	Office of Health Care Access Docket Number: 13-31828-CON
NR Connecticut, LLC, d/b/a Retreat at South Connecticut	**Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, CT**

AFFIDAVIT OF JOSEPH A. TRONCALE, M.D., F.A.S.A.M.

I, Joseph A. Troncale, M.D., F.A.S.A.M.., hereby declare under penalty of perjury that the following is true and correct:

1. I am the Medical Director of Retreat at Lancaster County and a Fellow of the American Society of Addition Medicine ("ASAM"). As a board certified family practitioner, I have over thirty-two years of experience as a Medical Director and clinician in treating substance abuse patients in both the acute care hospital setting (at Jefferson Hospital, UAB, Reading Hospital, and Lancaster General Hospital) as well as freestanding detoxification and rehabilitation centers such as the Caron Treatment Center in Wernersville, Pennsylvania and Retreat. A copy of my Curriculum Vitae is attached as Exhibit A to this Affidavit.

2. I am providing this Affidavit in support of Retreat's certificate of need ("CON") application to operate a 105-Bed Residential Substance Abuse Treatment Facility in New Haven, Connecticut and specifically to provide evidence and testimony to the Connecticut Office of Health Care Access ("OHCA") on the following three points:

A) It was inappropriate for OHCA to consider the detoxification and intensive inpatient services provided by short-term General and Children's Hospitals in Connecticut in assessing the need for Retreat's proposed facility as the services hospitals provide to substance abuse patients are wholly distinct from those of Retreat;

B) The comprehensive services that Retreat's facility would provide are clinically proven to be vastly superior to those provided by most acute care hospitals in effectively treating the disease of addiction; and

C) Approving Retreat's application would in fact be beneficial to Connecticut hospitals as Retreat's presence would help alleviate many of the human resource and financial pressures they face when treating substance abuse patients.

The Critical Distinctions between Hospital and Residential Inpatient Treatment

3. As demonstrated by the excerpt from the ASAM Textbook Principles of Addiction Medicine (3rd edition) attached to my Affidavit at Exhibit B, hospitals play a much different role in health care delivery to substance abuse patients when compared to the type of facility Retreat proposes to establish in New Haven. The key distinction is that the level of care in hospitals is geared to a significantly more acute population. As shown on page 7 of the excerpt, ASAM treatment criteria is based around five basic levels of care with hospitals typically providing a part of what is known as Level 4: Medically Managed Intensive Inpatient Treatment.

4. Quoting from the text of the excerpt at page 8, "Level IV programs provide a planned regimen of 24-hour medically directed evaluation, care and treatment of mental and substance-related disorders in an acute care inpatient setting.... Level 4 programs provide care to patients whose mental and substance-related problems are so severe that they require primary biomedical, psychiatric and nursing care. Treatment is provided 24 hours a day, and the full resources of a general acute care hospital or psychiatric hospital are available."

5. The reason that I say most hospitals typically provide "a part" of the Level 4 services described above is that, unless they are an ASAM certified Level 4 facility of which there are only 4 in Connecticut, hospitals typically focus only on providing short-term detoxification and

related biomedical and/or psychiatric services to substance abuse patients. These hospitals are simply not equipped to provide the longer-term follow-up care that is necessary to successfully treat the disease of addiction.

6. On the other hand, Retreat is proposing to provide Level 3.7 medically monitored inpatient treatment. Again, quoting from page 8 of the ASAM textbook excerpt, "Level III encompasses organized services staffed by designated addiction treatment and mental health personnel who provide a planned regimen of care in a 24-hour live-in setting. ... They are staffed 24 hours a day. Mutual and self-help group meetings generally are available on-site.... The defining characteristic of all Level III programs is that they serve individuals who need safe and stable living environments in order to develop their recovery skills."

7. When individuals are unable to maintain sobriety in an outpatient setting, it is frequently because of the need to get out of the environment in which they find themselves either because of family issues, lack of support systems or fear of detoxification. Level 3 care is ideal for most patients who need drug and alcohol detox and treatment as the majority of people with addiction problems are relatively young and are not medically compromised.

8. Conversely, Level 4 treatment is reserved for people who cannot be managed in a non-hospital setting. This would include patients who need medical monitoring, IV medications, psychiatric hospitalization and/or intensive care. The intensity of these services are simply not needed by the average substance abuse patient and thus hospital providers should not be seen as an existing or competing provider in evaluating clear public need for a Level 3.7 facility.

Retreat's Proposed Facility Would Provide Better Treatment Than Hospitals

9. What should be obvious from the above is that the largest percentage of actively addicted patients can be detoxified and treated at the inpatient medically monitored level. My experience

from having served as both a Medical Director and a clinician in these two different types of care settings is that care in the hospital setting, which is primarily centered around care in overburdened Emergency Departments, can often be a detriment to the patient as many get stuck in the "revolving door" of repeated hospital admissions. These patients then quickly get labeled as ED "frequent flyers" while their condition worsens without ever getting the comprehensive services they need.

10. The clinical literature also supports this conclusion. Attached at Exhibit C to my Affidavit is a Substance Abuse and Mental Health Services Administration ("SAMHSA") Treatment Improvement Protocol entitled *2 Settings, Levels of Care, and Patient Placement.* Quoting from page 4 of the Protocol, it states as follows:

> A freestanding urgent care center or emergency department reasonably can be expected to provide assessment and acute biomedical (including psychiatric) care. However, these settings often are unable to provide satisfactory psychosocial stabilization or complete biomedical stabilization (which includes both the initiation and taper of medications used in the treatment of substance withdrawal syndromes). Appropriate triage and successful linkage to ongoing detoxification services is essential.

11. The same Protocol goes on to say at page 5 that "For patients with substance use disorders, care in these settings is not complete until successful linkage is made to treatment that is focused specifically on the substance use disorder. To accomplish this, a comprehensive assessment, taking into account psychosocial as well as biomedical issues, is recommended wherever possible."

12. These statements from SAMHSA's Protocol comport with my experiences in the field as the entire culture and training of staff in most short-term hospitals is different than that of a Level 3.7 facility where there is a whole milieu of services geared to treat substance abuse patients. These services and the medical and nursing expertise necessary to provide them do not exist in the hospital setting except at very specialized Level 4 ASAM-certified facilities. As a

result, most general hospitals work with doctors and nurses who do not treat withdrawal regularly and, therefore, tend to under-recognize addiction and undertreat the symptoms.

13. I would contrast the relative lack of addiction services in hospitals with those available at Retreat where, even prior to admission, we begin focusing our assessment tools on the patient's care and stabilization through a thorough review of the medical and psychological history that takes into account past diagnosis and treatment episodes. Once this initial clinical assessment has been completed, the patient will be admitted and within 24-36 hours the patient will undergo rigorous assessments including a bio psychosocial assessment as well as both nursing and physician medical assessments. During these assessments, any patients identified as in need of psychiatric intervention will then meet with a Psychiatrist and be assigned a Clinical Specialist and a Primary Therapist simultaneously.

14. As opposed to the triage and detoxification-focused services that most hospitals provide, Retreat provides patients with an integrated team of physicians, psychiatrists, nurses, clinical specialists and therapists with extensive substance abuse backgrounds to coordinate care and adapt treatment planning to individual patient needs. This results in far better outcomes for the patient and the delivery system as a whole as the "revolving door" recidivism rate that I described above is also greatly reduced.

Level 3.7 Facilities Provide Care to Patients with Co-occurring Disorders and are Less Costly than Hospitals

15. In my review of the record in the current CON proceeding, I also noted repeated instances where the Intervenors wrongly questioned Retreat's ability to treat patients with co-occurring mental disorders (also referred to as dual diagnosis patients) to imply that our facility would not relieve stress on overburdened Hospital Emergency Departments. This is untrue. Retreat's clinicians are all trained to treat patients with bipolar disorder, depression, anxiety,

PTSD, personality disorder, and behavioral issues such as impulse control, decision-making, anger management, and other mental health problems. This is done seamlessly and simultaneously with substance abuse treatment.

16. As was pointed out at the public hearing, Retreat's rate of transfer from its Lancaster facility to local hospitals for care of any kind is exceedingly low. Moreover, the ASAM literature attached to my Affidavit at Exhibit B, page 9, makes clear that "Individuals whose co-occurring mental disorders best fit within the category of moderate severity disorders are appropriately treated in programs designed to treat primary substance use disorders." The definition of moderate severity disorders on the same page would encompass the behavioral health symptomology of the vast majority of individuals in need of substance abuse services in Connecticut.

17. I would also point out that the American Hospital Association ("AHA") has also recognized that overstressed Emergency Departments are far from an appropriate setting to treat patients with psychiatric disorders, including those with substance abuse issues. To this point, attached to my Affidavit at Exhibit D is an American Hospital Association *Trendwatch* article entitled *Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes* that makes clear that the all too common practice of ED boarding – holding patients in the ED until scarce psychiatric hospital or residential substance abuse facility inpatient beds becomes available – actually harms patients. *See* p. 5 ("Boarding can adversely affect patients by exacerbating their conditions as patients are held in typically loud, hectic environments not conducive to their recovery."). Approving Retreat's CON would help alleviate this problem in Connecticut.

18. Lastly, and very importantly, approval of Retreat's CON could help Connecticut reduce the unnecessary costs that are borne by the health care system as a result of having too few inpatient detox beds outside of the acute care setting. And again there is empirical evidence to support my statement. As shown at Exhibit E to my Affidavit, a 2012 research article entitled *The Impact of Psychiatric Patient Boarding in Emergency Departments*, took the numerous studies chronicling the adverse effects of psychiatric patient boarding a step further by studying its impact on length of stay (LOS) and financial loss for an academic medical center Emergency Department with over 68,000 adult visits.

19. The results of the study speak for themselves – ED LOS was 3.2 times longer for psychiatric admissions (an average of 1,089 minutes) versus 340 minutes for non-psychiatric admissions. The financial impact of the boarding practice resulted in a direct loss for the hospital of $1,198 per patient compared to the non-psychiatric admissions and, when factoring in the losses from reduced bed turnover due to the extended stay of the psychiatric patients, this figure climbed to a total loss of $2,264 per psychiatric patient admission.

20. In its 2012 Statewide Health Care Facilities and Services Plan, OHCA reported, among other things, that substance abuse related visits to Connecticut hospital EDs have increased 26%, more than double the rate of the second highest reason, which is psychiatric, and that hospital EDs were acting as clearinghouses for substance abuse diagnoses as opposed to having these services come from more appropriate specialty facilities providing less intensive and expensive levels of care.

21. In my professional opinion, Retreat's proposed facility in New Haven can be the more appropriate and affordable specialty provider that Connecticut so desperately needs.

FURTHER AFFIANT SAYETH NOT.

Joseph A. Troncale, M.D., F.A.S.A.M.

STATE OF PENNSYLVANIA)
) *ss.* _____
COUNTY OF: Lancaster)

On this, the **22nd day of May, 2014,** before me, **Joseph A. Troncale, M.D.,** the undersigned officer, personally appeared Joseph A. Troncale, M.D., known to me (or satisfactorily proven) to be the person whose name is subscribed to within the instrument, and acknowledged that **he** executed the same for the purposes therein contained.

In witness whereof, I hereunto set my hand and official seal.

Notary Public
Name: **Joann M. Michalski**
My commission expires:

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
JOANN M. MICHALSKI, Notary Public
Ephrata Boro., Chester County
My Commission Expires April 2, 2016

CURRICULUM VITAE
JOSEPH A. TRONCALE, M.D.
Addiction Professional Magazine's Physician of the Year 2010

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Date and Place of Birth:	April 18, 1952; Birmingham, AL
Citizenship:	USA
Marital Status:	Married
Academic Appointment:	Clinical Associate Professor of Psychiatry Penn State University Medical Center
Specialty Boards:	American Board of Family Practice Certificate of Qualifications in Geriatric Medicine, (1992-2002) Diplomate, American Board of Family Practice, (1983-1990), Recertified (1989-1996) (1995-2002) (2002-2008)(2007-2014) Certified: American Society of Addiction Medicine (1999-2009) Fellow: American Society of Addiction Medicine (2008)
Education:	Bachelor of Science, 1974 University of Alabama Tuscaloosa, Alabama Doctor of Medicine, 1979 University of South Alabama College of Medicine Mobile, Alabama
Postgraduate Training:	Flexible Internship, 1979-1980 University of South Alabama Mobile, Alabama Family Practice Residency, 1980-1982 University of South Alabama Mobile, Alabama

Military Service:

Currently LTC in the United States Army Reserve
Recommissioned, February 2006 – Physician, 339 MC HSP CSH, Det 1, Harrisburg, Pennsylvania

April 1981 – June 1986: General Med Officer, 3343rd USA Hospital, Mobile, Alabama
July 1986 – January 1987; Prev Med Officer, 5th Medical GP, Birmingham, Alabama
February 1987 – August 1987; Gen Med Officer, 3345th USA Hospital,Birmingham, Alabama

Academic Qualifications:	Appointments:
2010	Physician – Lancaster General Hospital, Occupational Medicine Department
2001-2009	Medical Director, Caron Treatment Centers,Wernersville, Pennsylvania
1997-2001	Medical Director, Emergency Department and Susquehanna Addictions Center, Managing physician, Twin Rose Primary Healthcare
1994-1997	Associate Director, Department of Family and Community Medicine, Director of Family Health Service Clinic, Lancaster General Hospital, Family Practice residency Program, Lancaster, Pennsylvania
1993-1994	Acting Director, Department of Family Practice, Saint Joseph Hospital, Reading, Pennsylvania
1991-1994	Residency Program Director, Saint Joseph Hospital, Reading, Pennsylvania (Affiliate of Hershey Medical Center, Penn State University)
1990-1991	Clinical Associate Professor, Department of Family Medicine, Jefferson Medical College, Thomas Jefferson University, Philadelphia, Pennsylvania (full time faculty)
1988-1990	Department Director and Residency Program Director, The Reading Hospital and Medical Center, Reading, Pennsylvania
1986-1988	Associate Professor, Residency Program Director, Department of Family Medicine, University of Alabama at Birmingham
1982-1986	Assistant Professor, Undergraduate Director Department of Family Practice, University of South Alabama College of Medicine, Mobile, Alabama

Committee Appointments/Offices Held:

Chair, ASAM Workgroup on Families and Generational Issues (2005-present)
Board Member, Lancaster General Hospital – Susquehanna Division (1996-98)
President, Berks County Chapter of Pennsylvania Academy of Family Practice (1992-1984)
Member, Appointed to Board of Directors, Pennsylvania Academy of Family Physicians (1989-1992)
Member, Obstetrics Committee, Department of Family Medicine, Jefferson Medical College, (1990-1991)
Member, Residency Education Committee, Department of Family Medicine, Jefferson Medical College (1990-1991)

Member, Residency Program Directors Committee, The Reading Hospital and Medical Center, Reading, Pennsylvania (1988-1990)
Member, Executive Committee of the Medical Staff, The Reading Hospital and Medical Center, Reading, Pennsylvania (1988-1990)

Committee Appointments/Offices Held (continued)

Member, Board of Directors, Lancaster General Hospital Susquehanna Division, 2000-2001
Member, Planning Committee of the Board of Directors,
The Reading Hospital and Medical Center, Reading, Pennsylvania (1988-1990
Chairman, Executive Committee, Department of Family Medicine,
The Reading Hospital and Medical Center, Reading, Pennsylvania (1988-1990)
Member, Education Committee, Alabama Academy of Family Practice (1987-1988)

Chapters Authored:

Troncale, J.A.: Asthma. Saunders Manual of Medical Practice. Pages 117-119, 1996.
Troncale, J.A.: Headache. When to Call the Surgeon. Pages 1-10, 1998

Articles:

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Troncale, J.A.: Opiates: Their History and Its Relevance to Today's Treatment. Counselor Magazine, April 2002
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Troncale, J.A.: The Art and Science of Bedside Diagnosis, in The Journal of Family Practice. Vol. 31, No. 2, 1990.

Software Reviewed:

Troncale, J.A.: Drug Interaction Facts on Disk in The Journal of Family Practice, 1996.
Troncale, J.A.: Physicians' GenRx 1994 in The Journal of Family Practice, Vol 39, No. 2, August 1994.

Volunteer Services:

House assistant (live-in house parent with wife. L'arche, a home for mentally handicapped) 1977-1979, both in Mobile, Alabama and Syracuse, New York.

Professional Society Memberships:

American Academy of Family Physicians
Pennsylvania Academy of Family Physicians
American Society of Addiction Medicine

Honors

CIBA-Geigy Community Services Award, 1977
Eugene D. Bondurant Award for Excellence in Psychiatry, 1979
Army Achievement Medal, 1982
Army Achievement Medal (First Oak Leaf Cluster), 1986
Residents' Appreciation Award, 1986, University of South Alabama
Residents' Appreciation Award, 1990, Reading Hospital and Medical Center
Teacher of the Year Award, 1994, St. Joseph Hospital
Faculty of the Year Award, 1997, Lancaster General Hospital
Army Commendation Medal, 2006
Army Achievement Medal (Second Oak Leaf Cluster), 2007
Physician of the Year: Addiction Professional Magazine 2010

ASAM Textbook Chapter 4-5

PRINT

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The ASAM Placement Criteria and Matching Patients to Treatment

David Mee-Lee, M.D.
Gerald R. Shulman, M.A., M.A.C., FACATA

When considering treatment matching, treatment planning, and the use of patient placement criteria, certain distinctions and definitions must be clarified, particularly the distinction between "placement matching" and "modality matching." In placement matching, a patient is referred to a particular setting, such as intensive outpatient or residential care, while modality matching attempts to match a patient's needs to a specific treatment approach (such as motivational enhancement therapy), regardless of setting. When placement matching is disconnected from modality matching, treatment is likely to be less effective because it fails to respond to the individual needs of the patient.

Good treatment planning thus combines modality matching (for all pertinent problems and priorities identified in the assessment) with placement matching (which identifies the least intensive level of care that can safely and effectively provide the resources that will meet the patient's needs (Mee-Lee, 1998).

Selecting an Appropriate Treatment

Evolving Approaches to Treatment Matching. The process of matching patients to treatment services has evolved through at least four approaches, each with a fundamentally different philosophy (Mee-Lee, 2001).

Complications-driven treatment gives only cursory attention to the diagnosis of substance use disorder. In this approach, rather than actively treating the primary alcohol or other drug disorder that is causing the patients symptoms, only the secondary complications or sequelae are addressed. The gastritis or bleeding esophageal varices are controlled; the depression is medicated; fractures are splinted or pinned, but care for the addictive disorder is superficial or non-existent.

In contrast, *diagnosis, program-driven treatment* recognizes the primacy of the substance use disorder, but the diagnosis alone drives the treatment plan, rather than the specific assessed needs of the patient. Patients are assigned to fixed lengths of stay in programs with static approaches, often in response to available funding or benefit structures.

Individualized, assessment-driven treatment emphasizes multidimensional assessment. Problems are identified and prioritized in the context of the patient's severity of illness and level of function. Treatment services are matched to the patient's needs over a continuum of care (Shulman, 1994). Ongoing assessment of progress and treatment response influences future treatment recommendations. This continuous quality improvement cycle—assessment, treatment matching, level of care placement, and progress evaluation through assessment (see Figure 1)—represents an approach to care that much of the addiction treatment field still struggles to implement (Mee-Lee, 1998).

In *outcomes-driven treatment*, which is the newest approach, the promise of matching patients to treatment has yet to be fully realized. For all the current rhetoric about outcomes, performance measures, accountability, and evidence-based treatment, this approach to addiction treatment is only just beginning to be articulated and actualized.

Uses of Placement Criteria. Placement criteria are irrelevant to the first two approaches to patient placement (complications-driven and program-driven treatment). In the latter two approaches (assessment-driven treatment and

outcomes-driven treatment), however, placement criteria play an integral role by providing a structure for assessment that cuses on the patient's assessed needs. Criteria also provide a nomenclature to describe an expanded set of treatment options and guidelines to promote the use of a broader continuum of services. Overall, the placement criteria are intended to enhance the efficient use of limited resources, increase patient retention in treatment, prevent dropout and relapse, and thus improve patient outcomes.

The Concept of "Unbundling." At present, most addiction treatment services are "bundled," meaning that a number of different services are packaged together and paid for as a unit. Similarly, the first edition of the ASAM criteria "bundled" clinical services with environmental supports in fixed levels of care. Today, however, there is increasing recognition that clinical services can be and often are provided separately from environmental supports. Indeed, many managed care companies and public treatment systems are suggesting that treatment modality and intensity be "unbundled" from the treatment setting.

Unbundling is a practice that allows any type of clinical service (such as psychiatric consultation) to be delivered in any setting (such as a therapeutic community). With unbundling, the type and intensity of treatment are based on the patient's needs and not on limitations imposed by the treatment setting. The unbundling concept thus is designed to maximize individualized care and to encourage the delivery of necessary treatment in any clinically feasible setting.

A transition to unbundled treatment would require a paradigm shift in state program licensure and reimbursement. In terms of treatment, there would no longer be "programs" but rather a constellation of services to meet the needs of each patient. The systems currently in use for billing, reimbursement, and funding would not support unbundled treatment. All of these obstacles are reasons for delaying an abrupt change to the new paradigm, but the ASAM criteria encourage exploration of unbundling by suggesting ways to match risk and severity of needs with specific services and intensity of treatment.

Understanding the ASAM Patient Placement Criteria

Four features characterize the ASAM Patient Placement Criteria: (1) individualized treatment planning, (2) ready access to services, (3) attention to multiple treatment needs, and (4) ongoing reassessment and modification of the plan.

Functionally, the criteria are used to match treatment settings, interventions, and services to each individual's particular problems and (often-changing) treatment needs. The ASAM criteria advocate for individualized, assessment-driven treatment and the flexible use of services across a broad continuum of care.

The criteria also advocate for a system in which treatment is readily available, because patients are lost when the treatment they need is not immediately available and readily accessible. By expanding the criteria to incorporate outpatient care, especially for those in early stages of readiness to change, the ASAM criteria have helped to reduce waiting lists for residential treatment and thus have improved access to care.

The criteria are based in a philosophy that effective treatment attends to multiple needs of each individual, not just his or her alcohol or drug use. To be effective, treatment must address any associated medical, psychological, social, vocational, and legal problems. Through its six assessment dimensions, the ASAM criteria underscore the importance of multidimensional assessment and treatment (Figure 2).

Objectivity. The criteria are as objective, measurable, and quantifiable as possible. Certain aspects of the criteria require subjective interpretation. In this regard, the assessment and treatment of substance-related disorders is no different from biomedical or psychiatric conditions in which diagnosis or assessment and treatment is a mix of objectively measured

criteria and experientially based professional judgments.

Principles Guiding the Criteria. Several important principles have guided development of the ASAM criteria.

Goals of Treatment: The goals of intervention and treatment (including safe and comfortable detoxification, motivational enhancement to accept the need for recovery, the attainment of skills to maintain abstinence, and the like.) determine the methods, intensity, frequency, and types of services provided. The health care professional's decision to prescribe a type of service, and subsequent discharge of a patient from a level of care, are based on how that treatment and its duration will influence the resolution of the dysfunction and positively alter the prognosis for the patient's long-term outcome.

Thus, in addiction treatment, the treatment may extend beyond simple resolution of observable biomedical distress to the achievement of overall healthier functioning. The patient demonstrates a response to treatment through new insights, attitudes and behaviors. Addiction treatment programs have as their goal not simply stabilizing the patient's condition, but altering the course of the patient's disease.

Individualized Treatment Plan: Treatment should be tailored to the needs of the individual and guided by an individualized treatment plan that is developed in consultation with the patient. Such a plan should be based on a comprehensive bio-psychosocial assessment of the patient and, when possible, a comprehensive evaluation of the family as well.

The plan should list problems (such as obstacles to recovery, knowledge or skill deficits, dysfunction or loss), strengths (such as readiness to change, a positive social support system, and a strong connection to a source of spiritual support) and priorities (such as obstacles to treatment and risks, identified within the list of problems and arranged according to severity), goals (a statement to guide realistic, achievable, short-term resolution or reduction of the problems), methods or strategies (the treatment services to be provided, the site of those services, the staff responsible for delivering treatment), and a timetable for follow-through with the treatment plan that promotes accountability.

The plan should be written so as to facilitate measurement of progress. As with other disease processes, length of service should be linked directly to the patient's response to treatment (for example, attainment of the treatment goals and degree of resolution of the identified clinical problems).

Choice of Treatment Levels: Referral to a specific level of care must be based on a careful assessment of the patient. The goal that underlies the criteria is the placement of the patient in the most appropriate level of care. For both clinical and financial reasons, the preferred level of care is the least intensive level that meets treatment objectives, while providing safety and security for the patient. Moreover, while the levels of care are presented as discrete levels, in reality they represent benchmarks or points along a continuum of treatment services that could be used in a variety of ways, depending on a patient's needs and response. A patient could begin at a more intensive level and move to a more or less intensive level of care, depending on his or her individual needs.

Continuum of Care: In order to provide the most clinically appropriate and cost-effective treatment system, a continuum of care must be available. Such a continuum may be offered by a single provider or multiple providers. For the continuum to work most effectively, it is best distinguished by three characteristics: (1) seamless transfer between levels of care, (2) philosophical congruence among the various providers of care, and (3) timely arrival of the patient's clinical record at the next provider. It is most helpful if providers envision admitting the patient into the continuum *through* their program rather than admitting the patient *to* their program.

Many providers of treatment services offer only one of the many levels of care described. In such situations, movement between levels might mean referring the patient out of the provider's own network of care. While lack of reimbursement for some levels of care, or lack of availability of other levels of care may render this impossible at present, the goal of these criteria is to stimulate the development of efficient and effective services that can be made available to all patients.

Progress Through the Levels of Care: As a patient moves through treatment in any level of care, his or her progress in all six dimensions should be continually assessed. Such multidimensional assessment ensures comprehensive treatment. In the process of patient assessment, certain problems and priorities are identified as justifying admission to a particular level of care. The resolution of those problems and priorities determines when a patient can be treated at a different level of care or discharged from treatment. The appearance of new problems may require services that can be effectively provided at the same level of care, or that require a more or less intensive level of care.

Each time the patient's response to treatment is assessed, new priorities for recovery are identified. The intensity of the strategies incorporated in the treatment plan helps to determine the most efficient and effective level of care that can safely provide the care articulated in the individualized treatment plan. Patients may, however, worsen or fail to improve in a given level of care or with a given type of program. When this happens, changes the level of care or program should be based on a reassessment of the treatment plan, with modifications to achieve a better therapeutic response.

Length of Stay: The length of stay or service is determined by the patient's progress toward achieving his or her treatment plan goals and objectives. Fixed length of stay or program-driven treatment is not individualized and does not respond to the particular problems of a given patient. While fixed length of stay programs are more convenient and predictable for the provider, they may be less effective for individuals.

Clinical versus Reimbursement Considerations: The ASAM criteria describe a wide range of levels and types of care. Not all of these services are available in all locations, nor are they covered by all payers. Clinicians who make placement decisions are expected to supplement the criteria with their own clinical judgment, their knowledge of the patient, and their knowledge of the available resources. The ASAM criteria are not intended as a reimbursement guideline, but rather as a clinical guideline for making the most appropriate placement recommendation for an individual patient with a specific set of symptoms and behaviors. If the criteria only covered the levels of care commonly reimbursable by private insurance carriers, they would not address many of the resources of the public sector and, thus, would tacitly endorse limitations on a complete continuum of care.

Treatment Failure: Two incorrect assumptions are associated with the concept of "treatment failure." The first is that the disorder is acute rather than chronic, so that the only criterion for success is total and complete amelioration of the problem. Such expectations are recognized as inappropriate in the treatment of other chronic disorders, such as diabetes or hypertension. No one expects that simply because a patient has been treated on one occasion for his or her hypertension, there will never be another episode. The same recognition of chronicity should be applied to the treatment of addictive disorders, for which appropriate criteria would involve reductions in the intensity or severity of symptoms, the duration of symptoms, and the frequency of symptoms.

The second assumption is that responsibility for treatment "failure" always rests with the patient (as in, "The patient was not ready"). However, poor treatment outcomes also may be related to a provider's failure to provide services tailored to the patient's needs.

Finally, there is a concern that some benefit managers require that a patient "fail" at one level of care as a prerequisite for approving admission to a more intensive level of care (for example, "failure" in outpatient treatment as a prerequisite for admission to inpatient treatment). In fact, such a requirement is no more rational than treating every patient in an inpatient program or using a fixed length of stay for all. Such a strategy potentially puts the patient at risk because it delays care at a more appropriate level of treatment, and potentially increases health care costs if restricting the appropriate level of treatment allows the addictive disorder to progress.

The ASAM Criteria and State Licensure or Certification. The ASAM criteria contain descriptions of treatment programs at each level of care, including the setting, staffing, support systems, therapies, assessments, documentation, and treatment plan reviews typically found at that level. This information should be useful to providers who are preparing to serve a

particular group of patients, as well as to clinicians who are making placement decisions. Nevertheless, the descriptions are not requirements and are not intended to replace or supersede the relevant statutes, licensure or certification requirements of any state.

Assessment Dimensions

The ASAM criteria identify the following problem areas (dimensions) as the most important in formulating an individualized treatment plan and in making subsequent patient placement decisions. (Note that the information given here is for the adult criteria only. A detailed discussion of the adolescent criteria is found in Section 13 of this text.)

Dimension 1: Acute Intoxication and/or Withdrawal Potential. What risk is associated with the patient's current level of acute intoxication? Is there significant risk of severe withdrawal symptoms or seizures, based on the patient's previous withdrawal history, amount, frequency, and recency of discontinuation or significant reduction of alcohol or other drug use? Are there current signs of withdrawal? Does the patient have supports to assist in ambulatory detoxification, if medically safe? Has the patient been using multiple substances in the same drug class? Is there a withdrawal scale score available?

In the adult ASAM Placement Criteria, detoxification services can be provided at any of five levels of care. Specific criteria, organized by drug class (alcohol, sedative-hypnotics, opioids, et al.) guide the decision as to which detoxification level is safe and efficient for a patient in withdrawal.

Dimension 2: Biomedical Conditions and Complications. Are there current physical illnesses, other than withdrawal, that need to be addressed because they are exacerbated by withdrawal, create risk or may complicate treatment? Are there chronic conditions that affect treatment? Is there need for medical services that might interfere with treatment?

Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications (diagnosable mental disorders or mental health problems that do not present sufficient signs and symptoms to reach the diagnostic threshold). Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create or complicate treatment? Are there chronic conditions that affect treatment? Do any emotional, behavioral or cognitive problems appear to be an expected part of the addictive disorder, or do they appear to be autonomous? Even if connected to the addiction, are they severe enough to warrant specific mental health treatment? Is the patient suicidal, and if so, what is the lethality? Is the patient able to manage the activities of daily living? Can he or she cope with any emotional, behavioral or cognitive problems? If the patient has been prescribed psychotropic medications, is he or she compliant?

Dimension 4: Readiness to Change. Is the patient actively resisting treatment? Does the patient feel coerced into treatment? How ready is the patient to change? If he or she is willing to accept treatment, how strongly does the patient disagree with others' perception that she or he has an addictive or mental disorder? Does the patient appear to be compliant only to avoid a negative consequence, or does he or she appear to be internally distressed in a self-motivated way about his or her alcohol or other drug use or mental health problem? At what point is the patient in the stages of change? Is there leverage for change available?

Dimension 5: Relapse, Continued Use or Continued Problem Potential. Is the patient in immediate danger of continued severe mental health distress and/or alcohol or drug use? Does the patient have any recognition or understanding of, or skills in, coping with his or her addictive or mental disorder in order to prevent relapse, continued use or continued problems such as suicidal behavior? How severe are the problems and further distress that may continue or reappear if the patient is not successfully engaged in treatment at this time? How aware is the patient of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others? What is the patient's ability to remain abstinent or psychiatrically stable, based on history? What is the patient's current level of craving and how successfully can

he or she resist using? If on psychotropic medications, is the patient compliant? If the patient has another chronic disorder (e.g., diabetes), what is the history of compliance with treatment for that disorder?

Dimension 6: Recovery Environment. Do any family members, significant others, living situations, or school or work situations pose a threat to the patient's safety or engagement in treatment? Does the patient have supportive friendships, financial resources, or educational or vocational resources that can increase the likelihood of successful treatment? Are there legal, vocational, social service agency or criminal justice mandates that may enhance the patient's motivation for engagement in treatment? Are there transportation, child care, housing, or employment issues that need to be clarified and addressed?

The prognosis for resolution of problems in the various dimensions depends on the clinician's knowledge of problem severity and the level of difficulty in resolving these problems. This knowledge then forms the basis for the clinician and patient participating together in establishing a mutually agreeable treatment plan. The goals for each problem may need to be reviewed from the standpoint of resolution of the acute crisis and/or alteration of the course of the chronic illness.

Interactions Across Dimensions in Assessing for Level of Care. The ASAM criteria function best when individuals are assessed in each dimension independently and also in terms of the interaction across dimensions. For example, when assessing an individual for severity, a history of moderate or severe withdrawal *without* any current intoxication or withdrawal, or current intoxication without a history of significant withdrawal problems should generate a lesser level of concern than a combination of a history of moderate or severe withdrawal *with* current symptoms of intoxication or withdrawal.

In reality, there is considerable interaction across dimensions. For example, significant problems with readiness to change (Dimension 4), coupled with a poor recovery environment (Dimension 6) or moderate problems with relapse or continued use (Dimension 5), may increase the risk of relapse. Another commonly seen combination involves problems in Dimension 2 (such as chronic pain which distract the patient from the recovery process) coupled with problems in Dimensions 4, 5 or 6.

The converse also is true. For example, problems with relapse potential (Dimension 5) may be offset by a high degree of readiness to change (Dimension 4) or a very supportive recovery environment (Dimension 6). The interaction of these factors may result in a lower level of severity than is seen in any dimension alone.

The lesson here is that assessments are most accurate when they take into account all of the factors (dimensions) that affect each individual's receptivity and ability to engage in treatment at a particular point in time.

Continued Service and Discharge Criteria. In a departure from earlier editions, the current edition of the criteria (*ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised* [*ASAM PPC-2R*]; Mee-Lee, Shulman et al., 2001) contains only admission criteria, leaving the decisions about continued service, transfer, or discharge to general guidelines and the judgment of the treatment professional. This change was made in recognition of the fact that, in the process of patient assessment, certain problems and priorities are identified as justifying admission to a particular level of care. It is the resolution of those problems and priorities that determines when a patient can be treated at a different level of care or discharged. The appearance of new problems may require services that can be provided effectively at the same level of care, or transfer of the patient to a more or less intensive level of care.

The assessment process for continued service or discharge/transfer is the same as for admission, with the reassessment of multidimensional severity determining the treatment priorities, intensity of needed services and the decision about ongoing level of care. Decisions concerning continued service, transfer, or discharge involve review of the treatment plan and assessment of the patient's progress. That is, they involve the same type of multidimensional assessment process that led to admission to the current level of care.

Levels of Care

The ASAM criteria conceptualize treatment as a continuum marked by five basic levels of care, which are numbered in Roman numerals from Levels 0.5 through Level IV. Thus, the ASAM criteria provides the addiction field with a nomenclature for describing the continuum of addiction services, as follows:

Level 0.5: Early Intervention
Level I: Outpatient Services
Level II: Intensive Outpatient/Partial Hospitalization Services
Level III: Residential/Inpatient Services
Level IV: Medically Managed Intensive Inpatient Services

Within each level, a decimal number (ranging from .1 to .9) expresses gradations of intensity within the existing levels of care. This structure allows improved precision of description and better "inter-rater" reliability by focusing on five broad levels of care. Thus the ASAM criteria describe gradations within each level of care. For example, a **II.1** level of care provides a benchmark for intensity at the minimum description of Level II care (also see the Rapid Reference section of this text for a summary crosswalk of the levels of care).

Level 0.5: Early Intervention. Professional services for early intervention constitutes a service for specific individuals who, for a known reason, are at risk of developing substance-related problems or for those for whom there is not yet sufficient information to document a substance use disorder.

Level I: Outpatient Treatment. Level I encompasses organized, non-residential services, which may be delivered in a wide variety of settings. Addiction or mental health treatment personnel provide professionally directed evaluation, treatment and recovery service. Such services are provided in regularly scheduled sessions and follow a defined set of policies and procedures or medical protocols.

Level I outpatient services are designed to treat the individual's level of clinical severity and to help the individual achieve permanent changes in his or her alcohol- and drug-using behavior and mental functioning. To accomplish this, services must address major lifestyle, attitudinal, and behavioral issues that have the potential to undermine the goals of treatment or inhibit the individual's ability to cope with major life tasks without the non-medical use of alcohol or other drugs.

In the current edition (*ASAM PPC-2R*), Level I has been expanded to promote greater access to care for dual diagnosis patients, unmotivated patients who are mandated into treatment, and others who previously only had access to care if they agreed to intensive periods of primary treatment. The expansion reflects recent knowledge of and experience with cognitive behavioral therapies such as motivational interviewing, motivational enhancement, solution-focused therapy, and stages of change work, all of which may be appropriate for patients who previously would have been turned away as not ready for treatment, or in denial and thus in need of coerced intensive treatment. The expansion thus can enhance access to care and facilitate earlier engagement of patients in treatment, thereby allowing better utilization of resources and improving the effectiveness of recovery efforts.

Level II: Intensive Outpatient Treatment/Partial Hospitalization. Level II is an organized outpatient service that delivers treatment services during the day, before or after work or school, in the evening or on weekends. For appropriately selected patients, such programs provide essential education and treatment components while allowing patients to apply their newly acquired skills within "real world" environments. Programs have the capacity to arrange for medical and psychiatric consultation, psychopharmacological consultation, medication management, and 24-hour crisis services.

Level II programs can provide comprehensive biopsychosocial assessments and individualized treatment plans, including formulation of problem statements, treatment goals and measurable objectives—all developed in consultation with the patient. Such programs typically have active affiliations with other levels of care, and their staff can help patients access

support services such as child care, vocational training and transportation.

Level III: Residential/Inpatient Treatment. Level III encompasses organized services staffed by designated addiction treatment and mental health personnel who provide a planned regimen of care in a 24-hour live-in setting. Such services adhere to defined sets of policies and procedures. They are housed in, or affiliated with, permanent facilities where patients can reside safely. They are staffed 24 hours a day. Mutual and self-help group meetings generally are available on-site.

Level III encompasses four types of programs: Level III.1: Clinically Managed Low-Intensity Residential Treatment; Level III.3: Clinically Managed Medium-Intensity Residential Treatment; Level III.5: Clinically Managed High-Intensity Residential Treatment; and Level III.7: Medically Monitored Inpatient Treatment.

The defining characteristic of all Level III programs is that they serve individuals who need safe and stable living environments in order to develop their recovery skills. Such living environments may be housed in the same facility where treatment services are provided or they may be in a separate facility affiliated with the treatment provider.

Level IV: Medically Managed Intensive Inpatient Treatment. Level IV programs provide a planned regimen of 24-hour medically directed evaluation, care and treatment of mental and substance-related disorders in an acute care inpatient setting. They are staffed by designated addiction-credentialed physicians, including psychiatrists, as well as other mental health- and addiction-credentialed clinicians. Such services are delivered under a defined set of policies and procedures and has permanent facilities that include inpatient beds.

Level IV programs provide care to patients whose mental and substance-related problems are so severe that they require primary biomedical, psychiatric and nursing care. Treatment is provided 24 hours a day, and the full resources of a general acute care hospital or psychiatric hospital are available. The treatment is specific to mental and substance-related disorders; however, the skills of the interdisciplinary team and the availability of support services allow the conjoint treatment of any co-occurring biomedical conditions that need to be addressed.

Placement Dilemmas

Even those using the ASAM criteria regularly encounter "real world" dilemmas surrounding access, reimbursement, funding, resource allocation, and availability of services, particularly for patients with co-occurring medical or psychiatric disorders.

Co-Occurring Disorders. When the first edition of the ASAM criteria was published in 1991, the criteria were designed for programs that offered only addiction treatment services. However, even that early edition also acknowledged that some patients come to treatment with medical (Dimension 2) and psychiatric (Dimension 3) disorders that coexist with their substance-related problems. Clinical reality suggests that programs and practitioners who are committed to meeting the total needs of the patients they serve must be able to meet the needs of these "dual diagnosis" patients. This concept is particularly relevant today, as the range of patient needs and clinical variability continues to broaden.

Factors contributing to this clinical reality include the expansion of substance use and substance-related disorders in younger populations; greater sensitivity to substance use problems in the mental health, welfare, and criminal justice systems; and increased commitment to earlier intervention in substance use disorders in preference to fragmented services and incarceration. A major factor has been the growing body of scientific evidence pointing to addictive disorders as diseases of the brain; another is the development of pharmacotherapies for addiction. Greater understanding of the uses and effects of psychosocial and cognitive-behavioral strategies also has heightened awareness of a broadened range of modalities to meet individual needs.

The *ASAM PPC-2R* thus incorporates criteria that address the large subset of individuals who present for treatment with co-occurring Axis I substance-related disorders and Axis I/Axis II mental disorders. Individuals with such co-occurring disorders

(often referred to as "dual diagnoses") can be conceptualized as belonging to one of two general categories:

Moderate Severity Disorders: Such persons present with stable mood or anxiety disorders of moderate severity (including resolving bipolar disorder), or with personality disorders of moderate severity (although some persons with severe levels of antisocial personality disorder may be appropriately placed in this group), or with signs and symptoms of a mental health disorder that are not so severe as to meet the diagnostic threshold.

High Severity Disorders: Such persons present with schizophrenia-spectrum disorders, severe mood disorders with psychotic features, severe anxiety disorders, or severe personality disorders (such as fragile borderline conditions).

Individuals whose co-occurring mental disorders best fit within the category of moderate severity disorders are appropriately treated in programs designed to treat primary substance use disorders. Those with concurrent high severity mental disorders, on the other hand, generally are best managed in dual diagnosis specialty programs that can offer integration mental health and addiction treatment approaches. Some patients may require immediate stabilization of their psychiatric symptoms before they can be engaged in ongoing addiction treatment and recovery. Depending on the severity of their symptoms, such patients may require referral to medical and/or psychiatric services outside the *ASAM PPC-2R* levels of care (see Table 1).

Once stabilization has been achieved, the initial placement for recovery services should reflect an assessment of the patient's status in all six dimensions. The principle here is that the highest severity problem (particularly those in Dimensions 1, 2 or 3) should determine the patient's initial placement. Subsequent resolution of this problem creates an opportunity to transfer the patient to a less intensive level of care. Addressing the individual's recovery needs thus may involve a sequence of services across several levels of care (involving a "step down" or "step up process"). For example, a patient who is assessed in Dimension 2 as hypertensive should be placed in a Level III.7 or Level IV program to stabilize his or her medical condition, before being transferred to a Level I program for treatment of the addictive disorder.

What should be avoided is the notion of "averaging" severity across dimensions to arrive at a placement determination.

Patients whose biomedical or psychiatric disorders are so severe that stabilizing them is the highest priority are most appropriately treated in a medical or psychiatric facility or unit before addiction treatment is initiated.

Assessment of Imminent Danger. If a patient has problems in Dimensions 4 and 5 that require 24-hour supervision and treatment interventions (such as boundary setting), without which treatment services cannot be effectively delivered, and/or the individual is in imminent danger, then the mere addition of room and board would be inadequate to meet the individual's needs. Such a patient needs placement in a residential program that offers clinical staff and services 24 hours a day in order to respond to the patient's issues that pose the imminent danger. Assessment of risk should guide the decision.

Mandated Level of Care or Length of Service. In some cases, an individual is referred for treatment at a specific level of care and/or for a specific length of service (for example, an offender in the criminal justice system may be given a choice of a prison term or a fixed length of stay in a treatment center). Such mandated or court-ordered referrals may not be based on clinical considerations and thus may be inconsistent with a placement decision arrived at through the ASAM criteria. In such a case, the provider should make reasonable attempts to have the order amended to reflect the assessed clinical level or length of service.

If the court order or other mandate cannot be amended, the individual may be continuing treatment at a level of care or for a length of stay greater than is clinically indicated. The resident's readiness for discharge or transfer and the staff's attempts to implement a clinically appropriate placement should be noted in the clinical record, and the treatment plan should be updated in a manner that provides the resident with the opportunity to continue the recovery process at the same level of care even though it could be continued at a less intensive level of care.

Logistical Impediments. Logistical problems can arise anywhere, but are found most frequently in rural and underserved inner-city areas. When logistical considerations are an impediment to the indicated services (for example, lack of available transportation is a barrier to a patient's access to an indicated outpatient program), an outpatient service combined with unsupervised/minimally supervised housing may be an appropriate treatment intervention. In cities or towns, such a domiciliary option might be found in a group living situation (such as a Salvation Army program, motel accommodations, YMCA/YWCA or mission). In rural and other underserved areas, options could include (1) the creation of a supervised housing situation by using unused treatment beds, (2) assertive community treatment models in which the treatment is brought to rural areas (such as Native American settlements) and provided in weekend intensive models at sites such as community centers and churches, (3) vans that are sent out to pick up patients and bring them to a treatment site, and (4) using a van or motor home as an office or group therapy room

Need for a Safe Environment. When a patient lives in a recovery environment that is so toxic as to preclude recovery efforts (as through victimization or exposure to an active addict) and a Level I or II outpatient service is indicated, the patient may need referral to a safe place to live while in treatment, as well as to treatment itself.

Assuring Individualized Treatment. Many programs claim to provide individualized care, but how is the referring clinician to know that such care actually is provided? There are at least three efficient ways to determine whether a program is providing truly individualized treatment:

1. Take 10 closed clinical case records and compare the treatment plans. If the reviewer cannot clearly distinguish patients by their treatment plans, the treatment is not individualized.

2. Review the progress notes and determine whether they relate back to the objectives or strategies to the treatment plan.

3. For programs that receive reimbursement from multiple payers, compare lengths of service with sources of payment. If the lengths of stay correspond to payer type, then the program is payment-driven rather than offering individualized treatment.

Exceptions to the Patient Placement Criteria. In making treatment placement decisions, three important factors override the patient-treatment match with regard to levels of care:

1. Lack of availability of appropriate, criteria-selected care;

2. Failure of a patient to progress at a given level of care, so as to warrant a reassessment of the treatment plan with a view to modifying the treatment approach. Such situations may require transfer to a specialized program at the same level of care or to a more intensive or less intensive level of care to achieve a better therapeutic response; and State laws regulating the practice of medicine or licensure of a facility that require the use of different criteria.

Unique clinical presentations or extenuating circumstances require some flexibility in application of the criteria to ensure the safety and welfare of the patient.

Research on the ASAM Criteria

Since the publication of the first edition, there has been over a decade of experience with the ASAM criteria. Use of the second edition (*ASAM PPC-2*; Mee-Lee, Shulman et al., 1996) has been mandated or recommended to publicly funded treatment programs in nearly 30 states, by the U.S. Department of Defense, and by two large health maintenance organizations. While this does not constitute universal acceptance, there clearly is movement toward the common language

they provide to the providers and managers of care, as well as a strong focus on multidimensional assessment and individualized care.

Formal research into the criteria also is encouraged. In the earliest such study (Plough, Shirley et al., 1996), counselors used a simple, one-page summary of the criteria. The results suggested that use of even a primitive version of the ASAM criteria is associated with improved treatment retention.

In 1994, the National Institute on Drug Abuse (NIDA) funded the first randomized controlled trial using the ASAM criteria, and it is hoped that clinical outcomes research will drive future revisions of the criteria. There also have been two retrospective studies: one applied an abbreviated *PPC-1* algorithm to telephone survey data (Morey, 1996), while the other implemented only the psychosocial dimensions (McKay, Cacciola et al., 1997). A solution has been developed to address the problem of interviewer ease of use of criteria, and this solution has been tested in three prospective studies. It consists of a comprehensive implementation designed by Gastfriend and his associates to offer the counselor a sequence of questions and scoring options on the screen of a microcomputer (Turner, Turner et al., 1999).

There have been two naturalistic studies and one randomized controlled trial of placement criteria (the results of which are not yet published). Overall, the early studies have shown adequate reliability, good concurrent validity, and some degree of predictive validity (Gastfriend, Lu et al., 2000).

Conclusions

Four important missions underlie the ASAM criteria: (1) to enable patients to receive the most appropriate and highest quality treatment services, (2) to encourage the development of a broad continuum of care, (3) to promote the effective, efficient use of care resources, and (4) to help protect access to and funding for care. The use of placement criteria in treatment planning thus represents far more than a narrow utilization review or case management process. Correctly applied and implemented, the ASAM criteria can assist in improving the "placement match" by redesigning the place of treatment and the level of care.

Effective implementation of the newest version of the ASAM criteria (*ASAM PPC-2R*) will require a shift in thinking toward outcomes-driven case management. A variety of treatment agencies will need to make this shift, including regulatory agencies, clinical and medical staff, and referral sources (such as courts, probation officers, child protective services, employers, and employee assistance professionals (Heatherton, 2000).

The ASAM criteria offer a system for improving the "modality match" through the use of multidimensional assessment and treatment planning that permits more objective evaluation of patient outcomes. With improved outcome analysis driving treatment decisions, the problem of access to care and funding of treatment can be championed more effectively.

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TABLE 1.

Matching Patients with Co-Occurring Disorders to Services

Patients	Services
Addiction-Only Patients: Individuals who exhibit substance abuse or dependence problems without co-occurring mental health problems or diagnosable Axis I or II disorders.	**Addiction Only Services (AOS):**Services are directed toward the amelioration of substance-related disorders. No services are available the treatment of co-occurring mental health problems or diagnosable disorders. (Such a program is clinically inappropriate for dually diagnosed individuals.)
Patients with Co-Occurring Mental Health Problems of Mild to Moderate Severity: Individuals who exhibit (1) sub-threshold diagnostic (traits, symptoms) Axis I or II disorders or (2) diagnosable but stable Axis I or II disorders (for example, bipolar disorder but compliant with and stable on medication).	**Dual Diagnosis Capable (DDC):** The primary focus is on substance use disorders, but the program is capable of treating patients with sub-threshold or diagnosable but stable Axis I or II disorders. Psychiatric services are available on-site or by consultation; at least some staff are competent to understand and identify signs and symptoms of acute psychiatric conditions.
Patients with Co-Occurring Mental Health Problems of Moderate to High Severity: Individuals who exhibit moderate to severe diagnosable Axis I or II disorders, who are not stable and require mental health as well as addiction treatment.	**Dual Diagnosis Enhanced (DDE)**: Psychiatric services are available on-site or closely coordinated; all staff are crosstrained in addiction and mental health disorders and are competent to understand and identify signs and symptoms of acute psychiatric conditions and to treat mental health problems along with the substance use disorders. Treatment for the mental and substance disorders is integrated (similar to a traditional "dual diagnosis" program).

SOURCE: Mee-Lee D, Shulman GD, Fishman M et al. (2001). ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition-Revised (ASAM PPC-2R). *Chevy Chase , MD : American Society of Addiction Medicine.*

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2 Settings, Levels of Care, and Patient Placement

Establishing criteria that take into account all the possible needs of patients receiving detoxification and treatment services is an extraordinarily complex task. This chapter discusses the criteria for placing patients in the appropriate treatment settings and offering the required intensity of services (i.e., level of care).

Overview

Role of Various Settings in the Delivery of Services

Physician's Office

Freestanding Urgent Care Center or Emergency Department

Freestanding Substance Abuse Treatment or Mental Health Facility

Intensive Outpatient and Partial Hospitalization Programs

Acute Care Inpatient Settings

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Role of Various Settings in the Delivery of Services

Addiction medicine has sought to develop an efficient system of care that matches patients' clinical needs with the appropriate care setting in the least restrictive and most cost-effective manner. (For an explanation of least restrictive care, see the text box below.) Challenges to effective placement matching for clients arise from a number of factors:

- Deficits in the full range of care settings and levels of care
- Limitations imposed by third-party payors (e.g., strict adherence to standardized admission criteria)
- Clinicians' lack of authority (and sometimes sufficient knowledge) to determine the most appropriate care setting and level of care
- Insurance that does not have a substance use disorder benefit available as part of its patient coverage
- Absence of any health insurance at all (Gastfriend et al. 2000)

No clear solution or formula to meet these challenges has emerged.

Least Restrictive Care

Least restrictive refers to patients' civil rights and their right to choice of care. There are four specific themes of historical and clinical importance:

1. Patients should be treated in those settings that least interfere with their civil rights and freedom to participate in society.

2. Patients should be able to disagree with clinician recommendations for care. While this includes the right to refuse any care at all, it also includes the right to obtain care in a setting of their choice (as long as considerations of dangerousness and mental competency are satisfied). It implies a patient's right to seek a higher or different level of care than that which the clinician has planned.

3. Patients should be informed participants in defining their care plan. Such planning should be done in collaboration with their healthcare providers.

4. Careful consideration of State laws and agency policies is required for patients who are unable to act in their own self-interests. Because the legal complexities of this issue will vary from State to State the TIP cannot provide definitive guidance here, but providers need to consider whether or not the person is "gravely" incapacitated, suicidal, or homicidal; likely to commit grave bodily injury; or, in some States, likely to cause injury to property. In such cases, State law and/or case law may hold providers responsible if they do not commit the patient to care, but in other cases programs may be open to lawsuits for forcibly holding a patient.

In spite of the impediments, some progress has been made in developing comprehensive patient placement criteria. Because the choice of a treatment setting and intensity of treatment (level of care) are so important, the American Society of Addiction Medicine (ASAM) created the *Patient Placement Criteria, Second Edition, Revised* (PPC-2R) a consensus-based clinical tool for matching patients to the appropriate setting and level of care. The ASAM PPC-2R represents an effort to define how care settings may be matched to patient needs and special characteristics. These criteria currently define the most broadly accepted standard of care for the treatment of substance use disorders. ASAM criteria are intended to provide flexible clinical guidelines; these criteria may not be appropriate for particular patients or specific care settings.

The PPC-2R identifies six "assessment dimensions to be evaluated in making placement decisions" (ASAM 2001, p. 4). They are as follows:

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral, or Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse, Continued Use, or Continued Problem Potential
6. Recovery/Living Environment

The ASAM PPC-2R describes both the settings in which services may take place and the intensity of services (i.e., level of care) that patients may receive in particular settings. It is important to reiterate, however, that the ASAM PPC-2R criteria do not characterize all the details that may be essential to the success of treatment (Gastfriend et al. 2000). Moreover, traditional assumptions that certain treatment can be delivered only in a particular setting may not be applicable or valuable to patients. Clinical judgment and consideration of the patient's particular situation are required for appropriate detoxification and treatment.

In addition to the general placement criteria for treatment for substance-related disorders, ASAM also has developed a second set of placement criteria, which are more important for the purposes of this TIP—the five "Adult Detoxification" placement levels of care within Dimension 1 (ASAM 2001). These "Adult Detoxification" levels of care are

1. *Level I-D: Ambulatory Detoxification Without Extended Onsite Monitoring* (e.g., physician's office, home health care agency). This level of care is an organized outpatient service monitored at predetermined intervals.
2. *Level II-D: Ambulatory Detoxification With Extended Onsite Monitoring* (e.g., day hospital service). This level of care is monitored by appropriately credentialed and licensed nurses.
3. *Level III.2-D: Clinically Managed Residential Detoxification* (e.g., nonmedical or social detoxification setting). This level emphasizes peer and social support and is intended for patients whose intoxication and/or withdrawal is sufficient to warrant 24-hour support.

4. *Level III.7-D: Medically Monitored Inpatient Detoxification* (e.g., freestanding detoxification center). Unlike Level III.2.D, this level provides 24-hour medically supervised detoxification services.
5. *Level IV-D: Medically Managed Intensive Inpatient Detoxification* (e.g., psychiatric hospital inpatient center). This level provides 24-hour care in an acute care inpatient settings.

As described by the ASAM PPC-2R, the domain of detoxification refers not only to the reduction of the physiological and psychological features of withdrawal syndromes, but also to the process of interrupting the momentum of compulsive use in persons diagnosed with substance dependence (ASAM 2001). Because of the force of this momentum and the inherent difficulties in overcoming it even when there is no clear withdrawal syndrome, this phase of treatment frequently requires a greater intensity of services initially to establish participation in treatment activities and patient role induction. That is, this phase should increase the patient's readiness for and commitment to substance abuse treatment and foster a solid therapeutic alliance between the patient and care provider.

It is important to note that ASAM PPC-2R criteria are only guidelines, and that there are no uniform protocols for determining which patients are placed in which level of care. For further information on patient placement, readers are advised to consult TIP 13, *The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders* (Center for Substance Abuse Treatment [CSAT] 1995*h*).

Because this TIP is geared to audiences that may or may not be familiar with the ASAM PPC-2R levels of care, this section discusses the services and staffing specific to the care settings that are familiar to a broad audience.

Physician's Office

It has been estimated that nearly one half of the patients who visit a primary care provider have some type of problem related to substance use (Miller and Gold 1998). Indeed, because the physician may be the first point of contact for these people, initiation of treatment often begins in the family physician's office (Prater et al. 1999). Physicians should use prudence in determining which patients may undergo detoxification safely on an outpatient basis. As a general rule, outpatient treatment is just as effective as inpatient treatment for patients with mild to moderate withdrawal symptoms (Hayashida 1998).

For physicians treating patients with substance use disorders, preparing the patient to enter treatment and developing a therapeutic alliance between patient and clinician should begin as soon as possible. This includes providing the patient and his family with information on the detoxification process and subsequent substance abuse treatment, in addition to providing medical care or referrals if necessary. Staffing should include certified interpreters for the deaf and other language interpreters if the program is serving patients in need of those services. Physicians should be able to accommodate frequent followup visits during the management of acute withdrawal. Medications should be dispensed in limited amounts.

Level of care

Ambulatory detoxification without extended onsite monitoring

This level of detoxification (ASAM's Level I-D) is an organized outpatient service, which may be delivered in an office setting, healthcare or addiction treatment facility, or in a patient's home by trained clinicians who provide medically supervised evaluation, detoxification, and referral services according to a predetermined schedule. Such services are provided in regularly scheduled sessions. These services should be delivered under a defined set of policies and procedures or medical protocols (ASAM 2001). Ambulatory detoxification is considered appropriate only when a positive and helpful social support network is available to the patient. In this level of care, outpatient detoxification services should be designed to treat the patient's level of clinical severity, to achieve safe and comfortable withdrawal from mood-altering drugs, and to effectively facilitate the patient's transition into treatment and recovery.

Ambulatory detoxification with extended onsite monitoring

Essential to this level of care—and distinguishing it from Ambulatory Detoxification Without Extended Onsite Monitoring—is the availability of appropriately credentialed and licensed nurses (such as registered nurses [RNs] or licensed practical nurses [LPNs]) who monitor patients over a period of several hours each day of service (ASAM 2001). Otherwise, this level of detoxification (ASAM's Level II-D) also is an organized outpatient service. Like Level I-D, in this level of care detoxification services are provided in regularly scheduled sessions and delivered under a defined set of policies and procedures or medical protocols. Outpatient services are designed to treat the patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs, including alcohol, and to effectively facilitate the patient's entry into ongoing treatment and recovery (ASAM 2001).

Staffing

Although they need not be present in the treatment setting at all times, physicians and nurses are essential to office-based detoxification. In States where physician assistants, nurse practitioners, or advance practice clinical nurse specialists are licensed as physician extenders, they may perform the duties ordinarily carried out by a physician (ASAM 2001).

Because detoxification is conducted on an outpatient basis in these settings, it is important for medical and nursing personnel to be readily available to evaluate and confirm that detoxification in the less supervised setting is safe. All clinicians who assess and treat patients should be able to obtain and interpret information regarding the needs of these persons, and all should be knowledgeable about the biomedical and psychosocial dimensions of alcohol and illicit drug dependence. Requisite skills and knowledge base include the following:

- Understanding how to interpret the signs and symptoms of alcohol and other drug intoxication and withdrawal
- Understanding the appropriate treatment and monitoring of these conditions
- The ability to facilitate the individual's entry into treatment

It is essential that medical consultation is readily available in emergencies. It is desirable that medical staff link patients to treatment services, although this may be an unreasonable expectation that cannot be met in a busy office setting. Linkage to treatment services may be provided by the physician or by designated counselors, psychologists, social workers, and acupuncturists who are available either onsite or through the healthcare system (ASAM 2001).

Freestanding Urgent Care Center or Emergency Department

There are several distinctions between urgent care facilities and emergency rooms (ERs). Urgent care often is used by patients who cannot or do not want to wait until they see their doctor in his or her office, whereas emergency rooms are utilized more often by patients who perceive themselves to be in a crisis situation. Unlike emergency departments, which are required to operate 24 hours a day, freestanding urgent care centers usually have specific hours of operation. Staffing for urgent care centers generally is more limited than for an ER. Standard staffing includes only a physician, an RN, a technician, and a secretary. Despite these distinctions, in actual practice there is considerable overlap between the two—the ER will see medical problems that could be handled by visits to offices, and urgent care facilities will handle some cases of emergency medicine.

A freestanding urgent care center or emergency department reasonably can be expected to provide assessment and acute biomedical (including psychiatric) care. However, these settings often are unable to provide satisfactory psychosocial stabilization or complete biomedical stabilization (which includes both the initiation and taper of medications used in the treatment of substance withdrawal syndromes). Appropriate triage and successful linkage to ongoing detoxification services is essential. The ongoing detoxification services may be provided in an inpatient, residential, or outpatient setting. Patients with more than moderate biomedical or psychosocial complications are more likely to require treatment in an inpatient setting. Care in these settings can be quite costly and should be accessed only when there are serious concerns about a patient's safety.

A timely and accurate assessment in an emergency department is of the highest importance. This will permit the rapid transfer of the patient to a setting where complete care can be provided. Ideally, personnel in the emergency

department will have at least a small amount of experience and expertise in identifying critically ill substance-using patients who may be about to experience or are already experiencing withdrawal symptoms. Three essential rules apply to emergency departments and their handling of intoxicated patients and patients who have begun to experience withdrawal:

- Emergency departments and their clinicians should never simply administer medications to intoxicated persons and then send them home.
- No intoxicated patient should ever be allowed to leave a hospital setting. All such persons should be referred to the appropriate detoxification setting if possible, although there are legal restrictions that forbid holding persons against their will under certain conditions (Armenian et al. 1999).
- A clear distinction must be made between acute intoxication on the one hand and withdrawal on the other. Acute intoxication, it must be remembered, creates special issues and challenges that need to be addressed. The risk of suicidality in patients who present in a state of intoxication needs to be carefully assessed. Because of their volatility and often risky behavior, patients who are intoxicated, as well as those patients who have begun to experience withdrawal, merit special attention. For more on treating intoxicated patients, see chapter 3.

Level of care

Care is provided to patients whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care services. The services are delivered under a defined set of physician-managed procedures or medical protocols. Both settings provide medically directed assessment and acute care that includes the initiation of detoxification for substance use withdrawal. Neither setting is likely to offer satisfactory biomedical stabilization or 24-hour observation. Generally speaking, triage to inpatient care can easily be facilitated from either setting.

Freestanding urgent care centers and emergency departments are outpatient settings that are uniquely designed to address the needs of patients in biomedical crisis. For patients with substance use disorders, care in these settings is not complete until successful linkage is made to treatment that is focused specifically on the substance use disorder. To accomplish this, a comprehensive assessment, taking into account psychosocial as well as biomedical issues, is recommended wherever possible.

Appreciation of the value of multidimensional patient assessment is central to the clinician's ability to decide which triage (linkage) options are least restrictive and most cost-effective for a given patient.

Staffing

Both emergency departments and freestanding urgent care units are staffed by physicians. The same rules regarding who may provide care apply here as they did in the discussion of staffing of office-based detoxification (ASAM 2001). An RN or other licensed and credentialed nurse is available for primary nursing care and observation. Psychologists, social workers, addiction counselors, and acupuncturists usually are not available in these settings. The physician or attending nurse usually facilitates linkage to substance abuse treatment.

Freestanding Substance Abuse Treatment or Mental Health Facility

Freestanding substance abuse treatment facilities may or may not be equipped to provide adequate assessment and treatment of co-occurring psychiatric conditions and biopsychosocial problems, as the range of services varies considerably from one facility to another. Inpatient mental health facilities, on the other hand, are able generally to provide treatment for substance use disorders and co-occurring psychiatric conditions. Nonetheless, like substance abuse treatment facilities, the range of available services varies from one mental health facility to another.

General guidelines for considering patient placement in either of these settings are provided below; however, it should be emphasized that a clear understanding of the specific services that a given setting provides is indispensable to identifying the least restrictive and most cost-effective treatment option that may be available. Concern for safety is of primary importance, and the final decision regarding placement always rests with the treating physician.

Level of care

Medically Monitored Inpatient Detoxification

Inpatient detoxification provides 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal. Since this level of care is relatively more restrictive and more costly than a residential treatment option, the treatment mission in this setting should be clearly focused and limited in scope. Primary emphasis should be placed on ensuring that the patient is medically stable (including the initiation and tapering of medications used for the treatment of substance use withdrawal); assessing for adequate biopsychosocial stability, quickly intervening to establish this adequately; and facilitating effective linkage to and engagement in other appropriate inpatient and outpatient services.

Inpatient settings provide medically managed intensive inpatient detoxification. At this level of care, physicians are available 24 hours per day by telephone. A physician should be available to assess the patient within 24 hours of admission (or sooner, if medically necessary) and should be available to provide onsite monitoring of care and further evaluation on a daily basis. An RN or other qualified nursing specialist should be present to administer an initial assessment. A nurse will be responsible for overseeing the monitoring of the patient's progress and medication administration on an hourly basis, if needed. Appropriately licensed and credentialed staff should be available to administer medications in accordance with physician orders.

Clinically Managed Residential Detoxification

Residential settings vary greatly in the level of care that they provide. Those with intensive medical supervision involving physicians, nurse practitioners, physician assistants, and nurses can handle all but the most demanding complications of intoxication and withdrawal. On the other hand, some residential settings have minimally intensive medical oversight. Residential detoxification in settings with limited medical oversight often is referred to as "social detoxification." (Though the "social detoxification" model is not limited to residential facilities.) Facilities with lower levels of care should have clear procedures in place for implementing and pursuing appropriate medical referral and linkage, especially in the case of emergencies. For example, a patient who is in danger of seizures or delirium tremens needs to be referred to the appropriate medical facility for acute care of presenting symptoms, possibly medicated, and then returned to a social detoxification setting for continuing monitoring and observation. The establishment of this kind of collaborative relationship between institutions provides a good example of a cost-effective way to provide adequate care to patients.

Residential detoxification programs provide 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal. They are characterized by an emphasis on peer and social support (ASAM 2001). Standards published by such groups as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF) provide further information on quality measures for residential detoxification. Additional information is available on the JCAHO Web site (www.jcaho.org) and the CARF Web site (www.carf.org

Staffing

Inpatient detoxification programs employ licensed, certified, or registered clinicians who provide a planned regimen of 24-hour, professionally directed evaluation, care, and treatment services for patients and their families. An interdisciplinary team of appropriately trained clinicians (such as physicians, RNs and LPNs, counselors, social workers, and psychologists) should be available to assess and treat the patient and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members should be appropriate to the range and severity of the patient's problems (ASAM 2001).

Residential detoxification programs are staffed by appropriately credentialed personnel who are trained and competent to implement physician-approved protocols for patient observation and supervision. These persons also are responsible for determining the appropriate level of care and facilitating the patient's transition to ongoing care. Medical evaluation and consultation should be available 24 hours a day, in accordance with treatment/transfer practice

guidelines. All clinicians who assess and treat patients should be able to obtain and interpret information regarding the needs of these persons and should be knowledgeable about the biomedical and psychosocial dimensions of alcohol and other drug dependence. Such knowledge includes awareness of the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the appropriate treatment and monitoring of those conditions and how to facilitate the individual's entry into ongoing care. Staff should ensure that patients are taking medications according to their physician's orders and legal requirements (ASAM 2001).

Some residential detoxification programs are staffed to supervise self-administered medications for the management of withdrawal. All such programs should rely on established clinical protocols to identify patients who have biomedical needs that exceed the capacity of the facility and to identify which programs will likely have a need for transferring such patients to more appropriate treatment settings.

Intensive Outpatient and Partial Hospitalization Programs

An intensive outpatient program (IOP) or partial hospitalization program (PHP) is appropriate for patients with mild to moderate withdrawal symptoms. Thorough psychosocial assessment and intervention should be available in addition to biomedical assessment and stabilization. Many of these programs have close clinical and/or administrative ties to hospital centers. When needed, triage to a higher level of care should be easy to accomplish. Outpatient treatment should be delivered in conjunction with all components of detoxification.

Level of care

This level of detoxification is an organized outpatient service that requires patients to be present onsite for several hours a day. It is thus similar to a physician's office in that ambulatory detoxification with extended onsite monitoring is provided. Unlike the physician's office, in the IOP and PHP it is standard practice to have a multidisciplinary team available to provide or facilitate linkage to a range of medically supervised evaluation, detoxification, and referral services.

Detoxification services also are provided in regularly scheduled sessions and delivered under a defined set of policies and procedures or medical protocols. These outpatient services are designed to treat the patient's level of clinical severity, to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol), and to effectively facilitate the patient's engagement in ongoing treatment and recovery (ASAM 2001).

A partial hospitalization program may occupy the same setting (i.e., physical space) as an acute care inpatient treatment program. Although occupying the same space, the levels of care provided by these two programs are distinct yet complementary. Acute care inpatient programs provide detoxification services to patients in danger of severe withdrawal and who therefore need the highest level of medically managed intensive care, including access to life support equipment and 24-hour medical support. In contrast, partial hospitalization programs provide services to patients with mild to moderate symptoms of withdrawal that are not likely to be severe or life-threatening and that do not require 24-hour medical support. The transition from an acute care inpatient program to either a partial hospitalization or intensive outpatient program sometimes is referred to as a "step-down." Typically, whether these programs share space and staff with an acute care inpatient program or are physically distinct from a hospital structure, they have close clinical and/or administrative ties to hospital centers. Collaborative working relationships are indispensable in pursuing the goal of providing patients with the most appropriate level of care in the most cost-effective setting.

Staffing

IOPs and PHPs should be staffed by physicians who are available daily as active members of an interdisciplinary team of appropriately trained professionals and who medically manage the care of the patient. An RN or other licensed and credentialed nurse should be available for primary nursing care and observation during the treatment day. Addiction counselors or licensed or registered addiction clinicians should be available to administer planned interventions according to the assessed needs of the patient. The multidisciplinary professionals (such as physicians, nurses, counselors, social workers, psychologists, and acupuncturists) should be available as an interdisciplinary team to

assess and care for the patient with a substance-related disorder, as well as patients with both a substance use disorder and a co-occurring biomedical, emotional, or behavioral condition. Successful linkage to treatment for the substance use disorder (in addition to biomedical stabilization) is central to the mission of an intensive outpatient or partial hospitalization program (ASAM 2001). For more information, see the TIP *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* [CSAT in development *d*].

Acute Care Inpatient Settings

There are several types of acute care inpatient settings. They include

- Acute care general hospitals
- Acute care addiction treatment units in acute care general hospitals
- Acute care psychiatric hospitals
- Other appropriately licensed chemical dependency specialty hospitals

These settings share the ready availability of acute care medical and nursing staff, life support equipment, and ready access to the full resources of an acute care general hospital or its psychiatric unit. This level of care provides medically managed intensive inpatient detoxification (ASAM 2001).

Level of care

Acute inpatient care is an organized service that provides medically monitored inpatient detoxification that is delivered by medical and nursing professionals. Medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds is provided for patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. Services should be delivered under a set of policies and procedures or clinical protocols designated and approved by a qualified physician (ASAM 2001). Additional information on acute inpatient programs is available on the JCAHO Web site (www.jcaho.org) and the CARF Web site (www.carf.org).

Staffing

Acute care inpatient detoxification programs typically are staffed by physicians who are available 24 hours a day as active members of an interdisciplinary team of appropriately trained professionals and who medically manage the care of the patient. In some States, these duties may be performed by an RN or physician assistant. An RN or LPN, as usual, is available for primary nursing care and observation 24 hours a day. Facility-approved addiction counselors or licensed or registered addiction clinicians should be available 8 hours a day to administer planned interventions according to the assessed needs of the patient. An interdisciplinary team of appropriately trained clinicians (such as physicians, nurses, counselors, social workers, and psychologists) should be available to assess and treat the patient with a substance-related disorder, or a patient with co-occurring substance use, biomedical, psychological, or behavioral conditions (ASAM 2001).

Other Concerns Regarding Levels of Care and Placement

In part because of the need to keep costs to a minimum and in part as the result of research in the field, outpatient detoxification is becoming the standard for treatment of symptoms of withdrawal from substance dependence in many locales. Most alcohol treatment programs have found that more than 90 percent of patients with withdrawal symptoms can be treated as outpatients (Abbott et al. 1995). Careful screening of these patients is essential to reserve for inpatient treatment those clients with possibly complicated withdrawal; for example, patients with subacute medical or psychiatric conditions (that in and of themselves would not require hospitalization) and those in danger of seizures or delirium tremens should receive inpatient care. Inpatient addiction treatment programs will vary in the level of acute medical or psychiatric care that can be provided. Figure 2-1 presents an overview of issues to consider in deciding between inpatient and outpatient detoxification.

Figure 2-1: Issues To Consider in Determining Whether Inpatient or Outpatient Detoxification Is Preferred

Considerations	Indications
Ability to arrive at clinic on a daily basis	Necessary if outpatient detoxification is to be carried out
History of previous delirium tremens or withdrawal seizures	Contraindication to outpatient detoxification: recurrence likely; specific situation may suggest that an attempt at outpatient detoxification is possible
No capacity for informed consent	Protective environment (inpatient) indicated
Suicidal/homicidal/psychotic condition	Protective environment (inpatient) indicated
Able/willing to follow treatment recommendations	Protective environment (inpatient) indicated if unable to follow recommendations
Co-occurring medical conditions	Unstable medical conditions such as diabetes, hypertension, or pregnancy: all relatively strong contraindications to outpatient detoxification
Supportive person to assist	Not essential but advisable for outpatient detoxification

Source: Consensus Panelist Sylvia Dennison, M.D.

ASAM criteria are being adopted extensively on the basis of their "face validity," though their outcome validity has yet to be clinically proven. Early studies of more versus less restrictive and intensive treatment settings on randomized samples generally have failed to show group differences, and studies continue to show this pattern (Gastfriend et al. 2000). Whether patients undergoing detoxification will have better results as outpatients rather than as inpatients remains to be established (Hayashida 1998).

Another consideration is that ASAM placement guidelines are not always the best guide to placing a patient in the proper setting at the proper level. For example, what is the clinician to do with the patient who qualifies for outpatient treatment according to the ASAM guidelines but is homeless in sub-zero temperatures? No provision is made for such cases. The ASAM guidelines are to be regarded as a "work in progress," as their authors readily admit (ASAM 2001, p. 19). Nevertheless, they are an important set of guidelines that are of great help to clinicians. For administrators, the standards published by such groups as JCAHO and CARF offer guidance for overall program operations. Additional information is available on the JCAHO Web site (www.jcaho.org) and the CARF Web site (www.carf.org).

It has become clear that detoxification involves much more than simply medically withdrawing a patient from alcohol or other drugs. Detoxification, whether done on an inpatient, residential, or outpatient basis, frequently is the initial therapeutic encounter between patient and clinician. Irrespective of the substance involved, a detoxification episode should provide an opportunity for biomedical (including psychiatric) assessment, referral for appropriate services, and linkage to treatment services. Chapter 3 provides an overview of the psychosocial and biomedical issues relevant to detoxification, strategies to engage the patient, and an overview of providing adequate linkage to follow up treatment and services.

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TRENDWATCH

Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes

One in four Americans experiences a mental illness or substance abuse disorder each year, and the majority also has a comorbid physical health condition.[1] In 2009, more than 2 million discharges from community hospitals were for a primary diagnosis of mental illness or substance abuse disorder.[2,3]

The range of effective treatment options for behavioral health disorders—which encompass both mental illness and substance abuse disorders—is expanding. Research indicates that better integration of behavioral health care services into the broader health care continuum can have a positive impact on quality, costs and outcomes.

Mental illnesses are specific, diagnosable disorders. Each is characterized by intense alterations in thinking, mood and/or behavior over time. Substance abuse disorders are conditions resulting from the inappropriate use of alcohol, prescription drugs and/or illegal drugs.[4] Behavioral health disorders may also include a range of addictive behaviors, such as gambling or eating disorders, characterized by an inability to abstain from the behavior and a lack of awareness of the problem.[5]

Health reform creates new impetus and opportunity for better managing the care delivered to individuals with these conditions. Expansion of health insurance generally, along with improved coverage of behavioral health treatment under parity laws, will broaden access to needed services. At the same time, increased provider accountability will spur efforts to coordinate care across currently fragmented settings to improve the efficiency and effectiveness of care delivered to individuals with behavioral health conditions.

Many providers already are working with private payers to meet these same goals. Initiatives span value-based purchasing, accountable care organizations, patient-centered medical homes, and efforts to reduce readmissions. These initiatives will have important implications for the delivery of behavioral health care. And as the demand for behavioral health services is likely to continue to outstrip capacity, improving care integration can help to better manage this need.

Highly Prevalent, Behavioral Health Disorders Have a Significant Economic and Social Impact

Behavioral health disorders affect a substantial portion of the U.S. population. Nearly half of all Americans will develop a mental illness during their lifetime.[6] An estimated 22.5 million Americans suffered with substance abuse or dependence in 2009,[7] and 27 percent of Americans will suffer from a substance abuse disorder during their lifetimes.[8] While behavioral health disorders primarily affect adults, they also are prevalent among children. Among children, mental health conditions were the fourth most common reason for admission to the hospital in 2009.[9] Studies reveal that approximately 17 percent of Medicare beneficiaries have a mental illness.[10] An analysis of Medicaid beneficiaries across 13 states found that more than 11 percent of beneficiaries used behavioral health services in a year.[11]

The economic and social costs associated with behavioral health are significant, underscoring the importance of treating these conditions.[12] In the majority of cases, behavioral health conditions are serious enough to cause limitations in daily living and social activities.[13] For example, behavioral health conditions hinder worker productivity and raise absenteeism, resulting in reduced income

American Hospital Association

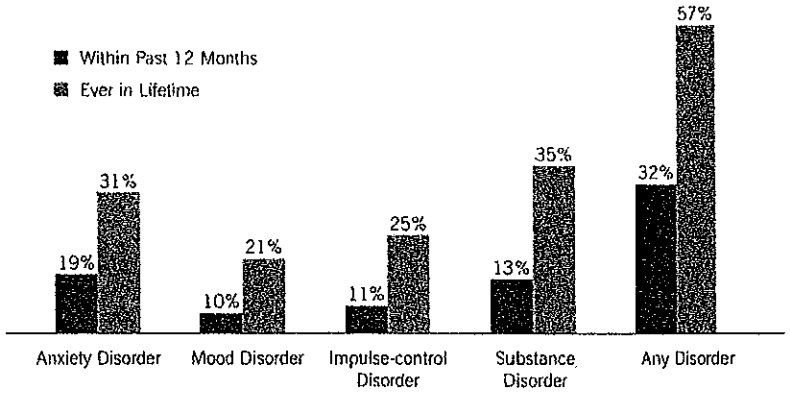
or unemployment.[14] In 2007, persons diagnosed with serious mental illness had annual earnings averaging $16,000 less than the general population.[15] Each year, approximately 217 million days of work are lost or partially lost due to productivity decline related to mental disorders, costing United States employers $21.7 billion annually.[16, 17]

Behavioral health disorders also can have a profound social impact. Individuals with behavioral health conditions are more likely to live in poverty, have a lower socioeconomic status, and lower educational attainment.[18] Lack of treatment amplifies these outcomes and increases the likelihood that individuals will end up homeless or incarcerated.[19]

These social impacts, in conjunction with treatment costs, present a significant and growing economic burden that has made mental illness one of the five most costly conditions nationwide.[20] In 2008, the U.S. spent nearly $60 billion on mental health services, up from $35 billion in 1996.[21] In contrast to general health care services, in which public and private payers account for roughly equal shares of spending, public payers account for the majority of behavioral health expenditures. In 2005, Medicaid and state and local governments accounted for 61 percent of behavioral health care expenditures, compared with 46 percent for all health services.[22]

Behavioral health conditions are prevalent among adults in the U.S.

Chart 1: Percent of U.S. Adults Meeting Diagnostic Behavioral Health Criteria, 2007



Note: Anxiety disorder includes panic disorder, agoraphobia, specific phobia, social phobia, generalized anxiety disorder, post-traumatic stress disorder, obsessive compulsive disorder, and adult separation anxiety disorder. Impulse-control disorder includes oppositional defiant disorder, conduct disorder, attention deficit/hyperactivity disorder, and intermittent explosive disorder. Substance disorder includes alcohol abuse, drug abuse, and nicotine dependence.

Source: Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

Behavioral Health Disorders and Medical Conditions Often Co-occur, Raising the Risk of Suboptimal Outcomes

Individuals with behavioral health disorders often have co-occurring physical health conditions. In the past year, 34 million adults—17 percent of American adults—had comorbid mental health and medical conditions.[23] Mental health and medical conditions are risk factors for each other and the presence of one can complicate the treatment of the other. For example, a recent study found that individuals with bipolar disorder, on average, have a greater number of medical conditions than individuals without claims for mental illness.[24] And a study of Medicaid beneficiaries in New York State determined that, among patients at high risk of hospitalization, 69 percent had a history of mental illness and 54 percent had a history of both mental illness and alcohol and substance use.[25]

Individuals with co-occurring physical and mental health conditions present many treatment challenges. A physical condition may exacerbate a mental health condition, while a mental health condition may hinder treatment for a physical ailment. Medical conditions with a significant symptom burden, such as migraine headaches, chronic bronchitis, and back pain are associated with increased incidence of major depression.[26] About one fifth of patients hospitalized for a heart attack suffer from major depression, which roughly triples their risk of dying from a future heart attack or other heart condition.[27] Depressed patients also are three times more likely than non-depressed patients to be noncompliant with treatment recommendations.[28] Moreover, individuals with mental illness more frequently have risk factors, such as smoking and obesity, which contribute to increased likelihood of chronic conditions such as stroke and diabetes.[29]

Patients with comorbid mental health and medical conditions experience higher health care costs, with much of the difference attributable to higher medical, not mental health, expenditures. One analysis found that although the presence of comorbid depression or

anxiety boosts medical and mental health care costs, more than 80 percent of the increase stems from medical spending. Monthly costs for a patient with a chronic disease and depression are $560 more than for a person with a chronic disease without depression.[30]

The presence of comorbid conditions also can lead to suboptimal patient outcomes. Research indicates that individuals with mental illness die younger than people without such diagnoses, but from the same leading causes of death as occur nationwide, such as heart disease and cancer.[31] Individuals with serious mental illness die, on average, 25 years earlier than the general population.[32] Such poor outcomes may be linked to lack of appropriate care. One study found that almost one third of patients with schizophrenia did not receive appropriate medical treatment for their diabetes, and 62 percent and 88 percent, respectively, did not receive appropriate treatment for high blood pressure and high cholesterol.[33]

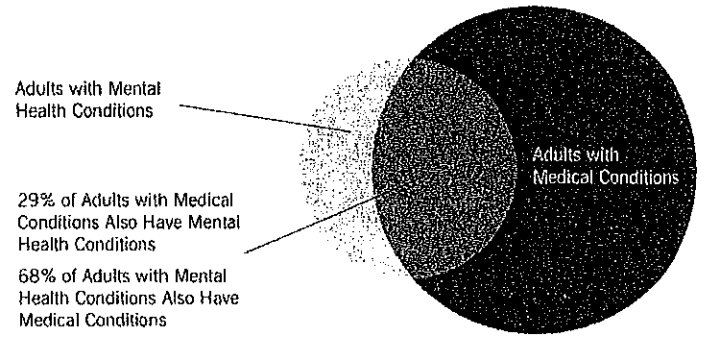
Individuals with comorbid conditions are at heightened risk of returning to the hospital after discharge. A Canadian study found that 37 percent of patients with mental illness discharged from acute care hospitals were readmitted within a period of one year, compared with only 27 percent of patients discharged without a mental illness.[34] In addition, individuals with substance use disorders are among the highest-risk populations for medical and psychiatric rehospitalizations.[35]

Patients with comorbid mental and physical health conditions are readmitted for a broad range of reasons. Specifically, these patients have multiple health conditions, may lack a strong support system, and may not adhere to treatment regimens. These factors can impede recovery and increase the likelihood that patients will return to the hospital. One study found that heart attack patients who were depressed were more likely to be readmitted in the year after discharge.[36] Another study concluded that patients with severe anxiety had a threefold risk of cardiac-related readmission, compared to those without anxiety.[37]

Among children, the risk of rehospitalization was highest during the first 30 days following a first psychiatric hospitalization and remained elevated until about 90 days post-discharge.[38] This finding underscores the vulnerability of patients during the immediate post-discharge period and highlights the importance of integrated care and post-discharge support services.

Individuals with behavioral health conditions frequently have co-ocurring physical health conditions.

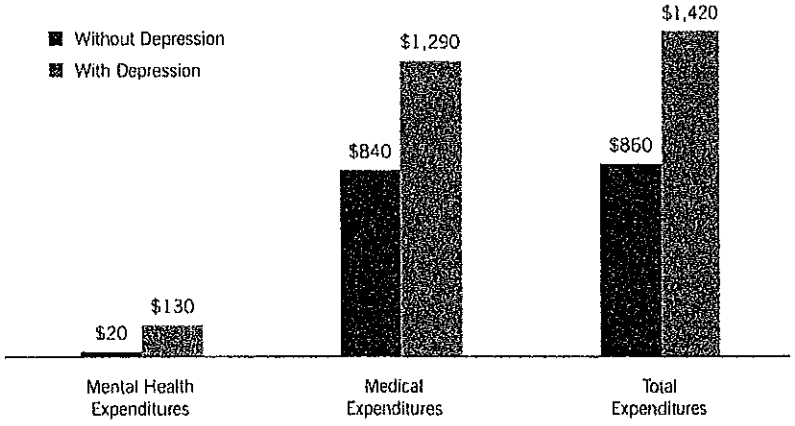
Chart 2: Percentage of Adults with Mental Health Conditions and/or Medical Conditions, 2001-2003



Source: Druss, B.G., and Walker, E.R. February 2011. *Mental Disorders and Medical Comorbidity*. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation.

The presence of a mental health disorder raises treatment costs for chronic medical conditions.

Chart 3: Monthly Health Care Expenditures for Chronic Conditions, with and without Comorbid Depression, 2005



Source: Melek, S., and Norris, D. (2008). *Chronic Conditions and Comorbid Psychological Disorders*. Cited in: Druss, B.G., and Walker, E.R. (February 2011). *Mental Disorders and Medical Comorbidity*. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation.

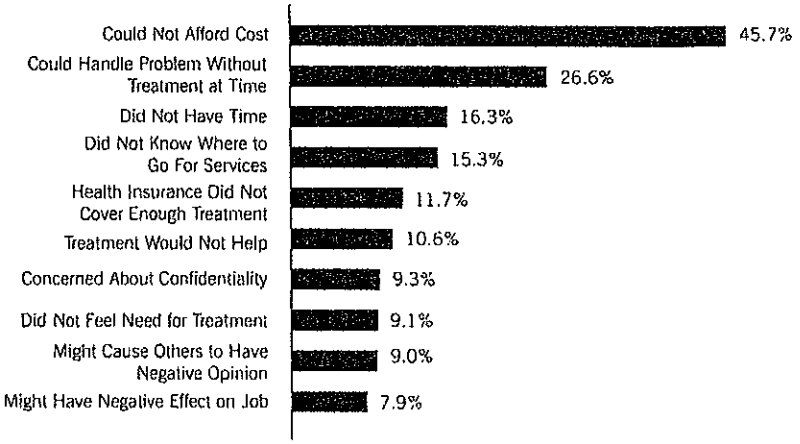
Fragmented Care Delivery and Provider Shortages Impede Effective Treatment for Behavioral Health Conditions

Behavioral health care is fragmented. Individuals who seek behavioral health care often receive treatment in both the inpatient and outpatient settings from generalists and specialists, and rely on a myriad of community resources.[39] Patients with physical health conditions can receive care from yet another group of providers who do not have linkages to those delivering behavioral health care. Even more troubling, the majority of adults with a diagnosable behavioral health disorder do not get any treatment for their behavioral health conditions.[40]

One of the biggest barriers to accessing behavioral health services is a critical shortage of treatment capacity. Currently, 55 percent of U.S. counties have no practicing psychiatrists, psychologists or social workers.[41] There also is a shortage of facilities formally providing behavioral health care. Only 27 percent of community hospitals have an organized, inpatient psychiatric unit,[42] while state and county psychiatric hospitals are closing due to state budget and other funding constraints.[43] Many states have slashed their mental health budgets.[44] Twenty-eight states and Washington, DC reduced their mental health funding by a total of $1.6 billion between fiscal years 2009 and 2012.[45]

Cost is a common barrier to receiving mental health care services.

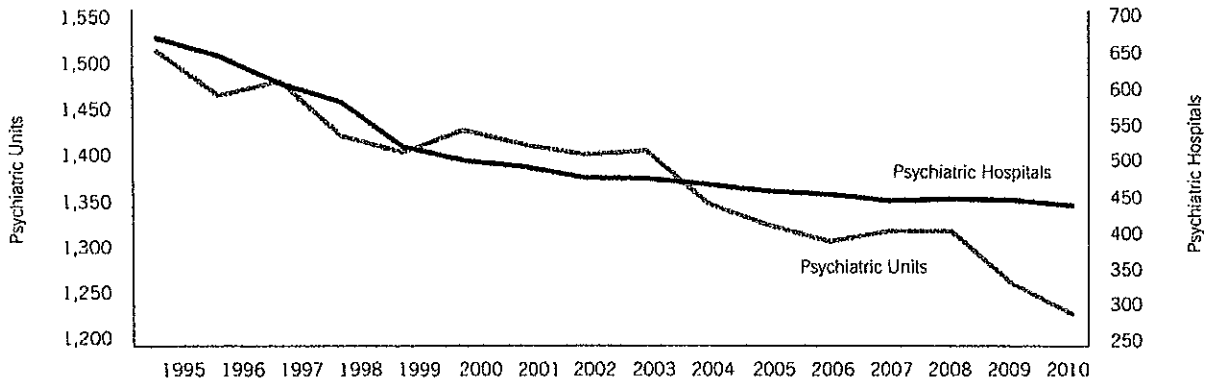
Chart 4: Reasons for Not Receiving Mental Health Services, Among Adults Reporting Unmet Need, 2009



Note: Excludes those who reported unmet need but received some services.
Source: Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

The health care system's capacity to deliver mental health services has been shrinking.

Chart 5: Total Number of Psychiatric Units[1] in U.S. Hospitals and Total Number of Freestanding Psychiatric Hospitals[2] in U.S., 1995-2010



Note: Includes all registered and non-registered hospitals in the U.S.
(1) Hospitals with a psychiatric unit are registered community hospitals that reported having a hospital-based inpatient psychiatric care unit for that year.
(2) Freestanding psychiatric hospitals also include children's psychiatric hospitals and alcoholism/chemical dependency hospitals.
Source: Health Forum, AHA Annual Survey of Hospitals, 1995-2010.

To achieve these cuts, states have eliminated or downsized emergency and long-term hospital treatment, and community mental health treatment programs, among other services. Colorado, for example, has reduced payment rates for mental health providers and cut funding for residential treatment.[46] States are making decisions to reduce services as demand for behavioral services is increasing. Emergency department (ED) visits involving a primary diagnosis of mental illness or substance abuse disorder increased from about 4.2 million in 2006 to more than 5 million visits in 2009.[47,48]

Due to this increased utilization and a shortage of beds, ED boarding—the practice in which admitted patients are held in the ED until inpatient beds become available—is growing for patients with behavioral health care needs at hospitals nationwide. In 2008, 80 percent of ED medical directors surveyed reported that their hospitals board psychiatric patients and 42 percent reported a rising trend.[49] Boarding can adversely affect psychiatric patients by exacerbating their conditions, as patients are held in typically loud, hectic environments not conducive to their recovery.

Treatment Settings for Behavioral Health Care

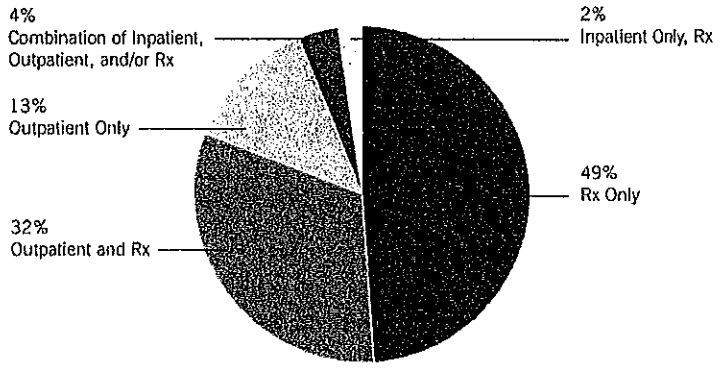
The first point of contact for individuals seeking mental health care is typically a primary care provider.[50] In fact, primary care is the sole form of health care used by more than one third of patients receiving care for a mental health condition.[51] Patients also may access mental health care through specialists (e.g., psychiatrists), social service providers (e.g., counselors) and informal volunteers (e.g., support groups).[52] Mental health services are delivered at a range of locations, including hospitals, outpatient clinics and community settings. Of the 30 million adults receiving mental health services in 2009, the most common services were outpatient therapy, outpatient prescription drugs or a combination of the two.[53]

Although mental health care is most frequently delivered on an outpatient basis, community and psychiatric hospitals remain a vital source of care for behavioral health patients.[54] Nearly all hospitals report that they provide care to patients with mental health and substance abuse disorders.[55] The most common behavioral health conditions treated in hospitals include mood disorders, substance-related disorders, delirium/dementia, anxiety disorders and schizophrenia.[56] Hospitals treat these and other conditions by stabilizing patients, establishing treatment regimens and transitioning patients to outpatient and community-based services.

Overall, about 27 percent of behavioral health care expenditures in 2005 went toward hospital-based services—inpatient care provided by community and psychiatric hospitals.[57] Psychiatric hospitals offer inpatient psychiatric and nursing services, conduct procedures and observe patients so that they do not harm themselves. Notably, the vast majority of inpatient behavioral health services are provided in community hospitals.

Treatment for behavioral health problems is most frequently delivered on an outpatient basis.

Chart 6: Types of Mental Health Services Used in Past Year, Among Adults Receiving Treatment, 2009



Note: Excludes treatment for substance abuse disorders.
Source: Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

Treatment Works

Despite the challenges of delivering and coordinating behavioral health care within the broader health care system, effective treatment for behavioral health conditions does exist. For instance, pharmacotherapy has become an increasingly important part of behavioral health treatment. A wave of new, effective drug treatments for depression, anxiety and schizophrenia has boosted medication as a share of mental health expenditures from 7 percent in 1986 to 27 percent in 2005. Effective drug treatments also have allowed more patients to receive care in the outpatient setting, which accounted for 33 percent of mental health expenditures in 2005, up from 24 percent in 1986.[58]

Pharmacologic treatments, such as antidepressants have been shown to improve quality of life for mental health patients.[59] Medications also are often enhanced with psychosocial treatments. Cognitive behavior therapy, in combination with psychotropic medication, has decreased symptoms of principal generalized anxiety disorder, panic disorder and social anxiety disorder.[60]

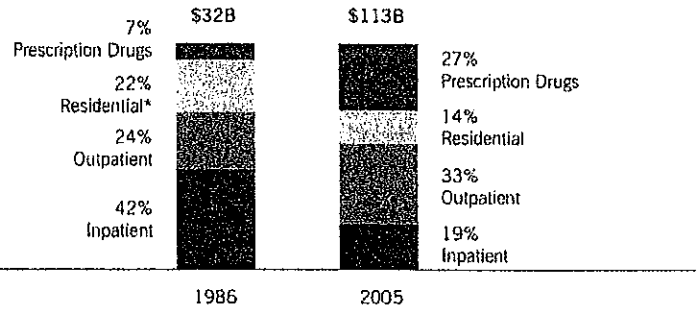
The relative ease of seeking treatment in ambulatory settings, along with shifting perceptions of behavioral health, may encourage more individuals to seek treatment. A survey comparing perceptions of major depression found that more individuals attribute the condition to neurobiological causes and endorse treatment for depression in 2006 than did in 1996.[61]

Treatment has been shown to have a positive economic impact by reducing employer costs and boosting worker productivity. In one study, work impairment of employees with mental illness (defined as when emotional distress has an impact on day-to-day functioning) was cut nearly in half after three weeks of outpatient treatment, from 31 percent to 18 percent.[62] Employer-based initiatives to increase access to mental health treatment have also proven beneficial. For example, Employee Assistance Programs have been shown to reduce medical, disability, and workers' compensation claims, improve worker productivity and decrease absenteeism.[63]

Treatment also has evolved to meet patient needs. Technological advances, such as telepsychiatry, have improved care for patients in rural and other underserved areas. Telepsychiatry—a form of video conferencing that can be used to provide psychiatric services—has been shown to be as effective as face-to-face communication,[64] as well as to increase access and diagnosis and enhance care coordination.[65]

Increased utilization of prescription drugs and decreased reliance on inpatient services has shifted spending over time.

Chart 7: Distribution of Mental Health Expenditures by Type of Service, 1986 and 2005



Note: Excludes spending on insurance administration. Data not adjusted for inflation.
* Residential treatment includes spending in nursing home units of hospitals or in nursing homes affiliated with hospitals.
Source: Substance Abuse and Mental Health Services Administration. (2011). National Expenditures for Mental Health Services & Substance Abuse Treatment 1986-2005. Washington, DC. As cited in Kaiser Commission on Medicaid and the Uninsured. (April 2011). *Mental Health Financing in the United States: A Primer*. Washington, DC.

South Carolina Telepsychiatry Network

The South Carolina Department of Mental Health and the South Carolina Hospital Association received funds to develop a statewide telepsychiatry network. The program allows mental health providers to conduct psychiatric consultations via telephone and video conferencing, giving patients in 27 participating hospital EDs greater access to mental health specialists.[66] The program has produced measurable results, both in terms of patient outcomes and cost savings. The statewide average length of stay for patients experiencing a behavioral crisis across participating hospitals declined from six days to three days. One hospital, Springs Memorial, reported a savings of $150,000 in the first eight months of its participation in the service.[67]

Aleda E. Lutz VA Medical Center, Saginaw, MI

The Aleda E. Lutz Veterans Administration (VA) Medical Center in Saginaw, MI has been using telepsychiatry for the past five years to provide individual therapy and counseling as well as ongoing evaluation and assessment for behavioral health patients.[68]

Before initiating telepsychiatry, one onsite visit with the mental health professional is recommended to complete a psychosocial exam and establish a relationship. After that visit, patients are offered the option of receiving follow-up sessions using telepsychiatry. Before a telepsychiatry session begins, there is a reconciliation of all critical patient information from the electronic medical record and from recent tests and medication adjustments. The telepsychiatry technicians (THTs), who are onsite with the patients, and the health care provider at the remote site have protocols for how to handle specific situations or emergencies. For example, if a patient with post-traumatic stress disorder needs direct intervention during a session, the provider, who may be up to 150 miles away, may immediately call the THT (usually a nurse) on his/her cell phone and tell him/her to provide immediate hands-on care and evaluate the patient for appropriate care.

The number of VA rural sites using telepsychiatry is skyrocketing. Patients are very satisfied with the use of telepsychiatry especially because it can reduce their time spent driving to a medical care session by as much as three hours each way. Patient concerns about confidentiality of information being shared over the lines are allayed by the T3 encryption system as well as the very solid firewalls that are in place to protect their privacy.

The VA's 1,100 sites of care in the U.S., South Pacific and Puerto Rico are connected by an electronic medical record that allows health care providers to share information and coordinate care across sites. Substantial resources are required to support the technology and infrastructure as well as to train health care workers to use the equipment. The VA home telepsychiatry program served approximately 35,000 patients in 2009 and had $72 million in expenditures. By 2011, expenditures reached $163 million.

Integrating Behavioral Health into the Broader Care Continuum Can Reduce Costs and Improve Outcomes

The delivery of behavioral health services is usually separate from and uncoordinated with the broader health care delivery system. For individuals with comorbid behavioral and physical health conditions, this fragmentation compromises quality of care and clinical outcomes. Integration of care between the behavioral health and general medical care treatment settings and providers, can reduce costs and improve outcomes for these patients.

Integration of care can range from brief screening and intervention for comorbid conditions, to coordinated communication between medical and behavioral health providers, to full integration of care delivery across the care continuum with respect to all of the medical and behavioral health care needs of a particular patient. Integration entails both improving the screening and treatment for behavioral health care needs within primary, acute and post-acute care settings, as well as improving the medical care of people receiving services in behavioral health care settings.

One study of an integrated care model found that 44 percent of adults with a serious mental illness who received primary care services within the mental health setting had diabetes and hypertension screenings, while none of the patients without integrated care were screened. Additionally, ED visits were 42 percent lower among the group that received integrated primary care services.[69]

Another study of administration of a brief screening and intervention for substance abuse among patients admitted to a large urban hospital found a nearly 50 percent reduction in re-injuries requiring an ED visit and in injuries requiring a hospital readmission within three years.[70]

Similarly, individuals with serious mental illness enrolled in a Veterans Affairs mental health clinic who were randomized to receive integrated care were more likely to receive primary and preventive care, and demonstrated superior outcomes compared to their counterparts not receiving integrated care. Integrated care included primary care and case management given on site at the mental health clinic, patient education

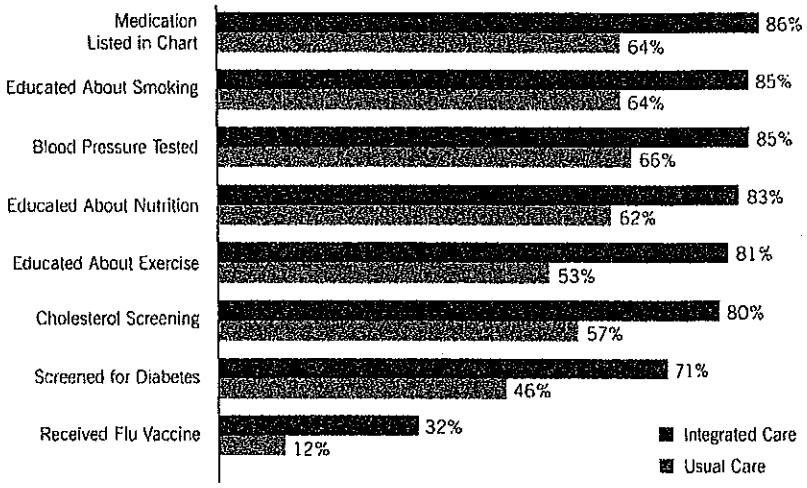
and close collaboration between physical and mental health providers.[71]

A substantial body of clinical evidence has demonstrated the benefits of collaborative care for patients with depression, in particular. A literature review of 45 studies found that patients with major depressive disorder treated with collaborative care interventions experienced enhanced treatment outcomes—including reduced financial burden, substantial increases in treatment adherence, and long-term improvement in depression symptoms and functional outcomes—compared with those receiving usual care.[72]

Integration of care across treatment settings can reduce readmission rates for patients with behavioral health conditions. In Florida, eight psychiatric hospitals partnered with a health plan to improve patients' transitions to outpatient care, with the goal of reducing preventable readmissions.

Integration of behavioral and physical health care can improve access to appropriate care.

Chart 8: Receipt of Preventive Care Services in 12 Months among Patients with Serious Psychiatric Illness Receiving Integrated Care vs. Patients Receiving Usual Care



Source: Druss, B., et al. (2001). Integrated Medical Care for Patients with Serious Psychiatric Illness. A Randomized Trial. *Archives of General Psychiatry*, 58, 861-868.

Mayo Clinic, Rochester, MN

The Mayo Clinic in Rochester, MN is delivering integrated primary and behavioral health care to more than 140,000 patients—including clinic employees, their dependents and other patients seen by Mayo's primary care physicians—using a team-based approach.[73] Mayo's employed primary care physicians, clinical nurse specialists, psychiatrists, psychologists, nurses, social workers and clinic administrators make up the patient's health care team. This team collaborates using a common patient screening tool and electronic health record to ensure the patient is receiving comprehensive primary and behavioral health care. The team also is linked with existing community-based services to ensure continuity of care for the patient.

At the initial mental health visit, patients complete self-rated scales—known as the PHQ-9 and used in a variety of health care settings nationwide—for depression, anxiety, bi-polar disorder and substance abuse which help assess the severity and urgency of the patient's condition. The patient's score on the PHQ-9 helps inform the health care team of the type of care the patient requires. The PHQ-9 also is completed at all follow-up visits for patients with depression. The health care team can adjust the patient's medication, start or increase therapy and address suicide risks based on the patient's score. Patients that receive a score of 10 or higher on the PHQ-9 are added to a registry and monitored for up to 12 months by one of Mayo's 11 registered nurse care coordinators. The care coordinators monitor the patient's condition, share their findings with the patient's psychiatrist and the health care team, assist patients with referrals to other community resources and develop a relapse prevention plan with the patient. The patients also have the opportunity to participate in a depression improvement program offered in Minnesota known as DIAMOND (Depression Improvement Across Minnesota Offering a New Direction).

Mayo's implementation of the team-based approach, the use of the PHQ-9 and the registered nurse care coordinators have significantly improved outcomes and continuity of care for patients. In 2010, two of Mayo's clinics reported the best patient outcomes in the state.

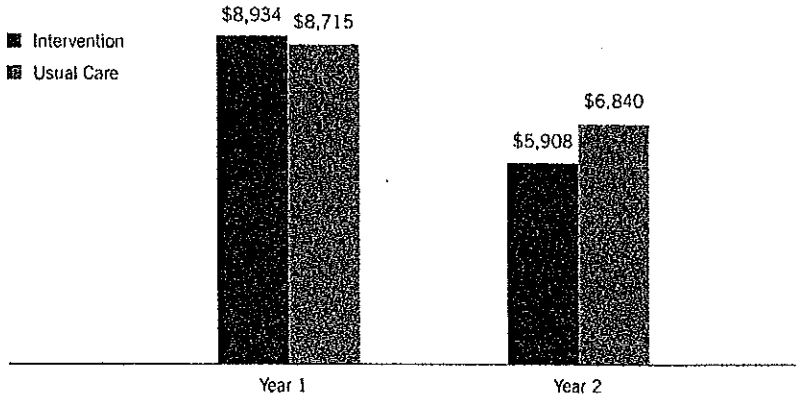
The hospitals focused on coordinating care in the inpatient setting with support services post-discharge. Their efforts cut readmission rates at the eight hospitals. After implementing the program, the readmission rate among the participating hospitals fell from 17.7 percent to 10.4 percent.[74]

Beyond improving quality of care and outcomes for patients, integrating care also can save money. In the Florida program, instituting a visit from a physician on the day of discharge reduced costs by 14 percent. Another study of a care coordination and education program, which deployed medical case managers to assist psychiatric outpatients at a community mental health center, found that participating patients had lower costs by the second year of the program than non-participating patients.[75]

Further, integration has been shown to reduce health care costs in the long term. One study found that older patients with depression who received collaborative care management from both a primary care physician and a nurse or psychologist care manager had lower mean health care costs across four years compared with patients receiving usual primary care.[76] Another study found that coordinating care for patients with diabetes and comorbid major depression through a nurse intervention reduced 5-year mean total medical costs by $3,907, compared with patients receiving usual primary care.[77]

Coordination of care can reduce costs for individuals with behavioral health conditions.

Chart 9: Total Costs at 1 and 2 Years for Patients with Serious and Persistent Mental Illnesses Receiving a Medical Care Management Intervention vs. Usual Care



Source: Dirks, B.G., et al. (2011). Budget Impact and Sustainability of Medical Care Management for Persons with Serious Mental Illness. *American Journal of Psychiatry*. AiA, 1-8.

St. Anthony Hospital, Oklahoma, OK

St. Anthony Hospital in Oklahoma City, OK is an acute care inpatient hospital that serves as a regional referral facility in behavioral medicine and also offers residential inpatient care for adolescents and children. In 2008, St. Anthony initiated a number of changes to its internal processes to address the high rates of behavioral health patients admitted through its ED and to reduce the time mentally ill patients spent in the ED in a crisis situation.[78]

The hospital established a mental health admissions office in the ED and began conducting behavioral health evaluations of patients prior to bed placement in the ED. De-escalation training was conducted for all ED and security staff and the Oklahoma City Police Department was enlisted to improve and assist in the transfer of patients to the behavioral health crisis center. St. Anthony also focused on avoiding unnecessary admissions and readmissions of behavioral health patients by ensuring patients are connected with the right resources and provided the appropriate care in the appropriate setting.

As a result of these changes St. Anthony's average wait time for patients to see a mental health professional decreased from two hours to 20 minutes, and patients now see a mental health professional before seeing an ED physician. Additionally, the average wait time for patients in the ED has decreased from 44 minutes to 28 minutes. Furthermore, the average length of stay in the ED for mental health patients has dropped from 254 minutes to 177 minutes.

Although St. Anthony has recently seen an increase in patients seeking services through the ED—on average 83 more patients a month seek care in the ED—they have experienced a 12-20 percent reduction in admissions.

Affordable Care Act Provisions Will Promote Service Integration, Quality Enhancement and Improved Access for Those with Behavioral Health Care Needs

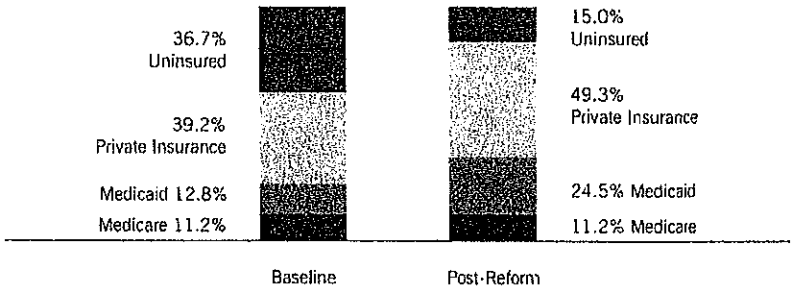
Overall, the health care system has been shifting toward a focus on value and accountability. The *Patient Protection and Affordable Care Act* (ACA)[79] furthers these efforts by promoting new care delivery models and creating new imperatives for providers to better integrate care. These ACA reforms, in addition to coverage expansion, and the previously enacted mental health parity law should facilitate the integration of behavioral health care into the broader care continuum. While many of the ACA delivery system reforms apply to Medicare and Medicaid, private insurers often adopt similar reforms once tested and found to be effective.

First, the ACA supports emerging models of care delivery—specifically accountable care organizations (ACOs) and patient-centered medical homes—that aim to coordinate and manage the full spectrum of health care needs of an individual. ACOs join physicians, hospitals and other providers to manage and be held accountable for the quality and costs of care for their patients. While ACOs are already being tested by private payers, the ACA adds the model to Medicare, giving participating providers an opportunity to share in cost savings if they meet quality goals.[80]

In the Medicaid program, the ACA creates a health home program to promote integrated care for beneficiaries with chronic ailments, including behavioral health conditions. Beneficiaries with a serious and persistent mental illness, or with a mental health or substance abuse disorder and a comorbid chronic medical condition, are eligible to participate in the health home program. Each health home will include a team of physicians and other providers, including behavioral health care professionals. In addition to medical services, the team will deliver comprehensive care management, care coordination, health promotion and other patient and family support.[81]

A substantial number of uninsured adults with mental health needs will gain coverage under health reform.

Chart 10: Simulated Change in Coverage After Reform Among Adults with Probable Depression or Serious Psychological Distress



Note: Based on data for adults ages 18-64 in the 2004-2006 Medical Expenditure Panel Surveys.
Source: Garfield, R., et al. (2011). The Impact of National Health Care Reform on Adults With Severe Mental Disorders. *American Journal of Psychiatry*, 168(5): 486–494.

Second, the ACA creates new incentives for providers to better manage patients' transitions among settings and providers of care and the community. The Hospital Readmissions Reduction Program lowers Medicare payment to hospitals with greater than expected readmissions. In the initial years, the program includes measures of all-cause readmissions for heart failure, heart attack and pneumonia.[82] Given the role that behavioral health needs play in compliance with care regimens and care seeking behaviors, and the greater likelihood of readmission among patients with a comorbid behavioral health condition, identifying and addressing behavioral health needs pre-discharge will be crucial for hospitals looking to reduce their readmission rates.

Likewise, the ACA encourages the use of bundled payment rates across acute and post-acute providers for specified episodes of care in both Medicare and Medicaid.[83] By promoting coordination across these providers, this program also could help improve care transitions for patients with behavioral health needs.

Third, the ACA sets new standards for quality of behavioral health care. The law establishes new quality measures focused on mental health care to be used in a psychiatric hospital public reporting program in Medicare. Beginning with rate year 2014, psychiatric hospitals that do not submit their data will be subject to a 2 percent payment penalty.[84] The ACA also establishes a Psychiatric Hospital Value-based Purchasing pilot program in Medicare that will test the use of incentive payments for hospitals that meet certain performance standards.[85] Finally, the ACA should help improve access to behavioral health services by expanding insurance coverage for all Americans[86] and supporting workforce[87] development grants and other efforts to expand the behavioral health care workforce. In addition to the ACA changes, the *Mental Health Parity and Addiction Equity Act of 2008* also improves coverage by requiring health insurers to apply treatment limitations, enrollee financial responsibility requirements, and in-network versus out-of-network benefits equally to behavioral health and physical health care.[88]

Conclusion

As providers take on shared accountability for health care across the continuum, they should not overlook patients' behavioral health care needs. Behavioral health disorders are prevalent among U.S. adults, and the consequences of not addressing these conditions in a coordinated fashion are poorer physical and mental health outcomes and higher health care costs.

Health care organizations and providers that can effectively integrate care across treatment settings as well as between the behavioral and physical health care systems should realize gains in quality and outcomes, and reduced treatment costs.

POLICY QUESTIONS

- How can policymakers further promote integration of behavioral and physical health care?
- Will the behavioral health provider workforce be adequate to accommodate the expected influx of new patients following coverage expansions in 2014?
- How will the distribution of behavioral health financing change under health reform? Will public payers continue to account for the majority of spending?
- How will delivery system reforms account for the unique needs of behavioral health patients? And how can they be leveraged to spur improved integration of physical and behavioral health care?

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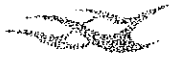

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Research Article

The Impact of Psychiatric Patient Boarding in Emergency Departments

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Objectives. Studies have demonstrated the adverse effects of emergency department (ED) boarding. This study examines the impact of resource utilization, throughput, and financial impact for psychiatric patients awaiting inpatient placement. *Methods.* The authors retrospectively studied all psychiatric and non-psychiatric adult admissions in an Academic Medical Center ED (>68,000 adult visits) from January 2007-2008. The main outcomes were ED length of stay (LOS) and associated reimbursement. *Results.* 1,438 patients were consulted to psychiatry with 505 (35.1%) requiring inpatient psychiatric care management. The mean psychiatric patient age was 42.5 years (SD 13.1 years), with 2.7 times more women than men. ED LOS was significantly longer for psychiatric admissions (1089 min, CI (1039–1140) versus 340 min, CI (304–375); $P < 0.001$) when compared to non-psychiatric admissions. The financial impact of psychiatric boarding accounted for a direct loss of ($1,198) compared to non-psychiatric admissions. Factoring the loss of bed turnover for waiting patients and opportunity cost due to loss of those patients, psychiatric patient boarding cost the department $2,264 per patient. *Conclusions.* Psychiatric patients awaiting inpatient placement remain in the ED 3.2 times longer than non-psychiatric patients, preventing 2.2 bed turnovers (additional patients) per psychiatric patient, and decreasing financial revenue.

1. Introduction

In recent years numerous studies have chronicled the adverse effects of emergency department boarding times on the prehospital, emergency department, and inpatient hospital financial and clinical outcomes in the USA and worldwide [1–13]. A small but increasing subset within this population are those patients presenting with psychiatric emergencies for which there is little published data. In the ever increasing challenges with access to health-care due to state and federal budget cuts, inpatient and outpatient psychiatric care options have noted substantial decreases. In some states, available inpatient capacity for primary psychiatric care has decreased by nearly 100% leading to increased queuing of those waiting for these resources and an increased burden on many emergency departments to board these patients while waiting for appropriate inpatient care options [14].

In addition, for the past 2 decades, emergency departments have seen increasing numbers of persons with psychiatric and substance abuse issues [14]; nationally, patients with mental health complaints account for 7% to 10% of ED visits [15, 16]. Despite accounting for a relatively small proportion of an emergency department's total census, these high-risk patients provide unique challenges for management. Substantial declines in mental health resources have contributed to increasing numbers of patients with mental health issues in emergency departments [14]. Inadequate outpatient psychiatric services for the uninsured and underinsured contribute to utilization of the emergency department as a primary source of psychiatric care. Reduced state and national funding and declining reimbursements resulted in inpatient unit closures and therefore prolonged ED stays [17]. Reduced availability of community-based referral options for follow-up care delays disposition and contributes to subsequent ED visits for similar complaints.

Patient "boarding," the holding of a patient in an ED bed while awaiting an inpatient mental health bed, is a frequently reported occurrence. Studies cite an average of a 7-hour wait for a bed following the decision to admit, with an extended duration if transfer to an outside facility

was required [15–17]. In a recent survey, numerous facilities reported instances of longer than 24 hours from bed request to patient transfer [17]. Prolonged ED stays are associated with increased risk of symptom exacerbation or elopement for patients with mental health/substance abuse issues. External stimuli from the busy emergency department can increase patient anxiety and agitation, which is potentially harmful for both patients and staff [15, 18]. Elopement from the emergency department prior to definitive screening and treatment can lead to increased risk of self-harm and suicide [18]. In addition, mental health patients in the emergency department contribute to other system issues such as increased ancillary resource utilization by safety attendants or security officers as a safety measure to protect staff and patients. This requirement leads to increased labor costs which have not been factored into this study. Patient care and customer relation issues can also arise as other patients are faced with the burden of additional wait time for emergency care. Poor clinical outcomes, evidenced as delays in care and increases in morbidity and mortality, have been directly associated with ED overcrowding and lack of available emergency beds and patients leaving without being seen [1–3, 18].

Patients with a psychiatric diagnosis, a substance abuse problem, or a dual diagnosis require specialized care to address their complex psychological, medical, and social needs. Optimally, these individuals are assessed and managed in safe, quiet, and calm areas, instead of the hurried, chaotic environment that is a characteristic of most emergency departments [18]. Generally, emergency physicians and nurses have modest clinical skills to manage these patients because most of their mental health training focused on initial diagnosis, care for related medical issues, and emergent interventions such as sedation or restraint. While some emergency departments have created positions such as a psychiatric or mental health liaison nurse or clinical nurse specialist to further address this concern, this alternative is not always feasible [19, 20]. Thus, the primary goal in most emergency departments is to keep the patients safe until they can be moved into a mental health unit or further stabilized and discharged home with an appropriate outpatient care plan [19, 20].

Acknowledging the varied adverse effects of prolonged emergency department (ED) boarding times on clinical and financial measures, this study sought to examine the impact on resources, throughput, and finances for all patients awaiting inpatient placement for emergent psychiatric conditions. Specifically, the study looked at the LOS for psychiatric patients as compared to nonpsychiatric adult inpatient admissions to floor or monitored beds (excluded ICU or step-down units), reimbursement for services provided during the ED care, and the opportunity cost of the impact on ED throughput.

2. Methods

This retrospective cohort analysis focused on all adult psychiatric admissions presenting to an Academic Emergency Department at a Level 1 Trauma Center and Tertiary Referral Center (>92,000 total patient visits; 68,000 adult visits), from January 2007 to January 2008. With 844 operational (885 licensed) patient beds including only 38 inpatient psychiatric beds, recurrent issues with psychiatric boarding in the 27 bed adult ED is common. The main outcomes were total ED LOS (arrival to transfer to inpatient bed or outside facility) and the physician and facility payment for services rendered. Data was collected from the electronic health record system within the institution using psychiatric consultation, department of admission or transfer as the identifier for those patients with a primary psychiatric admission diagnosis. Deidentified financial facility-based data were obtained for this population, as well as a cohort of general medicine patients requiring inpatient care on a floor or monitored bed; intensive care or step-down unit patients were excluded. This study was approved by the institutional review board.

The financial data in this study of ED psychiatric patient boarding was based on the facility payments received per admitted ED patient divided by the average total length of stay of all nonpsychiatric, non-ICU adult patients. This value was used to identify the average hourly ED bed payment. This hourly amount was then multiplied by the total LOS for the psychiatric patients to identify what the total payment should be for psychiatric patients based on this length of stay. Then this value was subtracted from the facility payments for the nonpsychiatric cohort to identify the potential payment loss. Secondary assessment of the average ED physician payments for the same cohort was obtained. This was then applied to the potential missed patients being seen during 12 hours per day which represent the daily duration that ED patients are awaiting an unavailable bed due to psychiatric patient boarding at this facility. The potential payment losses due to decreased bed turnover and the payment differences were combined to identify the psychiatric patient boarding losses per patient.

3. Results

Table 1 summarizes the demographic and length of stay data from the psychiatric and nonpsychiatric cohorts. During the study period, 1,438 patients were consulted to psychiatry with 505 (35.1%) requiring inpatient care management for their psychiatric condition. The mean age of the psychiatric patients was 43 years (SD 13.1 years), with 2.7 times more women than men compared to 52 years and a slight female predominance in the nonpsychiatric group. The psychiatric group was 50% white, non-Hispanic and 42% African American compared to 54% and 39% respectively in the nonpsychiatric group.

Table 1 also shows the length of stay data for the 505 psychiatric and 18768 nonpsychiatric admissions. The total ED LOS was significantly longer for psychiatric patient admissions (1089 min, CI [1039–1140] versus 340 min, CI [294–372]; $P < 0.001$) when compared to nonpsychiatric admissions. The duration from consultation to admission or transfer was also significantly longer for psychiatric patients (1017 min, CI [957–1082] versus 178 min, CI [159–201]; $P < 0.001$).

Table 1: Demographic and length of stay data of the patient cohorts.

	Psychiatric	Nonpsychiatric	Significance (P)
Total admissions	505 (2.6%)	18768 (97.4%)	
Age in years, median	43	52	$P < 0.05$
Sex (%)			
Male	37	43	$P < 0.05$
Female	63	57	
Racial categories (%)			
White	50	54	
African-American	42	39	**NS
Hispanic	6	5	
Asian	0.3	0.4	
Uninsured (%)	32	24	$P < 0.05$
Total length of stay (min)	1089	340	$P < 0.001$
Duration from Consultation to Admission (min)	1017	178	$P < 0.001$

Key: **NS: not statistically significant, min: minute.

The hourly payment for an ED bed was calculated to be \$99.50. When applied to the total LOS for the psychiatric patients less the facility average payment per admitted patient, the facility payment loss for each admitted or transferred psychiatric patient was \$1,198. This was then applied to the potential missed patients being seen assuming patients are awaiting an unavailable bed in the ED due to psychiatric patient boarding. Factoring the financial factors associated with the loss of bed turnover for waiting patients, psychiatric patient boarding awaiting inpatient placement cost the department \$2,264 per patient.

4. Discussion

Overcrowding in the ED is not just an inconvenience of elongated wait times, hallway boarding of patients, and frequently HIPAA privacy failures; it is evidence of a health care system quality failure. As has been clearly delineated in recent literature, overcrowded hospital and emergency department (ED) conditions are associated with an increased risk of death or disability [1–5], an increased door-to-needle time delay for treatment of patients with suspected acute myocardial infarction and poorer performance on pneumonia quality of care measures [6–8]. A recent meta-analysis also found overcrowding to be associated with increased transport delays, ambulance diversion, patients leaving without being seen, and medication errors, among other problems [10]. Each of these issues directly identify the impact on patient care but when discussed at the administrative level many improvement projects are limited by short-term financial discussions [11–13].

The aforementioned issues related to boarding are further exacerbated in the psychiatric population due to decreasing inpatient care beds and bed availability. While a small subset of the total admitted population in the study (2.6%), the total length of stay (1089 min; 18.2 hours) for psychiatric patients was significantly greater than the nonpsychiatric cohort (340 min; 5.7 hours). The duration from time of consultation to admission for these cohorts was (1017 versus 178 minutes, respectively). This identifies the examination time period for psychiatric patients was shorter by approximately 100 minutes. Uniform in the admission process for psychiatric patients is a preset laboratory screening panel, but unlike the nonpsychiatric subset, imaging was not routinely obtained and likely accounts for the examination time difference. A recent study by Weiss et al. found similar length of stay for admitted psychiatric patients and also found that the need for hospitalization, older age, intoxication, and insurance status were associated with increased length of stay [15].

The psychiatric cohort was younger (median age, 43 versus 52) and more predominately female (63 versus 57%). While there were minimal differences in racial categories between cohorts, the lack of insurance was higher in the psychiatric cohort (32 versus 24%). Given the median age and the sex breakdown of the cohorts, this was not seen to be a likely contributing factor in increased length of stay. However, the higher uninsured rate of the psychiatric may be associated with the increased length of stay [15].

The financial impact associated with admitted psychiatric patients within our patient population and payor mix was associated with a 40% decrease in average physician reimbursement when compared to the nonpsychiatric cohort. This aside, the increase in total length of stay per admitted psychiatric patient prevents the ED from caring for an additional 2.2 patients and growing due to resource limitations within the state. Applying the average financials for each ED patient that would otherwise be cared for, the impact from each psychiatric boarded patient represents a loss to the system of approximately \$2,400. Certainly, if greater than 20% of your ED capacity is being occupied with psychiatric boarded patients, the financial impact would be far greater than the conservative estimates presented as it would likely have downstream impact on system patient flow, patient satisfaction, potential shift in payor mix if seen as an undesirable place to receive care, ability to provide exceptional care, meeting all core measure expectations, and perceived community benefit from the ED. However, if even a fraction of the financial loss demonstrated were placed in to resource development and solution generation for this patient population, the net gain may be profound.

It is also important to recognize that while this was a single center study, in a survey of 328 ED Medical Directors in the United States, 79.2% report routine psychiatric patient boarding with 35.1% boarding greater than 1 patient per day and 38.9% boarding for between 8 and 24 hours. This survey sited lack of accepting transferring facility (19.9%), inability to transfer to an accepting facility due to bed availability (19.5%), and lack of in-house inpatient psychiatric beds (16.5%) as the most common reasons for

extended ED length of stay [21]. Recognizing one of the root causes for psychiatric boarding is lack of available care options is an essential part of initiating change. This may reflect the needs to improve the input, throughput, and outpatient care follow-up psychiatric inpatients and thereby creating available capacity. Further exploration of psychiatric care approaches to reduce hospitalization by identifying transition of care alternatives may expedite the transition to outpatient care, and subsequently have a positive effect on ED length of stay [19, 20].

5. Limitations

It is important to recognize that the data presented represents an experience from a single, large academic center with an inpatient psychiatric care unit and therefore is not uniformly generalizable. For those EDs that have an external but associated facility, boarding may not currently be an issue, just the medical clearance of this patient population. Other EDs may lack attached or affiliated inpatient psychiatric care options and therefore may face very similar issues, perhaps greater, depending on transfer center availability.

The data in this study was obtained from the electronic health record, rather than prospective data collection, which may not be a perfect reflection of the exact time allotment for each patient, but remains representative of the patient data as a whole. During the study period, the ED maintained a period of full capacity for all but an average 8 hour period from approximately 3 am–11 am during which time the financial impact of patient queuing or increased LWBS would not be appreciated. However, the associated decreased payments due to psychiatric boarding or elongated LOS would still equate to a loss but would not include a loss related to an increased LWBS population. It is also important to note that the cost related to increased resource utilization for security throughout the patient stay, or the associated increase in staffing number required, especially in the overnight hours when total patient volume otherwise decreases, is not included in this calculation but would only increase the associated financial impact.

Further assessment considering insurance status at time of presentation might further delineate the anticipated longer boarding for the uninsured yet; a large amount of uncompensated care is provided within the study facility which may not be the case, elsewhere. Regardless, in this current economic climate, available resources for this unique patient population are limited and likely to worsen into the foreseeable future even, with pending health care reform. Our data supports the premise that overcrowding is a complex process, but that growing number of psychiatric boarding patients not only magnifies this process but also has a notable financial impact on the facility. If not already noted, this should be a signal to those planning the future of health care—whether those developing APCs, medical home models, or further governmental developed social care networks—that the current resources for psychiatric patients are limited and the proverbial "safety net"—the ED—remains at the breaking point.

6. Conclusions

Psychiatric patients awaiting inpatient placement remain in the ED 3.2 times longer than nonpsychiatric ED patients. Longer length of stays of psychiatric patients prevent 2.2 bed turnovers (or additional patients seen) per psychiatric patient awaiting inpatient care. The loss of payments due to boarding psychiatric patients awaiting inpatient bed placement is an approximate $2,250. While the exact data may not be consistent between facilities and states due to resources and patient population, if appropriate access to psychiatric care is available, the improved efficiencies of care (and associated financials) would help foster greater financial support for further psychiatric care while improving ED capabilities. This may include improved medical home models that include psychiatric assessment and direct care disposition to inpatient facilities, transition of care alternatives besides current inpatient care models or perhaps improvement in baseline psychiatric care to decrease the need for emergent ED interventions.

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Connecticut Facilities – Bed Availability

May 15, 2014:

Facility	Time	Ins	Person	Result	Other
SCRC	3:05pm	N/A	Erica	No beds (maybe tomorrow)	She didn't ask for any other information.
Silver Hill Hospital	3:10pm	N/A	Mary	No beds until next Wednesday or Thursday.	She didn't ask for any other information.
MCCA	3:15pm	N/A	N/A	Went straight to voicemail	N/A
First Step	3:16pm	N/A	N/A	Phone rang many times to voicemail.	N/A
Blue Hills and ADRC	3:25pm	Aetna	Evelyn	"Just come in with my ID and insurance card. Also bring clean socks and underwear."	Also stated that they do not reserve beds – it's first come, first served.
Mountainside Treatment Center	3:32pm	N/A	Lisa	Receptionist told me everyone is on the phone and I would have to call back.	I called back at 4:06pm and received the same information.
Conn. Valley Hospital	4:15pm	Cigna	Cecilia	Stated they only accept state insurance.	I asked about SP and they denied that as well.
Rushford	3:42pm	N/A	N/A	I was put on hold for 10 minutes and finally hung up.	N/A
Stonington Institute	3:52pm	N/A	N/A	Went right to voicemail	N/A
SCADD	3:54pm	N/A	Alicia	Went right to voicemail	N/A
CHR	3:56pm	N/A	Megan M.	Went right to voicemail	N/A
Capital Region					
SW CT Mental Health					
CMHC					

Connecticut Facilities – Bed Availability

May 15, 2014 (cont'd):

Facility	Time	Ins	Person	Result	Other
SCRC	8:01pm	Aetna	Tamika	No beds until tomorrow	She didn't ask for any other information.
Silver Hill Hospital	8:08pm	N/A	Allison	No beds try and call back next week.	She didn't ask for any other information.
MCCA	8:18pm	N/A	Emma	No beds currently.	She did take down some information though.
First Step	8:22pm	N/A	Syeeta	They are full.	She did ask for information and told me to call back in the AM.
Blue Hills and ADRC	8:26pm	N/A	Tammy	Spoke to a nurse who said they are full.	I asked for her name and she said "one of the nurses."
Mountainside Treatment Center	8:29pm	N/A	Carl	After being on hold for 4 minutes I was told there are no beds.	N/A
Conn. Valley Hospital	8:43pm	N/A	N/A	Phone rang for 2+ minutes before I hung up.	N/A
Rushford	8:46pm	N/A	N/A	Admissions answering machine stated they were closed.	N/A
Stonington Institute	8:48pm	N/A	N/A	Phone rang for 2+ minutes before I hung up.	N/A
SCADD	8:52pm	N/A	Stephanie	No beds currently.	She asked for my name and # and stated someone will call back later.
CHR	8:53pm	N/A	N/A	Called and went to a busy signal.	Called 3 times.
Capital Region					
SW CT Mental Health					
CMHC					

Connecticut Facilities – Bed Availability

May 16, 2014:

Facility	Time	Ins	Person	Result	Other
SCRC	10:18am	N/A	N/A	No beds available. "I just gave away my last bed."	N/A
Silver Hill Hospital	10:21am	N/A	Jen	No beds available until next Thursday.	N/A
MCCA	10:23am	N/A	N/A	Pressed 2 for detox and it kept looping me back to the automated system.	Tried 3 more times w/ same results.
First Step	10:27am	N/A	Sonata	No beds today.	N/A
Blue Hills and ADRC	10:30am	N/A	Shane	"We have no beds. Try again later today."	N/A
Mountainside Treatment Center	10:32am	N/A	Evan	28 day rehab program. They do not offer detox.	N/A
Conn. Valley Hospital	10:34am	N/A	Steven	"No beds now, but try again later."	N/A
Rushford	10:39am	N/A	Greg	Full in both locations.	Maybe there would be a bed this coming weekend.
Stonington Institute	10:48am	N/A	Lin	No beds left today.	They asked to do a screening but I told them I would call back.
SCADD	10:50am	N/A	Laura	All staff are on the phone.	I had to leave a name and #
CHR	10:53	N/A	Megan	They don't do detox anymore.	Also they are an all women program now.
Capital Region					
SW CT Mental Health					
CMHC					

Connecticut Facilities – Bed Availability

May 17, 2014:

Facility	Time	Ins	Person	Result	Other
SCRC	8:28pm	N/A	refused	No bed available.	Operator refused to give his name
Silver Hill Hospital	8:32pm	N/A	nurse	Stated I would have to call back in the AM.	Asked if it is a 24 hour facility. His response was yes but they don't admit people at night.
MCCA	8:36pm	N/A	N/A	Phone rang and then went to voicemail.	N/A
First Step	8:38pm	N/A	Ed	No beds available	He asked for me to do a screening and I refused.
Blue Hills and ADRC	9:35pm	N/A	N/A	Rang 20 times to voicemail.	N/A
Mountainside Treatment Center	9:36pm	N/A	Beth	No beds available	She took down some basic info and said someone would call back in the morning.
Conn. Valley Hospital	9:45pm	N/A	Sue	She said I had to call back in the morning.	N/A
Rushford	9:47pm	N/A	N/A	Pressed 2 for admissions. Went to voicemail stating they were closed.	N/A
Stonington Institute	9:49pm	N/A	N/A	Pressed 1 for admissions. It rang 20 times and then cut off	N/A
SCADD	9:54pm	N/A	Darlene	She stated they are currently full.	N/A
CHR	9:56pm	N/A	Megan	Went to voicemail.	N/A
Capital Region	9:58pm	N/A	N/A	Direct to Blue Hills hospital. Woman stated they don't have beds available.	She stated to call back in the morning and ask for the admissions nurse.
SW CT Mental Health	10:06pm	N/A	N/A	Woman stated they were full and to call back on Monday.	She didn't ask for any of my information.
CMHC	10:08pm	N/A	N/A	I asked for any available and the woman said no and then hung up.	N/A

Connecticut Facilities – Bed Availability

May 20, 2014:

Facility	Time	Ins	Person	Result	Other
SCRC	3:59pm	N/A	N/A	Woman in admissions stated there were no beds at all	She stated to try again tomorrow
Silver Hill Hospital	4:05pm	N/A	Kathy	No beds currently	She state they won't have a bed until Friday
MCCA	4:09pm	N/A	Tina	No beds currently, but they will have a bed tomorrow.	She started to do a screening. I cut her off and said I would call back.
First Step	4:10pm	N/A	Louis	No beds currently	He started to do a screening. I cut her off and said I would call back.
Blue Hills and ADRC	4:12pm	N/A	Schabre	No beds currently.	She advised me to call back in the morning.
Mountainside Treatment Center	4:14pm	N/A	Lisa	She told me everyone is on the phone.	She took my name and # and said someone would call me back.
Conn. Valley Hospital	4:16pm	N/A	N/A	Admissions stated they are waiting to have someone call them back for the last bed.	The women advised me to call back in a few hours.
Rushford	4:18pm	N/A	N/A	The phone rang for 2 minutes and then went to a machine asking to leave a voicemail.	N/A
Stonington Institute	4:20pm	N/A	N/A	Went straight to voicemail.	N/A
SCADD	4:22pm	N/A	Joann / Steph	I called twice and both times they put me on hold and the call was disconnected.	N/A
CHR	4:26pm	N/A	Megan	Went straight to voicemail.	N/A
Capital Region					
SW CT Mental Health					
CMHC					

Connecticut Facilities – Bed Availability

May 20, 2014 (cont'd):

Facility	Time	Ins	Person	Result	Other
SCRC	9:02pm	N/A	N/A	No beds currently available	N/A
Silver Hill Hospital	9:05pm	N/A	Kathy	No beds currently available.	She state they won't have a bed until Friday
MCCA	9:07pm	N/A	Candice	No beds currently available, but they may have a bed tomorrow.	She started to do a screening. I cut her off and said I would call back.
First Step	9:08pm	N/A	N/A	No beds currently available.	She started to do a screening. I cut her off and said I would call back.
Blue Hills and ADRC	9:12pm	N/A	Schabre	No beds currently available..	She advised me to call back in the morning
Mountainside Treatment Center	9:14pm	N/A	Cindy	No beds currently. She advised that they would have a bed in the AM.	She wanted me to do a screening, I refused.
Conn. Valley Hospital	9:20pm	N/A	N/A	Admissions stated they are waiting to have someone call them back for the last bed.	The woman advised me to call back in a few hours (same info as 5 hours ago).
Rushford	9:00pm	N/A	N/A	They are closed. It went to voicemail.	N/A
Stonington Institute	9:02pm	N/A	N/A	Phone rang for 4 minutes. No option to leave voicemail.	N/A
SCADD	9:08pm	N/A	Joann	No beds this evening.	She stated to call tomorrow between 8 and 9am.
CHR	9:12pm	N/A	Megan	Went straight to voicemail.	N/A
Capital Region	9:14pm	N/A	N/A	Woman stated they were no beds and to call back in the morning.	N/A
SW CT Mental Health	9:17pm	N/A	N/A	Spoke to a woman who said I have to call back during business hours when the crisis center is open.	N/A
CMHC	9:20pm	N/A	N/A	Spoke to a woman who said I had to come in during business hours.	Although she was unsure if they would have a bed.

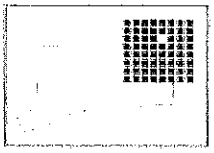
Connecticut Facilities – Bed Availability

May 21, 2014:

Facility	Time	Ins	Person	Result	Other
SCRC	9:12am	N/A	N/A	Transferred to the front desk were it went to a voicemail box that was full.	It looped me back to the automated menu again. That happened 3 times.
Silver Hill Hospital	9:16am	Aetna	Molly	No open bed until next week.	N/A
MCCA	9:21am	N/A	N/A	Transferred to admissions which went to voicemail after ringing and ringing.	N/A
First Step	9:24am	N/A	Kenyatta	Bed maybe open in the next day or two.	She tried to get a screening from me.
Blue Hills and ADRC	9:31am	N/A	Evelyn	"Just come in with my ID and insurance card. Also bring clean socks and underwear."	That was all just told me. She didn't get my DOB or my insurance #. Also stated they don't reserve beds, its first come first serve.
Mountainside Treatment Center	9:35am	N/A	Lisa	Everyone was on the phone.	She asked for a name and # for someone to call me back.
Conn. Valley Hospital	9:37am	Aetna	N/A	Receptionist told me they don't take Aetna because it's a private insurance.	All state insurance accept.
Rushford	9:39am	Aetna	Alicia	She stated they have 1 bed available, but they don't hold beds. She told me to come in ASAP.	She states Aetna is tough to get time for opiates and I might not be fully covered.
Stonington Institute	9:44am	N/A	N/A	Rang for 1+ minutes and then went to voicemail.	N/A
SCADD	9:46am	N/A	Mickey	She stated they have 1 bed left and she'd be willing to hold it.	But they don't use methadone or suboxone to detox.
CHR	9:50am	N/A	Megan	Went to voicemail.	N/A
Capital Region	9:53am	N/A	N/A	Was informed they don't take private insurance.	N/A
SW CT Mental Health	9:55am	N/A	N/A	Put on hold for 15 minutes. I hung up and was put on hold again for 10 minutes.	N/A

Connecticut Facilities – Bed Availability

CMHC	10:30am	N/A	N/A	Facility operates as a triage and helps those without insurance get help.	N/A



Connecticut College of Emergency Physicians
60 Kings Highway, North Haven, CT 06473
(203) 234-8055 www.ctacep.org

May 20, 2014

Ms. Kim Martone, Director of Operations
Office of Health Care Access
Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

Re: The Retreat Application for a Substance Abuse Facility

Dear Ms. Martone:

On behalf of the Connecticut College of Emergency Physicians (CCEP) representing the more than 400 emergency physicians, residents and medical students working at Connecticut hospitals we wish to express our support for The Retreat's 105-bed application for a treatment facility in New Haven. Emergency physicians are on the frontline of today's health system and our profession may understand more than most the need for this type of facility in Connecticut.

On a routine basis substance abuse patients find themselves turning to the emergency departments around the state because they have no place to obtain the proper treatment. A facility like The Retreat would offer these patients an opportunity to have both the short and long term substance abuse treatment they desirer. This continuity of care and intensive therapy will lead to a greater success for those seeking rehabilitation.

Emergency physicians hear on daily basis from our health care colleagues that they are sending patients to the emergency department for medical treatment because they are unable to find an available bed for their client. Emergency physicians will and do care for all individuals that come to the emergency department but this care comes at the highest level and cost. If substance abuse patients were given an alternative like The Retreat those unnecessary cost to the health care system could be avoided.

A state of the art facility like The Retreat would provide health care providers with an alternative to referring their clients to the emergency department for care.

CCEP most respectively request that OHCA approve the application for The Retreat's facility in New Haven. Please call upon us with any questions.

Sincerely,

Jorge Otero, MD
President of CCEP

NASW National Association of Social Workers / Connecticut Chapter

2139 Silas Deane Highway
Suite 205
Rocky Hill, CT 06067
(860) 257-8066 • (860) 257-8074 FAX

Raymie H. Wayne, Ph.D., JD, MSW, President
Stephen A. Karp, MSW, Executive Director
naswct@naswct.net
www.naswct.org

May 19, 2014

Kim Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
P. O. Box 340308
Hartford, Connecticut 06134

RE: The Retreat Application

Dear Ms. Martone:

On behalf of the National Association of Social Workers, Connecticut Chapter representing over 3000 members we are writing to you to express our support for The Retreat's application to open a 105 bed in-patient facility in New Haven to treat addictions.

NASW supports the least restrictive treatment environment for individuals. However we also recognize that there are times when an individual seeking to recover from a drug or alcohol addiction needs the intensity and security of an in-patient treatment center. In the state's efforts to move services into the community the in-patient side of care has been under-recognized as a key factor in the continuum of care. This has led to the current situation where our members who work with addictions tell us that there are an inadequate number of in-patient beds in Greater New Haven.

What we hear from our community clinicians is that there is a rise in the use of drugs, especially heroin that has become the inexpensive drug of choice. An example of what we are hearing from our members is as follows: a dually-diagnosed individual who was doing well in treatment had a relapse and the clinician could not find a bed in New Haven. The man was eventually admitted to CVH but his family has limited resources, including lack of transportation that added great stress to the situation and hindered the recovery. These issues all could have been avoided if sufficient beds were available in New Haven where the client and his family reside. Other NASW members in Greater New Haven report similar stories of not being able to get clients into needed in-patient care in a timely manner and in a geographically suitable location within the community where individuals have their natural support systems.

The other issue of concern is that lacking beds for adequate in-patient addiction care clinicians have no choice but to refer clients to the local hospitals Emergency Department

where the cost of care is far higher and the level of care needed does not truly demand emergency room care. From a health care delivery point of view this makes little sense, and in the future can be avoided by proposed option of The Retreat's application.

It is our chapter's recommendation that OHCA approve the opening of beds in New Haven.

Sincerely,

Stephen A. Karp, MSW
Executive Director

Cc: Lisa Davis

CONNECTICUT
PSYCHOLOGICAL ASSOCIATION

May 19, 2014

Ms. Kim Martone, Director of Operations
Office of Health Care Access
Department of Public Health
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134

Re: Need for Substance Use Treatment Facilities in CT

Dear Ms. Martone,

We are writing on behalf of the Connecticut Psychological Association (CPA), the largest organization of psychologists in the state. A great majority of our members are practicing clinicians who treat a range of behavioral health issues, including drug and alcohol abuse and addictions. CPA is aware of OHCA's current consideration of an application for a new substance use treatment facility in New Haven. Our understanding is this facility would provide both short- and long-term substance use treatment for insured patients. It is our opinion that such a facility is greatly needed in Connecticut, and we urge your approval.

The best substance use treatment provides intensive comprehensive care, as well as continuity of care, which involves a smooth transition between detoxification, psychological treatment, and rehabilitation. For many years, psychologists and other mental health providers in Connecticut have experienced the greatest difficulty finding available beds for insured patients who present with an immediate need for inpatient substance use treatment.

As a result of the shortage of substance use treatment beds, patients and practitioners have learned the best way to obtain one of the few available beds is through a direct referral from a hospital inpatient unit. Accordingly, patients and practitioners have found that patients often need to present at an Emergency Department, so they can be admitted to an inpatient unit in order to obtain that direct referral for a bed. Although there is often an overlap with substance abuse and suicidality, some patients go so far as to claim suicidal intentions (even in the absence of such intentions) when presenting at an Emergency Department, in an effort to ensure admission to a hospital inpatient unit. Often, patients, are discharged from the hospital inpatient unit once the physiological addiction and, if relevant, any immediate suicidal concerns, have been addressed. If a bed in a longer-term treatment facility is not available, which is often the

case, the patient is discharged with a plan for outpatient, self-moderated treatment. In this model, little attention is given to the more prominent psychological issues related to recovery; as a result, the patient is likely to struggle intensely, if not fail at his or her attempt to abstain from substance use. These failures, at the very least, may involve relapse, or in the worst cases result in death.

Based on our experience, the state of Connecticut has a tremendous need for a private pay substance use treatment center such as The Retreat, which would provide much-needed private pay beds, and would improve care, and continuity of care, for substance use and dual diagnosis patients. We urge your approval of a new substance use treatment facility in New Haven.

Please let us know if we can answer any questions or be of assistance in any way.

Barbara S. Bunk, PhD
President

Traci Cipriano, JD, PhD
Director of Professional Affairs

WELLSPAN HEALTH

May 22, 2014

Peter Schorr, CFO
Retreat at Lancaster County
1170 S State St
Ephrata, PA 17522

Mr Schorr:

We would like to let you know that Retreat at Lancaster County has been very helpful in our ER referral process. When we have a patient who is in need of substance abuse detox/rehab treatment services, Retreat admissions is easy to work with and accepts patients with many different commercial insurance plans, which is also extremely helpful to our staff and our patients. In the ER, we often have to refer patients out who need a different level of care and Retreat is very instrumental in allowing us to do this with ease.

We are happy to call Retreat when we have a patient in need of drug & alcohol treatment because we know the process will be easy and the patient will be able to get the treatment he/she needs in a timely manner. Thank you for your services. We recognize that this will be shared with the Connecticut Department of Public Health in an effort for Retreat to obtain a license in Connecticut.

Sincerely,

Crisis Intervention
York Hospital

CHRISTIANA CARE
HEALTH SERVICES

Project Engage
4755 Ogletown-Stanton Road
Newark, Delaware 19718

www.christianacare.org

May 22, 2014

Kimberly R. Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capital Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06434-0308

RE: NR Connecticut, LLC d/b/a Retreat at South Connecticut

Dear Ms. Martone:

Christiana Care Health Services would like to share with you what a pleasure it has been to work with Retreat at Lancaster. The staff at Retreat go above and beyond to make their substance abuse treatment services accessible to Christiana Care hospital patients and to stay in touch with us throughout the admissions process. Retreat works to clear barriers so that they can accept our patients, not turn them away.

Retreat at Lancaster is one of the few residential treatment programs able to accommodate referrals from our Emergency Department (ED) staff after hours. This helps reduce the time a patient needs to wait in the ED, and eases the patient load for the medical staff.

We've come to rely on Retreat for its commitment to delivering exceptional quality at every step – from our first phone call to check bed availability through the moment the Retreat driver escorts our patient to their facility. The staff is professional, friendly and dedicated to quick response times.

I believe the Retreat organization would be an excellent addition to any hospital's provider network for substance abuse services.

Sincerely,

Beverly Wilson
Program Manager
Project Engage
Christiana Care Health Services

LOC	Reg	Agency	Town	Location	Name	Phone	Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
Detox - 4.2													
	2	CVH	Middletown	Detox	Joann Chatfield	(800) 828-3396 x 5	1	20	19	0	0		
	4	Blue Hills	Hartford	Detox	Pat O'Brien	(860) 293-6415	0	21	21	0	0		
							1	**41**	**40**				
Detox - 3.7													
	1	RNP	Bridgeport	Detox	Sara Smith	(203) 333-3518	4	19	17	2	4		
	2	Cornell Sctt	New Haven	SCRC	Ben Metcalf	(203) 503-3300	9	26	24	1	8		
	2	Rushford	Middletown	Resid Detox	Tara Murphy	1-877-577-3233	0	16	15	8	7		
	3	SCADD	New London	Resid Detox	Admiting Nurse	(860) 447-1717	5	20	16	6	7		
	3	Stonington	North Stoning	Resid Detox	Andrea Keeney	(860) 445-3000		20				No	20
	4	ADRC	Hartford	Resid Detox	Admitting Nurse	(860) 714-3700	15	35	18	2	0		
	5	MCCA	Danbury	Resid Detox	Ana Carvalho	(203) 792-4515X123	0	12	12	3	3		
							33	**148**	**102**				**20**
Intensive Res													
	1	CASA	Bridgeport	Intensive	Kremlin DeVissiere	(203) 339-4112		10				No	10
	1	RNP	Bridgeport	Horizon	Sara Smith	(203) 333-3518		15				No	15
	2	CVH	Middletown	Intens (Men)	Joann Chatfield	(800) 828-3396 x 5	1	60	59	0	0		
	2	CVH	Middletown	Intens (Women)	Joann Chatfield	(800) 828-3396 x 5	1	30	29	0	0		
	2	Rushford	Middletown	Intensive	Tara Murphy	1-877-577-3233	0	42	42	1	1		
	3	CPAS	Putnam	Milestone	Michelle Blevin	(860) 928-1860		16				No	16
	4	ADRC	Hartford	SATEP ADRC	E. Navarro	(860) 714-3739	7	28	21	3	3		
	4	Blue Hills	Hartford	Intensive	Pat O'Brien	(860) 293-6415	0	21	21	0	0		
	4	Farrell	New Britain	Intensive	Ester Bryant	(860) 225-4641	1	24	21	2	0		
	5	MCCA	Danbury	McDonough	Maureen Gorman	(203)792-4515	0	22	21	2	1		
	5	McCall	Torrington	Carnes Wks	Tracy Donahue	(860) 496-2107	0	20	20	2	2		
							10	**288**	**234**				**41**
Intens Res Co-Occ													
	1	RNP	Bridgeport	New Prospects	Sara Smith	(203) 333-3518	0	23	23	0	0		
	5	CT Ren	Waterbury	McAuliffe Center	Steven Lockley	203-346-1931	6	20	14	0	0		
							6	**43**	**37**				
LTT Preg ♀													
	1	Liberation	Stamford	Fam In Recov	Maggie Young	(203) 352-1800		10				No	10
	2	Connection	New Haven	Elm's City Women's	Sondra Horne	(203) 752-9109		15				No	15
	2	Connection	Groton	Mother's Retreat	Sherrie Weaver	(860) 405-2107x108	0	8	8	0	0		
	2	Connection	Middletown	Halle House	Michelle Giardina	(860) 343-5513	0	8	8	0	0		
	2	Crossroad	New Haven	Amethyst House	Meryl Boyarsky	203-387-0094x198	5	15	9	1	0		
	3	CPAS	Putnam	New Life Res	Michelle Blevin	(860) 928-1860		8				No	8
	4	ADRC	Hartford	Coventry House	E. Navarro	(860) 714-3739		10				No	10
	5	Morris	Waterbury	Preg/Parenting ♀	Joan Hoskins	(203) 575-0117	3	8	6	0	1		
							8	**82**	**31**				**43**

LOC	Reg	Agency	Town	Location	Name	Phone	Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
LTT													
	1	APT	Bridgeport	Residential Serv	Dan lead	(203)337-9943	16	124	108	1	1		
	1	Liberation	Stamford	Liberation House	Maggie Young	203-391-7947		73				No	73
	2	Crossroad	New Haven	Men's Unit	Dr. Carl Williams	203-387-0094x150	74	133	59	0	0		
	2	Rushford	Middletown	Residential LT Treatr	Tara Murphy	1-877-577-3233	0	26	26	0	0		
	3	CPAS	Willimantic	T. Murphy	Terrence G. Smith	(860) 456-1769	3	14	10	1	0		
	3	Perceptions	Willimantic	Perception House	Jodi Noel	(860) 450-7130	1	20	18	1	0		
	3	SCADD	Lebanon	Lebanon Pines	Deborah Mirsky	(860)447-1717x209	3	110	105	3	1		
	4	Centro	Hartford	Women's Unit	Anna Alvarez	(860) 951-7006		15				No	15
	4	Centro	Hartford	Men's Unit	Eliezer Rodriquez	(860) 232-7353		15				No	15
	4	Youth Chall	Hartford	Men's Unit	Ronald Mason	(860) 528-5199	4	15	11	0	0		
	5	CNV Help	Waterbury	LTT	Erica Turnour	(203) 756-8984x108		34				No	34
	5	CT Ren	Waterbury	Renaissance East	Carol Pace	203-753-2341	5	32	27	0	0		
							106	**611**	**364**				**137**
LT Care													
	5	MCCA	Sharon	Trinity Glen	Lynn Muzzulin	(860) 672-6689		50				No	50
								50					**50**
Halfway Hs													
	1	CASA	Bridgeport	CASA Half/Way	Kremlin DeVissiere	(203) 339-4112		6				No	6
	2	Connection	Middletown	167 LibertySt	Patrick Fallon Patrick	(860) 343-5512	0	14	13	1	0		
	3	SCADD	Norwich	313 Main St Men	Jarrod Viens	(860) 889-3414	2	13	11	0	0		
	3	SCADD	New London	1000 BankSt Womer	Angela Massiello	(860) 447-8021	1	10	9	0	0		
	3	SCADD	New London	62 Coit St Women	Marilyn Glover	(860) 447-1017	2	11	9	0	0		
	4	ADRC	Hartford	SATEP Intermed	E. Navarro	(860) 714-3739	0	10	10	0	0		
	4	ADRC	Glastonbury	Clayton House	E. Navarro	(860) 714-3739		15				No	15
	5	McCall	Torrington	Intermed Res	Melissa Gray	(860) 496-2105	4	18	14	0	0		
							9	**97**	**66**				**21**
Recov Hs													
	1	CASA	Bridgeport	Recovery House	Carmen Santiago	(203) 336-4745		10				No	10
	2	Columbus	New Haven	Recovery House	Mahasa Crudup	(203) 772-2658		10				No	10
	2	Connection	New Haven	Recovery House	Rejeanne Toussaint	(203) 946-3081	0	20	20	0	0		
	3	CPAS	Willimantic	Oak St.	Terrence G. Smith	(860) 456-1769		10				No	10
	4	ADRC	Hartford	Recovery House	William Young	(860) 714-3705		10				No	10
	4	ADRC	Hartford	GA Recovery House	William Young	(860) 714-3705		20				No	20
	4	Mercy	Hartford	Mercy's Recovery Ho	Tenesha Grant	(860) 808-2114		8				No	8
	5	Morris	Waterbury	Therapeutic Shelter	Cindy Salmoirgahi	(203) 574-1419	15	21	6	0	0		
							15	**109**	**26**				**68**
Special Hsg													
	4	ADRC	Hartford	SATEP Male Hsg	John Morelli	(860) 714-3702	0	6	6	0	0		
	4	Mercy	Hartford	SATEP Women's AL	Eileen McKeever	(860) 808-2121	1	15	14	0	0		
							1	**21**	**20**				

LOC	Reg	Agency	Town	Location	Name	Phone	Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
Supp Rec Hsg													
	1	Miracle Hse	Bridgeport	Miracle House	Deborah Green	(203) 335-1306	3	5	2	0	0		
	1	Stam Shelter	Stamford	597 Pacific St	Jonathon Wells	(203) 348-3792			2	0	0	No	
	2	Believe in Me	New Haven	423 Dixwell Ave	James Walker	(203) 772-2771	-2	5	7	0	0		
	2	Evergreen	New Haven	Winthrop Ave	Pamela Allen	(203) 809-8714	2	11	9	0	0		
	2	Evergreen	New Haven	George St	Pamela Allen	(203) 809-8714	5	14	9	0	0		
	2	REHMA	New Haven	Gibbs Rec Hs			1	5	4	0	0		
	2	Stepping Stn	Meriden	168 Mt Pleasant	Sue Holly	(860) 538-8582	3	5	2	0	0		
	2	Stepping Stn	Merdien	Bunker Ave	Sue Holly	(860) 538-8582	4	5	1	0	0		
	2	Stepping Stn	Meriden	164 Mt Pleasant	Sue Holly	(860) 538-8582	3	5	2	0	0		
	2	Stepping Stn	Meriden	163 Mt Pleasant	Sue Holly	(860) 538-8582	1	5	4	0	0		
	3	Bethsaida	Norwich	Katie Blair Hse	Danielle Farrell	(860) 886-7511X204	3	3	0	0	0		
	3	Hope	Groton	Comm of Hope					1	0	0	No	
	3	Safe Hse	Willimantic	Safe Hs	Heather Meehan	(860) 456-7610X20			11	0	0	No	
	3	SCADD	Norwich	Washington St	Patrice Thomas	(860) 859-9702	-1	10	11	0	0		
	3	Shift	Mansfield	Stearns Rd	Eileen Hamon	(860) 208-4999		7				No	7
	3	Shift	Willimantic	Church St	Eileen Hamon	(860) 208-4999	6	6	0	0	0		
	3	Shift	Willimantic	Prospect St	Eileen Hamon	(860) 208-4999	7	7	0	0	0		
	4	Coram	New Britain	Kimball St	Jody Davis	(860) 348-3486	-1	5	6	0	0		
	4	Coram	New Britain	Walsh St	Jody Davis	(860) 348-3486	3	5	2	0	0		
	4	Coram	New Britain	Addison's Hse	Jody Davis	(860) 348-3486			3	0	0	No	
	4	My Sister's	Hartford	Pliny St	Kathleen Shaw	(860) 549-1634	7	10	3	0	0		
	4	Sober Sol	Waterbury	187-189 Wolcott Stre	David Ruth	(860) 533-9500	48	50	2	0	0		
	4	Sober Sol	East Hartford	80 Central Ave	David Ruth	(860) 533-9500	55	58	3	0	0		
	4	Sober Sol	East Hartford	42 Bissell St	David Ruth	(860) 533-9500	2	4	2	0	0		
	4	Sober Sol	Enfield	101-103 Prospect Str	David Ruth	(860) 533-9500	49	50	1	0	0		
	4	Sober Sol	Enfield	12 Pleasant Street	David Ruth	(860) 533-9500	48	50	2	0	0		
	4	Sober Sol	East Hartford	107 Ellington Rd	David Ruth	(860) 533-9500	5	6	1	0	0		
	4	Sober Sol	East Hartford	Bigelow St	David Ruth	(860) 533-9500	-1	5	6	0	0		
	4	Sober Sol	Manchester	West St	David Ruth	(860) 533-9500	0	7	7	0	0		
	4	Sober Sol	East Hartford	9-11 Burnside	David Ruth	(860) 533-9500	0	8	8	0	0		
	4	Sober Sol	Manchester	Cooper St	David Ruth	(860) 533-9500	-2	5	7	0	0		
	4	Sober Sol	East Hartford	444 Burnside	David Ruth	(860) 533-9500	4	5	1	0	0		
	4	Sober Sol	East Hartford	152 Ellington Rd	David Ruth	(860) 533-9500	5	6	1	0	0		
	4	Thom Morrow	Manchester	49 Birch St	Sue Morrow	(860) 783-8833		7				No	7
	4	Thom Morrow	Manchester	59 Birch St	Sue Morrow	(860) 783-8833		7				No	7
	5	ER Prop	Waterbury	47 Irion St	Val Collins	(203) 346-8087	1	5	4	0	0		
	5	ER Prop	Waterbury	35 Webb St	Val Collins	(203) 346-8087		15				No	15
	5	ER Prop	Waterbury	Taylor St	Val Collins	(203) 346-8087		5				No	5
	5	ER Prop	Waterbury	103 Walnut St	Val Collins	(203) 346-8087	1	5	4	0	0		
	5	MCCA	Danbury	Sobering Center	Peter Pizzillo	(203) 730-9947	1	16	15	0	0		
							260	**427**	**143**				**41**

LOC	Reg	Agency	Town	Location	Name	Phone	Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
Detox - 4.2													
	2	CVH	Middletown	Detox	Joann Chatfield	(800) 828-3396 x 5	0	20	20	0	0		
	4	Blue Hills	Hartford	Detox	Pat O'Brien	(860) 293-6415	0	21	21	0	0		
							0	**41**	**41**				
Detox - 3.7													
	1	RNP	Bridgeport	Detox	Sara Smith	(203) 333-3518	-2	19	19	5	3		
	2	Cornell Sctt	New Haven	SCRC	Ben Metcalf	(203) 503-3300		26				No	26
	2	Rushford	Middletown	Resid Detox	Tara Murphy	1-877-577-3233	1	16	13	7	5		
	3	SCADD	New London	Resid Detox	Admiting Nurse	(860) 447-1717	1	20	16	6	3		
	3	Stonington	North Stoning	Resid Detox	Andrea Keeney	(860) 445-3000		20				No	20
	4	ADRC	Hartford	Resid Detox	Admitting Nurse	(860) 714-3700	-4	35	37	7	5		
	5	MCCA	Danbury	Resid Detox	Ana Carvalho	(203) 792-4515X123	0	12	11	4	3		
							-4	**148**	**96**				**46**
Intensive Res													
	1	CASA	Bridgeport	Intensive	Kremlin DeVissiere	(203) 339-4112	4	10	4	2	0		
	1	RNP	Bridgeport	Horizon	Sara Smith	(203) 333-3518		15				No	15
	2	CVH	Middletown	Intens (Men)	Joann Chatfield	(800) 828-3396 x 5	0	60	60	0	0		
	2	CVH	Middletown	Intens (Women)	Joann Chatfield	(800) 828-3396 x 5	0	30	30	0	0		
	2	Rushford	Middletown	Intensive	Tara Murphy	1-877-577-3233	0	42	43	0	1		
	3	CPAS	Putnam	Milestone	Michelle Blevin	(860) 928-1860	2	16	14	0	0		
	4	ADRC	Hartford	SATEP ADRC	E. Navarro	(860) 714-3739	7	28	19	2	0		
	4	Blue Hills	Hartford	Intensive	Pat O'Brien	(860) 293-6415	0	21	21	0	0		
	4	Farrell	New Britain	Intensive	Ester Bryant	(860) 225-4641	3	24	19	2	0		
	5	MCCA	Danbury	McDonough	Maureen Gorman	(203)792-4515	1	22	21	1	1		
	5	McCall	Torrington	Carnes Wks	Tracy Donahue	(860) 496-2107	0	20	20	0	0		
							17	**288**	**251**				**15**
Intens Res Co-Occ													
	1	RNP	Bridgeport	New Prospects	Sara Smith	(203) 333-3518	2	23	22	1	2		
	5	CT Ren	Waterbury	McAuliffe Center	Steven Lockley	203-346-1931	6	20	14	0	0		
							8	**43**	**36**				
LTT Preg ♀													
	1	Liberation	Stamford	Fam In Recov	Maggie Young	(203) 352-1800		10				No	10
	2	Connection	New Haven	Elm's City Women's	Sondra Horne	(203) 752-9109		15				No	15
	2	Connection	Groton	Mother's Retreat	Sherrie Weaver	(860) 405-2107x108	0	8	8	0	0		
	2	Connection	Middletown	Halle House	Michelle Giardina	(860) 343-5513	0	8	8	0	0		
	2	Crossroad	New Haven	Amethyst House	Meryl Boyarsky	203-387-0094x198	4	15	11	0	0		
	3	CPAS	Putnam	New Life Res	Michelle Blevin	(860) 928-1860	1	8	7	0	0		
	4	ADRC	Hartford	Coventry House	E. Navarro	(860) 714-3739	2	10	8	0	0		
	5	Morris	Waterbury	Preg/Parenting ♀	Joan Hoskins	(203) 575-0117	3	8	5	0	0		
							10	**82**	**47**				**25**

LOC	Reg	Agency	Town	Location	Name	Phone	Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
LTT													
	1	APT	Bridgeport	Residential Serv	Dan lead	(203)337-9943	17	124	108	0	1		
	1	Liberation	Stamford	Liberation House	Maggie Young	203-391-7947		73				No	73
	2	Crossroad	New Haven	Men's Unit	Dr. Carl Williams	203-387-0094x150	72	133	59	2	0		
	2	Rushford	Middletown	Residential LT Treatr	Tara Murphy	1-877-577-3233	0	26	26	0	0		
	3	CPAS	Willimantic	T. Murphy	Terrence G. Smith	(860) 456-1769	3	14	11	0	0		
	3	Perceptions	Willimantic	Perception House	Jodi Noel	(860) 450-7130	1	20	18	1	0		
	3	SCADD	Lebanon	Lebanon Pines	Deborah Mirsky	(860)447-1717x209	4	110	104	3	1		
	4	Centro	Hartford	Women's Unit	Anna Alvarez	(860) 951-7006		15				No	15
	4	Centro	Hartford	Men's Unit	Eliezer Rodriquez	(860) 232-7353		15				No	15
	4	Youth Chall	Hartford	Men's Unit	Ronald Mason	(860) 528-5199	6	15	10	1	2		
	5	CNV Help	Waterbury	LTT	Erica Turnour	(203) 756-8984x108	0	34	32	2	0		
	5	CT Ren	Waterbury	Renaissance East	Carol Pace	203-753-2341	4	32	28	0	0		
							107	**611**	**396**				**103**
LT Care													
	5	MCCA	Sharon	Trinity Glen	Lynn Muzzulin	(860) 672-6689	6	50	44	0	0		
							6	**50**	**44**				
Halfway Hs													
	1	CASA	Bridgeport	CASA Half/Way	Kremlin DeVissiere	(203) 339-4112	-4	6	8	2	0		
	2	Connection	Middletown	167 LibertySt	Patrick Fallon Patrick	(860) 343-5512	1	14	13	0	0		
	3	SCADD	Norwich	313 Main St Men	Jarrod Viens	(860) 889-3414	4	13	11	0	2		
	3	SCADD	New London	1000 BankSt Womer	Angela Massiello	(860) 447-8021	1	10	9	0	0		
	3	SCADD	New London	62 Coit St Women	Marilyn Glover	(860) 447-1017	0	11	11	0	0		
	4	ADRC	Hartford	SATEP Intermed	E. Navarro	(860) 714-3739	0	10	10	0	0		
	4	ADRC	Glastonbury	Clayton House	E. Navarro	(860) 714-3739	4	15	11	0	0		
	5	McCall	Torrington	Intermed Res	Melissa Gray	(860) 496-2105	4	18	14	0	0		
							10	**97**	**87**				
Recov Hs													
	1	CASA	Bridgeport	Recovery House	Carmen Santiago	(203) 336-4745		10				No	10
	2	Columbus	New Haven	Recovery House	Mahasa Crudup	(203) 772-2658		10				No	10
	2	Connection	New Haven	Recovery House	Rejeanne Toussaint	(203) 946-3081	0	20	20	0	0		
	3	CPAS	Willimantic	Oak St.	Terrence G. Smith	(860) 456-1769	5	10	4	1	0		
	4	ADRC	Hartford	Recovery House	William Young	(860) 714-3705	3	10	7	0	0		
	4	ADRC	Hartford	GA Recovery House	William Young	(860) 714-3705	0	20	17	3	0		
	4	Mercy	Hartford	Mercy's Recovery Ho	Tenesha Grant	(860) 808-2114	0	8	8	0	0		
	5	Morris	Waterbury	Therapeutic Shelter	Cindy Salmoirgahi	(203) 574-1419	16	21	5	0	0		
							24	**109**	**61**				**20**
Special Hsg													
	4	ADRC	Hartford	SATEP Male Hsg	John Morelli	(860) 714-3702	0	6	6	0	0		
	4	Mercy	Hartford	SATEP Women's AL	Eileen McKeever	(860) 808-2121	1	15	14	0	0		
							1	**21**	**20**				

LOC	Reg	Agency	Town	Location	Name	Phone	Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
Supp Rec Hsg													
	1	Miracle Hse	Bridgeport	Miracle House	Deborah Green	(203) 335-1306	3	5	2	0	0		
	1	Stam Shelter	Stamford	597 Pacific St	Jonathon Wells	(203) 348-3792			2	0	0	No	
	2	Believe in Me	New Haven	423 Dixwell Ave	James Walker	(203) 772-2771	-3	5	8	0	0		
	2	Evergreen	New Haven	Winthrop Ave	Pamela Allen	(203) 809-8714	3	11	8	0	0		
	2	Evergreen	New Haven	George St	Pamela Allen	(203) 809-8714	7	14	7	0	0		
	2	REHMA	New Haven	Gibbs Rec Hs			1	5	4	0	0		
	2	Stepping Stn	Meriden	168 Mt Pleasant	Sue Holly	(860) 538-8582	3	5	2	0	0		
	2	Stepping Stn	Merdien	Bunker Ave	Sue Holly	(860) 538-8582	1	5	4	0	0		
	2	Stepping Stn	Meriden	164 Mt Pleasant	Sue Holly	(860) 538-8582	4	5	1	0	0		
	2	Stepping Stn	Meriden	163 Mt Pleasant	Sue Holly	(860) 538-8582	1	5	4	0	0		
	3	Bethsaida	Norwich	Katie Blair Hse	Danielle Farrell	(860) 886-7511X204	3	3	0	0	0		
	3	Hope	Groton	Comm of Hope					1	0	0	No	
	3	Safe Hse	Willimantic	Safe Hs	Heather Meehan	(860) 456-7610X20			11	0	0	No	
	3	SCADD	Norwich	Washington St	Patrice Thomas	(860) 859-9702	-5	10	13	2	0		
	3	Shift	Mansfield	Stearns Rd	Eileen Hamon	(860) 208-4999		7				No	7
	3	Shift	Willimantic	Church St	Eileen Hamon	(860) 208-4999	6	6	0	0	0		
	3	Shift	Willimantic	Prospect St	Eileen Hamon	(860) 208-4999	7	7	0	0	0		
	4	Coram	New Britain	Kimball St	Jody Davis	(860) 348-3486	1	5	4	0	0		
	4	Coram	New Britain	Walsh St	Jody Davis	(860) 348-3486	4	5	1	0	0		
	4	Coram	New Britain	Addison's Hse	Jody Davis	(860) 348-3486			3	0	0	No	
	4	My Sister's	Hartford	Pliny St	Kathleen Shaw	(860) 549-1634	4	10	6	0	0		
	4	Sober Sol	Waterbury	187-189 Wolcott Stre	David Ruth	(860) 533-9500	48	50	2	0	0		
	4	Sober Sol	East Hartford	80 Central Ave	David Ruth	(860) 533-9500	55	58	3	0	0		
	4	Sober Sol	East Hartford	42 Bissell St	David Ruth	(860) 533-9500	2	4	2	0	0		
	4	Sober Sol	Enfield	101-103 Prospect Str	David Ruth	(860) 533-9500	49	50	1	0	0		
	4	Sober Sol	Enfield	12 Pleasant Street	David Ruth	(860) 533-9500	47	50	3	0	0		
	4	Sober Sol	East Hartford	107 Ellington Rd	David Ruth	(860) 533-9500	5	6	1	0	0		
	4	Sober Sol	East Hartford	Bigelow St	David Ruth	(860) 533-9500	-1	5	6	0	0		
	4	Sober Sol	Manchester	West St	David Ruth	(860) 533-9500	2	7	5	0	0		
	4	Sober Sol	East Hartford	9-11 Burnside	David Ruth	(860) 533-9500	0	8	8	0	0		
	4	Sober Sol	Manchester	Cooper St	David Ruth	(860) 533-9500	-2	5	7	0	0		
	4	Sober Sol	East Hartford	444 Burnside	David Ruth	(860) 533-9500	4	5	1	0	0		
	4	Sober Sol	East Hartford	152 Ellington Rd	David Ruth	(860) 533-9500	5	6	1	0	0		
	4	Thom Morrow	Manchester	49 Birch St	Sue Morrow	(860) 783-8833		7				No	7
	4	Thom Morrow	Manchester	59 Birch St	Sue Morrow	(860) 783-8833		7				No	7
	5	ER Prop	Waterbury	47 Irion St	Val Collins	(203) 346-8087	0	5	5	0	0		
	5	ER Prop	Waterbury	35 Webb St	Val Collins	(203) 346-8087	13	15	2	0	0		
	5	ER Prop	Waterbury	Taylor St	Val Collins	(203) 346-8087		5				No	5
	5	ER Prop	Waterbury	103 Walnut St	Val Collins	(203) 346-8087	1	5	4	0	0		
	5	MCCA	Danbury	Sobering Center	Peter Pizzillo	(203) 730-9947	3	16	13	0	0		
							271	**427**	**145**				**26**

LOC	Reg	Agency	Town	Location	Name	Phone	Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
Detox - 4.2													
	2	CVH	Middletown	Detox	Joann Chatfield	(800) 828-3396 x 5	0	20	20	0	0		
	4	Blue Hills	Hartford	Detox	Pat O'Brien	(860) 293-6415	0	21	21	0	0		
							0	**41**	**41**				
Detox - 3.7													
	1	RNP	Bridgeport	Detox	Sara Smith	(203) 333-3518		19				No	19
	2	Cornell Sctt	New Haven	SCRC	Ben Metcalf	(203) 503-3300	3	26	25	2	4		
	2	Rushford	Middletown	Resid Detox	Tara Murphy	1-877-577-3233		16				No	16
	3	SCADD	New London	Resid Detox	Admiting Nurse	(860) 447-1717	0	20	19	4	3		
	3	Stonington	North Stoning	Resid Detox	Andrea Keeney	(860) 445-3000		20				No	20
	4	ADRC	Hartford	Resid Detox	Admitting Nurse	(860) 714-3700	5	35	30	6	6		
	5	MCCA	Danbury	Resid Detox	Ana Carvalho	(203) 792-4515X123		12				No	12
							8	**148**	**74**				**67**
Intensive Res													
	1	CASA	Bridgeport	Intensive	Kremlin DeVissiere	(203) 339-4112	0	10	9	1	0		
	1	RNP	Bridgeport	Horizon	Sara Smith	(203) 333-3518		15				No	15
	2	CVH	Middletown	Intens (Men)	Joann Chatfield	(800) 828-3396 x 5	0	60	60	0	0		
	2	CVH	Middletown	Intens (Women)	Joann Chatfield	(800) 828-3396 x 5	1	30	29	0	0		
	2	Rushford	Middletown	Intensive	Tara Murphy	1-877-577-3233		42				No	42
	3	CPAS	Putnam	Milestone	Michelle Blevin	(860) 928-1860	1	16	15	0	0		
	4	ADRC	Hartford	SATEP ADRC	E. Navarro	(860) 714-3739	4	28	23	2	1		
	4	Blue Hills	Hartford	Intensive	Pat O'Brien	(860) 293-6415	0	21	21	0	0		
	4	Farrell	New Britain	Intensive	Ester Bryant	(860) 225-4641	2	24	21	2	1		
	5	MCCA	Danbury	McDonough	Maureen Gorman	(203)792-4515		22				No	22
	5	McCall	Torrington	Carnes Wks	Tracy Donahue	(860) 496-2107		20				No	20
							8	**288**	**178**				**99**
Intens Res Co-Occ													
	1	RNP	Bridgeport	New Prospects	Sara Smith	(203) 333-3518		23				No	23
	5	CT Ren	Waterbury	McAuliffe Center	Steven Lockley	203-346-1931	5	20	15	0	0		
							5	**43**	**15**				**23**
LTT Preg ♀													
	1	Liberation	Stamford	Fam In Recov	Maggie Young	(203) 352-1800		10				No	10
	2	Connection	New Haven	Elm's City Women's	Sondra Horne	(203) 752-9109		15				No	15
	2	Connection	Groton	Mother's Retreat	Sherrie Weaver	(860) 405-2107x108	0	8	8	0	0		
	2	Connection	Middletown	Halle House	Michelle Giardina	(860) 343-5513	0	8	8	0	0		
	2	Crossroad	New Haven	Amethyst House	Meryl Boyarsky	203-387-0094x198	6	15	8	1	0		
	3	CPAS	Putnam	New Life Res	Michelle Blevin	(860) 928-1860	2	8	6	0	0		
	4	ADRC	Hartford	Coventry House	E. Navarro	(860) 714-3739		10				No	10
	5	Morris	Waterbury	Preg/Parenting ♀	Joan Hoskins	(203) 575-0117	3	8	5	0	0		
							11	**82**	**35**				**35**

LOC	Reg	Agency	Town	Location	Name	Phone	Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
LTT													
	1	APT	Bridgeport	Residential Serv	Dan lead	(203)337-9943		124				No	124
	1	Liberation	Stamford	Liberation House	Maggie Young	203-391-7947		73				No	73
	2	Crossroad	New Haven	Men's Unit	Dr. Carl Williams	203-387-0094x150	70	133	61	2	0		
	2	Rushford	Middletown	Residential LT Treatr	Tara Murphy	1-877-577-3233		26				No	26
	3	CPAS	Willimantic	T. Murphy	Terrence G. Smith	(860) 456-1769	2	14	11	1	0		
	3	Perceptions	Willimantic	Perception House	Jodi Noel	(860) 450-7130	1	20	18	1	0		
	3	SCADD	Lebanon	Lebanon Pines	Deborah Mirsky	(860)447-1717x209	3	110	104	3	0		
	4	Centro	Hartford	Women's Unit	Anna Alvarez	(860) 951-7006		15				No	15
	4	Centro	Hartford	Men's Unit	Eliezer Rodriquez	(860) 232-7353		15				No	15
	4	Youth Chall	Hartford	Men's Unit	Ronald Mason	(860) 528-5199	3	15	12	0	0		
	5	CNV Help	Waterbury	LTT	Erica Turnour	(203) 756-8984x108		34				No	34
	5	CT Ren	Waterbury	Renaissance East	Carol Pace	203-753-2341	2	32	28	2	0		
							81	**611**	**234**				**287**
LT Care													
	5	MCCA	Sharon	Trinity Glen	Lynn Muzzulin	(860) 672-6689	6	50	44	0	0		
							6	**50**	**44**				
Halfway Hs													
	1	CASA	Bridgeport	CASA Half/Way	Kremlin DeVissiere	(203) 339-4112	0	6	4	2	0		
	2	Connection	Middletown	167 LibertySt	Patrick Fallon Patrick	(860) 343-5512		14				No	14
	3	SCADD	Norwich	313 Main St Men	Jarrod Viens	(860) 889-3414	4	13	9	0	0		
	3	SCADD	New London	1000 BankSt Womer	Angela Massiello	(860) 447-8021	0	10	10	0	0		
	3	SCADD	New London	62 Coit St Women	Marilyn Glover	(860) 447-1017	0	11	11	0	0		
	4	ADRC	Hartford	SATEP Intermed	E. Navarro	(860) 714-3739	0	10	10	0	0		
	4	ADRC	Glastonbury	Clayton House	E. Navarro	(860) 714-3739		15				No	15
	5	McCall	Torrington	Intermed Res	Melissa Gray	(860) 496-2105	4	18	14	0	0		
							8	**97**	**58**				**29**
Recov Hs													
	1	CASA	Bridgeport	Recovery House	Carmen Santiago	(203) 336-4745	2	10	8	2	2		
	2	Columbus	New Haven	Recovery House	Mahasa Crudup	(203) 772-2658		10				No	10
	2	Connection	New Haven	Recovery House	Rejeanne Toussaint	(203) 946-3081	0	20	20	0	0		
	3	CPAS	Willimantic	Oak St.	Terrence G. Smith	(860) 456-1769	5	10	5	0	0		
	4	ADRC	Hartford	Recovery House	William Young	(860) 714-3705		10				No	10
	4	ADRC	Hartford	GA Recovery House	William Young	(860) 714-3705	0	20	19	1	0		
	4	Mercy	Hartford	Mercy's Recovery Ho	Tenesha Grant	(860) 808-2114		8				No	8
	5	Morris	Waterbury	Therapeutic Shelter	Cindy Salmoirgahi	(203) 574-1419	15	21	6	0	0		
							22	**109**	**58**				**28**
Special Hsg													
	4	ADRC	Hartford	SATEP Male Hsg	John Morelli	(860) 714-3702	0	6	6	0	0		
	4	Mercy	Hartford	SATEP Women's AL	Eileen McKeever	(860) 808-2121	1	15	14	0	0		
							1	**21**	**20**				

LOC	Reg	Agency	Town	Location	Name	Phone	Slots	DDAP Cap	Census	Admiss	D/C	Rpt?	No Data
Supp Rec Hsg													
	1	Miracle Hse	Bridgeport	Miracle House	Deborah Green	(203) 335-1306	3	5	2	0	0		
	1	Stam Shelter	Stamford	597 Pacific St	Jonathon Wells	(203) 348-3792			1	0	0	No	
	2	Believe in Me	New Haven	423 Dixwell Ave	James Walker	(203) 772-2771	-3	5	8	0	0		
	2	Evergreen	New Haven	Winthrop Ave	Pamela Allen	(203) 809-8714	4	11	7	0	0		
	2	Evergreen	New Haven	George St	Pamela Allen	(203) 809-8714	14	14	0	0	0		
	2	REHMA	New Haven	Gibbs Rec Hs			1	5	4	0	0		
	2	Stepping Stn	Meriden	168 Mt Pleasant	Sue Holly	(860) 538-8582	3	5	2	0	0		
	2	Stepping Stn	Merdien	Bunker Ave	Sue Holly	(860) 538-8582	3	5	2	0	0		
	2	Stepping Stn	Meriden	164 Mt Pleasant	Sue Holly	(860) 538-8582	3	5	2	0	0		
	2	Stepping Stn	Meriden	163 Mt Pleasant	Sue Holly	(860) 538-8582	2	5	3	0	0		
	3	Bethsaida	Norwich	Katie Blair Hse	Danielle Farrell	(860) 886-7511X204	3	3	0	0	0		
	3	Hope	Groton	Comm of Hope					0	0	0	No	
	3	Safe Hse	Willimantic	Safe Hs	Heather Meehan	(860) 456-7610X20			9	0	0	No	
	3	SCADD	Norwich	Washington St	Patrice Thomas	(860) 859-9702	-3	10	13	1	1		
	3	Shift	Mansfield	Stearns Rd	Eileen Hamon	(860) 208-4999		7				No	7
	3	Shift	Willimantic	Church St	Eileen Hamon	(860) 208-4999	6	6	0	0	0		
	3	Shift	Willimantic	Prospect St	Eileen Hamon	(860) 208-4999	7	7	0	0	0		
	4	Coram	New Britain	Kimball St	Jody Davis	(860) 348-3486	5	5	0	0	0		
	4	Coram	New Britain	Walsh St	Jody Davis	(860) 348-3486	5	5	0	0	0		
	4	Coram	New Britain	Addison's Hse	Jody Davis	(860) 348-3486			0	0	0	No	
	4	My Sister's	Hartford	Pliny St	Kathleen Shaw	(860) 549-1634	10	10	0	0	0		
	4	Sober Sol	Waterbury	187-189 Wolcott Stre	David Ruth	(860) 533-9500	48	50	2	0	0		
	4	Sober Sol	East Hartford	80 Central Ave	David Ruth	(860) 533-9500	58	58	0	0	0		
	4	Sober Sol	East Hartford	42 Bissell St	David Ruth	(860) 533-9500	4	4	0	0	0		
	4	Sober Sol	Enfield	101-103 Prospect Str	David Ruth	(860) 533-9500	48	50	2	0	0		
	4	Sober Sol	Enfield	12 Pleasant Street	David Ruth	(860) 533-9500	47	50	3	0	0		
	4	Sober Sol	East Hartford	107 Ellington Rd	David Ruth	(860) 533-9500	4	6	2	0	0		
	4	Sober Sol	East Hartford	Bigelow St	David Ruth	(860) 533-9500	0	5	5	0	0		
	4	Sober Sol	Manchester	West St	David Ruth	(860) 533-9500	0	7	7	0	0		
	4	Sober Sol	East Hartford	9-11 Burnside	David Ruth	(860) 533-9500	2	8	6	0	0		
	4	Sober Sol	Manchester	Cooper St	David Ruth	(860) 533-9500	-1	5	6	0	0		
	4	Sober Sol	East Hartford	444 Burnside	David Ruth	(860) 533-9500	5	5	0	0	0		
	4	Sober Sol	East Hartford	152 Ellington Rd	David Ruth	(860) 533-9500	5	6	1	0	0		
	4	Thom Morrow	Manchester	49 Birch St	Sue Morrow	(860) 783-8833		7				No	7
	4	Thom Morrow	Manchester	59 Birch St	Sue Morrow	(860) 783-8833		7				No	7
	5	ER Prop	Waterbury	47 Irion St	Val Collins	(203) 346-8087	1	5	4	0	0		
	5	ER Prop	Waterbury	35 Webb St	Val Collins	(203) 346-8087	13	15	2	0	0		
	5	ER Prop	Waterbury	Taylor St	Val Collins	(203) 346-8087		5				No	5
	5	ER Prop	Waterbury	103 Walnut St	Val Collins	(203) 346-8087	2	5	3	0	0		
	5	MCCA	Danbury	Sobering Center	Peter Pizzillo	(203) 730-9947	1	16	15	0	0		
							300	**427**	**111**				**26**

CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES



2012 REPORT ON STATEWIDE PRIORITY SERVICES

July 15, 2013

Introduction

Once every two years, the Department of Mental Health and Addiction Services (DMHAS) conducts a priority setting process that is meant to engage and draw upon the existing and extensive planning, advisory, and advocacy structures across the state. Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs) form the basis of the regional priority setting process, facilitating grassroots input and independent viewpoints. In this role, the RMHBs and RACs promote interaction across a broad spectrum of stakeholders to:

- Determine unmet behavioral health needs and identify emerging issues
- Gain broad stakeholder input on service priorities, needs and solutions
- Foster ongoing dialogue regarding identified unmet needs in the regions

The 2012 Priority Setting Process is the sixth since the initiation of this coordinated planning process in 2002. In the intervening years (odd numbered years), RMHBs and RACs provide "updates" informing DMHAS of progress made in addressing the identified unmet needs in their regions and alerting the department to any emerging issues. In conducting these regional assessments, the RMHBs and RACs utilize DMHAS service data, local needs assessments, and other planning documents to reach the conclusions found in their regional priority reports. Through various assessment methods, RMHBs and RACs collect information on: 1) root causes of identified problems and unmet needs; 2) solutions and resources that may be required, including those which may be low or no cost; 3) gaps and barriers to implementing proposed solutions; and 4) needed cross-system collaborations.

The purpose of the 2012 Priority Setting Process was to produce one integrated, relevant planning document that would inform the development of Connecticut's Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant applications, assist in the department's development of a biennial (state fiscal years 2014 and 2015) budget, and reduce duplication of effort across RMHBs and RACs. Each region presented its findings to DMHAS staff and developed individual regional priority reports. In developing the *2012 Statewide Priority Service Report* (Priority Report), DMHAS reviewed all regional surveys and reports. As such the Priority Report is a reflection of common themes found across regions.

The Statewide Priority Report, which follows, is shared and discussed with the Adult Behavioral Health Planning Council, the Mental Health and Addiction Services State Board and the Commissioner's Executive Group. Individual Regional priority reports can be found on the DMHAS website at:
http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=451050

The 2012 Priority Report is a summary of results from each regional report and is based upon the following assessment activities:

Treatment Provider Survey: Web-based survey administered to all DMHAS-operated and funded entities. Only one survey per provider agency was allowed and there was a 75% response rate statewide. Most of those provider agencies not responding were single service (e.g., housing) or smaller provider agencies. This was the third time the provider questionnaire was administered and the second time using the web-based application Survey Monkey. The questionnaire contained three sections: 1) perceived service availability from a list of clinical and support services; 2) a list of barriers that hinder access to or continuation of services; and 3) wait times for clinical services. Additionally, respondents could enter comments in the service availability and barriers sections. The survey had separate sections for mental health and addiction services.

Prevention Community Readiness Survey (CRS): In 2012, the CRS was administered for the third time and was targeted towards the needs of community prevention services. The survey was emailed to a wide range of prevention professionals and other stakeholders in all RAC communities and included a number of questions on perceived needs and resources in local communities.

Qualitative Methods: These consisted of focus groups held regionally by the RMHBs and RACs with key informants including consumers, family members, providers and referral organizations (such as town social workers, police, etc.). In some regions, the focus groups were held with targeted stakeholders such as young adults. Also RMHBs drew from their ongoing service assessments such as program evaluations and Catchment Area Council feedback. RACs drew upon their longstanding relationships with schools, law enforcement, human services organizations and other community stakeholders for their service assessments. Some regions conducted personal interviews with select stakeholders to better understand identified needs.

Additionally, the Priority Report includes findings from three focus groups held with community general hospital emergency department (ED) staff. The focus groups were conducted as part of the Office of Health Care Access (OHCA) Facility Plan process and were jointly facilitated by the Acute Care and Behavioral Health Subcommittees. The complete focus group findings and recommendations can be found at http://www.ct.gov/dph/lib/dph/ohca/publications/2012/ohcastatewide_facilities_and_services.pdf

Other: Local sources of need identification including the United Way assessments, municipal strategic planning projects and other planning activities were incorporated, where relevant, to the DMHAS population by the RACs and RMHBs.

In 2012, DMHAS contracted with the University of Connecticut Health Center (UCHC) to support regional priority setting efforts particularly as related to standardizing the focus group process. A set of suggested focus group questions and probes were developed with the assistance of RMHB and RAC representatives. A UCHC qualitative research associate provided support to the RMHBs/RACs as needed and attended most focus group sessions. Nonetheless, there were variations in how each region chose to conduct its qualitative assessment.

Mental Health Services

Availability – Provider Responses

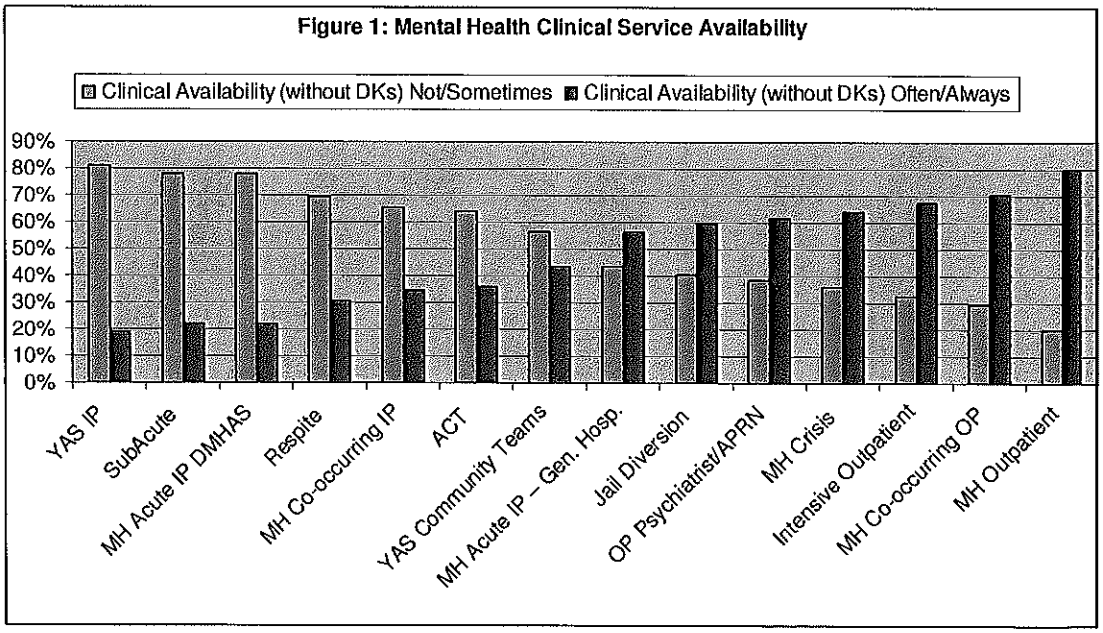
Mental health service providers were asked to rate the availability of clinical and support services based on their experience with clients they served directly in their agency and/or referred outside their agency. Response categories included "not available", "sometimes available", "often available" and "always available". Respondents were instructed to answer "don't know" if they were not familiar with the service. A total of 94 DMHAS funded (community-based, private nonprofits) and operated provider agencies responded to some or all questions, of which 89 stated they either provided both (N=68) mental health and substance use services or mental health only (N=21). Only one questionnaire per provider agency was allowed except in the instance that a provider delivered services in more than one DMHAS region. In that case, they were asked to complete one survey for each region based only upon the services delivered in each of the regions.

Services found to have limited availability (not available or sometimes available) for mental health clinical services included the following:

- Young Adult Services (YAS) inpatient
- Subacute Inpatient
- Acute Inpatient (DMHAS Operated)
- 24-hour Respite
- Co-occurring Residential
- Assertive Community Treatment
- Young Adult Services (YAS) Community Teams
- Acute Inpatient – Community General Hospital

All of the above clinical services having limited availability had more than 50% of providers rate the service as **not available or sometimes available**.

Figure 1 below displays responses for the fourteen mental health clinical service types included in the questionnaire. It should be noted that the analysis was based upon responses **excluding** "don't knows" (DKs). DKs ranged from a low of 3% for Outpatient to a high of 39% for YAS Community Teams. Not all agencies either provided certain services or referred clients to them and therefore did not have an informed perspective. Provider survey results with and without DKs can be found in **Appendix A** of this report. Outpatient services, including co-occurring, intensive, and standard, received the highest ratings of availability, along with crisis services, medication management, and jail diversion.

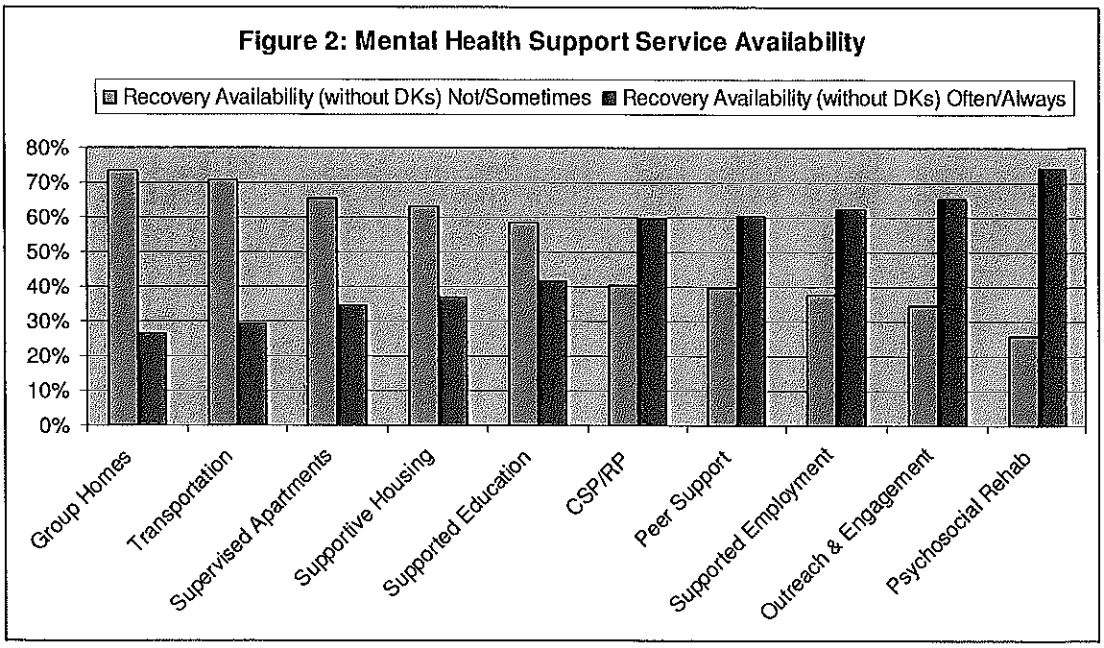


Providers were also asked to rate the availability of mental health **support services**, i.e., services that assist persons in their recovery and promote a life in the community. More than 50% of provider respondents rated the following support services as having limited availability:

- Group Homes (licensed)
- Transportation Services
- Supervised Apartments
- Supportive Housing
- Supported Education

The top four support services having the least perceived availability are related to housing and transportation; two areas that have been rated consistently as being priority unmet needs in past assessments. "Don't know" responses for the above services with limited availability ranged from 6.1% to 15.3% - somewhat lower than for mental health clinical services.

Figure 2 below displays **all ten** support services included in the provider survey questionnaire. Again, this analysis excluded DKs ranging from 5% - 19%. As the proportion of DKs was lower for recovery vs. clinical services, it would appear that provider respondents have greater interaction with the DMHAS recovery system. Support services rated as "always" or "often" available include case management/CSP, peer support, supported employment, outreach & engagement, and psychosocial rehabilitation.



Qualitative Findings

Summary of Focus Groups

For 2012, the RMHBs selected key areas of importance to guide their local needs assessments. These included: 1) **age-appropriate services for young people** who are newly diagnosed (who are not eligible for DMHAS' Young Adult Services programs) and **older adults**; 2) **integration of medical care** and medical issues for DMHAS clients with a serious mental illness; and 3) **access to care** relating to gaps and barriers at several specific entry/discharge point including Inpatient, EDs, Incarceration, and Shelters.

Age-Appropriate Services – Young Adults:

Availability of services for this population was reported by all regions as limited. For instance, the Eastern Region noted a "severe need" for residential services and in the South Central Region, specific mental health and recovery services such as vocational supports, supported education services, mobile crisis, respite and inpatient care were described as lacking. In the South West Region, the primary need identified was for age-appropriate young adult (including college students) recovery services. In several regions (South Central, North West and Eastern), young adults and providers reported a lack of available individual group therapy for this age group.

Repeatedly, young adults and their family members, along with service providers, stated that this population has difficultly connecting with or may be uncomfortable socializing and interacting with older (and sometimes more symptomatic) adults. Thus, young adults are often reluctant to connect with recovery programs and social clubs which they perceive as not geared for them. This adds to the difficultly of engaging this age group in

care. Several participants noted that many young adults are mostly interested in vocational and educational supports. But many programs won't address these needs if the individual is not in treatment. However, engaging youth first in something that interests them (such as vocational services) can be a means to encourage them to seek treatment. Furthermore, young adults emphasized the need for work skills training as well as volunteer experiences that would add to their resumes.

It was reported that this population often lacks resources for independent living, such as income, entitlements, and housing. In three regions, Eastern, North Central and South Central, the need for basic life skills training for young adults, such as maintaining a living space, money management, vocational skills, utilizing public transportation and social skill development, was identified as a need.

The second greatest barrier faced by young adults is housing and homelessness, as identified by the same three regions. South Central identified housing as "often or always" a barrier for young adults. The North Central Region found through surveys and focus groups that housing is the primary service need for young adults living with mental illness. Landlords are reportedly wary of renting to young adults due to lack of a credit history and their age. In addition, in the South Central and North Central Regions, housing authority staff discussed the need for increased communication with Local Mental Health Authorities (LMHAs) and housing staff regarding young adult residents who may decompensate or lack independent living skills. Housing Authorities are interested in collaborating to assist this population but are often met with barriers due to state and federal confidentiality requirements.

Providers in the Eastern and South Central Regions were concerned with the increasing numbers of homeless young adults with behavioral health needs. Both of these regions reported that many young adults (not served by YAS programs) are not connected with any [DMHAS] services and are homeless, "couch surfing" or staying with friends because they do not have a home. Both regions felt that increased homelessness outreach is needed to identify and connect with these young adults.

Age-Appropriate Services – Older Adults:

The specific barriers to care and recovery faced by the elderly/older adult behavioral health client arose as a secondary theme in several focus groups throughout the state. In addition, the North Central Region explored this subject in greater depth through a focus group dedicated to the topic by providers, family members, and consumers.

Across regions, providers reported an increasing number of older adults (over 60) in treatment, many with complicated medical co-morbidities. This creates additional challenges for agencies to manage these increasingly complex medical needs. Age-appropriate services for the elderly are reported to be very limited, including socialization, substance use treatment, geriatric psychiatry, and in-home care. In the North Central Region, participants report that there is a three-month waiting list for an appointment with a geriatric psychiatrist. Behavioral health services in general are not

specialized for older adults. There are few professionals trained in geriatric psychiatry and few geriatric inpatient units. Furthermore, focus group participants identified the need for skilled "geri-psych" nurses and case managers in emergency rooms along with appropriately trained mental health clinicians and home care professionals. Late onset alcoholism due to isolation and addiction from misuse of prescription and pain medication were raised as concerns as well.

Many older adults do not have family supports for daily living and service coordination. In addition, it was found that many older adults remain socially isolated and that there is "not enough" outreach by the behavioral health system to this population. Senior Centers and Adult Day Care Centers are often not welcoming to clients with severe and persistent mental illness and/or individuals with complex medical problems. In fact, senior center staff may not be adequately equipped to serve this population. At the same time, it is reportedly a challenge for psychosocial clubs to manage some of these elderly clients, leaving them without options for socialization. Focus group participants also reported transportation and "stigma" [and discrimination] as barriers for the older adult client in need of behavioral health services.

According to focus group participants in the North Central Region, older adults with behavioral health problems risk homelessness, home insecurity, and poverty due to a shortage of affordable housing with appropriate supports such as assisted living and services to maintain people in their homes and communities.

Accessing Services

Difficulty **navigating and understanding the behavioral health system** was an overwhelmingly consistent theme in focus groups across all regions. Providers, families and consumers alike voiced frustration with changes in service and resource availability. One provider in the North West Region stated that, "staying on top of the changes is a full-time job." Both inpatient and outpatient mental health and addiction services were reported to be confusing, cumbersome and uncoordinated by providers, consumers and family members.

Issues with "211" (United Way Infoline) referrals came up frequently in focus groups – some participants stated that they can never get through to an operator due to busy signals and long hold times. Others stated that they will call every agency referred to by 211 and none will be accepting new clients or they will have very long waitlists. In addition, different eligibility and other requirements among providers can be confusing for some. Determining entry points for the behavioral health system was frequently cited as challenging. The emergency department (ED) has become the primary entry point for many, leading to long and unnecessary wait times. In addition, ED focus group participants stated that trying to navigate the system for clients is time consuming and contributes to back-ups in ED waiting rooms. Participants explained that crisis clinicians in EDs get "really bogged down" with finding services and resources in the community and helping patients to access appointment. One ED physician stated that crisis clinicians spend half of their time doing this type of case management, which is an unreimbursed

service. An ED physician in the South Central Region stated, "I don't know how to get people into the system in some coordinated fashion."

Referral organizations such as town social service workers were also frustrated by constant changes in the system and the lack of coordination and communication within the system. Town social service workers, police officers, firemen, church groups and others reported the most difficulty with helping individuals navigate the system. It became clear throughout the qualitative process that many people in the community do not know how to find their way through the system or become incredibly frustrated at the difficulties they encounter in trying to access services. Some town social service staff felt they "used to know the system", then people or processes changed at an agency and they lost their connection.

Inpatient Care

Focus group participants in every region throughout the state identified **problems with accessing inpatient treatment** for behavioral health, including long-term, short-term and sub-acute. Providers from the community and ED voiced frustration with accessing inpatient psychiatric beds. They noted a lack of consistency regarding what inpatient services are available and difficulty determining how to access them. Overall, a trend towards shorter inpatient stays in community (general hospitals) inpatient beds was noted, with an average stay of a week or less. Furthermore, a **shortage of respite beds** throughout the state was a common theme in every region. Participants identified both of these shortages as leading to re-hospitalizations and inappropriate ED visits. The shorter lengths of stay in acute community general hospital inpatient settings was compounding problems especially when patients were unable to access outpatient services quickly after discharge. Given the trend to shorter lengths of stay for inpatient hospitalization, the lack of prompt access to outpatient and prescriber services impedes the chances for recovery and may result in re-hospitalization. In one region it was stated that all too often people are sent home from an inpatient psychiatric hospitalization without a treatment or coordination of care plan increasing the likelihood of readmission.

Outpatient Care

Consistently, **waiting for outpatient behavioral health services** was raised as a major barrier to care and recovery. Wait times for an initial assessment at an outpatient clinic varied across regions but ranged from two to six weeks (average wait time as reported in the Provider Survey was 13 days) as reported in the North West Region. In the South Central Region, participants noted that there is a 30-day wait for an initial assessment and then patients routinely wait 6 – 8 weeks for a medication appointment. In the Hartford area, participants described new intake policies requiring an orientation as a major barrier to care. They described an elaborate intake process which some outpatient clinics require including a multiple day "orientation" before receiving an initial assessment. In the New Haven Region, participants stated that wait times are also a major barrier, but outpatient clinics are "doing the best they can."

In some regions, focus groups spoke about how wait times impact patients leaving an inpatient unit or inmates released from Corrections: "when coming out of the hospital they need everything at once and need it really fast...the system is not friendly to new entrants." This results in a cycle in which a patient released from an inpatient setting or a behavioral health ED admission cycles back into the hospital or the ED as there are no supports while waiting for outpatient treatment. The long wait times for medication and outpatient health care services is concerning as "timely client engagement" is important for successful recovery.

The need for **"bridge" or interim care** for patients after a hospital or ED discharge while waiting to begin outpatient treatment was a major theme of focus groups throughout the state. Shelter and ED staff as well as inpatient providers reported that some inpatient psychiatrists and ED physicians will continue to prescribe for patients for several weeks after discharge until they are connected with an outpatient provider. The need for coordinated care, medication management, and some type of peer supports during the interim period was cited often as a critically needed service.

The North Central Region specifically addressed, in one focus group, the problems facing individuals leaving incarceration. In addition, this topic arose naturally in focus groups in all regions, including two ED focus groups. Overall, participants agree that the DMHAS Jail Diversion program is working very well and that communication between the Department of Correction (DOC), DMHAS and the Courts is strong. Two regions, Eastern and South Central, did not report any problems with Jail Diversion programs or with unplanned jail releases; however, South Central did report a need for more resources for those services.

Release of individuals from prison/jail without entitlements and referrals has improved somewhat but continues to be an issue, particularly with unexpected and unplanned releases. In several focus groups, participants noted that prisoners are frequently released from court without any medications, prescriptions or entitlements. In addition, prisoners are reportedly released with nothing "except the clothes on their back". As these releases are unexpected and unplanned, very often the released inmate does not have the necessary documents needed to obtain entitlements. It was noted in one group that DOC jails and prisons do not have voicemail systems, which can complicate pre-release planning and community referrals.

At the Bridgeport ED, focus group participants stated that released prisoners are dropped off "several times a month" in the ED by prison staff, as they have nowhere else to go to obtain medications and entitlements. Individuals may remain in the ED for several days while entitlements are secured and are then often admitted to the hospital for behavioral health treatment. This situation was identified by most regions with key informants reporting that correctional inmates are being released from prison (or directly from court) without medications or a referral to community services. In a focus group in Hartford, participants reported the same issues and described how re-entry individuals end up in shelters for long periods of time because they have no services. While providers admit that this group is a small part of the population, it remains a difficult problem needing to

be addressed. In the North West Region, it was noted that coordination of services for inmate releases from Garner Prison has improved. In the South West Region, participants reported difficulties for ex-offenders to access some recovery services. Other issues facing the re-entry population include limited housing and work options for individuals with histories of fire setting, assault or sexual offenses.

Integration of Medical Care and Behavioral Health

Another priority area identified by the RMHB was the "integration of medical care and medical issues for adults with serious mental illness." Specific questions explored within this topic included:

- How well is primary care and behavioral health integrated for DMHAS clients?
- What is the role of Federal Qualified Health Centers (FQHCs) in the delivery of behavioral health care?
- How well are FQHCs collaborating with behavioral health providers?
- What is the capacity of the current mental health and addiction services system to address the increasingly complex medical co-morbidities of an aging DMHAS population?

The North Central Region conducted two focus groups on the topic of older adults with medical concerns which addressed some of the questions above. In the remaining regions, these issues were discussed as general comments raised within focus groups.

Overall, focus group participants were concerned that DMHAS clients are aging and have higher rates of co-morbid medical issues than the general population. In addition, community providers reported increasingly complicated medical issues among the behavioral health population. This has placed a strain on resources and provider staff. Many programs, particularly residential programs and shelters, are not currently equipped to manage these medically compromised clients. One shelter director in the greater Hartford area reports that she has to turn away referrals weekly as she cannot safely serve those with complicated medical problems.

There were differing opinions amongst providers regarding the quality and effectiveness of integrated medical and behavioral health care. In the South West Region, in order to obtain behavioral health services at a FQHC, it is required that patients also obtain their health care there, promoting integrated behavioral health and medical care. According to their regional report, "coordinated efforts have ensured that consumers' mental health and physical health needs are being met, which in turn improves their overall health." In the Hartford area, some providers felt that persons recently discharged from inpatient hospitalization and DOC inmate re-entry populations had difficultly in receiving primary care due to lack of entitlements which creates a barrier to obtaining needed medications.

Two regions, the North West and East, reported problems with access to primary care and specialists. In the North West Region, it was reported that the newly opened FQHC is closed to behavioral health patients, creating a barrier to accessing integrated medical and

behavioral health care. This region also reports that EDs are frequently utilized to access primary care by the behavioral health population. In the Eastern Region, there is concern that access to medical care has worsened, reportedly due to local physicians refusing to accept new Medicare patients; however, access to the FQHC is very good. Despite the concern about access, providers in the Eastern Region reported that "community collaborations have helped make new in-roads and partnerships among community organizations [which] has helped to better align primary care and mental health services."

In several regions, there were some concerns raised in terms of how well FQHCs are collaborating with the behavioral health system. A common policy of most FQHCs is a medical screening or physical prior to obtaining behavioral health care services. This can delay a patient from receiving psychiatric medications by several weeks. Another concern is the low tolerance these clinics have for patient noncompliance. Issues such as missed appointments or substance use can lead to discharge from treatment, leaving these individuals without care. Coordination between primary and behavioral health care was one of the top five barriers identified in the 2012 DMHAS Provider Survey as hindering access to or continuing mental health care. For these reasons, it would appear that this identified need area would benefit from further exploration and discussion.

Three regions mentioned access or quality of dental care in their reports (North West, Eastern and South West). Overall, these regions report that access to dental care for individuals on entitlements is poor and that there are long waiting lists for dental appointments. In the Eastern Region, the only non-profit dental clinic, which is located in the southeastern area of the region, has a waiting list of a year and individuals have reported difficulty getting emergency dental appointments. In the North West, many focus group participants stated that they did not feel their dental care needs were adequately met, while in the South West, one provider indicated that the majority of consumers over 40 have dentures due partly to a lack of preventative dental care. Routinely, entitled clients must wait for a dental emergency before being able to receive care, necessitating an emergency extraction rather than tooth preservation.

Barriers

The provider survey included a section on barriers to services that hinder getting or continuing services. These 18 barriers were related to: 1) providers' operational issues (e.g., sufficient staffing, hours of operation, or qualified workforce), 2) service coordination (between mental health and substance abuse, human service or primary care providers), or 3) other service delivery concerns (e.g., client engagement, eligibility criteria, medication side effects).

The top five barriers that hinder receiving or continuing mental health services included:

- Lack of Housing
- Lack of Transportation
- Lack of Adequate Staffing
- Lack of Child Care

- Coordination between Primary and Behavioral Health Care (new to the 2012 survey)

Figure 3 below displays the results of the provider survey vs. the qualitative findings from the regions regarding barriers to mental health services. Both assessments ranked housing, transportation and coordination between primary and behavioral health in the top five. Of note is the barrier raised consistently in all regional qualitative assessments, namely difficulty in navigating services. Care Coordination for inmates return to the community was also one of the top five raised in focus group discussions.

Housing and transportation have been long identified barriers. In both of these areas, DMHAS has limited resources to affect change. While all levels of government have focused efforts at increasing the availability of affordable housing, there exists strong evidence that such housing is still out of the reach of many disadvantaged Connecticut residents. This situation has grown worse by the difficult economic environment of the last four years. Inroads to alleviating gaps in public transportation also have not met with adequate resources or policies that would support better access to the kind of recovery supports (employment, housing, socialization) needed by DMHAS consumers.

Figure 3: Barriers to Mental Health Services

Provider Agencies: Top 5 Service Barriers	**Always or Often a Barrier**		**Focus Groups: Top 5 Service Barriers (not in rank order)**
Lack of Housing	66.0%		Difficulty Navigating System
Lack of Transportation	58.8%		Lack of Housing Options (especially for young adults)
Lack of Adequate Staffing	46.9%		Transportation Services
Lack of Child Care	44.3%		Care Coordination for Inmates Re-entering Community
Coordination between Primary and Behavioral Health Care	43.3%		Coordination between Primary and Behavioral Health Care

Regional Analysis and Variations

As noted, each region was responsible for developing a Regional Priority Report based upon the regional survey findings, personal interviews with key informants, focus groups with consumers, family members and treatment providers, and other local needs assessment information.

DMHAS conducted an analysis of the **regional provider survey findings** to determine similarities and differences from the statewide results. For the most part, as would be expected, regional results mirrored the statewide findings. The following is a brief summary of that analysis. It is highly recommended that the regional reports be read in order to understand the differences in local service system structures that drive the regional priority needs identified.

Mental Health Services and Barriers

Statewide findings mirrored those mental health clinical services found to have limited availability within each region. As Figure 4 shows, only Young Adult Services Community Teams was found to have limited availability in only one of the five regions. Inpatient and residential services were those identified across the majority of regions as insufficient according to providers' responses in the 2012 survey.

Figure 4: Regional Mental Health Clinical Services with Limited Availability

Service	Number of Regions Reporting Limited Availability
Acute Inpatient - DMHAS	5
Young Adult Services Inpatient	5
Respite Care	4
Sub Acute Inpatient	4
Co-occurring Residential	3
Assertive Community Treatment	3
Young Adult Services Community Teams	1

Looking at access to mental health support services (Figure 5), most regions reported housing services (i.e., supervised apartments and supportive housing) and transportation as those recovery supports being limited in availability, similar to past priority setting assessments. Group homes were also found by most regions to be lacking in availability along with supported education and peer-to-peer services. Outreach and engagement, psychosocial rehabilitation and case management (not shown below) were seen as having poor availability in only one region each.

Figure 5: Regional Mental Health Support Services with Limited Availability

Service	Number of Regions Reporting Limited Availability
Group Homes (licensed)	4
Supervised Apartments	4
Transportation	4
Supportive Housing	3
Peer-to-Peer Services	3
Supported Education	3

Turning to barriers (Figure 6) that hinder accessing or continuing mental health services, housing within all regions and transportation in all but one region were seen as the most significant (always or often) barriers. This has been the case in a number of previous priority setting reports, although there have been some gains in housing affordability and availability. Insufficient staffing, i.e., too few staff for service demand, also was a top ranked barrier across the state. The next set of barriers were found in two regions and included long waitlists, lack of child care, payment requirements and, newly added to the 2012 survey, lack of coordination across behavioral health and primary care providers.

Several barriers were particular to only one region such as workforce development, length of stay limitations, and client engagement.

Figure 6: Regional Mental Health Barriers

Barrier	Number of Regions Reporting Limited Availability
Lack of Housing	5
Insufficient Staffing	5
Lack of Transportation	4
Long Wait Lists	2
Lack of Child Care	2
Payment Requirements	2
Coordination between Primary & Behavioral Health Care	2
Workforce Development	1
Length of Stay Limitations	1
Client Engagement	1

Recommendations – Mental Health Services

Service System Access & Navigation

One major area identified by the various stakeholders who contributed to the 2012 Priority Setting Process concerned mental health services access. This was characterized by too few services, a lack of coordination or a fragmented and confusing system. Below are recommendations offered to address some of these service system concerns.

Service Coordination and Enhancements

- Develop opportunities and practices with supported employment providers to share ideas/resources
- Promote collaboration between state agencies, hospitals, community health centers, Local Mental Health Authorities, and ValueOptions to create processes for same day access to outpatient, prescriber, and intensive care management after discharge from inpatient hospitalization
- Open provider meetings quarterly to inform interested stakeholders (e.g., referral agencies) of service changes, issues, and other areas of mutual interest
- Implement routine trainings for referral agencies and first responders on local service systems
- Continue to work with local police *leadership* to build or rebuild support for Crisis Intervention Teams (CITs) in departments that have lagged or lapsed in CIT training and commitment. The goal should be CIT officers on every shift in every town
- Make cooperation and participation across providers and other service systems a contract requirement

Service Expansion

- Identify champions of supportive housing who will advocate to resolving the housing issue
- Increase the number of private and agency-based therapists that accept Medicaid/Medicare coverage for one-on-one counseling sessions- explore best practice models, convene therapists to better understand how this may be accomplished and provide an on-line list of therapists
- Expand Crisis Intervention Team (CIT) services: Offer more CIT-type training to police and other first responders (e.g., EMTs) including the Hearing Voices workshop and consumer presentations
- Increase access to case management services to ensure coordinated wrap around services and/or increase capacity of residential case managers to provide wrap around services
- Expand inter-departmental funded programs between the Department of Correction and DMHAS
- Develop a range of housing, vocational, and case management options for people with varying needs and backgrounds
- Continue to support all forms of housing services
- Increase trauma informed services

Service Navigation

- Create navigator positions to assist persons accessing care – not just a referral but through admission and first appointment
- Actively recruit consumers as engagement specialists and crisis workers, both at Mobile Outreach and in hospital EDs

Services for Priority Populations

It is now well recognized that services tailored to the distinct needs and interests of individuals with a mental illness result in improved service engagement, retention, and outcomes. In 2012, two populations were the focus of the RMHB needs assessment process, namely young (age 18 – 26) and older (age 60+) adults. Both these service populations pose unique challenges to the current mental health service system. Refocusing services to be more engaging and supportive can provide lasting benefits. As stated in one recommendation regarding young adults: "Our approaches to marginal youth have failed to draw them into the system or the community. We need more empathy, imagination, and active engagement."

Young Adults

Service Coordination and Enhancements

- Institute training on age-appropriate service models for all providers serving young adults, i.e., expand Young Adult Services (YAS)-informed training to everyone
- Criminal justice collaboration to assure that young adults get treatment instead of incarceration
- Training for residential staff in providing life skills (for independent living – money management, social interaction, vocational, etc.)
- Increase partnerships with higher education institutions
- Streamline access to needed mental, behavioral, and physical health care services
- Promote recovery supports first such as housing and vocational training that provide some tangible immediate results that young adults are most interested in; then move towards treatment engagement

Service Expansion

- Increase Bureau of Rehabilitative Services for young adults
- Increase access to transitional, affordable, and supportive housing for those not eligible for Young Adult Services
- Provide outreach and expansion of supported employment and supported education services
- Generally, expand age appropriate services across the service system to better meet the unique service needs of young adults

Service Navigation

- Develop a web site for young adults that will engage them and serve them as a way to reach out to those needing mental health services
- Design or adopt an electronic/virtual system that would assist young adults to enhance their own mental health, and address mental health issues as they arise or develop in an anonymous and non-threatening venue

Other

- Secure representation of young adult representatives on DMHAS advisory bodies
- Formally support initiatives that are spearheaded by young adults, e.g., Young Adult Recovery Conference 2012

Elderly

Service Coordination

- Expand outreach and collaborative efforts with existing social network organizations (such as senior centers, churches, libraries, etc.) to disseminate mental health information
- Provide more training and consultation on earlier intervention techniques such as Mental Health First Aid
- Enhance discharge planning from hospital emergency departments and general hospitals
- Promote intersystem collaboration through a mental health and aging coalition whose aim is to improve policy and practices in the care of older adults
- Conduct training and promote workforce development to increase the numbers, clinical skills, and cultural competencies of professionals who work with older adults

Service Expansion

- Promote more in-home psychiatric care
- Continue to explore and develop innovative programs for intensive care management, coordination with primary and specialty health care and follow-up care coming out of the hospital
- Provide training and support to families who are caring for older adults with serious mental illness and substance use disorders
- Promote expansion of Money Follows the Person, Elder Home Care, and Mental Health Waiver programs and affordable assisted living to meet the growing demand

Service Navigation

- Continue and expand outreach and engagement efforts for older adults with serious mental illness and substance use disorders

Integrated Care

Serving the needs of persons with behavioral health care needs requires a holistic approach, one that understands the mind/body connection. Primary and behavioral health care must move to a seamless system in which there is no wrong door and services are comprehensive and well coordinated. Integrated care is an integral component of where the state is headed and a cornerstone of healthcare reform. Not all regions addressed this priority area, but several recommendations were noted in regional priority reports.

- Assist to secure dental coverage for consumers
    - Develop an inventory from providers and consumers of effective strategies to improve dental care amongst consumers

    - Develop basic dental care trainings for consumers and staff in conjunction with state and local resources; i.e., look at causes that are unique to consumers with mental health and strategies to improve care
- Provision of resources to implement smoking cessation pre-contemplation and treatment groups
    - Develop capacity for providers to provide training on how to implement smoking policies, practices, and services
- Work with colleges to increase access to mental health supports
    - Promote anti-stigma/discrimination campaigns, peer driven initiatives and suicide prevention
- Promote and organize local and regional Mental Health First Aid trainings
- Provide regional trainings on suicide trends and prevention across the life span

Substance Abuse Services

Availability – Provider Responses

As with mental health service providers, substance abuse provider agencies were asked to rate the availability of clinical and support services based on their experience with clients they served within their agency and/or referred outside their agencies. Response categories included "not available", "sometimes available", "often available" and "always available". Respondents were instructed to answer "don't know" if they were not familiar with the service. A total of 94 DMHAS funded (community-based, private nonprofits) and operated provider agencies responded to some or all questions of which 73 stated they either provided both (N=68) substance use and mental health services or substance abuse services only (N=5). Only one questionnaire per provider agency was allowed except in the instance that a provider delivered services in more than one DMHAS region. In that case, they were asked to complete one survey for each region based only upon the services delivered in each of the regions.

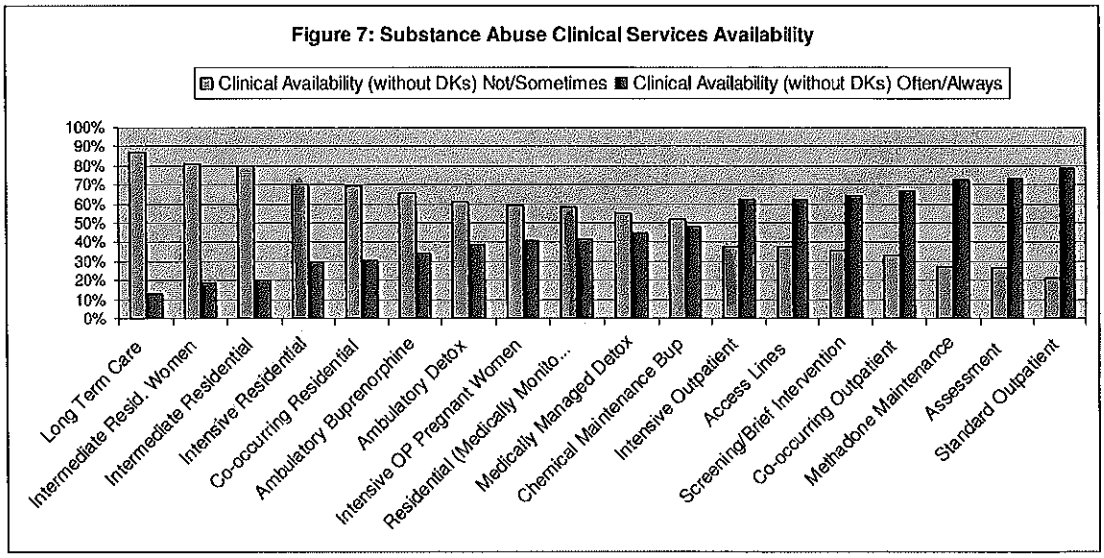
Services found to have limited availability (not available or sometimes available) for substance abuse clinical services included the following:

- All Levels of Residential Care (long-term, intermediate and intensive)
- Intermediate Residential – pregnant women
- Co-occurring Residential
- Ambulatory Detoxification (including Buprenorphine)
- Intensive Outpatient – Pregnant women
- Residential and Hospital Based Detoxification
- Chemical Maintenance/Buprenorphine

The above clinical services had limited availability with more than 50% of respondents rating the service as **not available or sometimes available**. It should be noted that these service types had "Don't Knows" (DKs) response rates ranging from a low of 14.0%

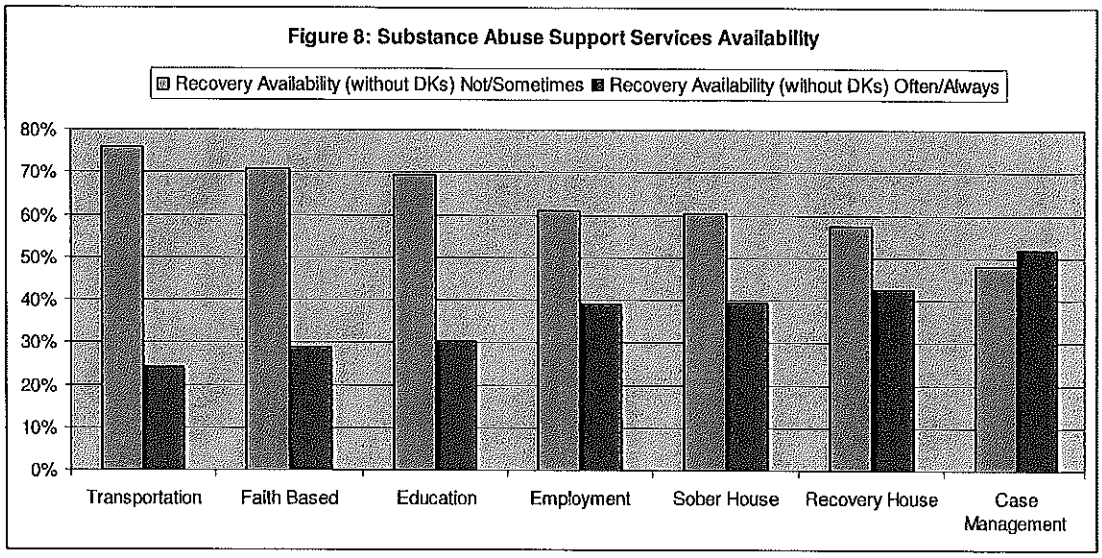
(Intensive Residential) to a high of 35.1% (Intensive Outpatient – Pregnant Women). Overall the range of DKs spanned from 10.6% to 35.1%. Again as was the method used to report availability of mental health services, DKs were excluded from the substance abuse services analysis.

Figure 7 below displays responses for all 18 service types included in the provider survey questionnaire. Standard and intensive outpatient services, screening and brief intervention, assessment, access lines and co-occurring outpatient services all received high ratings of availability.



Providers were asked to rate the availability of substance abuse support services, i.e., those that assist persons in their recovery and promote a life in the community. With the exception of case management, all categories of recovery support services were rated as having limited availability (Figure 8) including:

- Transportation
- Education
- Employment Services
- Sober Housing
- Faith Based Services



Similar to the results for mental health support services availability, addiction recovery supports perceived as lacking in availability included education, housing and transportation services. Faith based services was ranked much lower in its availability in 2012 than 2010 with only one quarter stating it was available "often or always". On the other hand, faith based services did have the highest percent of provider respondents stating they weren't familiar with the service (27.4%).

Qualitative Findings

Summary of Focus Groups

Substance abuse issues were explored through various qualitative methods throughout the state by both RACs and RMHBs. Some RACs conducted focus groups utilizing DMHAS *Priority Setting Framework* questions while others employed their own questions. In some regions (South West, South Central, and North Central), RACs and RMHBs jointly conducted focus groups while in other regions focus groups were conducted independently by RACs. A total of sixteen focus groups specifically dedicated to the topic of substance abuse were conducted across the state. Participants included persons in recovery and parents of young adults who are in recovery or who are currently abusing substances. A subset of these parents had experienced a substance related death of a young adult child. Others who participated in substance abuse focus groups included social workers, police, town social service and youth service workers, and physicians. In addition, substance abuse related information arose from the hospital emergency departments (ED) focus groups and from the general focus groups held by RMHBs. As substance abuse issues were not always explored in a consistent manner, drawing generalizations from the qualitative process was somewhat difficult.

Special Populations

Young Adults

Many of the perspectives and comments mentioned in the Mental Health section of this report regarding services for young adults also related to those with substance use disorders. Young adults with substance abuse issues have needs specific to their age, maturity and developmental stage. Young adults report difficulty connecting with older adults who make up the majority of clients in substance abuse programs. In addition, young adults may not see the experience of their older peers as relevant or may not feel respected or understood by them. The lack of age appropriate services was seen by providers as one of the major reasons for dropping out of substance abuse treatment. Additionally, recovery supports are limited for this age group with providers reporting that many young adults "want to do better but need better support for education, job search, sober housing, young adult recovery supports, mentors, etc." These young adults are seen as needing skills training for independent living and recovery, but often drop out of treatment before obtaining these skills.

Overall focus group participants reported variations in service availability and accessibility within regions as well as across regions for young adults. As is the case generally, inpatient and residential rehabilitative treatment (including intensive, intermediate, and long-term) is very limited for this population. Waitlists for outpatient substance abuse services also varies with some regions having more capacity than others. Rural areas of the state pose a unique challenge as services cluster around urban pockets and public transportation is lacking. The Eastern Region reported that Al A-Teen and other age appropriate mutual help group are limited in rural areas and even when they do exist, transportation may still be a barrier. Similar to the findings in the mental health assessment, focus group participants reported that access to and navigation of the system can be especially challenging for this population.

Lesbian, gay, bisexual, and transgender (LGBT) young adults were also noted as having unique needs – many do not feel safe in recovery programs and would prefer specialized services. LGBT young adults also have high rates of homelessness, substance abuse, alienation from family/parents and fewer resources.

Another concern was raised in two regions (North Central and North West) regarding the existence of program eligibility requirements preventing young adults from accessing substance abuse treatment services. For instance, it was reported that several young adults at the Faces of Recovery Listening Forum described instances when they were turned away from detoxification (detox) programs, because they weren't "high" enough (North Central).

Finally, the special needs of young adults who are pregnant or parenting was raised in the Eastern Region. Challenges such as child care or fear of losing custody of their child(ren) can be barriers to seeking substance abuse treatment.

Elderly

There is concern and increased awareness of the vulnerability of the elderly to prescription drug addiction and other substance abuse issues. This is an emerging issue which RACs and community providers are paying close attention to. It was noted in several regions that there are no or limited substance abuse programs specific for older adults. Also medical and behavioral health staff as well as referral agency staff are not educated and trained to recognize and treat older adults with substance use issues.

Women

The need for more gender specific programs and groups for women was raised in a few regions (North West and Eastern). Particularly, services for women with children were identified as an unmet need. The understanding that women in recovery face different barriers and have different needs from men was recognized. Furthermore, the need for a support network of providers and peer mentors who realize the "woman as a whole" who has physical, emotional, and spiritual needs during the recovery process was identified.

Ex-offenders

Persons in recovery with criminal histories, particularly those with arson or sexual offense records, face a severe lack of services. It is incredibly difficult for these individuals to obtain housing, employment and other services. These individuals are also often "hopeless" about their recovery and their limited options serve to reinforce their hopelessness.

Drug-free Safe Environments for Persons in Recovery

A primary theme that evolved from the focus groups was the need for drug-free, safe environments for individuals in recovery. This includes both immediately post-detox and over the long-term. Both sober houses and other group quarters were reportedly in limited supply throughout the state. Furthermore, many of these programs operate "off the grid" resulting in limited awareness of these programs. Participants frequently described having nowhere to go after detox or having to return to environments where family members were continuing to use. It is important to note that this topic arose naturally in all of the focus groups as opposed to facilitators directing the conversation.

Focus group participants in four regions discussed a need for siting sober houses and residential programs in areas outside of inner cities and neighborhoods where drugs are readily available. In Bridgeport, participants described how "sober houses" were sited in areas with easy access to drugs and "where you see people using" and where "you see drug transactions everywhere". One woman expressed dismay that a "beautiful new sober house" recently opened "right up the street from the crack house...so you have to walk by the crack house to get to the sober house." Participants expressed frustration with the situation stating: "I can't get clean here" and "you wonder why so many people fail". On the other hand, participants pointed to the difficulty of siting sober houses and residential

programs in safe neighborhoods due to opposition from the community: "people are fussy [in that neighborhood]...they say, we don't want those people here."

Service Access and Availability

Several systems issues were brought up as barriers to recovery from substance abuse. First, a persistent theme was the difficulty in navigating the substance abuse system, particularly for family members. Family members stated that they were very often unaware of available services or how to access them. Some reported having to hire third party insurance specialists or using the Office of the Healthcare Advocate to obtain services. Consumers also reported feeling as if services were "hidden". "We don't know where to go, don't know who's who...We don't know what services are offered; don't know how to get from point A to point B to C."

Another systems issues raised was barriers to accessing care by private insurance. Participants found fault with insurance companies which often determine the level of care based on policy coverage rather than on the person's need. There was a sense among participants that insurance carriers often prohibited access to what the individual or family member felt was the appropriate level of care. In addition, there were complaints that outpatient is "always required as a first step" when "failure" at this level could have serious consequences.

Detoxification

Access to detox is reportedly limited (i.e., inpatient hospital based) in the North West Region; however, in the remaining areas this was not raised as an issue. Detox related issues that were raised included admission criteria excluding those with serious mental illness or those with complicated medical co-morbidities. Participants report that some facilities state they are not equipped to manage individuals with active symptoms of serious mental illness or those who may become medically unstable due to medication interactions or are medically compromised.

Use of emergency rooms for detox services was commonly reported in both general and ED focus groups. Many ED staff reported that police often bring intoxicated individuals to the ED to detox, to get them off of the streets. Many of these individuals do not want to detox, but have nowhere to go and opted to go to the hospital instead of jail. At some general hospitals detox occurs "under the radar" as some persons are admitted as either medical or psychiatric patients.

Long wait times to access detox (and residential treatment) were commonly cited. It should be noted that wait times for detox reported in the 2012 DMHAS Provider Survey averaged one day. Family members in particular were very concerned regarding the importance of accessing services promptly, as an individual could lose motivation, thus missing an important "window of opportunity". In Bridgeport, CCAR members described longer wait periods. "They make you call to see if you really want to do it, but why should you have to wait...if you really want to do it [get treatment]?

Residential – Intermediate and Long-term Care

Another recurring theme was the lack of intermediate care and recovery supports, described as a "critical bridge between detox or crisis services". This theme was consistent in four regions (South West, South Central, North Central and Eastern). Across regions, providers and clients regularly discussed the need for intermediate residential services (i.e., greater than 30 days). Often, insurance will only cover an intensive residential treatment stay of less than 28 days; however, participants noted that this is not a sufficient length of treatment for individuals newly in recovery, especially after many years of substance use. For those accessing detox, the situation can be more difficult. Individuals receiving a three to five day detox stay are discharged with limited recovery supports or continued (e.g., intermediate) care. These individuals are described as having no where to go, either because family members may not be able to manage the stress of caring for or supporting them, or because family members themselves are continuing to use.

Residential substance abuse treatment is regarded as very effective overall; however, for those outside of the DMHAS system, access to this service is very limited, other than for wealthy individuals who can afford to pay for his service. Capacity within the DMHAS system for long-term residential was noted as being very limited.

Outpatient

Overall the quality of outpatient substance abuse treatment services is reported to be "strong" and a range of services available in most areas. The lack of methadone and/or Suboxone (i.e., Medication Assisted Treatment – MAT) was a commonly stated barrier to treatment, particularly in rural regions. Participants describe difficulty travelling out of town for treatment while managing competing demands such as bringing children to school or picking them up, work and other treatment meetings. Resistance from local residents or zoning commissions has been a barrier to siting these treatment centers outside of major cities.

Recovery Supports

Along with the lack of residential treatment services, participants report that persons in recovery often face a lack of community supports. In Bridgeport, one participant explained, "you need a person there in every stage…you need housing, food, clothes…need people to help you through until you are strong enough to be on your own…that is what is going to make the individual stay away from drugs." Participants stressed that recovery supports were essential to help those recently discharged from treatment "get back on your feet and stay clean." Lack of these recovery supports or "wraparound services" were consistently named as major barriers in the early stage of recovery, especially after detox. In the Eastern Region, the concept of "maximizing motivation" by ensuring access to services and supports at the point of detox was discussed as a necessity to prevent relapse. As clients experience roadblocks to recovery, their motivation can diminish. In addition, in the North West and South Central Regions,

there are no CCAR services (i.e., Recovery Center), which was consistently noted as a missing component in the recovery support network.

There were some concerns raised about Alcoholics Anonymous (AA) meetings restricting people who have co-occurring psychiatric disorders or for those with opioid addictions. Individuals using Methadone or Suboxone reported not feeling welcome in AA meetings. However, in areas where there are limited Narcotics Anonymous (NA) meetings, AA may be the only resource for those with opioid or other addictions. For those with co-occurring disorders, i.e., mental illness and a substance use disorder, there are even fewer recovery and support groups available.

Stigma and Discrimination

Stigma associated with addiction was a secondary theme raised by focus groups. Providers and persons in recovery reported continued and engrained stigma surrounding substance abuse and discrimination against individuals with addiction problems. Most participants agreed on the need to educate providers, physicians, and medical professionals regarding addictions and the disease model, and suggested that DMHAS can and should play a lead role in this effort.

Substance Specific Findings

Marijuana

Much attention was given to recently enacted legislation which decriminalized and "medicalized" marijuana. RACs and local prevention councils noted the increase in adolescents who view marijuana as "safe" or "harmless" and a misunderstanding among young people as to the legality of marijuana use and possession. The need to address marijuana prevention as a "legal" or "regulated" substance, in a similar manner as alcohol and tobacco, was emphasized. Furthermore, marijuana was identified as the "stepping stone" [gateway] drug for many youth.

Opioids

Addiction to opioids resulting from both legitimate and non-medical use of pain relievers, as well as increases in opioid overdoses, were significant concerns. Heroin was viewed as one of the primary substances for which individuals come to the ED for treatment. Several communities in Connecticut were found to have very high rates of overdoses in a recent study completed by Brown University.

Discussion of the rather low voluntary use by physicians of Connecticut's Prescription Monitoring Program (PMP) came up as a concern. RACs and prevention councils advocate the mandatory use of this system and/or improving education and outreach to physicians regarding the benefits of the PMP. The potential for the PMP to identify prescription drug abusers early and to engage them in treatment is seen as an underutilized and important resource.

Barriers

The provider survey included a section on barriers to services that hindered getting or continuing services. These 18 barriers were related to: 1) providers' operational issues (e.g., sufficient staffing, hours of operation, or qualified workforce), 2) service coordination (between other substance abuse, mental health, human service providers and primary care), or 3) other service delivery concerns (e.g., client engagement, eligibility criteria, medication side effects). Of the top five barriers identified by providers, housing and transportation were the two main barriers, each having a greater than 50% response rate of "always or often" hindering a person's access to services. These were followed by client engagement (i.e., readiness for treatment), adequate staffing levels, and child care, all below 50% as "always or often" a barrier. Added to the survey in 2012, **Coordination between Primary Care and Behavioral Health Services** was rated as a moderate barrier (34.6%) by addiction services providers.

Figure 9 below displays the results of the provider survey vs. the qualitative findings from the regions regarding barriers to substance abuse services. Both assessments identified transportation and housing (recovery supports) as pressing barriers to receiving substance use services or maintaining recovery. Navigating services was a significant impediment to obtaining services as also noted in the mental health qualitative assessments. Insurance coverage for appropriate treatment services for those not covered by entitlements or DMHAS services may be addressed within the context of healthcare reform.

Figure 9: Barriers to Substance Abuse Services

Provider Agencies: Top 5 Service Barriers	Always or Often a Barrier		Focus Groups: Top 5 Service Barriers (not in rank order)
Lack of Housing	56.8%		Difficulty Navigating System
Lack of Transportation	51.2%		Lack of Recovery Supports (young Adults)
Lack of Client Engagement	41.9%		Lack of Public Transportation in Rural Areas
Lack of Adequate Staffing	41.0%		Limiting Insurance Options
Lack of Child Care	38.5%		Stigma and Discrimination

Regional Analysis and Variations
Substance Abuse Services and Barriers

Those substance abuse clinical services found to have limited availability within each region mirrored the statewide findings. Looking at access to substance abuse services (Figure 10) as has been reported in past need assessments, all levels of residential care were seen as having limited availability. In 2012, the number of regions reporting all levels of residential care as having insufficient availability increased to all five regions with the exception of intensive. Ambulatory detoxification (with and without Buprenorphine) was reported also in more regions in 2012 as having poor availability.

Residential detoxification services were reported as only marginally lacking in availability across four regions, with the exception of the North West Region.

Figure 10: Regional Substance Abuse Clinical Services with Limited Availability

Service Type	Number of Regions Reporting Limited Availability
Long-term Residential	5
Intermediate Residential	5
Intermediate Residential – Pregnant Women	5
Co-occurring Residential	5
Intensive Residential	4
Intensive Outpatient – Pregnant Women	4
Residential Detoxification (medically monitored)	4
Ambulatory Detox - Buprenorphine	4
Chemical Maintenance - Buprenorphine	3
Ambulatory Detox	3
Medically Managed Detox	2
Central Access/Triage Line	2

Recovery supports for persons having a substance use disorder were seen as lacking across most regions for almost all categories (Figure 11). In 2012, both faith based and education services moved from one region reporting limited availability in 2010 to five regions in 2012. Employment services saw a similar jump from one to four regions in the two-year period. Recovery house and sober housing remained basically unchanged and case management changed from two regions to one in 2012.

Figure 11: Regional Substance Abuse Support Services with Limited Availability

Service Type	Number of Regions Reporting Limited Availability
Transportation	5
Education Services	5
Faith Based Services	5
Employment Services	4
Recovery House	4
Sober Housing	4
Case Management	1

For 2012, a number of regions had many fewer barriers that met the threshold of being a hindrance often or always. In fact, one region reported no barriers over 45% as being "often or always" a barrier. The reason for this is unknown. The ratings for those regions reporting no barriers with 50% or greater as "always or often" were essentially the same as in prior years. Housing and transportation (Figure 12) were top rated barriers in three regions followed by insufficient staffing reported by two regions. The remaining barriers, lack of client engagement, long wait lists, childcare, and lack of community supports, had only one region each report them as a significant barrier.

Figure 12: Regional Substance Abuse Service Barriers

Barrier	Number of Regions Reporting Limited Availability
Lack of Transportation	3
Lack of Housing	3
Insufficient Staffing	2
Lack of Client Engagement	1
Long Wait Lists	1
Lack of Child Care	1
Lack of Community Support	1

Recommendations – Substance Abuse Services

The following recommendations on improving the substance use service delivery system address many of the same areas needing attention that were mentioned in the mental health recommendations. Improving access to both clinical and recovery services, including assistance with navigating the public substance use system, is crucial. Assuring that vulnerable populations receive the right care at the right time is extremely important and can lead to better lasting results. Maximizing resources, building strong collaborations and providing training across affected service systems is essential in today's rapidly changing environment.

It is again emphasized that the individual regional priority reports be references as they provide a context in which the following recommendations were developed.

Service System Access & Navigation

- Continue to support and strengthen existing peer navigator/peer supports for clients entering treatment
- Implement a statewide 24-hour access line for substance abuse emergencies that "first responders" (e.g., 211 operators, service agency receptionists) and the general public can use
- Develop a website that contains current information on treatment bed availability for both DMHAS operated and private nonprofit provider agencies
- Replicate the Middlesex Hospital Community Collaborative model, which lowers the incidence of crisis situations through community-based management of high-risk individuals
- Explore and address policies and practices that are barriers to coordinated and effective behavioral health care equity
- Create (and post on DMHAS website) easy to understand flow charts describing points of entry and criteria for accessing and navigating the public substance abuse delivery system
- Place peer mentors in inpatient settings to help individuals understand and navigate the behavioral service system

- Establish priority treatment access points in the community for substance abuse clients presenting at hospital emergency rooms

Service Expansion

- Provide critical services that bridge detox or crisis services and community long-term support for a sustained recovery
- Conduct a comprehensive review of existing residential treatment bed capacity, at all levels, to assess the adequacy based upon current and future demand
- Encourage expansion of medication assisted therapy for opioid addicted persons including the prescribers of Suboxone
- Increase clinical services for people who are deaf/hearing impaired; especially those who do not meet the DMHAS target population criteria

Recovery Supports

- Enhance job readiness by integrating vocational services into clinical services
- Establish a practice improvement collaborative of substance abuse providers to share information on effective employment support practices
- Replicate the "Dry Dock" model which provides a non-threatening and accepting atmosphere allowing persons in recovery and their family members and friends to "normalize" activities (http://www.thedrydock.org)
- Expand the availability of recovery coaches and recovery support specialists throughout the system by increased training opportunities
- Promote family involvement in the recovery process
- Integrate and strengthen education services that prepare people for jobs
- Implement a standard of "best practices" for sober houses
- Expand prevention and recovery supports for substance abuse and co-occurring disorders

Young Adults

- Ensure the availability of age-appropriate clinical and recovery services for young adults
- Increase capacity to provide age-appropriate services using evidence based models
- Design or adopt an electronic/virtual system to engage young adults in clinical and recovery support
- Review clinical treatment programs in terms of effective practices regarding individual vs. group counseling
- Educate treatment providers as to the unique clinical and recovery needs of young adults

- Create an interagency coalition that promotes collaboration and improved communication between providers and agencies that work with youth and young adults
- Explore options for providing therapy in natural/comfortable settings for young people

Special Populations

- Recruit and train a selection of treatment providers on geriatric behavioral health care
- Create a Motherhood Program for single moms, modeled after the Fatherhood Initiatives, that addresses not just mothering and parenting skills but also basic life (relationship building, trust, managing finances, etc.) skills
- Expand current resources for substance abuse provider training on Veteran needs and benefits
- Promote cultural competencies through cross-training of staff within hospitals, primary care, psychiatry, senior and adult day care centers, senior housing, home health, protective services and behavioral health services

Other

- Support, through consistent funding, the state's Prescription Monitoring Program (managed by the Department of Consumer Protection) as an effective method of earlier intervention and improved outcomes for opioid addicted persons
- Advocate for uniform practices regarding how professionals prescribe medications through continuing medication education
- Promote drug overdose prevention by expanding educational efforts in the medical community and encouraging primary care providers to conduct brief screening assessments, utilize the Prescription Monitoring Program, and provide drug overdose information to patients and their family (or significant other) members
- Expand pre-release care coordination efforts of inmates released into the community
- Reduce the likelihood of overdoses in the correctional inmate population released to the community by providing pre-release education on the risk of resumption of former drug-taking behavior at levels used prior to incarceration
- Expand drug screenings to include testing for the new intoxicants (e.g., bath salts and synthetic marijuana)

Integrated Care & Wellness

- Promote collaborative relations that support resource sharing between local and regional primary care and wellness organizations and behavioral health providers
- Provide additional resources to implement smoking cessation programs within the addiction service system

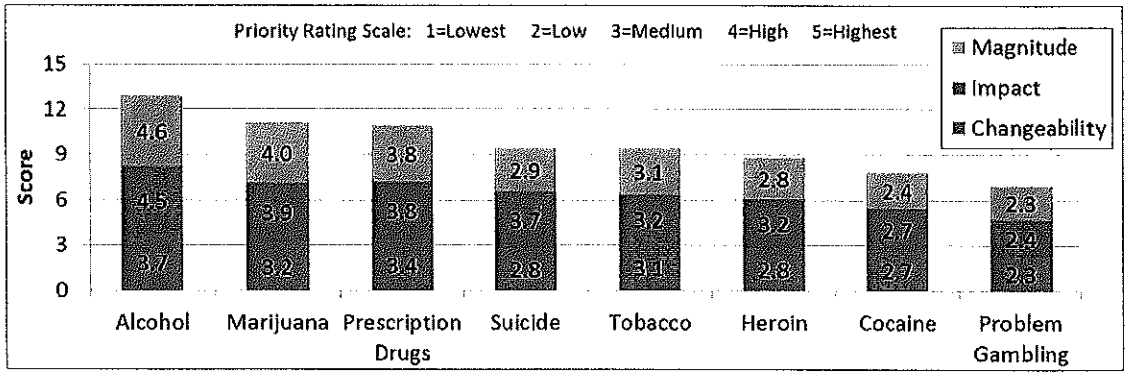
- Encourage the adaptation of Screening, Brief Intervention and Referral to Treatment (SBIRT) in all primary care settings
- Support the co-location of physical and behavioral health services so that clients receive integrated care

Prevention

Since 2006, DMHAS-funded prevention programs have practiced SAMHSA's Strategic Prevention Framework (SPF) at the state, regional and community levels. The SPF is a 5-step, data-driven process known to promote youth development and prevent problem behaviors across the life span. The steps are: 1) profile needs and response capacity; 2) mobilize and build needed capacity; 3) develop a strategic prevention plan; 4) implement evidence-based programs and strategies; and 5) monitor and evaluate effectiveness.

In 2012, the RACs, using data provided by the State Epidemiologic Outcomes Workgroup (SEOW) along with local data, produced a sub-regional epidemiological profile for 6 substances plus problem gambling and suicide. Each RAC convened a Community Needs Assessment Workgroup (CNAW) to use quantitative and qualitative data to describe and rank each problem with respect to magnitude, impact, and changeability (Figure 13). Taken together, sub-regional CNAWs ranked the 8 areas in the following order: Alcohol, Marijuana, Prescription Drugs, Suicide, Tobacco, Heroin, Cocaine, and Problem Gambling.

Figure 13: Regional Priority Need Ranking Results, 2012



Prevention Priority 1: Alcohol

Prevention of alcohol misuse continued as the top priority across Connecticut. Alcohol use by underage drinkers (12 – 20 year of age) in the previous month varied narrowly across the regions from 29.9% in the Northwest to 33.6% in the East. All regions exceeded the national average of 26.5%. Binge drinking, per the Substance Abuse and Mental Health Services Administration (SAMHSA) is defined as 5 or more drinks on one occasion on at least one day in the past 30 days. Binge drinking was highest among 18 –

25 year olds at 46.8% in Connecticut and 41.0% nationally. The values for binge drinking across Connecticut's regions exceeded the values nationally for all age groups examined. Perceptions of risk associated with binge drinking were generally lower across regions than the national average, but there were exceptions. Specifically, more risk associated with alcohol use was perceived for 12 – 17 year olds in the South West and North Central regions; for 18 – 25 year olds in the South Central region; and for those 18 and older in the South West and North Central regions. There was not a clear correlation between higher perceived risk and less alcohol use in the prior month, however.

Figure 14: Alcohol Use in the Five Regions Compared to all of Connecticut and the United States

Age Group	South West	South Central	Eastern	North Central	North West	Connecticut	United States
Alcohol Use in Past Month (%)							
12 - 17	18.3	20.3	15.7	17.5	18.1	18.2	14.4
18 - 25	*	70.5	*	68.8	66.1	68.2	61.2
12 - 20	30.6	33.3	33.6	30.1	29.9	31.4	26.5
18+	64.7	65.3	60.5	63.6	64.5	64.0	55.7
Binge Alcohol Use in Past Month (%)							
12 - 17	12.3	14.4	10.3	11.4	12.3	12.3	8.6
18 - 25	*	50.0	*	46.3	46.0	46.8	41.0
12 - 20	21.4	24.2	24.1	21.6	21.3	22.4	17.5
18+	28.5	29.9	26.7	27.6	26.4	28.0	25.0
Perceptions of Great Risk of Having 5+ Alcoholic Drinks 1 – 2 times/week							
12 - 17	41.1	38.7	36.8	41.0	37.4	39.4	40.1
18 - 25	32.7	33.7	28.0	31.6	29.2	31.4	33.4
18+	43.8	40.5	36.4	42.6	41.3	41.3	42.3

*low precision; no estimate reported
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010

Alcohol-induced deaths across the state rose from 5.1 per 100,000 in 1999 – 2001 per Connecticut Department of Public Health Mortality Statistics to 6.1 per 100,000 in 2007 – 2009. Alcohol-related motor vehicle accidents declined from 7.2 per 10,000 in 2007 per the National Traffic Highway Safety Administration Fatality Analysis Reporting System to 6.6 per 10,000 in 2010. Over the same time period, motor vehicle fatalities decreased from 3.8 to 3.2 per 10,000. School suspensions and expulsions also declined from 12.9 in the 2006/7 school year to 9.3 in the 2010/11 school year based on data from the Connecticut State Department of Education (DOE).

Solutions and Strategies

- Continue the "Set the Rules" media campaign to increase knowledge and awareness of the implications of the Social Host Law
- Collaborate with law enforcement on enforcing underage drinking laws
- Train Pediatricians and Family Physicians on SBIRT (Screening, Brief Intervention and Referral to Treatment)
- Offer server training to employees of alcohol retailers

- Support continued federal funding for Drug-Free Communities (DFC) Support Grants and Sober Truth on Preventing Underage Drinking Act (STOP) Grants for student surveys, school prevention efforts, and evidence-based alcohol retailer compliance checks
- Improve community readiness to collect and report data
- Support Local Prevention Councils (LPC)s implementation of evidence-based strategies

Prevention Priority 2: Marijuana

Marijuana is the most commonly used illicit drug in the United States and the 2008-10 National Survey on Drug Use and Health (NSDUH) reveals the percentage of past year marijuana use by those 12 and older was 13% in Connecticut compared to 11% nationally. Past month Marijuana use also exceeded the national average across regions where data was available.

Figure 15: Marijuana Use in the Five Regions Compared to all of Connecticut and the United States

Age Group	South West	South Central	Eastern	North Central	North West	Connecticut	United States
Marijuana Use in Past Month (%)							
12 - 17	7.6	9.5	8.9	8.4	9.9	8.8	7.2
18 - 25	18.7	23.9	*	23.4	22.3	22.2	17.7
26+	3.8	5.3	6.4	5.0	5.2	5.0	4.6
First Use of Marijuana (%)							
12 - 17	6.0	8.7	5.0	8.1	6.3	7.1	5.8
18 - 25	7.8	9.7	8.0	10.5	10.9	9.4	7.0
26+	*	*	*	*	*	0.2	0.2
Perceptions of Great Risk of Smoking Marijuana once a month (%)							
12 - 17	25.2	25.1	26.0	25.1	28.0	25.9	31.1
18 - 25	18.3	15.5	12.4	16.7	17.0	16.1	20.4
26+	34.2	34.2	*	39.4	38.1	36.0	37.6

*low precision; no estimate reported
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010

According to the January 3, 2013 NSDUH Report, "Between 2007 and 2011, the percentage of adolescents who perceived great risk from smoking Marijuana once or twice a week decreased from 54.6% to 44.8%, and the rate of past month Marijuana use among adolescents increased from 6.7% to 7.9%. In 2011, the percentages of adolescents reporting substance use in the past month were generally lower among those who perceived great risk from using substances than among those who did not perceive great risk."

NSDUH data show that the national decrease in perception of risk from smoking Marijuana 1 – 2 times per week was also true for Connecticut. The percentage of persons ages 12 and older in Connecticut who perceived a great risk of smoking Marijuana

decreased, from 35.8% in 2006-08 to 32.5% in 2008-10. Combined with the increase in the number of people 12 and older using Marijuana in the past year, these indicators may be evidence of greater acceptance of Marijuana use. The decline in perceptions of risk was mirrored across all state regions. The 18 – 25 year olds had the highest percentage of people using Marijuana for the first time, from 7.8% in the South West to 10.9% in the North West. These data do not compare favorably to the national data for this age group, which was 7.0%.

Solutions and Strategies

- Ongoing monitoring of regulations related to medical Marijuana
- Continuing education about harmful effects of Marijuana on brain development as well as raising awareness of drugged driving and Marijuana as a gateway drug
- Organize a grassroots group focused on minimizing the misuse of medical Marijuana
- Ongoing and widespread dissemination of information on myths and facts about Marijuana with a primary focus on the health related risks and clarification of the difference between legalization and decriminalization
- Ensure that Primary Care Physicians are kept updated on trends and research for Marijuana
- Support school police related to Marijuana and other illicit drugs
- Increase intensive affordable residential treatment for teens, especially those under 14
- Continue student surveys to provide information on prevalence, patterns, and consequences of Marijuana use

Prevention Priority 3: Prescription Drugs

Misuse of Prescription Drugs is second only to Marijuana as the nation's most prevalent illicit drug problem. Not surprisingly, 18 – 25 year olds had the highest prevalence of nonmedical use of prescription pain relievers. NSDUH trend data for Connecticut indicates that use peaked in 2006 (5.2%) and declined to a 10-year low in 2009 (3.8%), before rising again in 2011 (4.4%). The 2008-10 NSDUH estimates for Connecticut show that 10.4% of 18 – 25 year olds reported nonmedical use of pain relievers. Regional estimates range from a low of 9.4% in North Central to a high of 11.9% in North West, Connecticut.

At the state level, the rate of pharmaceutical-related school suspensions and expulsions increased dramatically from the 2006/7 school year at 1.59 to 4.56 in the 2009/10 school year, but then dropped back substantially in 2010/11 to 2.03 per 10,000, based on Connecticut State DOE data. This may have been driven by the dramatic increase in suspensions in North Central which rose to 9.98 in 2009/10, then fell back to 1.82 in 2010/11.

Figure 16: Non-Medical Pain Reliever Use in the Five Regions Compared to all of Connecticut and the United States

Age Group	South West	South Central	Eastern	North Central	North West	Connecticut	United States
Nonmedical use of Pain Relievers in Past Year (%)							
12 - 17	4.3	5.2	5.7	4.1	5.8	4.9	6.4
18 - 25	9.6	11.0	10.3	9.4	11.9	10.4	11.7
26+	2.5	2.9	2.8	2.3	2.3	2.7	3.5
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010							

Solutions and Strategies

- More data collection is needed to determine and address persons at risk for Prescription Drug abuse such as the elderly
- Support Medication Take-Back and Medical Drop Box programs on the local, regional, and statewide level to allow community members to safely dispose of Prescription and Over-the-Counter medications and educate the public to the dangers of Prescription Medication abuse
- Increase the number of people who can do small group presentations/discussions on Prescription Drug abuse
- Increase outreach capacity through dissemination of Prescription Drug information to schools, physicians, pharmacies, and realtors
- Increase the number of doctors screening for Prescription Drug abuse
- Implement parent education programs such as the Teen Influencer and PACT 360
- Expand Regional Prevention Committee and Local Prevention Council membership to include treatment professionals based upon a common goal of decreasing the impact of Prescription Medication misuse

Prevention Priority 4: Suicide

Suicide prevention has risen in priority from #5 in the previous 2010 process to #4 for the current report, displacing Tobacco. According to data from the Office of the Chief Medical Examiner, 352 women and 1263 men committed suicide in Connecticut between 2007 and 2011. The majority of these suicides occurred among those ages 30 – 59.

Figure 17: Thoughts of Suicide and Major Depressive Episodes in the Five Regions Compared to all of Connecticut and the United States

Age Group	South West	South Central	Eastern	North Central	North West	Connecticut	United States
Had Serious Thoughts of Suicide in Past Year (%)							
18 - 25	6.11	6.93	6.73	6.01	6.04	6.36	6.47
18+	3.57	4.13	4.44	3.59	3.77	3.85	3.76
26+	3.20	3.68	3.95	3.21	3.43	3.45	3.30
Had at Least One Major Depressive Episode in Past Year (%)							
18 – 25	7.82	7.87	7.96	7.50	8.01	7.79	8.16
18+	5.61	6.16	6.57	5.89	5.79	5.97	6.32
26+	7.82	8.14	8.73	7.64	7.90	8.00	8.24
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010							

Based on the 2008-10 NSDUH data, nearly all Connecticut regions were below the national average with respect to having at least one Major Depressive Episode in the past year, with the exception of the Eastern region for those 18+ and 26+. On the other hand, when the variable is serious thoughts of suicide in the past year, both the Eastern and South Central regions exceeded the Connecticut and national averages for each age category presented.

Solutions and Strategies

- Better integration of early suicide prevention and mental health promotion with overall delivery of prevention services in schools and communities
- Maximize the dissemination of Question, Persuade and Respond (QPR) gatekeeper and CONNECT suicide prevention training and the ONE WORD, ONE VOICE, ONE LIFE campaign
- Suicide as the result of bullying, including cyber bullying, is an area that should receive more resources to effectively intervene when self-injury and attempted suicide occur
- Improve capacity to collect and analyze current, accurate, local data and information about the nature and extent of suicide and self-injury
- Easy access to clinical interventions and support for help-seeking should be increased
- Continue to support anti-bullying programs in schools

Prevention Priority 5: Tobacco

Most Connecticut regions and age groups reviewed were at or below the national average as far as cigarette use in the past month was concerned with the exception of the North West region for 12 – 17 year olds and the North West and North Central regions for 18 - 25 year olds based on the NSDUH. Similarly, use of Tobacco products in the past month, based on NSDUH 2008-10 data, found most of Connecticut below the national average, except for, again the North West region for 12 – 17 year olds and 18 – 25 year olds. The perception of risk data is consistent with these other findings; in that individuals in Connecticut perceive greater risk from smoking at each age group than the national

average. Only in the Eastern region for persons 26+ was the perceived risk estimated as less than that for the nation.

The DMHAS Tobacco Prevention and Enforcement Program supports adherence to laws prohibiting the sale of cigarettes and Tobacco products to minors through compliance inspections. The rate of noncompliance has decreased substantially over the last 10 years. The Connecticut data reported reflects this improved outcome.

Figure 18: Cigarette and Tobacco Use in the Five Regions Compared to all of Connecticut and the United States

Age Group	South West	South Central	Eastern	North Central	North West	Connecticut	United States
Cigarette Use in Past Month (%)							
12 - 17	6.6	8.8	8.8	8.7	9.2	8.4	8.8
18 - 25	35.3	34.1	*	35.9	37.4	35.8	35.5
26+	18.9	20.8	22.9	21.8	20.3	20.9	23.2
Tobacco Product Use in Past Month (%)							
12 - 17	9.3	11.3	10.3	10.5	11.5	10.6	11.3
18 - 25	40.3	40.2	*	41.1	44.0	41.2	41.4
26+	22.0	25.0	26.5	24.7	23.7	24.3	27.7
Perceptions of Great Risk of Smoking 1+ packs of Cigarettes/Day (%)							
12 - 17	71.1	70.0	69.3	69.5	69.7	69.9	66.8
18 - 25	69.0	69.7	64.6	67.8	66.1	67.7	66.2
26+	77.9	76.1	72.9	74.3	76.1	75.6	73.6

*low precision; no estimate reported
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010

Connecticut State DOE information reveals decreasing numbers of schools suspensions and expulsions between the 2006/7 school year and the 2010/11 school year from 26% to 21%.

Solutions and Strategies

- Increase smoking cessation initiatives in behavioral health organizations
- Improve access to nicotine replacement therapy
- Promote the use of the American Lung Association program called Teens Against Tobacco Use (TATU) in which high school teens are trained to do one-class presentations to elementary or middle school aged children
- Increase the number of designated bilingual staff persons to work with small retail stores
- Improve knowledge of Medicaid billing practices for smoking cessation supports
- Increase dissemination of free smoking cessation curriculum, called learning About Healthy Living to clinicians
- Support the continuation of the Statewide Tobacco Education Program (STEP)

Prevention Priority 6 & 7: Heroin and Cocaine

Little data is available specific to Heroin and Cocaine. On national surveys they are both included under "Illicit Drugs", but state and regional level data is limited. The 2008-10 NSDUH estimates that in Connecticut, 3.56% of those 12+ (127,238 persons) used illicit drugs other than Marijuana during the past year. More concerning is the apparent trend for those 18 and older to continue to use illicit drugs at rates at or above the national average, particularly in South Central and North West regions.

Available data on Cocaine usage in the past year reveals Connecticut averages slightly exceed the national average for those 12 – 25, and then falls slightly below for those 26+.

Figure 19: Illicit Drug and Cocaine Use in the Five Regions Compared to all of Connecticut and the United States

Age Group	South West	South Central	Eastern	North Central	North West	Connecticut	United States
Past Month Illicit Drug use Other than Marijuana (%)							
12 - 17	4.3	4.6	4.4	4.1	4.8	4.4	4.5
18 - 25	7.9	8.5	8.0	7.9	9.4	8.3	8.0
26+	2.7	3.0	2.4	2.4	3.7	2.8	2.7
Past year Cocaine Use (%)							
12 - 17	*	1.1	1.4	1.2	1.1	1.2	1.1
18 - 25	4.6	5.0	5.9	6.0	4.6	5.3	5.2
26+	1.3	1.2	1.5	1.5	1.3	1.4	1.5
Illicit Drug Dependence in Past Year (%)							
12 - 17	2.3	2.4	2.4	2.5	3.2	2.6	2.5
18 - 25	5.6	6.6	5.0	5.5	6.2	5.8	5.5
26+	1.1	1.4	1.2	1.3	1.5	1.3	1.2

*low precision; no estimate reported
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010

Regions demonstrating highest prevalence of past year Cocaine use per NSDUH data, are the Eastern and North Central regions.

Connecticut exceeds national averages across age groups for the category Illicit Drug Dependence in the Past Year. This concerning result is most obvious for the 18 – 25 year old group which meets or exceeds the national average in each region except the East, and likewise for those 26+ in all regions except the South West. The younger age group (12 – 17) matches the 2.5% national average and only exceeds in the North West region.

Illicit drug-related school suspensions and expulsions rose between the 2006/7 school year and the 2010/11 school year across Connecticut from 20.6 to 24.1 per 10,000.

Solutions and Strategies

- Increase collection of local data and information about the incidence of Heroin and Cocaine use to inform future prevention activities

- Focus prevention activities on raising awareness and building partnerships as most people seem unaware of or in denial of the existence of illicit drug use in general, and Heroin and Cocaine use, in particular
- Maintain efforts in the areas of education, law enforcement, and treatment capacity for dealing with Heroin and Cocaine

Prevention Priority 8: Problem Gambling

The vast majority of individuals in Connecticut who gamble are able to do so with little or no adverse consequences. The prevalence of Problem Gambling is correlated to population and access to gambling opportunities. Gambling disorders are significantly more prevalent among males and younger persons than the general population.

According to the Connecticut Council on Problem Gambling's 2010 Annual Helpline Report, just over 300 problem gamblers called their helpline. Most were male (64.8%) and white (76.5%) and in their forties. The most recent study of youth gambling in Connecticut, from 2008, found that 90% of students surveyed reported having gambled in the past year and about 32% of students first gambled at age 11 or younger. Of those surveyed, 10.4% were classified as probable problem gamblers.

Solutions and Strategies

- Continue to deliver Gambling-Informed prevention services to the area and especially to at-risk populations such as college students and the elderly
- Hold quarterly regional meetings for providers implementing gambling prevention and treatment services
- Continue to disseminate the Taking Charge: A Path to Healthy Choices curriculum to address risk behaviors, problem solving, risk reduction, and healthy decision-making for middle and high school aged youth
- Sustain the Connecticut Women and Problem Gambling Project and the Congregation Assistance Program (CAP) for clergy and laypersons
- Sustain the Bettor Choice outpatient program for problem gamblers
- Improve data collection to measure changes in prevalence and to better understand the impact of problem gambling on Connecticut's communities
- Improve outreach to those already struggling financially who may be at a higher risk for problem gambling and to a broader range of cultural groups

Appendix A

Statewide
Regional Provider
Survey Results

Mental Health Services
With and Without "Don't Knows (DKs)"

Clinical Availability (with DKs)			
Service Type	**Not/Sometimes**	**Often/Always**	**Don't Know**
MH Acute IP DMHAS	67.4%	18.9%	13.7%
MH Co-occurring IP	60.2%	31.6%	8.2%
SubAcute	58.8%	16.5%	24.7%
YAS IP	57.1%	13.3%	29.6%
Respite	53.6%	23.7%	22.7%
ACT	44.3%	24.7%	30.9%
MH Acute IP – Gen. Hosp.	39.6%	51.0%	9.4%
OP Psychiatrist/APRN	35.4%	56.3%	8.3%
YAS Community Teams	34.7%	26.5%	38.8%
MH Crisis	32.7%	58.2%	9.2%
Jail Diversion	31.6%	46.9%	21.4%
Intensive Outpatient	30.6%	63.3%	6.1%
MH Co-occurring OP	27.6%	65.3%	7.1%
MH Outpatient	19.4%	77.6%	3.1%

Clinical Availability (without DKs)		
Service Type	**Not/Sometimes**	**Often/Always**
YAS IP	81.2%	18.8%
SubAcute	78.1%	21.9%
MH Acute IP DMHAS	78.0%	22.0%
Respite	69.3%	30.7%
MH Co-occurring IP	65.6%	34.4%
ACT	64.2%	35.8%
YAS Community Teams	56.7%	43.3%
MH Acute IP – Gen. Hosp.	43.7%	56.3%
Jail Diversion	40.3%	59.7%
OP Psychiatrist/APRN	38.6%	61.4%
MH Crisis	36.0%	64.0%
Intensive Outpatient	32.6%	67.4%
MH Co-occurring OP	29.7%	70.3%
MH Outpatient	20.0%	80.0%

Recovery Availability (with DKs)			
Service Type	**Not/Sometimes**	**Often/Always**	**Don't Know**
Transportation	66.3%	27.6%	6.1%
Group Homes	62.2%	22.4%	15.3%
Supervised Apartments	59.2%	31.6%	9.2%
Supportive Housing	58.3%	34.4%	7.3%
Supported Education	52.0%	36.7%	11.2%
Peer Support	35.7%	54.1%	10.2%
Supported Employment	35.1%	57.7%	7.2%
Outreach & Engagement	33.0%	61.9%	5.2%
CSP/RP	33.0%	48.5%	18.6%
Psychosocial Rehab	22.7%	66.0%	11.3%

Recovery Availability (without DKs)		
Service Type	**Not/Sometimes**	**Often/Always**
Group Homes	73.5%	26.5%
Transportation	70.7%	29.3%
Supervised Apartments	65.2%	34.8%
Supportive Housing	62.9%	37.1%
Supported Education	58.6%	41.4%
CSP/RP	40.5%	59.5%
Peer Support	39.8%	60.2%
Supported Employment	37.8%	62.2%
Outreach & Engagement	34.8%	65.2%
Psychosocial Rehab	25.6%	74.4%

Barriers to Treatment (with DKs)			
Service Type	**Not/Sometimes**	**Often/Always**	**Don't Know**
Housing	33.9%	63.9%	3.1%
Transportation	40.8%	58.2%	1.0%
Staffing	52.0%	45.9%	2.0%
Coordination between Primary Care & BH Care	56.1%	42.9%	1.0%
Long Waiting List	60.2%	39.8%	0.0%
Child Care	46.3%	36.8%	16.8%
Workforce Development	61.2%	35.7%	3.1%
Length of Stay Limitations	59.6%	35.4%	5.1%
Payment Requirements	62.2%	33.7%	4.1%
Public Awareness	69.4%	28.6%	2.0%
Client Engagement	72.7%	27.3%	0.0%
Coord. SA/MH Providers	73.5%	24.5%	2.0%
Community Supports	71.4%	24.5%	4.1%
Eligibility Criteria	74.7%	22.2%	3.0%
Medication Side Effects	73.5%	20.4%	6.1%
Coordination Human Services	78.6%	19.4%	2.0%
Language	80.4%	15.5%	4.1%
Hours of Operation	86.6%	13.4%	0.0%

Barriers to Treatment (without DKs)		
Service Type	**Not/Sometimes**	**Often/Always**
Housing	34.0%	66.0%
Transportation	41.2%	58.8%
Staffing	53.1%	46.9%
Child Care	55.7%	44.3%
Coordination between Primary Care & BH Care	56.7%	43.3%
Long Waiting List	60.2%	39.8%
Workforce Development	63.2%	36.8%
Length of Stay Limitations	62.8%	37.2%
Payment Requirements	64.9%	35.1%
Public Awareness	70.8%	29.2%
Client Engagement	72.7%	27.3%
Community Supports	73.5%	24.5%
Coord. SA/MH Providers	75.0%	25.0%
Eligibility Criteria	77.1%	22.9%
Medication Side Effects	78.3%	21.7%%
Coordination Human Services	80.2%	19.8%
Language	83.9%	16.1%
Hours of Operation	86.6%	13.4%

Addiction Services
With and Without "Don't Knows (DKs)"

Clinical Availability (with DKs)			
Service Type	**Not/Sometimes**	**Often/Always**	**Don't Know**
Long Term Care	70.7%	10.9%	18.5%
Intermediate Residential	68.1%	17.0%	14.9%
Intensive Residential	60.2%	25.8%	14.0%
Intermediate Resid. Women	60.2%	14.0%	25.8%
Co-occurring Residential	58.1%	25.8%	16.1%
Residential (Medically Monitored) Detoxification	46.8%	33.0%	20.2%
Ambulatory Buprenorphine	46.8%	24.5%	28.7%
Medically Managed Detox	45.7%	37.2%	17.0%
Ambulatory Detox	43.6%	27.7%	28.7%
Chemical Maintenance Bup	38.5%	35.2%	26.4%
Intensive OP Pregnant Women	38.3%	26.6%	35.1%
Intensive Outpatient	33.0%	54.3%	12.8%
Screening/Brief Intervention	30.9%	55.3%	13.8%
Co-occurring Outpatient	29.8%	59.6%	10.6%
Access Lines	28.7%	47.9%	23.4%
Methadone Maintenance	23.7%	62.4%	14.0%
Assessment	22.3%	60.6%	17.0%
Standard Outpatient	19.1%	70.2%	10.6%

Clinical Availability (without DKs)		
Service Type	**Not/Sometimes**	**Often/Always**
Long Term Care	86.7%	13.3%
Intermediate Resid. Women	81.2%	18.8%
Intermediate Residential	80.0%	20.0%
Intensive Residential	70.0%	30.0%
Co-occurring Residential	69.2%	30.8%
Ambulatory Buprenorphine	65.7%	34.3%
Ambulatory Detox	61.2%	38.8%
Intensive OP Pregnant Women	59.0%	41.0%
Residential (Medically Monitored) Detoxification	58.7%	41.3%
Medically Managed Detox	55.1%	44.9%
Chemical Maintenance Bup	52.2%	47.8%
Intensive Outpatient	37.8%	62.2%
Access Lines	37.5%	62.5%
Screening/Brief Intervention	35.8%	64.2%
Co-occurring Outpatient	33.3%	66.7%
Methadone Maintenance	27.5%	72.5%
Assessment	26.9%	73.1%
Standard Outpatient	21.4%	78.6%

Recovery Availability (with DKs)			
Service Type	**Not/Sometimes**	**Often/Always**	**Don't Know**
Transportation	66.3%	21.1%	12.6%
Education	57.9%	25.3%	16.8%
Employment	52.6%	33.7%	13.7%
Sober House	51.6%	33.7%	14.7%
Faith Based	51.6%	21.1%	27.4%
Recovery House	48.4%	35.8%	15.8%
Case Management	41.1%	44.2%	14.7%

Recovery Availability (without DKs)		
Service Type	**Not/Sometimes**	**Often/Always**
Transportation	75.9%	24.1%
Faith Based	71.0%	29.0%
Education	69.6%	30.4%
Employment	61.0%	39.0%
Sober House	60.5%	39.5%
Recovery House	57.5%	42.5%
Case Management	48.1%	51.9%

Barriers to Treatment (with DKs)			
Service Type	**Not/Sometimes**	**Often/Always**	**Don't Know**
Housing	36.8%	48.4%	14.7%
Transportation	42.1%	44.2%	13.7%
Client Engagement	52.6%	37.9%	9.5%
Staffing	48.4%	33.7%	17.9%
Long Waiting List	54.3%	31.9%	13.8%
Length of Stay Limitations	54.3%	30.9%	14.9%
Coordination between Primary Care & BH Care	56.0%	29.7$	14.3%
Community Supports	55.8%	28.4%	15.8%
Eligibility Criteria	58.9%	28.4%	12.6%
Child Care	42.6%	26.6%	30.9%
Payment Requirements	60.0%	25.3%	14.7%
Public Awareness	66.3%	25.3%	8.4%
Workforce Development	53.7%	25.3%	21.1%
Coordination Human Services	67.4%	21.1%	11.6%
Coord. SA/MH Providers	70.5%	20.0%	9.5%
Language	70.5%	15.8%	13.7%
Hours of Operation	74.7%	11.6%	13.7%
Medication Side Effects	71.6%	11.6%	16.8%

Barriers to Treatment (without DKs)		
Service Type	**Not/Sometimes**	**Often/Always**
Housing	43.2%	56.8%
Transportation	48.8%	51.2%
Client Engagement	58.1%	41.9%
Staffing	59.0%	41.0%
Child Care	61.5%	38.5%
Long Waiting List	63.0%	37.0%
Length of Stay Limitations	63.8%	36.3%
Coordination between Primary Care & BH Care	65.4%	34.6%
Community Supports	66.3%	33.8%
Eligibility Criteria	67.5%	32.5%
Workforce Development	68.0%	32.0%
Payment Requirements	70.4%	29.6%
Public Awareness	72.4%	27.6%
Coordination Human Services	76.2%	23.8%
Coord. SA/MH Providers	77.9%	22.1%
Language	81.7%	18.3%
Medication Side Effects	86.1%	13.9%
Hours of Operation	86.6%	13.4%

National Institute on Drug Abuse
The Science of Drug Abuse & Addiction

DrugFacts: Treatment Statistics

Print

Revised March 2011

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health,[1] 23.5 million persons aged 12 or older needed treatment for an illicit drug or alcohol abuse problem in 2009 (9.3 percent of persons aged 12 or older). Of these, only 2.6 million—11.2 percent of those who needed treatment—received it at a specialty facility.

SAMHSA also reports characteristics of admissions and discharges from substance abuse treatment facilities* in its Treatment Episode Data Set[2] (TEDS). According to TEDS, there were 1.8 million admissions in 2008 for treatment of alcohol and drug abuse to facilities that report to State administrative data systems. Most treatment admissions (41.4 percent) involved alcohol abuse. Heroin nd other opiates accounted for the largest percentage of drug-related admissions (20.0 percent), ollowed by marijuana (17.0 percent).

By Drug: Admissions to Publicly Funded Substance Abuse Treatment Programs, 2008

Percentage of Admissions**	Substance or Drug
23.1	Alcohol only
18.3	**Alcohol + another drug**
17.0	Marijuana
14.1	**Heroin**
8.1	Smoked cocaine (crack)
6.5	**Stimulants*** **
5.9	Opiates (not heroin) ****
3.2	**Nonsmoked cocaine (e.g., cocaine powder)**

0.6	Tranquilizers
0.2	**PCP**
0.2	Sedatives
0.1	**Hallucinogens**
0.1	Inhalants
0.4	**Other drugs**
2.2	None reported

About 60 percent of admissions were White, 21 percent were African-American, and 14 percent were Hispanic or Latino. Another 2.3 percent were American Indian or Alaska Native, and 1 percent were Asian/Pacific Islander.

By Race: Admissions to Publicly Funded Substance Abuse Treatment Programs, 2008

Percentage of Admissions**	Race/Ethnicity
59.8	White
20.9	**African-American**
13.7	Hispanic Origin
2.3	**American Indian or Alaska Native**
1.0	Asian/Pacific Islander
2.3	**Other**

The age range with the highest proportion of treatment admissions was the 25–29 group at 14.8 percent, followed by those 20–24 at 14.4 percent and those 40–44 at 12.6 percent.

By Age Group: Admissions to Publicly Funded Substance Abuse Treatment Programs, 2008

Percentage of Admissions**	Age Group
14.8	25-29
14.4	**20-24**

12.6	40-44
11.7	**35-39**
11.5	45-49
11.3	**30-34**
10.4	50-59
7.5	**12-17**
4.1	18-19
1.2	**60-64**
0.6	65 or older

Other Information Sources

For other information on treatment trends, visit SAMHSA's publications ordering page or its Center for Behavioral Health Statistics and Quality site.

For information on treatment research findings, visit our Treatment Research information page.

Data Sources

1. NSDUH (formerly known as the National Household Survey on Drug Abuse) is an annual survey of Americans aged 12 and older conducted by the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.
2. Treatment Episode Data Set (TEDS) 1998–2008: National Admissions to Substance Abuse Treatment Services is published by the Substance Abuse and Mental Health Services Administration, Office of Applied Studies. It contains demographic and substance abuse characteristics about treatment admissions to facilities that are licensed or certified by State substance abuse agencies.

Notes

* Includes facilities that are licensed or certified by the State substance abuse agency to provide substance abuse treatment. In general, facilities that report data are those that receive State alcohol and/or drug agency funds for the provision of alcohol and/or drug treatment services.

** Totals may add up to more or less than 100 percent because of rounding.

*** Methamphetamine accounted for 6.1 percent of admissions, and the remaining 0.4 percent were categorized as "Other Amphetamine."

**** These drugs include codeine, hydrocodone, hydromorphone, meperidine, morphine, opium, oxycodone, pentazocine, propoxyphene, tramadol, and any other drug with morphine-like effects. Nonprescription use of methadone is not included.

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AMERICAN FactFinder

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2008-2012 American Community Survey 5-Year Estimates

Supporting documentation on code lists, subject definitions, data accuracy, and statistical testing can be found on the American Community Survey website in the Data and Documentation section.

Sample size and data quality measures (including coverage rates, allocation rates, and response rates) can be found on the American Community Survey website in the Methodology section.

Although the American Community Survey (ACS) produces population, demographic and housing unit estimates, it is the Census Bureau's Population Estimates Program that produces and disseminates the official estimates of the population for the nation, states, counties, cities and towns and estimates of housing units for states and counties.

Subject	New Haven town, New Haven County, Connecticut			
	Estimate	Margin of Error	Percent	Percent Margin of Error
EMPLOYMENT STATUS				
Population 16 years and over	104,106	+/-835	104,106	(X)
In labor force	68,080	+/-1,311	65.4%	+/-1.2
Civilian labor force	67,993	+/-1,316	65.3%	+/-1.2
Employed	58,592	+/-1,304	56.3%	+/-1.2
Unemployed	9,401	+/-812	9.0%	+/-0.8
med Forces	87	+/-88	0.1%	+/-0.1
Not in labor force	36,026	+/-1,274	34.6%	+/-1.2
Civilian labor force	67,993	+/-1,316	67,993	(X)
Percent Unemployed	(X)	(X)	13.8%	+/-1.1
Females 16 years and over	55,694	+/-958	55,694	(X)
In labor force	35,100	+/-952	63.0%	+/-1.6
Civilian labor force	35,046	+/-960	62.9%	+/-1.6
Employed	30,749	+/-967	55.2%	+/-1.6
Own children under 6 years	9,578	+/-676	9,578	(X)
All parents in family in labor force	6,966	+/-555	72.7%	+/-4.2
Own children 6 to 17 years	18,121	+/-960	18,121	(X)
All parents in family in labor force	14,546	+/-1,015	80.3%	+/-3.3
COMMUTING TO WORK				
Workers 16 years and over	57,234	+/-1,270	57,234	(X)
Car, truck, or van -- drove alone	33,020	+/-1,247	57.7%	+/-2.1
Car, truck, or van -- carpooled	5,433	+/-660	9.5%	+/-1.1
Public transportation (excluding taxicab)	7,507	+/-747	13.1%	+/-1.2
Walked	7,090	+/-634	12.4%	+/-1.0
Other means	2,265	+/-372	4.0%	+/-0.6
Worked at home	1,919	+/-336	3.4%	+/-0.6
an travel time to work (minutes)	22.4	+/-0.7	(X)	(X)
OCCUPATION				
Civilian employed population 16 years and over	58,592	+/-1,304	58,592	(X)

Subject	New Haven town, New Haven County, Connecticut			
	Estimate	Margin of Error	Percent	Percent Margin of Error
Management, business, science, and arts occupations	22,319	+/-914	38.1%	+/-1.5
Service occupations	13,821	+/-905	23.6%	+/-1.5
s and office occupations	11,814	+/-801	20.2%	+/-1.2
atural resources, construction, and maintenance occupations	3,015	+/-394	5.1%	+/-0.7
Production, transportation, and material moving occupations	7,623	+/-711	13.0%	+/-1.1
INDUSTRY				
Civilian employed population 16 years and over	58,592	+/-1,304	58,592	(X)
Agriculture, forestry, fishing and hunting, and mining	352	+/-198	0.6%	+/-0.3
Construction	1,931	+/-345	3.3%	+/-0.6
Manufacturing	5,002	+/-554	8.5%	+/-0.9
Wholesale trade	899	+/-199	1.5%	+/-0.3
Retail trade	5,366	+/-550	9.2%	+/-0.9
Transportation and warehousing, and utilities	1,930	+/-292	3.3%	+/-0.5
Information	1,234	+/-287	2.1%	+/-0.5
Finance and insurance, and real estate and rental and leasing	2,527	+/-345	4.3%	+/-0.6
Professional, scientific, and management, and administrative and waste management services	4,627	+/-437	7.9%	+/-0.7
Educational services, and health care and social assistance	23,689	+/-1,063	40.4%	+/-1.7
Arts, entertainment, and recreation, and accommodation and food services	6,455	+/-781	11.0%	+/-1.3
Other services, except public administration	2,535	+/-382	4.3%	+/-0.6
Public administration	2,045	+/-336	3.5%	+/-0.6
CLASS OF WORKER				
Civilian employed population 16 years and over	58,592	+/-1,304	58,592	(X)
Private wage and salary workers	48,517	+/-1,410	82.8%	+/-1.3
ernment workers	7,677	+/-690	13.1%	+/-1.2
Self-employed in own not incorporated business workers	2,376	+/-344	4.1%	+/-0.6
Unpaid family workers	22	+/-27	0.0%	+/-0.1
INCOME AND BENEFITS (IN 2012 INFLATION-ADJUSTED DOLLARS)				
Total households	49,308	+/-990	49,308	(X)
Less than $10,000	7,163	+/-539	14.5%	+/-1.0
$10,000 to $14,999	3,794	+/-435	7.7%	+/-0.8
$15,000 to $24,999	6,638	+/-529	13.5%	+/-1.0
$25,000 to $34,999	5,480	+/-475	11.1%	+/-0.9
$35,000 to $49,999	6,199	+/-520	12.6%	+/-1.0
$50,000 to $74,999	7,665	+/-594	15.5%	+/-1.2
$75,000 to $99,999	4,686	+/-426	9.5%	+/-0.9
$100,000 to $149,999	4,669	+/-407	9.5%	+/-0.8
$150,000 to $199,999	1,575	+/-254	3.2%	+/-0.5
$200,000 or more	1,439	+/-206	2.9%	+/-0.4
Median household income (dollars)	38,482	+/-1,865	(X)	(X)
Mean household income (dollars)	57,058	+/-1,539	(X)	(X)
With earnings	37,748	+/-847	76.6%	+/-1.2
Mean earnings (dollars)	61,560	+/-1,746	(X)	(X)
With Social Security	11,104	+/-686	22.5%	+/-1.3
Mean Social Security income (dollars)	13,802	+/-453	(X)	(X)
With retirement income	4,386	+/-414	8.9%	+/-0.8
Mean retirement income (dollars)	21,265	+/-2,413	(X)	(X)
h Supplemental Security Income	3,603	+/-422	7.3%	+/-0.8
Mean Supplemental Security Income (dollars)	8,528	+/-570	(X)	(X)
With cash public assistance income	2,813	+/-364	5.7%	+/-0.7

Subject	New Haven town, New Haven County, Connecticut			
	Estimate	Margin of Error	Percent	Percent Margin of Error
Mean cash public assistance income (dollars)	4,932	+/-570	(X)	(X)
With Food Stamp/SNAP benefits in the past 12 months	11,745	+/-645	23.8%	+/-1.3
Families	26,343	+/-642	26,343	(X)
Less than $10,000	2,686	+/-354	10.2%	+/-1.3
$10,000 to $14,999	1,334	+/-220	5.1%	+/-0.8
$15,000 to $24,999	3,559	+/-416	13.5%	+/-1.5
$25,000 to $34,999	2,913	+/-413	11.1%	+/-1.5
$35,000 to $49,999	3,326	+/-438	12.6%	+/-1.7
$50,000 to $74,999	4,327	+/-500	16.4%	+/-1.8
$75,000 to $99,999	2,968	+/-355	11.3%	+/-1.4
$100,000 to $149,999	3,115	+/-362	11.8%	+/-1.4
$150,000 to $199,999	1,056	+/-200	4.0%	+/-0.8
$200,000 or more	1,059	+/-163	4.0%	+/-0.6
Median family income (dollars)	46,145	+/-2,593	(X)	(X)
Mean family income (dollars)	66,970	+/-2,571	(X)	(X)
Per capita income (dollars)	23,026	+/-660	(X)	(X)
Nonfamily households	22,965	+/-846	22,965	(X)
Median nonfamily income (dollars)	28,180	+/-1,896	(X)	(X)
Mean nonfamily income (dollars)	42,616	+/-2,271	(X)	(X)
Median earnings for workers (dollars)	25,131	+/-1,038	(X)	(X)
Median earnings for male full-time, year-round workers (dollars)	44,853	+/-2,060	(X)	(X)
Median earnings for female full-time, year-round workers (dollars)	39,739	+/-1,864	(X)	(X)
LTH INSURANCE COVERAGE				
ivilian noninstitutionalized population	128,205	+/-277	128,205	(X)
With health insurance coverage	110,190	+/-1,302	85.9%	+/-1.0
With private health insurance	70,419	+/-1,753	54.9%	+/-1.4
With public coverage	48,608	+/-1,608	37.9%	+/-1.3
No health insurance coverage	18,015	+/-1,265	14.1%	+/-1.0
Civilian noninstitutionalized population under 18 years	29,442	+/-896	29,442	(X)
No health insurance coverage	1,660	+/-475	5.6%	+/-1.6
Civilian noninstitutionalized population 18 to 64 years	87,425	+/-1,039	87,425	(X)
In labor force:	64,808	+/-1,361	64,808	(X)
Employed:	56,090	+/-1,347	56,090	(X)
With health insurance coverage	46,191	+/-1,380	82.4%	+/-1.6
With private health insurance	39,587	+/-1,295	70.6%	+/-1.7
With public coverage	7,801	+/-708	13.9%	+/-1.2
No health insurance coverage	9,899	+/-921	17.6%	+/-1.6
Unemployed:	8,718	+/-786	8,718	(X)
With health insurance coverage	5,546	+/-579	63.6%	+/-4.2
With private health insurance	1,863	+/-330	21.4%	+/-3.3
With public coverage	3,978	+/-471	45.6%	+/-4.1
No health insurance coverage	3,172	+/-496	36.4%	+/-4.2
Not in labor force:	22,617	+/-1,028	22,617	(X)
With health insurance coverage	19,428	+/-921	85.9%	+/-1.8
With private health insurance	11,170	+/-691	49.4%	+/-2.4
With public coverage	9,026	+/-642	39.9%	+/-2.1
No health insurance coverage	3,189	+/-454	14.1%	+/-1.8

Subject	New Haven town, New Haven County, Connecticut			
	Estimate	Margin of Error	Percent	Percent Margin of Error
PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL				
families	(X)	(X)	21.8%	+/-1.7
With related children under 18 years	(X)	(X)	31.3%	+/-2.7
With related children under 5 years only	(X)	(X)	20.5%	+/-4.9
Married couple families	(X)	(X)	8.6%	+/-1.5
With related children under 18 years	(X)	(X)	13.4%	+/-2.9
With related children under 5 years only	(X)	(X)	10.7%	+/-6.0
Families with female householder, no husband present	(X)	(X)	36.7%	+/-3.6
With related children under 18 years	(X)	(X)	45.1%	+/-4.5
With related children under 5 years only	(X)	(X)	39.3%	+/-12.7
All people	(X)	(X)	26.9%	+/-1.5
Under 18 years	(X)	(X)	37.3%	+/-3.1
Related children under 18 years	(X)	(X)	37.1%	+/-3.1
Related children under 5 years	(X)	(X)	35.9%	+/-4.0
Related children 5 to 17 years	(X)	(X)	37.6%	+/-3.8
18 years and over	(X)	(X)	23.6%	+/-1.3
18 to 64 years	(X)	(X)	24.6%	+/-1.3
65 years and over	(X)	(X)	16.5%	+/-2.3
People in families	(X)	(X)	24.0%	+/-2.0
Unrelated individuals 15 years and over	(X)	(X)	34.1%	+/-2.0

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

There were changes in the edit between 2009 and 2010 regarding Supplemental Security Income (SSI) and Social Security. The changes in the edit loosened restrictions on disability requirements for receipt of SSI resulting in an increase in the total number of SSI recipients in the American Community Survey. The changes also loosened restrictions on possible reported monthly amounts in Social Security income resulting in higher Social Security aggregate amounts. These results more closely match administrative counts compiled by the Social Security Administration.

Workers include members of the Armed Forces and civilians who were at work last week.

Industry codes are 4-digit codes and are based on the North American Industry Classification System 2007. The Industry categories adhere to the guidelines issued in Clarification Memorandum No. 2, "NAICS Alternate Aggregation Structure for Use By U.S. Statistical Agencies," issued by the Office of Management and Budget.

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Estimates of urban and rural population, housing units, and characteristics reflect boundaries of urban areas defined based on Census 2000 data. Boundaries for urban areas have not been updated since Census 2000. As a result, data for urban and rural areas from the ACS do not necessarily reflect the results of ongoing urbanization.

Source: U.S. Census Bureau, 2008-2012 American Community Survey

Explanation of Symbols:

1. An '**' entry in the margin of error column indicates that either no sample observations or too few sample observations were available to compute a standard error and thus the margin of error. A statistical test is not appropriate.
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2008-2012 American Community Survey 5-Year Estimates

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Sample size and data quality measures (including coverage rates, allocation rates, and response rates) can be found on the American Community Survey website in the Methodology section.

Although the American Community Survey (ACS) produces population, demographic and housing unit estimates, it is the Census Bureau's Population Estimates Program that produces and disseminates the official estimates of the population for the nation, states, counties, cities and towns and estimates of housing units for states and counties.

Subject	New Haven County, Connecticut			
	Estimate	Margin of Error	Percent	Percent Margin of Error
EMPLOYMENT STATUS				
Population 16 years and over	693,555	+/-583	693,555	(X)
In labor force	469,719	+/-2,747	67.7%	+/-0.4
Civilian labor force	469,325	+/-2,774	67.7%	+/-0.4
Employed	422,381	+/-2,867	60.9%	+/-0.4
Unemployed	46,944	+/-1,788	6.8%	+/-0.3
med Forces	394	+/-150	0.1%	+/-0.1
Not in labor force	223,836	+/-2,770	32.3%	+/-0.4
Civilian labor force	469,325	+/-2,774	469,325	(X)
Percent Unemployed	(X)	(X)	10.0%	+/-0.4
Females 16 years and over	364,497	+/-515	364,497	(X)
In labor force	233,086	+/-1,718	63.9%	+/-0.5
Civilian labor force	233,024	+/-1,734	63.9%	+/-0.5
Employed	211,845	+/-1,739	58.1%	+/-0.5
Own children under 6 years	56,797	+/-697	56,797	(X)
All parents in family in labor force	40,397	+/-1,206	71.1%	+/-1.8
Own children 6 to 17 years	127,119	+/-936	127,119	(X)
All parents in family in labor force	100,373	+/-1,688	79.0%	+/-1.2
COMMUTING TO WORK				
Workers 16 years and over	413,216	+/-2,858	413,216	(X)
Car, truck, or van -- drove alone	328,703	+/-2,698	79.5%	+/-0.5
Car, truck, or van -- carpooled	34,705	+/-1,427	8.4%	+/-0.3
Public transportation (excluding taxicab)	16,837	+/-1,040	4.1%	+/-0.2
Walked	13,643	+/-874	3.3%	+/-0.2
Other means	5,673	+/-594	1.4%	+/-0.1
Worked at home	13,655	+/-829	3.3%	+/-0.2
ean travel time to work (minutes)	24.1	+/-0.2	(X)	(X)
OCCUPATION				
Civilian employed population 16 years and over	422,381	+/-2,867	422,381	(X)

Subject	New Haven County, Connecticut			
	Estimate	Margin of Error	Percent	Percent Margin of Error
Management, business, science, and arts occupations	166,752	+/-2,458	39.5%	+/-0.6
Service occupations	73,184	+/-2,021	17.3%	+/-0.4
...es and office occupations	103,324	+/-2,168	24.5%	+/-0.5
...atural resources, construction, and maintenance occupations	31,024	+/-1,319	7.3%	+/-0.3
Production, transportation, and material moving occupations	48,097	+/-1,613	11.4%	+/-0.4
INDUSTRY				
Civilian employed population 16 years and over	422,381	+/-2,867	422,381	(X)
Agriculture, forestry, fishing and hunting, and mining	1,498	+/-325	0.4%	+/-0.1
Construction	22,359	+/-1,085	5.3%	+/-0.3
Manufacturing	51,271	+/-1,547	12.1%	+/-0.4
Wholesale trade	10,963	+/-671	2.6%	+/-0.2
Retail trade	46,653	+/-1,389	11.0%	+/-0.3
Transportation and warehousing, and utilities	16,833	+/-895	4.0%	+/-0.2
Information	11,031	+/-659	2.6%	+/-0.2
Finance and insurance, and real estate and rental and leasing	28,367	+/-1,282	6.7%	+/-0.3
Professional, scientific, and management, and administrative and waste management services	38,084	+/-1,292	9.0%	+/-0.3
Educational services, and health care and social assistance	129,676	+/-2,450	30.7%	+/-0.5
Arts, entertainment, and recreation, and accommodation and food services	31,310	+/-1,431	7.4%	+/-0.3
Other services, except public administration	17,827	+/-885	4.2%	+/-0.2
Public administration	16,509	+/-864	3.9%	+/-0.2
CLASS OF WORKER				
Civilian employed population 16 years and over	422,381	+/-2,867	422,381	(X)
Private wage and salary workers	341,323	+/-2,866	80.8%	+/-0.4
...ernment workers	57,378	+/-1,659	13.6%	+/-0.4
...elf-employed in own not incorporated business workers	23,324	+/-1,166	5.5%	+/-0.3
Unpaid family workers	356	+/-121	0.1%	+/-0.1
INCOME AND BENEFITS (IN 2012 INFLATION-ADJUSTED DOLLARS)				
Total households	329,956	+/-1,462	329,956	(X)
Less than $10,000	21,815	+/-1,031	6.6%	+/-0.3
$10,000 to $14,999	15,881	+/-940	4.8%	+/-0.3
$15,000 to $24,999	31,037	+/-1,102	9.4%	+/-0.3
$25,000 to $34,999	28,627	+/-1,083	8.7%	+/-0.3
$35,000 to $49,999	38,273	+/-1,118	11.6%	+/-0.3
$50,000 to $74,999	56,362	+/-1,415	17.1%	+/-0.4
$75,000 to $99,999	42,746	+/-1,318	13.0%	+/-0.4
$100,000 to $149,999	52,561	+/-1,562	15.9%	+/-0.5
$150,000 to $199,999	22,728	+/-1,010	6.9%	+/-0.3
$200,000 or more	19,926	+/-757	6.0%	+/-0.2
Median household income (dollars)	62,234	+/-677	(X)	(X)
Mean household income (dollars)	82,069	+/-776	(X)	(X)
With earnings	259,384	+/-1,611	78.6%	+/-0.4
Mean earnings (dollars)	85,823	+/-797	(X)	(X)
With Social Security	96,809	+/-1,348	29.3%	+/-0.4
Mean Social Security income (dollars)	17,222	+/-166	(X)	(X)
With retirement income	54,428	+/-1,221	16.5%	+/-0.4
Mean retirement income (dollars)	23,290	+/-755	(X)	(X)
...th Supplemental Security Income	14,681	+/-690	4.4%	+/-0.2
Mean Supplemental Security Income (dollars)	9,145	+/-262	(X)	(X)
With cash public assistance income	10,447	+/-641	3.2%	+/-0.2

Subject	New Haven County, Connecticut			
	Estimate	Margin of Error	Percent	Percent Margin of Error
Mean cash public assistance income (dollars)	4,377	+/-316	(X)	(X)
With Food Stamp/SNAP benefits in the past 12 months	39,353	+/-1,384	11.9%	+/-0.4
. amilies	214,719	+/-1,704	214,719	(X)
Less than $10,000	9,148	+/-753	4.3%	+/-0.3
$10,000 to $14,999	5,816	+/-575	2.7%	+/-0.3
$15,000 to $24,999	13,304	+/-692	6.2%	+/-0.3
$25,000 to $34,999	15,541	+/-807	7.2%	+/-0.4
$35,000 to $49,999	21,978	+/-864	10.2%	+/-0.4
$50,000 to $74,999	35,849	+/-1,122	16.7%	+/-0.5
$75,000 to $99,999	31,391	+/-1,149	14.6%	+/-0.5
$100,000 to $149,999	44,365	+/-1,362	20.7%	+/-0.6
$150,000 to $199,999	19,604	+/-936	9.1%	+/-0.4
$200,000 or more	17,723	+/-739	8.3%	+/-0.3
Median family income (dollars)	79,347	+/-1,055	(X)	(X)
Mean family income (dollars)	97,908	+/-1,050	(X)	(X)
Per capita income (dollars)	32,487	+/-315	(X)	(X)
Nonfamily households	115,237	+/-1,605	115,237	(X)
Median nonfamily income (dollars)	36,163	+/-988	(X)	(X)
Mean nonfamily income (dollars)	49,594	+/-1,247	(X)	(X)
Median earnings for workers (dollars)	36,403	+/-422	(X)	(X)
Median earnings for male full-time, year-round workers (dollars)	59,388	+/-879	(X)	(X)
Median earnings for female full-time, year-round workers (dollars)	46,588	+/-805	(X)	(X)
^LTH INSURANCE COVERAGE				
vilian noninstitutionalized population	849,727	+/-631	849,727	(X)
With health insurance coverage	775,992	+/-2,425	91.3%	+/-0.3
With private health insurance	613,443	+/-3,780	72.2%	+/-0.4
With public coverage	261,383	+/-3,254	30.8%	+/-0.4
No health insurance coverage	73,735	+/-2,327	8.7%	+/-0.3
Civilian noninstitutionalized population under 18 years	191,237	+/-130	191,237	(X)
No health insurance coverage	6,638	+/-822	3.5%	+/-0.4
Civilian noninstitutionalized population 18 to 64 years	540,003	+/-486	540,003	(X)
In labor force:	437,792	+/-2,410	437,792	(X)
Employed:	395,402	+/-2,739	395,402	(X)
With health insurance coverage	355,545	+/-2,662	89.9%	+/-0.4
With private health insurance	330,672	+/-2,806	83.6%	+/-0.5
With public coverage	32,198	+/-1,493	8.1%	+/-0.4
No health insurance coverage	39,857	+/-1,799	10.1%	+/-0.4
Unemployed:	42,390	+/-1,663	42,390	(X)
With health insurance coverage	29,175	+/-1,415	68.8%	+/-1.9
With private health insurance	16,927	+/-939	39.9%	+/-1.7
With public coverage	13,505	+/-882	31.9%	+/-1.5
No health insurance coverage	13,215	+/-934	31.2%	+/-1.9
Not in labor force:	102,211	+/-2,368	102,211	(X)
With health insurance coverage	89,093	+/-2,189	87.2%	+/-0.8
With private health insurance	57,127	+/-1,807	55.9%	+/-1.2
With public coverage	37,400	+/-1,451	36.6%	+/-1.1
lo health insurance coverage	13,118	+/-889	12.8%	+/-0.8

Subject	New Haven County, Connecticut			
	Estimate	Margin of Error	Percent	Percent Margin of Error
PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL				
amilies	(X)	(X)	9.1%	+/-0.5
.ith related children under 18 years	(X)	(X)	14.6%	+/-0.8
With related children under 5 years only	(X)	(X)	15.6%	+/-2.3
Married couple families	(X)	(X)	3.3%	+/-0.3
With related children under 18 years	(X)	(X)	4.7%	+/-0.6
With related children under 5 years only	(X)	(X)	5.7%	+/-1.7
Families with female householder, no husband present	(X)	(X)	27.0%	+/-1.6
With related children under 18 years	(X)	(X)	35.9%	+/-2.1
With related children under 5 years only	(X)	(X)	44.0%	+/-7.0
All people	(X)	(X)	12.0%	+/-0.4
Under 18 years	(X)	(X)	17.5%	+/-0.9
Related children under 18 years	(X)	(X)	17.2%	+/-0.9
Related children under 5 years	(X)	(X)	21.0%	+/-1.7
Related children 5 to 17 years	(X)	(X)	15.9%	+/-0.9
18 years and over	(X)	(X)	10.4%	+/-0.4
18 to 64 years	(X)	(X)	11.1%	+/-0.4
65 years and over	(X)	(X)	7.5%	+/-0.5
People in families	(X)	(X)	9.7%	+/-0.5
Unrelated individuals 15 years and over	(X)	(X)	22.0%	+/-0.8

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

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Source: U.S. Census Bureau, 2008-2012 American Community Survey

Explanation of Symbols:

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Subject	Connecticut			
	Estimate	Margin of Error	Percent	Percent Margin of Error
EMPLOYMENT STATUS				
Population 16 years and over	2,859,923	+/-1,046	2,859,923	(X)
In labor force	1,949,251	+/-5,170	68.2%	+/-0.2
Civilian labor force	1,940,413	+/-5,172	67.8%	+/-0.2
Employed	1,762,707	+/-5,695	61.6%	+/-0.2
Unemployed	177,706	+/-2,922	6.2%	+/-0.1
·med Forces	8,838	+/-503	0.3%	+/-0.1
Not in labor force	910,672	+/-5,149	31.8%	+/-0.2
Civilian labor force	1,940,413	+/-5,172	1,940,413	(X)
Percent Unemployed	(X)	(X)	9.2%	+/-0.2
Females 16 years and over	1,485,439	+/-817	1,485,439	(X)
In labor force	939,279	+/-3,351	63.2%	+/-0.2
Civilian labor force	938,290	+/-3,375	63.2%	+/-0.2
Employed	857,567	+/-3,673	57.7%	+/-0.2
Own children under 6 years	236,010	+/-1,577	236,010	(X)
All parents in family in labor force	162,617	+/-2,489	68.9%	+/-0.9
Own children 6 to 17 years	547,742	+/-1,754	547,742	(X)
All parents in family in labor force	414,277	+/-3,397	75.6%	+/-0.6
COMMUTING TO WORK				
Workers 16 years and over	1,730,076	+/-5,634	1,730,076	(X)
Car, truck, or van -- drove alone	1,362,328	+/-5,452	78.7%	+/-0.2
Car, truck, or van -- carpooled	146,721	+/-3,182	8.5%	+/-0.2
Public transportation (excluding taxicab)	78,653	+/-2,063	4.5%	+/-0.1
Walked	50,900	+/-1,683	2.9%	+/-0.1
Other means	20,663	+/-1,016	1.2%	+/-0.1
Worked at home	70,811	+/-2,091	4.1%	+/-0.1
·an travel time to work (minutes)	24.8	+/-0.1	(X)	(X)
OCCUPATION				
Civilian employed population 16 years and over	1,762,707	+/-5,695	1,762,707	(X)

Subject	Connecticut			
	Estimate	Margin of Error	Percent	Percent Margin of Error
Management, business, science, and arts occupations	721,154	+/-5,101	40.9%	+/-0.3
Service occupations	306,242	+/-3,937	17.4%	+/-0.2
les and office occupations	428,801	+/-4,273	24.3%	+/-0.2
natural resources, construction, and maintenance occupations	133,336	+/-2,480	7.6%	+/-0.1
Production, transportation, and material moving occupations	173,174	+/-3,402	9.8%	+/-0.2
INDUSTRY				
Civilian employed population 16 years and over	1,762,707	+/-5,695	1,762,707	(X)
Agriculture, forestry, fishing and hunting, and mining	6,786	+/-695	0.4%	+/-0.1
Construction	102,566	+/-2,297	5.8%	+/-0.1
Manufacturing	197,445	+/-3,048	11.2%	+/-0.2
Wholesale trade	43,172	+/-1,507	2.4%	+/-0.1
Retail trade	193,133	+/-3,195	11.0%	+/-0.2
Transportation and warehousing, and utilities	66,436	+/-1,794	3.8%	+/-0.1
Information	43,327	+/-1,474	2.5%	+/-0.1
Finance and insurance, and real estate and rental and leasing	165,347	+/-2,271	9.4%	+/-0.1
Professional, scientific, and management, and administrative and waste management services	190,556	+/-2,849	10.8%	+/-0.2
Educational services, and health care and social assistance	459,463	+/-4,525	26.1%	+/-0.2
Arts, entertainment, and recreation, and accommodation and food services	145,799	+/-3,338	8.3%	+/-0.2
Other services, except public administration	80,847	+/-2,039	4.6%	+/-0.1
Public administration	67,830	+/-1,446	3.8%	+/-0.1
CLASS OF WORKER				
Civilian employed population 16 years and over	1,762,707	+/-5,695	1,762,707	(X)
Private wage and salary workers	1,405,580	+/-5,516	79.7%	+/-0.2
vernment workers	239,107	+/-3,133	13.6%	+/-0.2
Self-employed in own not incorporated business workers	115,695	+/-2,368	6.6%	+/-0.1
Unpaid family workers	2,325	+/-334	0.1%	+/-0.1
INCOME AND BENEFITS (IN 2012 INFLATION-ADJUSTED DOLLARS)				
Total households	1,360,184	+/-3,254	1,360,184	(X)
Less than $10,000	75,058	+/-1,859	5.5%	+/-0.1
$10,000 to $14,999	54,957	+/-1,559	4.0%	+/-0.1
$15,000 to $24,999	112,156	+/-2,158	8.2%	+/-0.2
$25,000 to $34,999	106,343	+/-2,325	7.8%	+/-0.2
$35,000 to $49,999	149,868	+/-2,552	11.0%	+/-0.2
$50,000 to $74,999	227,033	+/-2,842	16.7%	+/-0.2
$75,000 to $99,999	182,040	+/-2,728	13.4%	+/-0.2
$100,000 to $149,999	229,474	+/-2,868	16.9%	+/-0.2
$150,000 to $199,999	102,997	+/-1,968	7.6%	+/-0.1
$200,000 or more	120,258	+/-1,999	8.8%	+/-0.1
Median household income (dollars)	69,519	+/-414	(X)	(X)
Mean household income (dollars)	97,051	+/-571	(X)	(X)
With earnings	1,088,616	+/-3,320	80.0%	+/-0.1
Mean earnings (dollars)	99,298	+/-619	(X)	(X)
With Social Security	391,495	+/-2,413	28.8%	+/-0.2
Mean Social Security income (dollars)	17,817	+/-85	(X)	(X)
With retirement income	240,578	+/-2,570	17.7%	+/-0.2
Mean retirement income (dollars)	25,396	+/-407	(X)	(X)
th Supplemental Security Income	49,030	+/-1,215	3.6%	+/-0.1
Mean Supplemental Security Income (dollars)	9,203	+/-151	(X)	(X)
With cash public assistance income	40,817	+/-1,228	3.0%	+/-0.1

Subject	Connecticut			
	Estimate	Margin of Error	Percent	Percent Margin of Error
Mean cash public assistance income (dollars)	4,405	+/-173	(X)	(X)
With Food Stamp/SNAP benefits in the past 12 months	129,644	+/-2,172	9.5%	+/-0.2
Families	907,600	+/-3,671	907,600	(X)
Less than $10,000	29,554	+/-1,242	3.3%	+/-0.1
$10,000 to $14,999	19,067	+/-999	2.1%	+/-0.1
$15,000 to $24,999	46,703	+/-1,242	5.1%	+/-0.1
$25,000 to $34,999	56,959	+/-1,598	6.3%	+/-0.2
$35,000 to $49,999	86,314	+/-1,974	9.5%	+/-0.2
$50,000 to $74,999	145,557	+/-2,491	16.0%	+/-0.3
$75,000 to $99,999	135,431	+/-2,475	14.9%	+/-0.3
$100,000 to $149,999	190,762	+/-2,586	21.0%	+/-0.3
$150,000 to $199,999	89,839	+/-1,819	9.9%	+/-0.2
$200,000 or more	107,414	+/-1,973	11.8%	+/-0.2
Median family income (dollars)	87,182	+/-585	(X)	(X)
Mean family income (dollars)	116,324	+/-788	(X)	(X)
Per capita income (dollars)	37,807	+/-222	(X)	(X)
Nonfamily households	452,584	+/-3,495	452,584	(X)
Median nonfamily income (dollars)	39,281	+/-547	(X)	(X)
Mean nonfamily income (dollars)	55,175	+/-692	(X)	(X)
Median earnings for workers (dollars)	37,923	+/-267	(X)	(X)
Median earnings for male full-time, year-round workers (dollars)	62,462	+/-413	(X)	(X)
Median earnings for female full-time, year-round workers (dollars)	48,004	+/-352	(X)	(X)
ALTH INSURANCE COVERAGE				
ivilian noninstitutionalized population	3,514,027	+/-498	3,514,027	(X)
With health insurance coverage	3,204,546	+/-5,829	91.2%	+/-0.2
With private health insurance	2,633,543	+/-9,989	74.9%	+/-0.3
With public coverage	983,714	+/-6,923	28.0%	+/-0.2
No health insurance coverage	309,481	+/-5,830	8.8%	+/-0.2
Civilian noninstitutionalized population under 18 years	811,021	+/-290	811,021	(X)
No health insurance coverage	28,798	+/-1,762	3.6%	+/-0.2
Civilian noninstitutionalized population 18 to 64 years	2,216,175	+/-746	2,216,175	(X)
In labor force:	1,806,841	+/-4,489	1,806,841	(X)
Employed:	1,647,595	+/-5,210	1,647,595	(X)
With health insurance coverage	1,474,093	+/-5,998	89.5%	+/-0.2
With private health insurance	1,385,285	+/-6,407	84.1%	+/-0.3
With public coverage	119,124	+/-2,584	7.2%	+/-0.2
No health insurance coverage	173,502	+/-4,065	10.5%	+/-0.2
Unemployed:	159,246	+/-2,664	159,246	(X)
With health insurance coverage	108,104	+/-2,325	67.9%	+/-0.9
With private health insurance	66,838	+/-1,644	42.0%	+/-0.9
With public coverage	45,516	+/-1,659	28.6%	+/-0.8
No health insurance coverage	51,142	+/-1,732	32.1%	+/-0.9
Not in labor force:	409,334	+/-4,573	409,334	(X)
With health insurance coverage	357,203	+/-4,205	87.3%	+/-0.4
With private health insurance	252,965	+/-3,703	61.8%	+/-0.6
With public coverage	126,379	+/-2,295	30.9%	+/-0.5
No health insurance coverage	52,131	+/-1,959	12.7%	+/-0.4

Subject	Connecticut			
	Estimate	Margin of Error	Percent	Percent Margin of Error
PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL				
families	(X)	(X)	7.1%	+/-0.2
With related children under 18 years	(X)	(X)	11.4%	+/-0.3
With related children under 5 years only	(X)	(X)	13.2%	+/-0.9
Married couple families	(X)	(X)	2.6%	+/-0.1
With related children under 18 years	(X)	(X)	3.5%	+/-0.3
With related children under 5 years only	(X)	(X)	3.9%	+/-0.7
Families with female householder, no husband present	(X)	(X)	23.4%	+/-0.7
With related children under 18 years	(X)	(X)	31.0%	+/-1.0
With related children under 5 years only	(X)	(X)	39.9%	+/-2.6
All people	(X)	(X)	10.0%	+/-0.2
Under 18 years	(X)	(X)	13.2%	+/-0.4
Related children under 18 years	(X)	(X)	13.0%	+/-0.4
Related children under 5 years	(X)	(X)	16.3%	+/-0.8
Related children 5 to 17 years	(X)	(X)	11.9%	+/-0.4
18 years and over	(X)	(X)	9.0%	+/-0.2
18 to 64 years	(X)	(X)	9.5%	+/-0.2
65 years and over	(X)	(X)	6.7%	+/-0.3
People in families	(X)	(X)	7.5%	+/-0.2
Unrelated individuals 15 years and over	(X)	(X)	20.8%	+/-0.5

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

There were changes in the edit between 2009 and 2010 regarding Supplemental Security Income (SSI) and Social Security. The changes in the edit loosened restrictions on disability requirements for receipt of SSI resulting in an increase in the total number of SSI recipients in the American Community Survey. The changes also loosened restrictions on possible reported monthly amounts in Social Security income resulting in higher Social Security aggregate amounts. These results more closely match administrative counts compiled by the Social Security Administration.

Workers include members of the Armed Forces and civilians who were at work last week.

Industry codes are 4-digit codes and are based on the North American Industry Classification System 2007. The Industry categories adhere to the guidelines issued in Clarification Memorandum No. 2, "NAICS Alternate Aggregation Structure for Use By U.S. Statistical Agencies," issued by the Office of Management and Budget.

While the 2008-2012 American Community Survey (ACS) data generally reflect the December 2009 Office of Management and Budget (OMB) definitions of metropolitan and micropolitan statistical areas; in certain instances the names, codes, and boundaries of the principal cities shown in ACS tables may differ from the OMB definitions due to differences in the effective dates of the geographic entities.

Estimates of urban and rural population, housing units, and characteristics reflect boundaries of urban areas defined based on Census 2000 data. Boundaries for urban areas have not been updated since Census 2000. As a result, data for urban and rural areas from the ACS do not necessarily reflect the results of ongoing urbanization.

Source: U.S. Census Bureau, 2008-2012 American Community Survey

Explanation of Symbols:

1. An '**' entry in the margin of error column indicates that either no sample observations or too few sample observations were available to compute a standard error and thus the margin of error. A statistical test is not appropriate.
2. An '-' entry in the estimate column indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest interval or upper interval of an open-ended distribution.
3. An '-' following a median estimate means the median falls in the lowest interval of an open-ended distribution.

4. An '+' following a median estimate means the median falls in the upper interval of an open-ended distribution.
5. An '***' entry in the margin of error column indicates that the median falls in the lowest interval or upper interval of an open-ended distribution. A statistical test is not appropriate.
6. An '*****' entry in the margin of error column indicates that the estimate is controlled. A statistical test for sampling variability is not appropriate.
7. An 'N' entry in the estimate and margin of error columns indicates that data for this geographic area cannot be displayed because the number of sample cases is too small.
8. An '(X)' means that the estimate is not applicable or not available.

The New Haven Register (http://dev.saxo.nhregister.com)

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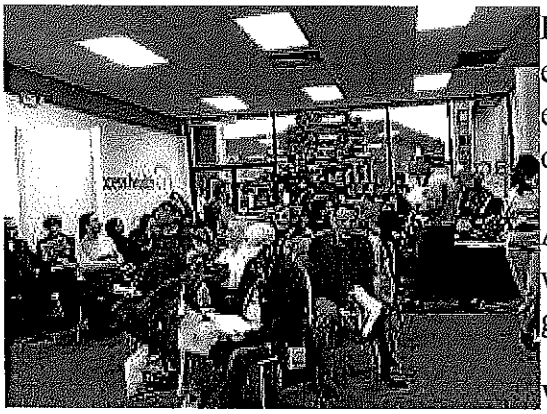
Connecticut enrolls total of 208,301 in health coverage

By The Associated Press

Thursday, April 17, 2014



HARTFORD >> Connecticut's health insurance exchange says it enrolled 208,301 individuals in health plans during the first open enrollment period for the Affordable Care Act, more than double the original goal of 100,000.

Access Health CT reported Thursday that 78,713 people signed up with private insurance carriers as of April 13. The rest enrolled in government-funded Medicaid.

When open enrollment ended March 31, Access Health CT had enrolled 197,878 people. But thousands of people left messages with Access Health CT, saying they attempted to enroll in person or online but didn't complete their applications.

Over the past two weeks, Access Health CT has made follow-up calls with about 10,000 people, ultimately increasing the final total.

Of the 78,713 who signed up for private plans, 78 percent received a tax subsidy while 22 percent did not.

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URL: http://dev.saxo.nhregister.com/general-news/20140417/connecticut-enrolls-total-of-208301-in-health-coverage

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HHS.gov/HealthCare

State-Level Estimates of Gains in Insurance Coverage Among Young Adults

Background on ASPE Issue Brief

New results from the National Health Interview Survey (NHIS) indicate that 3.1 million additional young adults have insurance coverage as of December 2011, due to the provision in the Affordable Care Act that allows 19 through 25 year olds to remain on their parents' insurance plans.

Methods

The NHIS survey is not large enough to allow estimates of how many young adults gained coverage within each State. So to estimate these numbers, analysts from the Department of Health and Human Services used the most recent state-level, Census Bureau data from before the Affordable Care Act provision went into effect. They calculated the number of 19 through 25 year olds who did not have health insurance in each state as of 2009 using the Census Bureau's largest source of state-level data, the American Community Survey. They then 'ivided up the estimated 3.1 million young adults who have gained insurance proportionately across all 50 states and the District of Columbia, based on their baseline number of uninsured adults in this age group.

This approach is only a rough approximation. It assumes that the effect of the Affordable Care Act's provision for young adults was similar across all states. This may not be true for several reasons, including differences in population demographics, parental availability of health insurance, and pre-existing laws in some states that already enabled a portion of young adults to enroll in their parents' plans.

However, it is notable that the pre-existing State laws in this realm did not apply to private self-insured plans, which are covered under the Affordable Care Act's dependent coverage provision. The majority of U.S. workers with insurance (60%) are in self-insured plans not subject to these state laws.[1]

Additionally, many states had age limits, requirements for student status, or exclusions for married young adults that further limited the impact of these laws. Due to these issues, the vast majority of young adults in the U.S. were not eligible for coverage under pre-existing state laws, which minimized their impact. This conclusion is supported by research published in peer review journals. One study showed that pre-existing state laws produced only a small gain in coverage of roughly three percent,[2] while two others showed no overall gain in coverage.[3],[4] There is no evidence that any state experienced anything close to the 10 percentage-point gain in coverage due to the Affordable Care Act's dependent coverage provision.

Results

Table 1: Estimated Number of Young Adults (19-25) by State Gaining Health Insurance Due to the

Affordable Care Act, through December 2011

State	Total Young Adults Gaining Health Insurance
Alabama	49,000
Alaska	9,000
Arizona	69,000
Arkansas	35,000
California	435,000
Colorado	50,000
Connecticut	23,000
District of Columbia	3,000
Delaware	6,000
Florida	224,000
Georgia	123,000
Hawaii	6,000
Idaho	17,000
Illinois	125,000
Indiana	62,000
Iowa	20,000
Kansas	25,000
Kentucky	48,000
Louisiana	53,000
Maine	9,000
Maryland	46,000
Massachusetts	21,000
Michigan	94,000
Minnesota	35,000
Mississippi	37,000
Missouri	55,000
Montana	12,000
North Carolina	95,000
North Dakota	5,000
New Hampshire	10,000
New Jersey	73,000
New Mexico	26,000
New York	160,000
Nebraska	18,000
Nevada	33,000
Ohio	97,000
Oklahoma	49,000

Oregon	43,000
Pennsylvania	91,000
Rhode Island	9,000
South Carolina	50,000
South Dakota	9,000
Tennessee	59,000
Texas	357,000
Utah	26,000
Vermont	5,000
Virginia	66,000
West Virginia	18,000
Washington	62,000
Wisconsin	43,000
Wyoming	6,000
TOTAL	**3,101,000**

Posted on: June 19, 2012

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[1] Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011

[2] Levine PB, McKnight R, Heep S. How Effective are Public Policies to Increase Health Insurance Coverage Among Young Adults? American Economic Journal: Economic Policy 2011;3:129-56.

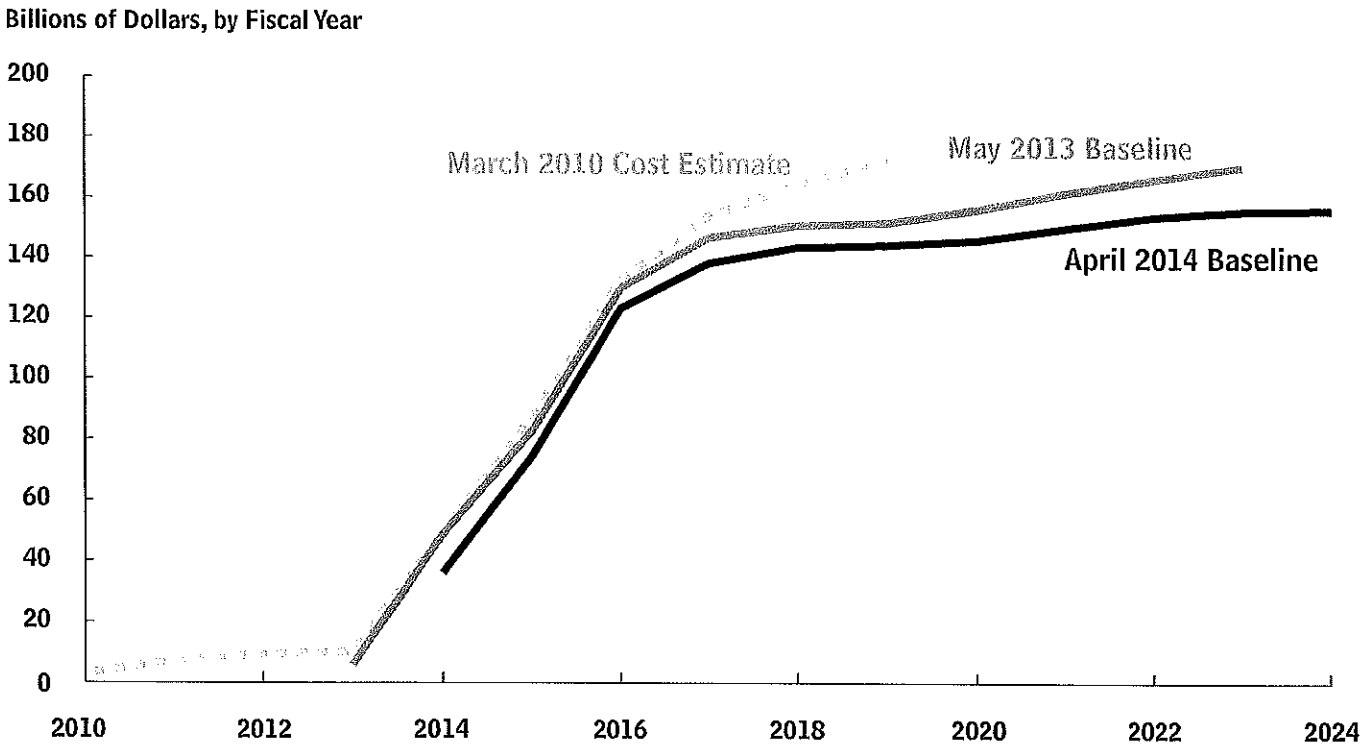
[3] Blum AB, Kleinman LC, Starfield B, Ross JS. Impact of state laws that extend eligibility for parents' health insurance coverage to young adults. Pediatrics 2012;129:426-32.

[4] Monheit AC, Cantor JC, DeLia D, Belloff D. How have state policies to expand dependent coverage affected the health insurance status of young adults? Health Serv Res 2011;46:251-67.

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

CBO

Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014



Comparison of CBO's Estimates of the Net Budgetary Effects of the Coverage Provisions of the Affordable Care Act

APRIL 2014

The Insurance Coverage Provisions and Their Effects on the Number of People With and Without Insurance

Among the key elements of the ACA's insurance coverage provisions that are encompassed by the estimates discussed here are the following:

- The ACA allows many individuals and families to purchase subsidized insurance through the exchanges (or marketplaces) operated either by the federal government or by a state government.
- States are permitted but not required to expand eligibility for Medicaid.
- Most legal residents of the United States must either obtain health insurance or pay a penalty for not doing so (under a provision known as the individual mandate).
- Certain employers that decline to offer their employees health insurance coverage that meets specified standards will be assessed penalties.
- A federal excise tax will be imposed on some health insurance plans with high premiums.
- Most insurers offering policies either for purchase through the exchanges or directly to consumers outside of the exchanges must meet several requirements: For example, they must accept all applicants regardless of health status; they may vary premiums only by age, smoking status, and geographic location; and they may not limit coverage for preexisting medical conditions.[4]
- Certain small employers that provide health insurance to their employees will be eligible to receive a tax credit of up to 50 percent of the cost of that insurance.

The ACA also made other changes to rules governing health insurance coverage that are not listed here. Those other provisions address coverage in the nongroup, small-group, and large-group markets, in some cases including self-insured employment-based plans.

4. Premiums charged for adults 21 or older may not vary according to age by a ratio of more than 3:1.

CBO and JCT estimate that the insurance coverage provisions of the ACA will increase the proportion of the nonelderly population with insurance from roughly 80 percent in the absence of the ACA to about 84 percent in 2014 and to about 89 percent in 2016 and beyond (see Table 2). CBO and JCT project that 12 million more nonelderly people will have health insurance in 2014 than would have had it in the absence of the ACA. They also project that 19 million more people will be insured in 2015, 25 million more will be insured in 2016, and 26 million more will be insured each year from 2017 through 2024 than would have been the case without the ACA.

Those gains in coverage will be the net result of many changes in insurance coverage relative to what would have occurred in the absence of the ACA. In 2018 and later years, 25 million people are projected to have coverage through the exchanges, and 13 million more, on net, are projected to have coverage through Medicaid and CHIP than would have had it in the absence of the ACA. Partly offsetting those increases, however, are projected net decreases in employment-based coverage and in coverage in the nongroup market outside the exchanges.

The estimated increase in insurance coverage in 2014 represents the number of people who are expected to be insured this year under current law minus the number who would have been insured this year in the absence of the ACA. That number may differ from the number of people who are expected to be insured this year minus the number who were insured last year, because people move in and out of insurance coverage over time as a result of changes in employment, family circumstances, and other factors. In particular, some people who had insurance coverage in 2013 and would have become uninsured in 2014 for one reason or another in the absence of the ACA will, under the ACA, be covered in 2014 through the exchanges, Medicaid, or CHIP. Those people are included in CBO and JCT's estimate of the increase in insurance coverage in 2014 that stems from the ACA.[5] CBO and JCT have not estimated the number of people who were uninsured in 2013 and will be insured in 2014.

5. Correspondingly, people who were uninsured in 2013 but would have obtained insurance in 2014 in the absence of the ACA are not counted as part of the increase in insurance coverage resulting from the ACA.

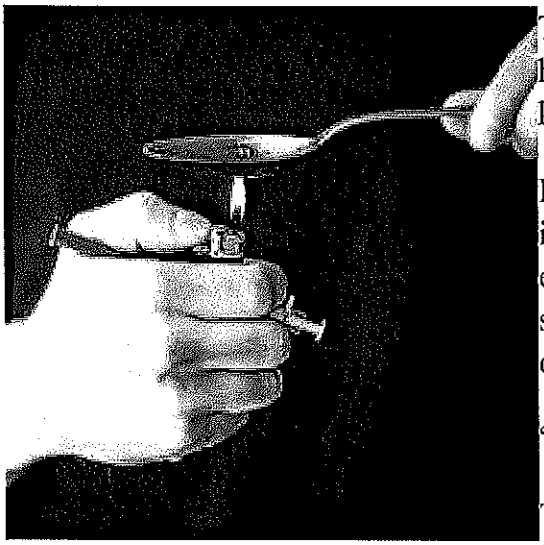
The New Haven Register (http://www.nhregister.com)

Heroin, opiate use soars in Valley, Greater New Haven as part of epidemic across Connecticut

In year, 117 people in 11 Valley, Greater New Haven towns overdosed

By Patricia Villers, New Haven Register

Monday, May 12, 2014



Towns in the Naugatuck Valley and elsewhere in Greater New Haven have seen a marked increase in the use of heroin and other opiates, in keeping with a disturbing trend throughout Connecticut.

Prescription drug and heroin abuse has grown to epidemic proportions in the Valley, as it has throughout the nation, says Pamela Mautte, executive director of the Valley Substance Abuse Action Council. She said experts say heroin addiction doesn't carry the stigma it did in past decades and is readily available.

"Opiate abuse is an epidemic across the nation," Mautte said.

The Valley Substance Abuse Action Council recently sponsored a "Call to Action," a forum focusing on opioid and heroin use and prescription drug misuse/abuse.

A meeting room at the Valley United Way office in Shelton was packed with more than 50 representatives of social service agencies, educators and law enforcement personnel who sought to shine a light on the escalating problem.

"Everyone has a role to play in the prevention of opiate use," Mautte said. "By engaging all sectors — education, business, faith, police, health care, neighbors — we can successfully combat opiate abuse."

According to statistics from the office of the chief medical examiner, 117 people overdosed from opioids in 2012 and 2013, Mautte said. Those numbers represent residents in the Valley Substance Abuse Action Council's 11-town service area, she said, which includes Ansonia, Derby, Seymour, Shelton, and Oxford in the Valley as well as Bethany, Orange, Woodbridge, Milford, New Haven and West Haven. The VSAAC, an Ansonia-based agency that is part of BHcare, a behavioral health organization, is one of 13 Regional Action Councils in Connecticut.

According to the Register Citizen, in 2013, 257 state residents died from heroin overdoses — 47 percent more than in 2012. At least eight of those confirmed deaths occurred in Torrington, with two deaths confirmed so far in 2014. According to the latest available figures from the state's medical examiner, 33 people died of heroin-

involved intoxication in January, a sharp increase from the 19 who died the same month in 2013.

From the Valley to the Shoreline and throughout Greater New Haven, officials are sounding the alarm.

Milford Prevention Council Advisory Committee member Carol Cruz said, so far this year, the city has had two drug overdoses that were non-fatal. Cruz said from 2001 to 2013, there were seven overdoses in Milford — one that resulted in death. Two years ago, a 25-year-old woman in Milford died of a heroin overdose, Cruz said.

Officials need "to recognize there is an epidemic" in the city, she said.

In addition, she said, 45 percent of drug overdose victims between 2011 and 2013 in Connecticut were former inmates.

The Centers for Disease Control and Prevention labeled the abuse of prescription drugs an epidemic, Mautte said. Statistics from the CDC say "nearly 15,000 people die every year of overdoses involving prescription painkillers."

She pointed to a 2011-12 CDC-financed study led by Traci C. Green, assistant professor of emergency medicine and epidemiology at Brown University in Providence, R.I.

Mautte said Green and her field team focused on communities in Rhode Island and Connecticut.

Ansonia and Seymour were two of the four Connecticut communities that were studied, Mautte said, because of the high numbers of drug users.

"We worked closely with Traci on the study," Mautte said. They found "so many avenues" that people use to turn to addiction, she said.

"Heroin users hide (their addiction) from people," Mautte said. "One of the reasons we had (at the) forum was to take action, since we've been watching an increase in opiate use."

She said addiction "affects everybody — friends, family members, co-workers. We want people not to have a stigma about it. (Addiction) needs to be treated like any medical condition. Treatment works," Mautte said. "People recover."

Mautte said communities need to put prevention strategies in place at the local, state, and national levels. "We need funding but we also need collaboration from a cross-section of the community," she said.

READ MORE: Advocates say access to overdose reversal drug Narcan must be increased

Wallingford resident Richard Figlewski is in his eighth year of recovery from substance abuse. He is the founder of The Dry Dock in Wallingford, an organization that helps others in recovery.

Figlewski said since the he founded The Dry Dock four years ago, the problem of heroin and opiate abuse has grown.

He said even though doctors and hospitals have gotten "stingier" in prescribing painkillers, "it really doesn't make a difference when you're an addict."

When addicts are cut off from prescription medications, they will go to their next alternative, and that's heroin, Figlewski said.

"Heroin is cheaper, and it's much less expensive than prescription drugs because a lot of people are looking for it," he said.

Figlewski said what scares him the most is that young people today are not afraid of using heroin. "There's no fear," he said.

Figlewski said The Dry Dock is not a treatment center, even though treatment does happen there. He called it a social place that features music and food. "We have a lot of people coming in, about 2,000 a month," he said.

Christian Meagher, communications specialist at Griffin Hospital in Derby, provided statistics on the number of "encounters" in the past three years with people who came into the hospital with "the diagnosis code of opiate use." He said the time frame for which statistics were readily available was May 2011 through April 2014.

During those three years, the hospital saw an increase of 36.8 percent in encounters. Meagher said the encounters could have occurred "anywhere in the hospital, but the majority are through our ED (emergency department)."

Meagher said from May 2011 through April 2012, 1,323 encounters were recorded. From May 2012 to April 2013, there were 1,728 encounters, and the most recent numbers from May 2013 to April 2014 were 1,810.

Meagher stressed the number of such encounters does not necessarily mean that is the number of individuals diagnosed, since sometimes the same people with addiction problems return to the hospital.

Meagher said he could not comment on the increase in heroin and opiate use, nor did he have hospital statistics on drug overdoses.

Police are on alert.

The Valley police departments have seen a significant increase in drug arrests in recent years, and they have reported that 80 to 90 percent of property crimes are drug-related.

Ansonia police spokesman Lt. Andrew Cota said although he didn't have a complete breakdown of each kind of narcotic arrest made, he provided total narcotic arrests since March 2011.

"Essentially, this is also when we started the Anti-Crime Unit," Cota said. "We made a total of 206 arrests for controlled drug purchases."

Cota said officers made 55 more drug arrests in that time as a result of search warrants executed throughout the city.

"We have in fact seen an increase in opiate/pill usage and arrests recently," Cota said. "We continue to search out and investigate narcotics cases throughout the city."

Derby police spokesman Lt. Sal Frosceno said his department made 59 drug/narcotic violation arrests in 2012 and 49 arrests in 2013.

In Seymour, Deputy Police Chief Paul Satkowski said drug arrests, for both marijuana and narcotics, like cocaine, pills and occasionally heroin (though rarely), increased from 2012 to 2013.

In 2012, police made 63 arrests for marijuana possession, and 75 arrests in 2013.

In 2012, police made nine arrests for narcotics possession, which Satkowski said include pills, cocaine and heroin, and that rose to 24 arrests in 2013. That's an increase of 167 percent.

So far this year, Satkowski said police have made "30 drug-related" arrests, but none for heroin.

"Narcotics and marijuana arrests are up in general," Satkowski said.

Satkowski said while he knows "there is heroin in the community, it's not something that has been prevalent here."

Have questions, feedback or ideas about our news coverage? Connect directly with New Haven Register editors at AsktheRegister.com. Register correspondent Jean Falbo-Sosnovich contributed to this story.

URL: http://www.nhregister.com/general-news/20140512/heroin-opiate-use-soars-in-valley-greater-new-haven-as-part-of-epidemic-across-connecticut

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Call to battle Connecticut's heroin epidemic

Bill Cummings
Updated 11:56 pm, Monday, March 17, 2014

HARTFORD -- Connecticut's U.S. senators are calling for more federal money and other assistance to battle a growing heroin epidemic in the state and across the nation.

"It's time for the federal government to partner with local government and do something about it," said U.S. Sen. Chris Murphy, D-Conn., referring to a dramatic rise in heroin-related deaths in Connecticut since 2012. Heroin-overdose deaths in the state climbed to 257 in 2013, compared to 174 in 2012, as the drug's use spread into suburbs and small towns, officials said.

"A lack of funding for treatment and enforcement is a big reason," Murphy said during a news conference Monday at the Alcohol and Drug Recovery Center in Hartford.

Hearst Connecticut Media on Sunday published the second part of a series on heroin addiction that looked at the recent deaths of two New Milford youths from overdoses. The third part of the series this coming Sunday will look at possible solutions to the growing epidemic.

Murphy, along with U.S. Sen. Richard Blumenthal, D-Conn., on Monday announced a five-point plan to help rein in the spread of heroin that includes increasing the $1.8 billion authorized by the Obama administration for the Substance Abuse and Mental Health Services Administration. The senators said they could not yet say how much federal spending should rise, noting they were working on the details of the plan.

The senators proposed increasing federal support for a law-enforcement crackdown on heroin trafficking, increasing funding to prevent heroin and prescription drug abuse, promoting community

collaboration among social service agencies and increasing the availability of heroin-overdose drugs that save lives.

Blumenthal said prescription painkillers like oxycodone are often a gateway to heroin, which is now far cheaper. He said a combination of moves by the international cartels that control the flow of heroin and the introduction of fentanyl, a synthetic version of heroin, has sharply reduced the price, Blumenthal said.

"There is a beltway of cheap, highly toxic and highly pure heroin coming into the country and our communities from organized corporate cartels in Colombia and Mexico," Blumenthal said. "These cartels are making billions of dollars at the expense of our lives and health and we need to crack down hard. It begins with prescription drugs. Cracking down on heroin also means a different attitude toward powerful pain relievers."

Dr. Charles McKay, chief of toxicology at Hartford Hospital, said the mixing of fentanyl and heroin is providing batches far stronger than users may realize, leading to unintended overdoses.

"People on the street are not good chemists. They don't mix things well," McKay said.

Murphy said, "This dramatic increase of heroin use and abuse in Connecticut is unlike anything we've ever seen. Our state has lost hundreds more people to heroin use in the last year, but we're not doing enough to change the way we address this crisis."

The senators threw their support behind a bill before the Connecticut General Assembly that seeks to resolve the fear of being sued if police officers administer naloxone, a heroin antidote that quickly revives a dying patient by reversing the effects of the drug.

Emergency medical personnel now administer naloxone, but health experts believe allowing police officers to also apply it, most likely through a nasal dose, could save more lives because officers are usually the first on the scene.

Hartford Deputy Police Chief Brian Foley said he supports the bill, explaining that heroin has spread far beyond urban areas.

"Hartford is the center of the current heroin problem," Foley said. "But other towns are all involved. We can sit in Frog Hollow (a troubled Hartford neighborhood) and pick off kids from every town."

Foley agreed that many heroin users start with prescription drugs like oxycodone. He said an estimated 40 percent of young heroin users initially obtain painkillers from their parents.

The senators said New York City and New Jersey are the main entry points in the Northeast for heroin.

"The New England supply chain begins in New Jersey and New York City and runs through Connecticut," Murphy said.

March 10, 2014|By DAVID OWENS, dowens@courant.com, The Hartford Courant

Accidental heroin deaths in Connecticut last year were up 48 percent from 2012, mirroring a trend across New England and the nation that the U.S. Attorney General Eric Holder on Monday called an "urgent public health crisis."

In Connecticut, 257 people died from heroin-related overdoses in 2013, up from 174 in 2012, according to data released by Chief Medical Examiner James R. Gill. In Hartford County, heroin overdose deaths increased 55 percent over the same period, to 82 in 2013 from 53 in 2012.

Heroin-related deaths and accidental overdoses have been on the rise throughout the Northeast. Authorities in Pennsylvania, Rhode Island, Massachusetts, Maine and Vermont have all reported significant increases in overdose deaths.

Vermont Gov. Peter Shumlin devoted most of his state of the state address in January to Vermont's heroin problem, which he called an "immediate health crisis." Fatal overdoses there nearly doubled from 2012 to 2013.

Heroin deaths nearly doubled from 2012 to 2013 in Hartford as well, and last month city police took the unusual step of warning addicts about an especially nasty batch of heroin contaminated with the synthetic opiate fentanyl. Heroin overdoses killed 31 people in Hartford in 2013, compared to 16 the previous year.

Accidental deaths from all drugs — including heroin, cocaine, morphine, codeine and mixes of drugs — increased 38 percent in Connecticut to 490 in 2013 from 355 in 2012, according to the data.

The steep death toll has continued into 2014, police said, although some overdose data are not available.

East Windsor has had four confirmed fatal heroin overdoses since Nov. 1, police said, and heroin is suspected in the deaths of three other people there as well. Fourteen-year-old East Windsor High School student Megan Koscinski died on Feb. 16.

"I would say 2014 is certainly going to be consistent with the rise in 2013," Hartford Deputy Police Chief Brian Foley said. Hartford narcotics detectives are "attacking it head-on," Foley said. "It is getting the majority of our narcotics attention right now. We're working with outside municipalities as necessary."

The especially dangerous heroin-fentanyl mix has attracted much attention, but the larger problem is the dramatic increase in the number of people using heroin, said Dr. Danyal Ibrahim, chief of toxicology at St. Francis Hospital and Medical Center in Hartford.

Efforts to curtail abuse of prescription opiates such as oxycodone have pushed addicts to heroin, he said.

Abuse of prescription opiates such as OxyContin began to emerge in the 1990s and exploded into a serious problem in the early 2000s. To curb abuse, the drug manufacturers reformulated OxyContin to make it more difficult to abuse, and the government aggressively prosecuted doctors who improperly prescribed the drugs. The reformulation made it more difficult for addicts to crush the drug into a powder they could then snort or inject.

Some addicts found ways to overcome the new formula. Others moved onto more readily available and less expensive heroin, Ibrahim said.

"If I am an addict on Vicodin or Percocet now experiencing withdrawal, an alternative is heroin because it works on the same receptors [in the brain]," Ibrahim said.

Theodore J. Cicero, a professor of neuropharmacology in psychiatry at Washington University in St. Louis, and a team of researchers noted the migration of prescription drug abusers to heroin in 2012 as a result of the reformulation of prescription narcotics.

They were so alarmed at what they found that they alerted the medical community in a letter to the New England Journal of Medicine. "It's a very new development [in] the last two to three years," Cicero said of the dramatic increase in heroin use by people who were abusing prescription drugs. "We're beginning to see all across the country an increase in overdose deaths."

Heroin use, which used to be confined mostly to cities and minority communities, has moved forcefully into the suburbs and rural areas. And the driver, Cicero said his research shows, is prescription drug abusers no longer able to get their hands on oxycodone who have moved on to heroin. "That's a very ominous development."

"Dealers have transitioned from shady people in the inner city to teenagers you go to school with, you work with," he said. There's also been a troubling change in attitude about heroin, he said.

"The whole social stigma with heroin has dissipated over time," Cicero said. "We see kids skipping right over prescription opiates and jumping right into heroin."

Although injecting heroin still carries a stigma, dealers introduce prescription drug addicts and others to heroin by telling them they can snort it or smoke it. Heroin is so addictive, though, that it's only a matter of time until users inject it.

The life of a heroin addict is already dangerous, especially for one who abuses heroin intravenously. Infections and diseases from sharing needles are a constant threat, Cicero said.

Prescription medications are predictable when they are abused. Users know the dose and what they are taking. Street drugs could be anything. Dealers add substances to heroin all along the supply chain so that he or she can increase profits.

"You can take a tablet, you can see a number on it, you can know it's oxycodone at a certain dose," Cicero said. With heroin, "you're buying a powder. The purity is uncertain. Addicts know that it's not pure, but they don't know exactly what the composition is. They make a guess at what the purity might be, inject, snort it ... and they end up dying."

And that's before heroin is mixed with fentanyl, which dramatically increases the chances of death in a heroin user.

Sometimes what is presented as heroin is pure fentanyl, said Lt. Ken Cain, head of the state police Statewide Narcotics Task Force. Other substances used to cut heroin include Benadryl, methadone, benzodiazepines and even veterinary drugs.

"Most drugs are not pure," said Dr. Kelly Johnson-Arbor, a toxicologist at Hartford Hospital. "What do you expect when you use heroin? Almost all of the heroin supply in the U.S. is contaminated. It's no surprise that we're seeing contaminants." The fentanyl, she said, "is a particularly bad one that causes more problems."

Cain said he suspects success in treating heroin addicts has also led to intoxication deaths. Addicts get into treatment, get clean and go to live in sober houses, he said.

"When those people relapse, they are more susceptible to overdosing and dying because their bodies are not used to the heroin," Cain said. "You get clean people who used to use 10 bags of heroin. They relapse. They get the same 10 bags and they put it into their body again." Their body can't handle it and they overdose.

Hospitals treat every heroin case differently because doctors can't know what the addict injected, Ibrahim said.

People who have accidentally overdosed are typically treated immediately with naloxone hydrochloride, which is also known as Narcan. The drug can dramatically reverse the results of an accidental overdose, and health officials are pushing for it to be widely available.

On Monday, Holder encouraged law enforcement agencies and first-responders to carry the drug.

Narcan is mostly useless to an addict unless there is someone nearby who can administer it.

"Narcan can be prescribed to people who live in close proximity to those who use opioids," said Mary Kate Mason, a spokeswoman for the state Department of Mental Health and Addiction Services. "You can't give it to yourself. You have to have friends or relatives available."

Paramedics can administer Narcan in Connecticut, and advocates are working to get Narcan into the hands of other first-responders, including police, firefighters, emergency medical technicians and others who would be in a position to aid someone who has accidentally overdosed.

"Connecticut is behind," said Shawn Lang, who has been working with an overdose prevention group the past year to get Narcan into the hands of those can use it to save lives.

"We would love Connecticut to model basically all our surrounding states so all first-responders — police officers, EMTs, firefighters — have Narcan available and can administer it," she said. "They're often the ones who arrive at the scene first. Those minutes are critical."

Police acknowledge that arresting drug dealers and seizing drugs will never solve the problem. Addicts need to have access to treatment and follow-up support to keep them from relapsing.

Cicero said his research, which includes surveys of and interviews with addicts, indicates there is a significant mental health component for many who become addicts.

"It's really very striking how psychiatrically problematic these individuals are," Cicero said. Addicts very often suffer from depression, anxiety and phobias.

"We find people are taking them to escape from life," Cicero said. "They want to blunt their emotional issues, feel better about themselves. We need to attack those fundamental problems."

The approach has been to treat substance abuse as an entity in itself, Cicero said. "What we're suggesting is it's a symptom of a larger problem. "You see how poorly people think of themselves and how much better they feel on drugs. There's something fundamental going on that we need to be addressing. From my perspective, that's the demand issue."

"When confronting the problem of substance abuse, it makes sense to focus attention on the most dangerous types of drugs," attorney general Holder said. "And right now, few substances are more lethal than prescription opiates and heroin."

Families torn apart by heroin

Two New Milford youths die of overdoses within 3-week span, leaving parents to ask what they could have done differently



Connecticut Post
Sunday, March 16, 2014

By Denis J. O'Malley

NEW MILFORD — Three weeks after Jessica Bradley confessed to her mother that she had tried heroin for the first time, the two drove to Rye, N.Y., for the wake of a friend.

It was late July, and Scott Lovito was just shy of his 22nd birthday when his mother, Kimberly Lapegna, found him dead of a heroin overdose in his bed in New Milford.

Before the long drive home to New Milford from Scott's native Westchester County, Jessica and her mother stopped for dinner.

"This is you," Juliette Bradley told Jessica, referring to Scott and his family gathered at the wake. "That's me standing there. That's your father standing there, and that's your brother. And is that what you want?"

"No, that it is not what I want," Jessica said. "I want to be well."

That evening fell within a four-week stretch of sobriety for Jessica, whose parents had started drug testing her since she came clean to them about her prescription drug abuse earlier that year and, more recently, her dabbling with heroin.

"And I really felt like, I really thought we had it," Juliette Bradley said in an interview with Hearst Connecticut Media. "I really thought she was committed to her recovery."

Three weeks later, Jessica relapsed, snorting a $5 bag of heroin in the bathroom of her

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Heroin deaths leave families in shock

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father's apartment after he had gone to bed.

"I heard the shower go on. She took a shower and when she was in the bathroom is when she did it, as far as I know," Sean Bradley said. "Then she came out, wrote in her journal and went to sleep — and never woke up."

Jessica died in her sleep of cardiac arrest in the early morning of Aug. 15.

An autopsy would later rule her death an accidental heroin overdose.

It was only the third time she had ever used the drug.

Parents in the dark

Before Lapegna found Scott lifeless, she had not known her son's drug use had progressed so far.

"I knew he smoked pot and was drinking," she said. "I was unaware he was even doing heroin until after he passed away."

One of the saddest parts of the story of Scott's and Jessica's drug abuse is that it is all too common. Heroin use statewide and nationally has skyrocketed since 2007, and spread out from cities to suburbs. Even in quaint, middle-class New Milford, the deaths of Scott and Jessica were only two of eight fatal opioid overdoses last year, at least four of which involved heroin.

"People need to be aware that this isn't some drug addiction problem where your kid's some junkie bootin' up with needles in the closet," Sean Bradley said. "This is affecting normal, middle- to upper-class families that are blind and naïve. They're going to a party, and when they go to a party this is what they're doing. They're popping pills, they're snorting heroin, they're snorting cocaine. They're pulling the wool over our eyes. I wanted other families to know that maybe they could save their child because our daughter was perfectly normal. She was a beautiful girl."

Jessica Bradley grew up on the shore of Candlewood Lake and attended the town's public schools through high school, where she graduated in 2011 as a star of the school's theater program.

Off the stage, she ran cross-country and played field hockey, but it was in the spotlight that she shined.

"My God, she just was so comfortable on the stage," her mother said.

"She didn't even need a microphone," her father said. "She could rock the halls."

After playing smaller roles in the school's productions in her freshman, sophomore and junior years, Jessica took the lead in "The Drowsy Chaperone" as a senior.

But for all her stage presence, at home she was still the same shy Jessica.

"She could always do that stuff, but she couldn't just come out in the living room and sing for us," Juliette Bradley said.

"No, we'd have to sit out there in the hall and listen to her behind the door," Sean Bradley said. "She'd close the door to sing."

Different paths

Scott Lovito grew up in lower Westchester and moved in with his grandparents in Greenwich to attend Greenwich High School and stay closer to his friends after his mother relocated to New Milford in 2007.

He moved in to the split-level house on Stephanie Drive with his mother, stepfather and two half-sisters in 2011, after his behavior, including drug use, had become too much for his grandparents, his mother said.

Outside his mother's watch, Scott's dalliances with alcohol and marijuana gave way to harder drugs, like prescription pills.

After a night spent crushing and snorting Xanax pills, Scott called his mother from a hospital early one morning in January 2011, clueless.

"I remember him calling me at 7:30 in the morning and saying 'Where am I? I think I'm in Stamford Hospital,' " Lapegna said.

Soon after, his family forced him to move in with them in New Milford.

"He came up here to kind of get his stuff together," said Scott's half-sister, Sarah Meagher, 15, a sophomore at New Milford High School. "He was probably kind of apprehensive about it, like he kind of didn't want to be here, but he made friends."

Things improved for Scott once he arrived in New Milford, his mother said.

Over the next two-and-a-half years he worked a series of jobs at car washes, big box stores and coffee shops and resumed his role as the doting older brother.

"He was kind of like a goofball, I guess — that's a perfect word to describe him," Sarah said. "If you were down in the dumps or something, he would always try to make you feel better. One time I was having trouble with my math homework. He was

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out with his friends, and he came home just to help me with my homework."

Finding their way

A few months later, in fall 2011, Jessica started at Western Connecticut State University in Danbury.

"She didn't want to be too far from home — that was her main thing," Juliette Bradley said. "She wanted to be able to come home on the weekends if she wanted."

Jessica started in the theater program, but switched to journalism, which seemed a good fit since she enjoyed creative writing and kept a journal.

"I think she was trying to figure it out like a lot of 19-year-old kids trying to find their way," Juliette Bradley said.

While she lived at school — living in the dorm at the Midtown Campus during her freshman year, then moving to the Westside Campus as a sophomore — Jessica held a job as a secretary in a law office, as well as working in restaurants and as a baby sitter.

"She worked all the time," Sean Bradley said.

A try at rehab

After taking on a series of jobs himself, Scott was looking for work in summer 2013 while also attending group drug counseling in Danbury that was ordered by a judge after his arrest on breach of peace stemming from a fight in November 2011.

"Did he do (the counseling)? Yes," Lapegna said. "And as soon as he was done, he was back smoking pot."

Eventually, there were signs he was using harder drugs again, as well. Sarah, his half-sister, recalled Christmas 2012, when Scott showed up high at his aunt's home in Port Chester, N.Y.

"He was kind of like high or something, and he was just kind of acting loopy," Sarah said. "So I kind of knew that he was doing other stuff than pot."

About a month before he died, Scott mentioned to his mother that kids in the New Milford area were using heroin.

"I said 'Scott, promise me please that you'll never do that,'" she said. "'It's a drug you'll never come back from.'"

Asking for help

When Jessica brought up heroin with her mother the weekend of the Fourth of July last year, it was to confess that she had tried the drug for the first time with Scott, her mother said.

Roughly a month earlier, Juliette Bradley learned her daughter was struggling with prescription painkiller abuse, a common precursor to heroin use.

"She had been using them regularly and she felt like she was getting in over her head, and it wasn't what she wanted for herself," Juliette Bradley said. "So she asked for help."

And she got it.

In-patient rehabilitation centers told the Bradleys that Jessica's habit was not severe enough for that option and recommended intensive outpatient therapy. The family chose the Midwestern Connecticut Council of Alcoholism in Danbury. Her parents also put her on "lockdown, they said, taking control of her computer, phone, money and car.

At first Jessica struggled with sobriety, failing some of the drug tests her mother gave her at home and eventually disclosing that she had progressed to heroin in early July.

"Once we found that out ... I took the kids on vacation down to Maryland and D.C. and Daytona, and we were gone for 10 days in July," Juliette Bradley said, adding she thought the trip would "put her in a good spot because she would not have access to anything."

It was around this time that Jessica started to find success with her recovery, passing all of her drug tests for about four weeks starting in mid-July.

A balmy night

In a small town, kids all get to know one another eventually. Jessica and Scott likely met through friends, though the exact nature of their relationship is unclear.

Jessica's upturn coincided with a different change of fortune for Scott.

Somewhere around midnight on July 22, Scott came home from a brief trip out with friends and joined his mother on the back porch.

They spent hours out in the quiet night talking about plans for the next morning and the 22nd birthday Scott planned to celebrate with friends in Greenwich in a couple of weeks.

When 2:30 a.m. rolled around, the mother and son turned in for the night. Scott headed downstairs to his room in the split-level's basement, planning to spend some time on his computer and try to video-chat with Jessica before going to sleep, Lapegna said.

As Scott made his way downstairs, his mother leaned over the bannister and called down to remind him that he would need to watch his infant sister the next morning while she went to an appointment and told him, "I love you — like every single night," she said.

"Scott, don't forget I need you to watch the baby tomorrow," she told him.

"Yeah, just don't take for-

They would be the last words she ever heard her son say.

About six hours later, Lapegna found Scott's body in his bed, cold and stiff.

"I knew he was gone," she said. "You walk in and you see that, and it's just beyond comprehension, even for me now. I lost it."

She did not learn until later, first from friends of her son and then from an autopsy, that Scott had fallen victim to a heroin habit. Lapegna never saw the signs — no needles, no track marks, no empty baggies in his bedroom.

"There was nothing," she said.

Even that last night he spent sitting with his mother in the balmy heat of late July on the back porch, nothing struck her as off about her son.

"The night before he passed, he went out for like an hour with his friends," she said. "He came back and he was fine."

After his death, some of Scott's friends reached out to Lapegna and filled in some details: in the hour he spent out the night before his death, Scott and a friend went and bought two $10 bags of heroin; some time before he came home, he snorted one in the car.

Those $10 bags of heroin

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contained fentanyl, a powerful opioid painkiller that dealers sometimes mix with heroin. It's a combination that has claimed dozens of lives across the country already this year.

The autopsy also found tramadol, an opioid painkiller Scott had been prescribed after a car crash about a year before his death.

Lapegna said she believes "it's very possible" Scott's painkillers led to heroin, a cheaper route to the same high.

Scott had started to sell the prescription pills to buy heroin, she said.

New Milford police officers responded to the home after Scott's death and investigated the scene.

Their official determination, which the medical examiner's autopsy corroborated, was that the death was the result of an accidental overdose.

Lapegna has issues with the investigation. She suspects there may have been two people who saw Scott at home that night after she went to bed. She wants to know if they were present when he overdosed, and, if they were, why no one called for help.

"They wrote it off basically as it's just another kid who overdosed," she said of the investigation.

New Milford Police Lt. Larry Ash said he was aware of Lapegna's issues, but that the department stands by the investigation and its findings, which were reviewed by the State Police Major Crime squad and the State's Attorney's Office in Litchfield County.

"The case has been thoroughly investigated by our agency," Ash said. "We feel that we've addressed her concerns as she's presented them to us and we continue to address her concerns."

Ash and New Milford Police Chief Shaun Boyne had scheduled a meeting with Lapegna.

Sad epilogue

Scott died soon after Jessica returned from the trip south with her mother and brother.

"That was a turning point," Sean Bradley said. "Mentally for her, she was very depressed over that. It really bothered her."

"It frightened her, as it should have," Juliette Bradley said.

Only then did Jessica's father, who is divorced from her mother, learn that Jessica had tried heroin.

"I was standing right there in the hallway, and I remember saying to her, 'Is this what you want to end up like?' "

he said during the interview in Juliette Bradley's home on Candlewood Lake.

Soon after, Sean Bradley took the kids on vacation with him, heading to Mexico for the first week of August.

"Then we came back, and she passed away a week later," he said.

It was a Wednesday night, Aug. 14, when Jessica called her father from the landline at the restaurant where she worked — a condition of her working to prove to her parents she was actually there — and told him she would be getting to his apartment later than expected.

"I'm running late; they asked me to clean eight extra tables," she said over the kitchen noise in the background, Sean Bradley said.

"She was like 'I'll be an extra 45 minutes.' I said 'OK.' "

What her parents later found out is that after hanging up with her father, Jessica drove back to New Milford, picked up a friend who knew a heroin dealer in Waterbury then drove there, returning a call from her mother on the way.

"She was happy," Juliette Bradley said. "She said she made a lot of money. I felt like she was doing well."

Jessica got to her father's apartment about 10 o'clock with a girlfriend who slept over.

After watching "Jimmy Kimmel Live" with Jessica, her father decided to call it a night.

"She started tickling me and annoying me, and I was like, 'I gotta go to sleep. I gotta get up for work,' " he said.

Before falling asleep, he heard the water running and figured Jessica was taking a shower.

By the time they checked on her in bed the next morning, Jessica was gone.

Later, her parents found an entry from that night in her journal, written between the time she snorted heroin and went to sleep.

It is a thing they preferred not to reveal, but her father paraphrased the entry, an epilogue to the young talent's life.

"I think she was sorry that she'd done it, let's put it that way," he said. "She was sorry that she'd done the drug. She enjoyed the high, but she was very remorseful about doing it. And she apologized, basically."

"But not like in a suicide-note way," her mother added. "She had indicated that she had done it, and she was so disappointed, you know, that she relapsed on her recovery."

In the seven months that have passed since, Sean Bradley has found some solace in a book of Bible passages related to grief and in daily visits to his daughter's grave in Center Cemetery.

"I go to her grave every day," he said.

"And I can't go," Juliette Bradley said. "I just haven't been able to go lately."

One relief they do share is their 15-year-old son.

"I have a big empty hole in my soul now, I don't think that'll ever change," Sean Bradley said. "I get joy in seeing our son."

The families don't know each other, but all these months after their children's deaths, Lapegna and the Bradleys share an ongoing disbelief.

"I still sometimes think it, too — It doesn't happen to people like us," Lapegna said. "It doesn't happen. But it does."

"It's just unbelievable, you know," Sean Bradley said. "You do all the things that you think are right to be doing, you're actively involved in your kids' lives — it's not supposed to happen like this."

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SEEKING FEDERAL HELP

Senators take aim against heroin

The five point plan to battle heroin

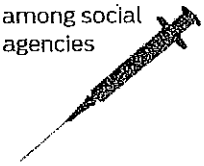
1 **Increase funding for addiction** treatment beyond the Obama administration's level of $1.8 billion.

2 **Increase federal support** for a law enforcement crackdown on heroin trafficking

3 **Increase funding to prevent** heroin and prescription drug abuse

4 **Promote** community collaboration among social agencies

5 **Increase availability** of naloxone, a heroin overdose drug that saves lives.



The impact

Heroin overdose deaths in Connecticut



By Bill Cummings

HARTFORD — Connecticut's U.S. senators are calling for more federal money and other assistance to battle a growing heroin epidemic in the state and across the nation.

"It's time for the federal government to partner with local government and do something about it," said U.S. Sen. Chris Murphy,

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Senators seeking federal help in fight against heroin

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D-Conn., referring to a dramatic rise in heroin-related deaths in Connecticut since 2012. Heroin-overdose deaths in the state climbed to 257 in 2013, compared to 174 in 2012, as the drug's use spread into suburbs and small towns, officials said.

"A lack of funding for treatment and enforcement is a big reason," Murphy said during a news conference Monday at the Alcohol and Drug Recovery Center in Hartford.

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"There is a beltway of cheap, highly toxic and highly pure heroin coming into the country and our communities from organized corporate cartels in Colombia and Mexico. These cartels are making billions of dollars at the expense of our lives and health and we need to crack down hard. It begins with prescription drugs. Cracking down on heroin also means a different attitude toward powerful pain relievers."

U.S. Sen. Richard Blumenthal, D-Conn.

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Senators against heroin

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Dr. Charles McKay, chief of toxicology at Hartford Hospital, said the mixing of fentanyl and heroin is providing batches far stronger than users may realize, leading to unintended overdoses.

"People on the street are not good chemists. They don't mix things well," McKay said.

Murphy said, "This dramatic increase of heroin use and abuse in Connecticut is unlike anything we've ever seen. Our state has lost hundreds more people to heroin use in the last year, but we're not doing enough to change the way we address this crisis."

The senators threw their support behind a bill before the Connecticut General Assembly that seeks to resolve the fear of being sued if police officers administer naloxone, a heroin antidote that quickly revives a dying patient by reversing the effects of the drug.

Emergency medical personnel now administer naloxone, but health experts believe allowing police officers to also apply it, most likely through a nasal dose, could save more lives because officers are usually the first on the scene.

Hartford Deputy Police Chief Brian Foley said he supports the bill, explaining that heroin has spread far beyond urban areas.

"Hartford is the center of the current heroin problem," Foley said. "But other towns are all involved. We can sit in Frog Hollow (a troubled Hartford neighborhood) and pick off kids from every town."

Foley agreed that many heroin users start with prescription drugs like oxycodone. He said an estimated 40 percent of young heroin users initially obtain painkillers from their parents.

The senators said New York City and New Jersey are the main entry points in the Northeast for heroin.

"The New England supply chain begins in New Jersey and New York City and runs through Connecticut," Murphy said.

NASW National Association of Social Workers / Connecticut Chapter

2139 Silas Deane Highway
Suite 205
Rocky Hill, CT 06067
(860) 257-8066 • (860) 257-8074 FAX

Raymie H. Wayne, Ph.D., JD, MSW, President
Stephen A. Karp, MSW, Executive Director
naswct@naswct.net
www.naswct.org

RECEIVED
JUN 24 2014
Office of
HEALTHCARE ACCESS

June 23, 2014

Kim Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
P. O. Box 340308
Hartford, Connecticut 06134

RE: The Retreat Application

Dear Ms. Martone:

This is a follow-up to our correspondence of May 19, 2014 in regards to the CON application by The Retreat. At the time we submitted our letter we were under the impression that The Retreat was applying for an initial CON and not appealing OHCA's proposed final decision on their application. Having now learned that this was an appeal I have reviewed OHCA's decision and are in agreement on two areas of concerns.

OHCA rightly points out that the New Haven community will not receive significant benefit from a facility that does not accept public insurance. Our support was contingent on scholarship care by The Retreat and indeed they state such care in their appeal. However the statistics presented by OHCA on New Haven residents with public insurance outweigh the benefit of scholarship care in regards to the New Haven community.

OHCA also notes the potential for other facilities to take on public insured patients while losing needed private care and commercially covered patients. This too concerns us as we recognize the importance of having a balanced system of care consisting of public, private for profit and private non-profit providers.

NASW/CT stands by our members concerns that there are not a sufficient number of suitable beds in Greater New Haven for treatment. However we believe this needs to be addressed in a manner that provides for all insurance coverage to be accepted.

After reviewing OHCA's proposed final decision and considering that we are in agreement on two key aspects of that decision we can no longer support The Retreat's appeal.

Sincerely,

Stephen A. Karp, MSW
Executive Director

Greer, Leslie

From: Greer, Leslie
Sent: Thursday, July 17, 2014 3:13 PM
To: Hansted, Kevin
Cc: Veyberman, Alla; Greci, Laurie; Lazarus, Steven; Riggott, Kaila; Martone, Kim; Horn, Marianne
Subject: RE: NR CT, LLC d/b/a Retreat at South CT Closure of Record
Attachments: 31828_201407171450-1.pdf

Tracking:

Recipient	Delivery
Hansted, Kevin	Delivered: 7/17/2014 3:13 PM
Veyberman, Alla	Delivered: 7/17/2014 3:13 PM
Greci, Laurie	Delivered: 7/17/2014 3:13 PM
Lazarus, Steven	Delivered: 7/17/2014 3:13 PM
Riggott, Kaila	Delivered: 7/17/2014 3:13 PM
Martone, Kim	Delivered: 7/17/2014 3:13 PM
Horn, Marianne	Delivered: 7/17/2014 3:13 PM

Thanks Kevin, good to know. The email was returned undeliverable to Attorney Beccaro.
Leslie

From: Hansted, Kevin
Sent: Thursday, July 17, 2014 2:58 PM
To: Greer, Leslie
Subject: RE: NR CT, LLC d/b/a Retreat at South CT Closure of Record

Leslie,

Did you also send this to Attorney Epstein? I think he is the new attorney.

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044

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From: Greer, Leslie
Sent: Thursday, July 17, 2014 2:57 PM

To: 'wbecarro@snet.net'
Cc: Veyberman, Alla; Greci, Laurie; Riggott, Kaila; Lazarus, Steven; Hansted, Kevin; Martone, Kim
Subject: NR CT, LLC d/b/a Retreat at South CT Closure of Record

Mr. Schorr/Atty Beccaro,
After several failed attempts to fax, attached is correspondence regarding closure of record for DN: 13-31828-CON.

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca
Please consider the environment before printing this message

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

July 17, 2014

Via Fax Only

Peter Schorr
President / CEO
NR Connecticut, LLC
12 New City Street
Essex, CT 06426

RE: Certificate of Need Application, Docket Number 13-31828-CON
NR Connecticut, LLC-d/b/a/Retreat at South Connecticut
Establish a 105 bed Residential Substance Abuse Treatment Facility in New Haven, CT
Closure of Record

Dear Mr. Schorr:

On May 23, 2014, the Office of Health Care Access ("OHCA") received the information requested by OHCA concerning Findings of Fact 9, 14 and 20 of the Proposed Final Decision issued in the above-referenced matter. With the receipt of this submission, the record on the above application is hereby closed as of June 1, 2014.

If you have any questions regarding this matter, please feel free to contact Laurie Greci at (860) 418-7032.

Sincerely,

Marianne Horn
Hearing Officer

MH:amv

C: Juda J. Epstein, Esq.
Joan W.Feldman, Esq.
Jennifer Groves Fusco, Esq.
William P. Beccaro, Esq.

* * * COMMUNICATION RESULT REPORT (JUL. 17. 2014 1:18PM) * * *

FAX HEADER:

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478 MEMORY TX		912033716001	OK	2/2

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E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JUDA J. EPSTEIN, ESQ.

FAX: (203) 371-6001

AGENCY: THE LAW OFFICE OF JUDA J. EPSTEIN

FROM: OHCA

DATE: 7/17/14

NUMBER OF PAGES: 2

(including transmittal sheet

Comments: DN: 13-31828-CON Closure of record

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

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P.O.Box 340308
Hartford, CT 06134

* * * COMMUNICATION RESULT REPORT (JUL. 17. 2014 1:19PM) * * *

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STATE OF CONNECTICUT
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OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JOAN W. FELDMAN, ESQ.

FAX: (860) 251-5211

AGENCY: SHIPMAN & GOODWIN

FROM: OHCA

DATE: 7/17/14

NUMBER OF PAGES: 2
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Comments: DN: 13-31828-CON Closure of record

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* * * COMMUNICATION RESULT REPORT (JUL. 17. 2014 1:20PM) * * *

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OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JOAN W. FELDMAN, ESQ.

FAX: (860) 251-5211

AGENCY: SHIPMAN & GOODWIN

FROM: OHCA

DATE: 7/17/14

NUMBER OF PAGES: 2
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Comments: DN: 13-31828-CON Closure of record

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

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* * * COMMUNICATION RESULT REPORT (JUL. 17. 2014 1:21PM) * * *

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STATE OF CONNECTICUT
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FAX SHEET

TO: JENNIFER GROVES FUSCO, ESQ.

FAX: (203) 772-2037

AGENCY: UPDIKE, KELLY & SPELLACY

FROM: OHCA

DATE: 7/17/14

NUMBER OF PAGES: 2
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Comments: DN: 13-31828-CON Closure of record

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* * * COMMUNICATION RESULT REPORT (JUL. 17. 2014 1:40PM) * * *

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E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: PETER SCHORR

FAX: (860) 767-0456

AGENCY: NR CONNECTICUT, LLC

FROM: OHCA

DATE: 7/17/14

NUMBER OF PAGES: 2

(including transmittal sheet

Comments: DN: 13-31828-CON Closure of record

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

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* * * COMMUNICATION RESULT REPORT (JUL. 17. 2014 1:29PM) * * *

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E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: WILLIAM P. BECCARO, ESQ.

FAX: (860) 767-0456

AGENCY: LAW OFFICE OF WILLIAM P. BECCARO

FROM: OHCA

DATE: 7/17/14

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: DN: 13-31828-CON Closure of record

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

August 14, 2014

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:	Notice of Final Decision Office of Health Care Access Docket Number: 13-31828-CON
NR Connecticut, LLC, d/b/a/ Retreat at South Connecticut	**Establish a 105-bed Residential Substance Abuse Treatment Facility in New Haven, CT**

To: Peter Schorr
President / CEO
NR Connecticut, LLC
12 New City Street
Essex, CT 06426

Dear Mr. Schorr:

On August 14, 2014, a decision was rendered as the finding and order of the Office of Health Care Access in the above-referenced matter. A copy of the decision is attached hereto for your information.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:lkg

Copy: Joan W.Feldman, Shipman & Goodwin, LLP
Jennifer Groves Fusco, Updike, Kelly & Spellacy, P.C

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Final Decision

Applicant: **NR Connecticut, LLC, d/b/a Retreat at South Connecticut**
915 Ella Grasso Boulevard, New Haven, CT

Docket Number: **13-31828-CON**

Project Title: **Establish a 105-Bed Residential Substance Abuse Treatment Facility**

Project Description: NR Connecticut, LLC, d/b/a Retreat at South Connecticut, ("Applicant" or "Retreat at South CT") seeks authorization to establish a 105 bed residential substance abuse treatment facility at 915 Ella Grasso Boulevard, New Haven, Connecticut.

Procedural History: The Applicant published notice of its intent to file the Certificate of Need ("CON") application in the *New Haven Register* on February 28, March 1 and 2, 2013. On March 25, 2013, the Office of Health Care Access ("OHCA") received the CON application from the Applicant for the above-referenced project. On July 8, 2013, OHCA deemed the CON application complete.

On July 17, 2013, OHCA notified the Applicant of the date, time and place of the public hearing. On July 19, 2013, a notice to the public announcing the hearing was published in the *New Haven Register.* Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a, a public hearing regarding the CON application was held on August 14, 2013.

Commissioner Jewel Mullen designated Attorney Marianne Horn as the hearing officer in this matter. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. § 19a-639a(f).

By petition dated August 9, 2013, APT Foundation, Inc. requested Intervenor status with full rights of cross-examination regarding the Applicant's CON application. The Hearing Officer designated APT Foundation, Inc. as an Intervenor with full rights of cross-examination.

By petition dated August 9, 2013, Cornell Scott-Hill Health Center requested Intervenor status with full rights of cross-examination regarding the Applicant's CON application. The Hearing Officer designated Cornell Scott-Hill Health Center as an Intervenor with full rights of cross-examination.

By petition dated August 9, 2013, Rushford Center, Inc. requested Intervenor status with full rights of cross-examination regarding the Applicant's CON application. The Hearing Officer designated Rushford Center, Inc. as an Intervenor with full rights of cross-examination.

By petition dated August 9, 2013, Stonington Behavioral Health, Inc., d/b/a Stonington Institute, requested Intervenor status with full rights of cross-examination regarding the Applicant's CON application. The Hearing Officer designated Stonington Institute as an Intervenor with full rights of cross-examination.

By petition dated August 9, 2013, Yale-New Haven Hospital requested Intervenor status with full rights of cross-examination regarding the Applicant's CON application. The Hearing Officer designated Yale New-Haven Hospital as an Intervenor with full rights of cross-examination.

On or about September 10, 2013, OHCA closed the record in this matter. On January 22, 2014, OHCA issued a Proposed Final Decision. On April 11, 2014, OHCA received Exceptions to its Proposed Final Decision dated January 22, 2014. Included in the Exceptions was a claim that the Applicant was not given advance notice of certain information as required by Connecticut General Statutes § 4-178 or the opportunity to respond to a late file submitted by the Intervenors. Specifically, the Applicant claimed that it was prejudiced by not having an opportunity to respond to the following:

1. OHCA's use of hospital discharges for drug abuse treatment to evaluate the need for a substance abuse program. (Proposed Final Decision, FF9);
2. OHCA's use of DMHAS bed census data submitted as a late file by the Intervenors. (Proposed Final Decision, FF14); and
3. OHCA's use of data from the Acute Care Hospital Inpatient Discharge Database. (Proposed Final Decision, FF20)

Thereafter, on May 9, 2014, the record in this matter was opened to take further evidence. Specifically, Retreat at South CT was asked to provide further evidence concerning Findings of Fact 9, 14 and 20 of the Proposed Final Decision. Retreat at South CT submitted its responses to OHCA on May 23, 2014. Thereafter, the record was closed as of June 1, 2014. In rendering this decision, Deputy Commissioner Davis considered all evidence in the record.

To the extent the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. *SAS Inst., Inc., v. S & H Computer Systems, Inc.,* 605 F.Supp. 816 (Md. Tenn. 1985).

Findings of Fact and Conclusions of Law

1. NR Connecticut, LLC ("Applicant") is a Connecticut limited liability company. Ex. A, p. 590

2. The Applicant proposes to establish the Retreat at South Connecticut ("Retreat at South CT"), a residential substance abuse treatment facility for adults aged 18 and older, at 915 Ella Grasso Boulevard, New Haven, Connecticut. Ex. A, pp.18, 27

3. The Applicant proposes to locate its residential substance abuse treatment facility in an existing 60,000 square foot two-story building in New Haven that will be renovated and upgraded to the same standards as its sister facility, Retreat at Lancaster County ("Lancaster facility"). Ex. A, p.18

4. The Lancaster facility is a 120-bed residential substance abuse treatment facility located on a 24 acre campus in Ephrata, Pennsylvania that has been operating since 2011. Ex. A, p. 44

5. The Applicant intends to provide the following levels of care[1,2] at the Retreat at South CT:
   a. Level 3.7[3] residential detoxification having continuous observation, monitoring and treatment under physician-approved procedures; and
   b. Residential rehabilitation, short-term (approximately 30 day stay).
   Ex. A, pp.18-19, 30

6. The Applicant proposes to have 26 Level 3.7 residential detoxification beds and 79 residential rehabilitation beds for a total number of 105 beds. Transcript of August 14, 2013, Public Hearing ("Tr.") Testimony of Mr. Peter Schorr, pp. 14-15

[1] The American Society of Addiction Medicine defines the listed levels of care.

[2] Levels of care for substance abuse treatment licensed by the Connecticut Department of Public Health identify Level 3.7 residential detoxification as residential detoxification and evaluation and short-term residential rehabilitation as intensive treatment. Source: Statewide Health Care Facilities and Service Plan, October 2012, pp. 280-287

[3] The Substance Abuse and Mental Health Services Administration ("SAMHSA") characterizes short-term residential rehabilitation treatment as having a length of stay of 30 days or less.

7. As shown in Table 1 below, Connecticut has 8 private non-profit providers of Level 3.7 detox with a total of 156 licensed beds. There are 11 private non-profit providers of short-term residential rehabilitation with a total of 256 licensed beds.[4]

Table 1: Existing Providers of Level 3.7 Residential Detoxification and Evaluation and Residential Rehabilitation Treatment in Connecticut

Provider Name and Program Name	Town	Services*	Beds
Chemical Abuse Services Agency, Inc., Casa Eugenio Maria de Hostos	Bridgeport	IT	10
Recovery Network of Programs, Inc., First Step	Bridgeport	RDE	19
Recovery Network of Programs, Inc., Horizons	Bridgeport	IT	15
Recovery Network of Programs, Inc., New Prospects	Bridgeport	IT	23
Midwestern Connecticut Council on Alcoholism, Inc., McDonough House	Danbury	IT RDE	20 10
Alcohol and Drug Recovery Centers, Inc. – Detoxification Center	Hartford	IT RDE	28 35
Rushford Center	Middletown	RDE IT	16 42
Farrell Treatment Center	New Britain	IT	24
Cornell Scott-Hill Health Corporation, South Central Rehabilitation Center	New Haven	RDE	29
Southeastern Council on Alcoholism and Drug Dependence, Inc., Altruism Acute Care and Evaluation	New London	RDE	20
Stonington Behavioral Health Inc., Stonington Institute	North Stonington	RDE IT	18 45
Community Health Resources, Milestone/New Life Center/Pathways	Putnam	IT, RDE	9** 9**
McCall Foundation, Carnes Weeks Center	Torrington	IT	20
Connecticut Renaissance, Inc., Patrick F. McAuliffe Center	Waterbury	IT	20
		Total Number of Beds for RDE	**156**
		Total Number of Beds for IT	**256**

* Services Abbreviations: RDE – Level 3.7 Residential Detox and Evaluation; IT – Intensive Inpatient (Residential Rehabilitation Treatment up to 30 days)

** The 18 available beds are not specifically assigned to either level or care, therefore, an equal number were assigned to each.

Source: Statewide Health Care Facilities and Service Plan, October 2012, pp. 280-287

8. The State of Connecticut's Department of Mental Health and Addiction Services ("DMHAS") operates, funds and coordinates inpatient and community-based services for adults having substance use or psychiatric disorders, or co-occurring psychiatric and substance use disorders who are indigent or medically indigent. DMHAS' Addiction Services Division, located at Connecticut Valley Hospital in Middletown and Blue Hills Hospital in Hartford, has 152 beds for the provision of residential detoxification and evaluation and short-term residential treatment. The Greater Bridgeport Community Mental Health has 20

[4] The bed totals do not include those available at licensed general hospitals or licensed hospitals for the mentally ill.

beds for patients with co-occurring disorders. Statewide Health Care Facilities and Services Plan, October 2012, p. 96

9. APT Foundation, Inc. ("APT"), a non-profit, community-based agency, provides ambulatory detoxification and outpatient treatment in New Haven and North Haven. APT accepts self-pay, Medicaid and commercial insurance. APT's payer mix is 60% Medicaid and 40% commercial insurance or self-pay. APT also offers free care. Ex. O, pp. 4, 5, 12

10. Cornell Scott-Hill Health Center ("CS-HHC"), a federally-qualified health center, is a provider of behavioral health services in New Haven. CS-HHC operates the South Central Rehabilitation Center, a 29-bed Level 3.7 residential detoxification facility, and the Grant Street Partnership Program, an outpatient treatment program. CS-HHC accepts all patients regardless of the source of payment. Ex. L, p. 12

11. Rushford Center, Inc. ("Rushford") provides inpatient and outpatient care for substance abuse. In Middletown, Rushford operates a 16-bed Level 3.7 unit and a 42-bed residential rehabilitation unit for adults. Rushford accepts patients with commercial insurance, Medicare and Medicaid. Ex. P, Prefiled Testimony of Jeffrey Walter, pp. 3, 12.

12. Stonington Behavioral Health, Inc. d/b/a Stonington Institute, Inc. ("Stonington") in Stonington, CT, offers a full continuum of services to adults with substance abuse and co-occurring disorders. Stonington has a 16-bed Level 3.7 residential detoxification unit for adults and a 38-bed unit for residential rehabilitation services for military personnel and veterans. Stonington is Medicare certified and accepts clients from every major commercial health plan network in Connecticut. Stonington's overall payer mix is 73% governmental payers and charity care and 27% commercial insurance and self-pay. Ex. Z, pp. 5, 6

13. The "Addiction Residential Census Report" that is compiled Monday through Friday by DMHAS provides information on the number of available beds at facilities providing Level 3.7 detox and residential rehab that receive DMHAS grant funds, as well as other providers that choose to report through the DMHAS portal.

Table 2: DMHAS Beds Availability Statistics for Detoxification and Rehabilitation Level 3.7 Facilities

Service	Available Beds*						
	8/13/2013	8/14/2013	8/15/2013	8/16/2013	8/19/2013	8/20/2013	8/21/2013
Detox	6	3	7	10	17	6	7
Rehab	24	23	26	35	31	14	24
Total	30	26	33	45	48	20	31

* Not all facilities report availability of beds each day.
Ex. FF

14. The DMHAS data provided by Rushford show that between 2009 and 2013 the number of admissions to Level 3.7 residential detoxification programs and number of beds increased 19.7% and 21.4% respectively, while the intensive residential rehabilitation programs' admissions and beds decreased by 11.5% and 4.4%, respectively.

Table 3: DMHAS Admissions and Beds Statistics for Detoxification and Rehabilitation Level 3.7 Facilities by State Fiscal Year

State Fiscal Year*	Detoxification Admissions	Beds	Residential Rehabilitation Admissions	Beds
2009	9,267	126	2,906	206
2010	8,709	131	2,907	206
2011	10,463	143	3,040	193
2012	11,035	153	2,877	193
2013	11,091	153	2,571	197

* July 1 to June 30.
Ex. GG, p. 1

15. The Applicant projects that it will provide the following volumes of services by persons and bed days for the first years of operation:

Table 4: Projected Volume by Fiscal Year*

Service type	FY 2014		FY 2015		FY 2016	
	Persons	Bed Days	Persons	Bed Days	Persons	Bed Days
Detoxification	1,320	7,260	1,440	7,920	1,440	7,920
Rehabilitation	1,320	21,780	1,440	23,760	1,440	23,760
Total Persons and Bed Days	**2,640**	**29,040**	**2,880**	**31,680**	**2,880**	**31,680**

*Assumes Applicant's fiscal year is Jan 1 – Dec 30
Ex. A, pp. 30; Ex. E, p. 682

16. In the most recent fiscal year, the Applicant provided services to 2,206 people at its Lancaster facility, where twelve (less than 1% of the admitted clients) were from Connecticut. Ex. A, p. 686

17. The proposed payer mix is based on self-pay and commercial insurance. Retreat at South CT projects the following patient population payer mix:

Table 5: Projected Payer Mix by Fiscal Year *

Payers	FY 2013	FY 2014	FY 2015	FY 2016
Commercial Insurers	85%	85%	85%	85%
Self-Pay/Uninsured	15%	15%	15%	15%
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

*Assumes Applicant's fiscal year is Jan 1 – Dec 30
Ex. A, p.35

18. Given the high rate of individuals in New Haven who are governmentally-insured, the proposed facility would not benefit these individuals since it will not accept Medicaid patients. Tr. Testimony of Mr. Robert Freeman, pp. 63, 65

19. The existing providers of the service proposed by the Applicant have capacity to meet the needs of the commercially-insured and self-pay patients, who are the target of the Applicant's proposal. Tr. Testimony of Jeffrey Walter, President and Chief Executive Officer of Rushford Center, p. 37-38; Tr. Testimony of Georganna Koppermann, Director of Business Development and Military Affairs at Stonington Institute, pp.56-57

20. The current providers of the service proposed by the Applicant rely upon patients who are commercially-insured or self-pay to offset the lower reimbursement rate realized by serving the governmentally-insured charity care population. Tr. Testimony of Mr. Walter, p.40; Tr. Testimony of William Sledge, M.D., Medical Director of the Yale-New Haven Psychiatric Hospital, pp. 67-70; Tr. Testimony of Ms. Koppermann, pp.60-62; Tr. Testimony of Douglas Bruce, M.D., Medical Director of South Central Rehabilitation Center at the Cornell Scott-Hill Health Center , pp.74, 75

21. The total estimated cost of the proposal is $7,566,000, including capitalized financing costs. Ex. A, p. 34

22. The Applicant projects an incremental gain in revenue from operations before taxes of $2.0 million, $4.6 million and $6.3 million, respectively, in the first three full fiscal years of operations.

Table 7: Projected Incremental Revenues and Expenditures by Fiscal Year*

Account Description	FY 2013	FY 2014	FY 2015
Net Patient Revenue	$12,596,215	$17,700,710	$20,032,140
Salaries/Benefits	6,148,924	7,030,851	7,241,777
Professional Services	637,093	712,282	728,105
Bad Debts	629,811	885,036	1,001,607
Lease Expense	914,400	2,014,832	2,215,277
Other Operating Expense	2,263,785	2,458,628	2,559,238
Total Operating Expense	10,594,013	13,101,629	13,746,004
Income from Operations	**$ 2,002,202**	**$ 4,599,081**	**$ 6,286,136**

*Assumes Applicant's fiscal year is Jan 1 – Dec 30
Ex. A, p. 654

23. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations adopted by OHCA. (Conn .Gen. Stat. § 19a-639(a)(1))

24. This CON application is consistent with the State Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

25. The Applicant has not established that there is a clear public need for its proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

26. The Applicant has not satisfactorily demonstrated that the proposal will financially strengthen the health care system in the state. (Conn. Gen. Stat. § 19a-639(a)(4))

27. The Applicant has not satisfactorily demonstrated that its proposal would improve the accessibility of health care delivery in the region, and therefore, no determination can be made as to the potential improvement in quality and cost effectiveness. (Conn. Gen. Stat. § 19a-639(a)(5))

28. The Applicant has shown that there will be an increase in access to the provision of health care services to the relevant populations and payer mix. (Conn. Gen. Stat. § 19a-639(a)(6))

29. The Applicant has not satisfactorily identified the population to be served by its proposal and has not satisfactorily demonstrated that this population has a need as proposed. (Conn. Gen. Stat. § 19a-639(a)(7))

30. The Applicant has not provided any historical utilization of behavioral health treatment services in the service area that would support this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

31. The utilization of existing health care facilities and services in the service area does not support this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

32. The Applicant has failed to satisfactorily demonstrate that the proposal will not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in General Statutes § 19a-639(a). The Applicant bears the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

NR Connecticut, LLC ("Applicant") is a Connecticut limited liability company. *FF 1* The Applicant proposes to establish a residential substance abuse treatment facility, The Retreat at South Connecticut in New Haven, Connecticut. *FF 2* The proposed facility will be established and operated similar to its sister facility, Retreat at Lancaster County, Pennsylvania. *FF 4* The proposed facility will offer Level 3.7 residential detoxification ("Level 3.7 detox") and rehabilitation and recovery ("residential rehab") services, as well as partial hospitalization, intensive outpatient treatment, continuing recovery-oriented care and community education services (collectively identified as "outpatient services"). *FF 5*

The Applicant proposes to have 26 Level 3.7 detox beds and 79 residential rehab beds for a total of 105 beds. *FF 6* The Applicant claims that based on the experience gained from operating the Lancaster facility, the optimum number of beds for the proposed facility is between 100 and 120 beds. *Ex. A, p. 667* Peter Schorr, President and CEO of the proposed facility, stated that the projected number of beds for the proposed facility and the split of beds by service is based on the fact that "it was a nursing home…140-something beds, and we can put more beds in there, but we decided that… our infrastructure would be comfortable if we had 105 beds. We chose to have 26 detox beds and 79 rehab beds." Mr. Schorr stated that "the rule of thumb is usually three rehab beds to one detox, and having that ratio will allow his clients to have a rehab bed available after graduating from detox." *Tr. Testimony of Mr. Peter Schorr, pp.14-15* The Applicant, however, provided no evidence that the bed ratio is appropriate for this type of facility. In addition, the Applicant provided no information concerning the percentage of clients that would be projected to enter a residential rehab program after completing inpatient detoxification.

The Applicant claims that Connecticut has a limited number of Level 3.7 detox and residential rehab beds that cannot keep pace with increasing demand. *Ex. A, p. 21* The Applicant also claims, through proprietary research and publicly available documentation, that it has identified the need in Connecticut for additional beds to provide these levels of service. *Ex. E, p. 667* Based on phone surveys conducted by the Applicant, the Applicant claims that the Level 3.7 facilities are operating at, or close to, 100% capacity and many of them have a long waiting list for a bed. *Ex. A. p. 22; Exhibit VV, pp. 3&4*

Additionally, the Applicant asserts that there are waiting lists at Connecticut's facilities and that many residents leave the state to obtain treatment. *Ex. A, pp. 20-22* Mr. Schorr stated that one of the reasons for opening the proposed facility in Connecticut is that there are people from Connecticut coming to Retreat at Lancaster. *Tr. Testimony of Mr. Peter Schorr, p.7* The Applicant expects that 75% of its patients will come from Connecticut and the remaining 25% from surrounding states. *Ex. E, p. 669* The Applicant claims that the proposed facility will help to fulfill the unmet needs not just of New Haven County but the entire state. *Ex. A, p. 27* In the most recent

fiscal year, however, the Applicant provided services to 2,206 people at its Lancaster facility, where twelve (less than 1%) of the admitted clients were from Connecticut. *FF 16* The reported number of Connecticut clients served in Pennsylvania does not support the Applicant's statements or the need for the proposal.

Based on SAMHSA's 2012 National Survey on Drug Use and Health, the Applicant claims that 269,645 Connecticut residents aged 18 and older need, but have not received, treatment for some form of substance use disorder.

Table 8: Estimated Number of Persons that May Benefit from the Proposal

Description	18 to 25 yrs. of age	26 and Older	Total
Population, based on Census 2010 estimates	350,601	2,277,969	2,268,570
Needing Treatment for Alcohol Abuse, % *	18.46%	6.32%	
Number	64,721	143,968	208,689
Needing Treatment for Illicit Drug Use, %*	8.16%	1.42%	
Number	28,609	32,347	60,956
		Total	**269,645**

* Rates used by Applicant based on SAMHSA's National Survey on Drug Use and Health, 2009 and 2010
Ex. A, pp. 25, 37, 352

However, Douglas Bruce, M.D., Medical Director of South Central Rehabilitation Center at the Cornell Scott Hill Health Center, New Haven, stated that there are many people that need addiction treatment, but do not necessarily want it. Dr. Bruce further stated that the issue is not a lack of access to beds. The issue is that a large number of people with substance use disorders are not seeking treatment and more beds will not address that problem. *Tr. Testimony of Dr. Douglas Bruce, pp. 74, 77*

Based upon Dr. Bruce's testimony, the estimated number of persons that the Applicant claims need treatment is not necessarily an indication of the number that will seek treatment. Other than the Applicant's statements proclaiming need, there is insufficient documentation to support the clear public need for the proposed facility. Furthermore, there is no evidence supporting the number of beds proposed for the facility. None of the existing facilities offering the residential rehab level of care have more than 45 beds, as compared to the Applicant's proposed 79 beds. *FF 6*

Mr. Schorr stated that "there are not enough beds in this state. There are not enough beds anywhere, let alone in just Connecticut." *Tr. Testimony of Mr. Schorr, pp. 13-14* However, Connecticut has 8 private non-profit providers of Level 3.7 detox with a total of 156 licensed beds. *FF 7* This bed total does not include those available at DMHAS operated facilities or licensed hospitals for the mentally ill. *FF 8,* There are 11 private providers of residential rehab with a licensed total of 274 beds. *FF 7* The Intervenors provided DMHAS reports that illustrated the availability of Level 3.7 detox and residential rehab beds at grant-funded facilities and other providers that choose to report their bed availability to DMHAS. From August 13 to 21, 2013, there were beds available at the two levels of care on each day reported. *FF 13* Not all facilities in Connecticut with these

levels of care report their bed availability, therefore, there may have been additional beds available on the reported days.

The Applicant argues that it is inappropriate to utilize the DMHAS data because it is inadequate and unreliable when trying to determine need in this situation. *Exhibit VV, pp. 5&6* The DMHAS data, including that supplied by the Applicant, indicates fluctuating levels of capacity at any given time. *FF 14; Exhibit VV, p. 8.* Setting aside the DMHAS data, two facilities, Rushford and Stonington Institute, provided testimony that there are normally beds available at their facilities. Jeffrey Walter, President and Chief Executive Officer of Rushford Center, stated that, based on the responses received from the Level 3.7 residential detoxification and intensive residential rehabilitation providers to a survey conducted by Rushford, "there was at least a 21% excess of capacity in the nine [survey] respondents and that most days in the year, there are beds available in each of these [nine] facilities." Mr. Walter also stated that in the most recent 12 months there were only 30 days out of 365 days where Rushford had no beds. *Tr. Testimony of Mr. Walter, pp. 37-38* Georganna Koppermann, Director of Business Development and Military Affairs at Stonington Institute, stated that Stonington Institute has ample capacity to meet the needs of the commercially-insured and self-pay patients who are the target of the Applicant's proposal. While Stonington's detox service operates close to capacity, due to the short length of stay, three to five days on average, several patients are discharged each day. The rehabilitation service, which caters to active duty military service members and veterans, consists of a 38-bed unit that operates at 60% capacity with approximately 22 beds filled at any given time. *Tr. Testimony of Ms. Koppermann, pp. 56-57* Based upon the evidence presented, there appears to be sufficient capacity for substance abuse treatment even though there may be temporary lags in bed availability.

The Applicant also argued that the proposed facility would ease the burden of patients presenting at Connecticut emergency departments for substance abuse treatment. However, the Applicant only presented anecdotal evidence to support its claim. *Exhibit VV, pp. 1-6* It cannot be assumed that an individual experiencing a substance abuse crisis would choose to present at the proposed facility rather than an emergency department, especially when that individual is in an incapacitated state. The Applicant also made several references to the Statewide Health Care Facilities and Services Plan in support of its position regarding overcrowded emergency departments. *Exhibit VV, pp. 5&6* While the Statewide Health Care Facilities and Services Plan does include discussions regarding patients presenting at emergency departments for substance abuse treatment, it does not specify the payer source for these individuals, as acknowledged by the Applicant. *Tr. Testimony of Mr. Schorr, p. 84* The Applicant will not accept Medicaid patients. . *Tr. Testimony of Mr. Schorr, p. 92* Although the Applicant submitted evidence that the percentage of persons commercially insured in the City of New Haven, County of New Haven, and State of Connecticut was 54.9%, 72.2%, and 74.9%, respectively, that still leaves a significant portion of the population without a means to pay for the Applicant's proposed service. *Exhibit VV, p.12* Therefore, it cannot be definitively stated that the Applicant's proposal would address the need identified by the Statewide Health Care Facilities and Services Plan.

In order to determine the need for the Applicant's services, the number of persons that may utilize the services must be determined. The Applicant utilized the rates of illicit drug and alcohol use reported from SAMHSA's National Survey on Drug Use and Health. *Ex. A, p. 25* These rates are for persons who need treatment, but did not receive treatment. The Applicant did

not demonstrate that there are persons that have sought treatment but were unable to find it in Connecticut. Based on the availability of beds as evidenced by the DMHAS report and that the number of persons that are seeking treatment has not been determined, the Applicant has failed to demonstrate that there is a clear public need for the proposal.

The Applicant proposes to provide its services to persons who have commercial insurance or who are able to pay for their treatment out-of-pocket. *FF 17* Several private non-profit providers offered testimony that their agencies have the capacity to provide Level 3.7 detox and residential rehab for those who seek it. These agencies provide services to all persons regardless of their ability to pay. *FF 19, 10, 11, 12* Having clients with commercial insurance enables these agencies to continue providing services to all who need them. *FF 20*

The Applicant claims that the proposed facility should have little or no impact on existing providers because the existing providers are unable to meet the demand for projected services. *Ex. A, p. 29* The Applicant did not provide any evidence that its proposal would not have an economic impact on the behavioral health care system in Connecticut. With many of the existing providers of the proposed services relying on reimbursement from government payers, the potential loss of clients with commercial insurance to the proposed facility may decrease their ability to provide services to all of their clients regardless of payer. *FF 20*The Applicant's proposal with its potential impact on the reimbursement from commercial payers to the existing providers will have a negative impact on the financial strength of the behavioral health system in the state.

Mr. Walter stated that the proposal will "impact …not only the providers, but the clients that we serve. The existing providers, including Rushford, depend on a payer mix that is a struggle to attain and to maintain, and …the entry of Retreat with 105 beds that are exclusively for people who have private insurance, is going to have a destabilizing effect on all of the providers …even a five percent swing in payer mix is going to have a devastating effect on our ability to continue to provide the quality of care that we really have to provide and that the community is expecting us to provide." *Tr. Testimony of Mr. Walter, p.40* Ms. Koppermann stated that "given the heavily-weighted governmentally-insured charity care population, 73%, we require 95% capacity to break even. In a business with a small operating margin, the loss of commercial and self-pay revenue will have a significant adverse impact on our bottom line…The proposal will serve to weaken the health care system by adversely affecting existing providers … who care for all patients, regardless of payer source and the impact on our bottom lines." *Tr. Testimony of Ms. Koppermann, pp.60-62* Dr. Bruce stated that "we operate on a very, very small margin. The commercial insurance does pay at a higher rate than Medicaid. We're providing free care to individuals. If we are to lose that commercial margin, it will put us into the red, and that will compromise our ability to continue to provide services to the largely Medicaid population in our community, as well as to people who are undocumented or do not have an ability to have insurance or afford care." *Tr. Testimony of Dr. Bruce, pp.74, 75*

Since the Applicant was unable to establish the clear public need for the proposal and that this proposal would avoid a duplication of services in the area, the Applicant has failed to establish that its proposal would improve the accessibility, quality or cost effectiveness of health care delivery in the region.

Order

Based upon the foregoing Findings of Fact and Discussion, the Certificate of Need application of NR Connecticut, LLC d/b/a Retreat at South Connecticut to establish a behavioral health treatment facility in New Haven, Connecticut, is hereby **DENIED**.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

8/14/14
Date

Lisa A. Davis, MBA, BS, RN
Deputy Commissioner

* * * COMMUNICATION RESULT REPORT (AUG. 15. 2014 8:34AM) * * *

FAX HEADER:

TRANSMITTED/STORED : AUG. 15. 2014 8:27AM FILE MODE	OPTION	ADDRESS	RESULT	PAGE
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E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Peter Schorr

FAX: (860) 767-0456

AGENCY:

FROM: Laurie Greci

DATE: 8/14/2014 15

NUMBER OF PAGES: 16
(including transmittal sheet

Comments:

RE: Docket 13-31828-CON
NR Connecticut, LLC, d/a/b Retreat at South CT

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 Fax: (860) 418-7053
410 Capitol Ave., MS#13HCA
P.O.Box 340308Hartford, CT 06134

* * * COMMUNICATION RESULT REPORT (AUG. 14. 2014 4:12PM) * * *

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* * * COMMUNICATION RESULT REPORT (AUG. 14. 2014 4:26PM) * * *

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* * * COMMUNICATION RESULT REPORT (AUG. 14. 2014 3:35PM) * * *

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STATE OF CONNECTICUT
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OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Joan W. Feldman, Esq.

FAX: (860) 251-5211

AGENCY: Shipman & Goodwin

FROM: Laurie Greci

DATE: 8/14/2014

NUMBER OF PAGES: 16
(including transmittal sheet

Comments:

RE: Docket 13-31828-CON
NR Connecticut, LLC, d/a/b Retreat at South CT

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E-3) NO ANSWER
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Juda J. Epstein, Esq.

FAX: (203) 371-6001

AGENCY: The Law Office of Juda J. Epstein

FROM: Laurie Greci

DATE: 8/14/2014

NUMBER OF PAGES: 16
(including transmittal sheet

Comments:

RE: Docket 13-31828-CON
NR Connecticut, LLC, d/a/b Retreat at South CT

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* * * COMMUNICATION RESULT REPORT (AUG. 14. 2014 3:39PM) * * *

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E-3) NO ANSWER
E-4) NO FACSIMILE CONNECTION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Jennifer Groves Fusco, Esq.

FAX: (203) 772-2037

AGENCY: Shipman & Goodwin

FROM: Laurie Greci

DATE: 8/14/2014

NUMBER OF PAGES: 16
(including transmittal sheet

Comments:

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410 Capitol Ave., MS#13HCA
P.O.Box 340308Hartford, CT 06134

ADMINISTRATIVE APPEAL UNDER GENERAL STATUTES SECTION 4-183 — CITATION AND RECOGNIZANCE
(For use when service is made by a proper officer or indifferent person)
JD-CV-138 New 1-14
C.G.S. § 4-183; P.B. § 14-7A

ADA NOTICE
The Judicial Branch of the State of Connecticut complies with the Americans with Disabilities Act (ADA). If you need a reasonable accommodation in accordance with the ADA, contact a court clerk or an ADA contact person listed at *www.jud.ct.gov/ADA.*

STATE OF CONNECTICUT
SUPERIOR COURT
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To Any Proper Officer or Indifferent Person:
By the authority of the State of Connecticut, you are commanded to serve, according to law, a copy of the Appeal and this Citation and Recognizance by personal service on the agency that made the decision that is being appealed at the address of the agency or, if allowed by law, at the Office of the Attorney General, 55 Elm Street, Hartford, Connecticut. Also serve, according to law, a copy of the Appeal and this Citation and Recognizance on each party named in the decision of the agency at the address of the party contained in the decision.

Instructions to Person Appealing Decision:
File the appeal and this Citation and Recognizance with the Clerk of the Superior Court for the Judicial District of New Britain or for the Judicial District in which the person appealing resides or, if that person is not a residence of this state, with the Clerk of the Judicial District of New Britain.

Name of case *(Plaintiff v. Defendant)*	Case type code *(See form JD-CV-1c)*
NR CONNECTICUT, LLC D/B/A RETREAT AT SOUTH CT V. CT DEPT. OF PUBLIC HEALTH	Major: M Minor: 90
Judicial District	**Address of Court**	**Telephone number of Court *(with area code)***
NEW BRITAIN	20 Franklin Square, New Britain, CT 06051	(860) 515-5145

Name(s) and address(es) of plaintiff(s)
NR Connecticut, LLC, D/B/A Retreat at South Connecticut
12 New City Street
Essex, CT 06426

Name(s) and address(es) of defendant(s)
Connecticut Department of Public Health, Office of Health Care Access Division
410 Capitol Avenue
Hartford, CT 06134

RECEIVED
DEC 23 2014
Office of HEALTHCARE ACCESS

Notice To Defendant

1. The Plaintiff will file the attached Appeal of a final administrative decision. The Appeal attached to these papers states the claims that each Plaintiff is making.
2. **To be notified of further proceedings, you or your attorney must file a form called an "Appearance" with the clerk of the above-named Court at the above Court address within thirty (30) days of service of this Citation and Recognizance and Appeal. You do not have to come to court on that date unless you receive a separate notice telling you to come to court.**
3. If you do not file an "Appearance" in a timely manner, the Court is authorized to enter a sanction against you.
4. The "Appearance" form may be obtained at the Court address above or at *www.jud.ct.gov* under "Court Forms."
5. If you have questions about the Citation and Recognizance and the Appeal, you should talk to an attorney quickly. The Clerk of Court is not allowed to give advice on legal questions.

Signed *(Sign and "x" proper box)*	Name of person signing at left	Date
☐ Commissioner of the Superior Court ☐ Assistant Clerk	**Juda J. Epstein**	**09/22/2014**

If this Citation is signed by a clerk:
a. The signing has been done so that the Plaintiff(s)will not be denied access to the courts.
b. It is the responsibility of the Plaintiff(s) to see that service is made in the manner provided by law.
c. The Clerk is not permitted to give any legal advice in connection with any lawsuit.
d. The Clerk signing this Citation at the request of the Plaintiff(s) is not responsible in any way for any errors or omissions in anything contained in the Appeal, or the service of the Citation or Appeal.

For Court Use Only
File Date

A True Copy Attest
ERNEST A. LADEN
STATE MARSHAL
FAIRFIELD COUNTY

I certify I have read and understand the above:	Signed *(Self-Represented Plaintiff)*	Date
Name and address of person recognized to prosecute in the amount of $250		
Signed *(Official taking recognizance; "x" proper box)* ☐ Commissioner of the Superior Court ☐ Assistant Clerk	Date	*Docket number*

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THE LAW OFFICE OF JUDA J. EPSTEIN
JURIS NO. 430291

RETURN DATE: OCTOBER 14, 2014	:	SUPERIOR COURT
NR CONNECTICUT, LLC, D/B/A RETREAT AT SOUTH CONNECTICUT	:	J.D. OF NEW BRITAIN
v.	:	AT NEW BRITAIN
CONNECTICUT DEPARTMENT OF PUBLIC HEALTH, OFFICE OF HEALTH CARE ACCESS DIVISION	:	SEPTEMBER 22, 2014

ADMINISTRATIVE APPEAL

To the Superior Court for the Judicial District of New Britain comes NR Connecticut, LLC, d/b/a Retreat at South Connecticut, appealing from the final decision of the Connecticut Department of Public Health, Office of Health Care Access Division, dated August 14, 2014, in Docket No. 13-31828-CON (the "Final Decision") and complains and says:

Introduction

1. The Plaintiff, NR Connecticut, LLC, d/b/a Retreat at South Connecticut ("Retreat") appeals from the Final Decision which erroneously denied it certificate of need ("CON") approval to establish and operate a 105-bed residential substance abuse treatment facility for adults 18 and over in downtown New Haven (the "Facility") despite compelling evidence that the disease of addiction has hit unprecedented levels in Connecticut and the need for qualified providers like Retreat is greater than ever. Indeed, in the months leading up to the issuance of the flawed Final Decision, Connecticut's two U.S.

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Senators called for more funding for treatment and other initiatives to combat widespread opiate abuse across the State while Connecticut's Medical Examiner announced that 257 people died from heroin-related overdoses alone in 2013 – a 48% increase over 2012 totals. The evidence that an epidemic of heroin, prescription drug and other substance abuse is raging across Connecticut was ignored by Defendant in the same manner that it cast aside data contained in its own Statewide Health Care Facilities and Services Plan which, among other things, estimated that there were 234,481 Connecticut residents who required substance abuse treatment but were not being treated by current providers.

2. The math is simple: Nearly a quarter of a million Connecticut residents who require substance abuse treatment are not getting the services they so desperately need and hundreds, if not thousands, of lives are at stake unless the situation changes. On the basis of the factual, legal and procedural errors set forth below, Retreat seeks reversal of the Final Decision so it can help the State of Connecticut address this unmet need that so glaringly exists.

The Parties

3. Retreat is a "health care facility" as defined by Section 19a-630 of the Connecticut General Statutes.

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4. The Defendant is the Connecticut Department of Public Health, Office of Health Care Access Division. This division, under the direction of the Commissioner of Public Health, is a successor to the former Office of Health Care Access and is overseen by a Deputy Commissioner of Public Health who exercises independent decision-making authority over all CON related matters. See Conn. Gen. Stat. §§ 19a-612(a), 19a-612d. The defendant will be referred to herein as OHCA.

Jurisdiction and Venue

5. This appeal is authorized by Sections 19a-641 and 4-183 of the Connecticut General Statutes. Section 19a-641 provides, in pertinent part, that "[a]ny health care facility or institution ... aggrieved by any final decision of [OHCA] under the provisions of 19a-630 to 19a-639e, inclusive, may appeal from such decision in accordance with the provisions of 4-183...."

6. Venue is proper in this Judicial District pursuant to Section 4-183(c).

Background

7. Section 19a-638(a)(1) of the Connecticut General Statutes requires a health care facility to obtain a CON from OHCA prior to its establishment.

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8. Section 19a-639 of the Connecticut General Statutes sets forth the guidelines and principles which must be considered by OHCA in its deliberations involving a CON application pursuant to Section 19a-638 of the Connecticut General Statutes. OHCA must make written findings concerning each of these guidelines and principles. See Conn. Gen. Stat. §19a-639(a).

9. On March 25, 2013, Retreat submitted a comprehensive 663-page CON application to OHCA (the "Application"). Specifically, Retreat sought approval in its Application to establish the Facility within a 60,000 square foot, two-story building purchased by Retreat at 915 Ella Grasso Boulevard in New Haven, Connecticut. Retreat proposed to provide Level 3.7 residential detoxification services providing continuous observation, monitoring and treatment under physician-approved procedures as well as residential rehabilitation and recovery services at the Facility. The estimated total capital expenditure for the Facility is $7,566,000.

10. OHCA subsequently requested additional information and/or clarification regarding the Application from Retreat. Retreat provided the requested information and/or clarification in a timely manner in accordance with OHCA's procedures. OHCA determined that the Application was complete on July 8, 2013.

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11. A hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes)(the "UAPA") and Section 19a-639a of the Connecticut General Statutes on August 14, 2013. The Commisioner of Public Health designated Marianne Horn as the hearing officer to conduct the hearing and to render a proposed decision.

12. At the hearing and in subsequent filings described below, Retreat submitted uncontroverted evidence to support approval of its Application under the relevant statutory criteria set forth in Section 19a-639(a) of the Connecticut General Statutes, specifically:

(a) Evidence compiled by the federal Substance Abuse and Mental Health Services Administration ("SAMHSA") showing that an estimated 281,222 adults in Connecticut are in need of treatment for alcohol and illicit drug dependence and abuse;

(b) Evidence from SAMHSA demonstrating that an estimated 3.7% of Connecticut's total population in need of treatment for drug abuse are abusing cocaine or heroin;

(c) Evidence from The National Survey on Drug Use and Health (NSUDH) showing that Connecticut's rate of unmet need for alcohol

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or illicit drug abuse or dependence has remained constant between 9 and 10% in recent years;

(d) Evidence that the above data from SAMHSA and NSUDH was cited and relied upon in OHCA's own 2012 Statewide Health Care Facilities and Services Plan ("OHCA Facility Plan") which is meant to serve as a blueprint for health care delivery and the allocation of health care resources in Connecticut;

(e) Evidence from the OHCA Facility Plan that while overall acute care hospital visits in the State declined by 1% from 2008 to 2011, substance abuse related admissions increased 26% over the same time period and that inappropriate use of the ED by behavioral health patients, including substance abuse patients, was a major cause of ED overcrowding which was negatively affecting overall quality of care;

(f) Evidence that as part of the OHCA Facility Plan process and as reported in the Plan, an OHCA-sponsored focus group with hospital emergency department (ED) staff "noted the shortage of inpatient beds for both adults and children needing psychiatric or substance use treatment services" and found that "[f]or opiate treatment, patients spend five to six hours in an ED [awaiting a referral while]

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[o]thers wait days for placement and are eventually stabilized and discharged from the ED before obtaining placement."

(g) Evidence that Senators Blumenthal and Murphy, U.S. Attorney General Holder and other regional and local leaders have all noted the dramatic increase in heroin-related deaths in Connecticut and New England generally, and have emphasized the need for improved treatment options for such addicted persons;

(h) Evidence that Retreat's Application was supported by numerous professionals and professional organizations involved in drug treament and the provision of health care in Connecticut -- including, but not limited to, the Connecticut College of Emergency Physicians and the Connecticut Psychological Association -- due to their acknowledgement and continued frustration with the State's severe shortage of substance abuse treatment beds;

(i) Evidence that the Connecticut Department of Mental Health and Addiction Services ("DMHAS") estimates that for every one person in Connecticut that seeks treatment and/or receives behavioral health care for addiction, there are six individuals with similar addictions who will neither gain access to nor receive such care;

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(j) Evidence of multiple telephonic surveys conducted by Retreat personnel of existing residential substance abuse treatment facilities (the same type of surveys which had been relied upon by OHCA in prior CON applications as demonstrating need for additional substance abuse treatment facilities) that corroborated the fact that there were long waiting lists and very few available detoxification beds available to Connecticut residents on a daily basis;

(k) Evidence from those surveys, that during its first set of surveys conducted as part of its initial CON application, only 6 out of 22 calls may have resulted in a successful placement. Subsequently, as part of its supplement to the record, Applicant conducted 84 additional calls to the 13 other substance abuse treatment facilities that have stated that they provide residential detoxification services. Of those 84 calls, 45 calls resulted in the surveyor learning that there were no beds available at that time, 5 calls resulted in learning that the facility could not help a mock commercially insured patient seeking treatment and another 30 calls resulted in the surveyor receiving only a voicemail, busy signal or being placed on hold for more than five minutes. Only 4 calls resulted in the surveyor being affirmatively told to present at the facility for an available bed. This disturbingly poor

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record demonstrates the very real frustrations and obstacles that patients seeking residential detoxification and rehabilitation treatment for substance abuse face when seeking help in Connecticut.

(l) Evidence that the DMHAS "Addiction Residential Census Report" is an unreliable and inherently flawed source of data for determining bed availability for the substance abuse patients that would seek Retreat's services, especially in light of other DMHAS data demonstrating that 70% of providers of intensive residential and co-occurring residential services self-reported that they never or only sometimes have bed availability;

(m) Evidence that Retreat's management currently operates a highly-regarded 120-bed residential substance abuse treatment facility located in Ephrata, Pennsylvania which has succeeded in coordinating care with local hospitals and relieving overburdened EDs of substance abuse patients who can be better treated in a residential setting;

(n) Evidence that Retreat's Level 3.7 medically monitored treatment programs, which are supervised by full-time, employed physicians and supported by a multi-disciplinary team of addiction treatment and mental health personnel, promote better outcomes and have proven

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to be more clinically appropriate than hospitals for most patients whose addiction problems require treatment in an inpatient as opposed to outpatient setting;

(o) Evidence that Retreat's multi-modal approach to drug and alcohol treatment, including specialty services for patients with co-occurring mental disorders and evidence-based programs tailored to meet the needs of vulnerable populations, such as veterans and first responders, coupled with the unique design and amenities offered at its proposed Facility would offer a level of service beyond what is currently available at Connecticut facilities that are willing to participate with insurance plans and provide residential substance abuse treatment to patients at affordable in-network rates;

(p) Evidence that the proposed Facility would admit patients on a 24/7 basis allowing patients to be admitted while they are in crisis and before they lose the impetus to seek rehabilitation as well as providing a readily available and convenient admissions process for local hospitals seeking to refer emergency room patients who would be better served by Level 3.7 detoxification services at all hours of the day or night;

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(q) Evidence that as a result of the Affordable Care Act, mental health parity laws and the creation of federal and state-run health insurance exchanges, including Access Health CT which in its first open enrollment period enrolled more than 208,301 individuals in exchange-offered health plans (exceeding its own projections by more than double), the number of individuals covered by insurance is expected to rise dramatically and drive up utilization of substance abuse facilities by individuals who previously have not sought treatment and/or did not have the ability to pay for such treatment;

(r) Evidence that Retreat will provide substantial charity care services to patients in need of Retreat's services who are not covered by insurance or otherwise are without the means to pay;

(s) Evidence that currently there is only a single 29-bed facility located within the City of New Haven that offers residential detoxification and rehabilitation treatment;

(t) Evidence that beyond its numerous clinical benefits, Retreat's Facility would provide an economic boost to New Haven and its surrounding community by employing 70 individuals initially, with an increase to over 100 employees within the first year of operation.

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(u) Evidence that greater access to high quality residential substance abuse treatment is sorely needed at a time when national studies continue to demonstrate that Connecticut ranks among the leading states in the nation in illicit drug use, New England continues to be an area of high intensity drug trafficking and news reports on a daily basis show that use of heroin and other highly-addictive drugs continues to grow across all segments of society.

13. On January 22, 2014, the Hearing Officer, issued a proposed final decision (the "Proposed Final Decision") recommending that Retreat's application for establishing the Facility in New Haven be denied despite making the incongruous findings of fact (FoFs) that the proposal is consistent with OHCA's Facility Plan and will increase substance abuse treatment for the relevant populations and payor mix. In correspondence transmitting the Proposed Final Decision, OHCA also notified Retreat that, pursuant to Connecticut General Statutes Section 4-179, Retreat could request the opportunity to file exceptions or a brief or a request to present an oral argument with the OHCA Deputy Commissioner who was to render the final decision, within twenty-one (21) days from the mailing of the Proposed Final Decision.

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14. In response to this offer, Retreat filed detailed exceptions to various findings of fact and conclusions set forth in the Proposed Final Decision. On multiple occasions, in the Proposed Final Decision, OHCA relied on data which it had allowed intervenors to submit by late file or that OHCA considered from its acute care hospital database without affording Retreat notice or the opportunity to object or offer rebuttal demonstrating that the agency's use of and/or reliance on such data was improper as well as factually and legally flawed.

15. On August 14, 2014, Deputy Commissioner Lisa A. Davis issued OHCA's Final Decision denying Retreat's Application. In its Final Decision, OHCA removed its erroneous findings related to the ability of hospitals to provide similar services to Retreat, modified its findings with respect to the agency's reliance on the flawed DMHAS Addiction Residential Census Reports, and removed irrelevant findings that referenced payor mix data from OHCA's Acute Hospital Inpatient Discharge Database through which it had attempted to show that such data served as a proxy for the number of government-insured versus commercially-insured residents in New Haven County.

16. Instead, OHCA's Final Decision did not controvert United States Census Bureau data provided by the Applicant which shows that 54.9% of New Haven residents; 72.2% of County of New Haven residents; and 74.9% of

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Connecticut residents are covered by commercial insurance policies of the type Retreat would be willing to accept at its proposed Facility.

Reasons for Appeal

17. Retreat has exhausted all administrative remedies and is aggrieved by the Final Decision which is a final decision within the meaning of Conn. Gen. Stat. § 4-183(a). Retreat is aggrieved by OHCA's findings, inferences, conclusions, decision and order in various ways, including, but not limited, to the following:

(a) OHCA's failure to consider, in making its finding that Applicant had failed to establish clear public need (Finding of Fact 25), that, *inter alia*, hundreds of thousands of Connecticut residents in need of what is often life-saving substance abuse treatment are not receiving these services;

(b) OHCA's failure to consider, in making its finding that Applicant has not satisfactorily demonstrated that the proposal will financially strengthen the health care system in the state (FoF 26), that, *inter alia*, Retreat would not be seeking any state or federal aid or subsidy to provide its services, would add substantial and much-needed additional capacity to the health care delivery system without public expense, and reduce the unnecessary expenditure of health care dollars

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by providing a more efficient and beneficial treatment setting for substance abuse patients than high-cost hospital emergency departments;

(c) OHCA's failure to consider, in making its finding that Applicant has not satisfactorily demonstrated that its proposal would improve the accessibility of health care delivery in the region (FoF 27), that, *inter alia*, the only other provider of residential detoxification and rehabilitation services in New Haven is a single, 29-bed federally qualified health center and that Retreat has shown through the successful performance of its flagship facility in Ephrata, Pennsylvania that it can attract new patients to seek substance abuse treatment;

(d) OHCA's failure to consider, in making its finding that Applicant has not satisfactorily demonstrated that the identified population to be served by its proposal has a need for the proposed services (FoF 29), that, *inter alia*, the clear and uncontroverted data from SAMHSA and the NSUDH contained in OHCA's own Facility Plan shows a glaring need for improved residential substance abuse treatment in Connecticut;

(e) OHCA's failure to consider, in making the finding that Applicant has not provided any historical utilization of behavioral health treatment services in the service area that would support this proposal

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(FoF 30), that, *inter alia*, DMHAS estimates that only one in seven Connecticut residents in need of substance abuse treatment will receive such care and that key stakeholders identified in OHCA's Facility Plan have gone on record to state that there is a severe shortage of residential detoxification beds and that the present health care delivery system is failing substance abuse patients;

(f) OHCA's failure to consider, in making the finding that the utilization of existing health care facilities and services in the service area does not support this proposal (FoF 31), that, *inter alia*, Retreat's proposed facility would allow for overburdened hospital EDs to discharge the growing number of substance abuse patients to a more appropriate treatment setting while freeing up acute care resources;

(g) OHCA's failure to consider, in making the finding that Applicant failed to satisfactorily demonstrate that the proposal will not result in an unnecessary duplication of existing services in the area (FoF 32), that, *inter alia*, Retreat's proposal would bring unique treatment modalities and a new level of affordable, high quality substance abuse care to Connecticut that would attract patients who are not currently seeking treatment at existing providers and also draw patients from outside the State.

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(h) OHCA's wrongful and explicit failure to consider any potential improvement in quality and cost effectiveness to be gained from the Retreat Facility, which is directly contrary to the standard for review set forth in 19a-639 (FoF 27);

(i) OHCA's consideration of the provision of or any change in the access to services for Medicaid recipients and indigent persons, and the impact upon the cost effectiveness of providing access to services provided under the Medicaid program; both of which standards were added to Connecticut General Statutes section 19a-639 after Retreat's Application had been filed;

(j) OHCA's inconsistent and arbitrary consideration of participation in Medicaid and Medicare as a criterion on which to deny CON approval as OHCA has recently approved several new and/or expanded substance abuse treatment facilities that sought to provide services exclusively to commercially insured and/or self-pay patients. Notably, OHCA approved 16 additional Level 3.7 inpatient residential detoxification beds at the Mountaintop Treatment Center in 2012 under Docket No. 11-31734-CON without raising any concern about such facility's lack of participation in Medicaid or Medicare or noting any services that Mountaintop would provide to individuals without the capacity to pay. Earlier this year, OHCA similarly approved the creation

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of an intensive outpatient behavioral health and substance abuse treatment facility in Old Saybrook (see Docket No. 13-31833-CON) that likewise would serve only commercially insured and self-pay patients. Further, in 2010, OHCA approved under Docket No. 09-31500-CON a residential substance abuse treatment facility catering exclusively to "physicians, attorneys, executives and other high-earning individuals," which would be exclusively self-pay at a cost of $50,000 to each patient. In these three, and other similar CON decisions, OHCA approved substance abuse treatment facilities that explicitly would only service individuals paying for their treatment or covered by commercial insurance, without any consideration of such applicant's refusal to accept Medicare or Medicaid. Tellingly, unlike Retreat, none of these Applicants made a promise to provide any charity care, including the provision of such care to Medicare and Medicaid beneficiaries if needed;

(k) OHCA's directly contradictory and arbitrary findings that Retreat would not improve the accessibility of health care delivery in the region, but would create an increase in access to the provision of health care services to the relevant populations and payor mix (FoF 27 and 28);

(l) OHCA's arbitrary and capricious conduct and departure from past precedent in failing to consider Retreat's multiple phone

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surveys reflecting that few, if any, detoxification beds are actually available in Connecticut for a patient in crisis on a given day;

(m) OHCA erred in its findings that Retreat would not provide services to Medicare and Medicaid patients; and

(n) OHCA erred by misinterpreting and misapplying the guidelines and principles set forth in Section 19a-639(a).

18. OHCA committed procedural and legal error by permitting numerous expert witnesses affiliated with other Connecticut-based substance abuse treatment facilities, who did not apply to be intervenors nor submit prior written testimony, to testify over Retreat's objections. Pursuant to Section 4-177c of the Connecticut General Statutes each party "shall be afforded the opportunity ... (2) at a hearing, to cross examine other parties, intervenors and witnesses...." During the hearing, Retreat was not afforded the opportunity by the Hearing Officer to cross-examine such witnesses in violation of the UAPA. Further, because Retreat was not given prior notice of such expert witnesses' testimony through the filing of an intervenor petition or other means, Retreat was denied the ability to effectively cross-examine such witnesses and was thereby severely prejudiced and denied due process of law.

19. Pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the review period for a completed application may not exceed 90 days, except with good cause shown, OHCA may extend the review period for an

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additional 60 days. In the event that a hearing is held, the review period may not exceed 60 days from the hearing date. As such, OHCA was required to provide a final decision to Retreat by October 4, 2013. Rather, OHCA did not render the proposed final decision for an additional three months until January 22, 2014. Retreat was substantially prejudiced by this delay, including, without limitation, paying taxes, finance charges and upkeep expenses with respect to the land and building where the proposed Facility will be located.

20. In addition to the foregoing, Retreat's legal rights and privileges have further been prejudiced because OHCA's findings, inferences and conclusions in its Final Decision and Order are:

a. In violation of constitutional or statutory provisions;

b. Made upon unlawful procedure;

c. Affected by other error of law;

d. Clearly erroneous in view of the reliable, probative, and substantive evidence on the whole record; and/or

e. Arbitrary or capricious or characterized by an abuse of discretion or a clearly unwarranted exercise of discretion.

See Conn. Gen. Stat. § 4-183.

21. Retreat is also aggrieved because, as a result of the Final Decision and Order, it will not be permitted to provide a state-of-the-art, cost-effective treatment option to substance abuse patients in Connecticut, whether they are

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covered by commercial insurance, government-sponsored health care coverage or in need of charity care.

Dated at Bridgeport, Connecticut this 22nd day of September, 2014.

Plaintiff/Appellant
NR CONNECTICUT, LLC,
d/b/a RETREAT AT SOUTH CONNECTICUT

By: _____

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CERTIFICATE OF SERVICE

This is to certify that a true and accurate copy of the foregoing was sent by U.S. Mail this 22nd day of September, 2014, to the following parties of record:

Jennifer G. Fusco, Esq.
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
New Haven, CT 06510

Representing: Yale-New Haven Hospital, Cornell Scott-Hill Health Center and APT Foundation

Joan W. Feldman, Esq.
Shipman & Goodwin, LLP
1 Constitution Plaza
Hartford, CT 06103

Representing: Rushford Center, Inc. and Stonington Behavioral Health, Inc. d/b/a Stonington Institute

Juda J. Epstein

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Agreed Settlement

Applicant: **NR Connecticut, LLC, d/b/a Retreat at South Connecticut**
915 Ella Grasso Boulevard, New Haven,CT

Docket Number: **13-31828-CON**

Project Title: **Establish a 105-Bed Residential Substance Abuse Treatment Facility**

AGREED SETTLEMENT

On or about March 25, 2013 , **NR Connecticut , LLC d/b/a Retreat at South Connecticut** ("Retreat") submitted a certificate of need ("CON") application to the Office of Health Care Access ("OHCA") of the Department of Public Health seeking approval to establish a 105 bed Residential Substance Abuse Treatment Facility to be located in New Haven, Connecticut.

The application was filed under Docket No. 13-31828-CON. On August 14, 2014, OHCA issued its Final Decision denying the Retreat's CON application. On or about September 23, 2014, Retreat filed an administrative appeal in the Superior Court for the Judicial District of New Britain bearing Docket No. **HHB-CV-14-6027073-S** (hereinafter the "Administrative Appeal")

Wherefore, Retreat and OHCA have sought to resolve the issues raised in the Administrative Appeal and entered into good-faith settlement discussions in order to avoid the continued expense of litigation;

NOW, THEREFORE, OHCA and the Retreat through their authorized representatives hereby stipulate and agree to the following terms of settlement with respect to the Retreat's request to establish a Residential Substance Abuse Treatment Facility to be located in New Haven, Connecticut:

1. The Retreat hereby modifies its request to establish a Residential Substance Abuse Treatment Facility to be located in New Haven, Connecticut by reducing the number of licensed beds to eighty (80) of which twenty (20) shall be dedicated residential detoxification and evaluation beds and sixty (60) shall be dedicated intensive treatment beds. The Retreat shall provide OHCA with notification of its official commencement of service operations within thirty (30) days of such commencement.

2. The Retreat's modified application is approved subject to the conditions and terms set forth herein.

3. Upon execution of this Settlement Agreement, the Retreat may seek State of Connecticut Department of Public Health ("DPH") licensure in order to authorize the utilization of eighty (80) beds, twenty (20) residential detoxification and evaluation beds and sixty (60) intensive treatment beds. The Retreat will also enter into a Pre-Licensure Consent Order that shall include a provision that the Retreat shall only implement utilization at the time of licensure of sixty (60) beds, fifteen (15) residential detoxification and evaluation beds and forty-five (45) intensive treatment beds, until such time as it complies with the requirements set forth in section 4 of this Agreement.

4. Twenty (20) of the licensed beds shall not be implemented until the Retreat has obtained a ninety percent (90%) bed utilization of the sixty (60) initially operational beds implemented at the time of licensure for a period of fourteen consecutive (14) days and only upon receipt by OHCA of an affidavit by Retreat's chief operating officer which identifies and attests to:
    a. The foregoing utilization of said beds;
    b. The Daily Census for said fourteen (14) day period ;
    c. The number of clients on the last day of said fourteen (14) day period by zip code;
    d. The number of clients admitted during said fourteen (14) day period;
    e. The number of clients discharged during said fourteen (14) day period; and
    f. Retreat's DPH license being in good standing.

5. OHCA shall review the affidavit provided under section 4 within ten (10) business days and, absent a finding of noncompliance, report to the Facility Licensing and Inspection Section of the Department of Public Health compliance with this provision.

6. At all times during the operation of this authorized facility, at least two beds shall be provided without charge to Connecticut residents who are either uninsured or whose only source of payment is Connecticut Medicaid or government payment programs (excluding insurance provided to state or federal employees or retirees). Upon issuance of the compliance finding under paragraph 5, a third bed shall be provided without charge to patients pursuant to the terms delineated hereinabove. The availability of the beds described in this section shall be included in marketing and community educational materials produced by the Retreat. Following the start of service operations, the Retreat

shall report to OHCA biannually on the monthly utilization of the beds described in this section and the number of patients denied admission due to the lack of available beds as described in this section. The reports shall be filed with OHCA within thirty (30) days of the end of the biannual period which shall be based on start of the service operations as reported pursuant to Section 1. The report shall identify by each month in the biannual period, whether these beds were occupied by uninsured patients or by Medicaid/government payor patients, how many days each bed was unfilled versus occupied and will confirm that these beds were occupied by Connecticut residents.

7. The Retreat shall provide services to patients with a dual diagnosis of a mental disorder and substance abuse where the primary diagnosis is substance abuse.

8. The Retreat shall develop relationships with Connecticut state agencies (including but not limited to Department of Children and Families, Department of Mental Health and Addiction Services, Department of Social Services), existing providers (hospitals, community health centers, school based health centers) and any other relevant community organizations in its service area to discuss and, when reasonably requested, participate in community needs assessments statewide to identify gaps in mental health and substance abuse services for all age groups in the State of Connecticut.

9. The Retreat shall file all reports with OHCA and DPH required by state statutes and regulations and this Agreed Settlement.

10. The Retreat shall maintain a referral listing for admissions and disposition of discharged patients for a period of three years from the commencement of service operations. For the first full year after the start of service operations, the Retreat shall file quarterly a summary of the referral sources for admissions and discharges locations. Said reports shall not require the identity of the particular source or location but shall list admission sources and discharge disposition by major categories (such as acute care hospital, psychiatric hospital, private practitioner, school, etc.). Said reports shall be due within thirty (30) days of the end of the reporting period.

11. The Retreat shall file the following reports with OHCA regarding its operations for the first three years of operations. Said reports shall contain monthly information and shall be filed quarterly. The reports shall be due within thirty (30) days of the end of the quarter based on the start of service operations as reported pursuant to section 1. The report shall be separate for the different residential service types and shall identify the following for each month within the quarter reported:

    a. The Average Daily Census;
    b. The number of clients on the last day of the month by zip code;
    c. The number of clients admitted during the month; and
    d. The number of clients discharged during the month.

12. During the first three years after the start of service operations, the Retreat shall develop and implement in Connecticut an educational program including but not limited to public service announcements, for active clients and State of Connecticut residents regarding drug overdose prevention with a specific emphasis on prescription drugs that contain opioids (e.g., oxycodone, hydrocodone, codeine).

13. During the first three years after the start of service operations, the Retreat shall develop and implement in Connecticut an educational program, including but not limited to public service announcements, to raise public awareness of the need for substance abusers to seek treatment and which identifies all treatment options.

14. The public service announcements referenced in Paragraphs 12 and 13 herein shall address any deficiencies identified in the community needs assessments referenced in Paragraph 8 herein as well as be consistent with and take into account statewide assessments for the types of services offered by the Retreat.

15. For three years following the start of service operations, the Retreat shall report to OHCA biannually regarding its efforts related to the educational programs referenced in sections 12 and 13. The reports shall be filed with OHCA within thirty (30) days of the end of the biannual period which shall be based on start of the service operations as reported pursuant to section 1 and shall include a description of the types of educational activities conducted during the six month period of the report and include as applicable the following:

    a. Identification of when and where the live sessions were conducted and the number of people in attendance;
    b. A copy of the initial brochure distributed by the Retreat and any subsequent revised brochures (including those released in languages other than English);
    c. Identification of the number of brochures that were distributed during the six month period reported;
    d. A description of the public service announcement(s), where or how aired and how many times the public service announcement(s) ran; and
    e. A description of the educational activities during this time period which occur in the form of grand rounds, case studies, meetings with discharge planners, and similar presentations with providers; the date of the presentation(s); number in attendance and a discussion of any identified referral pattern changes resulting from these presentations.

16. OHCA and Retreat agree that this settlement represents a final agreement between OHCA and Retreat with respect to OHCA Docket No. 13-31828-CON, however, Retreat reserves the right to enforce this Agreement. The execution of this settlement resolves

all objections, claims and disputes, which may or could have been raised by Retreat with regard to OHCA Docket Number 13-31828-CON.

17. Retreat hereby agrees to withdraw the Administrative Appeal within two (2) business days of the execution of this settlement and provide evidence thereof to OHCA.

18. OHCA may enforce this settlement under the provisions of Conn. Gen. Stat. §§ 19a-642 and 19a-653 with all fees and costs of such enforcement to be governed by State Law.

19. This settlement shall be binding upon Retreat and its successors and assigns.

Signed by Peter Schorr, CEO
(Print name) (Title)

5/13/15
Date

Duly Authorized Agent for
NR Connecticut , LLC d/b/a Retreat at South Connecticut

The above Agreed Settlement is hereby accepted and so ordered by the Department of Public Health, Office of Health Care Access on May 13, 2015.

Janet M. Brancifort

Janet M. Brancifort, MPH, RRT
Deputy Commissioner, Department of Public Health

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

June 10, 2015

Mr. Peter Schorr
President and Chief Executive Officer
NR Connecticut, LLC, d/b/a Retreat at South Connecticut
C/o 12 New City Street
Essex, CT 06426

RE: NR Connecticut, LLC, d/b/a Retreat at South Connecticut
Notice of CON Expiration Date for the Agreed Settlement Rendered
under Docket Number: 13-31828-CON

Dear Mr. Schorr:

On May 13, 2015, in an agreed settlement under Docket Number: 13-31828-CON, the Office of Health Care Access authorized a Certificate of Need ("CON") to NR Connecticut, LLC, d/b/a Retreat at South Connecticut for the establishment of an eighty (80) licensed bed residential substance abuse treatment facility in New Haven Connecticut. Pursuant to Section 19a-639b of the Connecticut General Statutes ("C.G.S."), ***"a certificate of need shall be valid for two years from the date of issuance by this office."***

With this letter, please be advised that pursuant to Section 19a-639b, C.G.S., the current CON authorization issued under Docket Number: 13-31828-CON will expire on May 13, 2017. Please contact me at (860) 418-7069 or Karen Roberts, Principal Health Care Analyst at (860) 418-7041, if you have any questions regarding this notification.

Sincerely,

Jack A. Huber

Jack A. Huber
Health Care Analyst

CC: Karen Roberts, Principal Health Care Analyst, DPH, OHCA

Roberts, Karen

From: Huber, Jack
Sent: Thursday, April 28, 2016 9:11 AM
To: wbeccaro@snet.net
Cc: Roberts, Karen; Cotto, Carmen
Subject: Letter Requesting a Status Update of the Retreat at South Connecticut Project
Attachments: Letter Requesting Retreat Project Update.pdf

Dear Attorney Beccaro - Please find attached a letter addressed to Mr. Peter Schorr requesting that he file with the Department of Public Health, Office of Health Care Access a status update of the Retreat at South Connecticut project. The status update shall include a description of the steps that have been accomplished to date in the implementation of the authorized Certificate of Need project. Should you have any questions concerning this notification, please contact Karen Roberts at (860) 418-7041. Thank you for your attention to this matter. Best Regards, Jack Huber

Jack A. Huber, Health Care Analyst
CT Department of Public Health | Office of Health Care Access |410 Capitol Avenue
P.O. Box 340308, MS #13HCA | Hartford, CT 06134-0308|Ph: 860-418-7069|Fax: 860-418-7053
Email: Jack.Huber@ct.gov |Web: www.ct.gov/ohca



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

April 28, 2016

Via Email Transmittal Only

Mr. Peter Schorr
President and CEO
NR Connecticut, LLC d/b/a Retreat at South Connecticut
C/o The Law Offices of William P. Beccaro
12 New City Street
Essex, Connecticut 06426

Re: Compliance with Agreed-Upon Stipulations set forth in Docket Number: 13-31828-CON
Establishment of a Residential Substance Abuse Treatment Facility in New Haven, CT
Request for Project Update

Dear Mr. Schorr:

On May 13, 2015, NR Connecticut, LLC, d/b/a Retreat at South Connecticut ("Retreat"), entered into an Agreed Settlement with the Department of Public Health, Office of Health Care Access ("OHCA") under Docket Number: 13-31828-CON for the establishment of an 80-bed residential substance abuse treatment facility in New Haven, Connecticut. As of this date, OHCA has not received any correspondence from Retreat regarding the implementation of this project. As such, OHCA requests that Retreat submit a status update of the project that includes a description of the steps that have been accomplished to date in the implementation of the authorized Certificate of Need project.

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184
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Hartford, Connecticut 06134-0308
www.ct.gov/dph
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Should you have any questions concerning this notification, please contact Karen Roberts at (860) 418-7041. Thank you for your attention to this matter.

Sincerely,

Kimberly R. Martone
Director of Operations

cc: Karen Roberts, Principal Health Care Analyst, DPH, OHCA

KRM:KR:jah

NR Connecticut, LLC

April 10, 2017

Via FedEx

Ms. Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capital Avenue, MS #13HCA
P. O. Box 340308
Hartford, CT 06106

Re: NR Connecticut, LLC Request for CON Modification

Dear Ms. Martone:

Enclosed please find NR Connecticut, LLC's request for a modification of the Certificate of Need previously authorized by the Agreed Settlement entered into on May 13, 2015 regarding 13-31828-CON.

Please feel free to contact me by telephone at 718-682-2600 extension 203 or by email at josephs@coalcapitalgroup.com with any questions or concerns. Thank you for your consideration.

Very truly yours,

Joseph Silberstein
Counsel

Enclosure

ACTIVE/8.2/AMURRAY/6530332v1

State of Connecticut
Office of Health Care Access
Form for Modification of a Previously Authorized Certificate of Need

All persons who are requesting a modification to a previously authorized Certificate of Need must complete this form. Completed forms should be submitted to the Director of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner	Petitioner
Full legal name	NR Connecticut, LLC	
Doing Business As	Retreat at South Connecticut	
Name of Parent Corporation		
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	915 Ella Grasso Boulevard, New Haven, CT	
Petitioner type (e.g., P for profit and NP for Not for Profit)	P	
Name of Contact person, including title	David Silberstein, CFO	
Contact person's street mailing address	1377 East 4th Street, 4th Floor, Brooklyn, NY 11230	
Contact person's phone, fax and e-mail address	Tel: 718-682-2600, ext. 201 Fax: 718-709-7477 davids@coalcapitalgroup.com	

SECTION II. GENERAL PROPOSAL INFORMATION

a. Title of Previously Authorized Project and Associated Docket Number(s):
Establish a 105-Bed Residential Substance Abuse Treatment Facility; 13-31828-CON; Agreed Settlement

b. Location of proposal (Town including street address):
915 Ella Grasso Boulevard, New Haven, CT

c. Type of Modification Request:

☐ Change in the Scope of the Authorized Certificate of Need Project

☒ Extension of CON Expiration Date

☐ Change in a CON Order Condition *(other than to extend expiration date)*

☐ Other – Describe: _____

SECTION III. IF REQUESTING A CHANGE IN THE SCOPE OF AUTHORIZED PROJECT:

a. Provide a one page description of the requested change in the scope of a previously authorized Certificate of Need project and provide a detailed rationale for such change:

SECTION IV. IF REQUESTING AN EXTENSION OF THE CON EXPIRATION DATE:

a. Certificate of Need expiration date per CON Final Decision: May 13, 2017, per Agreed Settlement accepted and ordered by the Department of Public Health on May 13, 2015.

b. Requested revised CON expiration date: June 30, 2018

c. Rationale for increased time to fully complete and implement the authorized project:

Applicant is establishing a Residential Substance Abuse Treatment Facility in a two-story, 60,000 square foot building situated on 2.72 acres in the City of New Haven. The building, which formerly housed a 120-bed skilled nursing facility, was originally constructed in 1973 and requires significant retrofitting to meet current building codes and the Applicant's planned use.

After conducting necessary engineering and other assessments of the property, Applicant engaged the services of Quisenberry Arcari Architects in September, 2015 to begin work on the extensive redesign and drawings necessary to secure approval of the architectural design and construction plans ("Plans") from the Department of Public Health ("DPH") Facility Licensing and Investigations Section Building and Fire Safety Unit and the New Haven Building Department.

As shown in the correspondence attached at Exhibit A, the Applicant has been diligently pursuing the project since that time. On March 10, 2017, after submitting the initial Plans for DPH review on July 11, 2016 and eight months of receiving and responding to follow-up questions from the Building and Fire Safety Unit, the Plans were approved. The Applicant had previously received the Building Permit from the New Haven Building Department on December 15, 2016.

Applicant has invested more than $7.3 million in the project to date, including the engagement of a General Contractor. Presently, the General Contractor is completing demolition work and staging the commencement of all the renovation work, but additional time for construction is needed due to unforeseen delays in the plan approvals and bidding process. Applicant anticipates that construction will be completed on or about February, 2018 with a Certificate of Occupancy and necessary inspections by the DPH to follow. Accordingly, Applicant seeks an extension of the Certificate of Need expiration date until June 30, 2018 so that it may continue its diligent and good faith efforts to complete the project and begin operations.

SECTION V. IF REQUESTING A CHANGE IN A CON FINAL DECISION CONDITION
(other than extension of the CON expiration date)

a. Identify the CON Condition that you are requesting to be revised or vacated.

_____

b. Provide the rationale for such requested change:

_____

_____

_____

_____

_____

SECTION VI. OTHER

a. Submit a completed CON Modification Affidavit. See Attached.

b. Identify any other pertinent changes to the findings of facts upon which the original CON authorization was based as a result of this requested modification. N/A

c. Identify what has been accomplished to date in terms of full project implementation.

Since entering into the Agreed Settlement, the Applicant has invested substantial time, effort and resources into the Approved Project and has taken significant steps towards establishing the approved residential substance abuse treatment facility. These accomplishments include: interior demolition of the building; installing a required water runoff separation drainage system; obtaining all required local zoning and ordinance approvals; obtaining all necessary permits and inspections; completing design plans in coordination with an architect, consultants, and engineers; obtaining builders' insurance; maintaining and repairing the land and building; installing a security system; employing a property management company, and paying all operating and maintenance costs and local and state property taxes.

CON MODIFICATION AFFIDAVIT

Applicant: NR Connecticut, LLC d/b/a Retreat at South Connecticut

Project Title: Establish a 105-Bed Residential Substance Abuse Treatment Facility

I, David Silberstein, CFO

of NR Connecticut, LLC being duly sworn, depose and state that the information provided in this CON Modification form is true and accurate to the best of my knowledge.

Signature

APRIL 10, 2017
Date

Subscribed and sworn to before me on 4/10/17

REIZY GROSS
NOTARY PUBLIC
NO. 01GR6329800
QUALIFIED IN
KINGS COUNTY
COMM. EXP.
08/31/2019
STATE OF NEW YORK

Notary Public/Commissioner of Superior Court

My commission expires: 8/31/19

From: Doyle, Christopher [mailto:Christopher.Doyle@ct.gov]
Sent: Wednesday, March 22, 2017 1:21 PM
To: Adam Tarfano <atarfano@qa-architects.com>
Cc: Bruno, Anthony M. <Anthony.M.Bruno@ct.gov>; Cass, Barbara <Barbara.Cass@ct.gov>
Subject: Technical assistance fee

Hi Adam,

Based on the project costs you have submitted, a technical assistance fee of **$17,462.50** has been assigned against this project.

It shall be sent to Tony Bruno, and the check shall be made payable to "Treasurer- State of Connecticut".

As soon as the check has been received, an approval will be issued to commence the project.

Regards,

Chris Doyle

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION
BUILDING AND FIRE SAFETY UNIT

March 10, 2017

Quisenberry Arcari Architects, LLC
318 Main Street
Farmington, Connecticut 06032
Attn: Mr. Adam Tarfano

Re: **Retreat of South Connecticut- facility renovations**
DPH Project #733

Dear Mr. Tarfano,

Final project documents as prepared by Quisenberry Arcari Architects, LLC have been received and reviewed for the above referenced project.

As a result of our review, the plan appears to satisfy the intent of the CT Public Health Code.

This approval is subject to the provisions of the Connecticut Public Health Code, State Fire Safety Code, Basic Building Codes, and local authorities having jurisdiction.

Prior to our final inspection, the following documents shall be transmitted to this Section:

1. A copy of the Building Permit issued by the City of New Haven Building Department;
2. Acceptance in writing of the completed project by the architect of record;
3. A copy of the certificate of occupancy issued by the City of New Haven Building Department;
4. A copy of the City of New Haven Fire Marshal certificate of inspection, as applicable;
5. Test reports and acceptance of all electrical; mechanical; fire suppression; smoke detection and fire alarm systems; annunciation systems on normal and emergency power; emergency generator and medical gas system, as applicable;
6. Air balancing reports for the HVAC systems if applicable.

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7. In accordance with CT General Statutes, Section 19a-491(f), Public Act No. 13-234 a technical assistance fee is required for this plan review, future meetings and inspections related to this project. A total cost of the project shall be sent to my attention so an accurate technical assistance fee shall be charged to this project.

Any changes to the approved plans and specifications shall be brought to the attention of this office.

During this project, all efforts shall be made to maintain the current level of services and minimize the disruption of services to patients and staff. All necessary safeguards shall be undertaken to ensure their health and safety. When installations of required systems are interrupted for any necessary reasons, the Project Manager shall immediately notify the local Fire Marshal and this Department.

Please notify this office when all related work, tests and certification have been completed and received by you. We will then schedule a date for our final inspection. Please contact this office at least 30 days prior to your anticipated opening date to schedule the final inspection.

Let me know if you have any questions. I can be reached at anthony.m.bruno@ct.gov

Sincerely,

Anthony M. Bruno
Building Construction and Fire Safety Unit Supervisor
Facility Licensing and Investigations Section
cd

Cc: File
Rose McLellan, FLIS Licensing Supervisor

Quisenberry Arcari
Architects LLC

February 27, 2017

Anthony M. Bruno, BFSI II
Building Construction & Fire Safety Unit Supervisor
Facilities Licensing & Investigations Section
410 Capitol Avenue – MS#12HFC P.O Box 340308
Hartford, CT 06134

Re: Retreat at South Connecticut
Facility Renovations
DPH Project #733.

Anthony,

This letter is a response to the review comments prepared by your office dated February 7, 2017 for the above referenced project.

1. Demonstrate compliance with section 3.1-2.2.2.8 of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition. i.e; no indication of provision for resident storage (closets, wardrobes, etc.) indicated in the submitted drawings. A wardrobe is required for EACH resident. Only one (1) is indicated within the rooms.
    a. **Response:**
        i. Refer to attached revised furniture drawings showing compliance with (1) wardrobe per resident.

2. Demonstrate compliance with section 3.1-2.2.2.2 (3) (a) of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition. i.e; the clearance around the beds in resident rooms #5, 14, and 28, are not of equal distance as required by the reference standard. No beds are indicated on the drawings in the referenced rooms submitted in the response. No point of reference.
    a. **Response:**
        i. Previously programmed resident rooms #5, 14, 28 and 37 have been revised to be Offices S123, S141, N121 and N139 respectively.

318 Main Street
Farmington, CT 06032

860 677.4594
860 677.8534 Fax

3. Demonstrate compliance with section 3.1-4.2.5 of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition. i.e; No clean utility room on each residential unit is indicated on the submitted drawings. Required on EACH resident unit. A central clean utility room does not meet the standard.
    a. **Response:**
        i. A Clean Utility Room has been provided in the following locations: C237, N112, and S140.

4. Demonstrate compliance with section 3.1-4.2.6 of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition. i.e; No soiled utility room on each residential unit is indicated on the submitted drawings. Required on EACH resident unit. A central soiled clean utility room does not meet the standard.
    a. **Response:**
        i. A Soiled Utility Room has been provided in the following locations: C224, N101.1, and S103.3.

If you have any further questions or concerns regarding this matter, please do not hesitate to call me or email me at atarfano@qa-architects.com

Sincerely,

Adam A. Tarfano, AIA

cc. Peter Schorr (Retreat)

318 Main Street
Farmington, CT 06032

860 677.4594
860 677.8534 Fax

Quisenberry Arcari
Architects LLC

January 6, 2016

Anthony M. Bruno, BFSI II
Building Construction & Fire Safety Unit Supervisor
Facilities Licensing & Investigations Section
410 Capitol Avenue – MS#12HFC P.O Box 340308
Hartford, CT 06134

Re: Retreat at South Connecticut
Facility Renovations
DPH Project #733.

Anthony,

This letter is a response to the review comments prepared by your office dated December 12, 2016 for the above referenced project.

1. The submitted drawings are missing Sheet A1.0 that details the basement of the facility.
    a. **Response:**
        i. Refer to attached drawing.

2. The submitted drawings are missing exterior elevation drawings of the facility, parking areas, and grounds.
    a. **Response:**
        i. The submitted documents do not include exterior elevation drawings, as the existing building does not require exterior façade scope of work. The parking areas are as shown on the survey. Refer to the attached drawing.

3. Demonstrate compliance with section 3.1-2.2.2.8 of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 Edition. i.e; no indication of provision for resident storage (closets, wardrobes, etc.) indicated in the submitted drawings.
    a. **Response:**
        i. Refer to attached furniture plans (80 bed scheme), which indicate wardrobes in every patient room.

4. Demonstrate compliance with section 3.1-2.2.2.2 (3) (a) of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 Edition. i.e; the clearance around the beds in resident rooms #5, 14, 28, and 33 are not of equal distance as required by the referenced standard.

318 Main Street
Farmington, CT 06032

860 677.4594
860 677.8534 Fax

a. **Response:**
    i. Refer to attached furniture drawings (80 Bed Scheme)

5. Demonstrate compliance with section 3.1-2.2.2.4 (1) of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 Edition. i.e; no provisions for visual privacy indicated in multiple resident rooms.
    a. **Response:**
        i. Refer to the attached revised reflected ceiling drawings of the patient rooms in the First Floor North & South wings, and Second Floor Core areas.

6. Demonstrate compliance with section 3.1-4.2.5 of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 Edition. i.e; no clean utility room on each residential unit is indicated on the submitted drawings.
    a. **Response:**
        i. (We currently do not have a clean utility room. Please specify a room to be indicated as a clean utility room. A clean utility room requires (1) of the following two options:
            1. Option 1 – A room with:
                a. Work Counter
                b. Hand-Washing Station
                c. Storage facilities for clean supplies
            2. Option 2 – A room with:
                a. If the room is used only for storage and holding as part of a system for distribution of clean materials, omission of the work counter and hand-washing station shall be permitted. If this option is chosen, please specify a room in the North, South, and Second Floor Core.

7. Demonstrate compliance with section 3.1-4.2.6 of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 Edition. i.e; no soiled utility room on each residential unit is indicated on the submitted drawings.
    a. **Response:**
        i. (We currently do have a soiled utility room. Please specify a room in each wing and second floor core to be indicated as a soiled utility room. A soiled utility room requires the following:
            1. Clinical sink or equivalent flushing-rim fixture with a rinsing hose or bedpan washer.
            2. Hand-washing station
            3. Space for soiled linen
            4. Space for waste receptacles.

318 Main Street
Farmington, CT 06032

860 677.4594
860 677.8534 Fax

8. Demonstrate compliance with section 3.1-4.6.1.1 of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 Edition. i.e; no provisions and/or narrative for storing and processing clean and soiled linen is indicated on the submitted drawings.
    a. **Response:**
        i. (It is unclear if we are using the existing laundry room or if we are providing new washer dryers in each wing? If we are using the basement laundry area, we will have to provide a room to hold soiled linens until they are ready to be transported to the basement. Please clarify)

9. Demonstrate compliance with section 3.1-2.2.2.6 (5) of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 Edition. i.e; no drawings for door hardware on shared residential bathroom doors is indicated on the submitted drawings.
    a. **Response:**
        i. All patient bathrooms are to receive Hardware Set #22.

Set: 22.0
Description: Patient Bathroom (VIF existing conditions)

3	Hinge (heavy weight)	T4A3786 (qty, size, nrp per spec)	US26D	MK
1	Privacy Set	LB 49 8265 LNB	US26D	SA
1	Surface Overhead Stop	10-X36	630	RF
1	Kick Plate	K1050 10" 4BE CSK	US32D	RO
1	Mop Plate	K1050 4" 4BE CSK	US32D	RO
3	Silencer	608		RO

If you have any further questions or concerns regarding this matter, please do not hesitate to call me or email me at atarfano@qa-architects.com

Sincerely,

Adam A. Tarfano, AIA

cc. Peter Schorr (Retreat)

318 Main Street
Farmington, CT 06032

860 677.4594
860 677.8534 Fax

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
BUILDING AND FIRE SAFETY UNIT

December 12, 2016

Quisenberry Arcari Architects, LLC
318 Main Street
Farmington, Connecticut 06032
Attn: Mr. Adam Tarfano

Re: **Retreat of South Connecticut**
Facility renovations
DPH Project #733

Dear Mr. Tarfano,

I have reviewed design plan #733, and your response to the design review comments letter from this office dated October 07, 2016 as prepared by your office for the above referenced project.

The following are review comments that will require a response and/or clarifications prior to a construction approval letter issued by CT Department of Public Health:

1. The submitted drawings are missing Sheet A1.0 that details the basement of the facility.
2. The submitted drawings is missing exterior elevation drawings of the facility, parking areas, and grounds.
3. Demonstrate compliance with section 3.1-2.2.2.8 of *Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition.* i.e; no indication of provision for resident storage (closets, wardrobes, etc.) indicated in the submitted drawings.
4. Demonstrate compliance with section 3.1-2.2.2.2 (3) (a) of *Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition.* i.e; the clearance around the beds in resident rooms #5, 14, 28, and 33 are not of equal distance as required by the referenced standard.
5. Demonstrate compliance with section 3.1-2.2.2.4 (1) of *Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition.* i.e; no provisions for visual privacy indicated in multiple resident rooms.
6. Demonstrate compliance with section 3.1-4.2.5 of *Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition.* i.e; No clean utility room on each residential unit is indicated on the submitted drawings.
7. Demonstrate compliance with section 3.1-4.2.6 of *Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition.* i.e; No soiled utility room on each residential unit is indicated on the submitted drawings.
8. Demonstrate compliance with section 3.1-4.6.1.1 of *Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition.* i.e; No provisions and/or narrative for storing and processing clean and soiled linen is indicated on the submitted drawings.
9. Demonstrate compliance with section 3.1-2.2.2.6 (5) of *Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition.* i.e; No drawings for door hardware on shared residential bathroom doors is indicated on the submitted drawings.

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P.O. Box 340308 Hartford, CT 06134
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Final approval for this project will be granted upon satisfactory responses to my design review comments. I can be reached at email at Anthony.m.bruno@ct.gov if you have any questions.

Sincerely,

Anthony M. Bruno, BFSI II
Building Construction & Fire Safety Unit Supervisor
Facilities Licensing & Investigations Section
cd

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
BUILDING AND FIRE SAFETY UNIT

October 7, 2016

Quisenberry Arcari Architects, LLC
318 Main Street
Farmington, Connecticut 06032
Attn: Mr. Adam Tarfano

Re: **Retreat of South Connecticut**
Facility renovations
DPH Project #733

Dear Mr. Tarfano,

I have reviewed design plan #733 as prepared by your office for the above referenced project.

The following are review comments that will require a response and/or clarifications prior to a construction approval letter issued by CT Department of Public Health:

1. Demonstrate compliance with section 3.11-6.2.4 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; no public restroom in proximity to the main lobby indicated on the submitted drawings.
2. Demonstrate compliance with section 3.11-5.5 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; no environmental services closet on patient wings indicated on the submitted drawings.
3. Demonstrate compliance with section 3.1-6.2.1 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; no detailed drawings of required patient drop off and pedestrian entrances.
4. Demonstrate compliance with section 2.5-2.2.2.1 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; patient rooms #38, #27, #24, #1, #3, #18, #15, and #23 indicate three (3) patients per room. The maximum allowed patients per room is two (2) per the referenced standard.
5. Demonstrate compliance with section 2.5-2.2.6.5 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; no nourishment rooms are indicated in the submitted drawings.
6. Demonstrate compliance with section 2.5-2.2.8.2 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; no visitors room on patient wings are indicated within the submitted drawings.
7. Demonstrate compliance with section 2.5-2.2.7.3 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; no staff storage locations for personal effects on the North Wing or South Wing are indicated on the submitted drawings.
8. Demonstrate compliance with section 2.5-2.2.2.3 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; Detox Rooms #1, #2, #3, #4, #5, #6, and #7 on the second (2nd) floor lack exterior windows as required by the referenced standard.

Phone: (860) 509-7500
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HFC
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

Final approval for this project will be granted upon satisfactory responses to my design review comments. I can be reached at email at Anthony.m.bruno@ct.gov if you have any questions.

Sincerely,

Anthony M. Bruno, BFSI II
Building Construction & Fire Safety Unit Supervisor
Facilities Licensing & Investigations Section
cd

Retreat
at South Connecticut

July 11, 2016

Christopher Doyle
Department of Public Health, Building and Fire Safety
410 Capitol Avenue
Hartford, CT 06134

RE: Retreat at South Connecticut, Final Plans Review

Dear Mr. Doyle:

As previously discussed, please find enclosed the full-sized, complete set of plans for your review. As a reminder, the property is located at:

915 Ella T. Grasso Blvd.
New Haven, CT 06519

If you have any questions and/or when you complete your review, I can be reached at:

(O): 855.859.8810
(C): 305-542-0687
(e): scott@retreatmail.com

Best Regards,

Scott Korogodsky
Corporate Administrative Director
Retreat Premier Addiction Treatment Centers

CC: Anthony Bruno

NR Connecticut, LLC

April 10, 2017

Via FedEx

Ms. Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capital Avenue, MS #13HCA
P. O. Box 340308
Hartford, CT 06106

Re: NR Connecticut, LLC Request for CON Modification

Dear Ms. Martone:

Enclosed please find NR Connecticut, LLC's request for a modification of the Certificate of Need previously authorized by the Agreed Settlement entered into on May 13, 2015 regarding 13-31828-CON.

Please feel free to contact me by telephone at 718-682-2600 extension 203 or by email at josephs@coalcapitalgroup.com with any questions or concerns. Thank you for your consideration.

Very truly yours,

Joseph Silberstein
Counsel

Enclosure

ACTIVE/8.2/AMURRAY/6530332v1

State of Connecticut
Office of Health Care Access
Form for Modification of a Previously Authorized Certificate of Need

All persons who are requesting a modification to a previously authorized Certificate of Need must complete this form. Completed forms should be submitted to the Director of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner	Petitioner
Full legal name	NR Connecticut, LLC	
Doing Business As	Retreat at South Connecticut	
Name of Parent Corporation		
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	915 Ella Grasso Boulevard, New Haven, CT	
Petitioner type (e.g., P for profit and NP for Not for Profit)	P	
Name of Contact person, including title	David Silberstein, CFO	
Contact person's street mailing address	1377 East 4th Street, 4th Floor, Brooklyn, NY 11230	
Contact person's phone, fax and e-mail address	Tel: 718-682-2600, ext. 201 Fax: 718-709-7477 davids@coalcapitalgroup.com	

SECTION II. GENERAL PROPOSAL INFORMATION

a. Title of Previously Authorized Project and Associated Docket Number(s):
Establish a 105-Bed Residential Substance Abuse Treatment Facility; 13-31828-CON; Agreed Settlement

b. Location of proposal (Town including street address):
915 Ella Grasso Boulevard, New Haven, CT

c. Type of Modification Request:

☐ Change in the Scope of the Authorized Certificate of Need Project

☒ Extension of CON Expiration Date

☐ Change in a CON Order Condition *(other than to extend expiration date)*

☐ Other – Describe: _____

SECTION III. IF REQUESTING A CHANGE IN THE SCOPE OF AUTHORIZED PROJECT:

a. Provide a one page description of the requested change in the scope of a previously authorized Certificate of Need project and provide a detailed rationale for such change:

SECTION IV. IF REQUESTING AN EXTENSION OF THE CON EXPIRATION DATE:

a. Certificate of Need expiration date per CON Final Decision: May 13, 2017, per Agreed Settlement accepted and ordered by the Department of Public Health on May 13, 2015.

b. Requested revised CON expiration date: June 30, 2018

c. Rationale for increased time to fully complete and implement the authorized project:

Applicant is establishing a Residential Substance Abuse Treatment Facility in a two-story, 60,000 square foot building situated on 2.72 acres in the City of New Haven. The building, which formerly housed a 120-bed skilled nursing facility, was originally constructed in 1973 and requires significant retrofitting to meet current building codes and the Applicant's planned use.

After conducting necessary engineering and other assessments of the property, Applicant engaged the services of Quisenberry Arcari Architects in September, 2015 to begin work on the extensive redesign and drawings necessary to secure approval of the architectural design and construction plans ("Plans") from the Department of Public Health ("DPH") Facility Licensing and Investigations Section Building and Fire Safety Unit and the New Haven Building Department.

As shown in the correspondence attached at Exhibit A, the Applicant has been diligently pursuing the project since that time. On March 10, 2017, after submitting the initial Plans for DPH review on July 11, 2016 and eight months of receiving and responding to follow-up questions from the Building and Fire Safety Unit, the Plans were approved. The Applicant had previously received the Building Permit from the New Haven Building Department on December 15, 2016.

Applicant has invested more than $7.3 million in the project to date, including the engagement of a General Contractor. Presently, the General Contractor is completing demolition work and staging the commencement of all the renovation work, but additional time for construction is needed due to unforeseen delays in the plan approvals and bidding process. Applicant anticipates that construction will be completed on or about February, 2018 with a Certificate of Occupancy and necessary inspections by the DPH to follow. Accordingly, Applicant seeks an extension of the Certificate of Need expiration date until June 30, 2018 so that it may continue its diligent and good faith efforts to complete the project and begin operations.

SECTION V. IF REQUESTING A CHANGE IN A CON FINAL DECISION CONDITION
(other than extension of the CON expiration date)

a. Identify the CON Condition that you are requesting to be revised or vacated.

_____

b. Provide the rationale for such requested change:

_____

_____

_____

_____

_____

SECTION VI. OTHER

a. Submit a completed CON Modification Affidavit. See Attached.

b. Identify any other pertinent changes to the findings of facts upon which the original CON authorization was based as a result of this requested modification. N/A

c. Identify what has been accomplished to date in terms of full project implementation.

Since entering into the Agreed Settlement, the Applicant has invested substantial time, effort and resources into the Approved Project and has taken significant steps towards establishing the approved residential substance abuse treatment facility. These accomplishments include: interior demolition of the building; installing a required water runoff separation drainage system; obtaining all required local zoning and ordinance approvals; obtaining all necessary permits and inspections; completing design plans in coordination with an architect, consultants, and engineers; obtaining builders' insurance; maintaining and repairing the land and building; installing a security system; employing a property management company, and paying all operating and maintenance costs and local and state property taxes.

CON MODIFICATION AFFIDAVIT

Applicant: NR Connecticut, LLC d/b/a Retreat at South Connecticut

Project Title: Establish a 105-Bed Residential Substance Abuse Treatment Facility

I, David Silberstein, CFO

of NR Connecticut, LLC being duly sworn, depose and state that the information provided in this CON Modification form is true and accurate to the best of my knowledge.

Signature

APRIL 10, 2017
Date

Subscribed and sworn to before me on 4/10/17

REIZY GROSS
NOTARY PUBLIC
NO. 01GR6329800
QUALIFIED IN
KINGS COUNTY
COMM. EXP.
08/31/2019
STATE OF NEW YORK

Notary Public/Commissioner of Superior Court

My commission expires: 8/31/19

From: Doyle, Christopher [mailto:Christopher.Doyle@ct.gov]
Sent: Wednesday, March 22, 2017 1:21 PM
To: Adam Tarfano <atarfano@qa-architects.com>
Cc: Bruno, Anthony M. <Anthony.M.Bruno@ct.gov>; Cass, Barbara <Barbara.Cass@ct.gov>
Subject: Technical assistance fee

Hi Adam,

Based on the project costs you have submitted, a technical assistance fee of **$17,462.50** has been assigned against this project.

It shall be sent to Tony Bruno, and the check shall be made payable to "Treasurer- State of Connecticut".

As soon as the check has been received, an approval will be issued to commence the project.

Regards,

Chris Doyle

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION
BUILDING AND FIRE SAFETY UNIT

March 10, 2017

Quisenberry Arcari Architects, LLC
318 Main Street
Farmington, Connecticut 06032
Attn: Mr. Adam Tarfano

Re: **Retreat of South Connecticut- facility renovations**
DPH Project #733

Dear Mr. Tarfano,

Final project documents as prepared by Quisenberry Arcari Architects, LLC have been received and reviewed for the above referenced project.

As a result of our review, the plan appears to satisfy the intent of the CT Public Health Code.

This approval is subject to the provisions of the Connecticut Public Health Code, State Fire Safety Code, Basic Building Codes, and local authorities having jurisdiction.

Prior to our final inspection, the following documents shall be transmitted to this Section:

1. A copy of the Building Permit issued by the City of New Haven Building Department;
2. Acceptance in writing of the completed project by the architect of record;
3. A copy of the certificate of occupancy issued by the City of New Haven Building Department;
4. A copy of the City of New Haven Fire Marshal certificate of inspection, as applicable;
5. Test reports and acceptance of all electrical; mechanical; fire suppression; smoke detection and fire alarm systems; annunciation systems on normal and emergency power; emergency generator and medical gas system, as applicable;
6. Air balancing reports for the HVAC systems if applicable.

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P.O. Box 340308 Hartford, CT 06134
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7. In accordance with CT General Statutes, Section 19a-491(f), Public Act No. 13-234 a technical assistance fee is required for this plan review, future meetings and inspections related to this project. A total cost of the project shall be sent to my attention so an accurate technical assistance fee shall be charged to this project.

Any changes to the approved plans and specifications shall be brought to the attention of this office.

During this project, all efforts shall be made to maintain the current level of services and minimize the disruption of services to patients and staff. All necessary safeguards shall be undertaken to ensure their health and safety. When installations of required systems are interrupted for any necessary reasons, the Project Manager shall immediately notify the local Fire Marshal and this Department.

Please notify this office when all related work, tests and certification have been completed and received by you. We will then schedule a date for our final inspection. Please contact this office at least 30 days prior to your anticipated opening date to schedule the final inspection.

Let me know if you have any questions. I can be reached at anthony.m.bruno@ct.gov

Sincerely,

Anthony M. Bruno
Building Construction and Fire Safety Unit Supervisor
Facility Licensing and Investigations Section
cd

Cc: File
Rose McLellan, FLIS Licensing Supervisor

Quisenberry Arcari
Architects LLC

February 27, 2017

Anthony M. Bruno, BFSI II
Building Construction & Fire Safety Unit Supervisor
Facilities Licensing & Investigations Section
410 Capitol Avenue – MS#12HFC P.O Box 340308
Hartford, CT 06134

Re: Retreat at South Connecticut
Facility Renovations
DPH Project #733.

Anthony,

This letter is a response to the review comments prepared by your office dated February 7, 2017 for the above referenced project.

1. Demonstrate compliance with section 3.1-2.2.2.8 of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition. i.e; no indication of provision for resident storage (closets, wardrobes, etc.) indicated in the submitted drawings. A wardrobe is required for EACH resident. Only one (1) is indicated within the rooms.
    a. **Response:**
        i. Refer to attached revised furniture drawings showing compliance with (1) wardrobe per resident.

2. Demonstrate compliance with section 3.1-2.2.2.2 (3) (a) of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition. i.e; the clearance around the beds in resident rooms #5, 14, and 28, are not of equal distance as required by the reference standard. No beds are indicated on the drawings in the referenced rooms submitted in the response. No point of reference.
    a. **Response:**
        i. Previously programmed resident rooms #5, 14, 28 and 37 have been revised to be Offices S123, S141, N121 and N139 respectively.

318 Main Street
Farmington, CT 06032

860 677.4594
860 677.8534 Fax

3. Demonstrate compliance with section 3.1-4.2.5 of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition. i.e; No clean utility room on each residential unit is indicated on the submitted drawings. Required on EACH resident unit. A central clean utility room does not meet the standard.
    a. **Response:**
        i. A Clean Utility Room has been provided in the following locations: C237, N112, and S140.

4. Demonstrate compliance with section 3.1-4.2.6 of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition. i.e; No soiled utility room on each residential unit is indicated on the submitted drawings. Required on EACH resident unit. A central soiled clean utility room does not meet the standard.
    a. **Response:**
        i. A Soiled Utility Room has been provided in the following locations: C224, N101.1, and S103.3.

If you have any further questions or concerns regarding this matter, please do not hesitate to call me or email me at atarfano@qa-architects.com

Sincerely,

Adam A. Tarfano, AIA

cc. Peter Schorr (Retreat)

318 Main Street
Farmington, CT 06032

860 677.4594
860 677.8534 Fax

Quisenberry Arcari
Architects LLC

January 6, 2016

Anthony M. Bruno, BFSI II
Building Construction & Fire Safety Unit Supervisor
Facilities Licensing & Investigations Section
410 Capitol Avenue – MS#12HFC P.O Box 340308
Hartford, CT 06134

Re: Retreat at South Connecticut
Facility Renovations
DPH Project #733.

Anthony,

This letter is a response to the review comments prepared by your office dated December 12, 2016 for the above referenced project.

1. The submitted drawings are missing Sheet A1.0 that details the basement of the facility.
    a. **Response:**
        i. Refer to attached drawing.

2. The submitted drawings are missing exterior elevation drawings of the facility, parking areas, and grounds.
    a. **Response:**
        i. The submitted documents do not include exterior elevation drawings, as the existing building does not require exterior façade scope of work. The parking areas are as shown on the survey. Refer to the attached drawing.

3. Demonstrate compliance with section 3.1-2.2.2.8 of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 Edition. i.e; no indication of provision for resident storage (closets, wardrobes, etc.) indicated in the submitted drawings.
    a. **Response:**
        i. Refer to attached furniture plans (80 bed scheme), which indicate wardrobes in every patient room.

4. Demonstrate compliance with section 3.1-2.2.2.2 (3) (a) of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 Edition. i.e; the clearance around the beds in resident rooms #5, 14, 28, and 33 are not of equal distance as required by the referenced standard.

318 Main Street
Farmington, CT 06032

860 677.4594
860 677.8534 Fax

a. **Response:**
    i. Refer to attached furniture drawings (80 Bed Scheme)

5. Demonstrate compliance with section 3.1-2.2.2.4 (1) of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 Edition. i.e; no provisions for visual privacy indicated in multiple resident rooms.
    a. **Response:**
        i. Refer to the attached revised reflected ceiling drawings of the patient rooms in the First Floor North & South wings, and Second Floor Core areas.

6. Demonstrate compliance with section 3.1-4.2.5 of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 Edition. i.e; no clean utility room on each residential unit is indicated on the submitted drawings.
    a. **Response:**
        i. (We currently do not have a clean utility room. Please specify a room to be indicated as a clean utility room. A clean utility room requires (1) of the following two options:
            1. Option 1 – A room with:
                a. Work Counter
                b. Hand-Washing Station
                c. Storage facilities for clean supplies
            2. Option 2 – A room with:
                a. If the room is used only for storage and holding as part of a system for distribution of clean materials, omission of the work counter and hand-washing station shall be permitted. If this option is chosen, please specify a room in the North, South, and Second Floor Core.

7. Demonstrate compliance with section 3.1-4.2.6 of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 Edition. i.e; no soiled utility room on each residential unit is indicated on the submitted drawings.
    a. **Response:**
        i. (We currently do have a soiled utility room. Please specify a room in each wing and second floor core to be indicated as a soiled utility room. A soiled utility room requires the following:
            1. Clinical sink or equivalent flushing-rim fixture with a rinsing hose or bedpan washer.
            2. Hand-washing station
            3. Space for soiled linen
            4. Space for waste receptacles.

318 Main Street
Farmington, CT 06032

860 677.4594
860 677.8534 Fax

8. Demonstrate compliance with section 3.1-4.6.1.1 of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 Edition. i.e; no provisions and/or narrative for storing and processing clean and soiled linen is indicated on the submitted drawings.
    a. **Response:**
        i. (It is unclear if we are using the existing laundry room or if we are providing new washer dryers in each wing? If we are using the basement laundry area, we will have to provide a room to hold soiled linens until they are ready to be transported to the basement. Please clarify)

9. Demonstrate compliance with section 3.1-2.2.2.6 (5) of Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 Edition. i.e; no drawings for door hardware on shared residential bathroom doors is indicated on the submitted drawings.
    a. **Response:**
        i. All patient bathrooms are to receive Hardware Set #22.

Set: 22.0
Description: Patient Bathroom (VIF existing conditions)

3	Hinge (heavy weight)	T4A3786 (qty, size, nrp per spec)	US26D	MK
1	Privacy Set	LB 49 8265 LNB	US26D	SA
1	Surface Overhead Stop	10-X36	630	RF
1	Kick Plate	K1050 10" 4BE CSK	US32D	RO
1	Mop Plate	K1050 4" 4BE CSK	US32D	RO
3	Silencer	608		RO

If you have any further questions or concerns regarding this matter, please do not hesitate to call me or email me at atarfano@qa-architects.com

Sincerely,

Adam A. Tarfano, AIA

cc. Peter Schorr (Retreat)

318 Main Street
Farmington, CT 06032

860 677.4594
860 677.8534 Fax

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
BUILDING AND FIRE SAFETY UNIT

December 12, 2016

Quisenberry Arcari Architects, LLC
318 Main Street
Farmington, Connecticut 06032
Attn: Mr. Adam Tarfano

Re: **Retreat of South Connecticut**
Facility renovations
DPH Project #733

Dear Mr. Tarfano,

I have reviewed design plan #733, and your response to the design review comments letter from this office dated October 07, 2016 as prepared by your office for the above referenced project.

The following are review comments that will require a response and/or clarifications prior to a construction approval letter issued by CT Department of Public Health:

1. The submitted drawings are missing Sheet A1.0 that details the basement of the facility.
2. The submitted drawings is missing exterior elevation drawings of the facility, parking areas, and grounds.
3. Demonstrate compliance with section 3.1-2.2.2.8 of *Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition.* i.e; no indication of provision for resident storage (closets, wardrobes, etc.) indicated in the submitted drawings.
4. Demonstrate compliance with section 3.1-2.2.2.2 (3) (a) of *Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition.* i.e; the clearance around the beds in resident rooms #5, 14, 28, and 33 are not of equal distance as required by the referenced standard.
5. Demonstrate compliance with section 3.1-2.2.2.4 (1) of *Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition.* i.e; no provisions for visual privacy indicated in multiple resident rooms.
6. Demonstrate compliance with section 3.1-4.2.5 of *Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition.* i.e; No clean utility room on each residential unit is indicated on the submitted drawings.
7. Demonstrate compliance with section 3.1-4.2.6 of *Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition.* i.e; No soiled utility room on each residential unit is indicated on the submitted drawings.
8. Demonstrate compliance with section 3.1-4.6.1.1 of *Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition.* i.e; No provisions and/or narrative for storing and processing clean and soiled linen is indicated on the submitted drawings.
9. Demonstrate compliance with section 3.1-2.2.2.6 (5) of *Guidelines for the Design and Construction of Residential Health, Care, and Support Facilities 2014 edition.* i.e; No drawings for door hardware on shared residential bathroom doors is indicated on the submitted drawings.

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P.O. Box 340308 Hartford, CT 06134
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Final approval for this project will be granted upon satisfactory responses to my design review comments. I can be reached at email at Anthony.m.bruno@ct.gov if you have any questions.

Sincerely,

Anthony M. Bruno, BFSI II
Building Construction & Fire Safety Unit Supervisor
Facilities Licensing & Investigations Section
cd

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
BUILDING AND FIRE SAFETY UNIT

October 7, 2016

Quisenberry Arcari Architects, LLC
318 Main Street
Farmington, Connecticut 06032
Attn: Mr. Adam Tarfano

Re: **Retreat of South Connecticut**
Facility renovations
DPH Project #733

Dear Mr. Tarfano,

I have reviewed design plan #733 as prepared by your office for the above referenced project.

The following are review comments that will require a response and/or clarifications prior to a construction approval letter issued by CT Department of Public Health:

1. Demonstrate compliance with section 3.11-6.2.4 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; no public restroom in proximity to the main lobby indicated on the submitted drawings.
2. Demonstrate compliance with section 3.11-5.5 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; no environmental services closet on patient wings indicated on the submitted drawings.
3. Demonstrate compliance with section 3.1-6.2.1 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; no detailed drawings of required patient drop off and pedestrian entrances.
4. Demonstrate compliance with section 2.5-2.2.2.1 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; patient rooms #38, #27, #24, #1, #3, #18, #15, and #23 indicate three (3) patients per room. The maximum allowed patients per room is two (2) per the referenced standard.
5. Demonstrate compliance with section 2.5-2.2.6.5 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; no nourishment rooms are indicated in the submitted drawings.
6. Demonstrate compliance with section 2.5-2.2.8.2 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; no visitors room on patient wings are indicated within the submitted drawings.
7. Demonstrate compliance with section 2.5-2.2.7.3 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; no staff storage locations for personal effects on the North Wing or South Wing are indicated on the submitted drawings.
8. Demonstrate compliance with section 2.5-2.2.2.3 of *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities 2014 edition* .i.e; Detox Rooms #1, #2, #3, #4, #5, #6, and #7 on the second (2nd) floor lack exterior windows as required by the referenced standard.

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Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HFC
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Final approval for this project will be granted upon satisfactory responses to my design review comments. I can be reached at email at Anthony.m.bruno@ct.gov if you have any questions.

Sincerely,

Anthony M. Bruno, BFSI II
Building Construction & Fire Safety Unit Supervisor
Facilities Licensing & Investigations Section
cd

Retreat
at South Connecticut

July 11, 2016

Christopher Doyle
Department of Public Health, Building and Fire Safety
410 Capitol Avenue
Hartford, CT 06134

RE: Retreat at South Connecticut, Final Plans Review

Dear Mr. Doyle:

As previously discussed, please find enclosed the full-sized, complete set of plans for your review. As a reminder, the property is located at:

915 Ella T. Grasso Blvd.
New Haven, CT 06519

If you have any questions and/or when you complete your review, I can be reached at:

(O): 855.859.8810
(C): 305-542-0687
(e): scott@retreatmail.com

Best Regards,

Scott Korogodsky
Corporate Administrative Director
Retreat Premier Addiction Treatment Centers

CC: Anthony Bruno

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

April 18, 2017

Jennifer Groves Fusco, Esq.
Principal
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
New Haven, CT 06510

Joan W. Feldman, Esq.
Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103-1919

RE: Docket Number 17-31828-MDF: A Request for Modification of the Certificate of Need authorized under Docket Number 13-31828-CON NR Connecticut, LLC d/b/a Retreat at South Connecticut

Dear Counsel:

On April 11, 2017, OHCA received a request for a modification from NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Retreat"). The request is to extend the expiration date of the CON to June 30, 2018. A copy of the complete modification request can be found on OHCA's website.

This letter is to inform you that OHCA will soon take action upon the request for modification. If you would like to submit any comments regarding this matter, please do so in writing to OHCA by 4:30 PM on Friday, May 5, 2017.

Sincerely,

Kimberly Martone
Director of Operations

cc: David Silberstein

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Olejarz, Barbara

From: Microsoft Outlook
To: JFeldman@goodwin.com; 'jfusco@uks.com'; davids@coalcapitalgroup.com
Sent: Tuesday, April 18, 2017 12:18 PM
Subject: Relayed: modification request for Retreat at South Connecticut - 17-31828-MDF

Delivery to these recipients or groups is complete, but no delivery notification was sent by the destination server:

JFeldman@goodwin.com (JFeldman@goodwin.com)

'jfusco@uks.com' (jfusco@uks.com)

davids@coalcapitalgroup.com (davids@coalcapitalgroup.com)

Subject: modification request for Retreat at South Connecticut - 17-31828-MDF

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

Final Decision

Modification of a Previously Authorized Certificate of Need

Applicant:	**NR Connecticut, LLC d/b/a Retreat at South Connecticut** **915 Ella Grasso Boulevard, New Haven, CT**
Docket Number:	**17-31828-MDF**
Project Description:	**Modification of previous Certificate of Need authorization 13-31828-CON**

Procedural History: On May 13, 2015, the Office of Health Care Access ("OHCA") issued a Certificate of Need ("CON") to NR Connecticut, LLC d/b/a Retreat at South Connecticut ("Retreat") under Docket Number 13-31828-CON, for the establishment of an 80-bed residential substance abuse treatment facility.

On April 18, 2017, OHCA received a Request for Modification from Retreat seeking to modify the expiration date of the CON from May 13, 2017 to June 30, 2018. As required by Conn. Gen. Stat. § 19a-639b(b), OHCA noticed this request on its website for 30 days and notified the other parties involved. OHCA did not receive any written comments or requests for a public hearing. Deputy Commissioner Addo reviewed the entire record in this matter.

Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Findings of Fact

1. The CON issued under Docket Number 13-31828-CON (the "CON") permitted Retreat to establish an 80-bed residential substance abuse treatment facility in New Haven, Connecticut.

2. The CON was valid until May 13, 2017.

3. The building in which the facility is to be established was built in 1973 and requires significant retrofitting to meet current building codes and Retreat's planned use.

4. Retreat engaged the services of an Architect in September, 2015 to begin work on the redesign and plans necessary for approval by the Department of Public Health ("DPH") Facility Licensing and Investigations Section ("FLIS") Building and Fire Safety Unit and the City of New Haven Building Department.

5. Retreat submitted the Plans to FLIS on July 11, 2016 and received approval on March 10, 2017 after diligently pursuing approval of its Plans.

6. Retreat received its Building Permit from the City of New Haven on December 15, 2016.

7. The General Contractor is presently in the process of completing demolition work and staging the commencement of the renovation work.

8. Additional time is needed due to unforeseen delays in the approval of the Plans and the bidding process.

9. It is anticipated that the construction will be completed in or about February, 2018 with a Certificate of Occupancy and necessary inspections by the FLIS to follow.

Discussion

Connecticut General Statutes § 4-181a (b) provides in relevant part: "On a showing of changed conditions, the agency may reverse or modify the final decision, at any time, at the request of any person or on the agency's own motion." Retreat has sufficiently demonstrated a change in conditions brought upon by unforeseen delays in the approval of its Plans and the bidding process.

Order

Based upon the foregoing, the request to modify the expiration date of the CON issued under Docket Number 13-31828-CON from May 13, 2017 to June 30, 2018 is hereby **APPROVED**. All other conditions entered under Docket Number 13-31828-CON remain in effect.

5/25/17
Date

Yvonne T. Addo, MBA
Deputy Commissioner

Olejarz, Barbara

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WITHDRAWAL

JD-CV-41 Rev. 6-12

Fill Out All Sections Below

STATE OF CONNECTICUT
SUPERIOR COURT
www.jud.ct.gov

Return date: **Oct-14-2014**
Docket number: **HHB-CV-14-6027073**

Name of case *(First-named Plaintiff vs. First-named Defendant)*

NR CONNECTICUT LLC D/B/A RETREAT AT SOUTH CONNECTI v. CONNECTICUT DEPARTMENT OF PUBLIC HEALTH, OFFICE O

[X] Judicial District [ ] Housing Session [ ] Geographical Area number ____

Address of court *(Number, street, town and zip code)*: **20 FRANKLIN SQUARE NEW BRITAIN, CT 06051**

Section I *(check only one box)* This Withdrawal is being filed because the dispute has been resolved by:

I. Court-Annexed ADR

411088 [ ] Early Intervention
411090 [ ] Attorney Trial Referee
411091 [ ] Fact-Finding
411093 [ ] Arbitration
411094 [ ] Mediation
411095 [ ] Special Masters
411096 [ ] Summary Jury Trial

II. Court Intervention

411098 [ ] Pretrial Conference
411099 [ ] Trial Management Conference
411100 [ ] Commencement of Trial (court trial - first witness sworn; jury trial - trial jurors sworn)

III. Private ADR

411102 [ ] Provider Name: ____

IV. Other

411103 [X] Discussion of Parties on Their Own
415602 [ ] Unilateral Action of Party or Parties

Section II Withdrawal

Dispositive *(Do not check the following two boxes if any intervening complaints, cross complaints, counterclaims, or third party complaints remain pending in this case. See below for partial withdrawal of action.)*

(WDACT) [X] The Plaintiff's action is WITHDRAWN AS TO ALL DEFENDANTS without costs to any party.

(WOARD) [ ] A judgment has been rendered against the following Defendant(s): ____

and the Plaintiff's action is WITHDRAWN AS TO ALL REMAINING DEFENDANTS without costs.

Partial

The following pleading(s), motion(s) or other paper(s) in the case named above is or are withdrawn:

(WDCOMP) [ ] Complaint
(WDCOUNT) [ ] Counts of the complaint: ____
(WDINTCO) [ ] Intervening Complaint
(WDTHPC) [ ] Third Party Complaint
(WAPPCOM) [ ] Apportionment Complaint
(WDCC) [ ] Cross Complaint (cross claim)
(WOC) [ ] Counterclaim

(WOAAP) [ ] Plaintiff(s): ____
(WOAAD) [ ] Complaint against defendant(s): ____ only without costs

(WOM) [ ] Motion: ____
[ ] Other: ____

Signature Required

Party **P-01 NR CONNECTICUT LLC D/B/A RETREAT AT**; By **EPSTEIN JUDA J LAW OFFICE OF** Attorney or Self-represented Party
Party ____; By ____ Attorney or Self-represented Party
Party ____; By ____ Attorney or Self-represented Party
Party ____; By ____ Attorney or Self-represented Party

Name & Address of Signer: **JUDA J EPSTEIN**
3543 MAIN STREET BRIDGEPORT, CT 06606 SECOND FLOOR

Section III Certification

I certify that a copy of this document was mailed or delivered electronically or non-electronically on *(date)* **May-14-2015** to all attorneys and self-represented parties of record and that written consent for electronic delivery was received from all attorneys and self-represented parties receiving electronic delivery.

Name and address of each party and attorney that copy was mailed or delivered to*
WALTER MENJIVAR - AG-HEALTH AND EDUCATION/55 ELM STREET/HARTFORD, CT 06106

*If necessary, attach additional sheet or sheets with name and address which the copy was mailed or delivered to.

Signed *(Signature of filer)*	Print or type name of person signing	Date signed
▶ **403992**	**JUDA J EPSTEIN**	**May-14-2015**
Mailing address *(Number, street, town, state and zip code)*		Telephone number
3543 MAIN STREET SECOND FLOOR BRIDGEPORT, CT 06606		**203-371-7007**

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Docket Number:	HHB-CV-14-6027073-S
Case Name:	NR CONNECTICUT LLC D/B/A RETREAT AT SOUTH CONNECTI v. CONNECTICUT DEPARTMENT OF PUBLIC HEALTH, OFFICE OF
Type of Transaction:	Pleading/Motion/Other document
Date Filed:	May-14-2015
Motion/Pleading by:	EPSTEIN JUDA J LAW OFFICE OF (430291)
Document Filed:	103.00 WITHDRAWAL OF ACTION
Date and Time of Transaction:	Thursday, May 14, 2015 3:40:59 PM

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