Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

State of Connecticut
Department of Public Health
Office of Health Care Access

Certificate of Need Application
Main Form
Required for all CON applications

Contents:

Supplemental Forms

In addition to completing this **Main Form** and **Financial Worksheet (A, B or C)**, the applicant(s) must complete the appropriate **Supplemental Form** listed below. All CON forms can be found on the OHCA website at OHCA Forms.

Conn. Gen. Stat. Section 19a-638(a)	Supplemental Form
(1)	**Establishment of a new health care facility (mental health and/or substance abuse)** - *see note below**
(2)	**Transfer of ownership of a health care facility** (excludes transfer of ownership/sale of hospital – see "Other" below)
(3)	**Transfer of ownership of a group practice**
(4)	**Establishment of a freestanding emergency department**
(5) (7) (8) (15)	**Termination of a service:** - inpatient or outpatient services offered by a hospital - surgical services by an outpatient surgical facility** - emergency department by a short-term acute care general hospital - inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title DI or XIX of the federal Social Security Act, 42 USC 301, as amended
(6)	**Establishment of an outpatient surgical facility**
(9)	**Establishment of cardiac services**
(10) (11)	**Acquisition of equipment:** - acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners - acquisition of nonhospital based linear accelerators
(12)	**Increase in licensed bed capacity** of a health care facility
(13)	**Acquisition of equipment utilizing [new] technology** that has not previously been used in the state
(14)	**Increase of two or more operating rooms** within any three-year period by an outpatient surgical facility or short-term acute care general hospital
Other	**Transfer of Ownership / Sale of Hospital**

*This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility**. For the establishment of other "health care facilities," as defined by Conn. Gen. Stat § 19a-630(11) - hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

**If termination is due to insufficient patient volume, or it is a subspecialty being terminated, a CON is not required.

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.

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

☑ (**New**). A completed supplemental application specific to the proposal type, available on OHCA's website under "OHCA Forms." A list of supplemental forms can be found on page 2.

☑ 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.

☑ 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) 418-7053, at the time of the publication)*

☑ Attached is a completed Financial Attachment

☑ Submission includes one (1) original hardcopy in a 3-ring binder and a USB flash drive containing:

1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.
2. An electronic copy of the applicant's responses in MS Word (the applications) and MS Excel (the financial attachment).

For OHCA Use Only:

Docket No.: _____ **Check No.:** 9855
OHCA Verified by: _____ **Date:** 3/21/17

Docket Number:

Applicant: New Era Rehabilitation Center

Contact Person: Deolu Kolade

Contact Person's Title: Director of Operations

Contact Person's Address: 38 Crawford Road, Westport, CT, 06880

Contact Person's Phone Number: 203.372.3333

Contact Person's Fax Number: 203.374.7515

Contact Person's Email Address: akolade@newerarehab.com

Project Town: Bridgeport, CT

Project Name: New Era Mental Health

Statute Reference: Section 19a-638, C.G.S.

Estimated Total Capital Expenditure: $0

General Information

Name of Applicant: New Era Rehabilitation Center, INC

Name of Co-Applicant:

Connecticut Statute Reference:

Main Site

MAIN SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME

STREET & NUMBER	TOWN	ZIP CODE
3851 Main Street	Bridgeport	06606

Project Site

PROJECT SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME

STREET & NUMBER	TOWN	ZIP CODE
3851 Main Street	Bridgeport	06606

Operator

OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)

STREET & NUMBER	TOWN	ZIP CODE

Chief Executive

NAME	TITLE
Ebenezer Kolade	Dr

STREET & NUMBER	STATE	ZIP CODE
38 Crawford Road	**CT**	**06606**

TOWN	E-MAIL ADDRESS
Westport	Akolade@newerarehab.com

TELEPHONE	FAX

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a copy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES ☑ NO ☐	
Does the Applicant have non-profit status? If yes, attach documentation.	YES ☐ NO ☑	
Identify the Applicant's ownership type.	PC ☐ LLC ☐ Corporation ☐	Other: S Corp ☑
Applicant's Fiscal Year (mm/dd)	Start: January	End: December

Contact:

Identify a single person that will act as the contact between OHCA and the Applicant.

Contact Information			
NAME: Adeoluwa Kolade		TITLE Mr.	
STREET & NUMBER 38 Crawford Road			
TOWN **Westport**	STATE **CT**	ZIP CODE **06880**	
TELEPHONE 203-543-9950	FAX	E-MAIL ADDRESS akolade@newerarehab.com	
RELATIONSHIP TO APPLICANT	Employee		

Identify the person primarily responsible for preparation of the application (optional):

Prepared by			
NAME		TITLE	
STREET & NUMBER			
TOWN	STATE	ZIP CODE	
TELEPHONE	FAX	E-MAIL ADDRESS	
RELATIONSHIP TO APPLICANT			

Affidavit

Applicant: NEW ERA REHABILITATION

Project Title: NEW NURSING AGENCY LICENSE

I, EBENEZER KOLADE, MD, CEO
(Name) (Position – CEO or CFO)

of New era rehab ctr being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

7/26/16
Date

Subscribed and sworn to before me on 26th July 2016.

Notary Public

Notary Public/Commissioner of Superior Court

My commission expires: My Commission Expires November 30, 2019

Executive Summary

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow.

With the advent of spending cuts to the state grant program for community mental health providers there is an increased need for facilities to address the states mentally ill and indigent. Individuals suffering from co-occurring substance abuse and mental abuse disorders are finding it increasingly difficult to find providers that can accept state insurance. The purpose of this proposal is to obtain a mental health license in order to increase the access to and the continuum of care, of patients currently being treated in New Era Rehabilitation Center as well as the greater Bridgeport Area.

According to the NSDUH, in 2014, about 1 in 5 adults aged 18 or older (18.1 percent, or 43.6 million adults) had any mental illness (AMI) in the past year, and 4.1 percent (9.8 million adults) had serious mental illness (SMI). This equals about 170,649 people suffering from mental illness in Fairfield County. The capacity for treatment is dwindling and more and more people are finding it difficult to find the necessary treatment that they need. To assist in the alleviation of this burden to the state.

NERC proposes granting the facility a mental health license. The expansion of services will cost the facility nothing in capital expenditure as it already runs a full service behavioral health facility. The target market are clients already enrolled in the facility, therefore there will be little to no duplication of services.

Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Care Access is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a "§" indicates it is actual text from the statute and may be helpful when responding to prompts.

Project Description

1. **Provide a detailed narrative describing the proposal. Explain how the Applicant(s) determined the necessity for the proposal and discuss the benefits for each Applicant separately (if multiple Applicants). Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline and why the proposal is needed in the community.**

New Era Rehabilitation Center, ("NERC"), a for-profit organization registered to conduct business in Connecticut, proposes to expand its current substance abuse and behavioral health services to include a full suite of mental health services in Bridgeport, Connecticut. NERC currently operates 2 outpatient behavioral health facilities, licensed by the Connecticut Department of Public Health (DPH) and accredited by the Council on Accreditation of Rehabilitation Facilities (CARF) and The Joint Commission, at both of its facilities in Bridgeport, Connecticut and New Haven Connecticut, respectively The new service will primarily serve~ existing clients suffering from addiction who receive other substance abuse treatment at NERC.

NERC has been operating addiction treatment programs since 2002, providing services to approximately 1000 clients annually, the majority of which are Medicaid recipients.. The proposed service will address the need to provide adequate mental health services and continuing treatment for the vast majority of NERC's client population - one-half of which is from Fairfield County. In order to maximize client outcomes and to reduce relapse to addiction, NERC will offer increase access to desperately needed mental health services. The proposed service expansion will take place at NERC's already existing location in Bridgeport, CT, the center provides a convenient location for clients as they are already receiving other services at the location. The location will also provide increased accessibility for mental health services within the greater Bridgeport Area.

The need for substance abuse services within the state of Connecticut far exceeds capacity. The current epidemic of opiate (e.g., heroin, prescription opioids) addiction is amplifying this need as well as changing the landscape of the treatment industry. Heroin has exceeded alcohol as the primary drug for which clients seek treatment. Accidental deaths associated with heroin overdose have reached an all-time high, creating a major public health crisis. According to the National Survey on Drug Use and Health (NSDUH)[i], it is estimated that up to 39.1 percent of people with substance abuse issues also suffer from a co-occurring mental illness disorder. This statistic become increasingly meaningful when coupled with the National Institute of Drug Abuse (NIDA) fact that of all of the adults who go through addiction treatment, only about 7 percent are treated for both their substance abuse and their co-occurring disorder. Also, by expanding the client scope away from individuals with co-occurring SUD and AMI, we find that 52.5% of individuals with AMI did not receive treatment, according to The Behavioral Health Barometer: Connecticut 2015.

The proposed expansion of service will begin immediately upon award of a certificate of need (CON) and issuance of a license by the Department of Public Health (DPH).

Existing clients suffering from co-occurring issues will be referred to the in house specialists to receive the treatment that they so desperately need. With a minimal capital outlay, and benefitting from administrative efficiencies of its existing infrastructure, NERC projects operating with a modest margin from start-up, and will be cost-effective. A gradual increase in both client volume and fees will ensure continued viability. Within the proposed space, NERC will be able to expand services to meet actual demand as it is presented. The proposed outpatient service will improve health care services in the area, improve client outcomes including reduced recidivism and reduced medical costs and costs to society by enabling clients to increase the likelihood of achieving sustained recovery. The introduction of this service will have minimal impact on the existing licensed providers in the area.

2. **Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between Applicant(s)? What have the Applicant(s) accomplished so far?).**

In the early spring of 2014, NERC transitioned from referring clients suffering from co-occurring disorders to local mental health agencies to evaluating and stabilizing them in-house. The initial intention was to stabilize clients and then slowly triage them to regular mental health providers outside of NERC. After piloting this service, NERC quickly found that segmenting the treatment of behavioral and mental health led to a lack of continuity of care. To better serve our clientele the agency intends to expand its service capability to include the full gamut of mental health services. NERC has already employed a psychiatrist who will have the ability to manage our clientele and help establish a robust mental health program.

3. **Provide the following information:**

   a. **utilizing OHCA Table 1, list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;**

   b. **identify in OHCA Table 2 the service area towns and the reason for their inclusion (e.g., provider availability, increased/decreased patient demand for service, market share);**

4. **List the health care facility license(s) that will be needed to implement the proposal;**

   - Mental Health Facility
   - Psychiatric Outpatient Facility

5. **Submit the following information as attachments to the application:**

   a. a copy of all State of Connecticut, Department of Public Health license(s) currently held by the Applicant(s);

   b. **a list of all key professional, administrative, clinical and direct service personnel related to the proposal and attach a copy of their Curriculum Vitae;**
      - Ebenezer Kolade, MD- Executive Director
      - Adeoluwa Kolade, MPH- Director of Operations
      - Maxine Cartwright, MD
      - Donna Rivera- LADC MATS

   c. **copies of any scholarly articles, studies or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles;**

d. **letters of support for the proposal;**

e. **the protocols or 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 the protocols or guidelines.**

f. **copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.**

Public Need and Access to Care

§ "Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;" (Conn.Gen.Stat. § 19a-639(a)(1))

6. **Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.**

§ "The relationship of the proposed project to the statewide health care facilities and services plan;" (Conn.Gen.Stat. § 19a-639(a)(2))

7. **Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available on OHCA's website.**

According to the CT Dept. of Public Health Statewide Health Care facilities and Services Plan, "More than one-half of the assessments identified substance abuse and mental health care as priority health needs in the community" as a key issue as well as "the need for the coordination of mental health and substance abuse care". This proposal is aligned with these issues directly. As a comprehensive behavioral health facility serving a drug dependent population of over 850 clients adding a mental health license will be a great help to the community. It will expand services to a population that is struggling to have proper access to care. It will also allow NERC to better coordinate its care for clients who are suffering from substance abuse issues as well as mental health issues by co-locating the two services. This is directly in line with a recommendation in the CT Dept. of Public Health Statewide Health Care facilities and Services Plan, to "Provide more focus in future plans which specifically discuss the coordination, interrelation, provision or co-location of mental health, primary care and/or oral health services within the various settings and how such interrelationship will benefit the behavioral health patient population." The granting of this proposal will help execute this recommendation and ultimately lead to better engagement of those clients and better health outcomes.

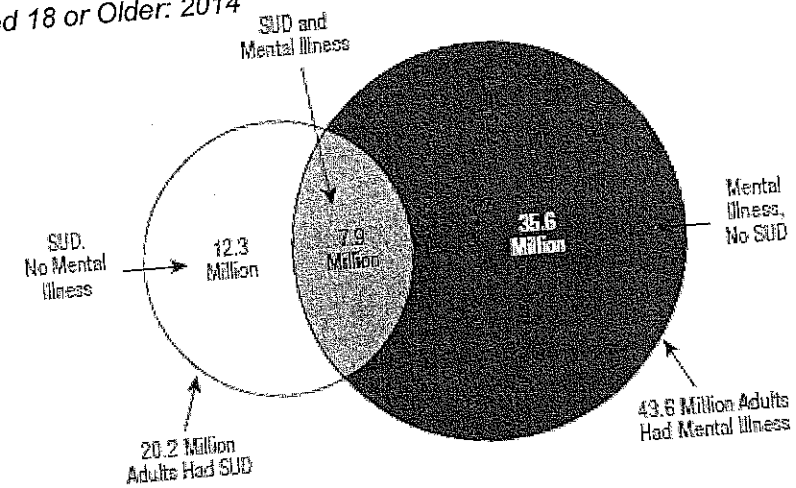
§ *"Whether there is a clear public need for the health care facility or services proposed by the applicant;" (Conn.Gen.Stat. § 19a-639(a)(3))*

8. With respect to the proposal, provide evidence and documentation to support clear public need:

a. identify the target patient population to be served;

The target patient population to be served includes adults, (18 years of age and above) suffering from any mental illness (AMI) and/or substance use disorders (SUD), who reside in Fairfield County, Connecticut. The most current national data available is for 2014 from the Substance Abuse and Mental Health Services Administration (SAMHSA) based upon results from the National Survey on Drug Use (NSDUH). According to the NSDUH, in 2014, about 1 in 5 adults aged 18 or older (18.1 percent, or 43.6 million adults) had any mental illness (AMI) in the past year, and 4.1 percent (9.8 million adults) had serious mental illness (SMI). About 3.3 percent of all adults in 2014 had both AMI and an SUD in the past year, and 1.0 percent had both SMI and an SUD.

Figure.1 Past Year Substance Use Disorders and Mental Illness among Adults Aged 18 or Older: 2014



According to the United States Census Bureau , the population of Fairfield County in 2015 was 948,053, (about 26% of the total population of Connecticut}. It reports that 76.1% of those are aged 18 and over - placing this estimate of the adult population in Fairfield County at 721,468. Extrapolating by applying the NSDUH prevalence estimate of 3.3%, the census data would suggest there are about 23,808 adults with SUD and AMI in Fairfield County.

It is important to recognize that actual data from Connecticut is not available. For example, DMHAS needs data reflect services only within the public-funded

treatment system and do not include data from private, for-profit providers who primarily serve selfpay clients. In addition, high net-worth clients who often receive treatment in programs located elsewhere across the country are not included in these statistics. Therefore, the estimate of 3.3% for the general United States population will be Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2014. used for projections.

b. discuss how the target patient population is currently being served;

NERC has defined the current target population as the co-occurring population currently being served at NERC. From our internal reports, the majority of individuals suffering from mental health issues in this population are largely going untreated. The majority of the population receive partial services from facility through the resident psychiatrist however as NERC does not have a mental health license the inability to bill for these services limits the amount that can actually be done to help patients.

c. document the need for the equipment and/or service in the community;

NERC plans to establish this new service in Bridgeport, CT. According to the US Census Bureau, 23.9% of that Bridgeport population is currently living in poverty. This is in comparison to the national average of 14.8%. The majority of the city utilizes a combination of Medicaid or state insurance to fund their healthcare needs. This fact makes it extremely difficult to receive mental health services as the majority of psychiatrists do not accept Medicaid or make low-income patients pay cash out of pocket. NERC plans to alleviate this burden by providing patients with an accessible and affordable alternative.

d. explain why the location of the facility or service was chosen;

The main rationale for locating an outpatient treatment facility in Bridgeport, CT is to enable us to better meet NERC's existing outpatient clients' continuing care needs; and to improve client health outcomes including reduced rates of relapse. By offering an industry- and client-preferred level of continuing care services (i.e., mental health and psychiatric services near their home communities within reasonable driving distance and on a public bus line, we will be better able to ensure that our clients' treatment is comprehensive and can be implemented with greater certainty through a lower level-of-care, delivered by the same provider. We chose Bridgeport because it is geographically, logistically and population-based at the center of Fairfield County -- where the highest concentration (70% of total) of our substance abuse clients live (see map in Figure 1 below). More specifically, the following factors were central to the choice of location:

Accessibility – NERC's Bridgeport facility is located on Bus Route 8 (North Main Street} -- a major bus line through Fairfield County. It is situated one (1) mile from exit 48 of the Merritt Parkway (Route 15} – the primary east-west State highway

through the center of lower Fairfield County.

Proximity - Since clients will travel to the facility car up to six times per week, drive time is an important factor. Our central location makes it possible to drive from virtually anywhere in the county within about 30 minutes.

Privacy - We are located in an attractive yet relatively non-descript commercial office mall to house our new services, rather than a dedicated building, in order to maximize client anonymity and privacy. Clients will share the main building entrance that serves several other businesses, ensuring that clients will not be seen walking directly into NERC's counseling offices. The parking area is large, as it is shared by occupants and visitors of a cluster of office buildings - removing the possible assumption by others that an individual is one of our clients.

e. provide incidence, prevalence or other demographic data that demonstrates community need;

The general population segment within which the target population rests includes adults (18 years of age and above} with co-occurring substance use and mental health disorders who reside in Fairfield County, Connecticut. The most current national data are available for 2014 from the Substance Abuse and Mental Health Services Administration (SAMHSA} based upon results from the National Survey on Drug Use and Health (NSDUH}. 2 The 2014 (most recent} NSDUH estimates the prevalence of SUD and AMI (including alcohol and illicit drugs} among adults in the United States at 3.3%.

According to the United States Census Bureau, the population of Fairfield County in 2015 was 948,053, (about 26% of the total population of Connecticut}. It reports that 76.1% of those are aged 18 and over - placing this estimate of the adult population in Fairfield County at 721,468. Extrapolating by applying the NSDUH prevalence estimate of 3.3%, the census data would suggest there are about 23,808 adults with SUD and AMI in Fairfield County. Actual data from Connecticut is not available. For example, DMHAS needs data reflect services only within the public-funded treatment system and do not include data from private, for-profit providers who primarily serve self-pay clients. In addition, high net-worth clients often receive treatment in programs located elsewhere across the country. Therefore, the estimate of 3.3% for the general United States population will be Source: *SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2014.* used for projections.

In reference to the need for treatment in Fairfield County, Connecticut, perhaps the most compelling, recent evidence available to demonstrate treatment need in Connecticut comes from the Behavioral Health Barometer- Connecticut 2014, issued by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in 2015.

The following excerpt validates the extrapolated estimate of treatment need suggested above [note that the figures below only include Serious Mental Illness (SMI) and excludes Any Mental Illness (AMI), the former is a subset of AMI's implying the statistics will be under reporting the total prevalence], and also identifies the percentage of those in need who are not served in any given year:

"According to SAMHSA's National Survey on Drug Use and Health (NSDUH), 23.2 million persons (9.4 percent of the U.S. population aged 12 or older) needed treatment for an illicit drug or alcohol use problem in 2007. Of these individuals, 2.4 million (10.4 percent of those who needed treatment) received treatment at a specialty facility (i.e., hospital, drug or alcohol rehabilitation or mental health center). Thus, 20.8 million persons (8.4 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive it. These estimates are similar to those in previous years".1

f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;

NERC plans to establish this new service in Bridgeport, CT. According to the US Census Bureau, 23.9% of the Bridgeport population is currently living in poverty and 72.8% of the population is either African-American or Hispanic. The majority of the city utilizes a combination of Medicaid or state insurance to fund their healthcare needs. This fact makes it extremely difficult to receive mental health services as the majority of psychiatrists do not accept Medicaid or make low-income patients pay cash out of pocket. NERC plans to alleviate this burden by providing patients with an accessible and affordable alternative for low income persons and racial and ethnic minorities. Furthermore according to the United State Census Bureau, 27.7% of Fairfield county residents are an ethnic minority (African American or Hispanic). With NERC's patient population being 25.7% minority, this is mirrored with in NERC's clinic population. We expect that the utilization of the of the services will be predominantly from

g. list any changes to the clinical services offered by the Applicant(s) and explain why the change was necessary;

No changes will be made to the clinical services.

h. explain how access to care will be affected;

Currently Fairfield county residents have very little options to receive mental health services. Private psychiatrists often times do not accept state insurance and community mental health centers keep complicated intake processes that often deter clients. With the advent of the NERC mental health services, we intend to provide a needed increase in the capacity.

i. discuss any alternative proposals that were considered.

No other proposals were discussed.

§ *"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; (Conn.Gen.Stat. § 19a-639(a)(5))*

9. Describe how the proposal will:

a. **improve the quality of health care in the region;**

In addition to adding a new, high quality mental health treatment program within the region, NERC will serve to improve health care outcomes for individuals beginning recovery from SUD. By providing essential, continuing engagement the proposed service will help minimize relapse and enhance transition to productive, independent and self-supporting healthy lifestyles in the community.

Various clinical studies have proven that increase engagement in treatment will result in positive health outcomes as well as an increase chance for achieving sustained recovery (e.g., long-term abstinence). According to the national Drug Abuse Treatment Outcome Study (DATOS), "The length of time clients stayed in treatment was directly related to improvements in follow-up outcomes, replicating findings from previous national treatment evaluations". Providing continuing, uninterrupted treatment, extending it into the community, enables clients to increases the likelihood to achieve positive health outcomes. This results in a reduction in the over-use of repeated acute care services such as the emergency room and other specialized settings.

Lastly, the introduction of this service will have minimal impact on the existing licensed providers in the area as NERC already possesses a sizable census receiving substance abuse services, adding mental health services will promote the continuum of care as well as engagement, ultimately leading to better health outcomes.

b. **improve accessibility of health care in the region;** and

c. **improve the cost effectiveness of health care delivery in the region.**

NERC mental health service will be designed to provide seamless, continuing treatment for individuals with substance use disorders (SUD). The majority of individuals suffering from opiate addiction are also suffering from a form of mental illness. By addressing the emerging and underlying emotional and mental health factors associated with relapse to substance use, the proposed service will reduce future healthcare costs related to relapse, including repeated addiction treatment and associated medical costs. By providing a dedicated regimen of clinical services that are closely coordinated with mental health treatment the proposed service will contribute to decreasing long-term behavioral healthcare costs - especially the need for chronic, acute care episodes, and particularly the costs associated with heroin overdose incidents. In addition to the aforementioned long term effects, by combining both substance abuse and mental health treatment,

there should be a decrease in the amount the transportation subsidies for clients receiving multiple services. Lastly, national studies 21 estimate that the benefit-cost ratio achieved by providing addiction treatment is 7:1 (i.e., $7.00 saved in societal costs for every $1.00 spent).This can only be further enhanced by providing the necessary Finally, by sharing administrative and support service infrastructure with the existing NERC treatment facility, NERC will minimize indirect costs, allowing for the greatest societal return from a minimal investment.

10. How will this proposal help improve the coordination of patient care (explain in detail regardless of whether your answer is in the negative or affirmative)?

Coordination of care is one of the key drivers that has led NERC to establish a mental health program. Currently the facility serves roughly 850 clients for substance abuse disorders, in an internal survey of NERC patients the organization found that over 90% of individuals receiving substance abuse services are also suffering from mental illness. We hope to establish a mental health program that will first assist in alleviating the burden of disease among our current client and then expand to further alleviate the burden of disease in the city and eventually the state as a whole.

11. Describe how this proposal will impact access to care for Medicaid recipients and indigent persons.

Currently 90% of NERC's current census is made up of individuals who utilize Medicaid to pay for their healthcare services. We expect the introduction of the service to further increase access of care to Medicaid recipients.

12. Provide a copy of the Applicant's charity care policy and sliding fee scale applicable to the proposal.

This is not applicable.

> § *"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;" (Conn.Gen.Stat. § 19a-639(a)(10))*

13. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

The proposal is focused on increasing access specifically for Medicaid recipients.

> § *"Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect*

health care costs or accessibility to care." (Conn.Gen.Stat. § 19a-639(a)(12))

14. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

There will be no change in price structure.

Financial Information

§ *"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;" (Conn.Gen.Stat. § 19a-639(a)(4))*

15. **Describe the impact of this proposal on the financial strength of the state's health care system or demonstrate that the proposal is financially feasible for the applicant.**

16. **Provide a final version of all capital expenditure/costs for the proposal using** OHCA Table 3.

Due to the services that NERC currently provide the organization does not need to spend any additional money to add this service. However, the facility forecasts the addition of another counselor that would approximately cost $60,000.

17. **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.**

If there are any unforeseen expenses NERC will be funding the project with cash.

18. **Include as an attachment:**

a. **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, statement of operations, tax return, or other set of books). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;**

Please find attached.

b. completed **Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale)**, available on OHCA's website under OHCA Forms, providing a summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the CON project," and "with the CON project." **Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.**

19. **Complete** OHCA Table 4 **utilizing the information reported in the attached Financial Worksheet.**

20. **Explain all assumptions used in developing the financial projections reported in the Financial Worksheet.**

The following are the assumptions utilized in developing the financial projections of the proposed service:

- NERC will begin the proposed service Dec. 1st
- Client census remains at 850 clients
- Reimbursement for Psychotherapy 60 min remains at $62.94 (Medicaid)
- Weeks in a year: 52 weeks per year
- Number of Psychotherapy sessions per week: Assuming 1 session per week
- 100% of the new clients will be on Medicaid

21. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.

There are no incremental losses from the operations.

22. Indicate the minimum number of units required to show an incremental gain from operations for each projected fiscal year.

Assuming the only operational expense associated with the proposed operation will be an added staff member at $40,000, there would need to be 636 units of the service provided to show an incremental gain.

Utilization

§ *"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;" (Conn.Gen.Stat. § 19a-639(a)(6))*

23. **Complete OHCA Table 5 and OHCA Table 6 for the past three fiscal years ("FY"), current fiscal year ("CFY") and first three projected FYs of the proposal, for each of the Applicant's existing and/or proposed services. Report the units by service, service type or service level.**

24. **Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Table 5 and 6.**

The following are the assumptions utilized in developing the financial projections of the proposed service:

- Client census for MMTP BPT location per year:
  - 2014: 436
  - 2015: 450
  - 2016: 466
- Client census for IOP BPT location per year:
  - 2014: 5
  - 2015: 34
  - 2016: 34*
    - * annualized
- Each client utilizes the MMTP service 1 per week or 52 per year
- Avg IOP utilization per client is 15 sessions

25. **Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal using OHCA Table 7 and provide all assumptions. Note: payer mix should be calculated from patient volumes, not patient revenues.**

§ *"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;" (Conn.Gen.Stat. § 19a-639(a)(7))*

26. **Describe the population (as identified in question 8(a)) by gender, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health,**

CT State Data Center) and document the source.

27. **Using OHCA Table 8, provide a breakdown of utilization by town for the most recently completed fiscal year. Utilization may be reported as number of persons, visits, scans or other unit appropriate for the information being reported.**

Number of Projected Population in Need					
Rank			Total Population	NSDUH Estimate	Population in Need
1	Bridgeport	City	143,412	18%	25,958
2	Stamford	City	121,784	18%	22,043
3	Norwalk	City	85,145	18%	15,411
4	Danbury	City	80,101	18%	14,498
5	Greenwich	Town	61,023	18%	11,045
6	Fairfield	Town	59,078	18%	10,693
7	Stratford	Town	51,116	18%	9,252
8	Shelton	Town	39,310	18%	7,115
9	Trumbull	Town	35,752	18%	6,471
10	Newtown	Town	27,235	18%	4,930
11	Westport	Town	26,249	18%	4,751
12	Ridgefield	Town	24,469	18%	4,429
13	Darien	Town	20,580	18%	3,725
14	New Canaan	Town	19,642	18%	3,555
15	Monroe	Town	19,398	18%	3,511
16	Bethel	Town	18,584	18%	3,364
17	Wilton	Town	17,973	18%	3,253
18	Brookfield	Town	16,339	18%	2,957
19	New Fairfield	Town	13,847	18%	2,506
20	Weston	Town	10,142	18%	1,836

21	Redding	Town	9,058	18%	1,639
22	Easton	Town	7,452	18%	1,349
23	Sherman	Town	3,598	18%	651
24	Newtown	Borough	2,035	18%	368
Total					165,311

§ "The utilization of existing health care facilities and health care services in the service area of the applicant;" (Conn.Gen.Stat. § 19a-639(a)(8))

28. **Using OHCA Table 9, identify all existing providers in the service area and, as available, list the services provided, population served, facility ID (see table footnote), address, hours/days of operation and current utilization of the facility. Include providers in the towns served or proposed to be served by the Applicant, as well as providers in towns contiguous to the service area.**

29. **Describe the effect of the proposal on these existing providers.**

NERC intends to focus treatment efforts on existing clients who are suffering from co-occurring mental health and substance abuse issues. These clients are already receiving basic mental health treatment at NERC, the facility intends to expand its services to better treat its existing client base. Therefore the facility foresees no significant effect on the existing providers.

30. **Describe the existing referral patterns in the area served by the proposal.**

Of the 18 facilities that provide mental health services, only 5 of them are located in Fairfield County. This comes as a surprise considering that Fairfield County is the most populated county within the state.

31. **Explain how current referral patterns will be affected by the proposal.**

NERC intends to focus treatment efforts on existing clients who are suffering from co-occurring mental health and substance abuse issues. Therefore the facility is not forecasting any referrals for the mental health services and does not expect there to be a significant change in the current patterns of referrals.

§ "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;" (Conn.Gen.Stat. § 19a-639(a)(9))

32. **If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.**

N/A

§ "Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region;" (Conn.Gen.Stat. § 19a-639(a)(11))

33. **Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.**

NERC is the only African-American owned and operated comprehensive behavioral health facility in the state of Connecticut. NERC's employees are split evenly among African-Americans, Caucasians and Hispanic proving that the facility is both racially mixed and ethnically diverse. By granting the facility a mental health license, the state will be positively impacting the diversity of health care throughout the geographic region.

Tables

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
Mental Health	3851 Main St, BPT, CT	Fairfield County	M-F 5am-2pm	New Service

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TABLE 2
SERVICE AREA TOWNS

List the official name of town* and provide the reason for inclusion.

Town*	Reason for Inclusion
Ansonia	NERC currently serves clients from here
Beacon Falls	NERC currently serves clients from here
Bethel	NERC currently serves clients from here
Bridgeport	NERC currently serves clients from here
Bridgewater	NERC currently serves clients from here
Bristol	NERC currently serves clients from here
Brookfield	NERC currently serves clients from here
Danbury	NERC currently serves clients from here
Derby	NERC currently serves clients from here
Easton	NERC currently serves clients from here
Fairfield	NERC currently serves clients from here
Harwinton	NERC currently serves clients from here
Milfod	NERC currently serves clients from here
Monroe	NERC currently serves clients from here
Naugatuck	NERC currently serves clients from here
New Canaan	NERC currently serves clients from here
New Fairfield	NERC currently serves clients from here
New Haven	NERC currently serves clients from here
New Milford	NERC currently serves clients from here
Norwalk	NERC currently serves clients from here
Oakville	NERC currently serves clients from here
Orange	NERC currently serves clients from here
Oxford	NERC currently serves clients from here
Redding	NERC currently serves clients from here
Ridgefield	NERC currently serves clients from here
Sandy Hook	NERC currently serves clients from here
Seymour	NERC currently serves clients from here
Shelton	NERC currently serves clients from here
Southbury	NERC currently serves clients from here
Staffordville	NERC currently serves clients from here
Stamdord	NERC currently serves clients from here
Stratford	NERC currently serves clients from here
Torrington	NERC currently serves clients from here
Trumbull	NERC currently serves clients from here
Waterbury	NERC currently serves clients from here
Watertown	NERC currently serves clients from here
West Haven	NERC currently serves clients from here
Westport	NERC currently serves clients from here
Winsted	NERC currently serves clients from here
Wolcott	NERC currently serves clients from here

* Village or place names are not acceptable.

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TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

Purchase/Lease	Cost
Equipment (Medical, Non-medical, Imaging)	0
Land/Building Purchase*	0
Construction/Renovation**	0
Other (specify)	0
Total Capital Expenditure (TCE)	**0**
Lease (Medical, Non-medical, Imaging)***	**0**
Total Lease Cost (TLC)	**0**
Total Project Cost (TCE+TLC)	

* 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.

** 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.

*** 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.

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TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2016*	FY 2017*	FY 2018*
Revenue from Operations	$278,195	$347,744	$417,292
Total Operating Expenses	$40,000	0	0
Gain/Loss from Operations	$238,195	$347,744	$417,292

* Fill in years using those reported in the Financial Worksheet attached.

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TABLE 5
HISTORICAL UTILIZATION BY SERVICE

Service**	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY 2013***	FY 2014***	FY 2015***	FY 2016***
Methadone Maintenance	N/A	22,672	23,400	24,232
IOP	N/A	75	540	540
Total	N/A	22,747	23,940	24,772

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the period covered.

** Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.

*** Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

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TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume		
	FY 2017**	FY 2018**	FY 2019**
Mental Health Outpatient	4,420	5,525	6,630
Methadone Maintenance	46,410	48,731	48,731
Total	50,830	54,256	55,361

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.

** 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. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

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TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Current FY 2016**		Projected					
			FY 2017**		FY 2018**		FY 2019**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*	208	89	196	83	186	83	177	79
Medicaid*								
CHAMPUS & TriCare							**177**	
Total Government	**208**		**196**		**186**		47	21
Commercial Insurers	36	14.7	40	17	44	17		
Uninsured								
Workers Compensation							**47**	
Total Non-Government	**36**		**40**		**44**			
Total Payer Mix								

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

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TABLE 8
UTILIZATION BY TOWN

Town	Utilization FY 2016**
Ansonia, CT	16
Beacon Falls, CT	4
Bethel, CT	6
Bridgeport, CT	206
Bridgewater, CT	1
Bristol, CT	1
Brookfield, CT	4
Danbury, CT	16
Derby, CT	8
Easton, CT	2
Faifield, CT	4
Fairfield, CT	7
Milford, CT	10
Monroe, CT	6
Naugatuck, CT	15
New Canaan, CT	1
New Haven, CT	1
New Milford, CT	4
Norwalk, CT	5
Oakville, CT	1
Orange, CT	1
Oxford, CT	6
Redding, CT	2
Ridgefield, CT	3
SHELTON, CT	1
Sandy Hook, CT	2
Seymour, CT	12
Shelton, CT	32
Southbury, CT	1
Staffordville, CT	1
Stamford, CT	1
Stratford, CT	17
Stratford , CT	1
Stratford, CT	8
Torrington , CT	3
Trumbull, CT	17
Waterbury, CT	26
Watertown, CT	1
West Haven, CT	3

Westport, CT	1
Winsted, CT	1
Wolcott, CT	1

* List inpatient/outpatient/ED volumes separately, if applicable
** Fill in most recently completed fiscal year.

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SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

Facility Name	Provider Name	Facility Address	City	Hours of Operation	NPI	Current Utilization
Angelus House	Wellspring Foundation, Inc.	158 Flanders Road	Bethlehem	N/A	N/A	N/A
Blue Sky Behavioral Health Clinic	Blue Sky Behavioral Health, LLC	52 Federal Road	Danbury	9am-8pm	N/A	N/A
Community Renewal Team, Inc. Behavioral Health	Community Renewal Team, Inc.	330 Market Street	Hartford	8am-4pm	1841301876	99
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	20 North Main Street	Norwalk	N/A	1619093523	26
Connecticut Counseling Centers, Inc.	Connecticut Counseling Centers, Inc.	4 Midland Road	Waterbury	N/A	1982720702	81
FSW, Inc. CT	FSW, Inc. CT	475 Clinton Avenue	Bridgeport	N/A	N/A	
McCall Foundation	McCall Foundation, Inc.	58 High Street	Torrington	8am-9pm	1043362429	6
McCall Foundation, Inc. - Winsted Satellite Office	McCall Foundation, Inc.	231 North Main Street	Winchester	8am-9pm	1467504779	9
New Directions, Inc. of North Central Connecticut	New Directions Inc. of North Central Connecticut	113 Elm Street	Enfield	06082	1295827475	340
New Prospects	Recovery Network of Programs, Inc.	392 Prospect Street	Bridgeport	8:30am-8:30pm	1407033152	N/A
Renfrew Center of Southern Connecticut	Renfrew Center of Southern Connecticut, LLC	1445 Putnam Avenue	Greenwich	N/A	N/A	N/A
Rushford Center, Inc.	Rushford Center, Inc.	883 Paddock Avenue	Meriden	8am-8pm	1275541005	94
Rushford Center, Inc.	Rushford Center, Inc.	1250 Silver Street	Middletown	8am-8pm	1275541005	64
Walden Behavioral Care	WBC Connecticut East, LLC	2400 Tamarack Avenue	South Windsor	7:30am-5pm	1730442179	
Wellspring Foundation Inc.	Wellspring Foundation, Inc.	21 Arch Bridge Road	Bethlehem	N/A	N/A	

SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

Service or Program Name	Population Served	Facility's Provider Name, Street Address and Town
Wellspring Foundation, Inc.	Bethlehem	Angelus House, 158 Flanders Road, Bethlehem
Blue Sky Behavioral Health, LLC	Danbury	Blue Sky Behavioral Health Clinic, 52 Federal Road, Danbury
Community Renewal Team, Inc.	Hartford	Community Renewal Team, Inc. Behavioral Health
Connecticut Counseling Centers, Inc.	Norwalk	Connecticut Counseling Centers, Inc.
Counseling Centers, Inc.	Waterbury	Connecticut Counseling Centers, Inc.
FSW, Inc. CT	Bridgeport	FSW, Inc. CT
McCall Foundation, Inc.	Torrington	McCall Foundation
McCall Foundation, Inc.	Winchester	McCall Foundation, Inc. - Winsted Satellite Office
New Directions Inc. of North Central Connecticut	Enfield	New Directions, Inc. of North Central Connecticut
Recovery Network of Programs, Inc.	Bridgeport	New Prospects
Renfrew Center of Southern Connecticut, LLC	Greenwich	Renfrew Center of Southern Connecticut
Rushford Center, Inc.	Meriden	Rushford Center, Inc.
Rushford Center, Inc.	Middletown	Rushford Center, Inc.
Stonington Behavioral Health, Inc.	Groton	Stonington Institute
Stonington Behavioral Health, Inc.	Groton	Stonington Institute
Stonington Behavioral Health, Inc.	North Stonington	Stonington Institute
WBC Connecticut East, LLC	South Windsor	Walden Behavioral Care
Wellspring Foundation, Inc.	Bethlehem	Wellspring Foundation Inc.

* Provide the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

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Connecticut Department of Public Health

Supplemental CON Application Form

Establishment of a New Health Care Facility (Mental Health and/or Substance Abuse Treatment)*

Conn. Gen. Stat. § 19a-638(1)

Applicant: New Era Rehabilitation Center

Project Name: Mental Health License

*This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility**. For the establishment of other "health care facilities," as defined by Conn. Gen. Stat § 19a-630(11) - hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

Affidavit

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the
(Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____
Notary Public/Commissioner of Superior Court

My commission expires: _____

2. **Project Description: New Facility (Mental Health and/or Substance Abuse)**

   a. **Describe any unique services (i.e., not readily available in the service area) that may be included in the proposal.**

   Services to be provided at the facility do not include any that would be considered unique among facilities within the service area serving a similar population in a mental health treatment facility. However, unlike the majority of mental health clinics, NERC will be able to provide clients with MAT, IOP, OP and Ambulatory Detox services, this will increase the coordination of care for the most at risk population in the area. This ability will be unique and better help the state manage patients and decrease the cost of healthcare.

   b. **List the type and number of DPH-licensed health care professionals that will be required to initiate the proposal.**

      a. In addition to the two (2) part-time, licensed physicians (MD) already engaged by New Era Rehabilitation Center – who will provide medical and psychiatric supervision –

         i. the following full-time DPH-licensed health care professional positions will be required to initiate the proposed mental health facility:
            1. Licensed Alcohol and Drug Counselor (LADC)
            2. Licensed Clinical Social Worker (LCSW)

3. **Projected Volume**

   a. **For each of the specific population groups to be served, report the following by service level (include all assumptions):**

      (i) An estimate of the number of persons within the population group by town that need the proposed service; and

Number of Persons Needing the Proposed Service by Town					
Rank			Total Population	NSDUH Estimate	Population in Need
1	Bridgeport	City	143,412	18%	25,958
2	Stamford	City	121,784	18%	22,043
3	Norwalk	City	85,145	18%	15,411
4	Danbury	City	80,101	18%	14,498

5	Greenwich	Town	61,023	18%	11,045
6	Fairfield	Town	59,078	18%	10,693
7	Stratford	Town	51,116	18%	9,252
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19	New Fairfield	Town	13,847	18%	2,506
20	Weston	Town	10,142	18%	1,836
21	Redding	Town	9,058	18%	1,639
22	Easton	Town	7,452	18%	1,349
23	Sherman	Town	3,598	18%	651
24	Newtown	Borough	2,035	18%	368
Total					165,311

(ii) The number of persons in need of the service that will be served by the proposal (estimated patient volume).

The specific target population to be served includes adults suffering from co-occurring mental health and substance abuse disorders currently enrolled in treatment at New Era Rehabilitation Center. NERC assumes that 20% of its total population will be utilizing the proposed service by in 3 years

b. **Provide statistical information from the Substance Abuse and Mental Health Administration ("SAMSHA"), or a similar organization demonstrating that the target population has a need for the proposed services.**

The previously cited National Survey on Drug Use and Health (NSDUH)-2014, issued by SAMHSA, indicates that 18.1% of those aged 18 and over are in need of treatment for AMI. The Behavioral Health Barometer: Connecticut, 2014 (SAMHSA, 2015) (also cited previously) provides an estimated percentage of the unmet need for AMI treatment among the population of adults in Connecticut of 52.5%. Both sources cited herein are Federal documents available in the public domain (excerpts are provided in Attachments).

Please note: provide only publicly available and verifiable information and document the source.

Attachments

1. Scholarly Articles
   a. NSDUH 2014; pg 32 &33
   b. CT Dept. of Public Health Statewide Health Care facilities and Services Plan; pg 2 & 3
   c. A National Survey of Care for Persons With Co-occurring Mental and Substance Use Disorders

2. DPH Financial Worksheets
3. Letter of Support

caused severe problems with their ability to manage at home, manage well at work, have relationships with others, or have a social life.[38]

In 2014, 6.6 percent of adults aged 18 or older (15.7 million people) had at least one MDE in the past year, and 4.3 percent of adults (10.2 million people) had an MDE with severe impairment in the past year (Figure 43). Adults in 2014 who had an MDE with severe impairment represent nearly two thirds (65.5 percent) of adults who had a past year MDE.[39]

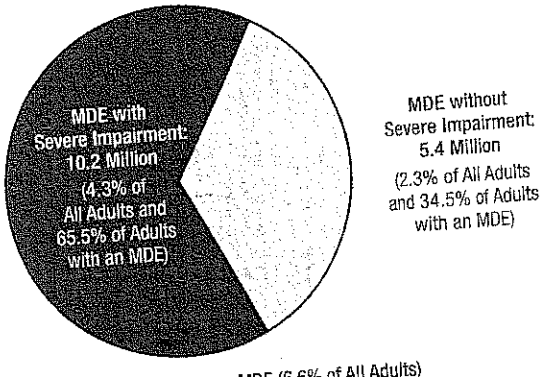
The percentage of adults who had a past year MDE remained stable between 2005 and 2014 (Figure 44). The percentage of adults with a past year MDE with severe impairment also remained stable between 2009 and 2014 (Figure 45).

By Adult Age Groups

Among adults aged 18 or older, the percentage having a past year MDE in 2014 was highest for young adults aged 18 to 25 (9.3 percent), followed by adults aged 26 to 49 (7.2 percent), then by those aged 50 or older (5.2 percent) (Figure 44). However, the percentages of adults aged 18 to 25 and those aged 26 to 49 who had a past year MDE were similar in 2006, 2007, 2009, and 2011. In addition, adults aged 50 or older in 2005 to 2013 were less likely than other adults to have a past year MDE.

The percentage of young adults aged 18 to 25 with a past year MDE was greater in 2014 than the percentages in 2006 to 2011 (Figure 44). Percentages of adults aged 26 to 49 and 50 or older in 2014 who had a past year MDE were similar to the corresponding percentages in 2005 to 2013.

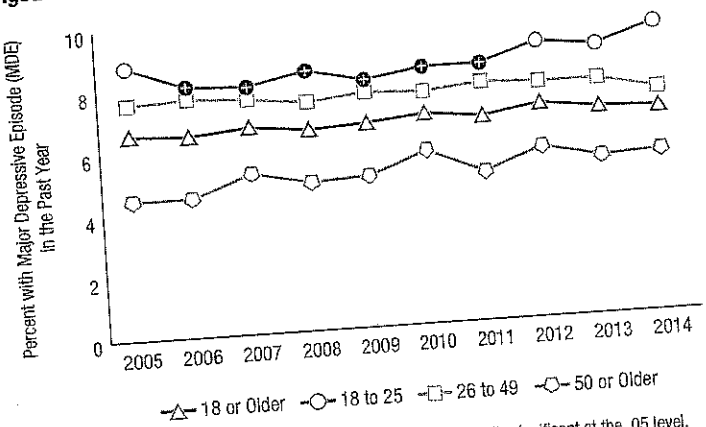
Figure 43. Major Depressive Episode and Major Depressive Episode with Severe Impairment in the Past Year among Adults Aged 18 or Older: 2014



MDE = major depressive episode.

Note: Adult respondents with unknown past year MDE data or unknown impairment data were excluded.

Figure 44. Major Depressive Episode in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2005-2014



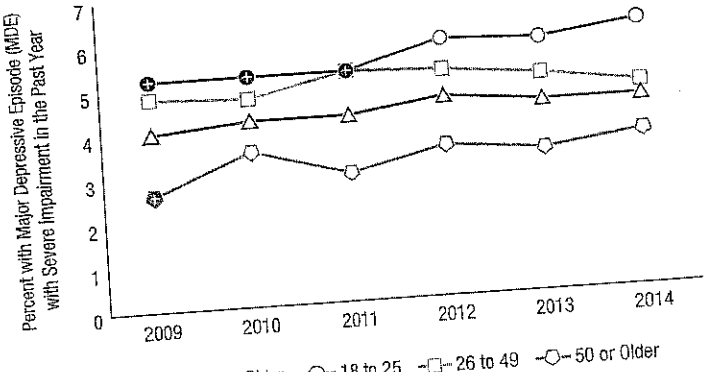
+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.

Figure 44 Table. Major Depressive Episode in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2005-2014

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
18 or Older	6.6	6.5	6.7	6.5	6.6	6.8	6.6	6.9	6.7	6.6
18 to 25	8.8	8.1+	8.0+	8.4+	8.0+	8.3+	8.3+	8.9	8.7	9.3
26 to 49	7.6	7.7	7.6	7.4	7.6	7.5	7.7	7.6	7.6	7.2
50 or Older	4.5	4.5	5.2	4.8	4.9	5.6	4.8	5.5	5.1	5.2

+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.

Figure 45. Major Depressive Episode with Severe Impairment in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2009-2014



+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.

Figure 45 Table. Major Depressive Episode with Severe Impairment in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2009-2014

	2009	2010	2011	2012	2013	2014
18 or Older	4.0	4.2	4.2	4.5	4.3	4.3
18 to 25	5.2+	5.2+	5.2+	5.8	5.7	6.0
26 to 49	4.8	4.7	5.2	5.1	4.9	4.6
50 or Older	2.6+	3.5	2.9	3.4	3.2	3.5

+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.

Among adults aged 18 or older, the percentage having a past year MDE with severe impairment in 2014 was highest for those aged 18 to 25 (6.0 percent), followed by those aged 26 to 49 (4.6 percent), then by those aged 50 or older (3.5 percent) (Figure 45). Adults aged 50 or older in 2009 to 2013 also were less likely than other adults to have an MDE with severe impairment. In addition, young adults aged 18 to 25 were more likely than adults aged 26 to 49 in 2010 and 2012 to have an MDE with severe impairment. In other years from 2009 to 2013, however, similar percentages of young adults and adults aged 26 to 49 had an MDE with severe impairment.

The percentage of young adults aged 18 to 25 with a past year MDE with severe impairment was greater in 2014 than in 2009 to 2011 (Figure 45). Percentages of adults aged 26 to 49 and 50 or older in 2014 who had a past year MDE with severe impairment were similar to the percentages in most years from 2009 to 2013.

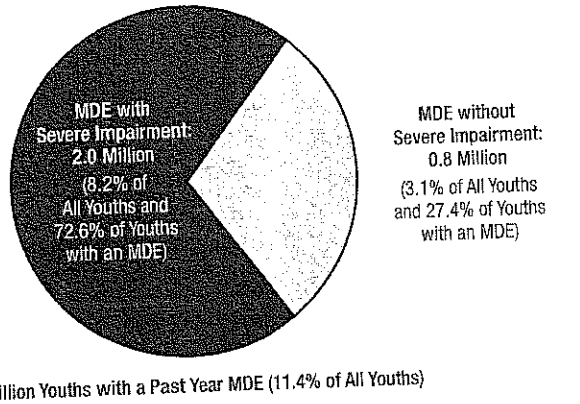
Past Year Major Depressive Episode (MDE) and MDE with Severe Impairment among Adolescents Aged 12 to 17

Although NSDUH does not have an overall measure of mental illness among adolescents aged 12 to 17, the survey provides estimates of having a past year MDE for this age group. MDE is defined using the diagnostic criteria from DSM-IV.[30] Similar to adults, adolescents were defined as having an MDE if they had a period of 2 weeks or longer in the past 12 months when they experienced a depressed mood or loss of interest or pleasure in daily activities, and they had at least some additional symptoms, such as problems with sleep, eating, energy, concentration, and self-worth. However, some wordings to the questions for adolescents were designed to make them more developmentally appropriate for youths.[40] Adolescents were defined as having an MDE with severe impairment if their depression caused severe problems with their ability to do chores at home, do well at work or school, get along with their family, or have a social life.[41]

In 2014, 11.4 percent of adolescents aged 12 to 17 (2.8 million adolescents) had an MDE during the past year, and 8.2 percent of adolescents (2.0 million adolescents) had a past year MDE with severe impairment in one or more role domains (Figure 46). Adolescents in 2014 who had an MDE with severe impairment represent nearly three fourths (72.6 percent) of adolescents who had a past year MDE.[40]

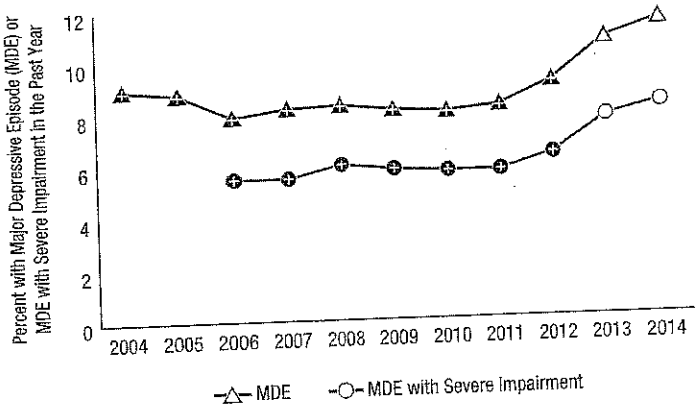
This percentage of adolescents aged 12 to 17 in 2014 who had a past year MDE was higher than the percentages in 2004 to 2012 (ranging from 7.9 to 9.1 percent), but it was similar to the percentage in 2013 (Figure 47). The percentage of adolescents in 2014 who had a past year MDE with severe impairment also was higher than the percentages in 2006 to 2012, which ranged from 5.5 to 6.3 percent.

Figure 46. Major Depressive Episode and Major Depressive Episode with Severe Impairment in the Past Year among Youths Aged 12 to 17: 2014



MDE = major depressive episode.
Note: Youth respondents with unknown past year MDE data or unknown impairment data were excluded.

Figure 47. Major Depressive Episode and Major Depressive Episode with Severe Impairment in the Past Year among Youths Aged 12 to 17: Percentages, 2004-2014



+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.

Figure 47 Table. Major Depressive Episode and Major Depressive Episode with Severe Impairment in the Past Year among Youths Aged 12 to 17: Percentages, 2004-2014

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
MDE	9.0+	8.8+	7.9+	8.2+	8.3+	8.1+	8.0+	8.2+	9.1+	10.7	11.4
MDE with Severe Impairment	N/A	N/A	5.5+	5.5+	6.0+	5.8+	5.7+	5.7+	6.3+	7.7	8.2

N/A = not available.
+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.

Co-Occurring Mental Health Issues and Substance Use Disorders among Adults

The coexistence of both a mental health issue and an SUD is referred to as a co-occurring disorder (i.e., a mental disorder and an SUD). Because NSDUH data allow estimates to be made for mental health issues and SUDs, it is possible to estimate the percentages of adults and adolescents with co-occurring disorders. This section presents findings on co-occurring mental health issues (including AMI, SMI, and MDE) and SUDs (i.e., illicit drug or alcohol dependence or abuse) among adults aged 18 or older in the United States. In addition, findings for adolescents aged 12 to 17 are presented in a later section on the co-occurrence of MDE and substance use and SUDs.

Mental Illness and Substance Use Disorders among Adults with a Disorder

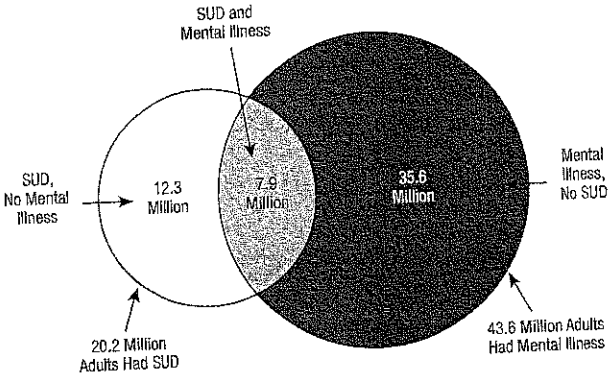
In 2014, among the 20.2 million adults with a past year SUD, 7.9 million (39.1 percent) had AMI in the past year (Figure 48 and Table A.18B in Appendix A). In contrast, among adults without a past year SUD, 16.2 percent (35.6 million adults) had AMI in the past year. Among adults with a past year SUD, the percentage of adults with co-occurring AMI in 2014 was similar to the percentages of adults with AMI in most years from 2008 to 2013.

The 7.9 million adults with AMI who met the criteria for an SUD in the past year (Figure 48) represent 18.2 percent of the 43.6 million adults with AMI (Figure 49). In contrast, 6.3 percent of adults who did not have past year AMI (12.3 million adults) met the criteria for an SUD (Figure 48 and Table A.19B in Appendix A). Among adults who had AMI in the past year, the percentage of adults with a co-occurring SUD in 2014 was similar to the percentages of adults with a co-occurring SUD in most years from 2008 to 2013 (Figure 49).

Among the 20.2 million adults aged 18 or older in 2014 who had a past year SUD, 2.3 million (11.3 percent) also had SMI in the past year (Figure 50 and Table A.18B). Among adults with a past year SUD, the percentage of adults with SMI in 2014 was similar to the percentages of adults with SMI in most years from 2008 to 2013.

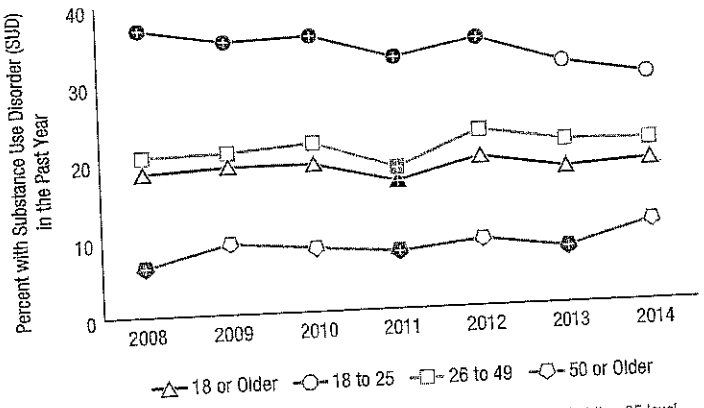
Among the 9.8 million adults aged 18 or older in 2014 who had past year SMI, the 2.3 million adults who met the criteria for an SUD in the past year represent 23.3 percent of adults with SMI (Figure 50 and Table A.19B). Among adults who had SMI in the past year, the percentage of adults with an SUD in 2014 was similar to the percentages in most years from 2008 to 2013 (Figure 51).

Figure 48. Past Year Substance Use Disorders and Mental Illness among Adults Aged 18 or Older: 2014



SUD = substance use disorder.

Figure 49. Past Year Substance Use Disorder among Adults Aged 18 or Older with Any Mental Illness in the Past Year, by Age Group: Percentages, 2008-2014



+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.

Figure 49 Table. Past Year Substance Use Disorder among Adults Aged 18 or Older with Any Mental Illness in the Past Year, by Age Group: Percentages, 2008-2014

	2008	2009	2010	2011	2012	2013	2014
18 or Older	18.4	19.0	19.0	16.5+	19.2	17.5	18.2
18 to 25	36.9+	35.1+	35.5+	32.4+	34.5+	31.1	29.3
26 to 49	20.5	20.8	21.7	18.2+	22.6	21.0	20.8
50 or Older	6.3+	9.1	8.2	7.4+	8.6	7.2+	10.3

+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.

By Adult Age Groups in 2014

Among adults aged 18 or older in 2014 with past year SUDs, the percentage of adults who had co-occurring AMI in the past year was highest among those aged 26 to 49 (42.7 percent) than among those aged 18 to 25 (36.0 percent) or those aged 50 or older (35.6 percent) (Table A.18B in Appendix A). The percentages of adults with SUDs who had co-occurring SMI in the past year were 12.3 percent for adults aged 26 to 49, 10.5 percent for those aged 50 or older, and 10.4 percent for those aged 18 to 25.

Among adults aged 18 or older in 2014 with past year AMI, the percentage of adults who had a co-occurring SUD in the past year was highest among those aged 18 to 25 (29.3 percent), followed by those aged 26 to 49 (20.8 percent), then by those aged 50 or older (10.3 percent) (Figure 49). Among adults aged 18 or older in 2014 with past year SMI, the percentage of adults who had a past year SUD was highest among those aged 18 to 25 (35.3 percent), followed by those aged 26 to 49 (24.9 percent), then by those aged 50 or older (15.1 percent) (Figure 51).

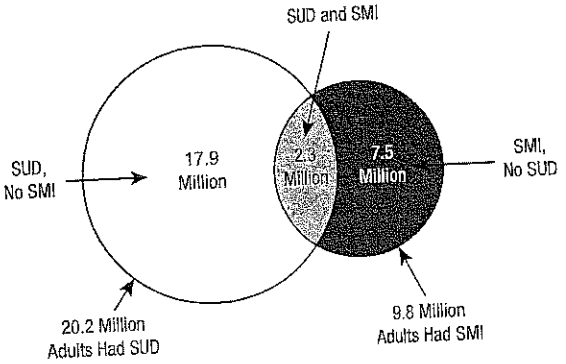
Co-Occurring Mental Illness and Substance Use Disorders among Adults in the General Population

Prior sections described the percentage of adults with mental illness among the subpopulation of adults who had a past year SUD or described the percentage of adults with an SUD among the subpopulation of adults with mental illness. This section presents findings on the percentages of adults who had co-occurring SUDs and mental illness among all adults in the United States. This type of presentation helps to provide further context for discussions of co-occurring disorders. Although the numbers of adults in the population who had co-occurring disorders are the same as presented in previous sections, the percentages presented in this section are based on the total population of adults.

In 2014, the estimate of 7.9 million adults aged 18 or older who had both mental illness and SUDs in the past year (Figure 48) corresponds to 3.3 percent of all adults (Table A.22B in Appendix A). This percentage for 2014 among all adults was similar to the percentages in most years from 2008 to 2013.

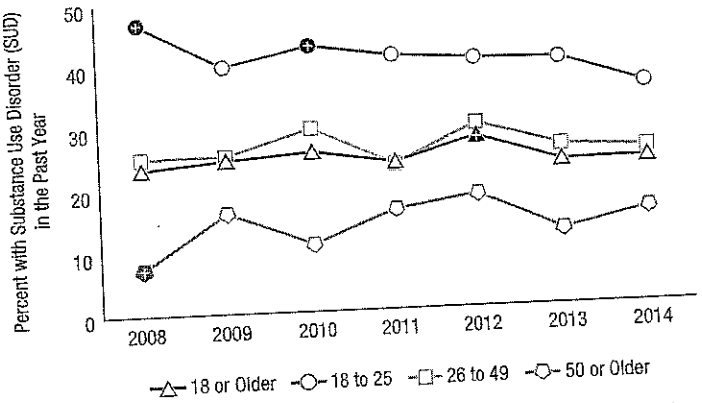
The estimate of 2.3 million adults aged 18 or older in 2014 who had co-occurring SMI and SUDs in the past year (Figure 50) corresponds to 1.0 percent of all adults (Table A.22B). This percentage among all adults in 2014 was similar to the percentages in 2008 to 2013.

Figure 50. Past Year Substance Use Disorders and Serious Mental Illness among Adults Aged 18 or Older: 2014



SMI = serious mental illness; SUD = substance use disorder.

Figure 51. Past Year Substance Use Disorder among Adults Aged 18 or Older with Serious Mental Illness in the Past Year, by Age Group: Percentages, 2008-2014



+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.

Figure 51 Table. Past Year Substance Use Disorder among Adults Aged 18 or Older with Serious Mental Illness in the Past Year, by Age Group: Percentages, 2008-2014

	2008	2009	2010	2011	2012	2013	2014
18 or Older	23.4	24.6	25.6	23.6	27.3+	23.1	23.3
18 to 25	46.8+	39.7	42.7+	40.8	39.9	39.6	35.3
26 to 49	25.2	25.3	29.4	23.3	29.4	25.6	24.9
50 or Older	7.3+	16.1	10.8	16.0	18.0	12.0	15.1

+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.

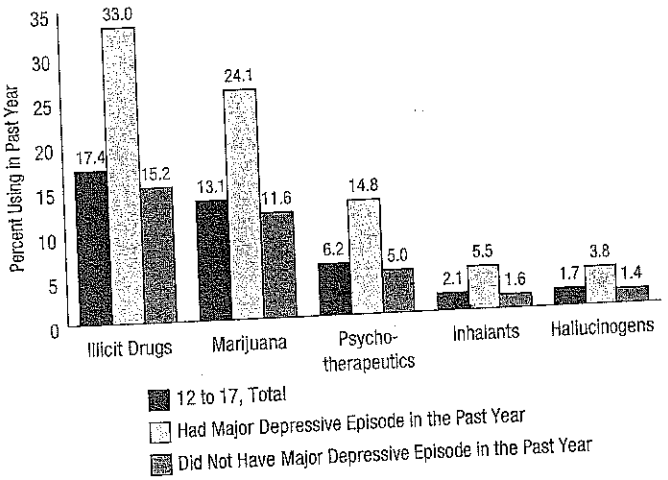
Co-Occurring Mental Health and Substance Use Issues among Adolescents

This section discusses co-occurring MDE and substance use among adolescents aged 12 to 17 in addition to discussing co-occurring MDE and SUDs among adolescents. Specifically, estimates of substance use and SUDs are described among adolescents with an MDE, estimates of MDE are described among those with SUDs, and estimates of co-occurring MDE and SUDs are described among all adolescents.

Substance Use and Substance Use Disorders among Adolescents with Major Depressive Episode

In 2014, the percentage of adolescents aged 12 to 17 who used illicit drugs in the past year was higher among those with a past year MDE than it was among those without a past year MDE (33.0 vs. 15.2 percent) (Figure 52). Youths with a past year MDE in 2014 also were more likely than those without an MDE to be users of marijuana, nonmedical users of psychotherapeutics, users of inhalants, and users of hallucinogens in the past year. (Because estimates of illicit drug use among adolescents that previously were mentioned in this report pertain to use in the past 30 days, percentages for past year illicit drug use measures among all adolescents are shown in Figure 52 as additional points of reference.)

Figure 52. Past Year Illicit Drug Use among Youths Aged 12 to 17, by Past Year Major Depressive Episode: Percentages, 2014



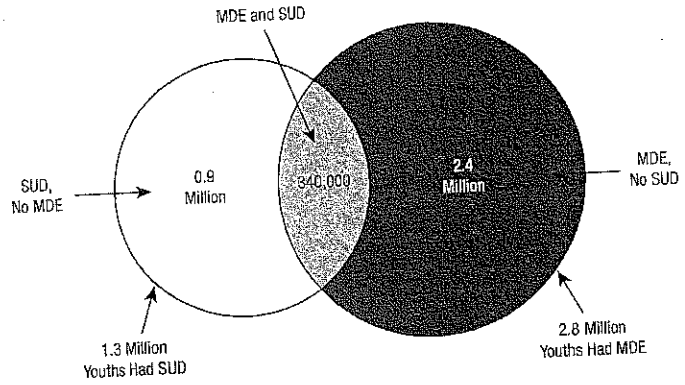
Among adolescents aged 12 to 17 in 2014, 1.6 percent of those with a past year MDE and 1.1 percent of those without a past year MDE were daily cigarette smokers in the past month (Table A.24B in Appendix A). In addition, 1.8 percent of adolescents aged 12 to 17 with a past year MDE and 0.9 percent of those without a past year MDE were heavy alcohol drinkers in the past month.

Among the 2.8 million adolescents aged 12 to 17 in 2014 who had a past year MDE, a total of 340,000 adolescents (12.4 percent) had a past year SUD (Figure 53). In contrast, among adolescents without a past year MDE, 858,000 (4.0 percent) had an SUD in the past year.

Major Depressive Episode among Adolescents with a Substance Use Disorder

An estimated 340,000 adolescents aged 12 to 17 in 2014 had a co-occurring MDE and an SUD in the past year (Figure 53) in 2014. This number of adolescents with a co-occurring MDE and an SUD represents 28.4 percent of the 1.3 million adolescents who had a past year SUD. Among adolescents without a past year SUD, 10.5 percent (2.4 million adolescents) had an MDE in the past year.

Figure 53. Past Year Substance Use Disorders and Major Depressive Episode in the Past Year among Youths Aged 12 to 17: 2014



MDE = major depressive episode; SUD = substance use disorder.
Note: Youth respondents with unknown MDE data were excluded.

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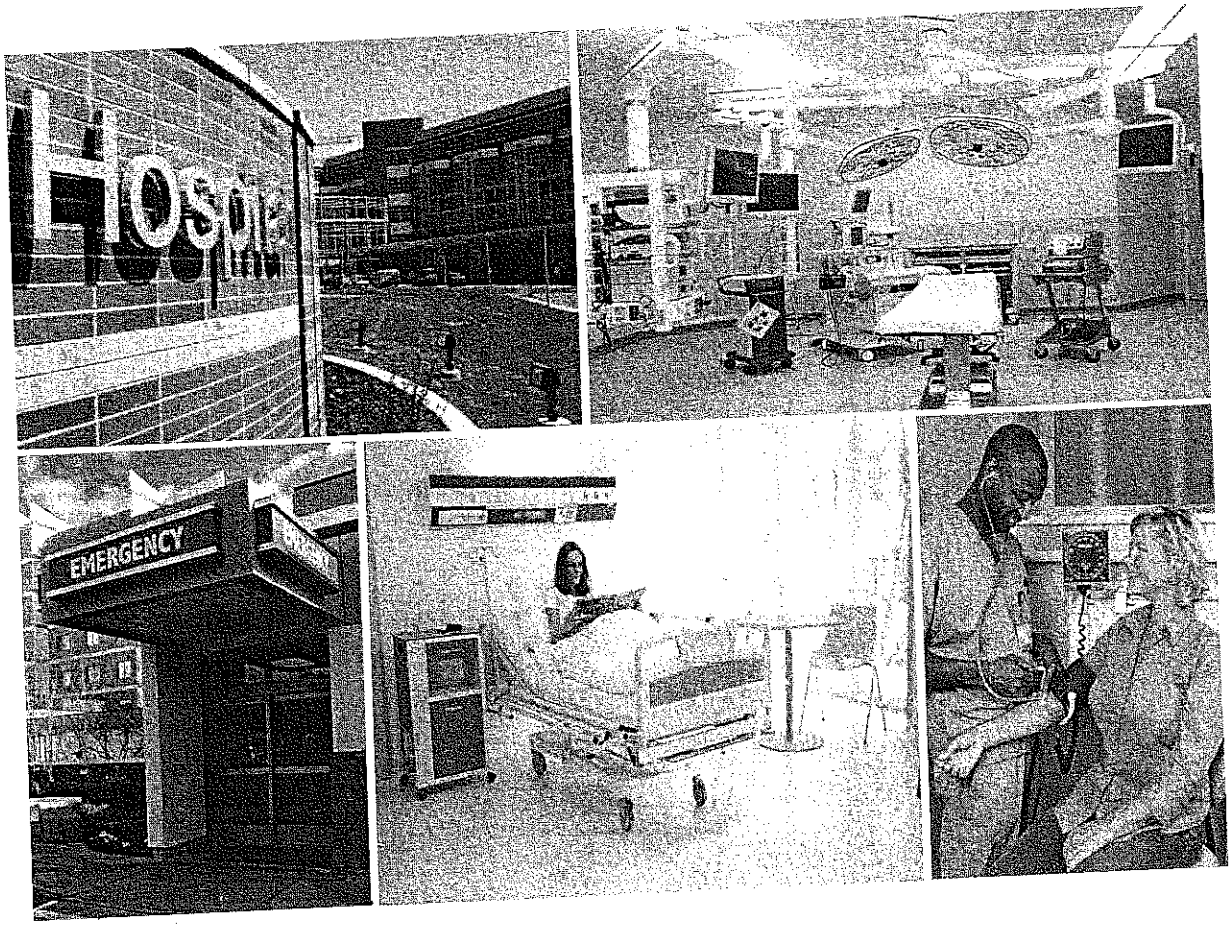
of Public Health

Statewide Health Care Facilities and Services Plan



2014 Supplement

STATEWIDE HEALTH CARE FACILITIES AND SERVICES PLAN

2014 SUPPLEMENT

Connecticut Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06106

February, 2015

DPH

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

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In addition to the Plan's Advisory Body and Subcommittee participants, the following DPH staff contributed to the development of this Plan:

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Carmen Cotto
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Karen Roberts

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LETTER FROM THE COMMISSIONER

Dear Friends of Public Health,

I am pleased to present to you the *Statewide Health Care Facilities and Services Plan 2014 Supplement*. This document aims to align with *Healthy Connecticut 2020* by focusing on implications of the health care environment and availability of and access to health care facilities and services for at-risk and vulnerable populations.

The supplemental plan builds upon the 2012 Plan by updating previous information and discussing how the health care environment has changed in the past two years with the implementation of the Patient Protection and Affordable Care Act. It provides an updated analysis of inpatient bed need, an equitable measure to determine how the state's inpatient acute care hospital beds are distributed and is helpful in identifying areas with unmet need.

The supplemental plan considers multiple determinants of health when examining unmet health care need. This planning effort uses hospital community health needs assessments (CHNAs) to identify geographic areas and population subgroups with potential unmet health care need and, using indices developed from outcomes and health status data, provides a standard for assessing need. Additionally, it presents an overview of current initiatives addressing prevention, reducing health inequities, improving access to primary care and enhancing care coordination.

I thank the many individuals and organizations that participated in this planning process. I encourage you to integrate this document into your organization's or community's ongoing planning activities to improve the health of all Connecticut residents.

Sincerely,

Jewel Mullen, MD, MPH, MPA
Commissioner

CONTENTS

Statewide Health Care Facilities and Services Plan 2014 Supplement

EXECUTIVE SUMMARY

OVERVIEW

The Department of Public Health (DPH) Office of Health Care Access' (OHCA) planning and regulatory activities are intended to increase accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources and provide financial stability and cost containment of health care services. Section 19a-634 of the Connecticut General Statutes (CGS) charges OHCA with the responsibility of developing and maintaining a *Statewide Health Care Facilities and Services Plan (the Plan)*, along with establishing and maintaining an inventory of all Connecticut health care facilities and services and conducting a biennial utilization study.

The supplemental plan, like the 2012 Statewide Health Care Facilities and Services Plan, is intended to be a resource for policymakers and those involved in the CON process. It presents information, policies and projections of need to guide planning for specific health care facilities and services. The primary focus of this supplement is to identify at-risk and vulnerable populations and to uncover areas of unmet health care need. It provides an updated analysis of inpatient bed need, an equitable measure to determine how the state's inpatient acute care hospital beds are distributed and is helpful in identifying areas with unmet need.

The Plan incorporates available health care facilities and services utilization, outcomes and health status data and community health needs assessments (CHNAs) to identify geographic areas and population subgroups with potential unmet health care need. These data serve as a foundation for projecting future health care needs.

KEY ISSUES

The Plan identifies key issues surrounding the delivery of health care in Connecticut:

- Connecticut's health care system landscape continues to transform under the Patient Protection and Affordable Care Act (PPACA). The transformation can be seen in the regulatory arena via Certificate of Need (CON) applications received by OHCA, as providers focus on creating new models of care that bring higher quality at a lower cost, thus delivering greater value in health care.

- Increasingly, Connecticut's hospitals are applying for regulatory approval to become members of larger umbrella corporate health care systems. These affiliations or mergers may be attributed to several factors, including the economic downturn, health care market competition, PPACA requirements and the need to achieve efficiencies in health care administration and delivery.

- Some Connecticut hospitals are pursuing strategies to remain financially viable and independent of large health care systems through the creation of alliances. These alliances seek to enhance purchasing power to extend the economies of scale enjoyed by larger systems and to share best practices and strategies to adapt to the evolving health care environment.

- Based on acute care bed need projections for 2020, Connecticut has an adequate supply of acute care inpatient beds statewide.
- In 2013, the largest proportion of emergency department (ED) visits was among patients with Medicaid (38%).
- From 2009 to 2013, there were almost 8 million visits made to an ED in Connecticut by state residents. Of these visits, one million were for psychiatric, drug or alcohol-related mental disorders
- Of the children visiting the ED for issues relating to behavioral health, nine out of ten were treated for a psychiatric-related disorder.
- The growth of urgent care settings has contributed to some concern that this type of care setting may contribute to fragmentation of care, inadequate follow-up and preventive care, and misdiagnoses, particularly for clinics that are not affiliated with a health care system.
- While Connecticut has an overall favorable health profile compared to the rest of the U.S., the health of Connecticut's residents is not equally distributed across population groups or geographic regions.
- In general, at-risk and vulnerable populations have a higher prevalence of chronic disease than the overall population.
- The Socioeconomic Status Index identifies 20 Connecticut towns as at-risk for unmet health care need.
- Black non-Hispanics and Hispanics were more likely than White non-Hispanics to have a potentially preventable hospitalization, avoidable ED visit or to visit the ED more than ten times within a year.
- One hundred forty Connecticut towns have better health outcomes than the state. Twenty-three of the remaining twenty-nine were urban core or urban periphery towns.
- Nearly all the CHNAs identified chronic disease, overweight, obesity, nutrition and physical activity as overlapping and major health issues regardless of socioeconomic status.
- More than one-half of the assessments identified substance abuse and mental health care as priority health needs in the community.
- A reconvened ED focus group identified the need for the coordination of mental health and substance abuse care.

RECOMMENDATIONS

Recommendations are intended to build upon the efforts and discussions conducted during the initial 2011-2012 planning process and reflect additional discussions held during the planning process for the 2014 supplemental plan.

Behavioral Health

1) Determine the resources available and options and approaches for further exploration of ways that Connecticut's behavioral health service delivery system can be measured to determine capacity as it relates to need and access to care;
2) Develop further understanding of recovery supports and how they relate to the overall care for behavioral health clients across all age groups;
3) Determine the feasibility of and resources available for a future inventory of distinct service levels as opposed to broad categorization of facilities using behavioral health licensure categories;
4) Provide more focus in future plans which specifically discuss the coordination, interrelation, provision or co-location of mental health, primary care and/or oral health services within the various settings and how such interrelationship will benefit the behavioral health patient population.

Acute Care/Ambulatory Surgery

5) Investigate the development of planning regions that best facilitate the ability to assess the availability of and future demand for care, taking into consideration existing hospital service areas;
6) Research, investigate and quantify the use of observation stays in Connecticut hospitals and determine how these data can be standardized in a way that would allow them to be incorporated in the acute care bed need model;
7) With respect to ambulatory surgery standards and guidelines, discuss and consider including backlogs in the service area, ability of physicians to schedule block times, patient throughput at other facilities, the quality of care at other facilities as additional factors for consideration in the next Plan, if such data is available to OHCA to verify and analyze.

Primary Care

8) The DPH Primary Care Office will collect and report real-time health workforce data and will support the analyses necessary to interpret this data to estimate both current and future health workforce needs;[1]
9) Utilize data from Behavioral Risk Factor Surveillance System and/or other surveys which have large enough samples so that results for questions related to health care access may be used for town, city or county level assessment and solutions;
10) Consider assessing/evaluating primary care provided by hospital-affiliated entities (e.g., urgent care centers) and determine if beneficial to patients;

11) Provide additional Plan focus on the provision of mental health and oral health services in primary care settings and assess the interrelation of these services with primary care.
12) Align OHCA planning efforts with SIM Grant activities (e.g., physician data collection, goals and objectives, etc.) and other relevant State planning efforts.

NEXT STEPS

As providers continue to assess their organizations, service array and delivery structures, OHCA's planning efforts will focus on the evolving health care system and available data to determine how best to meet the unmet need of residents in ways that benefit the community and assist providers in transforming to meet those needs. Future OHCA planning activities will include:

- Analyzing health care service specific data by health care systems, utilization and physician referral patterns to determine if there could be logical regionalization of certain services;
- Evaluating patient data and provider revenue patterns to identify shifts in demand for inpatient to outpatient services and between types of services for geographic regions;
- Identifying modalities through which the state may direct and/or assist providers to be more responsive to health care needs of communities;
- Analyzing all payer claims data to identify availability of and access to health care services, utilization patterns and the impact of expanded health insurance coverage through the PPACA.
- Monitoring the various settings where health care is now being delivered as additional data sources become available to OHCA.
- Reviewing CON statutes and regulations to ensure they are responsive to the evolving health care environment and make recommendations to better align the process with health care reform.
- Providing consumers with access to all available data.

Additionally, as more information becomes available to OHCA, the next plan will attempt to:

- Address the impact that technology may have on the demand, capacity or need for health care services;
- Facilitate communication between appropriate state agencies concerning innovations or changes that may affect future health planning.

DATA AVAILABILITY AND CHALLENGES

- Data-related challenges and gaps are important considerations when planning for appropriate allocation of health care facilities and services. The success of such planning is dependent upon the availability of comprehensive data spanning numerous service delivery settings. Discussion of data gaps and efforts to resolve them will help to build the foundation for better planning and greater understanding of the evolving health care system.

INTRODUCTION

LEGAL MANDATE AND PURPOSE

Section 19a-634 of the Connecticut General Statutes (see Appendix A) requires the Department of Public Health (DPH) Office of Health Care Access (OHCA) to conduct an annual statewide health care facility utilization study, establish and maintain an inventory of all Connecticut health care facilities, and services and certain equipment and to develop and maintain a Statewide Health Care Facilities and Services Plan. The Plan is intended to be a blueprint for health care delivery in Connecticut, serving as a resource guide for planning for specific health care facilities and services. In 2012, OHCA issued its first Statewide Health Care Facilities and Services Plan (Plan). This publication is a supplement to the 2012 Plan. It includes an updated discussion of the current health care environment in Connecticut and adds a "population health" and "health equity" perspective, focusing on those who have experienced social or economic disadvantages. While the 2012 Plan focused on standards, guidelines and methodologies, which will be codified into regulation for use in the Certificate of Need (CON) review process, this Plan focuses on the unmet health care need of vulnerable and at-risk populations and the alignment of public health and health care initiatives that aim to address these needs. The 2014 planning process also involved updating the 2012 inventory of health care facilities, services and equipment, available at http://www.ct.gov/dph/cwp/view.asp?a=3902&q=557564.

RELATIONSHIP TO THE CONNECTICUT STATE HEALTH ASSESSMENT AND IMPROVEMENT PLAN

Section 19a-7 of the Connecticut General Statutes (see Appendix B) establishes DPH as the "lead agency for public health planning," and charges the department with "assist[ing] communities in the development of collaborative health planning activities which address public health issues on a regional basis or which respond to public health needs having state-wide significance." DPH is required to prepare a multiyear assessment of the health of Connecticut's population and the availability of health facilities and a plan that includes: (1) policy recommendations regarding allocation of resources; (2) public health priorities; (3) quantitative goals and objectives with respect to the appropriate supply, distribution and organization of public health resources; and (4) evaluation of the implications of new technology for the organization, delivery and equitable distribution of services.

Healthy Connecticut 2020, available at http://www.ct.gov/dph/hct2020, includes the State Health Assessment (SHA) and the State Health Improvement Plan (SHIP), which were developed in 2013-2014 to identify priority public health needs and facilitate public health planning for residents of Connecticut.

Key findings from the SHA include:

- Chronic diseases and injuries are the leading causes of premature death and morbidity;
- Racial/ethnic minority groups suffer from many conditions at disproportionately higher rates;
- Specific age groups such as youth/young adults and older adults are more at risk for certain conditions;
- Unhealthy behaviors such as binge drinking and prescription drug misuse have increased over the last decade; and
- HIV, smoking and teen pregnancy rates have declined over the last decade.

A National Survey of Care for Persons With Co-occurring Mental and Substance Use Disorders

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Objective: **The delivery of appropriate treatment to persons who have mental and substance use disorders is of increasing concern to clinicians, administrators, and policy makers. This study sought to describe use of appropriate mental health and comprehensive substance abuse care among adults in the United States with probable co-occurring disorders.** *Methods:* **Data from the Healthcare for Communities survey, which is based on a national household sample studied in 1997 and 1998, were used to identify individuals who had probable co-occurring mental and substance use disorders. The sociodemographic and clinical characteristics of these individuals and their use of services were recorded. Logistic regression analysis was used to identify variables associated with receipt of mental health and substance abuse treatment and with receipt of appropriate treatment.** *Results:* **Estimates for the U.S. adult population based on the weighted survey data indicated that 3 percent of the population had co-occurring disorders. Seventy-two percent did not receive any specialty mental health or substance abuse treatment in the previous 12 months; only 8 percent received both specialty mental health care and specialty substance abuse treatment. Only 23 percent received appropriate mental health care, and 9 percent received supplemental substance abuse treatment. Perceived need for treatment was strongly associated with receipt of any mental health care and with receipt of appropriate care.** *Conclusions:* **Despite the availability of effective treatments, most individuals who had co-occurring mental health and substance use problems were not receiving effective treatment. Efforts to improve the care provided to persons who have co-occurring disorders should focus on strategies that increase the delivery of effective treatment. (*Psychiatric Services* 52:1062–1068, 2001)**

The co-occurrence of mental and substance use disorders, or dual diagnosis, is highly prevalent, and the delivery of appropriate treatment to persons who have dual diagnoses is of increasing concern to clinicians, administrators, and policy makers (1–3). Epidemiologic data suggest that of individuals who have a current addictive disorder, almost half have a co-occurring mental disorder; among individuals who have a current mental disorder, between 15 percent and 40 percent have a co-occurring addictive disorder (4,5). Although some of these co-occurring disorders are organic brain syndromes caused by the effects of substance use, the temporal relationships between the disorders and the high proportion of primary lifetime conditions suggest that most of them are primary independent disorders—that is, one did not cause the other (4). This independence implies that most people who have co-occurring disorders will need treatment for both their mental illness and their substance use problems.

Although persons who have dual diagnoses use mental health and substance abuse treatment services more frequently than persons who have only one disorder, most report having received no mental health or substance abuse treatment in the previous year (4–6). Among those who seek treatment, the outcomes of substance abuse and mental health treatment are typically worse (7–17)—and treatment costs higher (18–21)—than among persons who have only one disorder.

There are multiple reasons for poorer treatment outcomes. In addition to the inherent difficulty of treating two problems rather than one, a variety of institutional, attitudinal, and financial factors have been posited as affecting the clinical processes of care, which in turn affect outcomes (22–25). Substance abuse and mental health treatment programs are funded and managed separately, and coordination of treatment regimens across established bureaucracies has been difficult. The two treatment systems deal with clients in different ways that may conflict or may fail for clients who have

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multiple problems. Because resources in the public treatment system are scarce, each system tries to exclude individuals who are likely to require more resources, to fail in treatment, or to cause disruption to programs. Thus it has been difficult to respond to the needs of clients with dual diagnoses.

These systemic problems likely influence outcomes by affecting the delivery of appropriate care. However, no studies have used a nationally representative sample to assess the delivery of care to individuals who have co-occurring disorders. It is not known what individual-level factors—such as demographic characteristics, perceived need for treatment, and type of health insurance—affect access to appropriate care or what type of care individuals who have co-occurring disorders receive. Current guidelines recommend that services for individuals who have co-occurring disorders be available regardless of the setting in which the individual enters the service system (26,27). The proportion of individuals who receive parallel or integrated care or who receive care for only one disorder is not known.

This paper describes care among U.S. adults with probable co-occurring disorders. We examined the sociodemographic characteristics, health status, and perceived needs of individuals with co-occurring disorders, stratified by type of mental health disorder. We also looked at patterns of service use, the appropriateness of the mental health care these individuals are receiving, and the comprehensiveness of the substance abuse treatment they are receiving. Finally, we determined factors that predict access to care and the delivery of appropriate mental health or comprehensive substance abuse care.

Methods

Design

We used data drawn from the Healthcare for Communities (HCC) survey. The HCC survey studied a selected subset of adults who participated in the Community Tracking Study (CTS), a nationally representative study of the U.S. civilian, noninstitutionalized population (28). Some demographic data for our analyses came from the parent CTS survey. The CTS included both a national sample and a cluster sample of 60 randomly selected U.S. communities and was conducted in 1996 and 1997. The HCC survey was conducted from October 1997 through December 1998 and consisted of a random sample of 9,585 CTS respondents. The respondents were interviewed by telephone; the average duration of the telephone interviews was 34 minutes.

To provide more precise estimates of the need for and use of behavioral health care, the HCC survey oversampled individuals who had low incomes, had high levels of psychological distress, or used specialty mental health care, as indicated by their responses to the CTS survey. The design of the HCC survey has been described previously (29). We weighted the data so that they would be representative of the U.S. population. We used CTS data to adjust for the probability of selection, nonresponse, and the number of households in the HCC survey that did not have a telephone.

Measures

Independent variables. The short-form Composite International Diagnostic Interview (CIDI) (30) was used to assess the 12-month prevalence of major depression, dysthymia, or generalized anxiety disorder and lifetime mania on the basis of *DSM-III-R* criteria. Screening items from the CIDI, supplemented by additional items from the full interview, were used to assess for probable panic disorder (31). To reduce the potential number of false-positive responses, we required the presence of a limitation in social or role functioning by using items from the Short Form Health Questionnaire (SF-12) and the Sickness Impact Profile (32). The presence of chronic psychosis was assessed by asking respondents whether they had been hospitalized because of psychotic symptoms or had ever been told that they had schizophrenia or schizoaffective disorder. The Alcohol Use Disorders Identification Test (33) and items adapted from the CIDI were used to assess the presence of substance abuse or dependence within the previous 12 months.

Physical and mental health functioning was assessed with use of the SF-12 mental and physical subscales (34) as well as a count of the number of chronic medical conditions. Type of health insurance was categorized as no insurance, public insurance (Medicaid, Medicare, or both), and private insurance. We also asked the respondents whether they had been on probation or parole or in prison during the previous 12 months.

Outcome variables. Use of health services during the previous 12 months was determined by self-report and was categorized as either primary care with a behavioral health care component or specialty behavioral health care. Primary care with a behavioral health care component consisted of a clinician's suggesting that the respondent reduce his or her use of alcohol or drugs, referring the respondent to specialty behavioral health care, suggesting medication for a substance use or mental health problem, or counseling the respondent for at least five minutes about a mental health or substance use problem. Specialty behavioral health care distinguished between visits for mental health care and visits for substance abuse treatment. Mental health visits included visits to a psychiatrist, a psychologist, a social worker, a psychiatric nurse, or a counselor for an emotional or mental health problem; substance abuse visits included inpatient and outpatient visits for a substance use problem and excluded participation in self-help groups, such as Alcoholics Anonymous.

We defined integrated treatment as receipt of both mental health care and substance abuse care from one provider, which was determined by asking respondents whether they received treatment for both a mental health problem and a substance use problem at a single visit. Parallel treatment was defined as receipt of mental health care and substance abuse care from different providers during a 12-month period.

For persons who had a probable disorder, appropriate care for a bipolar or psychotic disorder was defined as use of any antipsychotic or mood stabilizer during the previous year. Appropriate care for a depressive or anxiety disorder was defined as receipt of appropriate counseling or use of psychotropic medication during the previous year. For counseling to be considered ap-

Table 1

Estimated percentage of adults with co-occurring mental and substance use disorders in the U.S. population in 1998 who had the indicated characteristic, by psychiatric diagnosis

Characteristic	Probable diagnosis			
	Depressive or anxiety disorder (N=180)		Bipolar or psychotic disorder (N=96)	
	% or mean	SE[1]	% or mean	SE
Age (mean years)	38	1.7	35	2.8
Sex (%)				
Female	31	4.9	30	6.5
Male	69	4.9	70	6.5
Race				
White	79	4.5	56	7.6
Black	10	2.7	35	7.6
Hispanic	11	4.0	9	4.0
Family income (mean, in thousands of dollars)	47	10.6	32	8.0
Employment status (%)				
Employed	91	2.5	78	5.0
Unemployed	9	2.5	22	5.0
Years of education (mean and SD)	13	.4	12	.2
On probation or parole or in prison during previous 12 months (%)	10	2.6	14	4.7
Health insurance (%)				
None	22	4.0	34	7.3
Public	19	4.5	22	6.6
Private	59	5.0	44	6.9
Number of chronic medical conditions (mean)[2]	2	.2	2	.3
Physical functioning score on SF-12 (mean) [3]	45	.5	44	.7
Emotional functioning score on SF-12 (mean) [3]	41	.7	44	.8
Perceived need for mental health care (%)				
Yes	51	5.4	55	7.5
No	49	5.4	45	7.5
Perceived need for substance abuse care (%)				
Yes	23	3.6	22	5.2
No	77	3.6	78	5.2

[1] Based on a weighted sample size

[2] Range, 0 to 11

[3] Possible scores range from 0 to 100, with higher scores indicating better health.

propriate, the respondent had to have had at least four visits in the previous year, but information on the type of counseling was not recorded. Appropriate medication for a depressive or anxiety disorder was defined as use of an efficacious antidepressant or antianxiety medication for at least two months at a dosage exceeding the minimum recommended dosage, as established by national guidelines (35,36). The relationship between dosage and effectiveness is less clear for antipsychotics and mood stabilizers, and varies according to age, diagnosis, and adverse effects. Thus although respondents were asked about dosages of these medications, the data were not analyzed.

For respondents who had multiple psychiatric disorders, we assessed the appropriateness of care for the most significant disorder on the basis of a hierarchy in which bipolar or psychotic disorder was ranked highest, major depression second, dysthymia third, panic disorder fourth, and generalized anxiety disorder fifth.

We defined comprehensive care for a substance use disorder as consisting of inpatient or outpatient substance abuse treatment that included a physical examination, a mental health evaluation, or job or relationship counseling. The management of medical and mental health problems and the provision of appropriate treatment improve the overall health and functioning of persons who are in recovery (37–39), and the provision of job or relationship counseling is likely to be an indicator of programs that provide comprehensive services. The number of services provided is related to treatment retention and to a variety of outcomes (40,41).

Statistical analyses

We used SUDAAN software (42) to estimate individual-level characteristics and to fit multivariate logistic regression models to the data. All estimates were weighted, and standard errors of the multivariate logistic regression estimates were adjusted to account for the complex design of the sample and clustering of individuals within communities.

Separate multiple logistic regressions were used to predict the four dependent variables—receipt of any specialty mental health care, receipt of any substance abuse care, receipt of any appropriate mental health treatment, and receipt of any comprehensive substance abuse treatment. We used the Aday and Andersen (43) model of health services use to select independent variables for inclusion in the models. Predictor variables were selected from each of the three components of this model—predisposing characteristics, enabling resources, and need for treatment—and were included in the model if they were bivariately associated with the dependent variable at a significance level of less than .20.

Because the number of predictors based on the Aday and Andersen model is large relative to the number of observations available for analysis, we were concerned about overfitting in our multivariate logistic regression analyses. To address this concern, we selected a final set of variables for each logistic regression on the basis of a backwards-elimination variable-selection procedure in which a logistic regression coefficient was retained in the final model only if it was significant at $p<.10$. There was no requirement for any specific variable to be included in the model.

Results

A total of 180 respondents (2 percent) had a probable 12-month depressive or anxiety disorder and a substance use disorder, and 96 respondents (1 percent) had a bipolar or psychotic disorder and a substance use disorder. Table 1 presents the 1998 survey data for respondents with dual diagnoses weighted to reflect the U.S. population, stratified by type of mental illness.

Table 2 presents estimates based on weighted survey data of the types of treatment received by adults with co-occurring mental and substance use disorders in the United States. The estimates indicate that 17 percent received alcohol, drug, or mental health treatment only from a primary care provider, and 23 percent received some treatment from a primary care provider and some from a specialty provider. Seventy-two percent did not receive any specialty mental health or substance abuse treatment in the previous 12 months, and 8 percent received both mental health and substance abuse treatment, either parallel or integrated. Among persons with a probable depressive or anxiety disorder, 32 percent received appropriate treatment; of those with a bipolar or psychotic disorder, 19 percent received an appropriate medication.

Estimates for persons in substance abuse treatment showed that 4 percent received a physical examination, 7 percent received a mental health evaluation or treatment, 2 percent received employment counseling, and 5 percent received some form of relationship or family counseling.

The associations between specific predictor variables and receipt of any mental health care or of any appropriate mental health care for individuals who had a probable co-occurring disorder are shown in Table 3. As we expected, women were more likely than men to have received any mental health care or appropriate mental health care. Having either public or private health insurance was also associated with receipt of mental health care; those with either type of insurance were significantly more likely to receive care than those with no insurance.

Although individuals who had a probable bipolar or psychotic disorder were twice as likely to have received any mental health care as those who had a probable depressive or anxiety disorder, they were less likely to have received appropriate mental health care. Each additional chronic medical condition increased the expected odds of receipt of any appropriate mental health care by 1.2. Perceived need for mental health care was also associated with receipt of care and with receipt of appropriate mental health treatment. Age, race, employment status, income, number of years of education, and physical and emotional functioning were not associated with the receipt of any mental health care or with the re-

Table 2

Estimates of treatment received in 1998 by U.S. adults with co-occurring mental and substance use disorders

Characteristic	%	SE[1]
Received alcohol, drug, or mental health treatment from a primary care provider	40	4.1
Treatment only from a primary care provider	17	3.1
Some treatment from a primary care provider and some from a specialty provider	23	3.6
Use of behavioral health care	72	3.5
No use	16	2.6
Mental health care only	4	1.4
Substance abuse care only	4	1.0
Parallel treatment	4	1.5
Integrated treatment	23	3.1
Received appropriate mental health care	9	2.1
Received comprehensive substance abuse care	4	1.3
Physical examination	7	1.9
Mental health evaluation or treatment	2	1.1
Job counseling	5	1.4
Relationship or family counseling		

[1] Based on weighted sample size

Table 3

Predictors of receipt of any mental health care or appropriate mental health care among adults with co-occurring mental and substance use disorders

Variable	Any mental health care (N=274)		Any appropriate mental health care (N=254)	
	Odds ratio	95% CI	Odds ratio	95% CI
Sex	1.0	—	1.0	—
Male	2.7	1.2–6.1	2.7	1.1–6.6
Female				
Probable diagnosis	1.0	—	1.0	—
Depressive or anxiety disorder	2.0	.96–4.3	.21	.09–.54
Bipolar or psychotic disorder				
Type of health insurance	1.0	—	—	—
None	8.2	2.5–27.8	—	—
Public	3.2	1.1–9.3	—	—
Private				
On probation or parole or in prison during previous 12 months	1.0	—	—	—
No	3.8	1.1–12.7	—	—
Yes				
Number of chronic medical conditions	—	—	1.2	1.0–1.4
Perceived need for mental health treatment	1.0	—	1.0	—
No	10.9	4.5–26.1	2.9	1.3–6.3
Yes				

Table 4

Predictors of receipt of any substance abuse care or comprehensive substance abuse care among 275 adults with co-occurring mental and substance use disorders

Variable	Any substance abuse care		Any comprehensive substance abuse care	
	Odds ratio	95% CI	Odds ratio	95% CI
Age	—	—	.97	.94–1.0
On probation or parole or in prison during previous 12 months				
No	1.0	—	1.0	—
Yes	4.1	1.3–13.0	3.6	1.1–12.3
Perceived need for mental health treatment				
No	—	—	1.0	—
Yes	—	—	3.2	.77–13.3
Perceived need for substance abuse treatment				
No	1.0	—	1.0	—
Yes	22.5	7.2–70.4	23	6.5–81.4

ceipt of appropriate mental health care.

Table 4 shows the effects of specific predictor variables on receipt of any substance abuse care or any comprehensive substance abuse care among individuals who had a probable co-occurring disorder. Similar to the results shown in Table 3, most predictor variables that we screened for inclusion were not associated with the dependent variables and thus were not included in the final models. Having been on probation or parole or in prison in the previous 12 months was positively associated with receipt of any substance abuse care and with receipt of comprehensive care. Perceived need for substance abuse care was also highly associated with receipt of any care and with receipt of comprehensive treatment. The type of co-occurring disorder was not associated with receipt of any care or of comprehensive care, and neither was sex, race, type of insurance, employment status, income, number of years of education, co-occurrence of medical conditions, or physical or mental health functioning.

Discussion

This study had several limitations. We identified respondents who had probable disorders on the basis of self-reported screening variables and did not confirm the diagnoses with diagnostic interviews. We relied on self-report to identify individuals who had substance use problems. Self-report may result in underestimation of the true prevalence, especially in the case of persons who are using illicit drugs. In addition, the HCC survey is based on a household sample. Many individuals who have severe mental illness and who abuse substances are homeless (44–46) or institutionalized (5) and thus would likely have been excluded from the survey.

Our measures of service use and treatment were also limited. Our definitions of service use and appropriate treatment were lenient, and our clinical measures of treatment lacked detail. For individuals who had a probable depressive or anxiety disorder, appropriate mental health treatment consisted of at least four visits during which counseling or appropriate medication at therapeutic dosages was provided; for persons who had a bipolar or psychotic disorder, such treatment consisted of an appropriate medication at any dose. We were unable to determine the content of the counseling visit or whether the counseling was effective. We were also unable to assess whether therapeutic dosages of medication were provided to persons who had probable bipolar or psychotic disorders. Some of the individuals whom we categorized as having received appropriate treatment thus may not in fact have received such treatment. Our measures of comprehensive substance abuse treatment were also broad and consisted of any treatment that included a physical examination, a mental health evaluation or treatment, or job or family counseling. We believe that these are indicators of good-quality care, but we did not evaluate the quality of care directly.

Several million Americans suffer from co-occurring mental health and substance use disorders (3). Our data show that the majority of those in our study had received no mental health or substance abuse treatment in the previous 12 months, confirming the results of earlier studies (4,5). This lack of treatment included both specialty visits and visits to a primary care provider during which behavioral health problems were addressed. In addition, many individuals did not receive care that was consistent with current treatment recommendations. Among the patients who had a probable co-occurring disorder, fewer than a third received appropriate mental health treatment, and only 9 percent received any supplemental substance abuse services. Despite the recommendation that individuals who have co-occurring disorders receive treatment for both their mental health and substance use problems, only 8 percent received either integrated or parallel treatment.

Receipt of mental health care was particularly uncommon among men and among persons who had no health insurance. Among the general population, health insurance status and gender are both important predictors of the use of health care services (47,48). The men in our sample were also less likely to have received appropriate mental health care.

Persons who had a probable bipolar or psychotic disorder were much less likely to have received appropriate mental health treatment than those who had a probable depressive or anxiety disorder. This finding may be related to the introduction of new medications for depression and anxiety that make it easier to treat depressive and anxiety disorders or may have been because our screening instruments captured a number of individuals who did not have a psychotic or bipolar disorder.

Perceived need for treatment was a strong predictor of receipt of mental health and substance abuse care as

well as appropriate mental health treatment and comprehensive substance abuse treatment. Although it is possible that a person who receives treatment becomes more aware of his or her need for care, the strong relationship we found suggests that public programs to increase recognition of the need for mental health or substance abuse treatment may be an important strategy for increasing access to effective care. Public education programs may also help to decrease the stigma associated with mental illness (49). Having been on probation or parole or in prison during the previous year was also associated with receipt of any substance abuse treatment and with receipt of comprehensive substance abuse treatment. This finding suggests that the criminal justice system may facilitate access to substance abuse treatment for individuals who have co-occurring disorders.

The low levels of treatment use are of particular concern because of recent studies suggesting that treatment improves a variety of outcomes. Effective treatments exist for depressive, anxiety, and psychotic disorders and have been recommended through national treatment guidelines (35,50–53). Some evidence from clinical trials suggests that treatment of depressive and anxiety disorders among substance abusers is also effective (54–59). Studies suggest that for individuals who have chronic or severe mental illness, integrated rather than parallel treatment programs are superior (60).

At a minimum, most experts agree that individuals who have co-occurring disorders should be receiving care for both their mental health and substance use problems (27). Although there is less consensus about what constitutes effective substance abuse treatment, many studies have shown that the management of medical and mental health care problems and the provision of appropriate treatment improve the overall health and functioning of people who are receiving substance abuse treatment (37–39). In addition, the number of services provided is related to treatment retention and to a variety of other outcomes (40,41) and is an indicator of good-quality substance abuse treatment.

Conclusions

Despite the availability of effective treatments and treatment models for both mental illness and substance abuse, most persons who have co-occurring disorders are not receiving care. Many of those who do receive care are not receiving effective care. Our findings are particularly worrisome given the broad definitions of appropriate and comprehensive care we used and may explain why individuals with co-occurring disorders have poor treatment outcomes.

Clinicians, administrators, and policy makers can use these results in several ways. Clinicians can recognize that they may not be providing appropriate care and can review their practice patterns to determine whether they can identify individuals with co-occurring disorders who may benefit from more effective treatment. Administrators can address the paucity of substance abuse services provided in mental health treatment programs (61) and the lack of mental health services provided in substance abuse treatment programs (62,63). Policy makers can address the lack of funding for integrated treatment programs for individuals who have serious mental illness and substance use problems. Efforts to improve the quality of care provided to people who have co-occurring disorders should focus on strategies that improve the delivery of effective treatments. ♦

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FOR-PROFIT

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

plicant:
nancial Worksheet (A)

LINE	Total Entity:	(1) FY Actual Results	(2) FY Projected W/out CON	(3) FY Projected Incremental	(4) FY Projected With CON	(5) FY Projected W/out CON	(6) FY Projected Incremental	(7) FY Projected With CON	(8) FY Projected W/out CON	(9) FY Projected Incremental	(10) FY Projected With CON	(11) FY Projected W/out CON	(12) FY Projected Incremental	(13) FY Projected With CON
	Description													
A.	OPERATING REVENUE	$3,479,836	$3,653,827	$278,195	$3,932,022	$3,836,519	$347,744	$4,184,262	$3,836,519	$417,292	$4,253,811	$3,836,519	$556,390	$4,392,908
1	Total Gross Patient Revenue				$0			$0			$0			$0
2	Less: Allowances				$0			$0			$0			$0
3	Less: Charity Care				$0			$0			$0			$0
4	Less: Other Deductions	$3,479,836	$3,653,827	$278,195	$3,932,022	$3,836,519	$347,744	$4,184,262	$3,836,519	$417,292	$4,253,811	$3,836,519	$556,390	$4,392,908
	Net Patient Service Revenue				$0			$0			$0			$0
5	Medicare	$2,586,092	$2,650,744	$278,195	$2,928,939	$2,783,281	$347,744	$3,131,025	$2,783,281	$417,292	$3,200,573	$2,783,281	$556,390	$2,783,281
6	Medicaid				$0			$0			$0			$0
7	CHAMPUS & TriCare				$0			$0			$0			$0
8	Other	$2,586,092	$2,650,744	$278,195	$2,928,939	$2,783,281	$347,744	$3,131,025	$2,783,281	$417,292	$3,200,573	$2,783,281	$556,390	$2,783,281
	Total Government				$0			$0			$0			$0
9	Commercial Insurers				$0			$0			$0			$0
10	Uninsured				$0			$0			$0			$0
11	Self Pay				$0			$0			$0			$0
12	Workers Compensation				$893,744			$0			$0			$0
13	Other	$893,744	$893,744		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Non-Government	$893,744	$893,744	$0	$893,744									
	Net Patient Service Revenue[a] (Government+Non-Government)	$3,479,836	$3,544,488	$278,195	$3,822,683	$2,783,281	$347,744	$3,131,025	$2,783,281	$417,292	$3,200,573	$2,783,281	$556,390	$3,339,671
14	Less: Provision for Bad Debts				$0			$0			$0			$0
	Net Patient Service Revenue less provision for bad debts	$3,479,836	$3,653,827	$278,195	$3,932,022	$3,836,519	$347,744	$4,184,262	$3,836,519	$417,292	$4,253,811	$3,836,519	$556,390	$4,392,908
15	Other Operating Revenue				$0			$0			$0			$0
17	Net Assets Released from Restrictions				$0			$0			$0			$0
	TOTAL OPERATING REVENUE	$3,479,836	$3,653,827	$278,195	$3,932,022	$3,836,519	$347,744	$4,184,262	$3,836,519	$417,292	$4,253,811	$3,836,519	$556,390	$4,392,908
B.	OPERATING EXPENSES	$1,776,125	$1,953,737		$1,953,737	$1,953,737		$1,953,737	$1,953,737		$1,953,737	$1,953,737		$1,953,737
1	Salaries and Wages				$0			$0	$0		$0	$0		$0
2	Fringe Benefits				$0			$0	$0		$0	$0		$0
3	Physicians Fees	$161,075	$161,075		$161,075	$161,075		$161,075	$161,075		$161,075	$161,075		$161,075
4	Supplies and Drugs	$302,598			$0			$0	$0		$0	$0		$0
5	Depreciation and Amortization				$0			$0	$0		$0	$0		$0
6	Provision for Bad Debts-Other[b]		$0		$0			$0	$0		$0	$0		$0
7	Interest Expense	$22,523	$32,010		$32,010	$32,010		$32,010	$32,010		$32,010	$32,010		$32,010
8	Malpractice Insurance Cost	$32,010	$228,587		$228,587	$228,587		$228,587	$228,587		$228,587	$228,587		$228,587
9	Lease Expense	$296,312	$1,067,010		$1,067,010	$1,067,010		$1,067,010	$1,067,010		$1,067,010	$1,067,010		$1,067,010
10	Other Operating Expenses	$1,067,010	$3,442,418	$0	$3,442,418	$3,442,418	$0	$3,442,418	$3,442,418	$0	$3,442,418	$3,442,418	$0	$3,442,418
	TOTAL OPERATING EXPENSES	$3,657,652												
	INCOME/(LOSS) FROM OPERATIONS	($177,816)	$211,409	$278,195	$489,604	$394,101	$347,744	$741,844	$394,101	$417,292	$811,393	$394,101	$556,390	$950,490
	NON-OPERATING REVENUE				$0			$0			$0			$0
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	($177,816)	$211,409	$278,195	$489,604	$394,101	$347,744	$741,844	$394,101	$417,292	$811,393	$394,101	$556,390	$950,490
	Principal Payments				$0			$0			$0			$0

C. PROFITABILITY SUMMARY

FOR-PROFIT

Applicant:

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY Actual Results	(2) FY Projected W/out CON	(3) FY Projected Incremental	(4) FY Projected With CON	(5) FY Projected W/out CON	(6) FY Projected Incremental	(7) FY Projected With CON	(8) FY Projected W/out CON	(9) FY Projected Incremental	(10) FY Projected With CON	(11) FY Projected W/out CON	(12) FY Projected Incremental	(13) FY Projected With CON
	Description													
1	Hospital Operating Margin	-5.1%	5.8%	100.0%	12.5%	10.3%	100.0%	17.7%	10.3%	100.0%	19.1%	10.3%	100.0%	21.6%
2	Hospital Non Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	-5.1%	5.8%	100.0%	12.5%	10.3%	100.0%	17.7%	10.3%	100.0%	19.1%	10.3%	100.0%	21.6%
D.	FTEs				0			0			0			0
E.	VOLUME STATISTICS[c]													
1	Inpatient Discharges	0			0			0			0			0
2	Outpatient Visits	44,200	46,410	4,420	50,830	48,731	5,525	54,256	48,731	6,630	55,361	48,731	8,840	57,571
	TOTAL VOLUME	44,200	46,410	4,420	50,830	48,731	5,525	54,256	48,731	6,630	55,361	48,731	8,840	57,571

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]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.

ANNCO CONSULTING LLC, CERTIFIED PUBLIC ACCOUNTANT
4634 WHITE PLAINS ROAD
BRONX, NY 10470
Phone: (718) 882-7500
Fax: (718) 708-4157
INFO@ANNCOCONSULTING.COM

May 11, 2016

NEW ERA REHABILITATION CENTER INC.
3715 MAIN STREET
BRIDGEPORT, CT 06606

Dear Sir,

I have prepared the 2015 Form 1120S for NEW ERA REHABILITATION CENTER INC. based on the information you provided. The return has been successfully e-filed and a copy is enclosed for NEW ERA REHABILITATION CENTER INC.'s records.

NEW ERA REHABILITATION CENTER INC.'s 2015 federal taxes have been paid in full.

I have also prepared the 2015 Connecticut 1065/1120SI tax return based on the information you provided. The 2015 return for NEW ERA REHABILITATION CENTER INC. has been successfully e-filed and a copy is enclosed for NEW ERA REHABILITATION CENTER INC.'s records.

The 2015 Connecticut taxes have been paid in full.

If you have any questions about the return(s) or about NEW ERA REHABILITATION CENTER INC.'s tax situation during the year, please do not hesitate to call me at (718) 882-7500. I appreciate this opportunity to serve you.

Sincerely,

ANNCO CONSULTING LLC, CERTIFIED PUBLIC ACCOUNTANT

Federal
Tax Return

NEW ERA REHABILITATION CENTER INC.

2015

ANNCO CONSULTING LLC, CERTIFIED PUBLIC ACCOUNTANT
4634 WHITE PLAINS ROAD
BRONX, NY 10470
Phone: (718) 882-7500
Fax: (718) 708-4157
INFO@ANNCOCONSULTING.COM

Form **1120S**

Department of the Treasury
Internal Revenue Service

U.S. Income Tax Return for an S Corporation

▶ Do not file this form unless the corporation has filed or is attaching Form 2553 to elect to be an S corporation.

▶ Information about Form 1120S and its separate instructions is at www.irs.gov/form1120s.

OMB No. 1545-0123

2015

For calendar year 2015 or tax year beginning , ending

A S election effective date: 3/2/2002	TYPE OR PRINT	Name: NEW ERA REHABILITATION CENTER INC.	D Employer identification number: 02-0596949
B Business activity code number (see instructions): 621498		Number, street, and room or suite no. If a P.O. box, see instructions.: 3715 MAIN STREET	E Date incorporated: 3/2/2002
C Check if Sch. M-3 attached ☐		City or town: BRIDGEPORT; State: CT; ZIP code: 06606	F Total assets (see instructions): $ 1,746,642
		Foreign country name; Foreign province/state/county; Foreign postal code	

G Is the corporation electing to be an S corporation beginning with this tax year? ☐ Yes ☐ No If "Yes," attach Form 2553 if not already filed

H Check if: (1) ☐ Final return (2) ☐ Name change (3) ☐ Address change (4) ☐ Amended return (5) ☐ S election termination or revocation

I Enter the number of shareholders who were shareholders during any part of the tax year . . . . . ▶ 2

Caution: Include **only** trade or business income and expenses on lines 1a through 21. See the instructions for more information.

Income	1a	Gross receipts or sales	1a 3,479,835		
	b	Returns and allowances	1b 528		
	c	Balance. Subtract line 1b from line 1a		1c	3,479,307
	2	Cost of goods sold (attach Form 1125-A)		2	
	3	Gross profit. Subtract line 2 from line 1c		3	3,479,307
	4	Net gain (loss) from Form 4797, line 17 (attach Form 4797)		4	
	5	Other income (loss) (see instructions—attach statement)		5	
	6	**Total income (loss).** Add lines 3 through 5 ▶		6	3,479,307
Deductions (see instructions for limitations)	7	Compensation of officers (see instructions — attach Form 1125-E)		7	579,377
	8	Salaries and wages (less employment credits)		8	1,516,611
	9	Repairs and maintenance		9	37,925
	10	Bad debts		10	
	11	Rents		11	296,312
	12	Taxes and licenses		12	147,145
	13	Interest		13	22,523
	14	Depreciation not claimed on Form 1125-A or elsewhere on return (attach Form 4562)		14	7,449
	15	Depletion **(Do not deduct oil and gas depletion.)**		15	
	16	Advertising		16	2,000
	17	Pension, profit-sharing, etc., plans		17	
	18	Employee benefit programs		18	59,621
	19	Other deductions (attach statement) ▶		19	988,615
	20	**Total deductions.** Add lines 7 through 19 ▶		20	3,657,578
	21	**Ordinary business income (loss).** Subtract line 20 from line 6		21	-178,271
Tax and Payments	22a	Excess net passive income or LIFO recapture tax (see instructions)	22a		
	b	Tax from Schedule D (Form 1120S)	22b	22c	0
	c	Add lines 22a and 22b (see instructions for additional taxes)			
	23a	2015 estimated tax payments and 2014 overpayment credited to 2015	23a		
	b	Tax deposited with Form 7004	23b		
	c	Credit for federal tax paid on fuels (attach Form 4136)	23c	23d	0
	d	Add lines 23a through 23c ▶ ☐		24	
	24	Estimated tax penalty (see instructions). Check if Form 2220 is attached		25	0
	25	**Amount owed.** If line 23d is smaller than the total of lines 22c and 24, enter amount owed		26	0
	26	**Overpayment.** If line 23d is larger than the total of lines 22c and 24, enter amount overpaid	**Refunded** ▶	27	0
	27	Enter amount from line 26 **Credited to 2016 estimated tax** ▶			

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Signature of officer ▶ Date ▶ Title

May the IRS discuss this return with the preparer shown below (see instructions)? ☐ Yes ☒ No

Paid Preparer Use Only

Print/Type preparer's name: ANIKE BOLARINWA	Preparer's signature	Date: 5/11/2016	Check ☐ if self-employed; PTIN: P00490246
Firm's name ▶ ANNCO CONSULTING LLC, CERTIFIED PUBLIC ACCOUNTAN			Firm's EIN ▶ 13-4187097
Firm's address ▶ 4634 WHITE PLAINS ROAD			Phone no. (718) 882-7500
City: BRONX	State: NY		ZIP code: 10470

For Paperwork Reduction Act Notice, see separate instructions. Form **1120S** (2015)

HTA

Schedule B Other Information (see instructions)

		Yes	No
1	Check accounting method: a [X] Cash b [ ] Accrual c [ ] Other (specify) ▶		
2	See the instructions and enter the: a Business activity ▶ REHAB CENTER b Product or service ▶ MEDICAL HELP		
3	At any time during the tax year, was any shareholder of the corporation a disregarded entity, a trust, an estate, or a nominee or similar person? If "Yes," attach Schedule B-1, Information on Certain Shareholders of an S Corporation		X
4	At the end of the tax year, did the corporation:		
a	Own directly 20% or more, or own, directly or indirectly, 50% or more of the total stock issued and outstanding of any foreign or domestic corporation? For rules of constructive ownership, see instructions. If "Yes," complete (i) through (v) below		X

(i) Name of Corporation	(ii) Employer Identification Number (if any)	(iii) Country of Incorporation	(iv) Percentage of Stock Owned	(v) If Percentage in (iv) is 100%, Enter the Date (if any) a Qualified Subchapter S Subsidiary Election Was Made

b	Own directly an interest of 20% or more, or own, directly or indirectly, an interest of 50% or more in the profit, loss, or capital in any foreign or domestic partnership (including an entity treated as a partnership) or in the beneficial interest of a trust? For rules of constructive ownership, see instructions. If "Yes," complete (i) through (v) below		X

(i) Name of Entity	(ii) Employer Identification Number (if any)	(iii) Type of Entity	(iv) Country of Organization	(v) Maximum Percentage Owned in Profit, Loss, or Capital

5 a	At the end of the tax year, did the corporation have any outstanding shares of restricted stock? If "Yes," complete lines (i) and (ii) below.		X
	(i) Total shares of restricted stock ▶		
	(ii) Total shares of non-restricted stock ▶		
b	At the end of the tax year, did the corporation have any outstanding stock options, warrants, or similar instruments? If "Yes," complete lines (i) and (ii) below.		X
	(i) Total shares of stock outstanding at the end of the tax year ▶		
	(ii) Total shares of stock outstanding if all instruments were executed ▶		
6	Has this corporation filed, or is it required to file, **Form 8918**, Material Advisor Disclosure Statement, to provide information on any reportable transaction? ▶ [ ]		X
7	Check this box if the corporation issued publicly offered debt instruments with original issue discount ▶ [ ] If checked, the corporation may have to file **Form 8281**, Information Return for Publicly Offered Original Issue Discount Instruments.		
8	If the corporation: **(a)** was a C corporation before it elected to be an S corporation **or** the corporation acquired an asset with a basis determined by reference to the basis of the asset (or the basis of any other property) in the hands of a C corporation **and (b)** has net unrealized built-in gain in excess of the net recognized built-in gain from prior years, enter the net unrealized built-in gain reduced by net recognized built-in gain from prior years (see instructions) ▶ $		
9	Enter the accumulated earnings and profits of the corporation at the end of the tax year. $		
10	Does the corporation satisfy **both** of the following conditions?		
a	The corporation's total receipts (see instructions) for the tax year were less than $250,000		X
b	The corporation's total assets at the end of the tax year were less than $250,000		X
	If "Yes," the corporation is not required to complete Schedules L and M-1.		
11	During the tax year, did the corporation have any non-shareholder debt that was canceled, was forgiven, or had the terms modified so as to reduce the principal amount of the debt?		X
	If "Yes," enter the amount of principal reduction $		X
12	During the tax year, was a qualified subchapter S subsidiary election terminated or revoked? If "Yes," see instructions	X	
13 a	Did the corporation make any payments in 2015 that would require it to file Form(s) 1099?		X
b	If "Yes," did the corporation file or will it file required Forms 1099?		

Form 1120S (2015) NEW ERA REHABILITATION CENTER INC. 02-0596949 Page 3

Schedule K Shareholders' Pro Rata Share Items

				Total amount
Income (Loss)	1	Ordinary business income (loss) (page 1, line 21)	1	-178,271
	2	Net rental real estate income (loss) (attach Form 8825)	2	
	3a	Other gross rental income (loss)	3a	
	b	Expenses from other rental activities (attach statement)	3b	
	c	Other net rental income (loss). Subtract line 3b from line 3a	3c	0
	4	Interest income	4	
	5	Dividends: a Ordinary dividends	5a	
		b Qualified dividends	5b	
	6	Royalties	6	
	7	Net short-term capital gain (loss) (attach Schedule D (Form 1120S))	7	
	8a	Net long-term capital gain (loss) (attach Schedule D (Form 1120S))	8a	
	b	Collectibles (28%) gain (loss)	8b	
	c	Unrecaptured section 1250 gain (attach statement)	8c	
	9	Net section 1231 gain (loss) (attach Form 4797)	9	
	10	Other income (loss) (see instructions) Type ▶	10	
Deductions	11	Section 179 deduction (attach Form 4562)	11	
	12a	Charitable contributions	12a	200
	b	Investment interest expense	12b	
	c	Section 59(e)(2) expenditures (1) Type ▶ (2) Amount ▶	12c(2)	
	d	Other deductions (see instructions) Type ▶	12d	
Credits	13a	Low-income housing credit (section 42(j)(5))	13a	
	b	Low-income housing credit (other)	13b	
	c	Qualified rehabilitation expenditures (rental real estate) (attach Form 3468, if applicable)	13c	
	d	Other rental real estate credits (see instructions) Type ▶	13d	
	e	Other rental credits (see instructions) Type ▶	13e	
	f	Biofuel producer credit (attach Form 6478)	13f	
	g	Other credits (see instructions) Type ▶	13g	
Foreign Transactions	14a	Name of country or U.S. possession ▶	14b	
	b	Gross income from all sources	14c	
	c	Gross income sourced at shareholder level		
		Foreign gross income sourced at corporate level		
	d	Passive category	14d	
	e	General category	14e	
	f	Other (attach statement)	14f	
		Deductions allocated and apportioned at shareholder level		
	g	Interest expense	14g	
	h	Other	14h	
		Deductions allocated and apportioned at corporate level to foreign source income		
	i	Passive category	14i	
	j	General category	14j	
	k	Other (attach statement)	14k	
		Other information		
	l	Total foreign taxes (check one): ▶ ☐ Paid ☐ Accrued	14l	
	m	Reduction in taxes available for credit (attach statement)	14m	
	n	Other foreign tax information (attach statement)		
Alternative Minimum Tax (AMT) Items	15a	Post-1986 depreciation adjustment	15a	
	b	Adjusted gain or loss	15b	
	c	Depletion (other than oil and gas)	15c	
	d	Oil, gas, and geothermal properties—gross income	15d	
	e	Oil, gas, and geothermal properties—deductions	15e	
	f	Other AMT items (attach statement)	15f	
Items Affecting Shareholder Basis	16a	Tax-exempt interest income	16a	
	b	Other tax-exempt income	16b	
	c	Nondeductible expenses	16c	34
	d	Distributions (attach statement if required) (see instructions)	16d	
	e	Repayment of loans from shareholders	16e	

Schedule K	Shareholders' Pro Rata Share Items (continued)		Total amount
Other Information	17a Investment income	17a	
	b Investment expenses	17b	
	c Dividend distributions paid from accumulated earnings and profits	17c	
	d Other items and amounts (attach statement)		
Reconciliation	18 **Income/loss reconciliation.** Combine the amounts on lines 1 through 10 in the far right column. From the result, subtract the sum of the amounts on lines 11 through 12d and 14l	18	-178,471

Schedule L Balance Sheets per Books	Beginning of tax year		End of tax year	
Assets	(a)	(b)	(c)	(d)
1 Cash		56,595		77,983
2a Trade notes and accounts receivable		0		0
b Less allowance for bad debts		23,873		23,873
3 Inventories				
4 U.S. government obligations				
5 Tax-exempt securities (see instructions)				
6 Other current assets (attach statement)				
7 Loans to shareholders				
8 Mortgage and real estate loans				
9 Other investments (attach statement)	599,304		599,304	
10a Buildings and other depreciable assets	552,493	46,811	559,942	39,362
b Less accumulated depreciation		0		0
11a Depletable assets				
b Less accumulated depletion				
12 Land (net of any amortization)	2,974,042		2,974,042	
13a Intangible assets (amortizable only)	1,073,469	1,900,573	1,368,618	1,605,424
b Less accumulated amortization				
14 Other assets (attach statement)		2,027,852		1,746,642
15 Total assets				
Liabilities and Shareholders' Equity				
16 Accounts payable		337,300		234,595
17 Mortgages, notes, bonds payable in less than 1 year				
18 Other current liabilities (attach statement)				
19 Loans from shareholders				
20 Mortgages, notes, bonds payable in 1 year or more				
21 Other liabilities (attach statement)		1,012,462		1,012,462
22 Capital stock				
23 Additional paid-in capital		678,090		499,585
24 Retained earnings				
25 Adjustments to shareholders' equity (attach statement)				
26 Less cost of treasury stock				
27 Total liabilities and shareholders' equity		2,027,852		1,746,642

Schedule M-1 Reconciliation of Income (Loss) per Books With Income (Loss) per Return

Note: The corporation may be required to file Schedule M-3 (see instructions)

1	Net income (loss) per books	-178,505	5	Income recorded on books this year not included on Schedule K, lines 1 through 10 (itemize):	
2	Income included on Schedule K, lines 1, 2, 3c, 4, 5a, 6, 7, 8a, 9, and 10, not recorded on books this year (itemize):		a	Tax-exempt interest $	0
3	Expenses recorded on books this year not included on Schedule K, lines 1 through 12 and 14l (itemize):		6	Deductions included on Schedule K, lines 1 through 12 and 14l, not charged against book income this year (itemize):	
a	Depreciation $		a	Depreciation $	0
b	Travel and entertainment $ 34	34	7	Add lines 5 and 6	0
4	Add lines 1 through 3	-178,471	8	Income (loss) (Schedule K, line 18). Line 4 less line 7	-178,471

Schedule M-2 Analysis of Accumulated Adjustments Account, Other Adjustments Account, and Shareholders' Undistributed Taxable Income Previously Taxed (see instructions)

		(a) Accumulated adjustments account	(b) Other adjustments account	(c) Shareholders' undistributed taxable income previously taxed
1	Balance at beginning of tax year	678,090		
2	Ordinary income from page 1, line 21			
3	Other additions	-178,271		
4	Loss from page 1, line 21	234		0
5	Other reductions	499,585	0	
6	Combine lines 1 through 5			0
7	Distributions other than dividend distributions	499,585	0	
8	Balance at end of tax year. Subtract line 7 from line 6			

NEW ERA REHABILITATION CENTER INC.
3715 MAIN STREET
BRIDGEPORT, CT 06606

May 11, 2016

EBENEZER KOLADE
38 CRAWFORD ROAD
WESTPORT, CT 06880

RE: NEW ERA REHABILITATION CENTER INC.
02-0596949

Enclosed is your current year Schedule K-1 (Form 1120S) for the above-referenced account. The amounts shown are your distributive share of the S corporation's income, deductions and credits incurred during the year and are to be reported on your income tax return. The amounts may differ from the distributions you actually received during the year. The difference may be due to a number of factors including the allocation of fees or other deductions, exclusion of tax-exempt income, or a variance between your taxable year and that of the S corporation.

If applicable, state tax information has been attached to the K-1. Since income tax requirements vary from state to state, the presentation of the state tax information will be different for each state. The information provided is based on your state of residence from our records. If information for your state of residence is not listed, please contact us at the number below.

If you have any questions concerning this information, please call

Sincerely,

NEW ERA REHABILITATION CENTER INC.

671113

Schedule K-1 (Form 1120S)
Department of the Treasury
Internal Revenue Service

2015

For calendar year 2015, or tax year beginning _____, 2015
ending _____, 20____

Final K-1 ☐ Amended K-1 ☐ OMB No. 1545-0123

Shareholder's Share of Income, Deductions, Credits, etc.

▶ See back of form and separate instructions.

Part I Information About the Corporation

A Corporation's employer identification number
02-0596949

B Corporation's name, address, city, state, and ZIP code
NEW ERA REHABILITATION CENTER INC.
3715 MAIN STREET
BRIDGEPORT, CT 06606

C IRS Center where corporation filed return
e-file

Part II Information About the Shareholder

D Shareholder's identifying number Shareholder: 1
126-70-2671

E Shareholder's name, address, city, state, and ZIP code
EBENEZER KOLADE
38 CRAWFORD ROAD
WESTPORT, CT 06880

F Shareholder's percentage of stock ownership for tax year 50.000000%

Part III Shareholder's Share of Current Year Income, Deductions, Credits, and Other Items

1	Ordinary business income (loss) -89,135	13	Credits
2	Net rental real estate income (loss)		
3	Other net rental income (loss)		
4	Interest income		
5a	Ordinary dividends		
5b	Qualified dividends	14	Foreign transactions
6	Royalties		
7	Net short-term capital gain (loss)		
8a	Net long-term capital gain (loss)		
8b	Collectibles (28%) gain (loss)		
8c	Unrecaptured section 1250 gain		
9	Net section 1231 gain (loss)		
10	Other income (loss)	15	Alternative minimum tax (AMT) items
11	Section 179 deduction	16	Items affecting shareholder basis C 17
12 A	Other deductions 100		
		17	Other information

* See attached statement for additional information.

For IRS Use Only

EBENEZER KOLADE 126-70-2671

K-1 Statement (Sch K-1, Form 1120S)

Line 12 - Deductions

A Code A - Cash contributions (50%) . . . . . A 100

Line 16 - Items affecting shareholder basis

C Code C - Nondeductible expenses . . . . . C 17

NEW ERA REHABILITATION CENTER INC.
3715 MAIN STREET
BRIDGEPORT, CT 06606

May 11, 2016

CHRISTINA KOLADE
38 CRAWFORD ROAD
WESTPORT, CT 06880

RE: NEW ERA REHABILITATION CENTER INC.
02-0596949

Enclosed is your current year Schedule K-1 (Form 1120S) for the above-referenced account. The amounts shown are your distributive share of the S corporation's income, deductions and credits incurred during the year and are to be reported on your income tax return. The amounts may differ from the distributions you actually received during the year. The difference may be due to a number of factors including the allocation of fees or other deductions, exclusion of tax-exempt income, or a variance between your taxable year and that of the S corporation.

If applicable, state tax information has been attached to the K-1. Since income tax requirements vary from state to state, the presentation of the state tax information will be different for each state. The information provided is based on your state of residence from our records. If information for your state of residence is not listed, please contact us at the number below.

If you have any questions concerning this information, please call

Sincerely,

NEW ERA REHABILITATION CENTER INC.

671113

Schedule K-1 (Form 1120S)
Department of the Treasury
Internal Revenue Service

2015

For calendar year 2015, or tax year beginning _____, 2015
ending _____, 20____

Final K-1 ☐ Amended K-1 ☐ OMB No. 1545-0123

Shareholder's Share of Income, Deductions, Credits, etc.

▶ See back of form and separate instructions.

Part I Information About the Corporation

A Corporation's employer identification number
02-0596949

B Corporation's name, address, city, state, and ZIP code
NEW ERA REHABILITATION CENTER INC.
3715 MAIN STREET
BRIDGEPORT, CT 06606

C IRS Center where corporation filed return
e-file

Part II Information About the Shareholder

D Shareholder's identifying number
100-72-9856
Shareholder: 2

E Shareholder's name, address, city, state, and ZIP code
CHRISTINA KOLADE
38 CRAWFORD ROAD
WESTPORT, CT 06880

F Shareholder's percentage of stock ownership for tax year 50.000000%

Part III Shareholder's Share of Current Year Income, Deductions, Credits, and Other Items

1	Ordinary business income (loss) -89,136	13	Credits
2	Net rental real estate income (loss)		
3	Other net rental income (loss)		
4	Interest income		
5a	Ordinary dividends		
5b	Qualified dividends	14	Foreign transactions
6	Royalties		
7	Net short-term capital gain (loss)		
8a	Net long-term capital gain (loss)		
8b	Collectibles (28%) gain (loss)		
8c	Unrecaptured section 1250 gain		
9	Net section 1231 gain (loss)		
10	Other income (loss)	15	Alternative minimum tax (AMT) items
11	Section 179 deduction	16	Items affecting shareholder basis
		C	17
12 A	Other deductions 100		
		17	Other information

* See attached statement for additional information.

For IRS Use Only

CHRISTINA KOLADE 100-72-9856

K-1 Statement (Sch K-1, Form 1120S)

Line 12 - Deductions

A Code A - Cash contributions (50%) . . . . . A 100

Line 16 - Items affecting shareholder basis

C Code C - Nondeductible expenses . . . . . C 17

Form **1125-E**
(Rev. December 2013)
Department of the Treasury
Internal Revenue Service

Compensation of Officers

▶ Attach to Form 1120, 1120-C, 1120-F, 1120-REIT, 1120-RIC, or 1120S
▶ Information about Form 1125-E and its separate instructions is at www.irs.gov/form1125e.

OMB No. 1545-2225

Name
NEW ERA REHABILITATION CENTER INC.

Employer identification number
02-0596949

Note. Complete Form 1125-E only if total receipts are $500,000 or more. See instructions for definition of total receipts.

(a) Name of officer	(b) Social security number	(c) Percent of time devoted to business	Percent of stock owned (d) Common	Percent of stock owned (e) Preferred	(f) Amount of compensation
1 EBENEZER KOLADE	126-70-2671	100.00%	50.00%	%	289,689
CHRISTINE KOLADE	100-72-9856	100.00%	50.00%	%	289,688
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	

2	Total compensation of officers	2	579,377
3	Compensation of officers claimed on Form 1125-A or elsewhere on return	3	
4	Subtract line 3 from line 2. Enter the result here and on Form 1120, page 1, line 12 or the appropriate line of your tax return	4	579,377

Form **4562**

Department of the Treasury
Internal Revenue Service (99)

Depreciation and Amortization
(Including Information on Listed Property)

► Attach to your tax return.

► Information about Form 4562 and its separate instructions is at www.irs.gov/form4562.

OMB No. 1545-0172

2015

Attachment Sequence No. 179

Name(s) shown on return	Business or activity to which this form relates	Identifying number
NEW ERA REHABILITATION CENTER INC.	1120S - REHAB CENTER	02-0596949

Part I Election To Expense Certain Property Under Section 179

Note: If you have any listed property, complete Part V before you complete Part I.

1	Maximum amount (see instructions)	1	
2	Total cost of section 179 property placed in service (see instructions)	2	
3	Threshold cost of section 179 property before reduction in limitation (see instructions)	3	
4	Reduction in limitation. Subtract line 3 from line 2. If zero or less, enter -0-	4	0
5	Dollar limitation for tax year. Subtract line 4 from line 1. If zero or less, enter -0-. If married filing separately, see instructions	5	0

6	(a) Description of property	(b) Cost (business use only)	(c) Elected cost
7			

7	Listed property. Enter the amount from line 29	8	0
8	Total elected cost of section 179 property. Add amounts in column (c), lines 6 and 7	9	0
9	Tentative deduction. Enter the **smaller** of line 5 or line 8	10	
10	Carryover of disallowed deduction from line 13 of your 2014 Form 4562.	11	
11	Business income limitation. Enter the smaller of business income (not less than zero) or line 5 (see instructions)	12	0
12	Section 179 expense deduction. Add lines 9 and 10, but do not enter more than line 11	► 13	0
13	Carryover of disallowed deduction to 2016. Add lines 9 and 10, less line 12		

Note: Do not use Part II or Part III below for listed property. Instead, use Part V.

Part II Special Depreciation Allowance and Other Depreciation (Do not include listed property.) (See instructions.)

14	Special depreciation allowance for qualified property (other than listed property) placed in service during the tax year (see instructions)	14	
15	Property subject to section 168(f)(1) election	15	
16	Other depreciation (including ACRS)	16	

Part III MACRS Depreciation (Do not include listed property.) (See instructions.)

Section A

17	MACRS deductions for assets placed in service in tax years beginning before 2015	17	3,495
18	If you are electing to group any assets placed in service during the tax year into one or more general asset accounts, check here ► ☐		

Section B - Assets Placed in Service During 2015 Tax Year Using the General Depreciation System

	(a) Classification of property	(b) Month and year placed in service	(c) Basis for depreciation (business/investment use only—see instructions)	(d) Recovery period	(e) Convention	(f) Method	(g) Depreciation deduction
19 a	3-year property						
b	5-year property						
c	7-year property						
d	10-year property						
e	15-year property						
f	20-year property			25 yrs.		S/L	
g	25-year property			27.5 yrs.	MM	S/L	
h	Residential rental property			27.5 yrs.	MM	S/L	
i	Nonresidential real property			39 yrs.	MM	S/L	
					MM	S/L	

Section C - Assets Placed in Service During 2015 Tax Year Using the Alternative Depreciation System

20 a	Class life					S/L	
b	12-year			12 yrs.		S/L	
c	40-year			40 yrs.	MM	S/L	

Part IV Summary (See instructions.)

21	Listed property. Enter amount from line 28	21	3,954
22	**Total.** Add amounts from line 12, lines 14 through 17, lines 19 and 20 in column (g), and line 21. Enter here and on the appropriate lines of your return. Partnerships and S corporations—see instructions	22	7,449
23	For assets shown above and placed in service during the current year, enter the portion of the basis attributable to section 263A costs	23	

Part V **Listed Property** (Include automobiles, certain other vehicles, certain aircraft, certain computers, and property used for entertainment, recreation, or amusement.)

Note: For any vehicle for which you are using the standard mileage rate or deducting lease expense, complete **only** 24a, 24b, columns (a) through (c) of Section A, all of Section B, and Section C if applicable.

Section A—Depreciation and Other Information (Caution: See the instructions for limits for passenger automobiles.)

24a Do you have evidence to support the business/investment use claimed? [X] Yes [ ] No **24b** If "Yes," is the evidence written? [ ] Yes [X] No

(a) Type of property (list vehicles first)	(b) Date placed in service	(c) Business/ investment use percentage	(d) Cost or other basis	(e) Basis for depreciation (business/ investment use only)	(f) Recovery period	(g) Method/ Convention	(h) Depreciation deduction	(i) Elected section 179 cost
25 Special depreciation allowance for qualified listed property placed in service during the tax year and used more than 50% in a qualified business use (see instructions)							**25**	
26 Property used more than 50% in a qualified business use:								
VEHICLES	1/20/2012	100.00%	80,000	34,320	5	200DB - HY	3,954	
VEHICLES - OLD	1/1/2006	100.00%	20,000	20,000	5	200DB - HY		
27 Property used 50% or less in a qualified business use:								
		%				S/L –		
		%				S/L –		
		%				S/L –		
							28	3,954
28 Add amounts in column (h), lines 25 through 27. Enter here and on line 21, page 1								
29 Add amounts in column (i), line 26. Enter here and on line 7, page 1								**29** 0

Section B—Information on Use of Vehicles

Complete this section for vehicles used by a sole proprietor, partner, or other "more than 5% owner," or related person. If you provided vehicles to your employees, first answer the questions in Section C to see if you meet an exception to completing this section for those vehicles.

	(a) Vehicle 1		(b) Vehicle 2		(c) Vehicle 3		(d) Vehicle 4		(e) Vehicle 5		(f) Vehicle 6	
30 Total business/investment miles driven during the year (**do not** include commuting miles)												
31 Total commuting miles driven during the year												
32 Total other personal (noncommuting) miles driven												
33 Total miles driven during the year. Add lines 30 through 32												
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
34 Was the vehicle available for personal use during off-duty hours?												
35 Was the vehicle used primarily by a more than 5% owner or related person?												
36 Is another vehicle available for personal use?												

Section C—Questions for Employers Who Provide Vehicles for Use by Their Employees

Answer these questions to determine if you meet an exception to completing Section B for vehicles used by employees who **are not** more than 5% owners or related persons (see instructions).

	Yes	**No**
37 Do you maintain a written policy statement that prohibits all personal use of vehicles, including commuting, by your employees?		
38 Do you maintain a written policy statement that prohibits personal use of vehicles, except commuting, by your employees? See the instructions for vehicles used by corporate officers, directors, or 1% or more owners		
39 Do you treat all use of vehicles by employees as personal use?		
40 Do you provide more than five vehicles to your employees, obtain information from your employees about the use of the vehicles, and retain the information received?		
41 Do you meet the requirements concerning qualified automobile demonstration use? (See instructions.)		

Note: If your answer to 37, 38, 39, 40, or 41 is "Yes," do not complete Section B for the covered vehicles.

Part VI **Amortization**

(a) Description of costs	(b) Date amortization begins	(c) Amortizable amount	(d) Code section	(e) Amortization period or percentage	(f) Amortization for this year
42 Amortization of costs that begins during your 2015 tax year (see instructions):					
43 Amortization of costs that began before your 2015 tax year				**43**	295,149
44 **Total.** Add amounts in column (f). See the instructions for where to report				**44**	295,149

W ERA REHABILITATION CENTER INC.

Explanations (1120S)

Item H(4) (1120S)- Amended Return Explanation

			0	0	
	Line Number	Description	Amount on Previous Return	Amount on Amended Return	Explanation
1					

W ERA REHABILITATION CENTER INC.

Line 5 (1120S) - Other Income (Loss)

Line 5 (1120S) - Ordinary Income (Loss) from Partnerships, Estates and Trusts 0

Name	EIN	Address	City	State	Zip Code	Foreign Country	Amount

NERA REHABILITATION CENTER INC.

Line 19 (1120S) - Other Deductions

1	Travel, Meals and Entertainment			1a 17,282
	a Travel	1b	67	
	b Meals and entertainment, subject to 50% limit	1c		
	c Meals and entertainment, subject to 80% limit (DOT)	1d	34	
	d Less disallowed			1e 33
	e Subtract line d from lines b and c			2 295,149
2	From Form 4562 - Amortization			3 562
3	Automobile and truck expenses			4 4,682
4	Bank charges			5 109,968
5	Consulting fees			6 6,382
6	Dues and subscriptions			7 92,831
7	Insurance			8 5,274
8	Janitorial			9 59,652
9	Legal and professional fees			10 45,731
10	Maintenance			11 2,094
11	Miscellaneous			12 35,395
12	Office expenses			13 231
13	Postage			14 715
14	Printing			15 11,134
15	Security			16 166,372
16	Supplies			17 11,613
17	Telephone			18 45,173
18	Utilities			19 2,094
19	Staff training			20 4,834
20	Payroll processing fees			21 2,106
21	Payroll expenses			22 69,308
22	Laboratory fess			23 988,615
23	Total other deductions			

IVERA REHABILITATION CENTER INC.

Line 22a (1120S) - Excess Net Passive Income Tax

1	Enter gross receipts for the tax year (see section 1362(d)(3)(B) for gross receipts from the sale of capital assets)*	1
2	Enter passive investment income as defined in section 1362(d)(3)(C)*	2
3	Enter 25% of line 1 (If line 2 is less than line 3, stop here. You are not liable for this tax.)	3 0
4	Excess passive investment income - Subtract line 3 from line 2	4 0
5	Enter deductions directly connected with the production of income on line 2 (see section 1375(b)(2))*	5
6	Net passive income - Subtract line 5 from line 2	6 0
7	Divide amount on line 4 by amount on line 2	7 0.0000%
8	Excess net passive income - Multiply line 6 by line 7	8 0
9	Enter taxable income (see instructions for taxable income below)	9 0
10	Enter smaller of line 8 or line 9	10 0
11	Excess net passive income tax - Enter 35% of line 10	11 0

*Income and deductions on lines 1, 2, and 5 are from total operations for the tax year. This includes applicable income and expenses from page 1, Form 1120S, as well as those reported separately on Schedule K. See section 1375(b)(4) for an exception regarding lines 2 and 5.

Line 9 worksheet - Computation of Corporate Taxable Income - (1120 Computation)

Line 9 taxable income is defined in Regulations section 1.1374-1(d). Figure this income by completing lines 1 through 28 of Form 1120, U.S. Corporation Income Tax Return. Include the Form 1120 computation with the worksheet computation you attach to Form 1120S. You do not have to attach the schedules, etc., called for on Form 1120. However, you may want to complete certain Form 1120 schedules, such as Schedule D (Form 1120), if you have capital gains or losses.

Income				
1	Gross receipts or sales (less returns and allowances)		1	3,479,307
2	Cost of goods sold (from 1125-A)		2	0
3	Gross profit. Subtract line 2 from line 1		3	3,479,307
4	Dividends		4	0
5	Interest		5	0
6	Gross rents		6	0
7	Gross royalties		7	0
8	Capital gain net income (Schedule D (Form 1120))		8	0
9	Net gain or (loss) from Form 4797, Part II, line 17		9	0
10	Other income		10	0
11	Total income. Add lines 3 through 10		11	3,479,307
Deductions				
12	Compensation of officers		12	579,377
13	Salaries and wages (less employment credits)		13	1,516,611
14	Repairs and maintenance		14	37,925
15	Bad debts		15	0
16	Rents		16	296,312
17	Taxes and licenses		17	147,145
18	Interest		18	22,523
19	Charitable contributions (see instructions for 10% limitation)		19	0
20a	Depreciation (from Form 4562)	20a 7,449		
20b	Less depreciation claimed elsewhere	20b 0	20c	7,449
21	Depletion		21	0
22	Advertising		22	2,000
23	Pension, profit-sharing, etc., plans		23	0
24	Employee benefit programs		24	59,621
25	Domestic production activities deduction		25	
26	Other deductions		26	988,615
27	Total deductions. Add lines 12 through 26		27	3,657,578
28	Taxable income for line 9 of the Excess Net Passive Income Tax. Subtract line 27 from line 11		28	-178,271

Line 22c (1120S) - Additional Taxes

Line 4a, Sch B (1120S) - Percent Total Voting Power Ownership of Stock

	Name of Corporation	Identifying Number	Country of Incorporation	Percent of Voting Stock Owned	Date Q Sub Election
1					

Line 4b, Sch B (1120S) - Stock Own Foreign or Domestic Partnership or Trust

	Name of Entity	Identifying Number	Type of Entity	Country of Organization	Maximum Percent Owned
1					

Line 3, Sch K (1120S) - Other Rental Activities

Line 10, Sch K (1120S) - Other Income (Loss)

Line 12a, Sch K (1120S) - Contributions

A	Code A - Cash contributions (50%)	A	200
	Total contributions	12a	200

Line 12d, Sch K (1120S) - Other Deductions

Line 12d, Sch K (1120S) - Domestic production activity information

Lines 13a and 13b, Sch K (1120S) - Low-Income Housing Credit

Buildings Placed in Service Before January 1, 2008

A	Code A - Low-Income housing credit (section 42(j)(5))		0
	Low-income housing credit from Form 8586		0
	From other partnerships, estates, and trusts	A	0
	Total		
B	Code B - Low-Income housing credit (other)		
	Low-income housing credit from Form 8586		0
	From other partnerships, estates, and trusts	B	0
	Total		

Buildings Placed in Service After December 31, 2007

C	Code C - Low-Income housing credit (section 42(j)(5))		0
	Low-income housing credit from Form 8586		0
	From other partnerships, estates, and trusts	C	0
	Total		
D	Code D - Low-Income housing credit (other)		
	Low-income housing credit from Form 8586		0
	From other partnerships, estates, and trusts	D	0
	Total		

13a	Low-income housing credit (section 42(j)(5))	13a	0
13b	Low-income housing credit (other)	13b	0

Line 13c, Sch K (1120S) - Qualified Rehabilitation Expenditures

E	Code E - Qualified rehabilitation expenditures (rental real estate)		0
	Total qualified rehabilitation expenditures from Form 3468		0
	Qualified rehabilitation expenditures (other than rental real estate)	13c	0
	Qualified rehabilitation expenditures (rental real estate)		

NERA REHABILITATION CENTER INC.

Line 13g, Sch K (1120S) - Other Credits

Line 13g, Sch K (1120S) - Renewable Electricity, Refined and Indian Coal Production Credit

1	Credit from Form 8835, Part I	1	0
2	Credit from Form 8835, Part II	2	0
3	Total	3	0

Line 14c, Sch K (1120S) - Foreign Gross Income Sourced at Shareholder Level

Lines 14d-f, Sch K (Form 1120S) - Foreign Income Transactions

14d. Passive 0
14e. General 0
14f. Other 0

	Description	Category	Check if Capital Gain/Loss	Check if Qualified Dividend	Amount
1					

Line 14k, Sch K (1120S) - Deductions Allocated at Corporate Level to Foreign Income - Other

Line 14l, Sch K (1120S) - Total Foreign Taxes

Line 14m, Sch K (1120S) - Reduction in Taxes Available for Credit

Line 14n, Sch K (1120S) - Other Foreign Tax Information

Line 15f, Sch K (1120S) - Other AMT Items

N ERA REHABILITATION CENTER INC.

Line 16d, Schedule K (1120S) - Distributions

A. Cash . . . . .

B. Property

Description	Date Acquired	Date Distributed	FMV on date of distribution	Basis in property

Total property 0

C. Other 0

Total distributions . . . . .

Line 17d, Sch K (1120S) - Other Items and Amounts

Line 6, Sch L (1120S) - Other Current Assets

Line 9, Sch L (1120S) - Other Investments

Line 14, Sch L (1120S) - Other Assets

Line 18, Sch L (1120S) - Other Current Liabilities

Line 21, Sch L (1120S) - Other Liabilities

Line 25, Sch L (1120S) - Adjustments to Shareholders' Equity

Line 2, Sch M-1 (1120S) - Income on Sch K, lines 1 through 10, Not on Books

Line 3, Sch M-1 (1120S) - Expenses on Books Not on Sch K, lines 1 through 12 and 14l

1	Nondeductible portion of meals, travel and entertainment expenses	1	34
2	Total expenses on books not on Sch K, lines 1 through 12 and 14l	2	34

NERA REHABILITATION CENTER INC.

Line 5, Sch M-1 (1120S) - Income on Books Not on Sch K, lines 1 through 10

Line 6, Sch M-1 (1120S) - Deductions on Sch K, lines 1 through 12 and 14l, Not on Books

This return MUST be filed electronically!
DO NOT MAIL paper return to DRS.

CT-1065/CT-1120SI

Department of Revenue Services
State of Connecticut
(Rev. 01/16)

Form CT-1065/CT-1120SI

Connecticut Composite Income Tax Return

2015

Complete this form in blue or black ink only. See instructions before completing this return.
Visit **www.ct.gov/TSC** to file and pay this return electronically.

For calendar year 2015, or other taxable year ▶ beginning _____, 2015, and ▶ ending _____, _____.

Name of pass-through entity (PE) ▶	Federal Employer ID Number (FEIN)
NEW ERA REHABILITATION CENTER INC.	02-0596949
Number and street ▶ 3715 MAIN STREET — **PO Box** ▶	**DRS use only** — 20
City or town ▶ BRIDGEPORT — **State** CT — **ZIP code** 06606 ▶	**Connecticut Tax Registration Number** 0000554-000

Type of PE ▶ ☐ **Electing large partnership (ELP)** ▶ ☐ **General partnership (GP)** ▶ ☒ **S corporation**
▶ ☐ **Limited liability partnership (LLP)** ▶ ☐ **Limited partnership (LP)** ▶ ☐ **Partnership** (LLC treated as a partnership)

Pass-Through Entity Information

Complete this section first and then complete Part I, *Schedule C*.

A. Check here if ▶ ☐ Final return (out of business in Connecticut) Date of dissolution: _____
☐ Amended return ☐ Short period return Explanation: _____

B. ☐ Change of address. See instructions, Page 16.

C. Total number of noncorporate members as of the close of the PE's taxable year:
Resident (RI, RE, RT) ▶ 2 Nonresident (NI, NE, NT, PE) ▶ 0

You are required to file this form and remit payments electronically. See instructions.

D. Enter the six-digit Business Code Number from federal Form 1065 or federal Form 1120S.
Business Code Number ▶ 621498

E. Date business began: 3/2/2002 Date business began in Connecticut: 3/2/2003

	Yes	No
F. Does this PE own, directly or indirectly, an interest in Connecticut real property? If the answer to this question is **Yes**, and either answer to Item G or H is **Yes**, provide a listing of all Connecticut real property owned.	▶ ☐	▶ ☒
G. Was a controlling interest in this PE transferred? If **Yes**, enter transferor name and Social Security Number (SSN) or FEIN, transferee name, and date of transfer below.	▶ ☐	▶ ☒
H. Did this PE transfer a controlling interest in an entity that owns, directly or indirectly, an interest in Connecticut real property? If **Yes**, enter name and FEIN, transferee name, and date of transfer below.	▶ ☐	▶ ☒

Transferor name: _____ SSN or FEIN: _____
Transferee name: _____ Date of transfer: _____

Name: _____ FEIN: _____
Transferee name: _____ Date of transfer: _____

Part I Schedule A – PE Computation of Composite Tax Due

1. Total Connecticut-sourced income included in composite return from Part I, *Schedule B*, Line 10, Column C.	1.	0 00
2. Multiply Line 1 by 6.99% (.0699).	2.	0 00
3. Members' credits from Part I, *Schedule B*, Line 12, Column E.	3.	0 00
4. Tax liability: Subtract Line 3 from Line 2.	4.	0 00
5. Payment made with Form CT-1065/CT-1120SI EXT.	5.	0 00
6. Parent PE only: Enter amount from Part I, *Schedule D*, Line 10, Column C.	6.	0 00
7. Add Line 5 and Line 6.	7.	0 00
8. Amount to be refunded to PE. If Line 7 is more than Line 4, subtract Line 4 from Line 7.	8.	0 00

For faster refund, use Direct Deposit by completing Lines 8a, 8b, and 8c.

8a. Checking ▶ ☐ Savings ▶ ☐ 8b. Routing number ▶ _____

8c. Account number ▶ _____ 8d. Will this refund go to a bank account outside the U.S.? ▶ ☐ Yes

9. Amount of tax owed: If Line 4 is more than Line 7, subtract Line 7 from Line 4.	9.	0 00
10. If late, enter penalty. See instructions.	10.	0 00
11. If late, enter interest. Multiply the amount on Line 9 by 1% (.01). Multiply the result by the number of months or fraction of a month late.	11.	0 00
12. Balance due with this return: Add Lines 9 through 11.	12.	0 00

Partnership: Attach a complete copy of federal Form 1065 (excluding federal K-1s).
S corporation: Attach a complete copy of federal Form 1120S (excluding federal K-1s).

For a faster refund, choose direct deposit (Lines 8a - 8c).

NEW ERA REHABILITATION CENTER INC. 02-0596949

Part I Schedule B – PE Member Composite Return Attach supplemental attachment(s), if needed.

Column A Member # From Part IV	Column B Identification Number See instructions.	Column C Connecticut-Sourced Income See instructions.	Column D Multiply Column C by 6.99% (0.0699)	Column E Members' Credit Schedule CT K-1, Part IV, Line 5, Col. B	Column F Connecticut Income Tax Liability Column D minus Column E
1.	▶	▶ 0 00	0 00	▶ 0 00	▶ 0 00
2.	▶	▶ 0 00	0 00	▶ 0 00	▶ 0 00
3.	▶	▶ 0 00	0 00	▶ 0 00	▶ 0 00
4.	▶	▶ 0 00	0 00	▶ 0 00	▶ 0 00
5.	▶	▶ 0 00	0 00	▶ 0 00	▶ 0 00
6.	▶	▶ 0 00	0 00	▶ 0 00	▶ 0 00
7.	▶	▶ 0 00	0 00	▶ 0 00	▶ 0 00
8.	▶	▶ 0 00	0 00	▶ 0 00	▶ 0 00
9. Subtotal(s) from supplemental attachment(s)		0 00	0 00	0 00	0 00
10. Add Lines 1 through 9, Column C. Enter amount here and on Part I, *Schedule A*, Line 1.		0 00			
11. Add Lines 1 through 9, Column D.			0 00		
12. Add Lines 1 through 9, Column E. Enter amount here and on Part I, *Schedule A*, Line 3				0 00	
13. Total composite return tax liability. Add Lines 1 through 9, Column F.					0 00

Part I Schedule C – Federal Schedule K Information (Form 1065 or Form 1120S)

All PEs must complete this schedule.

		Column A Amounts Reported by This PE on Federal Schedule K	Column B Amount From Subsidiary PE(s)	Column C Column A minus Column B
1. Ordinary business income (loss)	1.	▶ -178,271 00	▶ 0 00	-178,271 00
2. Net rental real estate income (loss)	2.	▶ 0 00	▶ 0 00	0 00
3. Other net rental income (loss)	3.	▶ 0 00	▶ 0 00	0 00
4. Guaranteed payments	4.	▶ 0 00	▶ 0 00	0 00
5. Interest income	5.	▶ 0 00	▶ 0 00	0 00
6a. Ordinary dividends	6a.	▶ 0 00	▶ 0 00	0 00
6b. Qualified dividends	6b.	▶ 0 00	▶ 0 00	0 00
7. Royalties	7.	▶ 0 00	▶ 0 00	0 00
8. Net short-term capital gain (loss)	8.	▶ 0 00	▶ 0 00	0 00
9a. Net long-term capital gain (loss)	9a.	▶ 0 00	▶ 0 00	0 00
9b. Collectibles (28%) gain (loss)	9b.	▶ 0 00	▶ 0 00	0 00
9c. Unrecaptured section 1250 gain	9c.	▶ 0 00	▶ 0 00	0 00
10. Net section 1231 gain (loss)	10.	▶ 0 00	▶ 0 00	0 00
11. Other income (loss): Attach statement.	11.	▶ 0 00	▶ 0 00	0 00
12. Section 179 deduction	12.	▶ 0 00	▶ 0 00	200 00
13. Other deductions: Attach statement.	13.	▶ 200 00	▶ 0 00	

Part I Schedule D – Connecticut-Sourced Income From Subsidiary PE(s) Attach supplemental attachment(s), if needed.

Only a parent PE must complete this schedule.

- Refer to federal Schedule K-1 and Schedule CT K-1 for amounts to enter in Columns A, B, and C.
- Amounts reported in Column B are subject to the passive activity limitations, at-risk limitations, and capital loss limitations.

Name of Subsidiary PE	FEIN	Column A Amount Reported on Federal K-1	Column B Amount From Connecticut Sources	Column C CT Income Tax Liability Schedule CT K-1, Part III, Line 1
1. ▶	▶	▶ 0 00	▶ 0 00	▶ 0 00
2. ▶	▶	▶ 0 00	▶ 0 00	▶ 0 00
3. ▶	▶	▶ 0 00	▶ 0 00	▶ 0 00
4. ▶	▶	▶ 0 00	▶ 0 00	▶ 0 00
5. ▶	▶	▶ 0 00	▶ 0 00	▶ 0 00
6. ▶	▶	▶ 0 00	▶ 0 00	▶ 0 00
7. ▶	▶	▶ 0 00	▶ 0 00	▶ 0 00
8. ▶	▶	▶ 0 00	▶ 0 00	▶ 0 00
9. Subtotal(s) from supplemental attachment(s)		0 00	0 00	0 00
10. Add Lines 1 through 9, Column C. Enter amount here and on Part I, *Schedule A*, Line 6.				

02-0596949

NEW ERA REHABILITATION CENTER INC.

Part II – Allocation and Apportionment of Income

Complete only if all of the following apply:

- There are one or more nonresident noncorporate members or one or more members that are PEs;
- The PE carries on business both within and outside Connecticut; **and**
- The PE does not maintain books and records that satisfactorily disclose the portion of income, gain, loss, or deduction derived from or connected with Connecticut sources.

		Column A Totals Everywhere	Column B Connecticut Only	Column C Fraction Enter as a decimal
				Divide Column B by Column A
1. Real property owned	1.	0 00	0 00	
2. Real property rented from others	2.	0 00	0 00	
3. Tangible personal property owned or rented	3.	0 00	0 00	▶ 0.000000
4. Property owned or rented: Add Lines 1, 2, and 3.	4. ▶	0 00	▶ 0 00	▶ 0.000000
5. Employee wages and salaries	5. ▶	0 00	▶ 0 00	▶ 0.000000
6. Gross income from sales and services	6. ▶	0 00	▶ 0 00	▶ 0.000000
7. Total: Add Lines 4, 5, and 6, Column C.			7.	▶ 0.000000
8. Apportionment fraction: Divide Line 7 by three or actual number of fractions.			8.	▶ 0.000000

Part III Place(s) of Business Attach supplemental attachment(s), if needed.

Complete only if the PE carries on business both **within and outside** Connecticut.

Location	Description	Owned or Rented to PE	Activity

Part IV – Member Information Attach supplemental attachment(s), if needed.

Member #	Member Name and Address See instructions for order in which to list and for member type codes.	Member Type Code	FEIN or SSN	Profit Sharing % Enter as a decimal.	Loss Sharing % Enter as a decimal.	Capital Ownership % Enter as a decimal.
▶ 1	▶ EBENEZER KOLADE 38 CRAWFORD ROAD WESTPORT, CT 06880	▶ RI	126-70-2671	▶	▶	▶ 50.0000%
▶ 2	▶ CHRISTINA KOLADE 38 CRAWFORD ROAD WESTPORT, CT 06880	▶ RI	100-72-9856	▶	▶	▶ 50.0000%
▶	▶	▶	▶	▶	▶	▶
▶	▶	▶	▶	▶	▶	▶

Part V – Member's Share of Connecticut Modifications Attach supplemental attachment(s), if needed.

		Member # 1	Member # 2	Member #	Totals for All Members
Additions: Enter all amounts as positive numbers.					
1. Interest on state and local government obligations other than Connecticut	1.	▶ 0 00	▶ 0 00	▶ 00	0 00
2. Mutual fund exempt-interest dividends from non-Connecticut state or municipal government obligations	2.	▶ 0 00	▶ 0 00	▶ 00	0 00
3. Certain deductions relating to income exempt from Connecticut income tax	3.	▶ 0 00	▶ 0 00	▶ 00	0 00
4. *Reserved for future use*	4.				
5. Other - specify:	5.	▶ 0 00	▶ 0 00	▶ 00	0 00
Subtractions: Enter all amounts as positive numbers.					
6. Interest on U.S. government obligations	6.	▶ 0 00	▶ 0 00	▶ 00	0 00
7. Exempt dividends from certain qualifying mutual funds derived from U.S. government obligations	7.	▶ 0 00	▶ 0 00	▶ 00	0 00
8. Certain expenses related to income exempt from federal income tax but subject to Connecticut tax	8.	▶ 0 00	▶ 0 00	▶ 00	0 00
9. *Reserved for future use*	9.				
10. Other - specify:	10.	▶ 0 00	▶ 0 00	▶ 00	0 00

NEW ERA REHABILITATION CENTER INC. 02-0596949

Part VI – Connecticut-Sourced Portion of Items From Federal Schedule K-1 of Form 1065 or Form 1120S.

Include member's share of Connecticut modifications from Part V.
Attach supplemental attachment(s), if needed.

		Member #	Member #	Member #	Totals for All Members
1. Ordinary business income (loss)	1.	▶ 00	▶ 00	▶ 00	0 00
2. Net rental real estate income (loss)	2.	▶ 00	▶ 00	▶ 00	0 00
3. Other net rental income (loss)	3.	▶ 00	▶ 00	▶ 00	0 00
4. Guaranteed payments	4.	▶ 00	▶ 00	▶ 00	0 00
5. Interest income	5.	▶ 00	▶ 00	▶ 00	0 00
6a. Ordinary dividends	6a.	▶ 00	▶ 00	▶ 00	0 00
6b. Qualified dividends	6b.	▶ 00	▶ 00	▶ 00	0 00
7. Royalties	7.	▶ 00	▶ 00	▶ 00	0 00
8. Net short-term capital gain (loss)	8.	▶ 00	▶ 00	▶ 00	0 00
9a. Net long-term capital gain (loss)	9a.	▶ 00	▶ 00	▶ 00	0 00
9b. Collectibles (28%) gain (loss)	9b.	▶ 00	▶ 00	▶ 00	0 00
9c. Unrecaptured section 1250 gain	9c.	▶ 00	▶ 00	▶ 00	0 00
10. Net section 1231 gain (loss)	10.	▶ 00	▶ 00	▶ 00	0 00
11. Other income (loss): Attach statement.	11.	▶ 00	▶ 00	▶ 00	0 00
12. Section 179 deduction	12.	▶ 00	▶ 00	▶ 00	0 00
13. Other deductions: Attach statement.	13.	▶ 00	▶ 00	▶ 00	0 00

Part VII – Connecticut Income Tax Credit Summary

Attach supplemental attachment(s), if needed.

		Member # 1	Member # 2	Member #	Totals for All Members
1. *Reserved for future use*	1.				
2. Job expansion tax credit	2.	▶ 0 00	▶ 0 00	▶ 00	▶ 0 00
3. Angel investor tax credit	3.	▶ 0 00	▶ 0 00	▶ 00	▶ 0 00
4. Insurance reinvestment fund tax credit	4.	▶ 0 00	▶ 0 00	▶ 00	▶ 0 00
5. Total credits: Add Lines 2 through 4.	5.	0 00	0 00	00	0 00

The PE must furnish Schedule CT K-1 to all members.

Visit the DRS website at **www.ct.gov/TSC** to use the **Taxpayer Service Center *(TSC)*** to file and pay this return electronically.

Paper returns may **only** be submitted by taxpayers who have been granted an electronic filing waiver from DRS or amended returns.

To pay by mail, make check payable to **Commissioner of Revenue Services.**

Mail return **with** payment to: Department of Revenue Services, State of Connecticut, PO Box 5019, Hartford CT 06102-5019.

Mail return **without** payment to: Department of Revenue Services, State of Connecticut, PO Box 2967, Hartford CT 06104-2967.

Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to DRS is a fine of not more than $5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer other than the taxpayer is based on all information of which the preparer has any knowledge.

Sign Here	Signature of general partner or corporate officer	Date	May DRS contact the preparer shown below about this return? ☐ Yes ☒ No (See instructions, Page 30.)
	Title	Telephone number	
Keep a copy of this return for your records.	Email address of general partner or corporate officer ▶		
	Paid preparer's signature	Date ▶ 5/11/2016	
	Paid preparer's name (printed) ANIKE BOLARINWA	Preparer's SSN or PTIN ▶ P00490246	☐ SSN ☒ PTIN
	Firm's name and address ANNCO CONSULTING LLC, CERTIFIED PUBLIC ACCOUNTA 4634 WHITE PLAINS ROAD, BRONX, NY 10470	FEIN 13-4187097	Telephone number (718) 882-7500

Department of Revenue Services
State of Connecticut
(Rev. 12/15)

Schedule CT K-1
Member's Share of Certain Connecticut Items

2015

For calendar year 2015 or other taxable year ► beginning _____, 2015, and ► ending _____, 20 ___.

Complete in blue or black ink only.

Pass-through entity (PE) Information		Member information	
Federal Employer ID Number (FEIN)	CT Tax Registration Number	Member's Social Security Number (SSN) or FEIN	► [X] SSN ► [ ] FEIN
► 02-0596949	► 0000554-000	► 126-70-2671	Member: 1
Name		Name	
► NEW ERA REHABILITATION CENTER INC.		► EBENEZER KOLADE	
Number and street address	PO Box	Number and street address	PO Box
► 3715 MAIN STREET		► 38 CRAWFORD ROAD	
City or town	State ZIP code	City or town	State ZIP code
► BRIDGEPORT	CT 06606	► WESTPORT	CT 06880

Check the box if this is an amended or a final Schedule CT K-1.

► [ ] Amended Schedule CT K-1 ► [ ] Final Schedule CT K-1

Type of member (check one):

► [X] RI ► [ ] RE ► [ ] RT ► [ ] PE
► [ ] NI ► [ ] NE ► [ ] NT ► [ ] CM

Part I - Connecticut Modifications

From Form CT-1065/CT-1120SI, Part V

Additions Enter all amounts as positive numbers.

1.	Interest on state and local obligations other than Connecticut	1.	0 00
2.	Mutual fund exempt-interest dividends from non-Connecticut state or municipal government obligations	2.	0 00
3.	Certain deductions relating to income exempt from Connecticut income tax	3.	0 00
4.	*Reserved for future use*	4.	
5.	Other - specify	5.	0 00

Subtractions Enter all amounts as positive numbers.

6.	Interest on U.S. government obligations	6.	0 00
7.	Exempt dividends from certain qualifying mutual funds derived from U.S. government obligations	7.	0 00
8.	Certain expenses related to income exempt from federal income tax but subject to Connecticut tax	8.	0 00
9.	*Reserved for future use*	9.	
10.	Other - specify	10.	0 00

Part II - Connecticut-Sourced Portion of Items From Federal Schedule K-1 of Form 1065 or 1120S

		Column A From Federal Schedule K-1	Column B From Form CT-1065/CT-1120SI, Part VI
1.	Ordinary business income (loss)	1. 0 00	► 0 00
2.	Net rental real estate income (loss)	2. 0 00	► 0 00
3.	Other net rental income (loss)	3. 0 00	► 0 00
4.	Guaranteed payments	4. 0 00	► 0 00
5.	Interest income	5. 0 00	► 0 00
6a.	Ordinary dividends	6a. 0 00	► 0 00
6b.	Qualified dividends	6b. 0 00	► 0 00
7.	Royalties	7. 0 00	► 0 00
8.	Net short-term capital gain (loss)	8. 0 00	► 0 00
9a.	Net long-term capital gain (loss)	9a. 0 00	► 0 00
9b.	Collectibles 28% gain (loss)	9b. 0 00	► 0 00
9c.	Unrecaptured section 1250 gain	9c. 0 00	► 0 00
10.	Net section 1231 gain (loss)	10. 0 00	► 0 00
11.	Other income (loss): Attach statement.	11. 0 00	► 0 00
12.	Section 179 deduction	12. 0 00	► 0 00
13.	Other deductions: Attach statement.	13. 0 00	► 0 00

Part III - Connecticut Income Tax Information

1.	Member's Connecticut income tax liability as reported by the PE for the member on Form CT-1065/CT-1120SI, Part I, *Schedule B*, Column F	1.	0 00

EBENEZER KOLADE

Member: 1

126-70-2671

Part IV - Connecticut Income Tax Credit Summary

		Column A Total credit earned by member in 2015 (from Form CT-1065/CT-1120SI, Part VII)	Column B Credit allowed on behalf of member on composite return (amounts from worksheet below)
1. *Reserved for future use.*	1.		
2. Job expansion tax credit	2.	► 0 00	► 0 00
3. Angel investor tax credit	3.	► 0 00	► 0 00
4. Insurance reinvestment fund tax credit	4.	► 0 00	► 0 00
5. Total credits: Add Lines 2 through 4.	5.	0 00	0 00

Income Tax Credit Worksheet

Completed for nonresident, noncorporate, and PE members only		Column A Tax credit limitation	Column B 2015 credit amount earned (enter amounts from Part IV, Column A)	Column C Amount of credit applied to 2015 income tax liability
1. Income tax liability: PE should enter member's amount from Form CT-1065/CT-1120SI, Part I, *Schedule B,* Column D.	1.	0 00		
2. *Reserved for future use.*	2.			
3. *Reserved for future use.*	3.			
4. Job expansion tax credit: Enter in Column C the lesser of Line 4, Column B, or Line 1, Column A.	4.		0 00	0 00
5. Balance of income tax liability: Subtract Line 4, Column C from Line 1, Column A. If less than zero, enter "0."	5.	0 00		
6. Angel investor tax credit: Enter in Column C the lesser of Line 6, Column B, or Line 5, Column A.	6.		0 00	0 00
7. Balance of income tax liability: Subtract Line 6, Column C from Line 5, Column A. If less than zero, enter "0."	7.	0 00		
8. Insurance reinvestment fund tax credit: Enter in Column C the lesser of Line 8, Column B, or Line 7, Column A.	8.		0 00	0 00

Department of Revenue Services
State of Connecticut
PO Box 150420
Hartford CT 06115-0420

(Rev. 12/15)

Form CT K-1T

Transmittal of Schedule CT K-1, Member's Share of Certain Connecticut Items

2015

For DRS use only
- - 20

Complete this form in blue or black ink only.

Pass-Through Entity Information

► Federal Employer ID Number (FEIN)	CT Tax Registration Number
02-0596949	0000554-000

► Pass-through entity name
NEW ERA REHABILITATION CENTER INC.

► Number and street address | PO Box
3715 MAIN STREET

► City or town | State | ZIP code
BRIDGEPORT | CT | 06606

Part I - Schedule CT K-1s Submitted

1. Total number of Schedule CT K-1s submitted with this Form CT K-1T ►	1.	2

Part II - Number of Members

	Column A Number of Members	Column B Ownership Percentage by Member Type
1. Resident (RI, RT, RE)	2	100.000000%
2. Nonresident (NI, NT, NE, PE)	0	0.000000%
3. Corporate (CM)	0	0.000000%

Part III - Summary of Schedule CT K-1 Information

1. Total Connecticut-sourced income (NI, NT, NE) ►	1.	0	00
2. Total Connecticut-sourced income (PE) ►	2.	0	00
3. Connecticut-sourced income: Amount from Form CT-1065/CT-1120SI, Part I, *Schedule* A, Line 1 ►	3.	0	00
4. Connecticut tax liability: Amount from Form CT-1065/CT-1120SI, Part I, *Schedule* A, Line 4 ►	4.	0	00

Part IV - Summary of Income Tax Credits

		Total Credit Allocated to Members	
1. *Reserved for future use.* ►	1.		
2. Job expansion tax credit ►	2.	0	00
3. Angel investor tax credit ►	3.	0	00
4. Insurance reinvestment fund tax credit ►	4.	0	00
5. Total credits earned in 2015: Add Lines 2 through 4. ►	5.	0	00

Do not attach Form CT K-1T or copies of **Schedule CT K-1,** *Member's Share of Certain Connecticut Items* to **Form CT-1065/CT-1120SI,** *Connecticut Composite Income Tax Return.* Form CT K-1T and copies of Schedule CT K-1 **must be mailed separately.**

Attach Schedule CT K-1s to Form CT K-1T and **mail to:**
Department of Revenue Services
State of Connecticut
PO Box 150420
Hartford CT 06115 - 0420

A penalty of $5 per schedule (up to a total of $2,000 per calendar year) will be imposed for failure to provide a copy of Schedule CT K-1 to DRS unless the failure is due to reasonable cause and not to willful neglect.

Declaration: I declare under the penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than $5,000, imprisonment for not more than five years, or both.

Sign Here	Signature	Date
Keep a copy of this return for your records.	Title	Telephone number

1833

Department of Revenue Services
State of Connecticut
(Rev. 12/15)

Schedule CT K-1
Member's Share of Certain Connecticut Items

2015

For calendar year 2015 or other taxable year ► beginning _____, 2015, and ► ending _____, 20 ____.

Complete in blue or black ink only.

Pass-through entity (PE) information		Member information	
Federal Employer ID Number (FEIN)	CT Tax Registration Number	Member's Social Security Number (SSN) or FEIN	► [X] SSN ► [ ] FEIN
► 02-0596949	► 0000554-000	► 100-72-9856	Member: 2
Name		Name	
► NEW ERA REHABILITATION CENTER INC.		► CHRISTINA KOLADE	
Number and street address / PO Box		Number and street address / PO Box	
► 3715 MAIN STREET		► 38 CRAWFORD ROAD	
City or town / State / ZIP code		City or town / State / ZIP code	
► BRIDGEPORT CT 06606		► WESTPORT CT 06880	

Check the box if this is an amended or a final Schedule CT K-1.

► [ ] Amended Schedule CT K-1 ► [ ] Final Schedule CT K-1

Type of member (check one): ► [X] RI ► [ ] RE ► [ ] RT ► [ ] PE ► [ ] NI ► [ ] NE ► [ ] NT ► [ ] CM

Part I - Connecticut Modifications

From Form CT-1065/CT-1120SI, Part V

Additions Enter all amounts as positive numbers.

1.	Interest on state and local obligations other than Connecticut ►	1. 0 00
2.	Mutual fund exempt-interest dividends from non-Connecticut state or municipal government obligations ►	2. 0 00
3.	Certain deductions relating to income exempt from Connecticut income tax ►	3. 0 00
4.	*Reserved for future use* ►	4.
5.	Other - specify _____ ►	5. 0 00

Subtractions Enter all amounts as positive numbers.

6.	Interest on U.S. government obligations ►	6. 0 00
7.	Exempt dividends from certain qualifying mutual funds derived from U.S. government obligations ►	7. 0 00
8.	Certain expenses related to income exempt from federal income tax but subject to Connecticut tax ►	8. 0 00
9.	*Reserved for future use* ►	9.
10.	Other - specify _____ ►	10. 0 00

Part II - Connecticut-Sourced Portion of Items From Federal Schedule K-1 of Form 1065 or 1120S

		Column A (From Federal Schedule K-1)	Column B (From Form CT-1065/CT-1120SI, Part VI)
1.	Ordinary business income (loss)	1. 0 00	► 0 00
2.	Net rental real estate income (loss)	2. 0 00	► 0 00
3.	Other net rental income (loss)	3. 0 00	► 0 00
4.	Guaranteed payments	4. 0 00	► 0 00
5.	Interest income	5. 0 00	► 0 00
6a.	Ordinary dividends	6a. 0 00	► 0 00
6b.	Qualified dividends	6b. 0 00	► 0 00
7.	Royalties	7. 0 00	► 0 00
8.	Net short-term capital gain (loss)	8. 0 00	► 0 00
9a.	Net long-term capital gain (loss)	9a. 0 00	► 0 00
9b.	Collectibles 28% gain (loss)	9b. 0 00	► 0 00
9c.	Unrecaptured section 1250 gain	9c. 0 00	► 0 00
10.	Net section 1231 gain (loss)	10. 0 00	► 0 00
11.	Other income (loss): Attach statement.	11. 0 00	► 0 00
12.	Section 179 deduction	12. 0 00	► 0 00
13.	Other deductions: Attach statement.	13. 0 00	► 0 00

Part III - Connecticut Income Tax Information

1.	Member's Connecticut income tax liability as reported by the PE for the member on Form CT-1065/CT-1120SI, Part I, *Schedule B*, Column F ►	1. 0 00

CHRISTINA KOLADE

Member: 2

100-72-9856

Part IV - Connecticut Income Tax Credit Summary

		Column A Total credit earned by member in 2015 (from Form CT-1065/CT-1120SI, Part VII)	Column B Credit allowed on behalf of member on composite return (amounts from worksheet below)
1. *Reserved for future use.*	1.		
2. Job expansion tax credit	2.	0 00	0 00
3. Angel investor tax credit	3.	0 00	0 00
4. Insurance reinvestment fund tax credit	4.	0 00	0 00
5. Total credits: Add Lines 2 through 4.	5.	0 00	0 00

Income Tax Credit Worksheet

Completed for nonresident, noncorporate, and PE members only		Column A Tax credit limitation	Column B 2015 credit amount earned (enter amounts from Part IV, Column A)	Column C Amount of credit applied to 2015 income tax liability
1. Income tax liability: PE should enter member's amount from Form CT-1065/CT-1120SI, Part I, *Schedule B*, Column D.	1.	0 00		
2. *Reserved for future use.*	2.			
3. *Reserved for future use.*	3.			
4. Job expansion tax credit: Enter in Column C the lesser of Line 4, Column B, or Line 1, Column A.	4.		0 00	0 00
5. Balance of income tax liability: Subtract Line 4, Column C from Line 1, Column A. If less than zero, enter "0."	5.	0 00		
6. Angel investor tax credit: Enter in Column C the lesser of Line 6, Column B, or Line 5, Column A.	6.		0 00	0 00
7. Balance of income tax liability: Subtract Line 6, Column C from Line 5, Column A. If less than zero, enter "0."	7.	0 00		
8. Insurance reinvestment fund tax credit: Enter in Column C the lesser of Line 8, Column B, or Line 7, Column A.	8.		0 00	0 00

Item F (CT 1065, 1120SI, K1) - Connecticut Real Property Owned

	Property Name	Street Address	Street Address 2	City	State	Zip Code
1						

t III (CT 1065, 1120SI, K1) - Places of Business

	Address1	Address2	City	State	Zip Code	Country	Description	Owned or Rented	Activity
1									

Linda Mascolo, DNP, MSN, CNS-BC, APRN, CWON
378 Hawthorne Ave.
Derby, Connecticut 06418
(203) 736-0681
Linda.mascolo@yahoo.com

CLINICAL NURSE SPECIALIST

OBJECTIVE: Clinical Nurse Specialist/APRN position in adult healthcare. To support and coordinate health education and care while providing optimal multidisciplinary care.

SUMMARY: Experienced Nursing Specialist with strong clinical background. Successful track record in education planning and presentation. Several years experience in various leadership roles, including administrative, managerial, and financial. Skilled author and presentation speaker.

Key Qualifications:

- National Speaker
- Education Material Development
- Respected Nursing Expert
- Industry Thought Leader
- Accomplished Author
- Leadership Training Skills

EXPERIENCE

2013-Present

Milford Hospital, Milford, CT
Director of Nurses
Responsibility, authority and accountability for patient care administration and practice of identified nursing units and services. Provides leadership and direction to respective Patient Care Managers and contributes to and supports the philosophy and objectives of the Nursing Department and hospital to effect quality patient care, staff development and patient and staff satisfaction.

2009-Present

Incorporated Skin, Wound and Ostomy Education, LLC
Director for Athena Online Wound Care Course
Serves as director for online wound care course. Develops educational materials and programs. Reviews, proofreads, and comments on learning materials. Regularly updates materials and presentations to ensure highest quality education standards.

2006-2013

Norwalk Hospital, Norwalk, CT
APRN/Wound and Ostomy Care Specialist
Coordinates and facilitates various aspects of wound-related care. Organized and expanded the ostomy program, establishing the first ostomy support group in the facility. Updates care policy and procedure. Manages program budgeting and finances.

2005-2006

Kinetic Concept Inc., San Antonio, TX
Regional Wound Closure Specialist

Regional educational consultant. Support sales staff as well as clients regarding current wound care evidence and best practice. Work in collaboration with the R&D department to implement marketing and product education. Support product promotion at regional and national conferences and seminars.

2003-2005

Hospital of St. Raphael, New Haven, CT

Clinical Nurse Specialist in Wound, Skin and Ostomy
Provided clinical support to three surgical units. Led monthly continuing education unit for wound and ostomy care nurses. Performed wound and ostomy-related nursing duties on all medical and surgical units as needed.

Hospital of St. Raphael, New Haven, CT **2001-2003**
Staff Development, Education and Clinical Resource
Served as clinical support for all surgical floors. Coordinated and facilitated the wound and ostomy service. Held the following offices/titles:

- Cardiac Arrest Team Co-Chairperson
- Stroke Program Data Coordinator

Hospital of St. Raphael, New Haven, CT **1999-2001**
Emergency Department Staff Nurse
Experienceded staff nurse in a Level 2 Trauma Center.
Taught Advanced Cardiac Life Support to both nursing and physician staff.
Mentored staff new to the Emergency Room setting.

Hospital of St. Raphael, New Haven, CT **1992-1999**
Staff Development, Education and Clinical Resource
Provided support to the off-shift clinical staff. Assisted in the implementation of mandatory education for the off-shift staff. Coordinated the Certified Nurse Aid Program, in addition to Graduate Nurse orientation programs.

Hospital of St. Raphael, New Haven, CT **1987-1992**
Surgical Intensive Care Unit – Nurse Care Coordinator
Served as Nurse Care Coordinator. Presented educational in-services to night staff in the unit. Supervised nursing staff, providing education and resources to the unit. Oversaw patient selection. Responsible for patient resuscitation in the event of collapse.

Griffin Hospital, Derby, CT **1972-1987**
Intensive Care Unit Staff Nurse/Manager
Served as staff nurse for 8 years, before being promoted to acting manager.

EDUCATION

Sacred Heart University — Fairfield, Connecticut
Doctorate of Nursing — 2013

Southern Connecticut State University — New Haven, Connecticut
Master of Science in Nursing — 2004

Southern Connecticut State University — New Haven, Connecticut
Bachelor of Science in Nursing — 2000

Greenwich Hospital School of Nursing — Greenwich, Connecticut
Diploma Registered Nurse — 1972

PROFESSIONAL ACCREDITATION

CWCN – Certified Wound Care Nurse

COCN – Certified Ostomy Care Nurse

CCRN – Certified Critical Care Nurse (1990 – 2005)

Served on the board of the South Central Chapter of the American Critical Care Association for 2 years

American Heart Association ACLS Instructor (1994-2008)

TNCC – Trauma Nurse Certification 1995-2004

CATN- Advanced Trauma Nurse Certification

SANE – Sexual Assault Nurse Certification 2000-2003

PROFESSIONAL AFFILIATIONS

Wound, Ostomy and Continence Nurses Society
Sigma Theta Tau International Nursing Honor Society
American Heart Association
Norwalk Hospital Institutional Review Board

PUBLICATIONS

"Perioperative Wound Documentation." *Journal of Wound, Ostomy and Continence* 36 (3S) (2009): S14.

"Skin Care Team Improves Assessment and Documentation." *Nursing* 36.10 (2006): 66-67.

"Wound VAC Management for Spinal or Bone Graft Infections." *Spine Surgery: Tricks of the Trade*. Ed. Alex R. Vaccaro and Todd J. Albert. New York: Thieme, 2003. Print.

PRESENTATIONS

June 22, 2013	A Retrospective Study of the Impact of Preoperative Stoma Siting on Hospital Length of Stay at National WOCN Conference in Seattle, WA
October, 2012	Stoma Site Marking :Impact on Patient Outcomes and Hospital Length of Stay presented at the New England Regional Conference In Danvers, MA.
June 2010	Poster Presentation at WOCN conference in Phoenix, AZ
March 2009	Fistula Control Presentation at WOCN Regional Meeting in Fairfax, VA
Oct. 2004	Improved Patient Outcomes Post Lower Extremity Amputation at National Skin and Wound Conference in Phoenix, AZ
	Local Presentations given on various topics e.g. Skin and Wounds, Blood Pressure and Stroke.

HONORS

- 2012 Carol Bauer Scholarship Award
- 2011 Nurse Exemplar Award
- 2010 Norwalk Hospital Quality Award
- 2009 Norwalk Hospital Presidents Award
- 2005 "Woman of Note" in New Haven, CT
- 2005 Seton Clinical Excellence Award
- 2005 Nightingale Nurse Award

Maurice E. Bunnell

38 Leigh Drive

East Haven, CT 06512

203-927-7309

bunnell@aya.yale.edu

LICENSURE

Advanced Practice Registered Nurse, 2002—Present.

Registered Nurse, 1976—Present.

PROFESSIONAL POSITIONS

Psychiatric APRN: Liberty HealthCare: Independent Contractor with "Connections, Inc." Medication Evaluation, Medication Management, 6/2014-Present.

Psychiatric APRN: Waterbury Hospital. Medication Evaluation, Medication Management, 6/2015-4/2016.

Director of Education; Psychiatric Home Care Nurse; VNS of Southern CT, 4/2013—Present.

Psychiatric Home Care Nurse; In-Service Director; Total Care Visiting Nurses; New Haven, CT, 02/2010–4/2013.

Psychiatric Home Care Nurse, All About You; East Haven, CT, 01/2009—02/2010.

Commissioner of Mental Health, Town of East Haven; East Haven, CT, 2009—2010.

- Responsible for overseeing Town of East Haven Counseling Services.

Educated the public on eliminating the stigma of mental illness. Presentation on the History of Mental Illness.

Adult Nurse Practitioner; Hill Health Center; Dual Diagnosis Clinic; New Haven, CT, 2005.

Psychiatric Home Care Nurse; In-Service Director; New England Homecare; New Haven, CT, 1997—2009.

Administrator; Psychiatric Home Care Nurse; PrimeCare of CT; New Haven, CT, 1995–1997.

Yale-New Haven Hospital; New Haven, CT.

- Charge Nurse; Ear, Nose, and Throat Clinic, 1994–1995.
- Staff nurse; Cardio-Thoracic Intensive Care Unit, 1993–1994.
- Nursing Analyst; Clinical Care Support System Project, 1990–1993.
- Private Duty Nurse; Medical and Surgical Units, 1982–1989.
- Researcher; Phrenic Pacemaker (Dr. William Glenn), 1982–1989.
- Staff Nurse; In-Patient Psychiatry, 1981–1982.
- Assistant Head Nurse and Staff Nurse; Orthopaedics/Ear, Nose & Throat Unit, 1976–1981.

EDUCATION

Sacred Heart University: Bridgeport, CT: Doctor of Nursing Practice Student.

Yale University School of Nursing; New Haven CT: M. S. N., 2002. Completion of Scholarly Praxis, "QTc Prolongation and Torsades de Pointes Associated with Antipsychotic Agents".

ANCC Board Certification Adult Psychiatric and Mental Health Nurse Practitioner.

ANCC Board Certification Adult Nurse Practitioner.

Southern Connecticut State University; New Haven, CT: B. S. N., 1994.

Quinnipiac University; Hamden, CT: A. D. N., 1976.

AWARDS

Florence Nightingale Excellence in Nursing, 1994.

Who's Who in American Nursing, 1996.

PROFESSIONAL MEMBERSHIPS

Sigma Theta Tau; Delta Mu Chapter.

American Nurses Association.

Neuroscience Institute.

Ebenezer A. Kolade, M.D., FASAM

38 Crawford Rd. | Westport, CT 06880
Office: 203.372.3333 | Fax: 203.374.7515
Email: ekolade@sbcglobal.net

PROFESSIONAL EXPERIENCE

New Era Rehabilitation Center Inc, Bridgeport, CT/ New Haven, CT — **06/02 – Present**
Chief Executive Director | Medical Director

- Supervising Medical, Nursing, Administration and Counseling Department.
- Clinical evaluation of all patients admitted into the program.

St. Barnabas Union Hospital, Bronx, NY — **07/90 – 05/02**
Medical Director of the Alcohol and Drug Detoxification Inpatient Program — *07/01 – 05/02*

- Supervising Medical, Nursing, Administration and Counseling Department.
- Clinical evaluation of patients admitted into the program.

Medical Supervisor of Alcohol and Drug Detoxification Inpatient Program — *10/98 – 06/01*

- Supervising all Medical Staff
- Clinical evaluation of patients admitted into the program.

Emergency Attending Physician — *07/92 – 09/98*

- Managing medical inpatients and running outpatient clinic.
- Managing inpatient alcohol and drug detoxification unit
- Medical consultation in surgical, psychiatric, Obstetrics and Gynecology unit

Residency in Internal Medicine — *07/90 – 06/92*

Brookdale Hospital Medical Center, Brooklyn, NY — **07/89 – 06/90**
Intern in Internal Medicine

Parkway Medical Office, Brooklyn, NY — **08/86 – 06/89**
Medical Physician

University College Hospital, Ibadan, Nigeria — **07/83 – 06/86**
OB/GYN Resident

- Outpatient and Inpatient management.
- Medical Student and Resident teaching

Mariere Memorial Hospital, Ughelli, Nigeria — **07/82 – 06/83**
General Medicine Practitioner

University of Ibadan, Nigeria — **07/81 – 06/82**
Rotating Internship

Ebenezer A. Kolade, M.D., FASAM

38 Crawford Rd. | Westport, CT 06880
Office: 203.372.3333 | Fax: 203.374.7515
Email: ekolade@sbcglobal.net

PROFESSIONAL EXPERIENCE

New Era Rehabilitation Center Inc, Bridgeport, CT/ New Haven, CT — **06/02 – Present**
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- Clinical evaluation of patients admitted into the program.

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- Supervising all Medical Staff
- Clinical evaluation of patients admitted into the program.

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- Medical consultation in surgical, psychiatric, Obstetrics and Gynecology unit

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Intern in Internal Medicine

Parkway Medical Office, Brooklyn, NY — **08/86 – 06/89**
Medical Physician

University College Hospital, Ibadan, Nigeria — **07/83 – 06/86**
OB/GYN Resident
- Outpatient and Inpatient management.
- Medical Student and Resident teaching

Mariere Memorial Hospital, Ughelli, Nigeria — **07/82 – 06/83**
General Medicine Practitioner

University of Ibadan, Nigeria — **07/81 – 06/82**
Rotating Internship

Adeoluwa A. Kolade
38 Crawford Road, Westport, 06880
Dakolade@gmail.com
, Tel-2035439950

EDUCATION

Emory University — Atlanta, GA — May 2009
Master's Degree: Management & Policy
Relevant Coursework: Finance, Financial Accounting, Portfolio Management, Securities Analysis, Statistics

The George Washington University — Washington, DC — May 2007
Bachelor of Criminal Law
Relevant Coursework: Microeconomics, Macroeconomics, Statistics

WORK EXPERIENCE

New Era Rehabilitation Center – Operations Department — Bridgeport, CT — Jan 2014 - Present
Director of Operations

- Responsible for the supervision of 40+ employees between 2 facilities
- Visionary with a track record for finding innovative ways to grow revenue and increase margins
- Manage all the accounts payable and receivable within the organization with full P&L responsibilities
- Forward-thinker with the ability to implement all new technology within the facility including electronic medical records
- Developed internal outreach and referral program that consistently generated 5 patient leads per week
- Well versed in conducting presentations, accustomed to conducting all formal correspondence with the state agencies and corporations
- Articulate communicator, capable of building lasting relationships with senior management of clients, partners and vendors
- Expertise in collecting, managing and interpreting key operation metrics and statistics
- Calm under pressure with the ability to manage crises

Stanbic IBTC- Investment Banking — Lagos, Nigeria — Jan 2012- Jan 2013
Analyst

- Lead analyst on the $20mm minority buy-out of a network and communications provider
- Lead analyst on a $50mm equity capital raising for Computer Warehouse Group, a top tier ICT company (private placement)
- Assisted in the rights issue of Flour Mills of Nigeria PLC
- Assisted in the Pre-IPO financing of SEPLAT: a large scale indigenous oil and gas exploration company
- Assisted in the dual IPO of SEPLAT: a large scale indigenous oil and gas exploration company
- Assisted in the IPO of a REIT with a total offer size of $180mm

Afrinvest –Wealth Management/Business Development — Lagos, Nigeria — Aug 2010 – Dec 2011
Analyst

- Performed securities valuations (DCF and Comparables) and contributed to the design of an in-house factor model in order to guide investment decisions for the Afrinvest Equity Fund
- Conducted a comprehensive global economic analysis that was used to guide the departments investment strategy for the year
- Contributed in the structuring of the Afrinvest Principles and Value Fund, a fund backed with convertible notes possessing both equity and debt properties
- Assisted in the creation of the fund structure, pitch book, information memorandum and conducted the due diligence of a possible acquisition of Access Asset Management as well as two potential funds that have not yet been released

New Era Rehabilitation Center – Operations Department — Bridgeport, CT — Aug 2009 - Aug 2010
Operations Manager

- Created detailed presentations in response to Requests For Proposals to provide treatment for a number of patients in the Fairfield County area that resulted in a $500k increase in revenue
- Developed financial models that were used for financial due diligence required for an acquisition and constructed 5-year strategic plan including SWOT analysis, financial budgets and growth projections
- Implemented and managed relevant statistics and metrics for the facility, including Counselor to Patient ratio, Census, Charge per patient, Reimbursement per Patient, number of billed patients per week etc.

PriceWaterhouseCoopers LLP. -Public Sector and Healthcare — Atlanta, GA — Jan 2009-Aug 2009
Consultant

- Developed a model to estimate the economic impact of substance abuse in various states
- Contributed to the re-organization of the Blanchard Valley Hospital Emergency Department which decreased patient wait times by 31% and patient length of stay by 27%
- Analyzed over 47,000 emergency department claims to determine service trend in order to implement re-organization strategy for Blanchard Valley Hospital
- Conducted statistical analysis on various facets of the U.S. healthcare industry in order to identify inefficiencies and made recommendations to rectify them; specifically a cost-benefit analysis on the effects of incarcerating substance abusers vs. treatment for substance abusers

Kathleen Whelan Ulm, Consultant
4 Madaket Court
Guilford, CT 06437

To Whom It May Concern,

I am writing to support the New Era Rehabilitation Center In their applications to become a provider of Mental Health Services at their Bridgeport and New Haven locations.

As a clinician in the field of mental health and addiction services for thirty years, I am aware of how mental health and other psychosocial needs complicate the treatment of this population. Today, New Era must turn to these two major communities to provide those services.
As a consultant for New Era over the past year, I have witnessed the challenges of connecting mentally ill substance abusers on methadone and Medicaid to resources in the community. And when they do find willing providers, they are often not well versed in the nuances of methadone maintenance, such as the interaction of psychotropic drugs with methadone. Communication between agencies is another challenge.

Studies conducted by Dartmouth and available through SAMHSA show evidence that if all services can be provided at the same agency, outcomes improve. This is especially important when working with clients in a special modality such as methadone maintenance. New Era is an expert in this modality. New Era MUST provide these services.

Sincerely,
Kathleen Whelan-Ulm, MA, LADC, CCS

Kathleen Whelan Ulm, MA, LADC, CCS

New Era Rehabilitation Center
3851 Main Street Bridgeport, CT 06606
Phone 203-372-3333 | Fax 203-374-7515 |

Fax Cover Sheet

TO: OHCA	FROM: Cindy Carroll
FAX: 860-418-7053	PAGES: 4 (Includes Cover Sheet)
PHONE:	DATE: 1/25/17
RE: Proof of CON AD	CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments:

Please see Attached for proof of Ad for CON-
-New Haven Register
-Connecticut Post
Three consecutive days 1/20, 1/21, 1/22

Thank you.

NEW HAVEN REGISTER THE REGISTER CITIZEN The Middletown Press Farmington Valley Times CONNECTICUT
SHORELINE TIMES The Foothills Trader WEST HARTFORD NEWS MINUTEMAN Connecticut Bride
Bulletin THE GRANBY NEWS the Dolphin THE LITCHFIELD COUNTY TIMES Post-Chronicle

RECEIPT

01/18/17

New Haven Register
100 Gando Drive
New Haven, CT 06513

Phone: **1-203-850-6628**

Account:	1013910
Name:	
Company:	NEW ERA REHABILITAION
Address:	3851 MAIN ST, 2ND FLOOR BRIDGEPORT, CT 06606
Telephone:	(203) 372-3333
Description:	certificate of need For additional s

Gross:	$155.45
Paid Amount:	- $155.45
Amount Due:	$0.00

Date:	01/18/17
Ad Date:	01/20/17
Class:	1060
Ad ID:	1235258
Ad Taker:	CRDHENDRIC30
Sales Person:	Denise Hendricks (200316)
Words:	23
Lines:	7
Agate Lines:	9
Column width:	1
Depth:	0.931
Inserts:	7
Blind Box:	

Publication

New Haven Register, nhregister.com, nhregister.com2

Ad sample

CERTIFICATE OF NEED FOR
Additional service
for mental health &
co-occuring program.
New Era Rehab Center
311 East Street
New Haven, CT 06511

We Appreciate Your Business!
Thank You !

21ST CENTURY media

Cindy Carroll

From: Denise Hendricks [dhendricks@newspaperclassifieds.com]
Sent: Wednesday, January 18, 2017 11:34 AM
To: Cindy Carroll
Subject: New Haven Register Proof/Receipt
Attachments: NEWERAREHA-45-1235258-1 (1).pdf

Cindy:

Attached is your proof/receipt. Deolu just called and gave me the credit card so your ad is all set to run Friday, Saturday & Sunday, Jan. 20, 21 & 22 in the New Haven Register in print and online. The total is $155.45.

Thank you so much.

--

Denise Hendricks

Regional Classified Sales Representative for:
Connecticut, Massachusetts & Michigan

Phone: 248.745.4501
Fax: 248.284.1440

dhendricks@newspaperclassifieds.com

Order Confirmation

Ad Order Number
0002226906

Customer
New Era ,Rehab

Payor Customer
New Era ,Rehab

Sales Rep.
asasser

Customer Account
236833

Payor Account
236833

Order Taker
asasser

Customer Address
3851 Main Street
BRIDGEPORT CT 06606 USA

Payor Address
3851 Main Street
BRIDGEPORT CT 06606 USA

Ordered By
Cindy

Customer Phone
203-372-3333

Payor Phone
203-372-3333

Order Source
E-mail

PO Number

Customer Fax

Customer EMail
ccarroll@neweracrehab.com

Ad Content Proof

Certificate of Need for additional service for Mental Health and Co-occurring program, New Era Rehab 3851 Main St, Bridgeport, CT 06606 .

Tear Sheets	Proofs	Affidavits	Special Pricing	Promo Type
0	0	0	None	

Order Notes:

Invoice Text:

Blind Box

Materials

Payment Method

Net Amount	Tax Amount	Total Amount	Payment Amt	Amount Due
$235.59	$0.00	$235.59	$0.00	$235.59

Ad Number	Ad Type	Ad Size	Pick Up Number
0002226906-01	CLS Liner	1.0 X 7 Li	0002194359

External Ad #

Ad Released
No

Ad Attributes

Color
<NONE>

Production Method
AdBooker

Production Notes

Product / Run Dates / Sort Text / Run Schedule Invoice Text	Placement/Class	# Inserts	Cost
Connecticut Post::	Announcements	3	$231.59
1/20/2017, 1/21/2017, 1/22/2017			
CERTIFICATEOFNEEDFORADDITIONALSERVICEFORMENTALHEALTHANDCOOCCI			
Certificate of Need for additional service for Mental Health and			
Connpost.com::	Announcements	3	$4.00
1/20/2017, 1/21/2017, 1/22/2017			
CERTIFICATEOFNEEDFORADDITIONALSERVICEFORMENTALHEALTHANDCOOCCI			
Certificate of Need for additional service for Mental Health and			

Order Confirmation

Ad Order Number	Customer	Payor Customer
0002181842	MACK,MICHELLE	MACK,MICHELLE
Sales Rep.	**Customer Account**	**Payor Account**
asasser	236833	236833
Order Taker	**Customer Address**	**Payor Address**
asasser	3851 Main st BRIDGEPORT CT 06606 USA	3851 Main st BRIDGEPORT CT 06606 USA
Ordered By		
Michelle	**Customer Phone**	**Payor Phone**
Order Source	203-372-3333	203-372-3333
Phone		
PO Number	**Customer Fax**	**Customer EMail**
		m.mack@newerarehab.com

Ad Content Proof

EXPANSION OF Services New Era Rehabilitation plan to expand serv ices for mental health treatment.

Tear Sheets	Proofs	Affidavits	Special Pricing	Promo Type
0	0	0	None	

Order Notes:

Invoice Text:

Blind Box	Materials	Payment Method
		Credit Card

Net Amount	Tax Amount	Total Amount	Payment Amt	Amount Due
$146.82	$0.00	$146.82	$146.82	$0.00

Ad Number	Ad Type	Ad Size	Pick Up Number
0002181842-01	CLS Liner	1.0 X 4 Li	

External Ad #	Ad Released	Ad Attributes
	No	

Color	Production Method	Production Notes
<NONE>	AdBooker	

Product Run Dates Sort Text Run Schedule Invoice Text	Placement/Class	# Inserts	Cost
Connecticut Post:: 7/13/2016, 7/14/2016, 7/15/2016 EXPANSIONOFSERVICESNEWERAREHABILITATIONPLANTOEXPANDSERVICESFORMENTAL Expansion of Services New Era Rehabilitation plan to expand serv	Announcements	3	$142.82
Connpost.com:: 7/13/2016, 7/14/2016, 7/15/2016 EXPANSIONOFSERVICESNEWERAREHABILITATIONPLANTOEXPANDSERVICESFORMENTAL Expansion of Services New Era Rehabilitation plan to expand serv	Announcements	3	$4.00

MARKETPLACE

203-333-4151
classifieds@hearstmediact
Hours: 8:30 a.m.–4:30 p.
Major Credit Cards Acce

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sale Autos
CT's #1
rship
unlimited
otivated
ability to

ANNOUNCEMENTS

EXPANSION OF Services New Era Rehabilitation plan to expand services for mental health treatment.

LOST AND FOUND

STRATFORD

MERCHAND

BATHR WOOD
GREAT FOR TC
$25 CALL 203
BATHROOM V
deep. Wht sin
cabinet 203-8
BATH TOP

NEW ERA
REHABILITATION
A LIFE TRANSFORMED

Certificate of Need
Additional Information
Docket Number 16-32115-CON

1. **Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the applicant.**

   See Attachment

2. **Place a checkmark (✓) in the "Needed 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.**

Table 1: DPH Licenses Needed for the Proposal

License	Needed for Proposal
Psychiatric Outpatient Clinic for Adults	✓
Mental Health Day Treatment (outpatient- one unit of service must be four (4) hours or more per person daily also known as Partial Hospitalization)	✓
Mental Health Residential Living Center	☐
Mental Health Community Residence	☐
Facility for the Care or the Treatment of Substance Abusive or Dependent Persons:	☐
Select at least one of the following if proposing substance abuse treatment services:	
Ambulatory Chemical Detox (outpatient) ☐	
Day or Evening Treatment (outpatient, one unit of service is less than four (4) hours per person daily, includes IOP & OP) ☐	
Chemical Maintenance (outpatient, administers Methadone, DEA involved in approval) ☐	
Outpatient Treatment (outpatient) ☐	
Care or Rehab (residential) ☐	
Intermediate and long term treatment and rehab (residential) ☐	
Detoxification & Evaluation (residential) ☐	

3. Explain how the proposed mental health treatment program will operate, including the services to be provided, treatment approaches and structure.

NERC's goal is to provide comprehensive, recovery-oriented care for adults 18 years and older with mental health and/or co-occurring disorders. NERC's treatment approach to recovery-oriented care is based on DMHAS Practice Guidelines that define recovery and recovery-oriented care:

- Recovery refers to the ways in which persons with mental illness, addiction, and/or medical/physical issues experience and manage their disorder in the process of maintaining and/or reclaiming their life in the community
- Recovery-oriented care is what psychiatric, addiction, primary medical treatment and rehabilitation practitioners offer in support of the person's recovery and/or management of his or her chronic illness/condition

NERC provides mental health services to clients in any of the substance abuse programs toward improving access, engagement and continuity of care. Individual person-centered recovery plans for clients will address all identified behavioral health needs. Clients are not expected or required to progress in treatment through a pre-determined continuum of care.

The services will be provided by a combination of licensed psychiatrists, psychiatric APRNs, Licensed Professional Counselors and Licensed Marriage and Family Therapists. The inter-disciplinary team will be employing medication therapy, individual and group counseling, staged interventions, motivational enhancement therapy, cognitive behavioral therapy and social support interventions. The structure of the treatment ranging from intake to discharge planning is outlined in the policy and procedures for the mental health program.

4. 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.

NERCs treatment approach will be based on DMHAS Practice guidelines that define recovery and recovery-oriented care.

5. Describe how other residents in the proposed service area of the NERC New Haven location would access the proposed services. How are these potential clients currently receiving mental health treatment?

NERC is located at 311 East Street, New Haven, CT. The facility is approximately 500 feet from

the Grand Ave and East Street bus stop. This bus stop is on the CT Transit C and D lines, making it very accessible from surrounding towns. In addition the facility is located less than a mile from Exit 2 on Interstate 91 and about 2 miles from Exit 46 on Interstate 95. NERC NH currently possesses a client base of nearly 400 MMTP clients who have no trouble accessing services by both public and private transportation methods.

Currently these patients receive treatment at the following facilities:

Connection Inc
Outpatient Clinic
205-209 Orange Street
1st Floor
New Haven, CT 06510

Yale New Haven Psychiatric Hospital
Adult Intensive Outpatient
425 George Street
New Haven, CT 06511

Cornell Scott Hill Health Center
Northside Community Outpatient Servs
226 Dixwell Avenue
2nd Floor Suite 200
New Haven, CT 06511

6. Provide the number of months covered in Table 8 on page 31. Also, please update the table to reflect utilization by town for the Bridgeport location only.

TABLE 8
UTILIZATION BY TOWN

Town	Utilization FY 2016**
	14
Ansonia, CT	4
Beacon Falls, CT	5
Bethel, CT	235
Bridgeport, CT	1
Bridgewater, CT	2
Bristol, CT	4
Brookfield, CT	14
Danbury, CT	8
Derby, CT	2
Easton, CT	11
Faifield, CT	9
Milford, CT	5
Monroe, CT	16
Naugatuck, CT	1
New Canaan, CT	1
New Fairfield, CT	1
New Haven, CT	4
New Milford, CT	4
Norwalk, CT	1
Orange, CT	6
Oxford, CT	1
Redding, CT	3
Ridgefield, CT	9
Seymour, CT	34
Shelton, CT	2
Sandy Hook, CT	12
Seymour, CT	32
Shelton, CT	2
Southbury, CT	1
Staffordville, CT	2
Stamford, CT	31
Stratford, CT	1
Thomaston, CT	3
Torrington , CT	20
Trumbull, CT	29
	1

Waterbury, CT	1
Watertown, CT	1
West Haven, CT	2
Westport, CT	2
Winsted, CT	471
Wolcott, CT	
Total	

** Table 8 represents a period of 9 months; 01/01/16 - 09/30/16.

7. **Page 42 states that 20% of the total population will utilize the proposed program within 3 years, yet page 18 states that over 90% of NERC clients receiving substance abuse treatment are also suffering from mental illness. What proportion of NERC Bridgeport clients are currently suffering from co-occurring disorders? Explain how they will access and utilize the proposed services.**

According to NERC data 85% of BPT patients are suffering from co-occurring disorders. This number is approximated from the number of patients who are utilizing the facilities in house psychiatrist to be stabilized prior to being referred out as well as the number of clients receiving prescriptions from an external psychiatrist.

All patients being treated at NERC will have access to our mental health services. If a client is currently receiving substance about treatment from NERC, the client will alert their SA counselor that they are interested in receiving MH services as well. The SA counselor will alert the designated MH counselor who will complete a Mental Health Screening Form III (MSFIII). If the client is appropriate for treatment at NERC based on needed level of care as well as capacity the patient will be referred to the proposed NERC MH program. Once formally admitted into the program, the client will be assigned a specific MH counselor who will be charged with creating and maintaining the client's treatment plan as well as liaising between the client and the medical professional.

8. **The data in the table below is taken from Tables 5 and 6 on page 29. Please revise Tables 5 and 6 to include utilization for the Bridgeport location only. Provide the unit of measure**

(clients, sessions or visits) for the utilization data provided in the table. Confirm that the volume for IOP is included in the projected utilization for the mental health outpatient program. Also, provide the method of annualizing and the number of actual months covered for fiscal year 2016. Explain the 90% increase in the projected utilization for methadone maintenance in 2017 compared with the current fiscal year, should this still exist after revising the data.

	Actual Volume			CFY Volume	Projected Volume		
Service**	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Methadone Maintenance	N/A	22,672	23,400	24,232	26,410	28,731	28,756
IOP	N/A	75	540	540			
Mental Health Outpatient					4,136	5,657	5,657
Total	N/A	22,747	23,940	24,772			

TABLE 5
HISTORICAL UTILIZATION BY SERVICE

	Actual Volume (Last 3 Completed FYs)			CFY Volume*
Service**	FY 2013***	FY 2014***	FY 2015***	FY 2016***
Methadone Maintenance	N/A	22,672 claims	23,400 claims	25,012 claims
IOP	N/A	75 sessions	540 sessions	540 sessions
Total	N/A	22,747	23,940	24,772

* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the period covered.

** Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.

*** Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

Methadone maintenance is billed as a weekly bundle. Each claim for this service represents 1 week of treatment per 1 client. The FY of 2016 is a projected number comprised of 11 months of actual data (January-September) while the remainder of the year assumes a consistent rate of treatment through year end. The 90% jump is actually the result of a typo. NERC expects to conclude 2016 with a total of 481 clients. Assuming we obtain the mental health license in Q1 2017, we expect increased interest from underserved populations suffering from co-occurring mental health and substance abuse disorders. The interest will bring our patient population to increase about 5.6%. This will bring our 2017 census to 508 clients. The following year we

forecast the rate increasing by a 3.25% to increase by roughly 8.8% to 553 clients and approximately remain steady at that census through 2019.

Although NERC possesses an IOP license it does not have the ability to mandate IOP attendance. Historically, this has made IOP attendance highly variable and difficult to forecast. However going forward we expect the majority of the IOP patients to be mental health patients suffering from co-occurring conditions. According to NERC internal data, 85% of our current population exhibit signs of co-occurring disorders (see question 7). Applying this to the projected 2017 census of 508 clients, NERC possesses a comorbid population of 432 clients. Assuming 20% of these clients opt to receive mental health treatment with NERC, NERC will add 86 clients (or 17%) to the proposed mental health program in 2017. In 2018 we expect the mental health program to grow to 111 clients or 20% of the projected 2018 census. In 2019 we expect the growth to taper and remain steady at that census. Utilizing NERC internal data, we expect clients in our mental health program to attend an average of 2 sessions per month.

TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service*	Projected Volume		
	FY 2017**	FY 2018**	FY 2019**
Mental Health Outpatient	4,420	5,525	6,630
Methadone Maintenance	46,410	48,731	48,731
Total	50,830	54,256	55,361

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.

** 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. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

9. **According to the Behavioral Health Treatment Services Locator on the Substance Abuse and Mental Health Services Administration website (https://findtreatment.samhsa.gov), NERC of Bridgeport currently accepts cash or self-pay. Does this location accept Access to Recovery (ATR) Vouchers and have the availability of a sliding fee scale, similar to the New Haven location? Will this be extended to the proposed mental health treatment program? Provide a copy of the charity care policy if it applies to the proposal.**

NERC is no longer involved with the Access to Recovery program. However, NERC's stance on charitable care is as follows, New Era Rehabilitation Center is committed to providing charity care to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to

advocate for those who are poor and disenfranchised, New Era Rehabilitation strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. The facility will do this on a case by case basis and availability of such charity will also be available dependent on the facilities ability to deliver such care at the individual's time of need.

10. Provide the referral sources for the substance abuse treatment program for the Bridgeport location only.

Currently the majority of Bridgeport clients enroll in the facility through client to client referrals. However we do regularly receive referrals from The Summit House, First Step Detox, alongside a number a handful of private physicians in the area.

11. Include any copies of agreements (e.g. memorandum of understanding, transfer agreement, operating agreement) related to the proposal. This includes any key referral and/or transfer agreements with local providers.

See Attachment

12. Update and resubmit the Financial Worksheet (A) on pages 62 and 63 based on the Bridgeport location only. Include the net patient service revenue for commercial insurers in line 9. Verify any revenue included under "Other" non-government net patient service revenue. Also, verify there is no projected incremental income from Medicaid in line 6, column 12. Please include labels identifying the fiscal years.

See Attachment

13. Update Table 4 on page 28 based on the updated Financial Worksheet (A) for the Bridgeport location. Also, the table shows that fiscal year 2016 is projected to have $40,000 in incremental operating expenses. Please reflect this appropriately in Financial Worksheet (A).

Table 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2016*	FY 2017*	FY 2018*
Revenue from Operations	$46,344	$195,782	$213,124
Total Operating Expenses	$40,000	$40,000	$40,000

Gain/Loss from Operations	$6,344	$155,782	$173,124

* Fill in years using those reported in the Financial Worksheet attached.

14. Page 14 states that the existing location was chosen for the mental health treatment program to improve client health outcomes, including reduced rates of relapse. What is the rate of relapse for the Bridgeport location clients? Provide evidence such as scholarly articles, studies or reports which demonstrate how the location of the proposed services impacts rates of relapse.

NERC intends to locate the mental health treatment program in the same location as its current substance abuse treatment program, 3851 Main Street, Bridgeport, CT. The idea that the location will help reduce the rate of relapse and improve client health outcomes is not related to the physical location itself, but instead the theory of collocation. NERC believes by collocating both the substance abuse and the mental health treatment programs this will ensure better continuity of care.

This is supported in the following excerpt from the book: Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series.

> ***"Collocation and clinical integration of services*** *Physical proximity of would-be collaborators facilitates collaboration (IOM, 2004a). This point is exemplified by the multiple studies of mental or substance-use health care showing that same-site delivery of both types of care or primary care is more effective in identifying comorbid conditions (Weisner et al., 2001), effectively links clients to the collocated services (Druss et al., 2001; Samet et al., 2001), and can improve treatment outcomes (Unutzer et al., 2001; Weisner et al., 2001). In a 1995 study of a nationally representative sample of all outpatient drug-use treatment units, same-site delivery of services was more effective than formal arrangements with external providers, referral agreements, or case management in ensuring that patients would utilize necessary services (a first step in collaborative care) (Friedmann et al., 2000a). For these reasons, the collocation of multiple services (mental, substance-use, and/or general health) at the same site is a frequently cited feature of many care collaboration programs. The congressionally mandated study of prevention and treatment of co-occurring substance-use and mental conditions (SAMHSA, undated) highlighted "integrated treatment" as an evidence-based approach for co-occurring disorders, defined, in part, as services delivered "in one setting." The report noted that such integrated treatment programs can take place in either the mental or substance-use treatment setting, but require that treatment and service for both conditions be delivered by appropriately trained staff "within the same setting."*

15. Update the list of services and service locations of existing providers on pages 33 and 34 based on the service area for the Bridgeport location only.

See Attachment

16. Update Table 7 on page 30 to reflect the payer mix of the Bridgeport location only, based on patient and visit volume. Utilize the table format below. Ensure visit totals are consistent with "Outpatient Visits" in the Financial Worksheet (A). Also, please explain the basis and the assumptions used to project the reported numbers.

CURRENT AND PROJECTED PAYER MIX FOR
NEW ERA REHABILITATION CENTER, INC., BY NUMBER OF CLIENTS AND VISITS

Payer		Current			Projected								
	FY 2016 9/27/16	FY 2016			FY 2017			FY 2018			FY 2019		
	Patient Vol.	Pat. Vol.	%	Claim Vol.	Pat. Vol.	%	Claim Vol.	Pat. Vol.	%	Claim Vol.	Pat. Vol.	%	Claim Vol.
Medicare*	0	0	0	0	0	0	0	0	0	0	0	0	0
Medicaid*	430	448	93%	23,296	475	94%	24,700	520	94%	27,040	520	94%	27,040
CHAMPUS & TriCare	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Government	**430**	**448**	**93.1%**	**23,296**	**475**	**93.5%**	**24,700**	**520**	**94.0%**	**27,040**	**520**	**94.0%**	**27,040**
Commercial Insurers	5	5	1.0%	260	5	1.0%	260	5	0.9%	260	5	0.9%	260
Self-pay	28	28	5.8%	1,456	28	5.5%	1,456	28	5.1%	1,456	28	5.1%	1,456
Uninsured		0	0	0	0	0	0	0	0	0	0	0	0
Workers Comp.		0	0	0	0	0	0	0	0	0	0	0	0
Total Non-Government	**33**	**33**	**7%**	**1,716**	**33**	**6%**	**1,716**	**33**	**6.0%**	**1,716**	**33**	**6%**	**1,716**
Total Payer Mix	**463**	**481**	**100%**	**25,012**	**508**	**100%**	**26,416**	**553**	**100%**	**28,756**	**553**	**100%**	**28,756**

referrals. However we do regularly receive referrals from The Summit House, First Step Detox, alongside a number a handful of private physicians in the area.

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NEW ERA REHABILITATION CENTER, INC., BY NUMBER OF CLIENTS AND VISITS

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Commercial insurers	5	5	1.0%	260	5	1.0%	260	5	0.9%	260	5	0.9%	260
Self-pay	28	28	5.8%	1,456	28	5.5%	1,456	28	5.1%	1,456	28	5.1%	1,456
Uninsured		0	0	0	0	0	0	0	0	0	0	0	0
Workers Comp.		0	0	0	0	0	0	0	0	0	0	0	0
Total Non-Government	**33**	**33**	**7%**	**1,716**	**33**	**6%**	**1,716**	**33**	**6.0%**	**1,716**	**33**	**6%**	**1,716**
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User, OHCA

From: Mitchell, Micheala
Sent: Wednesday, March 22, 2017 2:42 PM
To: 'Akolade@newerarehab.com'
Cc: Walker, Shauna; Riggott, Kaila; User, OHCA
Subject: CON 17-32149 and CON 17-32150

Dear Mr. Kolade:

On February 21, 2017, the Office of Health Care Access received two Certificate of Need applications from New Era Rehabilitation Center, Inc., seeking authorization to establish psychiatric outpatient and mental health day treatment clinics for adults in Bridgeport, CT and New Haven, CT. We will electronically mail you two letters requesting additional information needed to analyze those applications no later than March 23, 2017.

Please be advised that each Certificate of Need application is distinct from the other and will be reviewed by different analysts. The following guidance will help you and your staff address our additional inquiries:

- Answer each question completely.
- Ensure that each response corresponds with the appropriate application. Do not include responses related to the Bridgeport location with responses related to the New Haven location and vice versa.
- Review all revised financial worksheets and all revised utilization and payer mix tables to ensure that they are accurate, relate specifically the service area of the pertinent application, and are fully responsive to each question.

Additionally, documents that correspond with the New Era Bridgeport CON application (CON 17-32149), specifically the current Department of Public Health licenses and the transfer agreement, were only included in the New Era New Haven CON application (CON 17-32150). Unless informed otherwise, these documents will be appended to the New Era Bridgeport CON application.

If you would like to schedule time to meet with us so that we can explain our process to you in person, please contact Shauna Walker at (860) 418-7069 or Micheala Mitchell at (860) 418-7055 at your earliest convenience. Scheduling a meeting with our staff will not extend the deadline date by which your responses are due.

Thank you,

Micheala L. Mitchell
Staff Attorney, PHHO/OHCA
Connecticut Department of Public Health
410 Capitol Avenue, MS# 13-HCA, Hartford, CT 06134
Phone: (860) 418-7055
Email: micheala.mitchell@ct.gov

User, OHCA

From: Walker, Shauna
Sent: Thursday, March 23, 2017 1:49 PM
To: akolade@newerarehab.com
Cc: Mitchell, Micheala; Riggott, Kaila; User, OHCA
Subject: Completeness Questions on CON Application # 17-32149
Attachments: 17-32149 Completeness Letter.docx

Dear Mr. Kolade:

Attached is a request for additional information regarding CON application 17-32149 – Establishment of a Psychiatric Outpatient and Mental Health Day Treatment Clinic for Adults in Bridgeport. Responses are due by **Monday May 22, 2017 at 4:30 p.m.**

Please confirm receipt of this email.

Much Regards,

Shauna L. Walker
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7069
Email: Shauna.Walker@ct.gov

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

March 23, 2017 Via Email Only

Mr. Adeoluwa Kolade
New Era Rehabilitation Center, Inc.
38 Crawford Road
Westport, CT 06880
akolade@newerarehab.com

RE: Certificate of Need Application: Docket Number: 17-32149-CON
Establishment of a Psychiatric Outpatient and Mental Health Day Treatment Clinic for Adults in Bridgeport
Certificate of Need Completeness Letter

Dear Mr. Kolade:

On February 21, 2017, OHCA received the Certificate of Need application from New Era Rehabilitation Center, Inc., ("NERC" or "Applicant"), seeking authorization to establish a psychiatric outpatient and mental health day treatment clinic for adults in Bridgeport. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" to electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. ***Please email your responses to both of the following email addresses: OHCA@ct.gov and Kaila.Riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 138** and reference "**Docket Number: 17-32149-CON**."

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was transmitted. Therefore, please provide your written responses to OHCA no later than **May 22, 2017, 4:30 p.m.**, otherwise your application will be automatically considered withdrawn.

1. Documents that correspond with the New Era Bridgeport CON application (CON 17-32149), specifically the current Department of Public Health licenses and the transfer agreement, were only included in the New Era New Haven CON application (CON 17-32150). These documents will be appended to the New Era Bridgeport CON application. Please confirm this action is appropriate.

2. Page 18 of the application states that the benefit cost-ratio achieved by providing addiction treatment is 7:1. Provide a copy of the study that uses this estimate.

3. Complete the last sentence in subsection "f" on page 16 of the application.

4. Provide a copy of the chapter from the book "Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series," which describes the theory of collocation, as mentioned on page 136 of the application.

5. Update Table 8 on pp.127-128 of the application to reflect utilization by town of client origin for the complete fiscal year of 2016. Utilization by town should be for the Bridgeport location only. Ensure the total correctly reflects the sum of the utilization for each town.

6. Page 14 of the application states that NERC clients currently receive partial services from the resident psychiatrist. How will the services that NERC currently provides differ from the proposed mental health treatment program?

7. Page 125 of the application states that clients will not be expected or required to progress in treatment through a predetermined continuum of care. Please explain.

8. Update the tables on page 129 of the application to include volume for the complete fiscal year of 2016. Additionally, include projections for the fiscal year of 2020. Projected estimates should include volume for intensive outpatient treatment (IOP). Specify whether the volume for partial hospitalization is included in your projections. If not, please revise the projected volume to include figures for partial hospitalization. Volume should reflect the Bridgeport location only.

9. Page 130 of the application states that clients in the proposed mental health treatment program will attend an average of two sessions per month, yet page 21 states that clients will attend one session per week. Clarify the number of sessions clients are expected to attend in the proposed program.

10. Describe how residents in Bridgeport and surrounding towns, who are not NERC clients, will be referred to the proposed mental health treatment program (e.g., self-referrals, referrals through behavioral health professionals, Connecticut state agencies, etc.). How and where are these potential clients currently receiving mental health treatment? Describe the impact of the proposal on these providers.

11. Update and resubmit the Financial Worksheet (A) on pages 67 and 68 of the application based on the Bridgeport location only. Include the net patient service revenue for commercial insurers on line 9. Verify any revenue included under "Other" non-government net patient service revenue. Also, verify there is no projected incremental income from Medicaid on line 6, column 12. The data should reflect complete fiscal year 2016 and four years of projections. Please include labels identifying the fiscal years. Projected outpatient volume with CON should be grouped by service (i.e., methadone maintenance, IOP and mental health treatment). Specify whether the number of sessions and claims will be added together.

12. Page 20 of the application lists $60,000 as the cost of adding a staff member. Page 21 lists the same cost at $40,000. Please confirm the cost.

13. Page 38 of the application states that two full-time DPH-licensed health care professionals, a Licensed Alcohol and Drug Counselor (LADC) and a Licensed Clinical Social Worker (LCSW), will be required to initiate the proposed mental health treatment program. Explain if either of these individuals are already employed by New Era, as page 21 states that the proposal will require one additional staff member.

14. Update Table 4 on page 135 of the application based on the updated Financial Worksheet (A) for the Bridgeport location. Updated figures should be based on projections for FY2017 through FY2020.

15. Update the list of services and service locations of existing providers on pages 33 and 34 of the application based on the service area for the Bridgeport location only. Do any of these providers offer methadone maintenance and mental health treatment in the same setting?

16. Utilize **Table A** on page 4 of this correspondence to update the payer mix for the Bridgeport location. The figures should be based on client and claim volume for the proposed mental health treatment program. The total payer mix should equal the total reported in the updated Financial Worksheet (A) for outpatient visit volume and the updated projection tables for the proposed program. Explain the basis and the methods and calculations used to project the reported numbers.

TABLE A: MENTAL HEALTH TREATMENT PROGRAM
PROJECTED PAYER MIX FOR
NEW ERA REHABILITATION CENTER, INC., BY NUMBER OF CLIENTS AND VISITS

Payer	Projected Payer Mix											
	FY 2017			FY 2018			FY 2019			FY 2020		
	Client Vol.	%	Visit Vol.	Client Vol.	%	Visit Vol.	Client Vol.	%	Visit Vol.	Client Vol.	%	Visit Vol.
Medicare*												
Medicaid*												
CHAMPUS & TriCare												
Total Government												
Commercial Insurers												
Self-pay												
Uninsured												
Workers Compensation												
Total Non-Government												
Total Payer Mix												

If you have any questions concerning this letter, please contact Kaila Riggott at (860) 418-7037.

User, OHCA

From: Adeoluwa Kolade <akolade@newerarehab.com>
Sent: Tuesday, May 16, 2017 1:51 PM
To: Riggott, Kaila
Cc: User, OHCA
Subject: Re: Follow up Question- Docket Number: 17-32149-CON & Docket Number: 17-32150-CON
Attachments: NERC MH CON NH Follow Up questions 5.16. 2017.docx; NERC MH CON BPT Follow Up questions 5.16. 2017.docx; CON MH BPT workbook 2016-2017 5.16.2017.pdf; CON MH NH workbook 2016-2017 5.16.2017.pdf; CON MH NH workbook 2016-2017.xlsx; CON MH BPT workbook 2016-2017.xlsx; Chapter 5 of Improving the Quality of Health Care for MH and Substance Use conditions Quality Chasm Adaptation (Collocation Theory).pdf; NERC MH CON BPT Follow Up questions 5.16. 2017.pdf; NERC MH CON NH Follow Up questions 5.16. 2017.pdf

Good Afternoon,

Please find attached.

Best Regards,

Deolu Kolade, MPH
Director of Operations
New Era Rehabiliation Center
akolade@newerarehab.com
Mobile:203-543-9950
Office: 203-372-3333 Ext. 28

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

March 23, 2017 Via Email Only

Mr. Adeoluwa Kolade
New Era Rehabilitation Center, Inc.
38 Crawford Road
Westport, CT 06880
akolade@newerarehab.com

RE: Certificate of Need Application: Docket Number: 17-32149-CON
Establishment of a Psychiatric Outpatient and Mental Health Day Treatment Clinic for Adults in Bridgeport
Certificate of Need Completeness Letter

Dear Mr. Kolade:

On February 21, 2017, OHCA received the Certificate of Need application from New Era Rehabilitation Center, Inc., ("NERC" or "Applicant"), seeking authorization to establish a psychiatric outpatient and mental health day treatment clinic for adults in Bridgeport. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" to electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. ***Please email your responses to both of the following email addresses: OHCA@ct.gov and Kaila.Riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 138** and reference "**Docket Number: 17-32149-CON**."

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was transmitted. Therefore, please provide your written responses to OHCA no later than **May 22, 2017, 4:30 p.m.**, otherwise your application will be automatically considered withdrawn.


NEW ERA
REHABILITATION
A LIFE TRANSFORMED

1. **Documents that correspond with the New Era Bridgeport CON application (CON 17-32149), specifically the current Department of Public Health licenses and the transfer agreement, were only included in the New Era New Haven CON application (CON 17-32150). These documents will be appended to the New Era Bridgeport CON application. Please confirm this action is appropriate.**

    - Confirmed, this action is appropriate.

2. **Page 18 of the application states that the benefit cost-ratio achieved by providing addiction treatment is 7:1. Provide a copy of the study that uses this estimate.**

    - According to a fact sheet published by the Office of National Drug Control Policy entitled: *Cost Benefits of Investing Early In Substance Abuse Treatment*; "Research shows that every dollar spent on substance abuse treatment saves $4 in healthcare costs and $7 in law enforcement and other criminal justice costs. 10 On average, substance abuse treatment costs $1,583 per patient and is associated with a cost offset of $11,487, representing a greater than 7:1 ratio of benefits to costs." Please find attached.

3. **Complete the last sentence in subsection "f" on page 16 of the application.**

    - We expect that the utilization of the services will be predominantly from NERC's current census.

4. **Provide a copy of the chapter from the book "Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series," which describes the theory of collocation, as mentioned on page 136 of the application.**

    - See Attachment

5. Update Table 8 on pp.127-128 of the application to reflect utilization by town of client origin for the complete fiscal year of 2016. Utilization by town should be for the Bridgeport location only. Ensure the total correctly reflects the sum of the utilization for each town.

Town	Census
Ansonia, CT	17
Beacon Falls, CT	4
Bethel, CT	4
Bozrah, CT	1
Bridgeport, CT	205
Bristol, CT	1
Brookfield, CT	1
Danbury, CT	13
Derby, CT	8
East Haven, CT	1
Easton, CT	1
Faifield, CT	13
Milford, CT	11
Monroe, CT	5
Naugatuck, CT	14
New Canaan, CT	1
New Milford, CT	3
Norwalk, CT	4
Orange, CT	1
Oxford, CT	5
Redding, CT	1
Ridgefield, CT	3
Seymour, CT	1
Shelton, CT	2
Sandy Hook, CT	1
Seymour, CT	12
Shelton, CT	35
Southbury, CT	1
Staffordville, CT	1
Stamford, CT	1
Stratford, CT	30
Thomaston, CT	1
Torrington , CT	1
Trumbull, CT	25
Waterbury, CT	28
Watertown, CT	1
West Haven, CT	1
Winsted, CT	3
Wolcott, CT	4
Total	465

6. **Page 14 of the application states that NERC clients currently receive partial services from the resident psychiatrist. How will the services that NERC currently provides differ from the proposed mental health treatment program?**

   - The psychiatric services that the facility currently provide are only to stabilize patients to the point they receive substance abuse services. Without the license in question, NERC cannot treat mental health disorders. Therefore clients needing to continue their mental health treatment after being stabilized are referred to outside psychiatrists and/or other mental health facilities where they can continue their treatment. In addition, other mental health practitioners such as Licensed Professional Counselors, Licensed Clinical Social Workers and Licensed Marriage and Family Therapist currently cannot hold sessions with clients leaving a major gap in client's therapy. Lastly, NERC cannot currently administer groups that's focus directly on mental health issues. Therefore, after the receipt of the MH license, services will differ greatly in scope and comprehension.

7. **Page 125 of the application states that clients will not be expected or required to progress in treatment through a predetermined continuum of care. Please explain.**

   - Continuum of care is a concept involving a system that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensity of care. In relation to NERC, the facility has a proposed track of services starting from the most intensive to the least intensive. For example, a client suffering from SMI and SA would be advised to start the treatment program in PHP or IOP, in hopes they can eventually move down to a less intense form of treatment. However, if a client comes to the facility with less severe MI, they may be advised to start with weekly counseling sessions instead. This is what is meant by "not requiring clients to progress in treatment through a predetermined continuum of care", the facility will tailor the services offered to fit the particular needs of the client at any particular time.

8. **Update the tables on page 129 of the application to include volume for the complete fiscal year of 2016. Additionally, include projections for the fiscal year of 2020. Projected estimates should include volume for intensive outpatient treatment (IOP). Specify whether the volume for partial hospitalization is included in your projections. If not, please revise the projected volume to include figures for partial hospitalization. Volume should reflect the Bridgeport location only.**

	Actual Volume				Projected Volume			
Service**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Methadone Maintenance	0	22,972	23,400	24,804	24,908*	26,156	27,756	27,756
IOP	0	75	540	200	0	0	0	0
PHP	0	0	0	0	0	0	0	0
Mental Health Outpatient	0	0	0	0	575	2,414	2,562	2,562
Total	0	22,747	23,940	25,004	25,483	28,570	30,318	30,318

*** Assuming the MH license is received in September 2017 and the census increases 5% from 479 in 2017 to 503 in 2018**

*** MH Census: FY2017- 95.8; FY2018- 101; FY 2019- 107; FY2020- 107**

Find IOP visits for 2016

9. **Page 130 of the application states that clients in the proposed mental health treatment program will attend an average of two sessions per month, yet page 21 states that clients will attend one session per week. Clarify the number of sessions clients are expected to attend in the proposed program.**

    - NERC forecasts 2 session per month per client.

10. **Describe how residents in Bridgeport and surrounding towns, who are not NERC clients, will be referred to the proposed mental health treatment program (e.g., self-referrals, referrals through behavioral health professionals, Connecticut state agencies, etc.). How and where are these potential clients currently receiving mental health treatment? Describe the impact of the proposal on these providers.**

    - NERC expects the initial client base for the mental health program to be established by clients currently receiving substance abuse services at the facility. From internal data we know that over 80% of our new intakes are referred by existing clients. NERC expects this to continue with the mental health program as well. The initial group of NERC substance abuse clients that become NERC mental health clients, will most likely refer other potential clients looking for mental health services to NERC. NERC forecasts this to account for about 80% of our referrals. The remaining 20% will be a combination of independent therapists and agencies looking to place their clients into a more structured higher level of treatment.

    - Currently the city of Bridgeport is suffering from a dearth of mental health and psychiatric services. This is especially true for Medicaid recipients. Clients that are able to receive services in the Bridgeport area are currently utilizing the following facilities: Southwest, Bridgeport Mental Health, the Reach Program, LifeBridge Community Services and Bridges Healthcare. NERC does not expect its proposal to effect providers at all. Several agencies that provide mental health services to Medicaid clients have waiting lists of 3-4 months. If there is any effect we expect a decrease in the wait lists.

11. **Update and resubmit the Financial Worksheet (A) on pages 67 and 68 of the application based on the Bridgeport location only. Include the net patient service revenue for commercial insurers on line 9. Verify any revenue included under "Other" non-government net patient service revenue. Also, verify there is no projected incremental income from Medicaid on line 6, column 12. The data should reflect complete fiscal year 2016 and four years of projections. Please include labels identifying the fiscal years. Projected outpatient volume with CON should be grouped by service (i.e., methadone maintenance, IOP and mental health treatment). Specify whether the number of sessions and claims will be added together.**

    - **Assumptions**
        i. Each Mental Health Session will be billed at 90832 @ a rate of $67.67
        ii. MH Census: FY2017- 95.8; FY2018- 101; FY 2019- 107; FY2020- 112
        iii. Each client will receive 2 sessions per month

12. **Page 20 of the application lists $60,000 as the cost of adding a staff member. Page 21 lists the same cost at $40,000. Please confirm the cost**

    - The cost will be $60,000.

13. **Page 38 of the application states that two full-time DPH-licensed health care professionals, a Licensed Alcohol and Drug Counselor (LADC) and a Licensed Clinical Social Worker (LCSW), will be required to initiate the proposed mental health treatment program. Explain if either of these individuals are already employed by New Era, as page 21 states that the proposal will require one additional staff member.**

    - The Licensed and Alcohol and Drug Counselor is already employed at NERC.

14. **Update Table 4 on page 135 of the application based on the updated Financial Worksheet (A) for the Bridgeport location. Updated figures should be based on projections for FY2017 through FY2020.**

Table 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2017*	**FY 2018**	**FY 2019**	**FY 2020**
Revenue from Operations	$38,910	$163,355	$173,371	$173,371
Total Operating Expenses	$60,000	$60,000	$60,000	$60,000
Gain/Loss from Operations	($21,090)	$103,355	$113,371	$113,371

* Fill in years using those reported in the Financial Worksheet attached.

15. Update the list of services and service locations of existing providers on pages 33 and 34 of the application based on the service area for the Bridgeport location only. Do any of these providers offer methadone maintenance and mental health treatment in the same setting?

- St. Vincent's Behavioral Health
  2400 Main St
  (203) 362-3900

- Casa
  690 Arctic St
  (203) 339-4112

- Southwest Connecticut Mental Health System
  97 Middle St
  (203) 579-7300
- Greater Bridgeport Mental Health
  1635 Central Ave
  (203) 551-7400
  Opens at 8:00 AM

- Department of Mental Health
  753 Fairfield Ave # B
  (203) 455-2151

- Reach At Bridgeport Hospital
  305 Boston Ave #1
  (203) 384-3377

- St Vincent's Behavioral Health
  47 Long Lots Rd
  (203) 227-1251

- Jewish Family Services Inc
  Community Center
  2370 Park Ave
  (203) 366-5438
  Opens at 9:00 AM

- Hall Brook Behavioral Health
  2400 Main St
  (203) 362-3900

- Regional Network of Programs
  1635 Fairfield Ave
  (203) 333-3518

- Mental Health Association-Connecticut
  4270 Main St #400
  (203) 365-8444

- The Sterling Center
  731 Bridgeport Ave
  (203) 929-2400
  Opens at 11:00 AM

- Bridgeport Hospital
  267 Grant St
  (203) 384-3000
  Open 24 hours

- Four Seasons Therapy, LLC
  48 Alpine St
  (203) 583-4775

- Connecticut Renaissance Inc
  1120 Main St
  (203) 367-6827

- LifeBridge Community Services
  475 Clinton Ave
  (203) 368-4291

- Southwest Community Health Center
  743 South Ave
  (203) 330-6010

- Southwest Community Health Center
  1046 Fairfield Ave
  (203) 330-6054

16. **Utilize Table A on page 4 of this correspondence to update the payer mix for the Bridgeport location. The figures should be based on client and claim volume for the proposed mental health treatment program. The total payer mix should equal the total reported in the updated Financial Worksheet (A) for outpatient visit volume and the updated projection tables for the proposed program. Explain the basis and the methods and calculations used to project the reported numbers.**

- NERC assumes that 100% of its mental health program will be Medicaid clients.

TABLE A: MENTAL HEALTH TREATMENT PROGRAM
PROJECTED PAYER MIX FOR
NEW ERA REHABILITATION CENTER, INC., BY NUMBER OF CLIENTS AND VISITS

Payer	Projected Payer Mix											
	FY 2017			FY 2018			FY 2019			FY 2020		
	Client Vol.	%	Visit Vol.	Client Vol.	%	Visit Vol.	Client Vol.	%	Visit Vol.	Client Vol.	%	Visit Vol.
Medicare*	0	0	0									
Medicaid*	95.8	0	0	101	100	2,424	107	100	2,568	112	100	2,688
CHAMPUS & TriCare	0	0	0	0		0	0		0	0	0	0
Total Government	**95.8**	**0**	**0**	**101**	**100**	**2,424**	**107**	**100**	**2,568**	**112**	**100**	**2,688**
Commercial Insurers	0	0	0	0	0	0	0	0	0	0	0	0
Self-pay	0	0	0	0	0	0	0	0	0	0	0	0
Uninsured	0	0	0	0	0	0	0	0	0	0	0	0
Workers Compensation	0	0	0	0	0	0	0	0	0	0	0	0
Total Non-Government	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Payer Mix	**95.8**	**0**	**0**	**101**	**100**	**2,424**	**107**	**100**	**2,568**	**112**	**100**	**2,688**

The data in the table assumes the following: the MH license is received in September 2017; the census increases 5% from 479 in 2017 to 503 in 2018 to 535 in 2019 and the census remains stable through 2020; MH patients are assumed to be 20% of the total census; MH Census: FY2017- 95.8; FY2018- 101; FY 2019- 107; FY2020- 107. Lastly, patients are assumed to have 2 MH visits per month.

Attachments

1. Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (Chapter 5)

2. Financial Worksheet A

FOR-PROFIT

Applicant Name: NEW ERA REHAB
Financial Worksheet (B)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)		(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity:	FY 2016 Actual	FY 2017 (YTD 3/31/17) Projected	FY 2017 Projected	FY 2017 Projected	FY 2017 Projected	FY 2018 Projected	FY 2018 Projected	FY 2018 Projected	FY 2019 Projected	FY 2019 Projected	FY 2019 Projected	FY 2020 Projected	FY 2020 Projected	FY 2020 Projected
	Description	Results	W/out CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**														
1	Total Gross Patient Revenue		$0	$0	$0	$0			$0			$0			$0
2	Less: Allowances	$0	$0	$0	$0	$0			$0			$0			$0
3	Less: Charity Care	$0	$0	$0	$0	$0			$0			$0			$0
4	Less: Other Deductions	$0	$0	$0	$0	$0			$0			$0			$0
	Net Patient Service Revenue	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare	$0	$0	$0	$0	$0			$0			$0			$0
6	Medicaid	$1,961,779	$561,714	$2,246,856.40	$38,910	$2,285,767	$2,303,028	$163,355	$2,466,383	$2,418,179	$173,371	$2,591,550	$2,418,179	$173,371	$2,591,550
7	CHAMPUS & TriCare	$0	$0	$0	$0	$0			$0			$0			$0
8	Other	$0	$0	$0	$0	$0			$0			$0			$0
	Total Government	**$1,961,779**	**$561,714**	**$2,246,856**	**$38,910**	**$2,285,767**	**$2,303,028**	**$163,355**	**$2,466,383**	**$2,418,179**	**$173,371**	**$2,591,550**	**$2,418,179**	**$173,371**	**$2,591,550**
9	Commercial Insurers	$0	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
10	Uninsured	$0	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
11	Self Pay	$128,175	$34,825	$139,298.64	$0	$139,299	$57,576		$57,576	$60,454		$60,454	$60,454		$60,454
12	Workers Compensation	$0	$0	$0	$0	$0			$0			$0			$0
13	Other	$0	$0	$0	$0	$0			$0			$0			$0
	Total Non-Government	**$128,175**	**$34,825**	**$139,299**	**$0**	**$139,299**	**$57,576**	**$0**	**$57,576**	**$60,454**	**$0**	**$60,454**	**$60,454**	**$0**	**$60,454**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$2,089,954**	**$596,539**	**$2,386,155**	**$38,910**	**$2,425,065**	**$2,360,604**	**$163,355**	**$2,523,959**	**$2,478,634**	**$173,371**	**$2,652,004**	**$2,478,634**	**$173,371**	**$2,652,004**
14	Less: Provision for Bad Debts	$0	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
	Net Patient Service Revenue less provision for bad debts	**$2,089,954**	**$596,539**	**$2,386,155**	**$38,910**	**$2,425,065**	**$2,360,604**	**$163,355**	**$2,523,959**	**$2,478,634**	**$173,371**	**$2,652,004**	**$2,478,634**	**$173,371**	**$2,652,004**
15	Other Operating Revenue	$0	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
17	Net Assets Released from Restrictions	$0	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
	TOTAL OPERATING REVENUE	**$2,089,954**	**$596,539**	**$2,386,155**	**$38,910**	**$2,425,065**	**$2,360,604**	**$163,355**	**$2,523,959**	**$2,478,634**	**$173,371**	**$2,652,004**	**$2,478,634**	**$173,371**	**$2,652,004**
B.	**OPERATING EXPENSES**														
1	Salaries and Wages	$847,518	$569,999	$759,998	$60,000	$819,998	$771,398	$60,000	$831,398	$771,398	$60,000	$831,398	$771,398	$60,000	$831,398
2	Fringe Benefits	$0	$0	$0	$0	$0			$0			$0			$0
3	Physicians Fees	$0	$0	$88,000		$88,000	$67,000		$67,000	$67,000		$67,000	$67,000		$67,000
4	Supplies and Drugs	$96,645	$0	$104,377	$0	$104,377	$106,464		$106,464	$109,126		$109,126	$109,126		$109,126
5	Depreciation and Amortization	$181,559	$0	$181,559	$0	$181,559	$181,559		$181,559	$163,403		$163,403	$163,403		$163,403
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$13,514	$0	$13,514	$0	$13,514	$13,514		$13,514	$13,514		$13,514	$13,514		$13,514
8	Malpractice Insurance Cost	$19,206	$0	$19,206	$0	$19,206	$19,206		$19,206	$19,206		$19,206	$19,206		$19,206
9	Lease Expense	$196,590	$0	$196,590	$0	$196,590	$196,590		$196,590	$196,590		$196,590	$196,590		$196,590
10	Other Operating Expenses	$366,810	$0	$385,151	$0	$385,151	$423,666		$423,666	$444,849		$444,849	$444,849		$444,849
	TOTAL OPERATING EXPENSES	**$1,721,841**	**$0**	**$1,748,394**	**$60,000**	**$1,808,394**	**$1,779,397**	**$60,000**	**$1,839,397**	**$1,785,086**	**$60,000**	**$1,845,086**	**$1,785,086**	**$60,000**	**$1,845,086**
	INCOME/(LOSS) FROM OPERATIONS	**$368,113**	**$596,539**	**$637,761**	**($21,090)**	**$616,671**	**$581,207**	**$103,355**	**$684,562**	**$693,548**	**$113,371**	**$806,919**	**$693,548**	**$113,371**	**$806,919**
	NON-OPERATING INCOME	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**		**$0**	**$0**		**$0**			**$0**
	Income before provision for income taxes	**$368,113**	**$596,539**	**$637,761**	**($21,090)**	**$616,671**	**$581,207**	**$103,355**	**$684,562**	**$693,548**	**$113,371**	**$806,919**	**$693,548**	**$113,371**	**$806,919**
	Provision for income taxes[c]	**$147,245**	**$238,616**	**$255,104**	$0	**$246,668**	**$232,483**		**$232,483**	**$277,419**		$322,767			**$0**
	NET INCOME	**$220,868**	**$357,923**	**$382,657**	**($21,090)**	**$361,567**	**$348,724**	**$103,355**	**$452,079**	**$416,129**	**$113,371**	**$529,499**	**$693,548**	**$113,371**	**$806,919**
C.	**Retained Earnings, beginning of year**	**$0**	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Retained Earnings, end of year	**$0**	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Principal Payments	$0	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
D.	**PROFITABILITY SUMMARY**														
1	Hospital Operating Margin	**17.6%**	**100.0%**	**26.7%**	**-54.2%**	**25.4%**	**24.6%**	**63.3%**	**27.1%**	**28.0%**	**65.4%**	**30.4%**	**28.0%**	**65.4%**	**30.4%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**10.6%**	**60.0%**	**16.0%**	**-54.2%**	**14.9%**	**14.8%**	**63.3%**	**17.9%**	**16.8%**	**65.4%**	**20.0%**	**28.0%**	**65.4%**	**30.4%**
E.	**FTEs**	**0**	**0**	**0**	**0**	**0**			**0**			**0**			**0**
F.	**VOLUME STATISTICS[d]**														
1	Inpatient Discharges	0	0	0	0	**0**			**0**			**0**			**0**
2	Outpatient Visits	0	0	0	575	**575**		2,414	**2,414**		2,562	**2,562**		2,562	**2,562**
	TOTAL VOLUME	**0**	**0**	**0**	**575**	**575**	**0**	**2,414**	**2,414**	**0**	**2,562**	**2,562**	**0**	**2,562**	**2,562**

[a] Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b] Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c] Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
[d] 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.

FOR-PROFIT

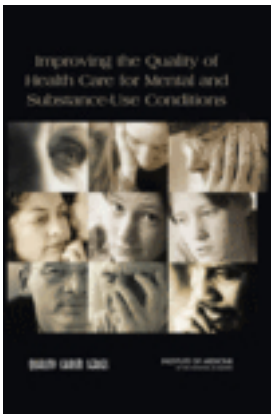
Applicant Name: NEW ERA REHAB
Financial Worksheet (B)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

OHCA0152

LINE	Total Entity: / Description	(1) FY 2016 Actual Results	FY 2017 (YTD 3/31/17) Projected W/out CON	(2) FY 2017 Projected W/out CON	(3) FY 2017 Projected Incremental	(4) FY 2017 Projected With CON	(5) FY 2018 Projected W/out CON	(6) FY 2018 Projected Incremental	(7) FY 2018 Projected With CON	(8) FY 2019 Projected W/out CON	(9) FY 2019 Projected Incremental	(10) FY 2019 Projected With CON	(11) FY 2020 Projected W/out CON	(12) FY 2020 Projected Incremental	(13) FY 2020 Projected With CON
A.	**OPERATING REVENUE**														
1	Total Gross Patient Revenue		$0	$0	$0	$0			$0			$0			$0
2	Less: Allowances	$0	$0	$0	$0	$0			$0			$0			$0
3	Less: Charity Care	$0	$0	$0	$0	$0			$0			$0			$0
4	Less: Other Deductions	$0	$0	$0	$0	$0			$0			$0			$0
	Net Patient Service Revenue	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare	$0	$0	$0	$0	$0			$0			$0			$0
6	Medicaid	$1,961,779	$561,714	$2,246,856.40	$38,910	$2,285,767	$2,303,028	$163,355	$2,466,383	$2,418,179	$173,371	$2,591,550	$2,418,179	$173,371	$2,591,550
7	CHAMPUS & TriCare	$0	$0	$0	$0	$0			$0			$0			$0
8	Other	$0	$0	$0	$0	$0			$0			$0			$0
	Total Government	**$1,961,779**	**$561,714**	**$2,246,856**	**$38,910**	**$2,285,767**	**$2,303,028**	**$163,355**	**$2,466,383**	**$2,418,179**	**$173,371**	**$2,591,550**	**$2,418,179**	**$173,371**	**$2,591,550**
9	Commercial Insurers	$0	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
10	Uninsured	$0	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
11	Self Pay	$128,175	$34,825	$139,298.64	$0	$139,299	$57,576		$57,576	$60,454		$60,454	$60,454		$60,454
12	Workers Compensation	$0	$0	$0	$0	$0			$0			$0			$0
13	Other	$0	$0	$0	$0	$0			$0			$0			$0
	Total Non-Government	**$128,175**	**$34,825**	**$139,299**	**$0**	**$139,299**	**$57,576**	**$0**	**$57,576**	**$60,454**	**$0**	**$60,454**	**$60,454**	**$0**	**$60,454**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$2,089,954**	**$596,539**	**$2,386,155**	**$38,910**	**$2,425,065**	**$2,360,604**	**$163,355**	**$2,523,959**	**$2,478,634**	**$173,371**	**$2,652,004**	**$2,478,634**	**$173,371**	**$2,652,004**
14	Less: Provision for Bad Debts	$0	$0	$0	$0	$0			$0			$0			$0
	Net Patient Service Revenue less provision for bad debts	**$2,089,954**	**$596,539**	**$2,386,155**	**$38,910**	**$2,425,065**	**$2,360,604**	**$163,355**	**$2,523,959**	**$2,478,634**	**$173,371**	**$2,652,004**	**$2,478,634**	**$173,371**	**$2,652,004**
15	Other Operating Revenue	$0	$0	$0	$0	$0			$0			$0			$0
17	Net Assets Released from Restrictions	$0	$0	$0	$0	$0			$0			$0			$0
	TOTAL OPERATING REVENUE	**$2,089,954**	**$596,539**	**$2,386,155**	**$38,910**	**$2,425,065**	**$2,360,604**	**$163,355**	**$2,523,959**	**$2,478,634**	**$173,371**	**$2,652,004**	**$2,478,634**	**$173,371**	**$2,652,004**
B.	**OPERATING EXPENSES**														
1	Salaries and Wages	$847,518	$569,999	$759,998	$60,000	$819,998	$771,398	$60,000	$831,398	$771,398	$60,000	$831,398	$771,398	$60,000	$831,398
2	Fringe Benefits	$0	$0	$0	$0	$0			$0			$0			$0
3	Physicians Fees	$0	$0	$88,000		$88,000	$67,000		$67,000	$67,000		$67,000	$67,000		$67,000
4	Supplies and Drugs	$96,645	$0	$104,377	$0	$104,377	$106,464		$106,464	$109,126		$109,126	$109,126		$109,126
5	Depreciation and Amortization	$181,559	$0	$181,559	$0	$181,559	$181,559		$181,559	$163,403		$163,403	$163,403		$163,403
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$13,514	$0	$13,514	$0	$13,514	$13,514		$13,514	$13,514		$13,514	$13,514		$13,514
8	Malpractice Insurance Cost	$19,206	$0	$19,206	$0	$19,206	$19,206		$19,206	$19,206		$19,206	$19,206		$19,206
9	Lease Expense	$196,590	$0	$196,590	$0	$196,590	$196,590		$196,590	$196,590		$196,590	$196,590		$196,590
10	Other Operating Expenses	$366,810	$0	$385,151	$0	$385,151	$423,666		$423,666	$444,849		$444,849	$444,849		$444,849
	TOTAL OPERATING EXPENSES	**$1,721,841**	**$0**	**$1,748,394**	**$60,000**	**$1,808,394**	**$1,779,397**	**$60,000**	**$1,839,397**	**$1,785,086**	**$60,000**	**$1,845,086**	**$1,785,086**	**$60,000**	**$1,845,086**
	INCOME/(LOSS) FROM OPERATIONS	**$368,113**	**$596,539**	**$637,761**	**($21,090)**	**$616,671**	**$581,207**	**$103,355**	**$684,562**	**$693,548**	**$113,371**	**$806,919**	**$693,548**	**$113,371**	**$806,919**
	NON-OPERATING INCOME	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**		**$0**	**$0**		**$0**			**$0**
	Income before provision for income taxes	**$368,113**	**$596,539**	**$637,761**	**($21,090)**	**$616,671**	**$581,207**	**$103,355**	**$684,562**	**$693,548**	**$113,371**	**$806,919**	**$693,548**	**$113,371**	**$806,919**
	Provision for income taxes[c]	**$147,245**	**$238,616**	**$255,104**	$0	**$246,668**	**$232,483**		**$232,483**	**$277,419**		**$322,767**			**$0**
	NET INCOME	**$220,868**	**$357,923**	**$382,657**	**($21,090)**	**$361,567**	**$348,724**	**$103,355**	**$452,079**	**$416,129**	**$113,371**	**$529,499**	**$693,548**	**$113,371**	**$806,919**
C.	**Retained Earnings, beginning of year**	**$0**	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Retained Earnings, end of year	**$0**	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Principal Payments	$0	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
D.	**PROFITABILITY SUMMARY**														
1	Hospital Operating Margin	**17.6%**	**100.0%**	**26.7%**	**-54.2%**	**25.4%**	**24.6%**	**63.3%**	**27.1%**	**28.0%**	**65.4%**	**30.4%**	**28.0%**	**65.4%**	**30.4%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**10.6%**	**60.0%**	**16.0%**	**-54.2%**	**14.9%**	**14.8%**	**63.3%**	**17.9%**	**16.8%**	**65.4%**	**20.0%**	**28.0%**	**65.4%**	**30.4%**
E.	**FTEs**	**0**	**0**	**0**	**0**	**0**			**0**			**0**			**0**
F.	**VOLUME STATISTICS[d]**														
1	Inpatient Discharges	0	0	0	0	**0**			**0**			**0**			**0**
2	Outpatient Visits	0	0	0	575	**575**		2,414	**2,414**		2,562	**2,562**		2,562	**2,562**
	TOTAL VOLUME	**0**	**0**	**0**	**575**	**575**	**0**	**2,414**	**2,414**	**0**	**2,562**	**2,562**	**0**	**2,562**	**2,562**

[a] Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b] Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c] Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
[d] 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.



Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series

Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders

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Improving the Quality of Health Care for Mental and Substance-Use Conditions

Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders

Board on Health Care Services

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5

Coordinating Care for Better Mental, Substance-Use, and General Health

Summary

Mental and substance-use problems and illnesses seldom occur in isolation. They frequently accompany each other, as well as a substantial number of general medical illnesses such as heart disease, cancers, diabetes, and neurological illnesses. Sometimes they masquerade as separate somatic problems. Consequently, mental, substance-use, and general health problems and illnesses are frequently intertwined, and coordination of all these types of health care is essential to improved health outcomes, especially for chronic illnesses. Moreover, mental and/or substance-use (M/SU) problems and illnesses frequently affect and are addressed by education, child welfare, and other human service systems. Improving the quality of M/SU health care—and general health care—depends upon the effective collaboration of all mental, substance-use, general health care, and other human service providers in coordinating the care of their patients.

However, these diverse providers often fail to detect and treat (or refer to other providers to treat) these co-occurring problems and also fail to collaborate in the care of these multiple health conditions—placing their patients' health and recovery in jeopardy. Collaboration by mental, substance-use, and general health care clinicians is especially difficult because of the multiple separations that characterize mental and substance-use health care: (1) the greater separation of mental and substance-use health care from general health care; (2) the separation of mental and substance-

use health care from each other; (3) society's reliance on the education, child welfare, and other non–health care sectors to secure M/SU services for many children and adults; and (4) the location of services needed by individuals with more-severe M/SU illnesses in public-sector programs apart from private-sector health care.

This mass of disconnected care delivery arrangements requires numerous patient interactions with different providers, organizations, and government agencies. It also requires multiple provider "handoffs" of patients for different services and transmittal of information to and joint planning by all these providers, organizations, and agencies if coordination is to occur. Overcoming these separations also is made difficult because of legal and organizational prohibitions on clinicians' sharing information about mental and substance-use diagnoses, medications, and other features of clinical care, as well as a failure to implement effective structures and processes for linking the multiple clinicians and organizations caring for patients. To overcome these obstacles, the committee recommends that individual treatment providers create clinically effective linkages among mental, substance-use, and general health care and other human service agencies caring for these patients. Complementary actions are also needed from government agencies, purchasers, and accrediting bodies to promote the creation of these linkages.

To enable these actions, changes are needed as well to address the less-evolved infrastructure for using information technology, some unique features of the M/SU treatment workforce that also have implication for effective care coordination, and marketplace practices. Because these issues are of such consequence, they are addressed separately in Chapters 6, 7, and 8, respectively.

CARE COORDINATION AND RELATED PRACTICES DEFINED

Crossing the Quality Chasm notes that the multiple clinicians and health care organizations serving patients in the American health care system typically fail to coordinate their care. That report further states that the resulting gaps in care, miscommunication, and redundancy are sources of significant patient suffering (IOM, 2001).[1] The *Quality Chasm's* health care quality framework addresses the need for better care coordination in

[1]In a subsequent report, produced at the request of the U.S. Department of Health and Human Services, the Institute of Medicine identified "care coordination" as one of 20 priority health care areas deserving of immediate attention by all participants in American health care (IOM, 2003a).

one of its ten rules and in another rule calls attention to the need for provider communication and collaboration to achieve this goal:

> *Cooperation among clinicians.* Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.
>
> *Shared knowledge and the free flow of information.* Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information. (IOM, 2001:62)

These two rules highlight two prerequisites to coordination of care: communication and collaboration across providers and within and across institutions. *Communication* exists when each clinician or treatment provider caring for a patient shares needed treatment information with other clinicians and providers caring for the patient. Information can be shared verbally; manually in writing; or through information technology, such as a shared electronic health record. *Collaboration* is multidimensional and requires the aggregation of several behaviors, including the following:

- **A shared understanding of goals and roles**—Collaboration is enhanced by a shared understanding of an agreed-upon collective goal (Gittell et al., 2000) and clarity regarding each clinician's role. Role confusion and role conflict are frequent barriers to interdisciplinary collaboration (Rice, 2000).
- **Effective communication**—Multiple studies have identified effective communication as a key feature of collaboration (Baggs and Schmitt, 1988; Knaus et al., 1986; Schmitt, 2001; Shortell et al., 1994). "Effective" is defined variously as frequent, timely, understandable, accurate, and satisfying (Gittell et al., 2000; Shortell et al., 1994).
- **Shared decision making**—In shared decision making, problems and strategies are openly discussed (Baggs and Schmitt, 1997; Baggs et al., 1999; Rice, 2000; Schmitt, 2001), and consensus is often used to arrive at a decision. Disagreements over treatment approaches and philosophies, roles and responsibilities, and ethical questions are common in health care settings. Positive ways of addressing these inevitable differences are identified as a key component of effective caregiver collaboration (Shortell et al., 1994).

It is important to note that, according to health services researchers, collaboration is not a dichotomous variable, simply present or absent. Rather, it is present to varying degrees (Schmitt, 2001).

Collaboration also is typically characterized by necessary precursors. Clinicians are more likely to collaborate when they perceive each other as having the knowledge necessary for good clinical care (Baggs and Schmitt, 1997). Mutual respect and trust are necessary precursors to collaboration as well (Baggs and Schmitt, 1988; Rice, 2000); personal respect and trust are intertwined with respect for and trust in clinical competence.

Care coordination is the outcome of effective collaboration. Coordinated care prevents drug–drug interactions and redundant care processes. It does not waste the patient's time or the resources of the health care system. Moreover, it promotes accurate diagnosis and treatment because all providers receive relevant diagnostic and treatment information from all other providers caring for a patient.

Care integration is related to care coordination. As defined by experts in health care organization and management (Shortell et al., 2000), integration of care and services can be of three types:

- "*Clinical integration* is the extent to which patient care services are *coordinated* across people, functions, activities, and sites over time so as to maximize the value of services delivered to patients" (p. 129).
- *Physician (or clinician) integration* is the extent to which clinicians are economically linked to an organized delivery system, use its facilities and services, and actively participate in its planning, management and governance.
- *Functional integration* is "the extent to which key support functions and activities (such as financial management, strategic planning, human resources management, and information management) are coordinated across operating units so as to add the greatest overall value to the system" (p. 31). The most important of these functions and activities are human resources deployment strategies, information technologies, and continuous improvement processes.

Shortell et al.'s *clinical* integration corresponds to care coordination as addressed in the *Quality Chasm* report.

In the context of co-occurring mental and substance-use problems and illnesses, the Substance Abuse and Mental Health Services Administration (SAMHSA) similarly identifies three levels of integration (SAMHSA, undated):

- *Integrated treatment* refers to interactions *between clinicians* to address the individual needs of the client/patient, and consists of "any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting" (p. 61).

- *Integrated program* refers to an organizational structure that ensures the provision of staff or linkages with other programs to address all of a client's needs.
- *Integrated systems* refers to an organizational structure that supports an array of programs for individuals with different needs through funding, credentialing/licensing, data collection/reporting, needs assessment, planning, and other system planning and operation functions.

SAMHSA's *integrated treatment* corresponds to Shortell et al.'s *clinical integration;* both appear to equate to *coordination of care* as used in the *Quality Chasm* report. In this report, we use the *Quality Chasm* terminology of *care coordination* and address the coordination of care at the level of the patient. We do not address issues surrounding the other levels of coordination or integration represented by Shortell et al.'s *clinician* and *functional integration* or SAMHSA's *integrated programs* and *systems*.

FAILED COORDINATION OF CARE FOR CO-OCCURRING CONDITIONS

Co-Occurring Mental, Substance-Use, and General Health Problems and Illnesses

Mental or substance-use problems and illnesses seldom occur in isolation. Approximately 15–43 percent of the time they occur together (Kessler et al., 1996; Kessler, 2004; Grant et al., 2004a,b; SAMHSA, 2004). They also accompany a wide variety of general medical conditions (Katon, 2003; Mertens et al., 2003), sometimes masquerade as separate somatic problems (Katon, 2003; Kroenke, 2003), and often go undetected (Kroenke et al., 2000; Saitz et al., 1997). As a result, individuals with M/SU problems and illnesses have a heightened need for coordinated care.

Co-Occurring Mental and Substance-Use Problems and Illnesses

The 1990–1992 National Comorbidity Survey well documented the high rates of co-occurring mental and substance use conditions, finding an estimated 42.7 percent of adults aged 15–54 with an alcohol or drug "disorder" also having a mental disorder, and 14.7 percent of those with a mental disorder also having an alcohol or drug disorder (Kessler et al., 1996; Kessler 2004). These findings are reaffirmed by more recent studies. According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA) 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions, 19.7 percent of the general adult (18 and older) U.S. population with any substance-use disorder is estimated to have at least one

co-occurring independent (non–substance-induced) mood disorder, and 17.7 percent to have at least one co-occurring independent anxiety disorder. Among respondents with a mood disorder, 20 percent had at least one substance-use disorder, as did 15 percent of those with an anxiety disorder. Rates of co-occurrence are higher among individuals who seek treatment for substance-use disorders; 40.7 percent, 33.4 percent, and 33.1 percent of those who sought treatment for an alcohol-use disorder had at least one independent mood disorder, anxiety disorder, or other drug use disorder, respectively. Among those seeking treatment for a drug-use disorder, 60.3 percent had at least one independent mood disorder, 42.6 percent at least one independent anxiety disorder, and 55.2 percent a comorbid alcohol-use disorder (Grant et al., 2004a).

Similar or higher rates of co-occurrence are found for other types of mental problems and illnesses (Grant et al., 2004b), as well as for serious mental illnesses generally. The 2003 National Survey on Drug Use and Health documented that among adults aged 18 and older not living in an institution or inpatient facility, an estimated 18 percent of those who had used illicit drugs in the past year also had a serious mental illness.[2] Over 21 percent of adults with substance "abuse" or dependence were estimated to have a serious mental illness, and 21.3 percent of adults with such an illness had been dependent on or "abused" alcohol or illicit drugs in the past year (SAMHSA, 2004).

One longitudinal study of patients in both mental health and drug treatment settings found that mental illnesses were as prevalent and serious among individuals treated in substance-use treatment facilities as among patients in mental health treatment facilities. Similarly, individuals served in mental health treatment facilities had substance-use illnesses at rates and severity comparable to those among individuals served in substance-use treatment facilities (Havassy et al., 2004).

Co-occurrence with General Health Conditions

M/SU problems and illnesses frequently accompany a substantial number of chronic general medical illnesses, such as diabetes, heart disease, neurologic illnesses, and cancers, sometimes masquerading as separate somatic problems (Katon, 2003). Approximately one in five patients hospitalized for a heart attack, for example, suffers from major depression, and evidence from multiple studies is "strikingly consistent" that post–heart attack depres-

[2]A serious mental illness was defined for this study as a diagnosable mental, behavioral, or emotional disorder that met criteria in the *Diagnostic and Statistical Manual*, fourth edition (DSM-IV) and resulted in functional impairment that substantially interfered with or limited one or more major life activities.

sion significantly increases one's risk for death: patients with depression are about three times more likely to die from a future attack or other heart problem (Bush et al., 2005:5). Depression and anxiety also are strongly associated with somatic symptoms such as headache, fatigue, dizziness, and pain, which are the leading cause of outpatient medical visits and often medically unexplained (Kroenke, 2003). They also are more often present in individuals with a number of medical conditions as yet not well understood, including chronic fatigue syndrome, fibromyalgia, irritable bowel syndrome, and nonulcer dyspepsia (Henningsen et al., 2003).

The converse also is true. Individuals with M/SU conditions often have increased prevalence of general medical conditions such as cardiovascular disease, high blood pressure, diabetes, arthritis, digestive disorders, and asthma (De Alba et al., 2004; Mertens et al., 2003; Miller et al., 2003; Sokol et al., 2004; Upshur, 2005). Persons with severe mental illnesses have much higher rates of HIV and hepatitis C than those found in the general population (Brunette et al., 2003; Rosenberg et al., 2001; Sullivan et al., 1999). Moreover, specific mental or substance-use diagnoses place individuals at higher risk for certain general medical conditions. For example, those in treatment for schizophrenia, depression, and bipolar illness are more likely than the general population to have asthma, chronic bronchitis, and emphysema (Sokol et al., 2004). Persons with anxiety disorders have higher rates of cardiac problems, hypertension, gastrointestinal problems, genitourinary disorders, and migraine (Harter et al., 2003). Individuals with schizophrenia are at increased risk for obesity, heart disease, diabetes, hyperlipidemia, hepatitis, and osteoporosis (American Diabetes Association et al., 2004; Goff et al., 2005; Green et al., 2003). And chronic heavy alcohol use is associated with liver disease, immune system disorders, cardiovascular diseases, and diabetes (Carlsson et al., 2000; Corrao et al., 2000; NIAAA, 2000).

Substance use, particularly injection drug use, carries a high risk of other serious illnesses. In a large cohort study of middle-class substance-using patients, the prevalence of hepatitis C was 27 percent in all substance users and 76 percent in injection drug users (Abraham et al., 1999). Injection drug use accounts for about 60 percent of new cases of hepatitis C (Alter, 1999) and remains the second most common risk behavior for acquisition of HIV in the United States (CDC, 2001). Evidence of past infection with hepatitis B also is common in injection drug users (Garfein, et al., 1996). Hepatitis C and coinfection with HIV and active hepatitis B are associated with more-severe liver disease (Zarski et al., 1998). Alcohol use is prevalent among HIV-infected patients (Conigliaro et al., 2003), and accelerates cognitive impairment in HIV-associated dementia complex (Fein et al., 1998; Tyor and Middaugh, 1999).

Given that patients with HIV infection are now living longer, the impact of comorbid conditions in these patients, including alcohol and drug-use

problems, has become increasingly important. Hepatitis C–related liver injury progresses more rapidly in both HIV coinfected persons and alcohol users. Laboratory and preliminary clinical evidence indicates that both alcohol use and hepatitis C can negatively affect immunologic and clinical HIV outcomes. Furthermore, both alcohol and drug use may adversely affect the prescription and efficacy of and adherence to HIV medications (Moore et al., 2004; Palepu et al., 2003; Samet et al., 2004).

The co-occurrence of mental, substance-use, and general health problems and illnesses has important implications for the recovery of individuals with these illnesses. All of these conditions need to be to be detected and treated; however, this often does not happen, and even when it does, providers dealing with one condition often fail to detect and treat the co-occurring illness and to collaborate in the coordinated care of these patients.

Failure to Detect, Treat, and Collaborate in the Care of Co-Occurring Illnesses

Although detection of some common mental illnesses, such as depression, has increased over the past decade, general medical providers still too often fail to detect alcohol, drug, or mental problems and illnesses (Friedmann et al., 2000b; Miller et al., 2003; Saitz et al., 1997, 2002). In a nationally representative survey of general internal medicine physicians, family medicine physicians, obstetrician/gynecologists, and psychiatrists, for example, 12 percent reported that they did not usually ask their new patients whether they drank alcohol, and fewer than 20 percent used any formal screening tool to detect problems among those who did drink (Friedmann et al., 2000b). Moreover, evidence indicates that general medical providers often assume that the health complaints of patients with a prior psychiatric diagnosis are psychologically rather than medically based (Graber et al., 2000).

Similarly, mental health and substance-use treatment providers frequently do not screen, assess, or address co-occurring mental or substance-use conditions (Friedmann et al., 2000b) or co-occurring general medical health problems. In a survey of patients of one community mental health center, 45 percent of respondents reported that their mental health provider did not ask about general medical issues (Miller et al., 2003).

Evidence presented in Chapter 4 documents some of the failures of providers to treat co-occurring conditions. Other studies have added to the evidence that even when co-occurring M/SU conditions are known, they are not treated (Edlund et al., 2004; Friedmann et al., 2000b, 2001). The above-cited longitudinal study of patients with comorbid conditions at four public residential treatment facilities for seriously mentally ill patients and three residential treatment facilities for individuals with substance-use ill-

nesses found no listings of co-occurring problems or illnesses in patient charts despite the existence of significant comorbidity. "Patient charts in the public mental health system generally include a primary psychiatric disorder; co-occurring psychiatric or substance use disorders are not systematically included. Substance abuse treatment sites only documented substance use disorders" (Havassy et al., 2004:140). In the national survey of primary care providers and psychiatrists described above, 18 percent of physicians reported that they typically offered no intervention (including a referral) to their problem-drinking patients, in part because of misplaced concern about patients' sensitivity on these issues (Friedmann et al., 2000b). Nearly the same proportion (15 percent) reported that they did not intervene when use of illicit drugs was detected (Friedmann et al., 2001). A 1997–1998 national survey found that among persons with probable co-occurring mental and substance-use disorders who received treatment for either condition, fewer than a third (28.6 percent) received treatment for the other (Watkins et al., 2001).

Additional evidence of the failure to coordinate care is found in the complaints of consumers of M/SU services. The President's New Freedom Commission reported that consumers often feel overwhelmed and bewildered when they must access and integrate mental health care and related services across multiple, disconnected providers in the public and private sectors (New Freedom Commission on Mental Health, 2003).

These failures to detect and treat co-occurring conditions take place in a health care system that has historically and currently separates care for mental and substance-use problems and illnesses from each other and from general health care, to a greater extent than is the case for other specialty health care. Absent or poor linkages characterize these separate care delivery arrangements. Numerous demonstration projects and strategies have been developed to better link health care for general, mental, and substance-use health conditions and related services. These include The Robert Wood Johnson Foundation's Depression in Primary Care: Linking Clinical and Systems Strategies Project (Upshur, 2005) and the MacArthur Foundation's RESPECT—Depression Project (Dietrich et al., 2004).

NUMEROUS, DISCONNECTED CARE DELIVERY ARRANGEMENTS

> "Every system is perfectly designed to achieve exactly the results it gets."
> (Berwick, 1998)

Organizations and providers offering treatment and services for mental, substance-use, and general health care conditions typically do so through separate care delivery arrangements:

- Arrangements for the delivery of health care for mental and substance-use conditions are typically separate from general health care (financially and organizationally more so than other specialty health care services).
- In spite of the frequent co-occurrence of M/SU problems and illnesses, the delivery of health care for these conditions also typically occurs through separate treatment providers and organizations.
- Some health care for mental and substance-use conditions and related services are delivered through governmental programs that are separate from private insurance—requiring coordination across public and private sectors of care.
- Non–health care sectors—education, child welfare, and juvenile and criminal justice systems—also separately arrange for M/SU services.

Traversing these separations is made difficult by a failure to put in place effective strategies for linking general, mental, and substance-use health care and the other human services systems that also deliver much-needed services for M/SU problems and illnesses; by a lack of agreement about which entity or entities should be held accountable for coordinating care; and by state and federal laws (and the policies and practices of some health care organizations) that limit information sharing across providers.[3]

Separation of M/SU Health Care from General Health Care

Although the proportion has been declining in recent years, two-thirds of Americans (64 percent in 2002) under the age of 65 receive health care through private insurance offered by their or their family member's employer (Fronstin, 2003). Over the past two decades, employers and other group purchasers of health care (e.g., state Medicaid agencies) have increasingly provided mental and substance-use health care benefits through health insurance plans that are separate administratively and financially from the plans through which individuals receive their general health care. These separate M/SU health plans are informally referred to as "carved out." In *payer* carve-outs, an employer or other payer offers prospective enrollees one or more health plans encompassing all of their covered health care except that for mental and substance-use conditions. Covered individuals are then enrolled in another health plan that includes a network of M/SU

[3]In addition, the less-evolved infrastructure for deploying information technology among mental health and substance-use treatment providers inhibits ease of coordination (see Chapter 6). Some of the unique features of the M/SU treatment workforce (e.g., the greater number of provider types, variation in their training and focus, and their greater location in solo or small group practices) that also contribute to this problem are addressed in Chapter 7.

providers chosen separately by the employer/payer. In *health plan* carve-outs, employees enroll in just one comprehensive health plan, and the administrators of that plan arrange internally to have M/SU health care provided and managed through a separate vendor. Estimates of the proportion of employees receiving M/SU health services through carve-out arrangements with managed behavioral health organizations (MBHOs) vary from 36 to 66 percent, reflecting differences in targeted survey respondents (e.g., employers, MBHOs, or employees) and what is being measured (e.g., carved-out services can include utilization review or case management only, or the provision of a full array of M/SU services) (Barry et al., 2003).

The MBHOs that provide these carve-out M/SU services arose in part in response to financial concerns. In the 1980s, employers' costs for behavioral health services were increasing at twice the rate of medical care overall and four times the rate of inflation. Evidence is clear that MBHOs have been successful in reducing these costs and also in achieving greater use of community-based care as opposed to institutionalization. They also have been credited with playing a role in keeping costs down in the face of broadened benefits, which has assisted in securing support for greater parity of mental health benefit coverage. Moreover, MBHOs have helped move clinicians from solo into group practices (Feldman, 2003), which, as discussed in Chapter 7, can facilitate quality improvement. Carve-out arrangements can nurture recognition and support for specialized knowledge of M/SU problems and illnesses and treatment expertise. They also can attenuate problems involving the adverse selection of individuals with M/SU illnesses in insurance plans (see Chapter 8).

In contrast to the clear evidence for the benefits described above, evidence for the effects of carve-out arrangements on quality of care is limited and mixed (Donohue and Frank, 2000; Grazier and Eselius, 1999; Hutchinson and Foster, 2003). However, models of safety and errors in health care suggest that whenever individuals are cared for by separate organizations, functional units, or providers, discontinuities in care can result unless the unavoidable gaps in care are anticipated, and strategies to bridge those gaps are implemented (Cook et al., 2000). A previous Institute of Medicine (IOM) report found that carved-out M/SU services "do not necessarily lead to poor coordination of care. . . . However the separation of primary care and behavioral health care systems brings risks to coordination and integration. . ." (IOM, 1997:116). The President's New Freedom Commission on Mental Health care deemed the separation between systems for mental and general health care so large as to constitute a "chasm" (New Freedom Commission on Mental Health, 2003).

Several factors could help account for problems with coordinating care in the presence of M/SU carve-outs. First, under carve-out arrangements, primary care physicians generally are not expected to treat (and may not

always be able to be reimbursed for treating) M/SU problems and illnesses (Feldman et al., 2005; Upshur, 2005). The employer or other purchaser of health insurance benefits for the individual has, by contract, specified that general health care is to be provided by one network of providers though a health plan covering that care, and M/SU care through a different health plan's network of specialty M/SU providers. This is different from the situation with other medical problems and illnesses. For example, when a patient seeks care for diabetes, asthma, allergies, heart problems, or other general medical conditions, the patient's primary care provider is allowed to treat these illnesses and can be reimbursed for those services. When the primary care provider and/or the patient decides that the problem requires the attention of a specialist, the provider makes a referral or the patient self-refers to a specialist. Use of a specialist comes about based generally on the primary care provider's and/or patient's judgment. In contrast, under M/SU carve-out arrangements, M/SU health care often is predetermined by the employer or other group purchaser to require the attention of a specialist and must therefore be provided by a second provider. As a result, one method of care coordination—care by the same provider—is not available to the patient. While not all primary care providers have the expertise and/or desire to treat M/SU illnesses (see Chapters 4 and 7), some do, and evidence indicates that many patients typically turn initially to their primary care provider for help with M/SU problems and illnesses (Mickus et al., 2000).

A second obstacle to care coordination is that information about the patient's health problem or illness, medications, and other treatments must now be shared across and meet the often differing privacy, confidentiality, and additional administrative requirements imposed by the different health plans. Consumers also are required to navigate the administrative requirements of both health plans.

Finally, as described in Chapter 4, the use of carve-outs poses difficulties for quality measurement and improvement—including measurement and improvement of coordination—in two ways. First, because primary care providers cannot always be reimbursed for M/SU health care, they sometimes provide the care but code the visit according to the patient's somatic complaint (for which the treatment they provide can be reimbursed) (Rost et al., 1994). This situation masks the true prevalence of M/SU illnesses in primary care and impedes quality measurement and improvement efforts. Moreover, the existence of two parallel health plans serving the patient creates some confusion about accountability for quality and coordination. For example, the National Committee for Quality Assurance's mental and substance-use quality measures (i.e., those contained in its Health Plan Employer Data and Information Set [HEDIS] measurement set) are required to be reported by comprehensive managed

care plans seeking accreditation, but not by MBHOs seeking accreditation.[4] Also, as discussed later in this chapter, accreditation standards do not always make clear the responsibilities for care coordination when an individual is served by two health plans, such as a managed care plan providing general health care and an MBHO.

Separation of Health Services for Mental and Substance-Use Conditions from Each Other

The mental health and substance-use treatment systems evolved separately in the United States as a result of the different historical understandings of and responses to these illnesses described in Chapter 2. This separation became increasingly institutionalized with the evolution of three separate institutes of the National Institutes of Health (NIH) (the National Institute of Mental Health [NIMH] in 1949 and National Institute on Alcohol Abuse and Alcoholism [NIAAA] and the National Institute on Drug Abuse [NIDA] in 1974) and separate programming and funding divisions within SAMHSA. This separation at the federal policy level is frequently mirrored at the state level, where separate state mental health and substance-use agencies exist (although they are combined in some states).

The separation of service delivery that mirrors this separation of policy making and funding does not optimally serve individuals with co-occurring mental and substance-use illnesses. A congressionally mandated study of the prevention and treatment of co-occurring substance-use and mental conditions (SAMHSA, undated) found that the difficulties faced by individuals with these co-occurring conditions in receiving successful treatment and achieving recovery are due in part to the existence of these two separate service systems. The study notes: "Too often, when individuals with co-occurring disorders do enter specialty care, they are likely to bounce back and forth between the mental health and substance abuse services systems, receiving treatment for the co-occurring disorder serially, at best" (SAMHSA, undated:*i*). The study further states that this separation of public-sector substance-use and mental health service systems is accompanied by marked differences in "staffing resources, philosophy of treatment, funding sources, community political factors, regulations, prior training of staff, credentials of staff, treatment approaches, medical staff resources, assertive community outreach capabilities, and routine types of evaluations and testing procedures performed" (SAMHSA, undated:*v*). Of greatest concern, the study found that individuals with these co-occurring conditions also may be

[4]Personal communication, Philip Renner, MBA, Assistant Vice President for Quality Measurement, NCQA on March 22, 2005.

excluded from mental health programs because of their substance-use condition and from substance-use treatment programs because of their mental condition (SAMHSA, undated).

Frequent Need for Individuals with Severe Mental Illnesses to Receive Care Through a Separate Public-Sector Delivery System

Treatment for M/SU conditions also is unique in that state and local governments manage public-sector health care systems that are separate from the private-sector health care system for individuals with M/SU illnesses. Indeed, "behavioral disorders remain essentially the only set of health problems for which state and local governments finance and manage a specialty treatment system. [Although] public funds pay for a large portion of the costs of care for certain other disorders (such as Medicare financing of dialysis), and public services exist for a few rare disorders such as leprosy, . . . the public mental health system is the only substantial disorder-specific treatment system in existence today" (Hogan, 1999:106).

Because (as discussed in Chapter 3) individuals with M/SU illnesses face greater limitations in their insurance coverage than is the case with coverage for other illnesses, some individuals with M/SU illnesses who start receiving their care through private insurance must switch to public insurance (Medicaid or the State Children's Health Insurance Program [SCHIP])[5] or other publicly funded programs at the state and local levels when their private insurance is exhausted. Evidence indicates that these benefit limits most often are reached by individuals with some of the most severe mental illness diagnoses, including depression, bipolar disorder, and psychoses. There is also evidence that other serious diagnoses appearing in childhood, such as autism, are excluded from coverage under certain private health benefit plans (Peele et al., 2002). The lesser availability of health insurance for severe mental illnesses and for substance-use treatment also helps explain the involvement of other public sectors (i.e., child welfare and juvenile justice) in the delivery of mental health care (as described below).

The federal Substance Abuse Prevention and Treatment (SAPT) and Community Mental Health Services (CMHS) Block Grant programs provide funds to states help fill these gaps. SAPT and CMHS grants to states support the planning, delivery, and evaluation of M/SU treatment services. SAPT funds can be used for individuals regardless of the severity of their substance-use problem or illness, while CMHS grant funds may be used only for individuals with serious mental illnesses and children with "serious

[5]The Medicaid and SCHIP programs also deliver mental health services to individuals for whom these programs are the primary source of health insurance as a result of low income.

emotional disturbances" (SAMHSA, undated). Some of these funds also are given to county and other local government units to use in the planning and delivery of care. In a number of states, major responsibility for mental health services rests with local government, and the extent of coordination between state and local governments is variable.

In addition, public mental health hospitals play a key role in the care of forensic patients—those charged with crimes and being evaluated for competence to stand trial or assume criminal responsibility, or for other issues; those found incompetent to stand trial and being treated to restore competence; those found not guilty by reason of insanity and being treated; those referred for presentencing evaluation; and those sent from prison for hospital-based treatment. In some states, these and related categories account for more than half of all inpatient beds in public mental hospitals. A growing number of people in each of these categories are also being treated in the public (or equivalent community mental health clinic–based) outpatient system. To a considerable extent, this is a function that the public sector has always served. But as other functions have shrunk or been transferred to the private sector (e.g., acute care in many states), forensic functions have come to account for a larger percentage of the public system.

Involvement of Non–Health Care Sectors in M/SU Health Care

M/SU problems and illnesses often are detected (sometimes for the first time) by agencies or organizations that are not part of the traditional health care sector, such as schools, employers, or the welfare and justice systems. These organizations often refer, arrange for, support, monitor, and sometimes deliver M/SU health services. School mental health services and the child welfare and juvenile justice systems provide access to mental health services for the majority of children (DHHS, 1999). The criminal justice system also plays a role in securing M/SU services for some adults. In the private sector, employee assistance programs play a key role in the identification, referral, and provision of services to individuals with M/SU problems and illnesses. Moreover, many other publicly funded entities, such as housing programs, programs for individuals who are homeless, income maintenance programs, and employment programs, provide services that are essential to the recovery of many individuals with severe and chronic M/SU illnesses. The involvement of this array of human service providers generally not considered to be part of the health care sector necessitates additional levels of care coordination. This coordination must be effected despite the inevitable difficulties of working with multiple bureaucracies and in systems with differing priorities, knowledge bases, and practices.

Schools

Most children and adolescents who receive health care for mental conditions receive that care through their schools, not from primary medical or specialty mental health care providers (Kessler et al., 2001). The approaches used by schools to deliver M/SU health care services are highly variable, ranging from (1) class-room based, teacher-implemented programs; to (2) multifaceted, schoolwide programs that employ multiple strategies, such as modification of school policies, classroom management strategies, curriculum changes, and facilitation of parent–school communications; to (3) therapy provided to an individual student, group, or family; to (4) other strategies, such as parent training and education, case management, and consultation. Some of these approaches are prevention-oriented, while others are designed to treat individuals with identified psychopathology. Service modality, intensity, and duration also vary according to individual needs (Rones and Hoagwood, 2000). Some programs rely primarily or exclusively on school-supported mental health professionals (e.g., school social workers, guidance counselors, school nurses), while others have varying degrees of linkage with community mental health agencies and providers (e.g., clinical psychologists, social workers, psychiatrists) who either provide the mental health services exclusively in the school or partner with school staff. In some cases, mental health providers from the school and/or community work on-site in school-based health centers in partnership with primary care providers (Weist et al., 2005).

A review of research on such school-based mental health services published between 1985 and 1999 found that although evidence exists for the effectiveness of a subset of strong programs across a range of emotional and behavioral problems, most school-based programs have no evidence to support their impact, and no programs are targeted to specific clinical syndromes such as anxiety, attention deficit hyperactivity disorder (ADHD), and depression. This same study also found that precisely what is provided by schools under the rubric of mental health services is largely unknown, as is whether those services are effective (Rones and Hoagwood, 2000).

To learn more about school-based mental health services, SAMHSA and Abt Associates recently conducted a national survey aimed at providing information on mental health services delivered in U.S. public schools, including:

- The types of mental health problems/issues encountered most frequently in the school setting.
- The types of mental health services delivered, and models and arrangements for their delivery in public elementary, middle, and secondary schools.

- Barriers to the provision and coordination of mental health services in school settings.
- The numbers, availability, and qualifications of mental health staff in public schools.

The final report is to be released during fall 2005.[6]

Experts on school-based mental health services note that (1) schools should not be viewed as responsible for meeting all the mental health needs of their students (in some cases they are already overburdened with demands that should be addressed elsewhere); and (2) connections between school-based mental health services and substance-use treatment services are nonexistent or tenuous (Weist et al., 2005). These two factors, plus the need to coordinate M/SU services with general health care, impose responsibilities on school-based M/SU providers to collaborate with other specialty and general health care providers serving the student, and for the other specialty and general health care providers to do the same.

Child Welfare Services

Almost half (47.9 percent) of a nationally representative, random sample of children aged 2–14 who were investigated by child welfare services in 1999–2000 had a clinically significant need for mental health care (Burns et al., 2004). Even higher rates have been observed in children placed in foster care arrangements (Landsverk, 2005). This is not surprising given that the circumstances of children who are the subject of reports of maltreatment and investigated by child welfare services are characterized by the presence of known risk factors for the development of emotional and behavioral problems, including abuse, neglect, poverty, domestic violence, and parental substance abuse (Burns et al., 2004). Moreover, substantial rates of substance use among adolescents in child welfare have been detected (Aarons et al., 2001).

Ensuring the well-being of children is typically considered part of the mandate of child welfare services, and the children served by these agencies also have very high rates of use of mental health services. However, the first nationally representative study examining the well-being of children and families that came to the attention of child welfare services (the National Survey of Child and Adolescent Well-Being [NSCAW]) found that three of four youths in child welfare who met a stringent criterion of need did not receive mental health care within 12 months of a child abuse and neglect investigation (Landsverk, 2005). States have traditionally used Medicaid to provide medical, developmental, and mental health services to children in

[6]Personal communication, Judith L. Teich, ACSW, Health Policy Analyst. Center for Mental Health Services/SAMHSA on July 15 and October 10, 2005.

foster care;[7] however, use of this resource requires that child welfare services first identify children in need of such services. Analysis of the NSCAW data found that although 94 percent of counties participating in the survey assessed all children entering foster care for physical health problems, only 47.8 percent had policies for assessing mental health problems (Leslie et al., 2003). Data from the NSCAW also indicate that underutilization of needed services can be alleviated when there is strong coordination between local child welfare and public mental health agencies (Hurlburt et al., 2004).

Justice Systems

Criminal justice system The proportion of U.S. citizens incarcerated has been increasing annually—from a rate of 601 persons in custody per 100,000 U.S. residents in 1995 to 715 persons in custody per 100,000 residents in 2003. As of mid-2003, the nation's prisons and jails[8] held 2,078,570 persons—one in every 140 U.S. residents (Harrison and Karberg, 2004). Corrections facilities increasingly must attend to M/SU treatment because of this growth in the proportion of the U.S. population that is incarcerated and the requirement that prisons and jails provide treatment to inmates with medical needs (Haney and Specter, 2003).

A rigorous epidemiologic study of the prevalence of mental and substance-use illnesses in correctional settings has not been undertaken.[9] According to the U.S. Bureau of Justice, however, approximately 16 percent of all persons in jails and state prisons reported having either a mental "condition" or an overnight stay in a psychiatric facility, as did 7 percent of those in federal prisons (Ditton, 1999). Consistent with the evidence in Chapter 3 indicating that those with mental illnesses are responsible for a small share of violence in society, this rate is not much higher than that among the U.S. population overall (13 percent of those over age 18 reported receiving mental health treatment in an inpatient or outpatient setting in 2003[10]) (SAMHSA, 2004). Also consistent with the evidence in

[7]Little information is available about the need for and use of mental health services for children whose families receive in-home services from the child welfare system (Landsverk, 2005).

[8]In general, prisons and jails differ by the inmates' length of sentence. Prisons hold those convicted of felonies and serving sentences longer than a year, while jails hold those awaiting adjudication, convicted of misdemeanors, and serving sentences of a year or less. Prisons are operated by the state; jails by counties and other localities (Wolff, 2004).

[9]A more rigorous epidemiologic study of the prevalence of mental and substance use illnesses in correctional settings, modeled on the prevalence studies of the general population in the United States (Kessler et al., 2001) and the correctional and general populations in the United Kingdom, has been called for (Wolff, 2004).

[10]This figure does not include treatment solely for substance use.

Chapter 3, substance use plays a larger role in incarceration. Over half of inmates in state prisons and local jails were under the influence of alcohol or other drugs at the time of their offense, as were 33 to 46 percent of federal prison inmates (Ditton, 1999). In an average year, moreover, approximately one-third of new admissions to prisons result from a violation of parole conditions, nearly 16 percent of which are for some type of drug-related violation, such as a positive test for drug use or possession of drugs (Hughes et al., 2001). Although the majority of prisons and jails screen, assess, and provide treatment for mental illnesses, far fewer prisoners receive treatment for their substance-use problems and illnesses. When they do, detoxification and self-help group/peer support counseling are most commonly provided (Wolff, 2004).

The police and courts also interact with systems providing treatment for M/SU illnesses as they exercise their judgment and license to divert individuals with such illnesses from criminal processing (Metzner, 2002). As discussed in Chapter 3, courts increasingly influence the receipt of treatment for M/SU illnesses through the use of specialty drug and mental health courts. Defendants in these courts have the option of treatment or incarceration. If they choose treatment, they may forgo criminal processing altogether, or undergo criminal processing but forgo sentencing. The court supervises compliance with treatment. Police also influence treatment; as the gatekeepers for the criminal justice process, they are charged with determining whether to "socialize, medicalize, or criminalize" the event. And probation and parole officers influence treatment in exercising their oversight over compliance with terms of probation and parole. All of these actors' decisions are influenced by their personal understanding of these issues, the culture of their agency, and their localities' enforcement policies and social norms (Wolff, 2004).

Appropriate decision making about diverting or prosecuting, exercising coercion into treatment in a way that preserves patient-centered care (see Chapter 3), and fulfilling the right of incarcerated persons to medical treatment requires policies and practices that reflect an understanding of M/SU problems and illnesses and their effective treatment, as well as knowledge of the availability of treatment in the local community. However, individual agents of the judicial system vary in their training on these issues, and the policies and practices of each locality vary according to local norms and the public's beliefs about M/SU illnesses[11] (Wolff, 2004). As a result, coordination with specialty M/SU providers, organizations, and systems is essential to the development of evidence-based criminal justice policies and

[11]Since the chief prosecutor in each jurisdiction is typically elected, the public's perception of M/SU illnesses and dangerousness, for example (see Chapter 3), even if erroneous, may shape policies and practices (Wolff, 2004).

practices and to the delivery of effective care to individuals in the criminal justice system.

However, numerous and sizable obstacles to coordination between M/SU health care and criminal justice systems have been documented. Several actions that are consistent with the *Quality Chasm* framework for redesigning health care have been recommended to overcome these obstacles. These include using performance measures of the coordination between M/SU health care and criminal justice systems at the system, agency, program, and individual levels; providing combined, interdisciplinary training in collaboration and coordination for personnel from both types of agencies and programs; incentivizing coordination through promotion, salary, and budget decisions; providing education and decision support to prosecutors and judges; and using information systems to facilitate the communication of information essential to responding appropriately to each individual (Wolff, 2004).

Juvenile justice system Primary components of the juvenile justice system include intake, detention centers, probation services, secure residential facilities, and aftercare programs (Cocozza, 2004). Although research on the prevalence and nature of M/SU illnesses in juvenile justice systems is limited (Cocozza, 2004), between 60 and 75 percent of youths in these systems are estimated to have a diagnosable mental health "disorder" (Cocozza 2004; Teplin et al., 2002; Wierson et al., 1992), and 20 percent are conservatively estimated to have a severe mental illness (Cocozza and Skowyra, 2000). Rates of co-occurring substance-use illnesses also are high (Cocozza, 2004; Grisso, 2004).

Moreover, in a 2003 survey of all (698) secure juvenile detention facilities in the United States,[12] two-thirds of the facilities reported holding youths (prior to, after, or absent any pending adjudication) because they were awaiting community mental health services. Further, like youths who are not abused or neglected but are placed in child welfare solely to obtain mental health services (discussed in Chapter 1), children who are not guilty of any offence are similarly placed in local juvenile justice systems and incarcerated solely to obtain mental health services not otherwise available. Although no formal counting and tracking of such children takes place, juvenile justice officials in 33 counties in the 17 states with the largest populations of children under age 18 estimated that approximately 9,000 such children entered their juvenile justice systems under these circumstances in 2001. County juvenile justice officials' estimates ranged from zero to 1,750, with a median of 140. Nationwide the number of children

[12]Response rate of 75 percent.

placed in juvenile justice systems is likely to be higher; 11 states reported to the Government Accountability Office (GAO) that they could not provide estimates even though they were aware that such placements occur (GAO, 2003).

Although the vast majority of juvenile justice facilities report providing some type of mental health service (Goldstrom et al., 2001), "numerous investigations suggest that many youth in the juvenile justice system do not receive needed mental health services and that available services are insufficient and inadequate." Most existing programs have not been evaluated, and some of the most popular and widely implemented programs have no evidence to support them and may actually be harmful. Juvenile justice systems, however, lack the training, service, and expertise to respond more effectively (Cocozza, 2004). Because many youths are in juvenile justice systems for relatively minor, nonviolent offenses, there also is a growing sentiment that whenever possible, youths with serious mental illnesses should be diverted from those systems. However, the limited amount of research on the efficacy of juvenile diversion programs has yielded mixed results. To achieve appropriate diversion and the provision of evidence-based care to children and youths in juvenile justice, coordination is crucial: "Almost every study and report that has focused on youth with mental health disorders who come in contact with the juvenile justice system has arrived at the same conclusion—that collaboration between mental health and juvenile justice (and other systems such as child welfare and education as well) at every level and at every stage is critical to any progress. The problem cannot be solved by any single agency" (Cocozza, 2004:35).

Employee Assistance Programs

An increasing number of individuals are covered by employee assistance programs (EAPs). An estimated 66.5 million employees were enrolled in such programs in 2000—a 245 percent increase since 1994 and a 13 percent increase over the year before (Fox et al., 2000). EAPs offered by employers[13] to their employees (and frequently employees' family members) vary in structure, types and qualifications of personnel, scope and length of services provided, location, and relationship to health plans providing M/SU and general health care services to the same employees. Although EAPs began as occupational programs to address alcohol-related problems in the workplace, they now typically offer consultation with personnel in identifying and resolving other job performance issues, and pro-

[13]Other organizations, such as labor organizations, unions, and professional associations, also sponsor EAPs.

vide further assessment, referral, and follow-up services. Additional services offered include assistance to employees experiencing stressful events, wellness training, assistance with work/life issues, legal assistance, and financial services. EAPs sometimes have a formal relationship with the M/SU services offered by a health plan and/or serve as a required gateway to M/SU services (Masi et al., 2004). Thus, an EAP's caseload can include individuals with severe M/SU problems and illnesses (Masi, 2004). EAPs are distinct in that their services are typically brief (an average of six counseling sessions) and often are provided via telephone or the Internet by a provider in a different location—perhaps several states away—and with round-the-clock access (Masi, 2004).

Linkages with Community and Other Human Services Resources

Individuals with M/SU problems and illnesses sometimes require additional services from a variety of community resources, such as self-help and support programs for individuals with specific diseases, housing services, income maintenance programs, and employment services, that are essential to the recovery of many individuals with severe and chronic M/SU illnesses. Appendix C contains a description of an array of such support services provided by the Veterans Health Administration to veterans with severe M/SU illnesses.

Discharge planning units or similar staff within inpatient facilities, as well as case management staff within outpatient treatment settings or programs, must assess patients for the need for these services, establish referral arrangements, and coordinate the services with the human service agencies providing them. Such coordination of care across inpatient and outpatient providers is essential to ensure timely access to these services. When discharge planning or outpatient care fails to ensure speedy access to these services and continuity of care within the community, patients are at risk for failure to implement their treatment plans, homelessness, incarceration, or other adverse outcomes.

Unclear Accountability for Coordination

Because patients receive care from multiple providers and delivery systems, there often is an unclear point (or points) of accountability for patients' treatment outcomes. When organizations or providers are reimbursed separately for the services they provide, each may perceive no responsibility for the services delivered by others and, as a result, for any patient outcomes likely to be affected by those services. Unless providers' accountability for sharing information or collaborating with other providers is explicitly identified in their agreements with purchasers, they may reasonably

believe that those other providers have primary responsibility for initiating and maintaining ongoing communication and collaboration.

Moreover, the concept of collaboration has not been clearly defined (Schmitt, 2001). Thus, when providers do accept responsibility for collaborating with other providers, what constitutes "collaboration" is left to their own interpretation based on historical local practice patterns and limitations imposed by their current workload. This unclear accountability has been acknowledged and addressed in a conceptual model for coordinated care delivery developed by the National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors. This model articulates a vision of coordinated care involving primary, mental health, substance-use, and other health and human service providers who share responsibility for delivering care to the full population in need of M/SU health care depending upon the predominance of medical, mental, or substance-use symptoms (SAMHSA, undated).

DIFFICULTIES IN INFORMATION SHARING

The sharing of patient information across providers treating the same patient so that care can be coordinated is widely acknowledged as necessary to effective and appropriate care. This need was acknowledged most recently in regulations governing the privacy of individually identifiable health information under the authority of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA's implementing regulations generally permit health care organizations to release—without requiring patient consent—individually identifiable information (except psychotherapy notes) about the patient to another provider or organization for treatment purposes.[14]

However, the HIPAA regulations are superseded by other federal and state statutory and regulatory provisions that may make it difficult for different providers or treatment organizations to share information. First, HIPAA itself (Section 264 (c)(2)) requires that regulations promulgated to implement its privacy provisions not supersede any contrary provisions of state law that impose more stringent requirements, standards, or implementation specifications pertaining to patient privacy. Each of the 50 states (and the District of Columbia) has a number of statutes governing the confidentiality of medical records, and specifically governing aspects of mental health records. Many of these statutes are more stringent than the HIPAA requirements, and the variation among them is great (see Appendix B for a detailed discussion of federal and state laws regarding confidential-

[14]45 CFR Part 164, Subpart E, § 164.502.

ity and the release of health care information pertaining to mental and substance-use conditions).

Second, regulations implementing HIPAA also permit health care organizations to implement their own patient consent policies for the release of patient information to other treating providers.[15] As a result, health care organizations may adopt even more stringent privacy protections that require participating providers to adhere to additional procedures before sharing patient information with other treatment providers or organizations.

Moreover, separate federal laws govern the release of information pertaining to an individual's treatment for drug or alcohol use. These laws do not permit sharing of records related to substance-use treatment or rehabilitation by organizations operated, regulated, or funded by the federal government without the patient's consent, except within a program or with an entity with administrative control over the program, between a program and organizations that provide support services such as billing and data processing, or in case of a "bona fide medical emergency." These federal laws are also superseded by any state laws that are more stringent (see Appendix B). The preamble to the HIPAA privacy regulations also recognizes the constraints of the substance-use confidentiality law and states that wherever one is more protective of privacy than the other, the more restrictive should govern (65 Fed. Reg. 82462, 82482–82483).

The bottom line is that clinicians providing treatment to individuals with M/SU illnesses must comply with multiple sets of rules governing the release of information: one prescribed federally and pertaining to information on treatment for alcohol or drug problems, state laws that pertain to information on health care for mental and substance-use conditions (depending upon whether they are more stringent than the federal rules), and other policies prescribed by the organization or multiple organizations under whose auspices patient care is provided.

STRUCTURES AND PROCESSES FOR COLLABORATION THAT CAN PROMOTE COORDINATED CARE

Because of the complexities described above, strategies to improve coordination of care need to be multidimensional (Gilbody et al., 2003; Pincus et al., 2003). A systematic review of studies of organizational and educational interventions to improve the management of depression in primary care settings found that initiatives with the most multidimensional approaches generally achieved positive results in their primary outcomes (Gilbody et al., 2003). Components of multidimensional strategies to im-

[15] 45 CFR Part 164 Subpart E § 164.506(b).

prove care coordination that can be used by providers and health care organizations at the locus of care include (1) screening for co-occurring conditions; (2) making a formal determination to either treat, or refer for treatment of, co-occurring conditions; (3) implementing more effective mechanisms for linking providers of different services to enable joint planning and coordinated treatment; and (4) providing organizational supports for collaboration between clinicians on- and off-site. Purchasers and quality oversight organizations can create incentives for providers to employ these strategies through their funding and accountability mechanisms and by exercising leadership within their spheres of influence.

Health Care Provider and Organization Strategies

Screening

Because of the high rates of comorbidity described above—especially among those seeking treatment—screening to detect the presence of comorbid conditions is a necessary first step in care coordination. Screening enables a service provider to determine whether an individual with a substance-use problem or illness shows signs of a mental health problem or illness, and vice versa. If a potential problem is identified, a more detailed assessment is undertaken. Routine screening has been shown to improve rates of accurate mental health and substance-use diagnosis (Pignone et al., 2002; Williams et al., 2002).

The above-mentioned congressionally mandated study of the prevention and treatment of co-occurring substance-use and mental conditions (SAMHSA, undated) identified screening as critical to the successful treatment of comorbid conditions. Similarly, because of the high prevalence of emotional and behavioral problems among children served by child welfare services, screening has been recommended for children in the child welfare system overall (Burns et al., 2004) and especially for those placed in foster care (American Academy of Child & Adolescent Psychiatry and Child Welfare League of America, 2003). The U.S. Preventive Services Task Force also has recommended two types of screening in primary care settings:

- Screening for alcohol misuse by adults, including pregnant women, along with behavioral counseling interventions.
- Screening for depression in adults in clinical practices that have systems in place to ensure accurate diagnosis, effective treatment, and follow-up (AHRQ, 2002–2003).

The U.S. Preventive Services Task Force has not addressed the issue of screening for comorbid mental or substance-use conditions among indi-

viduals presenting with either condition. To facilitate the adoption of screening and treatment for comorbid mental and substance-use illnesses, the task force could include among its recommended guidelines screening for a co-occurring mental or substance-use problem at the time of an individual's initial presentation with either condition.

As discussed earlier, however, when screening is done, it often is not performed effectively (Friedmann et al., 2000b; Saitz et al., 2002). Effectiveness can be increased by use of any of a broad range of available and reliable instruments for screening for mental illnesses and co-occurring substance-use problems and illnesses (NIAAA, 2002; Pignone et al., 2002; Williams et al., 2002). An example is the Patient Health Questionnaire, a self-administered instrument designed to screen for depression, anxiety disorders, alcohol abuse, and somatiform and eating disorders in primary care (Spitzer et al., 1999). Other very brief, single-question screens have been evaluated for use in screening for alcohol-use problems (Canagasaby and Vinson, 2005). NIAAA has developed a single question (one for men and one for women) for screening for alcohol-use problems in primary care and other settings (NIAAA, 2005).

Anticipation of Comorbidity and Formal Determination to Treat or Refer

Again because of the high prevalence of co-occurring conditions, especially among individuals seeking treatment, the congressionally mandated study of the prevention and treatment of co-occurring substance-use and mental conditions (SAMHSA, undated) stated that individuals with co-occurring disorders should be the expectation, not the exception, in the substance-use and mental health treatment systems. SAMHSA and others have concluded that substance-use treatment providers should expect and be prepared to treat patients with mental illnesses, and similarly that mental health care providers should be prepared to treat patients with substantial past and current drug problems (Havassy et al., 2004; SAMHSA, undated). In its report to Congress, SAMHSA stated that one of the principles for effective treatment of co-occurring disorders is that "any door is the right door"; that is, people with co-occurring disorders should be able to receive or be referred to appropriate services whenever they enter any agency for mental health or substance-use treatment.

This same principle is applicable to general health problems and illnesses as well. A review of innovative state practices for treating comorbid M/SU conditions found that agency staff *expected* their clients to present with co-occurring general health problems. They screened and assessed for related conditions, including HIV/AIDS, physical and sexual abuse, brain disorders, and physical disabilities. Staff were cross-trained in both mental health and substance-use disciplines (although they did not work outside of

their primary discipline) (NASMHPD and NASADAD, 2002). The congressionally mandated study also stated that with training and other supports, primary care settings can undertake diagnosis and treatment of these interrelated disorders (SAMHSA, undated). Alternatively, use of a systematic approach to referral to and consultation with a mental health specialist is often used in model programs for better care (Pincus et al., 2003).

Linking Mechanisms to Foster Collaborative Planning and Treatment

As discussed at the beginning of this chapter, the simple sharing of information, by itself, is insufficient to achieve care coordination. Care coordination is the result of collaboration, which exists when the sharing of information is accompanied by joint determination of treatment plans and goals for recovery, as well as the ongoing communication of changes in patient status and modification of treatment plans. Such collaboration requires structures and processes that enable, support, and promote it (IOM, 2004a).

Not surprisingly, available evidence indicates that referrals alone do not lead to collaboration or coordinated care (Friedmann et al., 2000a). Stronger approaches are needed to establish effective linkages among primary care, specialty mental health and substance-use treatment services, and other care systems that are involved in the delivery of M/SU treatment. These stronger linkage mechanisms vary in form and are theorized to exist along a continuum of efficacy. The extremes range from the ad hoc purchase of services from separate providers to on-site programs (see Figure 5-1) (D'Aunno, 1997; Friedmann et al., 2000a). Linkage mechanisms toward the right of the continuum are theorized to be stronger because they lower barriers or causes of "friction" (e.g., problems in identifying willing providers, clients' personal disorganization, and lack of transportation[16]) that prevent patients from receiving services.

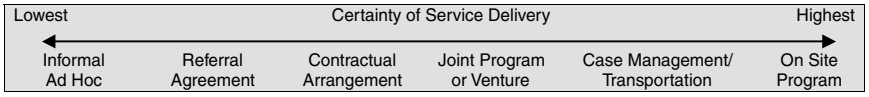

FIGURE 5-1 The continuum of linkage mechanisms.
SOURCE: Friedmann et al., 2000a. Reprinted, with permission, from Health Services Research, June 2000. Copyright 2000 by the Health Research and Educational Trust.

Approaches whose effectiveness in securing collaboration has some conceptual and/or empirical support include collocation and clinical integration of services, use of a shared patient record, case (or care) manage-

[16]These are in addition to the problems in insurance coverage discussed in Chapter 3.

ment, and formal agreements with external providers. Evidence to date also indicates that some of these approaches are more effective than others. Moreover, their successful implementation requires leadership within an organization, facilitating structures and processes within treatment settings, and often redesigned professional roles and training in these new roles.

Collocation and clinical integration of services Physical proximity of would-be collaborators facilitates collaboration (IOM, 2004a). This point is exemplified by the multiple studies of mental or substance-use health care showing that same-site delivery of both types of care or primary care is more effective in identifying comorbid conditions (Weisner et al., 2001), effectively links clients to the collocated services (Druss et al., 2001; Samet et al., 2001), and can improve treatment outcomes (Unutzer et al., 2001; Weisner et al., 2001). In a 1995 study of a nationally representative sample of all outpatient drug-use treatment units, same-site delivery of services was more effective than formal arrangements with external providers, referral agreements, or case management in ensuring that patients would utilize necessary services (a first step in collaborative care) (Friedmann et al., 2000a). For these reasons, the collocation of multiple services (mental, substance-use, and/or general health) at the same site is a frequently cited feature of many care collaboration programs. The congressionally mandated study of prevention and treatment of co-occurring substance-use and mental conditions (SAMHSA, undated) highlighted "integrated treatment" as an evidence-based approach for co-occurring disorders, defined, in part, as services delivered "in one setting." The report noted that such integrated treatment programs can take place in either the mental or substance-use treatment setting, but require that treatment and service for both conditions be delivered by appropriately trained staff "within the same setting."

Others have noted the benefits of integrating behavioral health specialists into primary settings, as well as the reciprocal strategy of including primary care providers at locations that deliver care to individuals with severe mental and substance-use illnesses. This type of collocation facilitates patient follow-through on a referrals, allows for face-to-face verbal communication in addition to or as an alternative to communicating in writing, and allows for informal sharing of the views of different disciplines and easy exchange of expertise (Pincus, 2003).

Such opportunities for face-to-face communication are important because multiple studies identify effective communication as a key feature of collaboration (Baggs and Schmitt, 1988; Knaus et al., 1986; Schmitt, 2001; Shortell et al., 1994). "Effective" communication is described as frequent and timely (Gittell et al., 2000; Shortell et al., 1994),[17] and is characterized

[17]As well as accurate, understandable, and satisfying.

by discussion with contributions by all parties, active listening, openness, a willingness to consider other ideas and ask for opinions, questioning (Baggs and Schmitt, 1997; Shortell et al., 1994), and the free flow of information among participants. This type of communication is less easily achieved through electronic, mail, and telephone communications. Nonetheless, when physical integration of services is not feasible, other efforts to promote effective collaboration (i.e., communication between providers by indirect means such as shared patient records or use of a case manager) may yield benefits.

Shared patient records Coordination of care provided by different providers can also be facilitated by shared patient records and documentation practices that promote interdisciplinary information exchange. Electronic health records (EHRs) are supported as an important mechanism for sharing such information and have been highlighted as one of the essential components of the developing National Health Information Infrastructure (NHII). EHRs allow (1) the longitudinal collection of electronic information pertaining to an individual's health and health care; (2) immediate electronic access—by authorized users only—to person- and population-level information; (3) provision of knowledge and decision support to enhance the quality, safety, and efficiency of patient care; and (4) support for efficient processes of health care delivery (IOM, 2003b). Although still in a minority, hospitals and ambulatory practices are increasingly investing in EHRs; these investments typically are being made by larger facilities, creating what is referred to as the "adoption gap" between large and small organizations (Brailer and Terasawa, 2003). Although sharing of patient information maintained in paper-based records can still take place, the capture and storage of patient information electronically is endorsed as a more thorough and efficient mechanism for timely access to needed information by the many providers serving a patient.

Case (care) management Case (or care) management refers to varying combinations of actions performed by a designated individual[18] (i.e., case manager) to arrange for, coordinate, and monitor health, psychological, and social services important to an individual's recovery from illness and the effects of these services on the patient's health. Although the services encompassed by case management often vary by the severity of the illness, the needs of the individual, and the specific model of case management

[18]We distinguish in this section between case management, provided by an additional resource *person* working with both the patient and the involved clinicians, and disease management *programs*. The latter often involve transfer of the overall medical and related health care management of a patient's specific disease to a separate organization or program, frequently through a contract. Disease management programs can also offer case management services by an individual as a part of their approach to disease management.

employed (Gilbody et al., 2003; Marshall et al., 2004), typical activities include assessment of the patient's need for supportive services; individual care planning, referral, and connection of the patient with other necessary services and supports; ongoing monitoring of the patients' care plan; advocacy; and monitoring of the patient's symptoms.

Although systematic reviews of the effectiveness of case management for individuals with serious mental illnesses have been conducted with different review strategies and produced conflicting findings (Marshall et al., 2004; Ziguras and Stuart, 2000) (perhaps in part because of the large number of different models of case management [Zwarenstein et al., 2000]), the approach continues to be a common component of many mental health treatment services for individuals with other than mild mental illnesses. A systematic review of studies of organizational and educational interventions to improve the management of depression in primary care settings found that although most initiatives used multiples strategies, case management was one of two approaches used most often in projects achieving positive outcomes and health-related quality of life[19] (Gilbody et al., 2003). More recently, within The Robert Wood Johnson Foundation's national program for depression treatment in primary care, all eight demonstration sites independently designed their interventions to incorporate case management, often with expanded roles for case managers that include ensuring that treatment guidelines and protocols are followed and that a depression registry is used by clinicians. Case managers also serve as intermediaries between patients' primary care providers and mental health specialists (Anonymous, 2004; Rollman et al., 2003). Case management is an essential element as well of the MacArthur Foundation's RESPECT—Depression Project for improving the treatment of depression in primary care, and of disease management programs such The John A. Hartford Foundation and California Health Care Foundation's Project IMPACT program for treating late-life depression (Unutzer et al., 2001).

Formal agreements with external providers Formal agreements with external providers also can influence patients' appropriate utilization of needed services (Friedmann et al., 2000a). Such agreements can include, for example, a substance-use treatment or mental health organization that contracts with a medical group practice to provide physical examinations and routine medical care for its patients. The advantages of this approach are

[19]In some studies, the case manger role was of low intensity and included follow-up phone calls to monitor medication adherence, providing brief patient education and medication counseling, or giving support over the phone. In other programs, nurse case managers took on additional roles that included, for example, ongoing support and monitoring of patient therapy and treatment response according to algorithms.

that it requires fewer organizational and physical plant resources than do collocated services, and it makes use of existing community resources (Samet et al., 2001). Specialty consultation with primary care providers is another frequently identified service that can be secured through a formal agreement with an external provider (Pincus et al., 2003). At a minimum, formal agreements with external providers should include not just the agreement to provide the referred service, but also provisions addressing information sharing, joint treatment planning, and monitoring of patient outcomes.

Organizational Support for Collaboration

Successfully implementing the above strategies for care coordination requires facilitating structures and processes within treatment settings. Collaboration also often requires changes in the design of work processes at treatment sites, in particular, flexibility in professional roles. Effective leadership is an overarching need to help health care providers successfully adopt, adapt to, and sustain these changes.

Facilitating structures and processes at treatment sites Structures and processes that encourage multidisciplinary providers to come together for joint treatment planning foster collaboration. For example, in acute, general inpatient care, there is evidence that using interdisciplinary rounds can be effective in improving patient care (Curley et al., 1998). Improvement in care can also be achieved by involving primary and mental health care providers in interdisciplinary team meetings (Druss et al., 2001; Unutzer et al., 2001) at which joint care planning takes place, or by providing case managers (see above) to facilitate patient education, monitoring, and communication between primary care providers and M/SU specialists (Feldman et al., 2005). In addition, a number of more general quality improvement strategies, such as medication algorithms, hold the potential to improve coordination of care by standardizing care processes and creating channels of communication. For instance, the Texas Medication Algorithm Project includes a clinical coordinator to help ensure appropriate coordination among clinicians, patients, and family members in promoting adherence to medication guidelines (Miller et al., 2004; Rush et al., 2003).

In a randomized controlled trial of the integration of medical care with mental health services, it was found that same-site location, common charting, enhanced channels of communication (including joint meetings and e-mail), and in-person contact facilitated the development of common goals and sharing of information between medical and mental health providers. Interdisciplinary team meetings involving primary and behavioral health care providers can do the same (Druss et al., 2001).

Heavy workloads can interfere with the formation of collaborative relationships. Collaboration requires that staff have the time to participate in such activities as interdisciplinary team meetings (Baggs and Schmitt, 1997). Illustrating this point, additional staff resources and reduced caseload were identified as two of several components of success in a randomized controlled trial of collocating and integrating medical care with mental health care (Druss et al., 2001). When staff are overwhelmed with caregiving responsibilities, they may not take the time to collaborate. Yet while unilateral decision making is easier in the short run, collaborative relationships are viewed as saving time in the long run (Baggs and Schmitt, 1997).

The committee also calls attention to the Chronic Care Model, used to improve the health care of individuals with chronic illnesses in primary care settings. This model has six components: (1) providing chronic illness self-management support to patients and their families (see Chapter 3); (2) redesigning care delivery structures and operations; (3) linking patients and their care with community resources to support their management of their illness (described above); (4) providing decision support to clinicians (see Chapter 4); (5) using computerized clinical information systems to support compliance with treatment protocols and monitor patient health indicators (see Chapter 6); and (6) aligning the health care organization's (or provider's) structures, goals, and values to support chronic care (discussed below) (Bodenheimer et al., 2002). The Chronic Care Model has been applied successfully to the treatment of a wide variety of general chronic illnesses, such as diabetes, asthma, and heart failure (The National Coalition on Health Care and The Institute for Healthcare Improvement, 2002), as well as to common mental illnesses such as depression (Badamgarev et al., 2003), and has been theorized to have the potential for improving the quality of care for persons with other M/SU illnesses (Watkins et al., 2003).

The Chronic Care Model also emphasizes the use of certain organizational structures and processes, including interdisciplinary practices in which a clear division of the roles and responsibilities of the various team members fosters their collaboration. Instituting such arrangements may necessitate new roles and divisions of labor among clinicians with differing training and expertise. In the Chronic Care Model, for example, physician team members are often responsible for the treatment of patients with acute conditions, intervene in stubbornly difficult chronic care problems, and train other team members. Nonphysician personnel support patients in the self-management of their illnesses and arrange for routine periodic health monitoring and follow-up. Providing chronic care consistent with this model requires support from health care organizations, health plans, purchasers, insurers, and other providers. Elements of the Chronic Care Model have been implemented in a variety of care settings, including private general medical practices, integrated delivery systems, and a community health

center for general health care (Bodenheimer et al., 2002). The committee believes this model should be developed for use in the care of individuals with chronic M/SU illnesses as a mechanism for improving coordination of care, as well as other dimensions of quality.

Flexibility in professional roles As seen in the Chronic Care Model, collaboration sometimes requires revision in professional roles, including the shifting of roles among health care professionals and the expansion of roles to include new tasks (Gilbody et al., 2003; Katon et al., 2001). It also often requires participating as part of an interdisciplinary team with certain prescribed roles (Unutzer et al., 2001). Research findings and other empirical evidence show that health care workers of all types are capable of performing new tasks necessitated by advances in therapeutics, shortages in the health care workforce, and the pressures of cost containment. For example, the development of safer and more effective medications for mental and substance-use illnesses (e.g., selective serotonin reuptake inhibitors) has enabled the treatment of depression by primary care clinicians. Other medications, such as buprenorphine, may do the same. Other developments that are likely to require redefinition of professional roles include the use of peer support personnel (described in Chapter 3) and the delivery of more M/SU health care in primary care settings and by primary care providers (Strosahl, 2005).

However, new communication patterns and changes in roles, especially functioning as part of an interdisciplinary team, can at times be uncomfortable for health professionals. Role confusion and conflict are a frequent barrier to interdisciplinary collaboration (Rice, 2000). As a result, it may be necessary to provide training and development in collaborative practice behaviors, such as effective communication and conflict resolution (Disch et al., 2001; Strosahl, 2005). Collaboration is enhanced by a shared understanding of agreed-upon collective goals and new individual roles (Gittell et al., 2000).

Leadership Leadership is well known to be a critical factor in the success of any major change initiative or quality improvement effort (Baldridge National Quality Program, 2003; Davenport et al., 1998) and an essential feature of successful programs in care coordination (NASMHPD, NASADAD, 2002). Effective leadership in part models the behaviors that are expected at the clinical care level. For example, in The Robert Wood Johnson Foundation's *Initiative on Depression in Primary Care*, leadership was one of six component interventions to overcome barriers to the delivery of effective care for depression in primary care settings. Teams of primary care, mental health, and senior administrative personnel were responsible for securing needed resources, representing stakeholder interests, promot-

ing adherence to practice standards, setting goals for key process measures and outcomes, and encouraging sustained efforts at continuous quality improvement (Pincus et al., 2003). Such activities ensure that the structures and processes that enable and nurture collaboration are in place at the locus of care.

Practices of Purchasers, Quality Oversight Organizations, and Public Policy Leaders

Clinicians and health care organizations will not be able to achieve full coordination of patient care without complementary and supporting activities on the part of federal and state governments, health care purchasers, quality oversight organizations, and other organizations that shape the environment in which clinical care is delivered. As noted earlier, care coordination has been identified by the IOM as one of 20 priority areas deserving immediate attention by all participants in the American health care system. Health care purchasers, quality oversight organizations, and public policy leaders can help give care coordination this immediate attention by (1) clarifying their expectations for information sharing, collaboration, and coordination in their purchasing agreements; (2) including the care coordination practices recommended above in their quality oversight standards and purchasing criteria; and (3) modeling collaborative practices across health care for general, mental, and substance-use health conditions in their policy-making and operational activities.

Purchaser Practices

Purchasers can stimulate and incentivize better coordination of care among general, mental, and substance-use health care by including care coordination as one of the quality-of-care parameters used to evaluate proposals and award contracts for the delivery of general, specialty M/SU, and comprehensive (general and M/SU) health care (see Chapter 8). In soliciting health plans and providers to deliver these health care services, purchasers can ask bidders to specify what care coordination practices they require of their clinicians, and how the organization supports clinicians and measures care coordination. When awarding contracts, purchasers can clarify in contracts with health care plans their expectations for information sharing, collaboration, and coordination. In addition, purchasers should allow primary care providers to bill for the M/SU treatment services they provide, a practice now under way in some MBHO settings (Feldman et al., 2005). Doing so will allow consumers and their primary care providers to determine jointly, as they do for other medical conditions, when specialty consultation and care are appropriate; enable coordination of care

through the use of a single provider to treat general and M/SU conditions; and eliminate the adverse consequences that arise when primary care providers code visits related to M/SU problems and illnesses as being due to somatic complaints.

Quality Oversight Practices

Many purchasers delegate their attention to care coordination and other quality-related issues by accepting the quality-of-care determinations made by expert quality oversight organizations, such as accrediting bodies. Four main organizations accredit M/SU health care organizations (and sometimes individual providers). The National Committee for Quality Assurance (NCQA) accredits managed care organizations, MBHOs, and disease management programs and recognizes physician practices through other oversight programs. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredits hospitals and specialty behavioral health care organizations. The Commission on Accreditation of Rehabilitation Facilities accredits a wide variety of behavioral health programs and services. Finally, the Council on Accreditation for Children and Family Services, Inc. accredits a wide variety of counseling and other M/SU programs and services, as well as EAPs. These accrediting bodies generally perform their quality oversight activities either through review of an organization's structures and operational practices or through measurement of an organization's or provider's clinical care processes and outcomes. Clinical care processes and outcomes are generally evaluated through performance measures (discussed in Chapter 4). Organizational structures and processes such as the linking strategies recommended above are typically reviewed through evaluation of compliance with the established structural and procedural standards that make up an organization's accreditation standards.

Although the accreditation standards of each of the above four organizations address care coordination and collaboration to some extent (CARF, 2005; COA, 2001; JCAHO, 2004; NCQA, 2004), accreditation standards for care coordination could be improved. For example, NCQA's MBHO accreditation standards address care coordination between M/SU and general health care in Standard QI 10, "Continuity and Coordination between Behavioral Health and Medical Care," which states (NCQA, 2004:91):

> The organization collaborates with relevant medical delivery systems or primary care physicians to monitor and improve coordination between behavioral health and medical care.

However, the following note is appended to this standard:

> Note: If the organization does not have any formal relationship with the medical delivery system through contracts, delegation, or otherwise, NCQA considers this standard NA. (NCQA, 2004:91). NCQA's customer support line clarifies that "NA" means "Not Applicable."[20]

Collaboration and Coordination in Policy Making and Programming

Throughout this report, the committee emphasizes the need for collaboration and coordination in mental, substance-use, and general health care policy making and programming that parallels desired collaboration and coordination at the care delivery level—for example, in the dissemination of information on innovations in new treatments (see Chapter 4), in the measurement of the quality of M/SU care (see Chapter 4), and in the development of information technology for M/SU care (see Chapter 6). Such attention to coordination and collaboration at the policy and programming represents an opportunity for federal, state, and local officials to model and promote the coordination and collaboration needed at the clinical level—across M/SU health care and across providers of these specialty health care services and general health care. The importance of seizing this opportunity is emphasized in the IOM report *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality*. That report, commissioned by Congress to examine and recommend quality improvement activities in six major federal programs,[21] concluded that the federal government must assume a strong leadership role in quality improvement:

> By exercising its roles as purchaser, regulator, provider of health services, and sponsor of applied health services research, the federal government has the necessary influence to direct the attention and resources of the health care sector in pursuit of quality. There is no other stakeholder with such a combination of roles and influence. (IOM, 2002:*x*)

Because coordination of care is one dimension of quality, the federal government needs to exercise leadership and model coordination and collaboration in general, mental, and substance-use health care. This coordination and collaboration should be practiced across the separate Centers

[20]Conversation with NCQA Customer Support on July 22, 2005.

[21]Even this initiative represents a missed opportunity for collaboration and coordination. Congress charged the IOM with examining the roles of Medicare, Medicaid, the Indian Health Service, the State Children's Health Insurance Program, the Department of Defense's TRICARE program, and the program of the Veterans Health Administration in enhancing health care quality, but not the role of federal M/SU programs administered by SAMHSA.

for Substance Abuse Prevention and Treatment and Center for Mental Health Services within SAMHSA, across SAMHSA and other operating divisions of the Department of Health and Human Services (DHHS), across DHHS and other departments, and across the public and private sectors.

A strong example of such leadership in coordination and collaboration is found in the federal action agenda, *Transforming Mental Health Care in America,* formulated to implement the recommendations of the President's New Freedom Commission on Mental Health. This action agenda is the collaborative product of 12 DHHS agencies (the Administration on Aging, Administration for Children and Families, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, Office for Disability, Office for Civil Rights, Office of Public Health and Science, and SAMHSA), five other departments (Education, Housing and Urban Development, Justice, Labor, and Veterans Affairs), and the Social Security Administration. To guide the implementation of this agenda, DHHS is leading an intra- and interagency Federal Executive Steering Committee composed of high-level representatives from DHHS agencies and other federal departments that serve individuals with mental illnesses (SAMHSA, 2005). This strong model of collaboration and coordination could be strengthened by including on the action agenda items addressing the substance-use problems and illnesses that so frequently accompany mental illnesses, and by including more explicitly in implementation activities the SAMHSA centers and state agencies responsible for planning and arranging for care for co-occurring substance-use illnesses. Similarly engaging key private-sector entities, especially those in the general health sector who deliver much care for mental illnesses, would strengthen this collaborative approach and help break down the separations discussed earlier in this chapter between mental and substance-use illnesses, between specialty M/SU and general health care, and between the public and private sectors.

New Mexico provides one example of processes now under way to achieve such coordination and collaboration at the state level (see Box 5-1). While the fruits of this initiative are not yet known, these efforts are testimony to the critical need for such coordination and collaboration at the policy level and the importance of high-level leadership in meeting this need.

BOX 5-1 New Mexico's Behavioral Health Collaborative: A Case Study in Policy Coordination

In 2003 the Governor of New Mexico identified as a major policy issue the fact that New Mexico's behavioral health system (like others across the United States) reflected the problems cited in the report of the President's New Freedom Commission: insufficient and inappropriate services, uneven access and quality, failure to maximize resources across funding streams, duplication of effort, higher administrative costs for providers, and overall fragmentation that makes service systems difficult to access and manage effectively. After consultation with key cabinet secretaries, the governor announced a new approach to address these problems through the creation of a high-level policy collaborative. This executive-level body was charged specifically with achieving better access, better services, and better value for taxpayer dollars in mental and substance-use health care.

This group, consisting of 17 members including the heads of 15 agencies, was established in law by the New Mexico legislature effective May 2004 and charged with creating a single behavioral health (mental and substance-use treatment) delivery system across multiple state agencies and funding sources. The vision that guided this effort, based on months of public participation, was that this single system must support recovery and resiliency so that consumers can participate fully in the life of their communities. The agencies forming the collaborative reflected these broad goals and included those responsible for such areas as housing, corrections, labor, and education, as well as primary health and human services agencies.

To ensure that this broad perspective would be reflected in the collaborative's actions, the group decided that decisions would be made whenever feasible by consensus, but that if votes were required, each agency would have a single vote regardless of its budget or size. The group is cochaired by the secretary of Human Services and (in alternating years) the secretary of Children, Youth, and Families or the secretary of Health. Such a broad policy vision clearly also required that the collaborative develop coordinated structures for the efficient management of a broad range of funds and services. Therefore, a request for proposals was issued, and a contractor was selected as the single statewide entity to manage approximately $350,000,000 in cross-agency funds for the first phase of the change process. In addition, the collaborative has formed senior-level coordination teams, including one focused specifically on cross-cutting policy issues. A single Behavioral Health Planning Council has also been established to form an ongoing partnership with consumers, families, providers, and state agencies in keeping the system on track. In addition, local collaboratives are being formed with cross-agency state assistance across all of the state's 13 judicial districts, as well as in its Native American communities, to ensure strong feedback and coordination involving stakeholders at the local level as a guide for collaborative state policies and actions. The overall transformation also is being carefully evaluated by multiple groups to help guide future work of this broad policy nature.

SOURCE: Personal communication, Leslie Tremaine, Behavioral Health Coordinator, New Mexico BH Collaborative, on July 28, 2005.

Recommendations

To address the complex obstacles to care coordination and collaboration described above, the committee recommends a set of related actions to be undertaken by individual clinicians, health care organizations, health plans, health care purchasers, accrediting organizations, and policy officials.

Recommendation 5-1. To make collaboration and coordination of patients' M/SU health care services the norm, providers of the services should establish clinically effective linkages within their own organizations and between providers of mental health and substance-use treatment. The necessary communications and interactions should take place with the patient's knowledge and consent and be fostered by:

- **Routine sharing of information on patients' problems and pharmacologic and nonpharmacologic treatments among providers of M/SU treatment.**
- **Valid, age-appropriate screening of patients for comorbid mental, substance-use, and general medical problems in these clinical settings and reliable monitoring of their progress.**

Recommendation 5-2. To facilitate the delivery of coordinated care by primary care, mental health, and substance-use treatment providers, government agencies, purchasers, health plans, and accreditation organizations should implement policies and incentives to continually increase collaboration among these providers to achieve evidence-based screening and care of their patients with general, mental, and/or substance-use health conditions. The following specific measures should be undertaken to carry out this recommendation:

- **Primary care and specialty M/SU health care providers should transition along a continuum of evidence-based coordination models from (1) formal agreements among mental, substance-use, and primary health care providers; to (2) case management of mental, substance-use, and primary health care; to (3) collocation of mental, substance-use, and primary health care services; and then to (4) delivery of mental, substance-use, and primary health care through clinically integrated practices of primary and M/SU care providers. Organizations should adopt models to which they can most easily transition from their current structure, that best meet the needs of their patient populations, and that ensure accountability.**

- **DHHS should fund demonstration programs to offer incentives for the transition of multiple primary care and M/SU practices along this continuum of coordination models.**
- **Purchasers should modify policies and practices that preclude paying for evidence-based screening, treatment, and coordination of M/SU care and require (with patients' knowledge and consent) all health care organizations with which they contract to ensure appropriate sharing of clinical information essential for coordination of care with other providers treating their patients.**
- **Organizations that accredit mental, substance-use, or primary health care organizations should use accrediting practices that assess, for all providers, the use of evidence-based approaches to coordinating mental, substance-use, and primary health care.**
- **Federal and state governments should revise laws, regulations, and administrative practices that create inappropriate barriers to the communication of information between providers of health care for mental and substance-use conditions and between those providers and providers of general care.**

With respect to the need for purchasers to modify practices that preclude paying for evidence-based screening, treatment, and coordination of health care for mental and substance-use conditions, the committee calls particular attention to practices that prevent primary care providers from receiving payment for delivery of the M/SU health services they provide and the failure of some benefit plans to cover certain evidence-based treatments.

Recommendation 5-3. To ensure the health of persons for whom they are responsible, M/SU providers should:

- **Coordinate their services with those of other human services and education agencies, such as schools, housing and vocational rehabilitation agencies, and providers of services for older adults.**
- **Establish referral arrangements for needed services.**

Providers of services to high-risk populations—such as child welfare agencies, criminal and juvenile justice agencies, and long-term care facilities for older adults—should use valid, age-appropriate, and culturally appropriate techniques to screen all entrants into their systems to detect M/SU problems and illnesses.

Recommendation 5-4. To provide leadership in coordination, DHHS should create a high-level, continuing entity reporting directly to the secretary to improve collaboration and coordination across its mental,

substance-use, and general health care agencies, including the Substance Abuse and Mental Health Services Administration; the Agency for Healthcare Research and Quality; the Centers for Disease Control and Prevention; and the Administration for Children, Youth, and Families. DHHS also should implement performance measures to monitor its progress toward achieving internal interagency collaboration and publicly report its performance on these measures annually. State governments should create analogous linkages across state agencies.

With respect to recommendation 5-4, the committee notes that this recommendation echoes the call made in the report *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality* for Congress to consider directing the Secretary of DHHS to produce an annual progress report "detailing the collaborative and individual efforts of the various government programs to redesign their quality enhancement processes" (IOM, 2002:11).

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NEW ERA REHABILITATION CENTER
3851 MAIN STREET
BRIDGEPORT, CT 06606

INTERAGENCY AGREEMENT

New Era Rehabilitation Center seeks to provide adequately for our client's healthcare requirements. We desire to establish interagency service agreements with other service area providers to make available health care services and resources not available directly in our clinic.

New Era Rehabilitation Center will consequently like to establish an agreement with St. Vincent's Medical Center whereby St. Vincent's will agree to provide necessary and appropriate assessment and treatment to our clients. The intention of this agreement is to establish such a relationship officially so as to facilitate the continuity of patient care.

St. Vincent's, where judged appropriate for the individual patient, accepts the transfer or admission of patients consistent with Dr. Kolade's status as a member of the Medical Staff of St. Vincent's Medical Center and consistent with St. Vincent's mission, policies and procedures; provided, however, that this agreement is not predicated upon any undertaking between the parties as to the existence, volume or value of any referrals between them. The parties hereto will not discriminate in accepting a patient on the basis of race, creed, sex or national origin and will comply with State and Federal Regulations.

As part of the agreement both New Era and St. Vincent's shall provide the other with pertinent information as needed directly related to the expeditious and efficacious treatment of patients, so as to assure appropriate and continued care. Any exchange of patient information shall be conducted in accordance with applicable State and Federal Regulations with regards to patient confidentiality, notably Federal Regulations on Confidentiality Alcohol and Substance Abuse Patient Records (Title 42CFR, Part 2) and Health Insurance Portability and Accountability Act of 1996 (HIPAA).

New Era Rehabilitation Center

By: _____
Ebenizer Kolade, M. D.

Its: Executive Director

Date: 6-16-08

St. Vincent's Medical Center

By: _____
Jose Missri, M. D.

Its: Chief Medical Officer

Date: 6-16-08

P142

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0266

Facility for the Care or Treatment of Substance Abusive or Dependent Persons

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

New Era Rehabilitation Center, Inc. of Bridgeport, CT, d/b/a New Era Rehabilitation Center, Inc. is hereby licensed to maintain and operate a private freestanding Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

New Era Rehabilitation Center, Inc. is located at 3851 Main St, Bridgeport, CT 06606 with:

Ebenezer A. Kolade, MD as Executive Director.

The service classification(s) and if applicable, the residential capacities are as follows:

Chemical Maintenance Treatment
Ambulatory Chemical Detoxification Treatment
Day or Evening Treatment
Outpatient Treatment

This license expires **June 30, 2018** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, July 1, 2016. **RENEWAL**

STATE DEPARTMENT OF PUBLIC HEALTH CONNECTICUT

Raul Pino, MD, MPH
Commissioner

OPIOID TREATMENT PROGRAM CERTIFICATION

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Rockville, MD 20850

OTP NUMBER
CT-10082-M

EXPIRATION DATE
March 31, 2018

New Era Rehabilitation Center, Inc
3851 Main St. 2nd Fl. .
Bridgeport, CT 06606

This certificate is issued under authority of 42 CFR § 8.11 (21 U.S.C. 823(g)(1))

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

Daryl W. Kade
Acting Director,
Center for Substance Abuse Treatment

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, BUSINESS ACTIVITY OR VALID AFTER EXPIRATION DATE

P143

OHCA0206

User, OHCA

From: Walker, Shauna
Sent: Tuesday, June 13, 2017 12:58 PM
To: akolade@newerarehab.com
Cc: User, OHCA; Riggott, Kaila; Mitchell, Micheala
Subject: 17-32149 CON Second Completeness Correspondence
Attachments: 17-32149 Second Completeness Letter.pdf

Dear Mr. Kolade:

Attached is a second request for additional information regarding CON application 17-32149 – Establishment of a Psychiatric Outpatient and Mental Health Day Treatment Clinic for Adults in Bridgeport, CT. Responses are due by **Monday, August 14, 2017 at 4:30 p.m.**

Please confirm receipt of this email.

Thank you,

Shauna L. Walker
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7069
Email: Shauna.Walker@ct.gov

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

June 13, 2017 Via Email Only

Mr. Adeoluwa Kolade
New Era Rehabilitation Center, Inc.
38 Crawford Road
Westport, CT 06880
akolade@newerarehab.com

RE: Certificate of Need Application: Docket Number: 17-32149-CON
Establishment of a Psychiatric Outpatient and Mental Health Day Treatment Clinic for Adults in Bridgeport
Certificate of Need Second Completeness Letter

Dear Mr. Kolade:

On May 16, 2017, OHCA received completeness responses from New Era Rehabilitation Center, Inc. ("NERC"), seeking authorization to establish a psychiatric outpatient and mental health day treatment clinic for adults in Bridgeport. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" to electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. ***Please email your responses to both of the following email addresses: OHCA@ct.gov and Kaila.Riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 204** and reference "**Docket Number: 17-32149-CON**."

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was transmitted. Therefore, please provide your written responses to OHCA no later than

August 14, 2017, 4:30 p.m., otherwise your application will be automatically considered withdrawn.

1. Page 125 of the application details the types of mental health treatment professionals that will provide mental health treatment to clients (e.g., licensed psychiatrists, psychiatric APRNS, Licensed Professional Counselors and Licensed Marriage and Family Therapists). Pages 20 and 143 contemplate the addition of one Licensed Clinical Social Worker with an annual associated cost of $60,000. Indicate whether the types of mental health treatment professionals listed on page 125 are part of NERC's current staff.

2. Question 5 on page 140 of the application requests the utilization for Fiscal Year ("FY") 2016 at the Bridgeport location. The census for Seymour, CT is listed twice and includes differing numerical values in each row. Clarify which of these figures are correct and revise accordingly.

3. Specify whether the projected volume for partial hospitalization is included in the table on page 141 of the application. If not, revise the projected volume to include figures for partial hospitalization using the table below. Volume should reflect the Bridgeport location only. Financial Worksheet (B) and the payer mix table on page 146 should be adjusted accordingly.

	Actual Volume				Projected Volume			
Service	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Methadone Maintenance	0	22,972	23,400	24,804	24,908	26,156	27,756	27,756
IOP	0	75	540	200	0	0	0	0
PHP	0	0	0	0	0	0	0	0
Mental Health Outpatient	0	0	0	0	575	2,414	2,562	2,562
Total	0	22,747	23,940	25,004	25,483	28,570	30,318	30,318

4. Page 146 of the application states that the client census will increase by 5% from FY 2017 to 2018 and has a calculated 6.4% increase from FY 2017 to 2018. Provide the methods and calculations used for these increases. Explain if they are derived from the historical increases in methadone maintenance claims, calculated as 1.9% from FY 2014 to 2015 and 6% from FY 2015 to 2016.

5. Indicate whether the providers listed on pages 141-142 of the application offer methadone maintenance and mental health treatment in the same setting.

6. Page 18 of the application states that 90% of NERC's current census is comprised of individuals who utilize Medicaid to pay for their healthcare services. Additionally, the payer mix table on page 133 projects that approximately 94% of clients will be insured under Medicaid, 1% of clients will be commercially insured and 5% of clients will self-pay. Conversely, Table A on page 146 of the application projects that 100% of clients

participating in the new service will be covered by Medicaid for FY's 2018, 2019, and 2020. Explain why the most recent projections do not include self-paying or commercially insured clients.

7. The footnote associated with the payer mix table on page 146 of the application states that the client census will remain stable from Fiscal Year ("FY") 2019 to 2020, with the client volume for the proposed mental health treatment program remaining at 107. Table A on page 146, however, shows the client census for the proposed program increasing from 107 in FY 2019 to 112 in FY 2020. Explain the discrepancy.

8. The total visit volumes in Table A on page 146 of the application are inconsistent with the reported volumes in the projection table on page 141 and the financial worksheet on page 148. Explain the discrepancies and revise, as necessary.

9. Page 21 of the application indicates that the client census will remain at 850 clients, yet page 146 states that the client census will approach 535 by FY 2019. Explain the difference in the reported census numbers and revise, as necessary.

If you have any questions concerning this letter, please feel free to contact Kaila Riggott at (860) 418-7037.

Shauna Walker Digitally signed by Shauna Walker
Date: 2017.06.13 12:52:53 -04'00'

User, OHCA

From: Adeoluwa Kolade <akolade@newerarehab.com>
Sent: Friday, July 28, 2017 10:29 AM
To: User, OHCA; Riggott, Kaila
Subject: NERC CON 2nd Set of Follow Up Questions
Attachments: CON MH BPT workbook 2016-2017 7.5.2017.xlsx; CON MH NH workbook 2016-2017 7.5.2017.xlsx; CON MH NH workbook 2016-2017 7.5.2017.pdf; CON MH BPT workbook 2016-2017 7.5.2017.pdf; NERC MH CON NH 2nd set Follow up questions 7.26.2017.pdf; NERC MH CON BPT 2nd set Follow up questions 7.26.2017.pdf; NERC MH CON NH 2nd set Follow up questions 7.26.2017.docx; NERC MH CON BPT 2nd set Follow up questions 7.26.2017.docx

Good Morning,

Please find attached.

Best Regards,

Deolu Kolade, MPH
Director of Operations
New Era Rehabiliation Center
akolade@newerarehab.com
Mobile:203-543-9950
Office: 203-372-3333 Ext. 28

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

June 13, 2017 Via Email Only

Mr. Adeoluwa Kolade
New Era Rehabilitation Center, Inc.
38 Crawford Road
Westport, CT 06880
akolade@newerarehab.com

RE: Certificate of Need Application: Docket Number: 17-32149-CON
Establishment of a Psychiatric Outpatient and Mental Health Day Treatment Clinic for Adults in Bridgeport
Certificate of Need Second Completeness Letter

Dear Mr. Kolade:

On May 16, 2017, OHCA received completeness responses from New Era Rehabilitation Center, Inc. ("NERC"), seeking authorization to establish a psychiatric outpatient and mental health day treatment clinic for adults in Bridgeport. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" to electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. ***Please email your responses to both of the following email addresses: OHCA@ct.gov and Kaila.Riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 204** and reference "**Docket Number: 17-32149-CON**."

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was transmitted. Therefore, please provide your written responses to OHCA no later than

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 ☐ Fax: (860) 418 7053
410 Capitol Avenue,
MS#13HCA Hartford,
Connecticut 06134-0308
www.ct.gov/dph

Accredited Health Department
PHAB
Public Health Accreditation Board


NEW ERA
REHABILITATION
A LIFE TRANSFORMED

1. **Page 125 of the application details the types of mental health treatment professionals that will provide mental health treatment to clients (e.g., licensed psychiatrists, psychiatric APRNS, Licensed Professional Counselors and Licensed Marriage and Family Therapists). Pages 20 and 143 contemplate the addition of one Licensed Clinical Social Worker with an annual associated cost of $60,000. Indicate whether the types of mental health treatment professionals listed on page 125 are part of NERC's current staff.**

   - Currently NERC employs the following professionals a licensed psychiatrist, licensed alcohol and drug counselor (LMFT candidate) and licensed master social worker (LCSW candidate). All other positions will be hired depending on need and availability.

2. **Question 5 on page 140 of the application requests the utilization for Fiscal Year ("FY") 2016 at the Bridgeport location. The census for Seymour, CT is listed twice and includes differing numerical values in each row. Clarify which of these figures are correct and revise accordingly.**

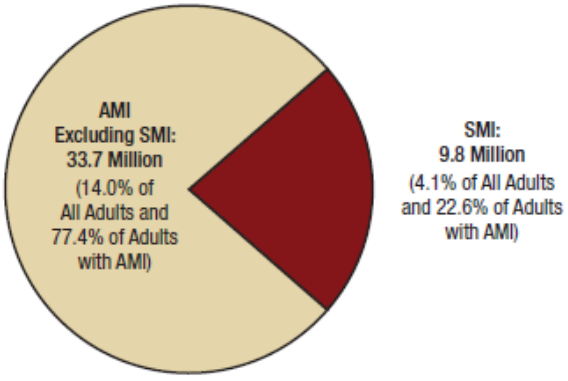
    - The correct amount is the sum of the two figures equaling 13. Please reference the revised table below.

Town	Census
Ansonia, CT	17
Beacon Falls, CT	4
Bethel, CT	4
Bozrah, CT	1
Bridgeport, CT	205
Bristol, CT	1
Brookfield, CT	1
Danbury, CT	13
Derby, CT	8
East Haven, CT	1
Easton, CT	1
Faifield, CT	13
Milford, CT	11
Monroe, CT	5
Naugatuck, CT	14
New Canaan, CT	1
New Milford, CT	3
Norwalk, CT	4
Orange, CT	1
Oxford, CT	5
Redding, CT	1
Ridgefield, CT	3
Shelton, CT	2
Sandy Hook, CT	1
Seymour, CT	13
Shelton, CT	35
Southbury, CT	1
Staffordville, CT	1
Stamford, CT	1
Stratford, CT	30
Thomaston, CT	1
Torrington , CT	1
Trumbull, CT	25
Waterbury, CT	28
Watertown, CT	1
West Haven, CT	1
Winsted, CT	3
Wolcott, CT	4
Total	465

3. **Specify whether the projected volume for partial hospitalization is included in the table on page 141 of the application. If not, revise the projected volume to include figures for partial hospitalization using the table below. Volume should reflect the Bridgeport location only. Financial Worksheet (B) and the payer mix table on page 146 should be adjusted accordingly.**

   - NERC forecasts 7.6% of the clients needing mental health services will need PHP. According to the latest NSDUH, this is one third of the percentage of individuals suffering from serious mental illness. The assumption of individuals suffering serious mental illness is derived from the chart below which states that 22.6% of adults with any mental illness suffered from serious mental illness within the last 12 months. As a prudent estimation NERC assumes that 1 in 3 clients suffering from SMI will remain in the facility to receive PHP services.

Figure 39. Any Mental Illness, Serious Mental Illness, and Any Mental Illness Excluding Serious Mental Illness in the Past Year among Adults Aged 18 or Older: 2014



43.6 Million Adults with AMI in the Past Year (18.1% of All Adults)

AMI = any mental illness; SMI = serious mental illness.

Source: National Survey of Drug Use and Health 2014

Service**	Actual Volume				Projected Volume			
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Methadone Maintenance	0	22,972	23,400	24,804	24,908*	26,156	27,756	27,756
IOP	0	75	540	200	0	0	0	0
PHP	0	0	0	0	473	1,996	2,114	2,114
Mental Health Outpatient	0	0	0	0	575	2,414	2,562	2,562
Total	0	22,747	23,940	25,004	25,956	30,566	32,432	32,432

4. **Page 146 of the application states that the client census will increase by 5% from FY 2017 to 2018 and has a calculated 6.4% increase from FY 2017 to 2018. Provide the methods and calculations used for these increases. Explain if they are derived from the historical increases in methadone maintenance claims, calculated as 1.9% from FY 2014 to 2015 and 6% from FY 2015 to 2016.**

    - NERC's 2017-2019 growth rate is based on the assumption that the DPH will award the licenses in September of 2017. NERC assumes the expansion of services will increase its appeal to clients looking for both mental health and substance abuse services in the Bridgeport area. The facility forecasts this increase in appeal will most likely be among Medicaid recipients as there is a shortage of mental health facilities accepting Medicaid in the state. In addition, NERC currently refers out about 75%-80% of its patients to receive mental health services at other facilities. The combination of the expanded services with the ability to retain a portion of patients who would have been previously referred out, will result in the forecasted growth rate. NERC believes it is modest and appropriate to assume the growth rate will increase approximately 2.5x from 1.9% to 5%.

5. **Indicate whether the providers listed on pages 141-142 of the application offer methadone maintenance and mental health treatment in the same setting.**

    - No, none of the facilities listed provide methadone maintenance services and mental health treatment in the same setting.

6. **Page 18 of the application states that 90% of NERC's current census is comprised of individuals who utilize Medicaid to pay for their healthcare services. Additionally, the payer mix table on page 133 projects that approximately 94% of clients will be insured under Medicaid, 1% of clients will be commercially insured and 5% of clients will self-pay. Conversely, Table A on page 146 of the application projects that 100% of clients participating in the new service will be covered by Medicaid for FY's 2018, 2019, and 2020. Explain why the most recent projections do not include self-paying or commercially insured clients.**

    - First, it is important to note that NERC's Charity Care Policy is not a traditional charity care policy whereby patients earning below specific income are eligible to receive free and/or subsidized services. NERC is a private for-profit facility and does not receive donations or grants to subsidize these clients who may need charity care. However patients who have lost their insurance coverage are allowed to continue receiving services on a case by case basis depending on their individual circumstances. Given the construct of the policy it is very likely that all new clients will be covered under Medicaid.

    - Furthermore, with the advent of the economic crisis in 2008 and the passing Affordable Care Act of 2010, NERC has seen a significant increase in the number of individuals who utilize Medicaid to pay for their healthcare services. In addition to the national trend, within the state of Connecticut there is a dearth of mental health services that accept Medicaid as payment. Considering this, NERC believes it is reasonable and modest to

assume that 100% of clients participating in the new services will be covered by Medicaid in the foreseeable future.

7. **The footnote associated with the payer mix table on page 146 of the application states that the client census will remain stable from Fiscal Year ("FY") 2019 to 2020, with the client volume for the proposed mental health treatment program remaining at 107. Table A on page 146, however, shows the client census for the proposed program increasing from 107 in FY 2019 to 112 in FY 2020. Explain the discrepancy.**

- Please find a revised version of Table A below.

TABLE A: MENTAL HEALTH TREATMENT PROGRAM
PROJECTED PAYER MIX FOR
NEW ERA REHABILITATION CENTER, INC., BY NUMBER OF CLIENTS AND VISITS

Payer	Projected Payer Mix											
	FY 2017			FY 2018			FY 2019			FY 2020		
	Client Vol.	%	Visit Vol.	Client Vol.	%	Visit Vol.	Client Vol.	%	Visit Vol.	Client Vol.	%	Visit Vol.
Medicare*	0	0	0									
Medicaid*	95.8	0	1,048	101	100	4,410	107	100	4,676	107	100	4,676
CHAMPUS & TriCare	0	0	0	0		0	0		0	0	0	0
Total Government	**95.8**	**0**	1,048	**101**	**100**	4,410	**107**	**100**	4,676	**107**	**100**	4,676
Commercial Insurers	0	0	0	0	0	0	0	0	0	0	0	0
Self-pay	0	0	0	0	0	0	0	0	0	0	0	0
Uninsured	0	0	0	0	0	0	0	0	0	0	0	0
Workers Compensation	0	0	0	0	0	0	0	0	0	0	0	0
Total Non-Government	**0**	**0**	**0**	**0**	**0**	0	**0**	**0**	**0**	**0**	**0**	**0**
Total Payer Mix	**95.8**	**0**	1,048	**101**	**100**	4,410	**107**	**100**	4,676	**107**	**100**	4,676

8. **The total visit volumes in Table A on page 146 of the application are inconsistent with the reported volumes in the projection table on page 141 and the financial worksheet on page 148. Explain the discrepancies and revise, as necessary.**

Service**	Actual Volume				Projected Volume			
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Methadone Maintenance	0	22,972	23,400	24,804	24,908*	26,156	27,756	27,756
IOP	0	75	540	200	0	0	0	0
PHP	0	0	0	0	473	1,996	2,114	2,114
Mental Health Outpatient	0	0	0	0	575	2,414	2,562	2,562
Total	0	22,747	23,940	25,004	25,956	30,566	32,432	32,432

*** Assuming the MH license is received in September 2017 and the census increases 5% from 479 in 2017 to 503 in 2018**
*** MH Census: FY2017- 95.8; FY2018- 101; FY 2019- 107; FY2020- 107**

9. **Page 21 of the application indicates that the client census will remain at 850 clients, yet page 146 states that the client census will approach 535 by FY 2019. Explain the difference in the reported census numbers and revise, as necessary.**

    - The initial CON application was done based on the aggregate of the 2 facilities, the 535 figure is based on the Bridgeport facility alone.

Applicant Name: NEW ERA REHAB
Financial Worksheet (B)

FOR-PROFIT

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2016 Actual Results	FY 2017 (YTD 3/31/17) Projected W/out CON	(2) FY 2017 Projected W/out CON	(3) FY 2017 Projected Incremental	(4) FY 2017 Projected With CON	(5) FY 2018 Projected W/out CON	(6) FY 2018 Projected Incremental	(7) FY 2018 Projected With CON	(8) FY 2019 Projected W/out CON	(9) FY 2019 Projected Incremental	(10) FY 2019 Projected With CON	(11) FY 2020 Projected W/out CON	(12) FY 2020 Projected Incremental	(13) FY 2020 Projected With CON
	Description														
A.	**OPERATING REVENUE**														
1	Total Gross Patient Revenue		$0	$0	$0	$0			$0			$0			$0
2	Less: Allowances	$0	$0	$0	$0	$0			$0			$0			$0
3	Less: Charity Care	$0	$0	$0	$0	$0			$0			$0			$0
4	Less: Other Deductions	$0	$0	$0	$0	$0			$0			$0			$0
	Net Patient Service Revenue	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5	Medicare	$0	$0	$0	$0	$0			$0			$0			$0
6	Medicaid	$1,961,779	$561,714	$2,246,856.40	$122,387	$2,369,244	$2,303,028	$515,387	$2,818,415	$2,418,179	$546,315	$2,964,495	$2,418,179	$546,315	$2,964,495
7	CHAMPUS & TriCare	$0	$0	$0	$0	$0			$0			$0			$0
8	Other	$0	$0	$0	$0	$0			$0			$0			$0
	Total Government	**$1,961,779**	**$561,714**	**$2,246,856**	**$122,387**	**$2,369,244**	**$2,303,028**	**$515,387**	**$2,818,415**	**$2,418,179**	**$546,315**	**$2,964,495**	**$2,418,179**	**$546,315**	**$2,964,495**
9	Commercial Insurers	$0	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
10	Uninsured	$0	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
11	Self Pay	$128,175	$34,825	$139,298.64	$0	$139,299	$57,576		$57,576	$60,454		$60,454	$60,454		$60,454
12	Workers Compensation	$0	$0	$0	$0	$0			$0			$0			$0
13	Other	$0	$0	$0	$0	$0			$0			$0			$0
	Total Non-Government	**$128,175**	**$34,825**	**$139,299**	**$0**	**$139,299**	**$57,576**	**$0**	**$57,576**	**$60,454**	**$0**	**$60,454**	**$60,454**	**$0**	**$60,454**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$2,089,954**	**$596,539**	**$2,386,155**	**$122,387**	**$2,508,542**	**$2,360,604**	**$515,387**	**$2,875,991**	**$2,478,634**	**$546,315**	**$3,024,949**	**$2,478,634**	**$546,315**	**$3,024,949**
14	Less: Provision for Bad Debts	$0	$0	$0	$0	$0			$0			$0			$0
	Net Patient Service Revenue less provision for bad debts	**$2,089,954**	**$596,539**	**$2,386,155**	**$122,387**	**$2,508,542**	**$2,360,604**	**$515,387**	**$2,875,991**	**$2,478,634**	**$546,315**	**$3,024,949**	**$2,478,634**	**$546,315**	**$3,024,949**
15	Other Operating Revenue	$0	$0	$0	$0	$0			$0			$0			$0
17	Net Assets Released from Restrictions	$0	$0	$0	$0	$0			$0			$0			$0
	TOTAL OPERATING REVENUE	**$2,089,954**	**$596,539**	**$2,386,155**	**$122,387**	**$2,508,542**	**$2,360,604**	**$515,387**	**$2,875,991**	**$2,478,634**	**$546,315**	**$3,024,949**	**$2,478,634**	**$546,315**	**$3,024,949**
B.	**OPERATING EXPENSES**														
1	Salaries and Wages	$847,518	$569,999	$759,998	$60,000	$819,998	$771,398	$60,000	$831,398	$771,398	$60,000	$831,398	$771,398	$60,000	$831,398
2	Fringe Benefits	$0	$0	$0	$0	$0			$0			$0			$0
3	Physicians Fees	$0	$0	$88,000		$88,000	$67,000		$67,000	$67,000		$67,000	$67,000		$67,000
4	Supplies and Drugs	$96,645	$0	$104,377	$0	$104,377	$106,464		$106,464	$109,126		$109,126	$109,126		$109,126
5	Depreciation and Amortization	$181,559	$0	$181,559	$0	$181,559	$181,559		$181,559	$163,403		$163,403	$163,403		$163,403
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$13,514	$0	$13,514	$0	$13,514	$13,514		$13,514	$13,514		$13,514	$13,514		$13,514
8	Malpractice Insurance Cost	$19,206	$0	$19,206	$0	$19,206	$19,206		$19,206	$19,206		$19,206	$19,206		$19,206
9	Lease Expense	$196,590	$0	$196,590	$0	$196,590	$196,590		$196,590	$196,590		$196,590	$196,590		$196,590
10	Other Operating Expenses	$366,810	$0	$385,151	$0	$385,151	$423,666		$423,666	$444,849		$444,849	$444,849		$444,849
	TOTAL OPERATING EXPENSES	**$1,721,841**	**$0**	**$1,748,394**	**$60,000**	**$1,808,394**	**$1,779,397**	**$60,000**	**$1,839,397**	**$1,785,086**	**$60,000**	**$1,845,086**	**$1,785,086**	**$60,000**	**$1,845,086**
	INCOME/(LOSS) FROM OPERATIONS	**$368,113**	**$596,539**	**$637,761**	**$62,387**	**$700,148**	**$581,207**	**$455,387**	**$1,036,594**	**$693,548**	**$486,315**	**$1,179,863**	**$693,548**	**$486,315**	**$1,179,863**
	NON-OPERATING INCOME	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**		**$0**	**$0**		**$0**			**$0**
	Income before provision for income taxes	**$368,113**	**$596,539**	**$637,761**	**$62,387**	**$700,148**	**$581,207**	**$455,387**	**$1,036,594**	**$693,548**	**$486,315**	**$1,179,863**	**$693,548**	**$486,315**	**$1,179,863**
	Provision for income taxes[c]	**$147,245**	**$238,616**	**$255,104**	$0	**$280,059**	**$232,483**		**$232,483**	**$277,419**		**$471,945**			**$0**
	NET INCOME	**$220,868**	**$357,923**	**$382,657**	**$62,387**	**$445,044**	**$348,724**	**$455,387**	**$804,112**	**$416,129**	**$486,315**	**$902,444**	**$693,548**	**$486,315**	**$1,179,863**
C.	**Retained Earnings, beginning of year**	**$0**	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Retained Earnings, end of year	**$0**	**$0**	**$0**	**$0**	**$0**			**$0**			**$0**			**$0**
	Principal Payments	$0	$0	$0	$0	**$0**			**$0**			**$0**			**$0**
D.	**PROFITABILITY SUMMARY**														
1	Hospital Operating Margin	**17.6%**	**100.0%**	**26.7%**	**51.0%**	**27.9%**	**24.6%**	**88.4%**	**36.0%**	**28.0%**	**89.0%**	**39.0%**	**28.0%**	**89.0%**	**39.0%**
2	Hospital Non Operating Margin	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**10.6%**	**60.0%**	**16.0%**	**51.0%**	**17.7%**	**14.8%**	**88.4%**	**28.0%**	**16.8%**	**89.0%**	**29.8%**	**28.0%**	**89.0%**	**39.0%**
E.	**FTEs**	**0**	**0**	**0**	**0**	**0**			**0**			**0**			**0**
F.	**VOLUME STATISTICS[d]**														
1	Inpatient Discharges	0	0	0	0	**0**			**0**			**0**			**0**
2	Outpatient Visits	0	0	0	575	**575**		2,414	**2,414**		2,562	**2,562**		2,562	**2,562**
3	PHP Visits				473			1,996			2,114			2,114	
	TOTAL VOLUME	**0**	**0**	**0**	**1,048**	**575**	**0**	**4,410**	**2,414**	**0**	**4,676**	**2,562**	**0**	**4,676**	**2,562**
	Total MH Patient Volume				**95.8**			**101**			**107**			**107**	
	PHP Patient Volume				**7.28**			**7.68**			**8.13**			**8.13**	

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

User, OHCA

From: Walker, Shauna
Sent: Friday, August 18, 2017 8:48 AM
To: akolade@newerarehab.com
Cc: Mitchell, Micheala; User, OHCA; Riggott, Kaila
Subject: Question Regarding CON 17-32149

Dear Mr. Kolade:

We have one follow-up question regarding your completeness responses received on July 28, 2017. Page 209 of the application states that NERC's Charity Care Policy allows patients who have lost their insurance coverage to continue receiving services on a case by case basis depending on their individual circumstances. Please clarify if this policy will apply to clients who lose Medicaid coverage while receiving treatment at the proposed mental health treatment program.

Thank you. We will follow-up with a phone call to ensure you've received our e-mail and to clarify any additional questions or concerns.

Regards,

Shauna L. Walker
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7069
Email: Shauna.Walker@ct.gov

User, OHCA

From: Walker, Shauna
Sent: Friday, August 25, 2017 5:37 PM
To: akolade@newerarehab.com
Cc: Riggott, Kaila; Mitchell, Micheala; User, OHCA
Subject: New Era Rehabilitation Center, Inc. (CON 17-32149)
Attachments: 17-32149-CON Notification of Application Deemed Complete.pdf; image001.jpg; image002.jpg

Mr. Kolade:

Attached is a letter deeming the above-referenced application complete. Please confirm receipt of this email and the attachment.

Regards,

Shauna L. Walker
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7069
Email: Shauna.Walker@ct.gov<mailto:Shauna.Walker@ct.gov>

[http://www.ct.gov/insidedph/lib/insidedph/communications/DPH-Color.gif] [http://www.phaboard.org/wp-content/uploads/PHAB-SEAL-COLOR.jpg]

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

August 25, 2017 Via Email Only

Mr. Adeoluwa Kolade
New Era Rehabilitation Center, Inc.
38 Crawford Road
Westport, CT 06880
akolade@newerarehab.com

RE: Certificate of Need Application: Docket Number: 17-32149-CON
Establishment of a Psychiatric Outpatient and Mental Health Day Treatment Clinic for Adults in Bridgeport

Dear Mr. Kolade:

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 August 25, 2017.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7055.

Sincerely,

Shauna Walker Digitally signed by Shauna Walker
Date: 2017.08.25 10:37:49 -04'00'

Shauna L. Walker
Associate Research Analyst

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

User, OHCA

From: Walker, Shauna
Sent: Friday, September 01, 2017 11:15 AM
To: User, OHCA
Cc: Mitchell, Micheala; Riggott, Kaila
Subject: FW: Question Regarding CON 17-32149
Attachments: NERC MH CON BPT 3rd set Follow up questions 9.01.2017.pdf; NERC MH CON BPT 3rd set Follow up questions 9.01.2017.docx

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From: Adeoluwa Kolade [mailto:akolade@newerarehab.com]
Sent: Friday, September 01, 2017 11:12 AM
To: Walker, Shauna <Shauna.Walker@ct.gov>
Subject: RE: Question Regarding CON 17-32149

Good Morning,

Please find attached.

Deolu Kolade

From: Walker, Shauna [mailto:Shauna.Walker@ct.gov]
Sent: Friday, August 18, 2017 8:48 AM
To: akolade@newerarehab.com
Cc: Mitchell, Micheala; User, OHCA; Riggott, Kaila
Subject: Question Regarding CON 17-32149

Dear Mr. Kolade:

We have one follow-up question regarding your completeness responses received on July 28, 2017. Page 209 of the application states that NERC's Charity Care Policy allows patients who have lost their insurance coverage to continue receiving services on a case by case basis depending on their individual circumstances. Please clarify if this policy will apply to clients who lose Medicaid coverage while receiving treatment at the proposed mental health treatment program.

Thank you. We will follow-up with a phone call to ensure you've received our e-mail and to clarify any additional questions or concerns.

Regards,

Shauna L. Walker
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7069
Email: Shauna.Walker@ct.gov


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Advancing
public health
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Public Health Accreditation Board

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

June 13, 2017 Via Email Only

Mr. Adeoluwa Kolade
New Era Rehabilitation Center, Inc.
38 Crawford Road
Westport, CT 06880
akolade@newerarehab.com

RE: Certificate of Need Application: Docket Number: 17-32149-CON
Establishment of a Psychiatric Outpatient and Mental Health Day Treatment Clinic for Adults in Bridgeport
Certificate of Need Second Completeness Letter

Dear Mr. Kolade:

On May 16, 2017, OHCA received completeness responses from New Era Rehabilitation Center, Inc. ("NERC"), seeking authorization to establish a psychiatric outpatient and mental health day treatment clinic for adults in Bridgeport. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" to electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. ***Please email your responses to both of the following email addresses: OHCA@ct.gov and Kaila.Riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 204** and reference "**Docket Number: 17-32149-CON**."

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was transmitted. Therefore, please provide your written responses to OHCA no later than

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 ☐ Fax: (860) 418 7053
410 Capitol Avenue,
MS#13HCA Hartford,
Connecticut 06134-0308
www.ct.gov/dph

Accredited Health Department
PHAB
Public Health Accreditation Board


NEW ERA
REHABILITATION
A LIFE TRANSFORMED

1. **Page 209 of the application states that NERC's Charity Care Policy allows patients who have lost their insurance coverage to continue receiving services on a case by case basis depending on their individual circumstances. Please clarify if this policy will apply to clients who lose Medicaid coverage while receiving treatment at the proposed mental health treatment program.**

    - Yes, NERC's Charity Care Policy will apply to individuals who may lose their Medicaid coverage.

User, OHCA

From: Walker, Shauna
Sent: Wednesday, October 25, 2017 11:44 AM
To: Adeoluwa Kolade
Cc: Mitchell, Micheala; Riggott, Kaila; User, OHCA
Subject: Additional Questions for CON 17-32149

Dear Mr. Kolade:

Per our conversation, we would like responses to the following questions:

1. Why was a psychiatrist added to the staff?
2. Approximately when was the psychiatrist added to the staff?
3. What types of mental health diagnoses have been seen amongst the facility's comorbid population? Do you have data available regarding the diagnoses of these clients?

Please email your responses to us in a Word document no later than Monday, October 30, 2017. Begin your response with page number **219.**

Thank you!

Shauna L. Walker
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: (860) 418-7069
Email: Shauna.Walker@ct.gov

User, OHCA

From: Walker, Shauna
Sent: Tuesday, October 31, 2017 7:17 AM
To: User, OHCA
Subject: FW: Additional Questions for CON 17-32149
Attachments: NERC MH CON BPT 4th set Follow up questions 10.26.2017.docx

---

From: Adeoluwa Kolade [mailto:akolade@newerarehab.com]
Sent: Monday, October 30, 2017 2:08 PM
To: Walker, Shauna <Shauna.Walker@ct.gov>
Subject: RE: Additional Questions for CON 17-32149

Good Afternoon,

Please find attached.

Best Regards,

Deolu

From: Walker, Shauna [mailto:Shauna.Walker@ct.gov]
Sent: Wednesday, October 25, 2017 11:44 AM
To: Adeoluwa Kolade
Cc: Mitchell, Micheala; Riggott, Kaila; User, OHCA
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Thank you!

Shauna L. Walker
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Public Health Accreditation Board


NEW ERA
REHABILITATION
A LIFE TRANSFORMED

1. **Why was a psychiatrist added to the staff?**
    a. NERC added an in-house psychiatrist to better address the growing need stabilize clients who are suffering from underlying mental health issues prior to starting their addiction treatment.

2. **Approximately when was the psychiatrist added to the staff?**
    a. April 2015

3. **What types of mental health diagnoses have been seen amongst the facility's comorbid population? Do you have data available regarding the diagnoses of these clients?**
    a. The majority of NERC dual diagnosis patients are suffering from depression, anxiety panic disorders, schizophrenia, borderline personality and bipolar disorders. These disorders are documented in the clients chart. This information is supported through their initial biopsychosocial assessments, release of information from their mental health providers and updates to their treatment plans via progress notes. The information is not segmented by diagnoses however NERC knows there are currently 178 clients in Bridgeport that are co-occurring substance abuse and mental health.

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

Agreed Settlement

Applicant: **New Era Rehabilitation Center, Inc.**
3851 Main Street
Bridgeport, CT 06606

Docket Number: **17-32149-CON**

Project Title: **Establishment of a Psychiatric Outpatient and Mental Health Day Treatment Clinic for Adults in Bridgeport, Connecticut**

Project Description: New Era Rehabilitation Center, Inc., ("NERC" or "Applicant") is proposing to establish a psychiatric outpatient and mental health day treatment clinic for adults at 3851 Main Street, Bridgeport, Connecticut.

Procedural History: The Applicant published notice of its intent to file a Certificate of Need ("CON") application in *The Connecticut Post* (Bridgeport) on January 20, 21 and 22, 2017. On February 21, 2017, the Office of Health Care Access ("OHCA") received the CON application from the Applicant for the above-referenced project and deemed the application complete on August 25, 2017. OHCA received no responses from the public concerning the proposal and no hearing requests from the public per Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a(e). Deputy Commissioner Addo considered the entire record in this matter.

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Findings of Fact and Conclusions of Law

1. NERC is a for-profit entity, licensed by the Department of Public Health ("DPH"), to operate free-standing facilities for the care of substance abusive or dependent adults in the cities of Bridgeport and New Haven, Connecticut. In operation since 2002, the Applicant provides addiction treatment to nearly 1,000 clients annually. Ex. A, p. 9.

2. The Applicant currently provides chemical maintenance, ambulatory detoxification and day or evening outpatient treatment to clients. Ex. D, p. 205.

3. Approximately one-half of the Applicant's clients receive treatment at the Bridgeport facility. Ex. F, p. 215.

4. At present, NERC clients exhibiting symptoms of depression, schizophrenia, and borderline personality, bipolar and anxiety disorders receive partial services from the Applicant's resident psychiatrist. Without the appropriate licensure, however, the Applicant's "in-house" services are limited to stabilizing clients prior to referring them to an external psychiatrist. Ex. A, p. 14; Ex. D, p. 144; Ex. K, p. 219.

5. The Applicant estimates that it currently refers between 75%-80% of its dually diagnosed clients to other facilities for mental health treatment. Ex. F, p. 213.

6. The Applicant is proposing to establish a clinic to provide psychiatric outpatient care and mental health day treatment to adults, ages 18 years and older, suffering from mental illness and/or substance use disorders at its existing location in Bridgeport.[1] Ex. A, pp. 9, 11, 13, 124.

7. The addition of a mental health treatment program at the Applicant's existing location is intended to ensure continuity of care, improve health outcomes and reduce relapse rates for current clients. Ex. A, pp. 9, 14.

8. The theory of collocation, as described in the book "Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series," states that same-site delivery of mental and substance-use health care or primary care is more effective in identifying comorbid conditions, effectively linking clients to the collocated services and improving treatment outcomes than formal arrangements with external providers.[2] Ex. A, p. 136; Ex. D, p. 182.

9. Participants in the proposed program will come primarily from the Applicant's existing dually-diagnosed client base. The program will also serve other adults throughout Fairfield County in need of mental health services. Ex. A, pp. 13-14; Ex. D, p. 145.

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[1] The term "psychiatric outpatient" treatment is mental health treatment wherein the unit of service is less than 4 hours of treatment per client. "Mental health day treatment" is also provided on an outpatient basis, however, the unit of service consists of at least 4, but no more than 12 hours of treatment per client. Conn. Agencies Regs. §19a-495-550 (a)(14).

[2] Institute of Medicine. 2006. *Improving the Quality of Health Care for Mental and Substance-Use Conditions*. Washington, DC: The National Academies Press. https://doi.org/10.17226/11470

10. The Applicant will provide a comprehensive treatment approach based on the Department of Mental Health and Addiction Services ("DMHAS") practice guidelines defining recovery and recovery-oriented care.[3] Ex. A, p. 125.

11. The Applicant plans to implement individual, person-centered, recovery plans for clients that will address all identified behavioral health needs. Ex. A, p. 125.

12. An interdisciplinary team comprised of a licensed psychiatrist, professional counselor and social worker will employ medication therapy, individual and group counseling, staged interventions and other therapies to promote recovery. Ex. A, p. 125; Ex. F, p. 210.

13. As illustrated in Table 1, nearly 75% of clients who received treatment at the Applicant's Bridgeport facility in fiscal year ("FY") 2016 were residents of the proposed service area (Fairfield County).

TABLE 1
FY 2016 CLIENT ORIGIN FOR NERC

SERVICE AREA	NO. OF CLIENTS	PERCENT OF CT TOTAL
Bridgeport	205	44%
Shelton	37	8%
Stratford	30	6%
Trumbull	25	5%
Danbury	13	3%
Fairfield	13	3%
Monroe	5	1%
Bethel	4	1%
Norwalk	4	1%
Ridgefield	3	1%
Brookfield	1	*
Easton	1	*
New Canaan	1	*
Newtown	1	*
Redding	1	*
Stamford	1	*
Fairfield County Total	**345**	**74%**
Other Connecticut	**120**	**26%**
Connecticut Total	**465**	**100%**

*Less than half of one percent.
Ex. D, p. 140; Ex. F, p. 207.

[3] Recovery refers to the ways in which people with mental illness, addiction and/or medical/physical issues experience and manage their disorder in the process of maintaining and/or reclaiming their life in the community. Recovery-oriented care is offered by psychiatric, addiction, primary medical treatment and rehabilitation practitioners in support of the person's recovery and/or management of his or her chronic illness/condition.

14. Adults ages 18 and older comprise 76% of Fairfield County's total population. Prevalence rates based upon national data indicate that approximately 24,000 adults in Fairfield County have co-occurring mental health and substance use disorders.

TABLE 2
ESTIMATE OF CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS INCIDENCE IN FAIRFIELD COUNTY

SUBSTANCE USE DISORDER	POPULATION (18 and over)[1]	PREVALENCE[2]	INCIDENCE
Fairfield County	721,468	3.3%	23,808
Connecticut	2,826,827	3.3%	93,285
Service area as percent of Connecticut	**23%**	**n/a**	**23%**

Sources:
[1] 2015 U.S. *Census.*
[2] Substance Abuse and Mental Health Services Administration. 2015. *Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH): 2014*. HHS Publication No. SMA-15-4927. Rockville, MD.
Ex. A, p. 15.

15. The Applicant's total client census in FY 2016 was 465.[4] For FY 2017, the total client census is expected to increase slightly to 479. It is anticipated that 20% of the total client census will opt to receive services at the proposed mental health treatment program.

TABLE 3
NEW ERA REHABILITATION CENTER, INC., HISTORICAL UTILIZATION

SERVICE/PROGRAM	HISTORICAL VOLUME		
	FY 2014	FY 2015	FY 2016
Chemical ("Methadone") Maintenance–Number of Claims[1]	22,972	23,400	24,804
Outpatient Treatment ("OP") – Number of Sessions[2]	75	540	200

Fiscal Year is January 1 – December 31
[1]Number of claims. Billed as a weekly bundle with a claim representing one week of treatment per client.
[2]Number of sessions. OP program attendance is not mandated by provider and therefore highly variable.

[4] The total client census refers to the total number of individuals receiving services from NERC.

TABLE 4
NEW ERA REHABILITATION CENTER, INC., PROJECTED UTILIZATION NUMBER OF CLIENTS

SERVICE/PROGRAM	CURRENT	PROJECTED		
	FY 2017	FY 2018	FY 2019	FY 2020
Mental Health Day Treatment	7	8	8	8
Psychiatric Outpatient Clinic	89	93	99	99
Total	96	101	107	107

Fiscal Year is January 1 – December 31
Assumes NERC will receive appropriate DPH licenses in September 2017 and a 5% total client census increase from 479 in 2017 to 503 in 2018. 5% client census growth estimated as 2.5 times the historical increase in methadone maintenance claims from 2014 to 2015 (1.9%), based on a combination of the demand for expanded services with the ability to retain a portion of the clients who would have been previously referred to other providers. Additionally, it is estimated that 7.6% of NERC clients receiving mental health services will need mental health day treatment. According to the 2014 National Survey of Drug Use and Health, this is one third the percentage of individuals suffering from serious mental illness.
Ex. A, pp. 129-130; Ex. D, pp. 143-144, 149; Ex. F, pp. 212-213, 216.

16. The majority of NERC clients enroll in the Bridgeport facility's existing substance abuse treatment program through client-to-client referrals. Referrals are also received from private physicians and local organizations such as The Summit House and First Step Detox. Ex. A, p. 131.

17. The Applicant estimates that approximately 80% of referrals for the proposed program will be derived from client-to-client referrals. The remaining 20% of referrals will come from a combination of independent therapists and agencies looking to place their clients into a more structured, higher level of treatment. Ex. D, p. 145.

18. The Applicant has a transfer agreement with St. Vincent's Medical Center in Bridgeport, Connecticut. St. Vincent's Medical Center will provide necessary assessment and treatment of the Applicant's clients to assure appropriate and continued care for services and resources not available at the clinic. Ex. D, p. 204.

19. Although 13 providers in Bridgeport and the surrounding area that provide mental health treatment to adults with co-occurring mental health and substance use disorders, none offer methadone maintenance and mental health treatment in the same setting.

TABLE 5
PROVIDERS OF THE PROPOSED SERVICES IN SERVICE AREA

TOWN	PROVIDER	STREET ADDRESS
Bridgeport	Chemical Abuse Services Agency, Inc.	690 Arctic St.
Bridgeport	Connecticut Renaissance Inc.	1120 Main St.
Bridgeport	Four Seasons Therapy, LLC	48 Alpine St.
Bridgeport	Greater Bridgeport Community Mental Health System	1635 Central Ave.
Bridgeport	Jewish Family Services Inc. Community Center	2370 Park Ave.
Bridgeport	Lifebridge Community Services	475 Clinton Ave.
Bridgeport	Mental Health Association-Connecticut	4270 Main St., #400
Bridgeport	Recovery Network of Programs	1635 Fairfield Ave.
Bridgeport	Saint Vincent's Medical Center Outpatient Behavioral Health	2400 Main St.
Bridgeport	Southwest Community Health Center	1046 Fairfield Ave.
Shelton	The Sterling Center	731 Bridgeport Ave.
Stratford	Reach at Bridgeport Hospital	305 Boston Ave., #1
Westport	Saint Vincent's Medical Center Outpatient Behavioral Health	47 Long Lots Rd.

Sources:
Substance Abuse and Mental Health Services Administration, Behavioral Health Treatment Services Locator, https://findtreatment.samhsa.gov, accessed May 22, 2017.
Ex. D, pp. 147-148; Ex. F, p. 213.

20. NERC accepts both commercially insured and Medicaid clients, with the vast majority of clients covered under Medicaid. Ex. A, pp. 14, 18, 137.

21. Additionally, NERC provides charity care to clients who have lost their insurance coverage to allow them to continue to receive services. This policy will continue to be applied on a case-by-case basis depending on each client's individual circumstance. Ex. F, p. 213; Ex. I, p. 218.

22. As a result of an upward trend in Medicaid clients currently receiving treatment at the Applicant's existing clinics and a shortage of mental health programs willing to accept Medicaid, the Applicant projects that 100% of clients who will participate in the proposed program will be covered by Medicaid.

TABLE 6
PROJECTED PAYER MIX FOR APPLICANT BY NUMBER OF CLIENTS AND VISITS[3]

Payer	FY 2018			FY 2019			FY 2020		
	Client Vol.	%	Visit Vol.	Client Vol.	%	Visit Vol.	Client Vol.	%	Visit Vol.
Medicare[1]	0	0	0	0	0	0	0	0	0
Medicaid[1,2]	101	100	4,410	107	100	4,676	107	100	4,676
CHAMPUS & TriCare	0	0	0	0	0	0	0	0	0
Total Government	**101**	**100**	**4,410**	**107**	**100**	**4,676**	**107**	**100**	**4,676**
Commercial Insurers	0	0	0	0	0	0	0	0	0
Self-pay	0	0	0	0	0	0	0	0	0
Uninsured	0	0	0	0	0	0	0	0	0
Workers Compensation	0	0	0	0	0	0	0	0	0
Total Non-Government	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Payer Mix	**101**	**100**	**4,410**	**107**	**100**	**4,676**	**107**	**100**	**4,676**

[1]Includes managed care activity.
[2]Approximately 94% of current NERC clients utilize Medicaid to pay for their healthcare services.
[3]Assumes 20% of the total client census will be mental health clients and a 5% annual census increase through 2019, stabilizing through 2020.
Ex A, p. 137; Ex. D, p. 149; Ex. F, pp. 213-214.

23. The Applicant anticipates there will be no associated capital costs for the proposed program. Ex. A, p. 20.

24. The Applicant projects incremental gains from the onset of operations based on two mental health treatment sessions per client per month, the current Medicaid reimbursement rate for psychotherapy and an assumed total client census across all programs increasing from 479 in FY 2017 to 535 by FY 2019.

TABLE 7
APPLICANT'S PROJECTED INCREMENTAL GAIN FROM OPERATIONS

	FY 2017	FY 2018	FY 2019	FY 2020
Revenue from Operations	$122,387	$515,387	$546,315	$546,315
Total Operating Expenses[1]	$60,000	$60,000	$60,000	$60,000
Income (Loss) from Operations	**$62,387**	**$455,387**	**$486,315**	**$486,315**

[1] The addition of another counselor, if necessary, will cost approximately $60,000.

Ex. A, pp. 20- 21; Ex. D, pp. 144-145, 149; Ex. F, pp. 215-216.

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 not yet adopted by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1)).

26. This CON application is consistent with the Statewide Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2)); Ex. A, p. 12.

27. The Applicant has established that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3)); Ex. A, p. 15.

28. The Applicant has demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4)); Ex. A, pp. 20-21.

29. The Applicant has satisfactorily demonstrated that the proposal will improve the accessibility and maintain the quality and cost effectiveness of health care delivery in the region. (Conn. Gen. Stat.§ 19a-639(a)(5)); Ex. A, pp. 17-18.

30. The Applicant has shown that there would be no adverse change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6)); Ex. A, p. 18; Ex. D, p. 149; Ex. F, pp. 213-214.

31. The Applicant has satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7)); Ex. A, p. 14.

32. The Applicant's historical provision of services in the area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8)); Ex. F, p. 211.

33. The Applicant has satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9)); Ex. A, p. 25.

34. The Applicant has demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10)); Ex. A, p. 18.

35. The Applicant has demonstrated that the proposal will not negatively impact the diversity of health care providers and client choice in the region. (Conn. Gen. Stat. § 19a-639(a)(11)); Ex. A, p. 25.

36. The Applicant has satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or accessibility to care. (Conn. Gen. Stat. § 19a-639(a)(12)); Ex. A, pp. 18-19.

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 § 19a-639(a) of the Statutes. 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).*

NERC is a for-profit entity licensed by the DPH to provide outpatient substance abuse treatment in the cities of New Haven and Bridgeport, Connecticut. Approximately one-half of the Applicant's census of 1,000 clients receive addiction treatment at its Bridgeport clinic. Nearly 24,000 adults live with co-occurring substance abuse and psychiatric disorders in Fairfield County. The Applicant seeks to expand the services presently available at its Bridgeport location by acquiring licensure to establish a psychiatric outpatient and mental health day treatment program for adults living with depression, schizophrenia, bipolar disorder and other mental health diagnoses. *FF1; FF3-4; FF6; FF14.*

According to a 2006 publication from the Institute of Medicine, collocating mental health and substance use care within the same setting increases access to services, enhances continuity of care and improves health-related outcomes including the identification of comorbid conditions and relapse reduction. Although there are existing providers within the city of Bridgeport and surrounding area that offer treatment to adults with co-occurring mental health and substance use disorders, the Applicant is currently the only provider that will collocate methadone maintenance and mental health treatment at one facility. The proposal will increase access to indigent populations as almost 100% of NERC clients participating in the proposed program will be covered by Medicaid; discretionary charity care will be available to those whose insurance lapses. *FF7-8; FF21-22.*

As there are no anticipated capital costs associated with the proposal, incremental gains are expected from the onset of operations, demonstrating its financial feasibility. In order to ensure that access to care will improve for the Medicaid population, and that the proposal is consistent with the Statewide Health Care Facilities and Services Plan, OHCA requires that the Applicant agree to take certain actions as stated in the order attached hereto. *FF23-24.*

Order

Based upon the foregoing Findings of Fact and Discussion, the Applicant's request to establish a psychiatric outpatient and mental health day treatment clinic is hereby **Approved** under Conn. Gen. Stat. § 19a-639(a) subject to the enumerated conditions (the "Conditions") set forth below.

All references to days in these Conditions shall mean calendar days, and OHCA shall mean the Office of Health Care Access or its successor.

1. Upon execution of this Agreement, the Applicant shall immediately apply to the Connecticut Department of Social Services and be approved as a Medicaid provider for the proposed service and make all efforts to comply with the requirements of participation. The Applicant shall provide documentation to OHCA evidencing approval of its enrollment application. Such documentation shall be filed within thirty (30) days of approval as a Connecticut Medicaid provider.

2. NERC shall provide notification to OHCA of the date of commencement of operations and shall provide a copy of the facility license(s) it has obtained. Such notification shall be provided within thirty (30) days of start of operations.

3. OHCA and NERC agree that this settlement represents a final agreement between OHCA and NERC with respect to OHCA Docket No. 17-32149-CON. The execution of this agreed settlement resolves all objections, claims and disputes, which may have been raised by NERC with regard to OHCA Docket Number 17-32149-CON.

4. OHCA may enforce this settlement under the provisions of Conn. Gen. Stat. §§ 19a-642; 19a-653 and all other remedies available at law, with all fees and costs of such enforcement to be paid by the Applicant.

5. This settlement shall be binding upon the Applicant and its successors and assigns.

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

Yvonne Addo

12/6/2017
Date

Yvonne T. Addo, MBA
Deputy Commissioner

Ebenezer Kolade

12/5/17
Date

Ebenezer Kolade, FASAM, FACF
Duly Authorized Agent for
New Era Rehabilitation Center, Inc.

Olejarz, Barbara

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To: akolade@newerarehab.com
Sent: Thursday, December 07, 2017 10:43 AM
Subject: Relayed: Agreed Settlements

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Olejarz, Barbara

From: Olejarz, Barbara
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To: 'akolade@newerarehab.com'
Subject: Agreed Settlements
Attachments: 32150 agreement.pdf; 32149 agreement.pdf

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Gloria.Sancho@ct.gov	Delivered: 12/7/2017 10:43 AM

12/7/17

Dr. Kolade,

Attached are two Agreed Settlements for New Era Rehabilitation Center, Inc. to establish services in New Haven and Bridgeport

Sincerely,

Barbara K. Olejarz
Administrative Assistant to Kimberly Martone
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Department of Public Health
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