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United Way

United Way
of Meriden and Wallingford

May 23, 2012

Commissioner Jewel Mullen, MD, MPH, MPA
State of Connecticut
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Dr. Mullen:

As an executive of the United Way of Meriden and Wallingford, I am writing to express sincere support for MidState Medical Center's proposal to terminate the provision of inpatient psychiatric services. Specifically, I support that MidState, after careful and thoughtful planning, determined that it can best service its patients and the community by coordinating with its Hartford HealthCare affiliate to offer inpatient behavioral health services at The Hospital of Central Connecticut.

While it may seem unusual for a local agency to support the movement of services to a place outside its community, this initiative fits our interests in promoting collaboration in order to provide the best care possible. MidState continues to be a leader in addressing community health and has worked with community-based organizations as well as other organizations within the Hartford Healthcare system to address community need.

MidState has done the responsible thing by determining that it is more cost-effective to operate a larger more specialized behavioral health unit than it is to operate a 6-8 bed unit. Providers in this state must figure out ways to focus on the services they provide best and most cost effectively. By assuring that MidState patients will have enhanced access at The Hospital of Central Connecticut and that transportation concerns will be addressed for those that need assistance, MidState is acting in the best interests of the community it serves. Let's applaud their leadership for making these difficult decisions.

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

James Ieronimo
Chief Professional Officer

35 Pleasant Street • Suite 1E • Meriden, CT 06450-5786 • tel 203.235.4403 • fax 203.235.4404
www.unitedwaymw.org

Town of Wallingford, Connecticut

PETER J. STRUBLE
FIRE CHIEF

RICHARD W. HEIDGERD
DEPUTY FIRE CHIEF

STEPHEN J. ALSUP
DEPUTY FIRE CHIEF

DEPARTMENT OF FIRE SERVICES
75 MASONIC AVENUE
WALLINGFORD, CONNECTICUT 06492-3019
TELEPHONE (203) 294-2730

July 11, 2012

Commissioner Jewel Mullen, MD, MPH, MPA
State of Connecticut
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Dr. Mullen:

As the Fire Chief of the Wallingford Fire Department, a leading provider of emergency medical services for our town, I know all too well the challenges of our health care delivery system. As the health care climate continues to change, health care providers must always work towards improving the quality of and access to the services the community needs most. The leadership at MidState Medical Center has always made this a priority for the people it serves.

MidState's proposal to close its inpatient psychiatry unit and transfer services to its system partner, The Hospital of Central Connecticut, is an example of how MidState is enhancing, protecting and increasing access to needed services in the community by aligning with the resources of the Hartford HealthCare system.

The Wallingford Fire Department supports the proposed plan. Patients in a behavioral health crisis will continue to be brought to MidState's Emergency Department for initial evaluation and treatment as they always have. The secure, private behavioral health unit in the Emergency Department, which opened in 2010, is well equipped to handle the acute needs of patients. Should patients need to be admitted as an inpatient, they will be transferred to The Hospital of Central Connecticut. There they will have access to a greater breadth and depth of services on a larger 32-bed unit.

The arrangement within MidState's proposal is truly the right thing for our patients, our community and our hospital. Should you have any questions, feel free to contact me at 203-294-2730.

Sincerely,

Peter Struble
Fire Chief
Wallingford Fire Department

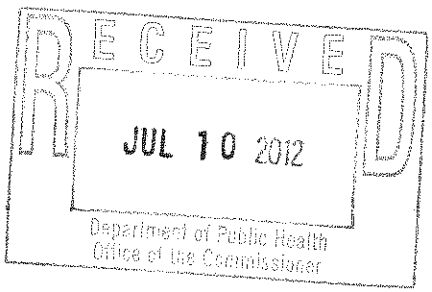
SENATOR TERRY GERRATANA
Sixth District

Legislative Office Building, Room 3000
Hartford, CT 06106-1591
Tel. 860-240-0584
Toll-free 1-800-842-1420
www.SenatorGerratana.cga.ct.gov

State of Connecticut
SENATE

Chair
Select Committee on Children
Public Health Committee
Member
Judiciary Committee
Regulations Review Committee

July 6, 2012



Commissioner Jewel Mullen, MD, MPH, MPA
State of Connecticut
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Dr. Mullen:

As Senator of the 6th District and Chair of the Public Health Committee, I am writing to express my support for MidState Medical Center's proposal to coordinate with its Hartford Healthcare affiliate to offer inpatient behavioral health services at The Hospital of Central Connecticut (HOCC).

MidState has developed a responsible proposal, following careful and thoughtful planning, that involves terminating its inpatient psychiatric services and collaborating with HOCC, which intends to renovate and provide an expanded inpatient unit on its own campus. It is my understanding that the new HOCC program will provide ten (10) beds for MidState patients. This plan offers more appropriate, cost-effective care for patients than is possible at MidState now as well as expanded access to inpatient behavioral health services for the entire region. By assuring that MidState patients will have enhanced access at HOCC, and that transportation concerns will be addressed for those that need assistance, MidState is acting in the best interests of the community it serves. I applaud their leadership for making these difficult decisions.

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Senator Terry Gerratana

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

July 24, 2012

The Honorable Terry Gerratana
Senator
State of Connecticut
Legislative Office Building, Room 3000
Hartford, CT 06106-1591

Re: Certificate of Need
MidState Medical Center, Docket Number: 12-31775-CON
Proposal to Coordinate with its Hartford Healthcare Affiliate to Offer Inpatient Behavioral Health Services at The Hospital of Central Connecticut

Dear Senator Gerratana:

On July 10, 2012, the Department of Public Health ("DPH") received your letter addressed to Commissioner Mullen concerning the Certificate of Need ("CON") for the proposal by MidState Medical Center to coordinate with its Hartford Healthcare Affiliate to offer inpatient behavioral health services at The Hospital of Central Connecticut.

I welcome and appreciate your comments regarding this matter. I have forwarded your letter to DPH's Office of Health Care Access ("OHCA"). Your letter will be made part of OHCA's formal record of the CON application docket. Please be advised, once a decision has been rendered it will be posted and available on OHCA's website at http:// www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone at (860) 418-7029.

Sincerely,

Lisa Adams

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

LAD:KRM:bko

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
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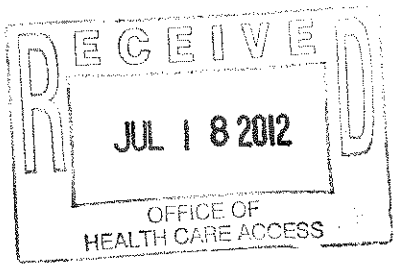
12-31775-CON

SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

July 17, 2012



Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: **MidState Medical Center**
Termination of Inpatient Behavioral Health Services

Dear Ms. Martone:

On behalf of MidState Medical Center ("MidState"), enclosed please find a Certificate of Need Application for MidState's Termination of Inpatient Behavioral Health Services at MidState Medical Center.

As requested, I have included one original and four hard copies of the Certificate of Need Application in 3-ring binders along with a CD containing the electronic version of the enclosed documents and materials. Also attached to this letter is a check for the $500.00 filing fee.

Please do not hesitate to contact me at 860-251-5104 if you have any questions.

Sincerely,

Joan Feldman

Joan Feldman, Esq.

JWF/tja
Enclosures

Application Checklist

Instructions:

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

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

For OHCA Use Only:

Docket No.: 12-31775-CON **Check No.:** 210211
OHCA Verified by: SP **Date:** 7/19/12

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

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

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

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

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

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

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

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

MIDSTATE MEDICAL CENTER
ATTN: ACCOUNTS PAYABLE
PO BOX 5037
HARTFORD, CT 06102-5037

51-57
119

Check Number
210211
FLEET BANK

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER

VOID VOID VOID

Five hundred and 00/100 Dollars

Pay to the order of

TREASURER STATE OF CONNECTICUT
DEPT OF PUBLIC HEALTH
410 CAPITOL AVE MS#12FLIS
PO BOX 340308
HARTFORD, CT 06134-0308

Date	Payment Amount
06/12/2012	********$500.00

VOID AFTER 90 DAYS

THE BACK OF THIS DOCUMENT CONTAINS LAID LINES AND AN ARTIFICIAL WATERMARK. HOLD AT AN ANGLE TO VIEW.

⑈210211⑈ ⑆011900571⑆ 00013 09331⑈

TREASURER STATE OF CONNECTICUT
DEPT OF PUBLIC HEALTH
410 CAPITOL AVE MS#12FLIS
PO BOX 340308
HARTFORD, CT 06134-0308

Entity	Vendor ID / Location	Check Number
VPNK	08112 001	210211

MIDSTATE MEDICAL CENTER

Invoice Number	Invoice Date	Gross Amount	Discount Amount	Withholding Amount	Net Amount
CON APP FEE X8539	06/05/2012	500.00			500.00

002

TOTALS	**$500.00**	**0.00**	**0.00**	**$500.00**

HH574485 1/03

Record-Journal
202203
1242673
11 CROWN STREET, P.O. BOX 915 • MERIDEN, CONNECTICUT 06450-0915
203-317-2405 or 203-317-2414 • Fax 203-235-3482

AFFIDAVIT OF PUBLICATION

THIS IS TO CERTIFY that the attached clipping is a true copy of a notice published in the RECORD-JOURNAL **APRIL 22, 23, 24, 2012**

PUBLIC/ LEGAL NOTICES

CONNECTICUT

LEGAL NOTICE

MidState Medical Center ("MidState") is filing an application for a Certificate of Need under section 19a-638(a)(4) of the Connecticut General Statutes requesting approval to terminate the provision of inpatient psychiatric services provided at 435 Lewis Avenue, Meriden, Connecticut 06451-2101. MidState's proposal to terminate inpatient psychiatric services will include plans for quality alternative access to inpatient psychiatric services. MidState's total capital expenditure for this project is $0.

Ord/Inv/Jb:
Client:
APR 25 2012
Vdr code:
Or entrd:

The Record-Journal Publishing Company

State of Connecticut

} SS. Meriden

Pam Adamski

Pam Adamski, Business Office Manager

The foregoing affidavit was signed and sworn before me this 23 day of APRIL 2012.

Angela Grabiec

Angela Grabiec
Notary Public
My Commission Expires June 30, 2013

AFFIDAVIT

Applicant: **MidState Medical Center**

1. Project Title: Termination of Inpatient Behavioral Health Services at MidState Medical Center

I, **Lucille Janatka, President & Chief Executive Officer**
(Individual's Name) (Position Title – CEO or CFO)

of **MidState Medical Center**, being duly sworn, depose and state that
(Hospital or Facility Name)

MidState Medical Center's information submitted in this Certificate of
(Hospital or Facility Name)

Need Application is accurate and correct to the best of my knowledge.

Signature L. Janatka 7.6.12
Date

Subscribed and sworn to before me on July 6, 2012

Notary Public/Commissioner of Superior Court

My commission expires: 12/31/16

AFFIDAVIT

Applicant: **The Hospital of Central Connecticut**

2. Project Title: Termination of Inpatient Behavioral Health Services at MidState Medical Center

I, **Clarence Silvia**, **President & Chief Executive Officer**
(Individual's Name) (Position Title – CEO or CFO)

of **The Hospital of Central Connecticut**, being duly sworn, depose and state that
(Hospital or Facility Name)

The Hospital of Central Connecticut's information submitted in this Certificate of
(Hospital or Facility Name)

Need Application is accurate and correct to the best of my knowledge.

Signature _____ Date 7/12/12

Subscribed and sworn to before me on 7/12/12

Notary Public/Commissioner of Superior Court

My commission expires: _____

LINDA R. TOMPKINS
NOTARY PUBLIC
MY COMMISSION EXPIRES APRIL 30, 2017

AFFIDAVIT

Applicant: **Hartford HealthCare** Corporation ("Hartford HealthCare")

1. Project Title: Termination of Inpatient Behavioral Health Services at MidState Medical Center

I, **Elliot Joseph, President & Chief Executive Officer**
(Individual's Name) (Position Title – CEO or CFO)

of **Hartford HealthCare**, being duly sworn, depose and state that
(Hospital or Facility Name)

Hartford HealthCare's information submitted in this Certificate of
(Hospital or Facility Name)

Need Application is accurate and correct to the best of my knowledge.

Signature

7-12-12
Date

Subscribed and sworn to before me on July 12, 2012

Notary Public/~~Commissioner of Superior Court~~

My commission expires: _____

PATRICIA B. CHOUINARD NOTARY PUBLIC My Commission EXPIRES 02-28-2017 CONNECTICUT

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

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

Docket Number:			
Applicant:	**Applicant # 1** MidState Medical Center	**Applicant # 2** The Hospital of Central Connecticut	**Applicant # 3** Hartford HealthCare Corporation
Contact Person:	Barbara A. Durdy	Claudio Capone	Karen Goyette
Contact Person's Title:	Director, Business Development	Director, Strategic Business Planning & Physician Relations	VP, Strategic Planning & Business Development
Contact Person's Address:	435 Lewis Avenue, Meriden, CT 06451	100 Grand Street, New Britain, Connecticut 06050	80 Seymour Street, Hartford, Connecticut, 06102
Contact Person's Phone Number:	203-694-8539	860-224-5279	860-545-1532
Contact Person's Fax Number:	203-694-7601	860-224-5740	860-545-2127
Contact Person's Email Address:	bdurdy@midstatemedical.org	ccapone@thocc.org	karen.goyette@hhchealth.org
Project Town:	Meriden, CT	Meriden, CT	Meriden, CT
Project Name:	Termination of Inpatient Behavioral Health Services at MidState Medical Center	Termination of Inpatient Behavioral Health Services at MidState Medical Center	Termination of Inpatient Behavioral Health Services at MidState Medical Center
Statute Reference:	Section 19a-638, C.G.S.	Section 19a-638, C.G.S.	Section 19a-638, C.G.S.
Estimated Total Capital Expenditure:	$0	$4,744,340.00	$0

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

a. Provide a narrative detailing the proposal.

INTRODUCTION AND BACKGROUND

MidState Medical Center ("MidState") is a member of Hartford HealthCare Corporation ("HHC"), an integrated health care delivery system (the "System"). One of the principal goals of the System is to deliver high quality, cost-effective, personalized and coordinated care through collaboration by and integration with its System members and other community providers. Achieving these goals requires flexibility, coordination and responsible planning. In the instant case, it also requires centralization of services and the intentional avoidance of duplication. MidState proposes to terminate its six (6)-bed inpatient behavioral health unit in conjunction with a plan to arrange for preferred inpatient status at The Hospital of Central Connecticut ("THOCC") and the enhancement of community-based services provided by Rushford Center, Inc., ("Rushford") both of whom are System members and affiliates of MidState (the "Proposal").[1]

At the onset, it is important to note that the very fact that the System recognizes a need to create a center of excellence and reduce costs in response to healthcare reform does not mean that a judgment has been made that the services currently provided by MidState's inpatient behavioral health unit are inferior. Rather, centralization or regionalization of certain services is necessary to permit the System to concentrate its resources and achieve certain economies of scale. If the System and its members are to ensure the future stability of the System and its members, such steps must be taken. Without this type of leadership and innovation, the affected communities will not be well served into the future.

As background, THOCC currently operates a twenty-two (22)-bed unit dedicated to inpatient behavioral health services at its New Britain campus. As part of this Proposal, the inpatient behavioral health services at THOCC will be expanded by ten (10) beds. This expansion will be accomplished by renovating existing space to create a new unit, significantly redesigned and enhanced to offer a more therapeutic milieu. Consistent with the System's objectives of improving quality and operating efficiencies, the System has determined that behavioral health patients who would have historically accessed MidState for inpatient care would be better served if they received their inpatient behavioral health services in THOCC's newly redesigned thirty-two (32) bed unit rather than in MidState's current six (6)-bed unit.

Accordingly, MidState proposes to discontinue its provision of inpatient behavioral health services to coincide with THOCC's expansion of its inpatient behavioral health unit as more particularly described below. To implement this Proposal, MidState, THOCC and Rushford will enter into the Memorandum of Understanding (the "MOU") attached hereto as Exhibit 2 to address significant aspects of the coordinated effort. The MOU, among other things, provides that MidState patients requiring inpatient admission

[1] Please see Letters of Support attached hereto as Exhibit 1.

for their behavioral health care needs would have direct and preferential access to receive inpatient behavioral care at THOCC's newly redesigned thirty-two (32)-bed unit, which is located approximately nine (9) miles from MidState. Most importantly, the Proposal's plan to terminate inpatient behavioral services at MidState is part of a System-wide plan to achieve maximum efficiencies, offer more specialized care and improve access to behavioral health services in Central Connecticut.

While this Proposal involves MidState's termination of inpatient behavioral health services, it will not eliminate or diminish access to inpatient behavioral health services or beds for MidState patients because these same patients, who are in need of an inpatient admission, will be given preferential admission status for up to ten (10) beds in the THOCC's redesigned thirty-two (32)-bed inpatient behavioral health unit. Moreover, and as further described below, MidState will work concurrently with Rushford to enhance community-based services so that behavioral health patients have more services available to them so that they may remain stable in the community and avoid inpatient admission.

CURRENT INPATIENT BEHAVIORAL HEALTH SERVICES AT MIDSTATE

MidState currently operates and staffs a general six (6)-bed inpatient unit for adult behavioral health patients. As reflected in Table 1 below, in FY 2011, MidState's inpatient behavioral health unit operated with an average daily census ("ADC") of 5.1 patients, an average length of stay ("ALOS") of 6.4 days, and discharged 282 patients.

Table 1

MidState Medical Center Inpatient Behavioral Health	**FY11**
Discharges - Inpatient Unit	**282**
ADC	**5.1**
ALOS	**6.4 days**

Given that its behavioral health unit is relatively small, MidState staffs this unit on a daily basis with one full-time psychiatrist and one full-time advanced practice registered nurse who manage the patients on the unit, the acute behavioral health unit ("ABU") in the emergency department and the inpatient behavioral health consultation service for the entire hospital. MidState's behavioral health occupational therapist and nursing staff provide daily generalized group therapy sessions for MidState's behavioral health inpatients. However, the range of behavioral health programs and services is limited by the size of the inpatient program. Specialized therapies, such as Dialectical Behavior Therapy ("DBT"), Cognitive Behavior Techniques and other specialized programs of care cannot be effectively or efficiently provided due to the limited number of patients and diverse diagnoses of patients. For example, on a typical day, patients on the inpatient behavioral health unit may have diagnoses as disparate as acute psychosis, schizo-affective disorder, bipolar disorder, major depression, co-occurring psychiatric and

substance use disorders, or personality disorders. Given this diversity, group therapeutic programs are a challenge.

In addition to the inpatient behavioral health unit, MidState operates a nine (9)-bed, secure, acute behavioral health unit ("ABU") within its emergency department. The ABU is newly designed with all private patient rooms and is staffed by psychiatric nurses. The majority of the behavioral health patients that are admitted to the MidState inpatient behavioral health unit are admitted directly from the ABU. Currently, all behavioral health patients presenting in the ABU are evaluated by Rushford's clinical staff on behalf of MidState, and then triaged to the most appropriate level of care. Not all patients that are evaluated in the ABU are admitted to the MidState inpatient behavioral health unit. In fact, approximately fifty percent (50%) of MidState's ABU patients requiring inpatient behavioral health services are transferred to other inpatient facilities within the State of Connecticut. In FY 2011, 223 pediatric, adult and geriatric referrals were made from MidState's emergency department to other acute care facilities. See Table 2 below.

Table 2

MidState Medical Center
FY 2011 Transfers of Behavioral Health Patients
Emergency Department to Other Acute Care Facilities

Hospital	Total # Transfers	Distance (miles) to MidState	Time of Travel to MidState
Hartford Hospital/Institute of Living	33	22	26 mins.
Natchaug Hospital	8	46	57 mins.
The Hospital of Central Connecticut	1	9	18 mins.
Saint Francis Hospital and Medical Center	42	24	28 mins.
St. Vincent's Hospital	42	38	47 mins.
Yale-New Haven Hospital	11	24	28 mins.
Waterbury Hospital	2	17	23 mins.
Hospital of Saint Raphael	10	23	29 mins.
Connecticut Valley Hospital	3	10	20 mins.
Riverview Hospital	1	12	20 mins.
Masonicare	45	9	12 mins.
Sharon Hospital	6	60	1 hour, 21 mins.
Hebrew Home	12	25	34 mins.
Silver Hills	3	55	1 hour, 8 mins.
Manchester Memorial Hospital	1	27	34 mins.
Stamford Hospital	1	61	1 hour, 16 mins.
Johnson Memorial Hospital	1	45	55 mins.
St. Jude Children's Hospital	1	99	2 hours, 6 mins.
	223		

Referrals from MidState to other Connecticut acute care facilities are generally made for a variety of reasons, including but not limited to, providing a more age-specific level of behavioral health care (e.g., geriatric or pediatric); the patient's acuity level requires more intensive care; the patient has specialized treatment needs that MidState cannot provide; or there is a lack of bed availability. Thus, the reality is that about fifty percent (50%) of the patients who come through MidState's emergency department are currently receiving their inpatient behavioral health services at locations other than MidState and outside of the Meriden community. Patients requiring transfer from MidState to other acute care facilities are currently transferred by ground ambulance.

EXPANDED ACCESS TO INPATIENT BEHAVIORAL HEALTH SERVICES

THOCC plans to renovate and expand its twenty-two (22)-bed behavioral health inpatient unit on its New Britain campus. As a result of this renovation, THOCC will increase the number of staffed inpatient behavioral health beds by ten (10) for a total of thirty-two (32) beds and dedicate at least ten (10) of the thirty-two (32) beds to patients admitted directly from MidState's emergency department.

Table 3

Proposed Bed Allocation at HOCC

	Current # Beds	Proposed # Beds	Inc / (Decr)
MidState	**6**	**10**	**4**
THOCC	**22**	**22**	**0**
Total	**28**	**32**	**4**

The System's plan to regionalize inpatient behavioral health services is consistent with the concept of avoiding unnecessary duplication and utilizing limited resources in the most effective manner for the community. Through the redesign and expansion of the inpatient unit at THOCC, an additional four (4) inpatient beds can be made available to MidState patients, significantly increasing access to inpatient beds for the MidState community. Assuming an ALOS of eight (8) days[2], the increase of four (4) available beds at THOCC will result in additional capacity to accommodate an additional 155 MidState inpatient admissions, significantly reducing the number of patients transferred from MidState's emergency department to other more distant inpatient facilities. Of course, patients will retain the freedom to choose other facilities (when appropriate) and referrals from MidState to other facilities will continue for patients who choose to go elsewhere or require very specialized care (e.g., pediatric and geriatric patients). It is the position of the Applicants that having MidState patients remain within the System's

[2] State average based on most recent published CHIME data.

behavioral health network provides a greater opportunity to coordinate care for these patients.

As more particularly set forth in the MOU, patients who are determined by MidState to need inpatient behavioral health treatment will receive preferential admission to ten (10) beds on the THOCC inpatient behavioral health unit. For example, if there are nine (9) patients from MidState and one bed open on the THOCC inpatient unit and two patients need inpatient admission, one in the THOCC emergency department and one in the MidState emergency department, the MidState patient will be given preference for admission to the MidState designated bed in THOCC's redesigned thirty-two (32)-bed unit.

The expansion of inpatient capacity along with the enhancement of services offered by Rushford (as further described below) in the community will ensure that MidState patients will have continued access to high quality behavioral health services. The attached MOU set forth as Exhibit 2 outlines the operational processes relating to inpatient behavioral health admissions from MidState, along with the commitment of the Applicants to coordinate follow-up care in the MidState community.

THOCC ENHANCED SERVICES

The newly expanded THOCC inpatient behavioral health unit will provide MidState patients and families with a broader range of therapy groups and other clinical interventions and services that are not feasible on a smaller unit, but that are considered best practice when caring for behavioral health patients. For example, at THOCC inpatient behavioral health unit, specialized group therapies will be available. These are evidence-based therapies for particular diagnostic categories. Examples include cognitive behavioral therapy for mood and personality disorders, motivational interviewing for substance abuse, and dialectical behavioral therapy for patients who engage in self-harm behaviors. In addition, meetings are routinely scheduled with patients' families in which psycho-education regarding follow-up care is provided with the objective of avoiding repeat admissions. Most importantly, the THOCC unit will be staffed by four (4) full-time psychiatrists all of whom are board certified in general adult psychiatry and have a psychiatric subspecialty, such as, substance abuse and the care of psychiatric patients with medical co-morbidities. Please see Exhibit 3 for the resumes CVs of THOCC's physician staff.

THOCC psychiatrists utilize evidence-based pharmacology therapies based on data derived from National Institute of Mental Health sponsored studies including Clinical Antipsychotic Trials of Intervention Effectiveness, Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study, Sequenced Treatment Alternatives to Relieve Depression Study and Systemic Treatment Enhancement Program for Bipolar Depression. THOCC also routinely employs the use of clozapine for treatment resistant

schizophrenia and long-acting, injectable antipsychotic medications for patients that are chronically non-compliant with treatment.[3]

Additionally, because of its size, the newly expanded THOCC inpatient unit will permit the separation of patients based on clinical acuity or diagnosis. The unit will also feature a quiet/activity room which will enable clinicians to de-escalate patients to avoid seclusion and restraint. As stated above, there will be at least four (4) attending psychiatrists on the new unit, all of whom have training and/or certification in general adult psychiatry and a psychiatric subspecialty. This planning and investment by THOCC in its inpatient unit represents System-wide commitment and planning and is intended to facilitate best practices. Please see Exhibit 4 for a schematic drawing of the proposed inpatient unit at THOCC.

As an integrated healthcare delivery system, the System is dedicating considerable resources to the provision of high quality behavioral health services. By way of example, the System includes Rushford and Natchaug Hospital and the Institute of Living, two large behavioral health inpatient providers. In addition, the System has made it a priority for FY 2013 that it proactively manage co-morbid psychiatric and/or substance abuse conditions based upon standardized protocols. This initiative involves the implementation of behavioral health intervention teams in each of the acute care hospitals to identify and manage medical patients that are likely to have a co-morbid substance abuse or psychiatric condition that impacts their course of hospitalization, length of stay and potential readmission. It is also the goal of the System to establish a consistent service delivery model for behavioral health consultations, incorporating and standardizing methodologies considered to be best practice. Please see Exhibit 5 for journal articles on best practices for inpatient psychiatry.

The ultimate goal of this Proposal is to expand access and enhance the array of behavioral health services delivered while at the same time lowering the cost of providing inpatient behavioral health care by avoiding unnecessary system duplication and maximizing efficiencies. For example, in FY 2011, the direct cost per day of providing inpatient psychiatric care at MidState was $1,421 per day, while the direct cost per day at THOCC was significantly less at $578 per day, even though a broader range of services was provided at THOCC. While this decision is not cost driven, it is in fact relevant to the planning process and the decisions that hospitals must responsibly make to leverage their ever-shrinking reimbursement.

TRANSPORTATION ASSISTANCE

It is anticipated that family members of some MidState area patients will require transportation assistance to visit and participate in treatment of loved ones at the THOCC inpatient behavioral health unit. Transportation assistance to and from THOCC and from

[3] By way of example, other clinical initiatives at THOCC include obtaining an electrocardiogram for all patients taking antipsychotic medications, establishing follow-up care within no more than one (1) week after discharge and screening appropriate patients for hepatitis B and C and sexually-transmitted diseases, including human immunodeficiency virus as part of protocol.

and to the MidState campus will be provided daily at convenient times through the use of taxi vouchers and or hospital shuttles for members of the patient's immediate family (i.e., spouse or significant other, mother, father, children) who lack their own transportation and cannot use public transportation. Public bus transportation from Meriden direct to the THOCC main campus is also available for patient families during the day, on the hour, weekdays and Saturdays. As it becomes clearer what the transportation needs are to assure a family-centered program approach, MidState will tailor the transportation program to meet those needs.

ENHANCED SERVICES IN THE COMMUNITY AND FOLLOW-UP CARE

The majority of behavioral health services are provided on an outpatient basis in the community by private practitioners and freestanding community health centers. Greater effort is needed by all providers to keep patients stabilized while in the community in order to reduce the number of inpatient behavioral health admissions and readmissions. Accordingly, Rushford will work cooperatively with THOCC and MidState to arrange post discharge community-based care for MidState patients. Inpatients returning to the Meriden-Wallingford area will be provided direct and timely access to Rushford's continuum of care, including partial hospitalization, intensive outpatient care, individual and group therapy, medication management and community support services and programs. The discharge planning process is expected to begin within twenty-four (24) hours of admission to THOCC. Specifically, Rushford personnel will be concurrently notified of the admission of MidState patients to THOCC and will contact the THOCC inpatient behavioral health unit within twenty-four (24) hours to initiate discharge planning. In addition, Rushford will provide priority access at its Meriden outpatient center for discharged THOCC inpatients, including those in need of next-day appointments. Care coordination between MidState, THOCC and Rushford will be further facilitated by the exchange of electronic medical information between System members.

Furthermore, as part of this Proposal, Rushford will follow up with every MidState patient discharged from the inpatient unit at THOCC to ensure that there are no barriers to compliance with discharge plans or accessibility to services in the community. Focus on securing the appropriate community resources for behavioral health patients in the community will help to keep patients well and reduce the demand for inpatient services. In addition, MidState and Rushford will make every effort to connect patients presenting in the MidState emergency department or at Rushford Crisis Intervention Access Points with primary care providers in the community for the purpose of promoting early intervention, prevention and self-management initiatives.

Additionally, Rushford is currently evaluating the need and feasibility of expanding its partial hospitalization program to included patient boarding at its Meriden campus. Rushford clinicians are tracking the number of patients presenting to the ABU at MidState who would potentially qualify for this level of service. If implemented, this program will further help reduce the number of admissions and readmissions and shorten

the length of stay for certain patients admitted to the THOCC inpatient unit. Please see Exhibit 6 for a description of services provided by Rushford.

IMPACT ON MIDSTATE STAFF

MidState anticipates that approximately ten (10) staff positions will be impacted by the proposed termination of its inpatient behavioral health services. MidState's objective is not to displace staff. Rather, our objective is to work with staff and do our best to provide them ample opportunities for employment. Affected employees may seek employment opportunities with MidState or with other System health care providers. In addition, MidState will offer training to any behavioral health nurse who chooses to transition into a different nursing role at MidState.

COMMUNITY SUPPORT

MidState engaged in discussions with its community partners and medical staff regarding this Proposal. During the months of February through June 2012, MidState representatives met with community physicians, medical staff physicians, and patient advocacy groups including NAMI-CT, Connecticut Legal Rights Project, Connecticut Behavioral Health Partnership, Regional Mental Health Board, Mental Health Association of Connecticut and Catchment Area Council to discuss the plan to terminate inpatient behavioral health services at MidState. In addition, meetings were held with the Commissioner of the State Department of Mental Health and Addiction Services ("DMHAS"), other State and Town officials, and State and Federal Senators and Representatives from MidState's and THOCC's service areas in order to receive feedback on the Proposal and to address concerns. MidState believes it has made best efforts to address all of the comments, concerns, and suggestions it heard in developing its plan with THOCC to assure coordinated high-quality inpatient behavioral health services in Central Connecticut. While there may continue to be some in the community who still have concerns about this change, MidState, THOCC and Rushford are committed to continuing the dialogue to assure that the behavioral health services that are offered best serve the needs of the community.

MIDSTATE'S PROPOSED PLAN FOR UTILIZATION OF ITS SIX BEHAVIORAL HEALTH BEDS

Should this Proposal be approved, MidState intends to use the six (6) beds in accordance with its Master Facilities Plan which is currently under development. Potentially having access to these additional beds will mitigate the need for using available shell space for inpatient beds in the future.

b. For each of the Applicant's programs, identify the location, population served, hours of operation, and whether the program is proposed for termination.

Table 4

Program	Program Location	Population Served	Hours of Operation	Proposed for Termination
MidState 6-bed Inpatient Behavioral Health Unit	435 Lewis Avenue, Meriden, CT 06451	Adult behavioral health	365/24/7	Yes
MidState 9-bed ABU	435 Lewis Avenue, Meriden, CT 06451	Adult, adolescent and pediatric behavioral health	365/24/7	No
THOCC Inpatient Behavioral Health Unit	100 Grand Street, New Britain, CT 06050	Adult and adolescent behavioral health	365/24/7	No

c. Describe the history of the services proposed for termination, including when they were begun and whether CON authorization was received.

Under the original CON which established MidState (DN 92-567-CON), MidState established a ten (10) bed "swing unit" which would have the ability to serve either psychiatric or medical/surgical patients. Due to a historically greater demand for medical/surgical beds, the inpatient psychiatric service has operated as a six (6)-bed unit. MidState also accommodates patients with both medical and behavioral health diagnoses on its medical floors as appropriate. See subsection 1.d. below.

d. Explain in detail the Applicant's rationale for this termination of services, and the process undertaken by the Applicant in making the decision to terminate.

MidState has long recognized the operational, clinical and financial challenges of operating a small inpatient behavioral health unit. In 2007, MidState filed an Application (DN 07-30964-CON) with the Office of Health Care Access ("OHCA") to expand the emergency department, increase the number of licensed beds, terminate its inpatient behavioral health service and arrange for behavioral health inpatient transfers to the Institute of Living. MidState's proposal to terminate its inpatient behavioral health service was denied by OHCA in the Final Decision dated March 4, 2008. At that time, there was significant opposition to the idea of terminating the service from certain members of the medical staff, employees and some patient advocacy groups. The 2007 proposal was significantly different than this Proposal. The earlier proposal did not offer preferential admissions and transportation for loved ones. In addition, the 2007 proposal did not include a plan to enhance the community resources that this Proposal includes. In addition, MidState has invested considerable time and effort vetting the Proposal and incorporating suggestions from all interested parties.

In February 2011, THOCC joined the System. In March 2011, work began on a System-wide plan to enhance access to inpatient psychiatric services, and to provide the highest quality care in a more cost effective manner.[4] Please see Exhibit 7 for the relevant portions of the System initiative related to this Proposal.

e. Did the proposed termination require the vote of the Board of Directors of the Applicant? If so, provide copy of the minutes (excerpted for other unrelated material) for the meeting(s) the proposed termination was discussed and voted.

This Proposal was approved by the System's Board of Directors in July of 2011, the MidState Board of Directors in May of 2012, and THOCC Board of Directors in December of 2011. Please see Exhibit 8 for the relevant excerpts from the Boards' meeting minutes.

2. Termination's Impact on Patients and Provider Community

a. List all existing providers (name, address, services provided, hours and days of operation, and current utilization) of the services proposed for termination in the towns served by the Applicant, and in nearby towns.

Table 5

Hospital	Inpatient Behavioral Health Beds	Distance in Miles From MidState	Days/Hours of Operation	*FY 2011 Discharges
The Hospital of Central Connecticut - New Britain Campus	22	9	365/24/7	790
Masonicare - Wallingford	30	9	365/24/7	not available
Middlesex Hospital - Middletown	20	10	365/24/7	890
Saint Mary's Hospital - Waterbury	12	15	365/24/7	661
Bristol Hospital - Bristol	16	16	365/24/7	1,072
Institute of Living - Hartford Hospital, Hartford	70	17	365/24/7	4,395
Waterbury Hospital - Waterbury	24	17	365/24/7	979
Hospital of Saint Raphael - New Haven	25	19	365/24/7	1,323
Yale-New Haven Hospital - New Haven	20	21	365/24/7	3,601

* data source: CHIME based on MSDRG

b. Discuss what steps the Applicant has undertaken to ensure continued access to the services proposed for termination for the Applicant's patients.

The MOU between MidState, THOCC and Rushford details the operational and logistical considerations for continued and expanded access by MidState patients to THOCC's

[4] The System's behavioral health network known as "Hartford HealthCare Behavioral Health Network" is Connecticut's largest behavioral health provider network and represents 27% of all Connecticut inpatient behavioral health admissions to non-government entities and more than 140,000 outpatient visits annually. Members of the Hartford HealthCare Behavioral Health Network include: Hartford Hospital, Institute of Living, THOCC, MidState, Natchaug Hospital, and Rushford.

inpatient behavioral health unit and their return back to the community. Please see Exhibit 2 for a copy of the MOU.

c. For each provider to whom the Applicant proposes to transfer or refer clients, provide the current available capacity, as well as the total capacity and actual utilization for the current year and last completed year.

For FY 2011, THOCC's inpatient behavioral health unit experienced an average occupancy rate of 85%. For the first six (6) months of FY 2012, the average occupancy rate was 93%. The increase in occupancy reflects an increase in the ALOS from seven (7) days to over eleven (11) days. The ALOS has increased either due to higher acuity and/or difficulty in acquiring safe and appropriate placement. THOCC is actively trying to improve the placement process of these patients into the right care environment through enhanced collaboration with private and state agencies. THOCC is also exploring increasing access to partial hospitalization programs to serve those patients deemed appropriate for such a transition.

d. Identify any special populations that utilize the services and explain how these clients will continue to access this service after the service location closes.

Pediatric and geriatric behavioral health patients will continue to have access to the ABU for emergent behavioral health services. If inpatient care is required, the current transfer process for these patients will remain in effect.

e. Provide evidence (e.g. written agreements or memorandum of understanding) that other providers in the area are willing and able to absorb the displaced patients.

Please see Exhibit 2 for the MOU between THOCC, MidState and Rushford.

f. Describe how clients will be notified about the termination and transferred to other providers.

MidState has developed a formal communication plan which will be used to notify all stakeholder groups about the Proposal. At the appropriate time, written communications developed by MidState will be distributed to patients and their families, community physicians, and health and human service agencies in the community. Patients requiring inpatient behavioral health services will be transported by ambulance to THOCC for direct admission in accordance with protocols established in the MOU. Please see Exhibit 9 for a copy of the communication plan.

3. **Actual and Projected Volume**

   a. **Provide volumes for the most recently completed FY by town.**

Table 6

MidState Medical Center
FY11 Inpatient Behavioral Health Discharges by Town

Norwalk	**1**	**Newington**	**1**
Shelton	**1**	**East Haven**	**1**
Bristol	**1**	**Hamden**	**3**
East Hartford	**1**	**North Branford**	**2**
Columbus	**1**	**New Britain**	**4**
Clinton	**1**	**Waterbury**	**4**
Cromwell	**1**	**Berlin**	**1**
Durham	**1**	**North Haven**	**2**
Old Saybrook	**1**	**Southington**	**6**
Beacon Falls	**1**	**Middletown**	**6**
East Berlin	**1**	**Cheshire**	**9**
Naugatuck	**1**	**Wallingford**	**39**
Colchester	**1**	**Meriden**	**182**
New Haven	**1**	**Brooklyn**	**1**
Hartford	**1**	**Other States**	**6**
Grand Total All Towns			**282**

The majority (i.e. 78%) of inpatient behavioral health patients at MidState are residents of Meriden and Wallingford.

   b. **Complete the following table for the past three fiscal years ("FY") and current fiscal year ("CFY"), for both number of visits and number of admissions, by service.**

Table 7: Historical and Current Visits & Admissions

	Actual Volume (Last 3 Completed FYs[5])			**CFY Volume***
	FY 2009	FY 2010	FY 2011	FYTD 2012 (6 months)
Service**				
Inpatient Psychiatry Unit				
Total	**300**	**266**	**282**	**102**

[5] MidState's fiscal year covers the period from October 1st to September 30th.

* 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 six months, report actual volume and identify the period covered.
** Identify each service type and add lines as necessary. Provide both number of visits and number of admissions for each service listed.
*** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

c. Explain any increases and/or decreases in volume seen in the tables above.

Generally, the variation in total inpatient behavioral health discharges from year to year is due to changes in the ALOS for the service. In FY 2009, the ALOS was 6.6 days, increasing to 6.8 days in FY 2010 and then decreasing to 6.4 days in FY 2011. MidState has experienced a decrease in total discharge volume for the first (6) six months in FY 2012 due to increasing ALOS. For the six (6) months ending March 2012, MidState's inpatient unit has operated at 88% capacity which equates to an ADC of 5.3. The decrease in volume experienced during the first two (2) months of FY 2012 is likely due to the increasing ALOS on the unit. MidState has also recently experienced an increase in illness severity on the inpatient unit and longer than normal wait times for available beds for patients at State facilities. Both of these factors have lead to increasing ALOS on the unit not an increase in patient demand. Historical utilization for the inpatients unit at MidState and THOCC is set forth in Table 8 below.

Table 8
Historical Inpatient Utilization

	MidState Inpatient Unit		
	2009	**2010**	**2011**
Days	**1,976**	**1,855**	**1,820**
Discharges	**300**	**266**	**282**
ALOS	**6.6**	**6.8**	**6.4**
Available Beds	**6**	**6**	**6**
Occupancy	**90%**	**85%**	**83%**
	THOCC Inpatient Unit		
	2009	**2010**	**2011**
Days	**7,078**	**6,294**	**6,838**
Discharges	**811**	**851**	**790**
ALOS	**8.7**	**7.4**	**8.7**
Available Beds	**22**	**22**	**22**
Occupancy	**88%**	**78%**	**85%**

For the past 3 fiscal years, the inpatient behavioral health units at MidState and THOCC have operated with occupancy rates between 80% and 90%, with the number of discharges varying year to year based on the ALOS. As stated earlier, the System, along with THOCC and Rushford is looking at ways to decrease the ALOS, including developing a partial hospital

program, along with utilizing the Rushford Crisis Stabilization Unit to further support patients in the MidState community. Projected utilization for THOCC's new and expanded unit is presented in Table 9 below.

Table 9

Projected Utilization

	Proposed Inpatient Unit at THOCC		
	Year 1	**Year 2**	**Year 3**
Days	**9,928**	**9,928**	**9,928**
Discharges	**1241**	**1241**	**1241**
ALOS	**8.0**	**8.0**	**8.0**
Available Beds	**32**	**32**	**32**
Occupancy	**85%**	**85%**	**85%**

The projections for the THOCC's proposed unit are conservatively stated based on an ALOS of 8 days, which is currently the average for the state of Connecticut.

4. Quality Measures

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

MidState Medical Center
Lucille Janatka, President and Chief Executive Officer
Cindy Russo, Senior Vice President of Operations
Ralph Becker, Vice President and Chief Financial Officer
Chris Scully, Director, Inpatient Psychiatric Services
Richard H. Anderson, MD, Section Chief, Psychiatry

The Hospital of Central Connecticut
Clarence Silvia, President and Chief Executive Officer
Michael Balkunas, MD, Section Chief Psychiatry
Pamela Salvatore, Director Inpatient Psychiatric Services

Rushford Center
Jeff Walter, President and Chief Executive Officer
Kathleen Ulm, Vice President of Mental Health Services

Please see Exhibit 10 for copies of their resumes / curriculum vitae.

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

This Proposal is an important step forward in developing a fully integrated network for the delivery of personalized, coordinated behavioral health services in Central Connecticut.

c. Identify when the Applicants' funding and/or licensing agencies (e.g. DPH, DMHAS) were notified of the proposed termination, and when the Applicants' licenses will be returned.

Representatives of MidState met with the Commissioner of DMHAS on February 17, 2012 to discuss and review the Proposal and address any concerns that DMHAS may have. We believe that the Commissioner supports the Proposal. Neither MidState nor THOCC is requesting any change in DPH licensure.

d. Describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

This Proposal expands access to high quality, cost effective inpatient behavioral health services and greatly improves the coordination of and delivery system for these services. Thus, consumers of health care services and payers will be impacted positively as a result of this Proposal.

5. Organizational and Financial Information

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

MidState and THOCC are both Connecticut Corporations that are wholly-owned subsidiaries of HHC. HHC is a Connecticut non-stock corporation.

b. Does the Applicant have non-profit status?
☒Yes (Provide documentation) ☐ No

Please see Exhibit 11 for a copy of MidState's, THOCC's and HHC's IRS Determination Letters.

c. Financial Statements

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

Copies of the FY 2011 audited financial statements for MidState and THOCC are on file with OHCA.

ii. <u>If the Applicant is not a Connecticut hospital (other health care facilities):</u> Audited financial statements for the most recently completed fiscal year. If

audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

A copy of the FY 2011 audited financial statement for Hartford HealthCare is on file with OHCA.

d. Submit a final version of all capital expenditures/costs.

Please see Exhibit 12 for a schedule of capital costs related to this project.

e. 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.

The capital costs associated with this project will be financed entirely by THOCC's income from operations.

f. Demonstrate how this proposal will affect the financial strength of the state's health care system.

This Proposal will have a positive effect on the State's health care system by lowering the cost of providing care and avoiding duplication of services while at the same time enhancing access and improving the delivery system for behavioral health services.

In particular, savings are anticipated from improving the coordination of patient care throughout the full continuum of behavioral services (integration of inpatient and outpatient behavioral health services). The integration of behavioral health services by System members, as discussed in this application, will improve the quality of services provided and help to reduce admission and readmission rates for behavioral health patients. Savings will also likely accrue to the State of Connecticut Medicaid Program, Medicare, and commercial payers due to the efficiencies of consolidating admissions at THOCC.

6. Financial Attachments I & II

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

Please see Exhibit 13 for Financial Attachment I for MidState and THOCC.

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

Please see Exhibit 14 for Financial Attachment II for MidState, THOCC and HHC.

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

Please see Exhibit 13 for assumptions used in developing Financial Attachments I and II.

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

Reimbursement for inpatient behavioral health services from commercial payers is contractually determined on a contract by contract basis.

e. Was the Applicant being reimbursed by payers for these services? Did reimbursement levels enter into the determination to terminate?

MidState receives reimbursement for inpatient behavioral health services from Medicare, Medicaid, and most commercial payers. Approximately 13% of patients admitted to the inpatient unit are uninsured. Reimbursement levels did not influence the decision to terminate these services at MidState.

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

The financial projections include 234 incremental discharges related to this Proposal and a financial gain to the System of $1.5M. The incremental discharges are due to the expanded inpatient capacity at HOCC.

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

N/A. No incremental losses are projected.

h. Describe how this proposal is cost effective.

Like most health care providers in this period of healthcare reform, MidState and THOCC, are focused on avoiding capital expenditures, improving clinical outcomes and improving the patient experience. Unsustainable healthcare costs require that hospitals be bold and innovative in order to continue to provide services of the highest quality in the most efficient manner.

The direct cost per day of providing inpatient psychiatric care differs greatly between MidState's six (6)-bed unit at $1,421 per day, and the twenty-two (22)-bed unit at THOCC at $578 per day. The difference is largely due to inefficiencies associated with operating a small unit. Direct cost per patient day for the newly consolidated inpatient psychiatric unit is projected to be approximately $650 per day which is considerably lower than the cost of providing care at MidState currently. One of the primary objectives of this Proposal is to enhance the scope and quality of services provided while at the same time reducing the cost of providing care.

MidState and THOCC are focused on enhancing access and improving the quality of behavioral health services. This proposal demonstrates that commitment and is an important step forward in the development of an integrated health care delivery system in Central Connecticut.

List of Exhibits

1. Letters of Support

2 Memorandum of Understanding (MOU) between MidState Medical Center, The Hospital of Central Connecticut and Rushford Center, Inc.

3. Copies of Curriculum Vitae for The Hospital of Central Connecticut Staff Psychiatrists

4. Schematic Drawing of New Inpatient Behavioral Health Unit at The Hospital of Central Connecticut

5. Supporting Articles from Medical Journals

6. Description of Services Provided by Rushford Center, Inc.

7. Excerpts from the Hartford HealthCare Behavioral Health Network Balanced Scorecard Initiative

8. Excerpts of Minutes from the Hartford HealthCare Board of Directors Meeting

   Excerpts of Minutes from The Hospital of Central Connecticut Board of Directors Meeting

   Copy of the MidState Medical Center Board of Directors Resolution Approving this Application

   Excerpts from the May 15, 2012 MidState Medical Center Board of Directors meeting recommending the filing of this CON Application

9. Copy of MidState Medical Center Communication Plan

10. Resumes and Curriculum Vitae for Key Administrative and Clinical Personnel Related to this Proposal
    MidState Medical Center
    The Hospital of Central Connecticut
    Rushford Center

11. IRS Determination Letters, MidState, The Hospital of Central Connecticut and Hartford HealthCare

12. Schedule of Capital Costs - The Hospital of Central Connecticut

13. Financial Attachment I
MidsState Medical Center
The Hospital of Central Connecticut
Hartford HealthCare

14. Financial Attachment II
MidsState Medical Center
The Hospital of Central Connecticut

EXHIBIT 1

Letters of Support

Richard H. Anderson, MD
185 Center Street, Suite F
Wallingford, CT 06492
Phone: 203 269 6512 Fax: 203 284 3447

May 25, 2012

Commissioner Jewel Mullen
State of Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Commissioner Mullen:

I am a psychiatrist on the active medical staff of MidState Medical Center as well as MidState's Director of the Division of Psychiatry. I have been on the medical staff of MidState practicing psychiatry for many years. I maintain a private practice in the community and as part of my practice will, on occasion, need to admit patients of mine who require inpatient treatment to the MidState inpatient psychiatric unit. As you know, MidState operates a small six bed psychiatric unit. MidState provides high quality short-term inpatient behavioral health services, allowing me to manage my patients during acute episodes, or while they await transfer to a more specialized facility. The unit, however, may not be able to provide certain therapies that could be beneficial to my patient.

I understand that MidState is requesting approval from the Office of Health Care Access to terminate its inpatient behavioral health unit. I am in full support of the request based upon the assured access for at least 10 patients from the MidState community to The Hospital of Central Connecticut's newly renovated and expanded inpatient behavioral health unit. I do not believe that MidState's closure of beds will create an access problem at all for our patients in that there will actually be an increase in the number of beds available to them. In addition, I believe the plan to assist with transportation is very supportive and thoughtful on the part of MidState. In sum, I fully support the effort to consolidate services for the purpose of providing cost-effective, high-quality inpatient behavioral health services.

Sincerely,

Richard H. Anderson, MD

MidState Medical Center
A Hartford HealthCare Partner

Commissioner Jewel Mullen, MD, MPH, MPA
State of Connecticut
Department of Public Health
410 Capital Avenue
Hartford, Connecticut 06134

May 15, 2012

Dear Commissioner Mullen:

I am a doctor on the active medical staff of MidState Medical Center. I am an emergency physician and the Medical Director of the Emergency Department. We work closely with psychiatry to facilitate admissions of psychiatric patients who require inpatient psychiatric care. As you know, MidState operates a small six bed psychiatric unit. MidState provides high quality short term inpatient behavioral health services. The unit due to its size does not offer more chronic and severely ill patients the level of specialization that ideally would be available to them in a larger more diverse unit. I understand that MidState is requesting approval from the Office of Health Care Access to terminate its inpatient behavioral health unit. I am in full support of the request based upon MidState's efforts to assure access for at least 10 patients from the MidState community to The Hospital of Central Connecticut's newly renovated and expanded inpatient behavioral health unit. I do not believe that MidState's closure of beds will create an access problem at all for our patients in that there will actually be an increase in the number of beds available to them. In addition, I believe that the plan to assist with transportation is very supportive and thoughtful on the part of MidState. In sum, I fully support the effort to consolidate services for the purpose of providing cost-effective, high quality inpatient behavioral health services.

Sincerely,

Donald Lombino, MD
Chairman of the Trust Board/EMP
Director of Emergency Medicine
MidState Medical Center

Hartford HealthCare

Dear Commissioner Mullen:

The purpose of this letter is to support the MidState Medical Center proposal to terminate inpatient psychiatric services and consolidate these services at The Hospital of Central Connecticut (HOCC). As described in MidState's Certificate of Need application, this proposal is the result of a collaborative planning process among member institutions of the Hartford Health Care Behavioral Health network – namely MidState, HOCC, Rushford, Natchaug Hospital, and Hartford Hospital/Institute of Living.

Please be assured that Hartford Hospital/Institute of Living and Natchaug Hospital are committed to working closely with MidState and HOCC to coordinate care amongst our respective institutions.

The Hartford HealthCare Behavioral Health Network is developing an integrated behavioral health care system by adopting a single electronic health record and using a health information exchange to enable coordinated admissions and discharge protocols among all network institutions. This development is relevant to the MidState proposal because the EHR/HIE is expected to be fully operational coincident with the opening of HOCC's expanded inpatient psychiatric unit in mid-2013. At that time, all system Emergency Departments and inpatient units will have access to real-time information about bed availability in each BHN inpatient unit and will have developed specific protocols for filling bed vacancies within the health system. We believe this is just one example of the many enhancements we plan to implement in the future to improve the delivery of behavioral health services in our State. MidState's proposal is an important first step that we fully endorse.

Please do not hesitate to contact us if we can provide further details or answer any questions.

Sincerely,

Harold Schwartz MD

Harold Schwartz, MD
Psychiatrist in Chief, Hartford Hospital/Institute of Living

Stephen W. Larcen, PHD
President & CEO, Natchaug Hospital

80 Seymour Street Hartford, CT 06702 860 123 4567 tel 860 234 5678 fax www.hartfordhealthcare.org

Masonicare

Stephen B. McPherson
President and Chief Executive Officer

Tel: 203-679-5000
Fax: 203-679-5001

May 23, 2012

Jewell Mullen, M.D., Commissioner
State of Connecticut Department of Health
MS#13
410 Capitol Avenue
Hartford, CT 06134

Dear Commissioner Mullen:

As provider of inpatient psychiatric services for the geriatric population, I strongly support MidState Medical Center's decision to close its behavioral health unit in order to offer an alternative inpatient behavioral health setting to the community that focuses on providing cost-effective specialty inpatient behavioral health services. Without this collaboration with The Hospital of Central Connecticut, MidState patients would not likely have access to this level of specialized care. We have a long standing collaborative relationship with MidState in providing specialized behavioral health inpatient care to the geriatric patient population which has been most successful to both the patients and our organizations. The fact that MidState and The Hospital of Central Connecticut are part of the same integrated delivery system reinforces the belief that these two institutions will work together to assure that patients from the MidState service area will receive coordinated and high quality inpatient behavioral health services.

On behalf of those that require inpatient behavioral health services, I respectfully request that you approve MidState's application.

Sincerely,

Stephen B. McPherson
SBM/dr

MERIDEN WALLINGFORD INDEPENDENT PHYSICIANS' ASSOCIATION

Commissioner Jewel Mullen, MD, MPH, MPA
State of Connecticut
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

July 16, 2012

Dear Dr. Mullen:

By way of introduction, I represent the Meriden – Wallingford IPA – an association of approximately 250 physicians who are actively engaged in the practice of medicine in the Central Connecticut region. Founded in 1986, our IPA represents the interests of our physician members by working to ensure that our patients have access to quality and affordable healthcare services in our community.

I am writing to you to express our support for MidState Medical Center's plans to consolidate its existing inpatient psychiatric beds with those of its affiliate at the Hospital of Central Connecticut in New Britain. As we understand it, this consolidation will result in a 34-bed unit at the Hospital of Central Connecticut of which no less than 10 beds that will be allocated to residents of MidState Medical Center's service area.

While our community clinicians have long supported the existing psychiatric unit at MidState Medical Center, we have come to understand and appreciate the significant limitations the present scenario presents to our physicians and patients alike. In reality, the current unit at MidState Medical Center is far too small to provide the level of access and quality of care we believe our patients deserve to have in a psychiatric unit.

Consolidation of MidState Medical Center's psychiatric unit with that of the Hospital of Central Connecticut will have the scale and scope necessary to significantly enhance the level and quality of inpatient behavioral health services to our local patients.

After much deliberation we have come to conclude that the enhancement in access and quality of care incorporated in MidState Medical Center's application outweighs the geographic relocation of these inpatient psychiatric services to New Britain. It would be our hope and expectation that your Department will find itself drawing a similar conclusion.

I'd be happy to discuss this matter or address any concerns or questions you might have in this regard at your earliest convenience. I thank you in advance for your attention to this important issue.

Sincerely,

Alexander J. Shak

Alexander J. Shak
Senior Consultant

8 Research Parkway, Wallingford, CT 06492 Phone 203.626.0405 Fax 203.626.0406

July 6, 2012

Commissioner Jewel Mullen, MD, MPH, MPA
State of Connecticut
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Dr. Mullen:

As Senator of the 6th District and Chair of the Public Health Committee, I am writing to express my support for MidState Medical Center's proposal to coordinate with its Hartford Healthcare affiliate to offer inpatient behavioral health services at The Hospital of Central Connecticut (HOCC).

MidState has developed a responsible proposal, following careful and thoughtful planning, that involves terminating its inpatient psychiatric services and collaborating with HOCC, which intends to renovate and provide an expanded inpatient unit on its own campus. It is my understanding that the new HOCC program will provide ten (10) beds for MidState patients. This plan offers more appropriate, cost-effective care for patients than is possible at MidState now as well as expanded access to inpatient behavioral health services for the entire region. By assuring that MidState patients will have enhanced access at HOCC, and that transportation concerns will be addressed for those that need assistance, MidState is acting in the best interests of the community it serves. I applaud their leadership for making these difficult decisions.

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Senator Terry Gerratana

Town of Wallingford, Connecticut

PETER J. STRUBLE
FIRE CHIEF

RICHARD W. HEIDGERD
DEPUTY FIRE CHIEF

STEPHEN J. ALSUP
DEPUTY FIRE CHIEF

DEPARTMENT OF FIRE SERVICES
75 MASONIC AVENUE
WALLINGFORD, CONNECTICUT 06492-3019
TELEPHONE (203) 294-2730

July 11, 2012

Commissioner Jewel Mullen, MD, MPH, MPA
State of Connecticut
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Dr. Mullen:

As the Fire Chief of the Wallingford Fire Department, a leading provider of emergency medical services for our town, I know all too well the challenges of our health care delivery system. As the health care climate continues to change, health care providers must always work towards improving the quality of and access to the services the community needs most. The leadership at MidState Medical Center has always made this a priority for the people it serves.

MidState's proposal to close its inpatient psychiatry unit and transfer services to its system partner, The Hospital of Central Connecticut, is an example of how MidState is enhancing, protecting and increasing access to needed services in the community by aligning with the resources of the Hartford HealthCare system.

The Wallingford Fire Department supports the proposed plan. Patients in a behavioral health crisis will continue to be brought to MidState's Emergency Department for initial evaluation and treatment as they always have. The secure, private behavioral health unit in the Emergency Department, which opened in 2010, is well equipped to handle the acute needs of patients. Should patients need to be admitted as an inpatient, they will be transferred to The Hospital of Central Connecticut. There they will have access to a greater breadth and depth of services on a larger 32-bed unit.

The arrangement within MidState's proposal is truly the right thing for our patients, our community and our hospital. Should you have any questions, feel free to contact me at 203-294-2730.

Sincerely,

Peter Struble
Fire Chief
Wallingford Fire Department

GIVE. ADVOCATE. VOLUNTEER.
LIVE UNITED®

United Way

United Way
of Meriden and Wallingford

May 23, 2012

Commissioner Jewel Mullen, MD, MPH, MPA
State of Connecticut
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Dr. Mullen:

As an executive of the United Way of Meriden and Wallingford, I am writing to express sincere support for MidState Medical Center's proposal to terminate the provision of inpatient psychiatric services. Specifically, I support that MidState, after careful and thoughtful planning, determined that it can best service its patients and the community by coordinating with its Hartford HealthCare affiliate to offer inpatient behavioral health services at The Hospital of Central Connecticut.

While it may seem unusual for a local agency to support the movement of services to a place outside its community, this initiative fits our interests in promoting collaboration in order to provide the best care possible. MidState continues to be a leader in addressing community health and has worked with community-based organizations as well as other organizations within the Hartford Healthcare system to address community need.

MidState has done the responsible thing by determining that it is more cost-effective to operate a larger more specialized behavioral health unit than it is to operate a 6-8 bed unit. Providers in this state must figure out ways to focus on the services they provide best and most cost effectively. By assuring that MidState patients will have enhanced access at The Hospital of Central Connecticut and that transportation concerns will be addressed for those that need assistance, MidState is acting in the best interests of the community it serves. Let's applaud their leadership for making these difficult decisions.

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

James Ieronimo
Chief Professional Officer

35 Pleasant Street • Suite 1E • Meriden, CT 06450-5786 • tel 203.235.4403 • fax 203.235.4404
www.unitedwaymw.org

Greater Meriden Chamber

May 15, 2012

Commissioner Jewel Mullen, MD, MPH, MPA
State of Connecticut
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Dr. Mullen:

As President of the Greater Meriden Chamber of Commerce, I am writing to express my sincere support for MidState Medical Center's proposal to terminate the provision of inpatient psychiatric services. Specifically, I support that MidState, after careful and thoughtful planning, determined that it can best service its patients and the community by coordinating with its Hartford HealthCare affiliate to offer inpatient behavioral health services at The Hospital of Central Connecticut.

MidState has done the responsible thing by determining that it is more cost-effective to operate a larger more specialized behavioral health unit than it is to operate a 6-8 bed unit. Providers in this State must figure out ways to focus on the services they provides best and most cost effectively.

By assuring that MidState patients will have enhanced access at The Hospital of Central Connecticut, and that transportation concerns will be addressed for those that need assistance, MidState is acting in the best interests of the community it serves. I applaud their leadership for making these difficult decisions.

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Séan W. Moore
President

The Greater Meriden Chamber of Commerce serves its member businesses in Meriden, Wallingford, Southington, Berlin, Cheshire and Middletown, CT
Our offices are located at 3 Colony Street, Suite 301, Meriden, CT 06451
Ph: 203.235.7901 Fx: 203.686.0172
info@meridenchamber.com www.meridenchamber.com

EXHIBIT 2

Memorandum of Understanding (MOU) between MidState Medical Center, The Hospital of Central Connecticut and Rushford Center, Inc.

Memorandum of Understanding
For Access to Inpatient Psychiatric Services and Follow-up Care
For MidState Patients
By And
Between
MidState Medical Center ("MidState"),
The Hospital of Central Connecticut ("THOCC")
And
Rushford Center Inc. ("Rushford")

1. Purpose: The purpose of this Memorandum of Understanding ("MOU") is to establish the principles by which access to inpatient psychiatric services at The Hospital of Central Connecticut ("THOCC") is secured for MidState Medical Center ("MidState") patients, and to further assure that the delivery of outpatient services by Rushford Center, Inc. ("Rushford") in the community are properly coordinated so that MidState patients with behavioral health needs can remain healthy, stable and vital in the community.

2. Rationale: The parties seek to consolidate their inpatient behavioral health services on the THOCC campus while assuring MidState patients easy access from both the MidState and THOCC Emergency Departments; and delivery of cost-effective care which continues to meet community need. The parties as members of the Hartford Health Care Behavioral Health Network ("HHC BHN"), have collaborated to develop a new, expanded inpatient psychiatric unit at THOCC, on its New Britain campus. This unit provides 32-beds and replaces the hospital's previous 22-bed unit. MidState has operated six (6) beds which will be terminated, pursuant to the approval of a Certificate of Need by the State Office of Health Care Access (OHCA). MidState provides nine (9) behavioral health crisis beds in its Emergency Department and will continue to do so.

3. Access Principles and Admission Procedures: The intent of this MOU is to provide ready access to no fewer than ten (10) beds on the THOCC inpatient behavioral health unit for MidState patients. More specifically, MidState patients will receive preferential access to an inpatient bed on the THOCC unit up to ten (10) beds. Once the ten beds are full, MidState patients will have the same access to the remainder of the beds as any other patient. It is anticipated that the majority of such MidState patients will be referred to THOCC from the MidState Emergency Department. MidState will have real-time access to bed availability information on the THOCC inpatient unit. In addition, MidState clinicians will communicate directly with THOCC attending psychiatrists to review each case and make an admission determination. In the event that a bed is not immediately available and is not expected to be available within a reasonable amount of time, MidState behavioral health personnel will contact other inpatient units within the Hartford Health Care Behavioral Health Network- namely, Hartford Hospital/Institute of Living and Natchaug Hospital to gain access to another bed within the health system.

4. Family Visitation and Involvement in Treatment; Transportation Assistance: Family members are encouraged to visit the THOCC unit and participate in treatment. It is

anticipated that family members of some MidState patients will require transportation assistance to visit and participate in treatment at the THOCC inpatient unit. Assistance will be provided for family members in need who lack their own transportation and who are unable to use public transportation.

5. Discharge Planning and Procedures for Follow-up Care: Rushford will work cooperatively with MidState and THOCC to arrange for appropriate follow-up, community-based care for MidState patients. This process is expected to begin shortly post admission. With respect to those patients transferred from the MidState Emergency Department, Rushford personnel will be notified of the admission and will contact the THOCC inpatient unit to initiate joint discharge planning. For MidState patients who are admitted to THOCC, THOCC personnel will contact the designated Rushford hospital liaison staff person to initiate the discharge planning process. Rushford will provide priority access at its Meriden outpatient center for discharging THOCC inpatients, including next-day appointments. Rushford will provide regular follow-up with MidState patients discharged from the THOCC inpatient unit to ensure compliance with discharge instructions and medications.

6. Committee on Access, Quality, and Operations: THOCC will form a committee with representation from MidState and Rushford which will meet monthly, or as otherwise determined by the parties, to monitor compliance with the principles of this MOU and review access and quality data reports for MidState patients.

7. Amendments: This MOU may be amended only by the consent in writing of each party.

8. Effective Date: This MOU shall be effective the latter of MidState's closure of its psychiatric unit, the opening date of the new THOCC inpatient unit, and any regulatory approvals relating to MidState's termination of its inpatient behavioral health unit.

SIGNATURE PAGE TO FOLLOW

IN WITNESS WHEREOF, the parties hereto have executed this MOU as of the day and year written below.

MIDSTATE MEDICAL CENTER

Lucille Janatka
President and CEO

3/13/12
Date

THE HOSPITAL OF CENTRAL CONNECTICUT

Clarence Silvia
President and CEO

3/13/12
Date

RUSHFORD CENTER, INC.

Jeffrey Walter
President and CEO

9/13/12
Date

EXHIBIT 3

Copies of Curriculum Vitae for The Hospital of Central Connecticut Staff Psychiatrists

The Hospital of Central Connecticut
100 Grand St.
New Britain Connecticut 06050
(860)224-5900 x 2656
e-mail mbalkunas@thocc.org

Michael E Balkunas MD

Experience

Medical Director of Psychiatry and Behavioral Health Research
The Hospital of Central Connecticut
February 2006 - present
Supervise all aspects of clinical research. Serve as principal investigator for all studies. Liaison with research sponsors. Manage clinical research staff. Prepare annual budget. Develop collaborative interdepartmental research programs.

Chief of Psychiatry and Behavioral Health
The Hospital of Central Connecticut
December 2004 - present
Responsible for all administrative and clinical aspects of psychiatric and behavioral health services including adult inpatient unit, emergency department crisis team, consultation and liaison team, psychiatric research, and multiple outpatient programs. Formulate annual budget, improve and develop clinical programs, recruit clinical staff, liaison with all departments in the general hospital. Direct consultation-liaison service, inpatient psychiatric unit, quality improvement and peer review processes. Prepare for JCAHO surveys. Implement resident and physician assistant education programs. Serve on Hospital Operations Group, Staff Executive Committee, Committee on Performance Improvement, Pharmacy and Therapeutics Committee, Community Access to Care Committee and Pain Control Performance Improvement Committee. Member of Physician Standards Hospital Initiative. Lead Initiative on Revenue and Cost Analysis for all hospital departments.

Chief and Chairman of Psychiatry/Assistant Professor of Psychiatry
Memorial Health University Medical Center/
Mercer School of Medicine
August 2003 – November 2004
Provide leadership, organization, management and strategic direction for all psychiatric education, research and related clinical programs. Manage the Psychiatric Group of the Coastal Empire. Create new department of psychiatric billing and collections. Serve on Medical Executive and related committees. Assist in development of innovative funding strategies.

Director of Psychiatric Education
Memorial Health University Medical Center/
Mercer School of Medicine
August 2003 – November 2004
Develop and maintain all psychiatric educational programs for house staff, medical students, physician assistants and pharmacy students. Design research studies and promote academic activities. Establish psychiatric library and conference center.

Vice Chairman of Psychiatry
Memorial Health University Medical Center/
Mercer School of Medicine
July 2002 – August 2003
Assist chairman in all aspects of management of Department of Psychiatry including clinical, academic, business and regulatory programs.

Medical Director- Inpatient Psychiatry
Memorial Health University Medical Center Health/
Mercer School of Medicine
July 2002 – August 2003
Responsible for all phases of clinical care for 64 inpatient psychiatric beds including a 10 bed medical–psychiatry unit. Develop treatment protocols, policies and procedures, quality improvement and adherence to JCAHO standards. Liaison with community providers. Recruit clinical staff.

Director of Consultation Liaison Service
Memorial Health University Medical Center/
Mercer School of Medicine
November 2002 – November 2004
Supervise and provide psychiatric consultations to a 500 bed university medical center. Supervise and teach residents, medical students, physician assistants and pharmacy students. Liaison with all clinical departments.

Chairman of Clinical Committee
Savannah Area Behavioral Health Collaborative
July 2002 – November 2004
Develop all clinical programs for outpatient public mental health clinics serving citizens of Chatham County. Organize system into a comprehensive continuum of care. Assist in preparation of business plans and strategic direction. Advise on construction of new outpatient mental health center.

General Psychiatrist
Private Practice in Savannah GA
March 1999 – August 2003
Owner/ President of solo practice with 700- 800 patients ranging in age from 4 to 95. Attending duties at two area hospitals. Treatment of adolescents in residential care, adult psychiatric patients, patients with developmental disabilities and patients in medical psychiatry unit.

Psychiatric consultant to area hospitals, nursing homes and group homes. Manager of billing and collections department.

Staff Psychiatrist
Charter Savannah Behavioral Health System- Savannah GA
July 1996 – March 1999
Treatment of children, adolescents, adults and geriatric patients in both inpatient and outpatient settings. Educate staff and develop treatment protocols. Help create innovative public inpatient and outpatient treatment programs.

Medical Director
Charter Beaufort Counseling Center- Beaufort SC
July 1996 – March 1999
Responsible for all clinical matters pertaining to the operation of outpatient psychiatric center including supervision of all therapists and ancillary staff. Initiate contracts with area mental health providers and organize region wide system of continuum of care.

Education

Doctor of Medicine 1992
State University of New York- Stony Brook

Bachelor of Arts- Psychology 1982
New York University

Training

Chief Resident in Psychiatry 1995 to 1996
University Hospital, Stony Brook, NY

Resident in Psychiatry 1993 to 1996
University Hospital, Stony Brook, NY
Create psychiatric education program for School of Social Work. Maintain and improve outpatient ECT program. Recruit house staff and serve as liaison to clinical departments.

Intern in Medicine 1992 to 1993
University Hospital, Stony Brook, NY

Clinical Trials

Schizophrenia

A 24-week, Multicenter, Double-blind, Randomized, Parallel-group, Dose Ranging Study of the Efficacy and Safety of Oral Doses of AVE1625 5, 10 and 30mg and Placebo on Top of an Established Treatment Regimen of Either Olanzapine, Risperidone/Paliperidone, Quitiapine, or Arpiprazole Monotherapy in the Treatment of Cognitive Impairment on Schizophrenia. Investigator. Sponsor: Sanofi-Aventis.

A Multicenter, Randomized, Placebo-controlled, Double-blind, Parallel-group Phase IIb Proof of Concept Study with 3 Oral Dose Groups of AZD3480 during 12 Weeks Treatment of Cognitive Deficits in Patients with Schizophrenia. Investigator. Sponsor: AstraZeneca.

A Randomized, Multicenter, Double-blind, Parallel Group Study to Compare the Effects of Bifeprunox and Quetiapine on Weight Changes in Stable Schizophrenia Patients. Investigator. Sponsor: Solvay Pharmaceuticals

Predicting Response to Risperidone Treatment Through Identification of Early-onset of Antipsychotic Drug Action in Schizophrenia. Investigator. Sponsor: Eli Lilly.

A Multicenter, Double-Blind Study on the Effects of Aripiprazole on Overweight Patients Treated with Olanzapine for Schizophrenia or Schizoaffective Disorder. Investigator. Sponsor: Bristol-Myers Squibb.

A Multicenter, Open-label, Flexible-dose, Parallel group Evaluation of the Cataractogenic Potential of Quetiapine Fumarate (Seroquel) and Risperidone (Risperdal) in the Long-term Treatment of Patients with Schizophrenia or Schizoaffective Disorder. Investigator. Sponsor: AstraZeneca.

A Multicenter, Randomized, Double-blind, Fixed-dose, Efficacy and Safety Trial of Farampator (Org 24448) (250 and 500 mg b.i.d.) vs. Placebo as Augmentation Therapy in Schizophrenic Subjects Currently Receiving Risperidone. Investigator. Sponsor: Organon.

Olanzapine Versus Aripiprazole in the Treatment of Acutely Ill Patients with Schizophrenia. Investigator. Sponsor: Eli Lilly.

Efficacy of High Dose Olanzapine in a Controlled, Fixed Dose- response Trial for the Treatment of Schizophrenia and Schizoaffective Disorder. Sub-Investigator. Sponsor: Eli Lilly.

A Phase III Double-Blinded placebo controlled study of M100907 for psychosis. Sub-investigator. Sponsor: Hoechst Marion Rousse.

A Comparison of the Effects of Quetiapine and Haloperidol in Schizophrenic Patients with a History of and Demonstrated, Partial Response to Conventional Antipsychotic Treatment. Sub-investigator. Sponsor: AstraZeneca.

Bipolar

A Three-week, Double-blind, Multicenter, Placebo-controlled Study Evaluating the Efficacy and Safety of Add-on Oral Ziprasidone in Subjects with Acute Mania Treated with Lithium or Divalproex. Investigator. Sponsor: Pfizer Pharmaceuticals.

A Phase III, Randomized, Placebo-controlled, Double-blind Trial Evaluating the Safety and Efficacy of Sublingual Asenapine vs. Olanzapine and Placebo on Inpatients with Acute Manic episodes. Investigator. Sponsor: Pfizer/Organon.

A Multi-center, Randomized, Parallel-group, Double-blind, Phase III Comparison of the Efficacy and Safety of Quetiapine Fumarate (oral tablets 400 mg to 800 mg daily in divided doses) to Placebo When Used As Adjunct to Mood Stabilizers (Lithium or Divalproex) in the Maintenance of Bipolar I Disorder in Adult Patients. Sub-Investigator. Sponsor: AstraZeneca.

Generalized Anxiety Disorder

A Multicenter, Randomized, Double-blind, Parallel-group, Placebo-controlled, Active-controlled Study of the Efficacy and Safety of Sustained-release Quetiapine Fumarate (SEROQUEL) Compared with Placebo in the Treatment of Generalized Anxiety Disorder (Gold Study) Investigator. Sponsor: AstraZeneca.

An Eight-Week, Multicenter, Randomized, Double-blind, Placebo-controlled Study, with Escitalopram as an Active Control, to Evaluate the Efficacy, Safety and Tolerability of a Saredutant 100 mg Dose Once Daily, in Patients with Generalized Anxiety Disorder. Investigator. Sponsor: Sanofi-Aventis.

A Randomized, Double-blind, Placebo and Active Comparator Controlled, Parallel-group Safety and Efficacy Study of OROS® Alprazolam in Adults with Generalized Anxiety Disorder. Sub-Investigator. Sponsor: Jazz Pharmaceuticals.

A Long-Term, Open-label, Safety and Efficacy Study of OROS Alprazolam in Adults with Generalized Anxiety Disorder (GAD) Sub-Investigator. Sponsor: Jazz Pharmaceuticals.

A Multi-center, Randomized, Placebo-controlled, Double-blind Study to Assess the Safety and Tolerability of Oral Ocinaplon in Patients with GAD and to Compare Effects of Ocinaplon 30 mg and Ocinaplon 60 mg to Placebo. Sub-Investigator. Sponsor: DOV Pharmaceuticals.

Major Depressive Disorder

A Double-Blind, Randomized, Placebo-Controlled Study Examining the Safety, Efficacy and Tolerability of SEP-225289 in Subjects with Major Depressive Disorder (including Atypical and Melancholic Features). Investigator. Sponsor: Sepracor

An Eight-Week, Double-blind, Placebo-controlled study to Evaluate the Efficacy, Safety, and Tolerability of Saredutant 100 mg Once Daily in Combination with Escitalopram 10 mg Once Daily in Patients with Major Depressive Disorder. Investigator. Sponsor: Sanofi-Aventis.

Duloxetine Versus Placebo in Patients with Major Depressive Disorder (MDD): Assessment of Energy and Vitality in MDD. Investigator. Sponsor: Eli Lilly.

An Eight-week, Double-blind, placebo-controlled, Multicenter Study with Escitalopram (10 mg qd) as Positive Control, Evaluating the Efficacy, Safety, and Tolerability of a Fixed Dose of SR58611A (350 mg q12) in Outpatients with Major Depressive Disorder (MDD). Investigator. Sponsor: Eli Lilly.

Social Anxiety Disorder

A Randomized, Double-blind Comparison of LY686017, Paroxetine, and Placebo in the Treatment of Social Anxiety Disorder. Investigator. Sponsor: Eli Lilly.

Insomnia

A Parallel III, Randomized, Double-blind, Placebo-controlled, Parallel-group, Multicenter, Outpatient Study to Assess the Efficacy and Safety of Doxepin HCl in Elderly Patients with Primary Sleep Maintenance. Investigator. Sponsor: Somaxon Pharmaceuticals.

Migraine

Study TRX109013, A Randomized, Double-blind, Double-dummy, Placebo-controlled, Crossover Study to Evaluate the Efficacy of TREXIMA (Sumatriptan + Naproxen Sodium) versus Butalbital-containing Combination Medications (BCM) for the Acute Treatment of Migraine When Administered During the Moderate-Severe Phase of the Migraine

Presentations

March 2008 *Delirium and Dementia in the medically ill*
Internal Medicine Resident Lecture, The Hospital of Central CT

Jan 2008 *Depression and Anxiety in the medically ill*
Internal Medicine Resident Lecture, The Hospital of Central CT

June 2007 *Neuroleptic Malignant Syndrome in a patient with Lewy Body Dementia*
Medical Grand Rounds, The Hospital of Central CT

April 2007 *Substance Abuse Disorders*
Internal Medicine Resident Lecture, The Hospital of Central CT

Nov 2006 *Top 10 in Psychiatry*
Internal Medicine Resident Lecture, The Hospital of Central CT

Sept 2006 *Treatment of Bipolar Depression*
Department of Psychiatry & Behavioral Health, The Hospital of Central CT

May 2006 *Clinical & Practical Tips in Psychiatry*
Internal Medicine Resident Lecture, The Hospital of Central CT

Oct 2005 *Psychiatry 2005*
Internal Medicine Resident Lecture, The Hospital of Central CT

March 2005 *Evidence Based Treatment of Depression*
Medical Grand Rounds, The Hospital of Central CT

July 2003-July 2004 *Psychiatry Clerkship Lecture Series*
Schizophrenia and other Psychotic Disorders
Mood Disorders
Anxiety Disorders
Substance Abuse Disorders
The Dementias
Personality Disorders
Biological Therapies in Psychiatry
Memorial Health University Medical Center
Mercer School of Medicine, Savannah, Georgia

June 2002 *Late life Depression*
Jewish Education Alliance, Savannah, Georgia

Feb 2002 *Remission as a goal in the treatment of Major Depressive Disorder*
Lecture to Primary Care Providers, Savannah, Georgia

April 2001 *Treatment of Depression and Anxiety in the Primary Care Patient*
Lecture to Primary Care Providers, Savannah, Georgia

July 1996-March 1999 *Clinical Staff Education Series*
Biological Therapies in Psychiatry
Schizophrenia
Transference and Counter Transference
Bipolar Disorder
Charter Savannah Behavioral Health System, Savannah, Georgia

Licenses

Connecticut

Honors

Outstanding Resident of the Year 1996

Special Interests

Integrated Healthcare Systems
Neuropsychiatry
Care of the chronically ill

Certifications

Diplomat of The American Board of Psychiatry and Neurology General Adult Psychiatry May 1999

Diplomat of The American Board of Psychiatry and Neurology Psychosomatic Medicine April 2008

Professional Memberships

American Psychiatric Association

American Society of Clinical Psychopharmacology

Connecticut State Medical Society

American Society of Addiction Medicine

American College of Physician Executives

CHRISTOPHER L. YERGEN, M.D.

22 Franklin Ave. Unit A ~ Hartford, CT 06114
508-887-1093 ~ cyergen01@gmail.com

EDUCATION and LICENSURE

HARTFORD HOSPITAL, Hartford, CT
Psychosomatic Medicine Fellowship *October 2010 – September 2011*

HARTFORD HOSPITAL/INSTITUTE OF LIVING ,Hartford, CT
Adult Psychiatry Residency *July 2006 – September 2010*

SABA UNIVERSITY SCHOOL OF MEDICINE, Saba, Netherlands Antilles *May 2002 – June 2006*
Doctor of Medicine, June 2006

- All clinical rotations were completed at ACGME accredited US hospitals

SABA UNIVERSITY SCHOOL OF MEDICINE, Saba, Netherlands Antilles *May 2002 – June 2006*
Bachelor of Health Sciences, December 2003

CARROLL COLLEGE, Helena, MT, USA *August 1999 – May 2001*
Study in the field of Biology, with a minor in Psychology and Chemistry

SPOKANE COMMUNITY COLLEGE, Spokane, WA, USA *August 1997 – May 1998*
Dual Enrollment Program while a sophomore in high school

STATE OF CONNECTICUT LICENSE, CT, USA
Granted Licensure as Physician/Surgeon in September, 2008 – License Number 046951

PROFESSIONAL CLINICAL EXPERIENCE

HARTFORD HOSPITAL, Hartford, CT
Psychosomatic Medicine Fellowship *October 2010 – September 2011*

- Fellowship consisted of training in a broad array of medical settings including inpatient medicine (with exposure to transplant, OB-GYN, surgical, intensive care, general medical, neurology, neurosurgery as well as palliative and oncology patients). Training consisted of a combination of clinical and didactic activities with a significant emphasis on teaching residents, medical and physician assistant students the skill and importance of integrating medical and psychiatric knowledge.

HARTFORD HOSPITAL/ INSTITUTE OF LIVING ADULT RESIDENCY PROGRAM, Hartford, CT
Adult Psychiatry Resident *July 2006 - September 2010*

- Residency consisted of training in a broad array of psychiatric settings including inpatient, outpatient, emergency room, psychosomatic medicine at Hartford Hospital and various day treatment settings and groups. Other areas that were studied included general medicine, and neurology to round out the educational experience. Psychiatric education not only focused on psychopharmacology training, but also was equally focused on psychodynamic therapeutic training.

SUPERVISOR OF 3rd YEAR RESIDENT'S CLINIC
IOL/HH Adult Psychiatry Residency *May 2010 – September 2010*

- Following the departure of the psychiatrist supervising all PGY III residents in their outpatient clinic work I was selected as the interim replacement for both supervision and case-based education for PGY III residents. I oversaw new patient evaluations, follow-up patient visits as well as medication clinics for all six residents in their 3rd year of training, as well as medical students from UCONN completing their outpatient psychiatry rotation.

EMPLOYMENT HISTORY

HARTFORD HOSPITAL / INSTITUTE OF LIVING, Hartford, CT — *September, 2008 – October 2011*
Attending Physician/Moonlighter

- Working numerous over-night shifts in Hartford Hospital's 15 bed psychiatric emergency department as the overseeing physician; involved in evaluation/assessment and triage to appropriate level-of-care.
- Frequently moonlighting (average 1 overnight shift per week) as the in house licensed physician at The Institute of Living's inpatient psychiatric hospital; a 111 bed psychiatric facility which serves Central Connecticut.

GREENACRES CHIROPRACTIC, Spokane Valley, WA — *June 2001 – September 2001*
Assistant Office Manager

- Cross-trained in three separate positions including office reception, medical billing and scheduling to facilitate daily functions of group chiropractic practice.
- Coordinated daily schedules of multiple practitioners and office staff to ensure efficient delivery of treatment by providers.

CARROLL COLLEGE, Helena, MT — *August 2000 – May 2001*
Inorganic Chemistry Laboratory Aide

- Utilized knowledge gained during studies of chemistry minor to assist in set-up and performance of laboratory experiments by first-year chemistry students.
- Assisted Professor of Chemistry in designing experiments to be utilized as an adjunct to didactic teaching.
- Functioned as a chemistry tutor for students requiring additional assistance during laboratory sessions.

Y-Curbing, Spokane, WA — *May 2000 – August 2000*
Landscape Construction and Design Associate

- Worked in direct connection with the company's owner and clients to facilitate ornamental landscape design and installation.

HONORS

CHIEF RESIDENT, Hartford, CT — *June 2009 – May 2010*
Hartford Hospital/Institute of Living Psychiatry Residency Program

GRADUATION COMMITTEE MEMBER, Hartford, CT — *2007, 2009*
Hartford Hospital/Institute of Living Psychiatry Residency Program

DEAN'S LIST, Saba, Netherlands Antilles — *May 2002 – April 2003*
Saba University School of Medicine

PROFESSIONAL AFFILIATIONS

American Psychiatric Association Member since 2006
American Medical Association Member since 2008

CONFERENCES

ANNUAL TARRYTOWN LEADERSHIP CONFERENCE, Norwalk, CT — *May 28, 2009 – May 31, 2009*

EDUCATIONAL ACTIVITIES

Academic Presentation, End-of-Fellowship September 2011

- *What is the Problem with Dying?*
- Presented to attending physicians, staff, residents and students of the Hartford Hospital Psychosomatic Medicine Department at the end of fellowship training. Focused on several end-of-life clinical cases from fellowship year as well as education on advancements in the management of death and dying for patients, families and providers.

Facilitator of Psychiatric Case Conference for Internal Medicine Residents October 2010 - September 2011

- Worked in collaboration with select Internal Medicine Residents to present a Psychosomatic case to University of Connecticut Residents rotating through Hartford Hospital for their monthly Psychiatry Case Conference. Topics covered included: decisional capacity, management of alcohol withdrawal, assault/violence in the medical setting, treating difficult patients, suicide risk assessment and management.

Grand Rounds Presentation June 2010

- *Treatment-Resistant Obsessive Compulsive Disorder: Current Research and Treatment Considerations*
- Presented as Grand Rounds for the first week of June, 2010 to attending physicians, residents, psychologists and social workers at the Institute of Living as well as mental health providers from the greater Hartford, CT area.

Psychiatric Evaluation of Asylum Seeking Resident of CT January - March 2010

- In conjunction with attending psychiatrist and language interpreter performed several hour-long evaluations of a gentleman seeking political asylum in the United States from his home government in India. Performed thorough psychiatric evaluation, including developmental history and cultural assimilation into the United States; compiled into psychiatric evaluation for use in United States Department of Justice Executive Office for Immigration Review, Immigration Court, Philadelphia, Pennsylvania.

Grand Rounds Presentation May 2009

- *Case Conference Presentation*
- In conjunction with fellow members of my PGY-III class I presented to all staff, residents and trainees of the Institute of Living a case presentation with educational topic focused on memory disorders, specifically "Transient Global Amnesia."

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POSTGRADUATE TRAINING

Fellowship	**Yale University School of Medicine, New Haven, CT** VA Connecticut Healthcare System Addiction Psychiatry, 2009-2010
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Residency	**Harlem Hospital Center, Columbia University, New York** Department of Psychiatry, 2006-2008
Internship	**Harlem Hospital Center, Columbia University, New York** Departments of Psychiatry, Medicine and Neurology, 2005-2006
Internship	**Municipal Hospital, University of Medicine, Constanta, Romania** Departments of Internal Medicine, Pediatrics and Surgery, 1995-1997

ACADEMIC TRAINING

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PROFESSIONAL EXPERIENCE

Psychiatrist	Mount Vernon Hospital, Sound Shore Medical System, New York, NY Moonlighting/Per Diem Psychiatrist, 2009-present

Physician, observership and volunteer, 2002 - 2004

- Our Neighborhood Medical Clinic, Sunnyside, NY
- Beacon Hill Medical Center, Dobbs Ferry, NY
- Medical Office, Dr. M. F. Sami, Whitestone, NY

Primary Care Physician, Constanta County Hospital, Romania, 1997 - 1999

PROFESSIONAL ORGANIZATIONS and SOCIETIES

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LICENSURE

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PROFESSIONAL AWARDS and HONORS

Chief Resident Harlem Hospital Center, Columbia University, New York
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Permanent Delegate Committee of Interns and Residents, New York, 2007-2008

Resident of the Year Harlem Hospital Center, Columbia University
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Merituous Scholarship, Student of the Year, 1992 - 1994
University of Medicine "Carol Davila", Bucharest, Romania

RESEARCH

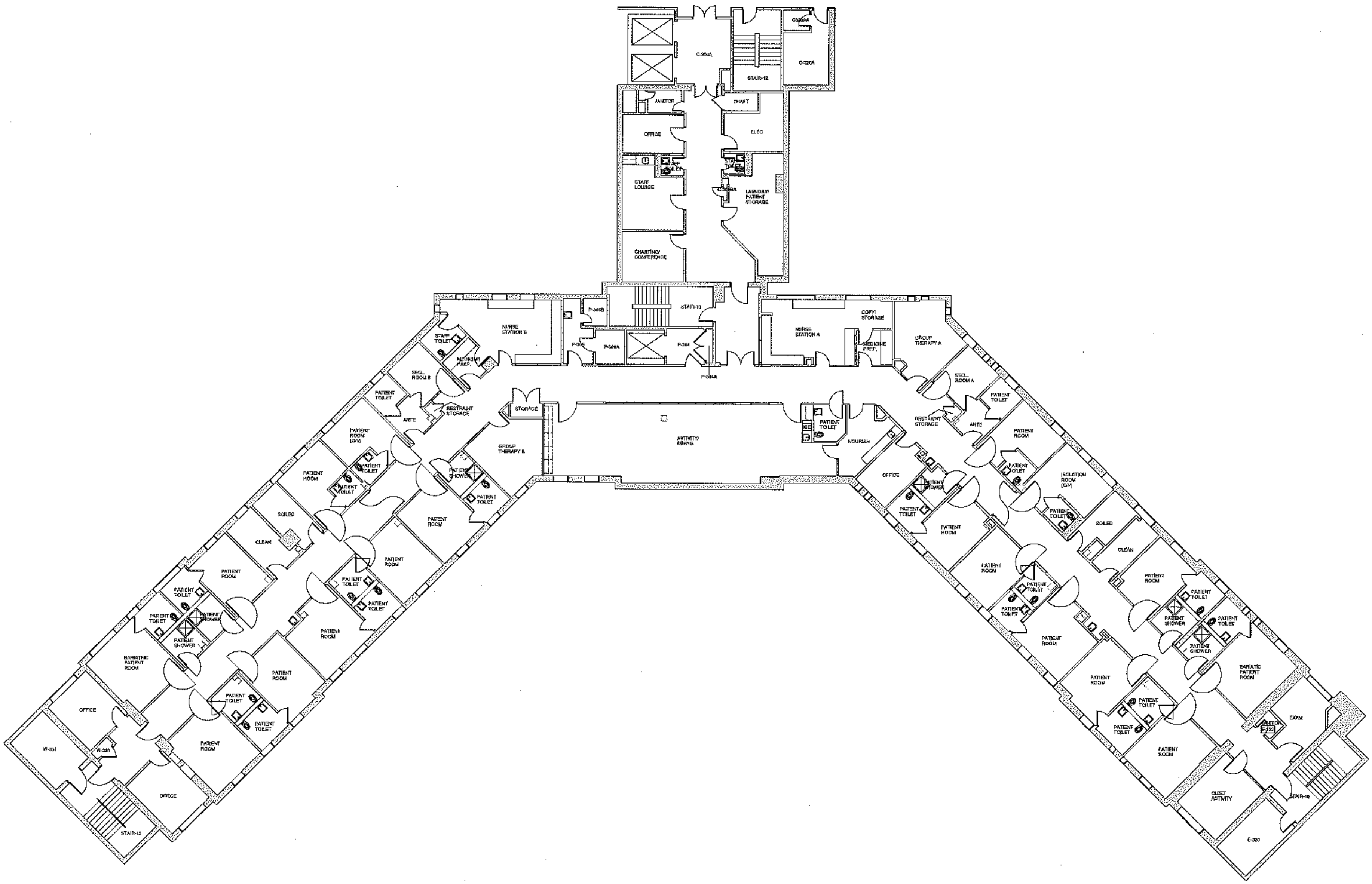
Morphological and Clinical Aspects of Gastric Cancer, Graduation Thesis, 1995
University of Medicine Carol Davila, Bucharest, Romania

Studies on the Clinical Manifestations and Treatment Responses in Infectious Hepatitis,
University of Constanta, Romania, 1996-1997

Infectious Hepatitis – Particular Clinical Manifestations, Presentation, 1997
Annual Scientific Meeting of University of Constanta, Romania

EXHIBIT 4

Schematic Drawing of New Inpatient Behavioral Health Unit at The Hospital of Central Connecticut



ARCHITECTS
STEFFIAN BRADLEY

sba

Notes

Seal

THE HOSPITAL OF CENTRAL CT
PSYCH UNIT E3 / W3

Project Number	Scale
2224.000	
Date	Issue

Title
BUILDING PLAN

A-002

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EXHIBIT 5

Supporting Articles from Medical Journals

Environmental and Therapeutic Issues in Psychiatric Hospital Design: Toward Best Practices

Bradley E. Karlin, Ph.D.
Robert A. Zeiss, Ph.D.

The psychiatric hospital environment plays a significant, though often underappreciated, role in patient and staff functioning. This column reviews the literature on important environmental and therapeutic issues in psychiatric hospital design. Research findings and clinical conjecture reported over the past 50 years indicate that intervening environmentally through clinically informed, patient-centered design can improve functioning both among and between patients and staff. This column identifies specific best practice considerations and recommendations for designing inpatient psychiatric facilities and may serve as a useful planning resource to those interested in adopting a patient-centered, inclusive approach to design and treatment. (*Psychiatric Services* 57:1376–1378, 2006)

Over the past 50 years there has been growing recognition and discussion of the impact of the psychiatric hospital environment on psychiatric patients, stimulated by the early work of Sommer and Ross (1). Empirical research on the effects of environmental factors in inpatient psychiatric settings is still in its infancy; there have been few studies using sophisticated experimental approaches or well-controlled designs. Nevertheless, numerous anecdotal reports and clinical conjecture, as well as a gradually increasing body of empirical data, address the significant therapeutic value of ward environment on psychiatric inpatients. [A bibliography is available in an online supplement to this column at ps.psychiatryonline.org.]

In this column we identify best practices in psychiatric hospital design, synthesizing important findings and themes reported in the extant literature and drawing on our firsthand experience in a consensus exercise to design a new inpatient psychiatry building with four 20-bed units at the Veterans Affairs (VA) Palo Alto Health Care System that will be completed by January 2009. We were active members of the design team and provided extensive clinical input to the design process. The design team followed an interdisciplinary team model and included internal representatives from various departments as well as architects contracted to lead the design process. This review was adopted as a major guiding document by the architectural firm and design team and has subsequently been incorporated into design efforts at other VA facilities. [Design plans for the new hospital are available in an online supplement to this column at ps.psychiatryonline.org.]

The review was conducted by surveying relevant research in MEDLINE, PsycINFO, and the associated literature, including Internet-based sources. Included were articles, reports, and empirical studies identifying salient environmental and therapeutic issues in psychiatric hospital design and patient care, as well as relevant research in related health care settings. The review identified important environmental issues, considerations, and recommendations across multiple domains that have potential for enhancing patient care and staff functioning. Findings are classified into the following five categories, consistent with those described by Harris and colleagues (2) for general hospital settings: ambient features, architectural features, interior design features, social features, and specific issues. The final category addresses issues highlighted in the extant literature that had particular significance in the design process at the VA Palo Alto.

Domains

Ambient features

Ambient features include attention to lighting, air quality, and noise. For lighting, soft, indirect, and pervasive or full-spectrum lighting are generally recommended. Spotlight-type recessed lighting should be used sparingly and carefully placed, so as not to focus directly on individuals. Ample natural daylight has been recommended by many authors and is highly valued by patients. Sunlight in patient rooms can promote recovery of psychiatric patients with severe depression. Also, good air quality—with fresh air, good ventilation, and neutral odors—is recommended, as it can facilitate recovery. In addition, highly reverberant spaces should be avoided.

Architectural features

Architectural features are the relatively permanent aspects of the hospital environment, which include the

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physical plan, layout, size, and shape of the units. Single or nondormitory-style patient rooms enhance privacy and autonomy and, in some cases, may promote participation in treatment activities. Private visiting areas increase privacy and intimacy.

Numerous authors have identified multiple windows with views of nature as a valuable design feature. Views of nature can reduce psychological distress and recovery time and enhance staff functioning and job satisfaction. Large, low windows may improve sensory abilities and reduce delirium and paranoia. Laminated safety glass in group rooms can open up the interior and provide a visual connection to the outside. Outdoor gardens and other elements of nature can serve as "positive distractions." Exposure to nature reduces stress and fatigue and may facilitate recovery. Furthermore, access to nature has been identified by consumers as a priority design factor in general health care environments.

Long, echoic corridors are discouraged by environmental psychologists because of perceptual distortions experienced by some psychiatric patients. Incorporating spatial flexibility into the design process (for example, installing flexible dividers for larger areas) allows for maximal use of available space. The proximity of seclusion rooms to nursing stations should be carefully considered. Close proximity may promote safety but may raise concerns over disruption, whereas greater distance may reduce environmental disruption but decrease staff responsiveness and available staffing resources. In the VA Palo Alto design process, a balance was achieved by locating seclusion rooms near and within sight of nursing stations but outside of main patient corridors and activity areas.

The presence of a staff lounge, garden, or similar congregate space can improve morale and job satisfaction and encourage professional communication. Space for incorporating new technology as it develops should be included in the architectural design. Unit design should encourage family participation and group activities by, for example, having sufficient group meeting space.

Interior design features

Interior design features are the less permanent aspects of the hospital environment. Planning for interior design should take into account the unit's symbolic meaning or the set of messages that the environment sends to its users. For example, having a clearly identifiable reception area and a method of greeting patients and visitors reflects customer service values and patient centeredness. Especially important in this regard is that interior design reinforces treatment goals and positive expectations of patients and staff. Davis and colleagues (3) describe the "physical ethos of the ward" as a "latent message" of expectations for improvement. An empirical investigation examining the effects of remodeling of two psychiatric wards found that remodeling improved patient satisfaction, self-image, and behavior, as well as staff mood and punctuality (4).

Furnishings. One of the most consistent recommendations in the body of literature on psychiatric hospital design is the importance of reducing the institutional feel of the facility and incorporating a homelike environment whenever possible. This type of atmosphere has been associated with enhanced emotional and intellectual well-being and improved patient behavior. Medical staff have also been noted to prefer noninstitutional environments.

Familiarity. Patient rooms should have a familiar tone. Research reveals that people prefer familiar rooms over decorative or stylish rooms. Upholstered furniture should be included whenever feasible. Although furniture can be used as a weapon and should not be easy to lift or throw, it should not be too heavy to allow for easy movement. Flexible design for interchanging pieces and resistance to damage are also important. Artwork (soothing, not exciting) is recommended. Images of nature can reduce anxiety. Some authors have suggested installing carpeting to enhance comfort and appearance, although this must be balanced against the likelihood of soiling. Above all, the decision to install carpeting should be made in consultation with nursing and housekeeping staff.

Color. Several authors have suggested incorporating color in the interior design. Studies of wall color choice have yielded inconsistent results. However, there are some fairly consistent general recommendations. First, monochromatic, bland color schemes and fashionable or trendy palettes or pastels should be avoided. Brighter colors may be preferred for patients with depression and some older adults, but they could be overstimulating for highly agitated patients. Second, warm blue tones often have a soothing or sedating effect, presumably because of their shorter wavelengths, and they may be particularly suitable for the calmest areas. Using closely related colors of the same value and intensity also has been reported to have a calming effect. Third, blue-green colors can have a negative effect on mood for patients with depression and less energy. And finally, seclusion room walls should be a "calm, but definitive color, not white or gray" (5).

Other interior design considerations. Unit design must accommodate the competing goals of stimulating patients who are withdrawn and depressed without overstimulating patients who are manic and agitated, while simultaneously fostering a sense of optimism about hospitalization.

Different functional areas may be differentiated through color, lighting, carpeting, wall graphics, and furnishings.

Inclusion of natural plants has been recommended by several authors and has been found to be preferred by staff. Devlin (6) found that the addition of plants was the feature rated most positively overall in his investigation of the redesign of multiple psychiatric units.

To promote safety, shatterproof windows, breakaway curtain rods, tamperproof electrical outlets, stainless-steel mirrors, and lockable water taps are recommended. Avoiding the construction of blind corners is also recommended. Furthermore, natural wood veneer has been used to soften the look of doors, hallway rails, and nursing stations. Finally, several authors recommend against having highly polished floors or other reflecting surfaces because of glare.

Social features

Patients should have the ability to control their level of social contact.

Designing spaces where patients can retreat, including spaces where they can form social relationships, is recommended. Areas prone to overcrowding should be avoided. Privacy may increase environmental satisfaction and place attachment. Day rooms should be open and flexible and encourage interaction with staff, while also allowing for personal autonomy. There is some evidence that small-group circular arrangement of furniture may promote socialization.

Specific issues

Open versus closed nursing stations. Open nursing stations have been recommended by several sources. Edwards and Hults (7) found significant positive psychological, behavioral, and social effects after the removal of glass partitions from psychiatric unit nursing stations at a VA hospital. Patient requests of nurses at nursing stations were dramatically reduced, as were negative beliefs of patients. Improvements in ward milieu and patient-staff communication were also noted. Closed nursing stations, which were more typical before the development of psychoactive drugs, often convey an image of staff inaccessibility and are not welcoming to patients and visitors.

Available reports of experiences with open nursing stations do not support concerns of patient abuse of increased access to nurses, although additional empirical research on this issue is needed. Contiguous, secure space, closed to patients, is recommended to maintain confidentiality of patient records.

Special considerations with older patients. There are unique issues and recommendations for designing facilities for older psychiatric patients, which were incorporated into the design of a geropsychiatric unit at the VA Palo Alto. Because of the decline in selective attention in late life and reduced stimulation among many older patients, it is especially important that moderate environmental stimulation be provided to older adults in careful balance. Glare and noise are particularly aggravating environmental factors, especially for those with sensory or cognitive impairment. Moreover, high levels of illumination are needed for older patients, particularly those with dementia. Low levels of light not only decrease visibility but can also promote agitation. In a study examining the effects of intra-institutional relocation on older long-term care residents, residents identified brighter lights as positive changes (8).

Pictures of familiar images and eras and a familiar dining experience can stimulate memory and enhance meaning and adjustment among older patients. Opportunities for exercise or other physical activity may also enhance personal well-being and provide energy outlets to reduce negative behaviors associated with dementia.

Furthermore, shorter corridors are easier for older patients to navigate and limit reverberation. Sufficient visual cues can promote orientation and reduce wandering. Suicide-proof (enclosed bottom) handrails and grab bars throughout the facility are particularly needed with older patients to promote balance and mobility. In addition, chairs (and commodes) should have sufficient height and arm length as well as adequate back support in order to facilitate balance when rising. It is also important that bathrooms be large enough to accommodate wheelchairs and care attendants. Finally, increasing the visibility of toilets may reduce incontinence among older patients with cognitive impairment.

Conclusions

Research findings and clinical conjecture reported over the past 50 years have indicated that the psychiatric hospital environment can play a significant, if often underrecognized, role in patient and staff functioning. High-quality care and positive clinical outcomes in inpatient psychiatric treatment necessitate a broad conceptualization of forces that lead to therapeutic changes that include attention to environmental design. Clinically informed, patient-centered design features can positively affect social, cognitive, motivational, emotional, and physical processes among patients and staff (9,10).

Our review of the research literature and experience with the design process strongly suggest an approach to design that is inclusive, dynamic, and interdisciplinary. Consultation and ongoing dialogue with internal staff, patients, and external professionals, throughout the design process (including postoccupancy, if possible) is recommended. In addition to providing a broader perspective and greater identification of salient design and patient care issues, such an approach yields important process outcomes. When given the opportunity to provide genuine input in the planning process and to feel like their opinions matter, staff members are more likely to accept realistic compromises and adapt to the final design of the facility (3,11,12).

References

1. Sommer R, Ross H: Social interaction on a geriatrics ward. International Journal of Social Psychiatry 4:128–133, 1958
2. Harris PB, McBride G, Ross C, et al: A place to heal: environmental sources of satisfaction among hospital patients. Journal of Applied Social Psychology 32:1276–1299, 2002
3. Davis C, Glick ID, Rosow I: The architectural design of a psychotherapeutic milieu. Hospital and Community Psychiatry 30: 453–460, 1979
4. Christenfeld R, Wagner J, Pastva G, et al: How physical settings affect chronic mental patients. Psychiatric Quarterly 60:253–264, 1989
5. Gutheil TG, Daly M: Clinical considerations in seclusion room design. Hospital and Community Psychiatry 31:268–270, 1980
6. Devlin AS: Psychiatric ward renovation: staff perception and patient behavior. Environment and Behavior 24:66–84, 1992
7. Edwards J, Hults MS: "Open" nursing stations on psychiatric wards. Perspectives in Psychiatric Care 8:209–217, 1970
8. Moye J, Domingos K, Pittman R, et al: When environmental re-design creates autonomy hindrance: learning from the investigation of local detail in the study of institutional relocation. Clinical Gerontologist 18:15–31, 1997
9. Tyson GA, Lambert G, Beattie L: The impact of ward design on the behaviour, occupational satisfaction and well-being of psychiatric nurses. International Journal of Mental Health Nursing 11:94–102, 2002
10. Whitehead C, Polsky R, Crookshank C, et al: Objective and subjective evaluation of psychiatric ward redesign. American Journal of Psychiatry 141:639–644, 1984
11. Cotton NS, Geraty RG: Therapeutic space design: planning an inpatient children's unit. American Journal of Orthopsychiatry 54:624–636, 1984
12. O'Driscoll MP, Evans R: Organizational factors and perceptions of climate in three psychiatric units. Human Relations 41:371–388, 1988

Article

Cognitive Therapy Versus Medication in Augmentation and Switch Strategies as Second-Step Treatments: A STAR*D Report

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Objective: The authors compared the effectiveness of cognitive therapy and pharmacotherapy as second-step strategies for outpatients with major depressive disorder who had received inadequate benefit from an initial trial of citalopram. Cognitive therapy was compared with medication augmentation and switch strategies.

Method: An equipoise-stratified randomization strategy was used to assign participants to either augmentation of citalopram with cognitive therapy (N=65) or medication (N=117; either sustained-release bupropion [N=56] or buspirone [N=61]) or switch to cognitive therapy (N=36) or another antidepressant (N=86; sertraline [N=27], sustained-release bupropion [N=28], or extended-release venlafaxine [N=31]). Treatment outcomes and the frequency of adverse events were compared.

Results: Less than one-third of participants consented to randomization strata that permitted comparison of cognitive therapy and pharmacotherapy. Among participants who were assigned to second-step treatment, those who received cognitive therapy (either alone or in combination with citalopram) had similar response and remission rates to those assigned to medication strategies. For those who continued on citalopram, medication augmentation resulted in significantly more rapid remission than augmentation with cognitive therapy. Among those who discontinued citalopram, there were no significant differences in outcome, although those who switched to a different antidepressant reported significantly more side effects than those who received cognitive therapy alone.

Conclusions: After an unsatisfactory response to citalopram, patients who consented to random assignment to either cognitive therapy or alternative pharmacologic strategies had generally comparable outcomes. Pharmacologic augmentation was more rapidly effective than cognitive therapy augmentation of citalopram, whereas switching to cognitive therapy was better tolerated than switching to a different antidepressant.

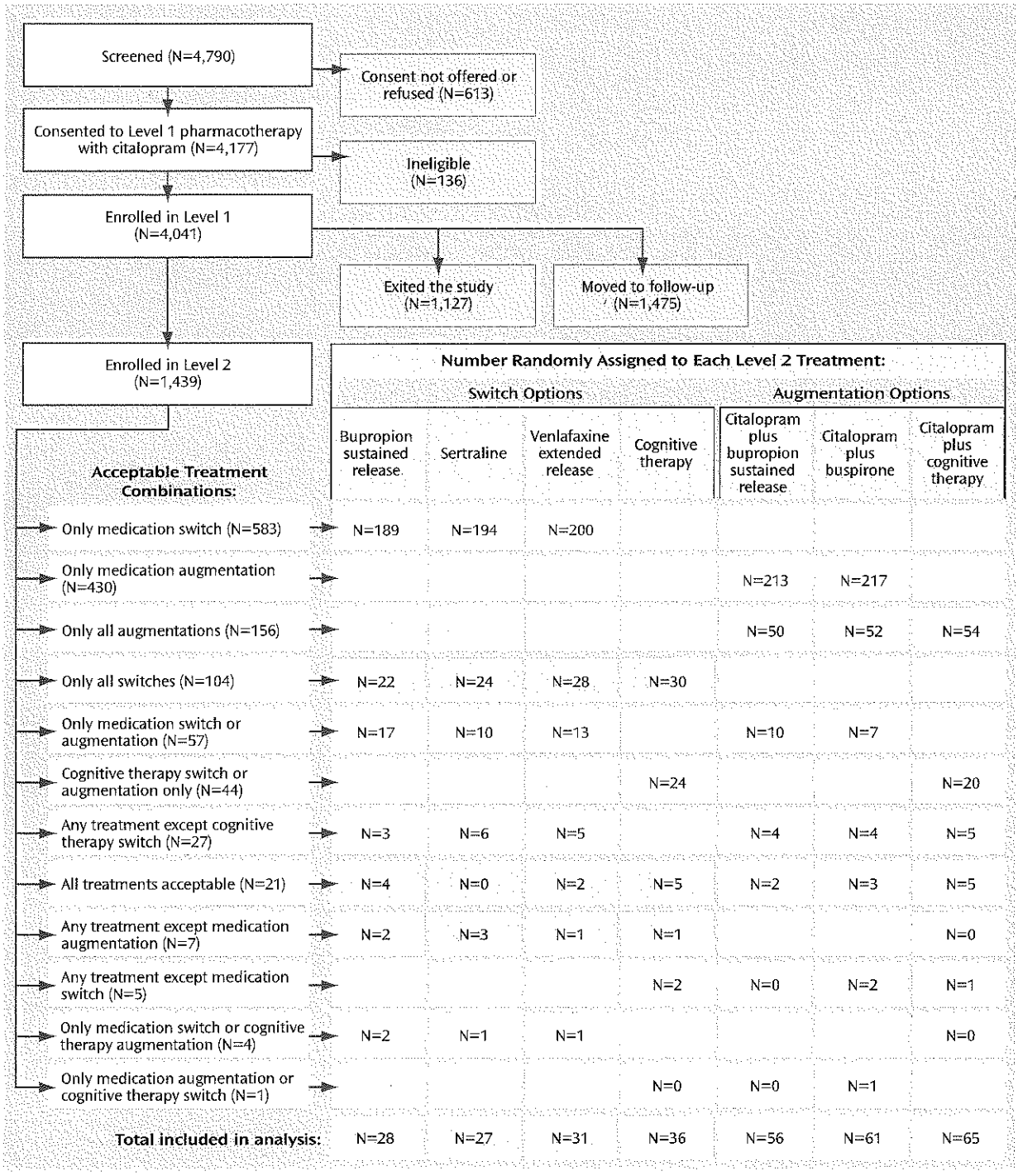
(Am J Psychiatry 2007; 164:739–752)

In controlled studies of acute therapy, less than 50% of patients with major depressive disorder remit during the initial course of antidepressant medication (1–3). For those who do not obtain adequate benefit from an initial course of pharmacotherapy, a wide variety of next-step strategies are available, including switching within and between classes of antidepressants, various augmentation and antidepressant combination strategies, and adding or switching to psychotherapy. Although the efficacy of most of these strategies has been established in randomized controlled trials, few comparative studies are available to help determine which of these options should be considered the preferred next step for patients who do not benefit adequately from an initial course of pharmacotherapy (4–6).

The Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial is a multicenter, multistage research project funded by the National Institute of Mental Health with the specific purpose of evaluating second-, third-, and fourth-step treatment options for patients with treatment-resistant depression (7, 8). In the first treatment step (up to 14 weeks with citalopram alone), approximately one-third of 2,876 participants remitted (9). In a previous report on second-step treatments (10), we compared switching from citalopram to alternative second-step antidepressants. There were no significant differences in outcome, with intent-to-treat remission rates ranging from 18% with sertraline (a selective serotonin reuptake inhibitor) to 21% with sustained-release bupropion (a norepinephrine-dopamine reuptake inhibitor) to 25% with extended-release venlafaxine (a serotonin-norepinephrine reuptake inhibitor). A second report compared sustained-release bupropion and buspirone as augmentation agents and found few differences in effec-

This article is featured in this month's AJP Audio and is discussed in an editorial by Dr. Weissman on p. 693.

FIGURE 1. Participant Flow for the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study, With Participants' Acceptance of Level 2 Treatment Options and Total Number of Participants in Each Treatment Option in an Analysis Comparing Cognitive Therapy and Pharmacotherapy[a]



[a] Shading indicates augmentation or switch strata in which comparison of cognitive therapy and pharmacotherapy was possible; participants who were willing to be randomly assigned to these strata were included in the analysis.

TABLE 1. Baseline Demographic and Clinical Characteristics of STAR*D Level 2 Participants Who Received Augmentation Treatments[a]

Characteristic	Total (N=182)		Augmentation Option: Cognitive Therapy (N=65)		Augmentation Option: Medication (N=117)		p
	N	%	N	%	N	%	
Female	119	65.4	41	63.1	78	66.7	0.6257
Race							0.5701
White	151	83.0	52	80.0	99	84.6	
Black	24	13.2	11	16.9	13	11.1	
Other	7	3.8	2	3.1	5	4.3	
Hispanic ethnicity	23	12.6	8	12.3	15	12.8	0.9205
Employment status							0.2244
Employed	95	52.2	35	53.8	60	51.3	
Unemployed	81	44.5	26	40.0	55	47.0	
Retired	6	3.3	4	6.2	2	1.7	
Health insurance							0.5202
Private	98	56.3	33	52.4	65	58.6	
Public	12	6.9	6	9.5	6	5.4	
None	64	36.8	24	38.1	40	36.0	
Marital status							0.9033
Single	47	25.8	16	24.6	31	26.5	
Married or cohabiting	84	46.2	30	46.2	54	46.2	
Divorced or separated	45	24.7	16	24.6	29	24.8	
Widowed	6	3.3	3	4.6	3	2.6	
Recurrent depression	144	85.2	50	86.2	94	84.7	0.7913
Psychiatric care setting	129	70.9	43	66.2	86	73.5	0.2956
Duration of index episode ≥2 years	45	24.7	19	29.2	26	22.2	0.2937
	Mean	SD	Mean	SD	Mean	SD	
Age	40.0	12.8	40.6	11.5	39.7	13.5	0.5588
Education (years)	14.1	3.1	14.1	3.4	14.1	2.9	0.9929
Monthly household income ($)	2,623	2,928	2,319	2,105	2,796	3,304	0.5208
Duration of illness (years)	16.7	12.5	16.3	12.2	17.0	12.7	0.7501
Number of episodes	5.6	9.4	7.3	14.1	4.6	5.4	0.7398
Duration of index episode (months)	23.4	48.2	29.6	49.4	20.0	47.5	0.6166
Quality of Life and Enjoyment Satisfaction Questionnaire score			41.8	13.5	47.7	14.9	0.0202
Hamilton Rating Scale for Depression score			17.8	5.7	16.0	6.7	0.0962
Quick Inventory of Depressive Symptomatology—Self Rating (16-item) Score			11.9	4.3	12.0	4.6	0.9495
Change in score during Level 1 (%)			−6.2	39.6	−5.3	33.8	0.8606

[a] Sums do not always equal N because of missing values. Percentages are based on available data.

tiveness, with both treatments resulting in intent-to-treat remission rates of 30% (11).

We now report on the utility of cognitive therapy following nonremission with, or intolerance to, citalopram as compared with pharmacologic augmentation and switch strategies. Cognitive therapy is the best-studied form of psychotherapy for acute therapy of major depressive disorder (1, 12) and has been proposed to be a useful alternative for patients who have not responded to antidepressant medications (13–15). A number of case series and small randomized trials suggest that cognitive therapy may indeed have a role in the management of treatment-resistant depression (16). The largest study to date (17) found that a form of cognitive behavior therapy was at least as effective when used as a second-step treatment after nonresponse to nefazodone as nefazodone was after nonresponse to the psychotherapy. However, no large-scale randomized studies have evaluated the utility of second-step psychotherapy as compared with medication interventions.

Method

The rationale and design of STAR*D and the specific elements of the cognitive therapy protocol have been detailed elsewhere (7–11, 18). A summary of the study design is presented below.

Participants

From July 2001 through April 2004, STAR*D enrolled 4,041 outpatients 18 to 75 years of age with a diagnosis of nonpsychotic major depressive disorder from 18 primary care and 23 psychiatric care practice settings across the United States. The diagnosis was clinically established and verified by a checklist based on DSM-IV criteria (19). Advertising for participants was proscribed to ensure that recruitment would produce a sample representative of patients seen in typical clinical practice. Written informed consent was obtained at study entry and again at enrollment in the second-step treatments.

Inclusion and Exclusion Criteria

STAR*D used broad inclusion and minimal exclusion criteria (7, 8) to ensure enrollment of a representative study sample of depressed patients seeking treatment in primary care, public mental health, and psychiatric clinics. For example, most forms of comorbidity commonly associated with depression were permitted. The minimum score on the 17-item Hamilton Rating Scale for

TABLE 2. Treatment Characteristics, Side Effect Measures, and Serious Adverse Events Among STAR*D Level 2 Participants Who Received Augmentation Treatments[a]

Characteristic	Augmentation Option				p
	Cognitive Therapy (N=65)		Medication (N=117)		
	Mean	SD	Mean	SD	
Time in treatment (weeks)	10.8	4.2	9.7	4.6	0.1481
	N	%	N	%	
<4 weeks in treatment	6	9.2	18	15.4	0.2397
<8 weeks in treatment	13	20.0	36	30.8	0.1165
	Mean	SD	Mean	SD	
Number of postbaseline visits	4.3	1.4	4.0	1.6	0.2811
Days to first postbaseline visit	18.2	7.7	16.5	6.4	0.0155
Maximum sustained-release bupropion dose (mg/day)			291	97	
Last sustained-release bupropion dose (mg/day)			283	103	
Maximum buspirone dose (mg/day)			45.5	15.4	
Last buspirone dose (mg/day)			45.1	16.0	
Maximum citalopram dose (mg/day)	57.7	8.4	58.0	9.2	0.8177
Last citalopram dose (mg/day)	57.1	9.0	56.5	10.4	0.6737
Number of cognitive therapy sessions	11.4	4.9			
Days to first cognitive therapy session	7.9	5.6			
	N	%	N	%	
Completed ≥16 cognitive therapy sessions	17	27.4			
Maximum side effect frequency					0.1059
No side effects	20	33.3	19	17.3	
10–25% of the time	16	26.7	38	34.5	
50–75% of the time	13	21.7	33	30.0	
90–100% of the time	11	18.3	20	18.2	
Maximum side effect intensity					0.1164
No side effects	19	31.7	19	17.3	
Minimal to mild	16	26.7	33	30.0	
Moderate to marked	21	35.0	42	38.2	
Severe to intolerable	4	6.7	16	14.5	
Maximum side effect burden					0.1314
No side effects	22	36.7	24	21.8	
Minimal to mild	25	41.7	47	42.7	
Moderate to marked	11	18.3	32	29.1	
Severe to intolerable	2	3.3	7	6.4	
Exited because of intolerance	6	9.2	22	18.8	0.0863
At least 1 serious adverse event	4	6.2	4	3.4	0.4588
At least 1 psychiatric serious adverse event	4	6.2	1	0.9	0.0556

[a] Sums do not always equal N because of missing values. Percentages are based on available data.

Depression (HAM-D) (20, 21) for enrollment was 14, indicating at least a moderate level of depression.

Treatment Protocol and Therapist Training

To ensure rigorous dosing, reflect actual practice, and enhance safety, treatments were not masked to participants or providers. The primary outcome measure was whether participants achieved symptom remission, defined as a score ≤7 on the HAM-D, which was administered by research outcome assessors who were blind to treatment assignments. The protocol recommended that medication treatment visits for all treatment levels be conducted at weeks 0, 2, 4, 6, 9, and 12; however, the visit schedule was flexible, and extra visits could be held if clinically indicated. Depressive symptom severity was assessed at each treatment visit using the clinician-administered version of the 16-item Quick Inventory of Depressive Symptomatology (QIDS-C) (22–24). If participants had a response (defined as a reduction of ≥50% in baseline QIDS-C score) without remission at week 12, they could continue treatment for an additional 2 weeks (14 weeks total) to determine whether remission would occur with additional time. Remission at the clinic visits was defined as a QIDS-C score ≤5. The frequency, intensity, and burden of side effects were monitored with a scale developed for the STAR*D study (25).

To increase the likelihood that each patient received an adequate course of pharmacotherapy, each STAR*D site had a clinical research coordinator who monitored the progress of each participant, treating physicians received in-service training based on a clinician manual, and a web-based medication monitoring system (26) provided ongoing feedback on patients' symptom ratings, side effect burden, and treatment regimen (9). The protocol for the initial course of pharmacotherapy in Level 1 of the STAR*D sequence called for starting citalopram at a dose of 20 mg/day, to be raised to 40 mg/day by week 4. In the case of nonresponse, the dose could be raised to 60 mg/day by week 6. All medication dose recommendations were flexible and could be applied on the basis of clinical judgment informed by scores on the side effect rating scale and the QIDS-C, which were obtained at treatment visits by researchers blind to the patients' HAM-D score. In the case of intolerable side effects, patients could be withdrawn from Level 1 and advanced to the next treatment level. Patients who did not achieve remission with citalopram were encouraged to move to Level 2 after 12 weeks of citalopram therapy. Those who achieved remission could enter a 12-month naturalistic follow-up phase, and those who had a response without remission were strongly encouraged to proceed to Level 2, although they could also elect to enter the follow-up phase. The flow of patient progress and outcomes from Level 1 to Level 2 is summarized in Figure 1.

Level 2 Treatments

For patients who did not remit with or tolerate the initial course of citalopram therapy, there were seven possible second-step treatment options. The aims of the study included comparing three augmentation options (adding sustained-release bupropion, buspirone, or cognitive therapy to ongoing citalopram

therapy) and four switch strategies (discontinuing citalopram and starting therapy with sertraline, sustained-release bupropion, extended-release venlafaxine, or cognitive therapy).

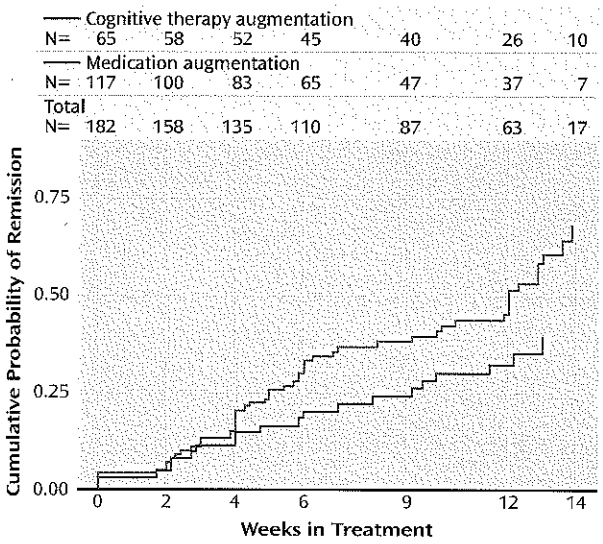
A novel element of the STAR*D research design, equipoise-stratified randomization (27), enabled participants—in consultation with their treating physician—to eliminate the possibility of being randomly assigned to treatment strategies they found unacceptable and still remain in the study (thereby mirroring practice). For example, participants could elect to be randomly assigned only to the switch treatments or only the augmentation treatments. They could also accept or decline cognitive therapy within either of these strategies. Or they could exclude all treatments except cognitive therapy alone (as a switch) and cognitive therapy as an augmentation to citalopram. They were subsequently randomly assigned to receive one of the remaining treatment options. In each unique cluster of acceptable treatment options, participants were treated as a stratum in data analyses. The numbers of participants in each stratum provided an approximate ranking of the overall acceptability of both the broader strategies (i.e., augmentation versus switch) and selected treatments.

Of the 4,041 outpatients enrolled in STAR*D Level 1, 1,439 (36%) did not achieve a satisfactory response with citalopram and moved to Level 2. In theory, if all participants had accepted all seven treatment options, on average two out of seven who entered Level 2, or 411 patients (1,439×2/7; 29%) would have been assigned to cognitive therapy. In fact, only 369 participants (26%) accepted one or both cognitive therapy options, and only 147 were assigned to cognitive therapy in Level 2 (including 44 who elected to accept only cognitive therapy options, either alone or as an augmentation to citalopram). Of the 752 patients who were willing to accept an augmentation strategy, 209 (28%) were willing to accept both cognitive therapy and pharmacotherapy among the options; 182 of them were randomly assigned to augmentation of citalopram with either cognitive therapy (N=65) or another medication (N=117). Among the 853 patients who were willing to accept a switch strategy, 132 (16%) were willing to accept both cognitive therapy and pharmacotherapy among the options; 122 of them were randomly assigned to either cognitive therapy alone (N=36) or a second course of pharmacotherapy (N=86). Across the switch and augmentation strata, there was essentially no difference in the acceptability of receiving cognitive therapy among patients treated at primary care sites and in psychiatric settings (25.4% and 25.8%, respectively).

Cognitive Therapy. To ensure that results were generalizable to clinical settings, selection and training of therapists mimicked good clinical practice. Each site's primary investigator proposed candidate practicing psychotherapists for the study. Candidate therapists submitted summaries of their relevant training and experience and video- or audiotapes of their work with depressed patients. Only one candidate was not accepted for further training, although a number of other candidates did not complete training. Candidate therapists received relevant readings and attended a 2-day workshop conducted by study investigators (E.S.F. and M.E.T.). Training followed the approach described by Shaw (28), which had been used by the cognitive therapy research group at the University of Pittsburgh for more than 15 years. Before they could participate in the study, therapists had to demonstrate competence (documented by fidelity ratings on the Cognitive Therapy Scale [18]) in the treatment of one patient who would have been eligible to participate in STAR*D. A total of 44 therapists (30 doctoral-level psychologists, one physician, 11 master's-level clinical social workers, and two nurses with advanced degrees) completed the certification process; each site had at least two certified therapists. Each therapist treated an average of 2.1 study patients (range=1–6 patients per therapist).

During the study, the psychotherapists' patients were monitored for adequate therapeutic response using a web-based system that was updated weekly. During monthly group supervision sessions, case conceptualizations, problems implementing cognitive therapy, and treatment strategies were reviewed in detail. If therapists experienced significant problems during the course of the study, additional sessions of individual supervision were provided. No therapists were withdrawn from study participation because of nonadherence to the cognitive therapy model (18).

FIGURE 2. Time to Remission and Cumulative Probability of Remission for STAR*D Level 2 Participants Receiving Augmentation Treatments, by Treatment Option[a]



[a] Log-rank=5.2124, p=0.0224.

The protocol required that cognitive therapy be scheduled twice weekly for weeks 1–4, then once weekly for the remaining 8 weeks (16 sessions total). When twice-weekly sessions were not practicable, the second session could be conducted by telephone. Patients who improved rapidly, as defined by at least three consecutive weeks of remission, could enter follow-up without completing all 16 visits. Patients who had a response but not remission by visit 16 could continue to Level 3 treatment or elect to continue cognitive therapy for an additional four weekly sessions, then twice a month for an additional four sessions and monthly for the final six sessions (research has shown that such patients benefit from continuation-phase cognitive therapy [29]).

Pharmacotherapy. Pharmacotherapy visits during Level 2 typically lasted 15–20 minutes. Although pharmacotherapists were not prevented from using psychotherapeutic strategies, it is unlikely that much in the way of psychotherapy was provided in these sessions beyond supportive encouragement and psychoeducation. For patients assigned to the augmentation options, the dose of citalopram was typically kept steady, although it could be reduced as needed to alleviate side effects. The target dosing for sustained-release bupropion was 200 mg/day for weeks 1–2, to be raised to 300 mg/day by week 4 and to 400 mg/day as a final dose. Buspirone dosing was to start at 15 mg/day for 1 week, to be raised to 30 mg/day for 1–2 weeks and then to 45 mg/day by week 4, with a maximum dose of 60 mg/day after week 6. For the switch options, citalopram was discontinued at the initial visit, and the new treatment was begun without a tapering or washout period. Sustained-release bupropion dosing was to start at 150 mg/day for 1 week, to be raised to 300 mg/day thereafter, with 400 mg/day as a final dose. Sertraline dosing was to start at 50 mg/day for 1 week, to be raised to 100 mg/day for weeks 3–4, to 150 mg/day for

TABLE 3. Outcome Measures for STAR*D Level 2 Participants Who Received Augmentation Treatments[a]

Measure[b]	Augmentation Option				p
	Cognitive Therapy (N=65)		Medication (N=117)		
	N	%	N	%	
Met criteria for remission on the Hamilton Rating Scale for Depression	15	23.1	39	33.3	0.1967
Quick Inventory of Depressive Symptomatology—Self-Rating (16-item)					
Met criteria for remission	20	30.8	39	33.3	0.7803
Met criteria for response	23	35.4	33	28.2	0.2493
	Mean	SD	Mean	SD	
Score at exit	8.2	5.1	8.2	4.8	0.9490
Change in score (%)	−29.8	40.5	−28.3	39.6	0.8302

[a] Sums do not always equal N because of missing values. Percentages are based on available data.
[b] Adjusted for days to first postbaseline visit.

weeks 5–9, and to 200 mg/day for weeks 10–12. The starting dose for extended-release venlafaxine was 37.5 mg/day for 3 days, to be raised to 75 mg/day for week 2, to 150 mg/day for weeks 3–4, to 225 mg/day for weeks 5–6, to 300 mg/day for weeks 7–9, and to 375 mg/day for weeks 10–12.

Measures

At study intake, clinical research coordinators collected standard sociodemographic information and self-reported psychiatric history (including an assessment of suicidality) and completed the HAM-D and QIDS-C, as well as the Cumulative Illness Rating Scale (30, 31) to measure medical comorbidity. The self-report Psychiatric Diagnostic Screening Questionnaire (32) was administered to assess for the presence of 11 concurrent psychiatric disorders (33).

For the primary outcome measure, the HAM-D was administered in telephone interviews conducted by the research outcome assessors at entry and exit from each treatment level. Secondary outcomes measures obtained by the research outcome assessors included the 30-item Inventory of Depressive Symptomatology—Clinician Rating (34–36), as well as the 5-item Income and Public Assistance Questionnaire to measure monthly income by source. Anxious depression was defined on the basis of pretreatment scores on the anxiety/somatization factor of the HAM-D (37). Items from the Inventory of Depressive Symptomatology were used to establish the presence or absence of atypical features (38) and melancholic features (39). Research outcome assessors blind to treatment assignments repeated the HAM-D, Inventory of Depressive Symptomatology, and Income and Public Assistance Questionnaire at the end of each treatment level.

A telephone-based interactive voice response system (40, 41) was used to collect function and quality-of-life measures from participants within 72 hours of study entry and exit of each level, including the 16-item Quality of Life Enjoyment and Satisfaction Questionnaire (42) to assess quality of life, the 12-item Short Form Health Survey (43) to evaluate perceptions of mental and physical function, and the Work and Social Adjustment Scale (44) to measure occupational and interpersonal impairment. The interactive voice response system was also used to administer the self-report version of the QIDS (QIDS-SR) (22–24) for assessment of depression symptom severity at study entry, at week 6, and at exit from each level. Secondary symptom outcome measures included response and remission rates defined a priori by the QIDS-SR score. Remission was defined as a QIDS-SR score ≤5; response was defined as a reduction of ≥50% from baseline QIDS-SR score.

Statistical Analyses

Summary statistics are presented in the form of means and standard deviations for continuous variables and counts and percentages for discrete variables. Parametric and nonparametric analysis of variance methods and chi-square tests were used to compare baseline clinical and demographic features, treatment options, side effect measures, and serious adverse event rates across treatment group and for the entire sample.

All analyses were conducted using all patients in each randomization group (45). Separate analyses were performed for the augmentation and switch strategies. The primary outcome measure was the intent-to-treat HAM-D remission rate at study exit. Participants for whom outcome HAM-D scores were missing were assumed not to have achieved remission (8). Secondary outcome measures included response and remission rates at study exit according to the QIDS-SR. Adjustments for potential confounding effects were limited because of sample size and the inability of the models to converge. Exact logistic regression models were used to compare remission and response rates after adjusting for significant between-group differences (the effect of days to first postbaseline visit for the comparison of augmentation strategies and income in the comparison of switch strategies). To determine whether cognitive therapy had a differential effect by practice setting, exact logistic regression models were fit, including main effects for treatment and setting, as well as the two-way interaction. Because assessment with the QIDS-SR was more frequent across the treatment protocol, this measure was used to estimate the rapidity of response. Times to first remission (QIDS-SR score ≤5) and first response (≥50% reduction from baseline QIDS-SR score) were defined as the first observed point using clinic visit data. Survival hazard functions were estimated using the Kaplan-Meier method, and log-rank tests were used to compare the cumulative proportions of remission and response among the treatment groups.

All Level 2 comparisons in STAR*D were planned to have at least 80% power to detect between-group differences in remission rates of ≥15% (assuming approximately 200 patients per arm, use of two-tailed tests, and an alpha level of 0.05). Because the numbers of consenting participants in the cognitive therapy arms were substantially smaller than planned, the study had 80% power to detect only larger between-group differences, on the order of 22.5% for the augmentation arm and 29% for the switch arm.

Results

Augmentation With Cognitive Therapy or Medication

The baseline sociodemographic and clinical characteristics of participants assigned to augmentation treatments are summarized in Table 1 (a larger version of this table is available in a data supplement that accompanies the online version of this article). The mean Work and Social Adjustment Scale scores were significantly different between groups (cognitive therapy augmentation: 25.1

[SD=8.4]; medication augmentation: 21.3 [SD=9.0]; t=2.45, df=142, p=0.016), and the mean Quality of Life Enjoyment and Satisfaction Questionnaire scores were significantly different between these groups (cognitive therapy augmentation: 41.8 [SD=13.5]; medication augmentation: 47.7 [SD=14.9]; t=–2.35, df=142, p=0.020). The cognitive therapy augmentation group thus initially had greater functional impairment and a lower quality of life. No other significant differences between groups were observed in baseline characteristics.

Patients in the cognitive therapy augmentation group attended an average of 11.4 sessions (SD=4.9), and 26% (17 of 65) of participants completed the full 16-session course of therapy. There were no significant differences between groups in mean number of weeks of Level 2 treatment or in the percentages of participants who discontinued treatment in less than 4 weeks or in less than 8 weeks. The only significant difference noted in Level 2 treatment characteristics was in mean days to first "on therapy" physician visit, which was slightly longer for the cognitive therapy augmentation group (18.2 days [SD=7.7] versus 16.5 days [SD=6.4]; χ^2=5.86, df=1, p=0.016).

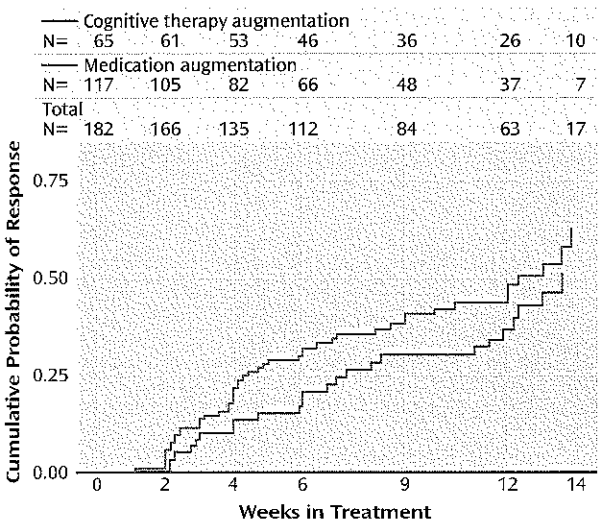
Augmentation with cognitive therapy and with medication were equally well tolerated. Four of the cognitive therapy augmentation patients experienced a psychiatric serious adverse event, as compared with only one of the medication augmentation patients (the difference was not statistically different). Data on Level 2 treatments, side effects, and serious adverse events for participants assigned to an augmentation treatment are listed in Table 2.

No significant differences were observed between groups in the percentages of participants who achieved remission according to HAM-D score (Table 3), nor in the percentages of those who achieved remission or response as assessed by the QIDS-SR. The two groups had almost identical final (intent-to-treat) scores on the QIDS-SR. Patients assigned to medication augmentation tended to reach remission and response criteria faster than those in the cognitive therapy augmentation condition (Figures 2 and 3), although only the difference in time to remission was statistically significant (p=0.022). Of those who achieved remission, the mean time to first remission was 55.3 days (SD=31.2) in the cognitive therapy group and 40.1 days (SD=25.8) in the medication group. There was no differential effect of cognitive therapy as a function of practice setting type (i.e., primary care versus psychiatric care settings).

Cognitive Therapy Switch Versus Medication Switch

The sociodemographic and clinical characteristics of participants assigned to switch therapies are summarized in Table 4 (a larger version of this table is available in a data supplement that accompanies the online version of this article). A significant difference between groups was noted in monthly household income (cognitive therapy switch: $1,526 [SD=1,331]; medication switch: $2,582 [SD=2,120]; χ^2=5.68, df=1, p=0.017). On measures of symptoms, illness features, and side effects, four significant differences were observed, including mean Level 2 baseline Work and Social Adjustment Scale score (cognitive therapy switch: 24.6 [SD=8.8]; medication switch: 20.9 [SD=7.7]; χ^2=4.66, df=1, p=0.031) and maximum Level 1 side effect intensity (χ^2=8.23, df=3, p=0.047). The group assigned to switch to cognitive therapy experienced somewhat fewer side effects during Level 1 citalopram therapy than those assigned to a medication switch, as would be expected if participants' treatment strategy preferences were related to side effect burden.

FIGURE 3. Time to Response and Cumulative Probability of Response for STAR*D Level 2 Participants Receiving Augmentation Treatments, by Treatment Option[a]



[a] Log-rank=1.8554, p=0.1732.

We found no significant difference between groups in the mean number of weeks in Level 2 treatment, the percentage of participants who discontinued treatment in less than 4 weeks or in less than 8 weeks, or in mean days to first postrandomization visit.

As Table 5 shows, there were large differences between the switch treatment groups in measures of the frequency, intensity, and burden of medication side effects in Level 2. For example, 48% of the patients assigned to a second course of antidepressant therapy reported at least a moderate degree of side effect intensity, and 34% reported at least a moderate level of side effect burden, as compared with none of the patients in the cognitive therapy switch arm. Nevertheless, the between-group differences in exiting Level 2 treatment because of intolerance were not statistically significant. There were no psychiatric serious adverse events in either arm.

No significant difference was observed between groups in the percentage of patients who met HAM-D criteria for remission. Cognitive therapy switch and medication

TABLE 4. Baseline Demographic and Clinical Characteristics of STAR*D Level 2 Participants Who Received Switch Treatments[a]

Characteristic	Total (N=122)		Switch Option: Cognitive Therapy (N=36)		Switch Option: Medication (N=86)		p
	N	%	N	%	N	%	
Female	75	61.5	22	61.1	53	61.6	0.9573
Race							0.4267
White	91	74.6	28	77.8	63	73.3	
Black	21	17.2	4	11.1	17	19.8	
Other	10	8.2	4	11.1	6	7.0	
Hispanic ethnicity	8	6.6	3	8.3	5	5.8	0.6924
Employment status							0.3487
Employed	74	61.2	19	52.8	55	64.7	
Unemployed	36	29.8	12	33.3	24	28.2	
Retired	11	9.1	5	13.9	6	7.1	
Health insurance							0.6939
Private	69	58.5	19	54.3	50	60.2	
Public	15	12.7	4	11.4	11	13.3	
None	34	28.8	12	34.3	22	26.5	
Marital status							0.8991
Single	33	27.0	9	25.0	24	27.9	
Married or cohabiting	49	40.2	16	44.4	33	38.4	
Divorced or separated	34	27.9	10	27.8	24	27.9	
Widowed	6	4.9	1	2.8	5	5.8	
Recurrent depression	80	72.7	24	75.0	56	71.8	0.7317
Psychiatric care setting	67	54.9	20	55.6	47	54.7	0.9270
Duration of index episode ≥2 years	26	21.5	7	19.4	19	22.4	0.7218
	Mean	SD	Mean	SD	Mean	SD	
Age	42.0	13.7	43.4	14.7	41.5	13.3	0.4790
Education (years)	14.3	3.2	14.5	3.1	14.2	3.3	0.7130
Monthly household income ($)	2,273	1,976	1,526	1,331	2,582	2,120	0.0172
Duration of illness (years)	17.6	14.4	18.0	14.8	17.5	14.3	0.8352
Number of episodes	8.5	16.7	8.7	18.8	8.4	16.0	0.8016
Duration of index episode (months)	23.8	48.4	17.4	31.2	26.5	54.0	0.4698
Quality of Life and Enjoyment Satisfaction Questionnaire score			43.3	14.7	45.5	13.4	0.4634
Hamilton Rating Scale for Depression score			16.4	6.2	17.7	6.6	0.3492
Quick Inventory of Depressive Symptomatology—Self-Rating (16-item) Score			11.2	4.3	12.1	4.6	0.3282
Change during Level 1 (%)			7.4	54.7	7.3	41.6	0.5567

[a] Sums do not always equal N because of missing values. Percentages are based on available data.

switch strategies resulted in similar degrees of change on the QIDS-SR and similar remission or response rates on this measure (Table 6). Rapidity of therapeutic benefit, as measured by time to QIDS-SR response and remission, was essentially identical in these two switch strategies (Figures 4 and 5). There was, again, no differential effect of cognitive therapy as a function of type of practice setting.

Discussion

Perhaps the most important finding of this study was that cognitive therapy, both alone and in combination with citalopram, was generally as effective as the various second-step pharmacologic strategies studied in STAR*D. Among participants who opted for an augmentation strategy, the addition of cognitive therapy ultimately resulted in about the same probability of remission and a similar degree of symptomatic improvement as adding sustained-release bupropion or buspirone. The benefit of cognitive therapy was slower to emerge, however, with a significant 20-day difference in median time to remission favoring pharmacologic augmentation. When speed of response is imperative, this 3-week advantage could be of considerable importance. An unanticipated finding was that pharmacologic augmentation was nearly as well tolerated as cognitive therapy augmentation. In fact, none of the between-group differences in side effect frequency, intensity, or burden were statistically significant.

Patients who switched treatments were likewise about as likely to benefit from cognitive therapy as those who were switched to sertraline, sustained-release bupropion, or extended-release venlafaxine. In contrast to the augmentation groups, the difference in speed of remission was not statistically significant. The major difference between switching to cognitive therapy and switching to another medication was that participants who received cognitive therapy alone were spared the side effect burden of a second course of pharmacotherapy. However, given that the percentage of patients who exited the study because of side effects did not differ between the cognitive therapy and medication switch arms, this advantage may be of limited clinical significance. As an aside, we thought it

TABLE 5. Treatment Characteristics, Side Effect Measures, and Serious Adverse Events Among STAR*D Level 2 Participants Who Received Switch Treatments[a]

Characteristic	Switch Option				p
	Cognitive Therapy (N=36)		Medication (N=86)		
	Mean	SD	Mean	SD	
Time in treatment (weeks)	7.8	5.6	8.7	5.1	0.3791
	N	%	N	%	
<4 weeks in treatment	12	33.3	23	26.7	0.4630
<8 weeks in treatment	14	38.9	32	37.2	0.8614
	Mean	SD	Mean	SD	
Number of postbaseline visits	3.9	1.8	3.8	1.7	0.8242
Days to first postbaseline visit	13.5	5.7	16.7	9.5	0.0806
Maximum dose of sustained-release bupropion (mg/day)			289	116	
Ending dose of sustained-release bupropion (mg/day)			270	117	
Maximum dose of sertraline (mg/day)			139	47	
Ending dose of sertraline (mg/day)			137	50	
Maximum dose of extended-release venlafaxine (mg/day)			221	106	
Ending dose of extended-release venlafaxine (mg/day)			221	106	
Number of cognitive therapy sessions	11.0	6.2			
Days to first cognitive therapy session	7.1	4.1			
	N	%	N	%	
Completed ≥16 cognitive therapy sessions	10	34.5			
Maximum side effect frequency					
No side effects	2	100	14	18.4	
10–25% of the time	0	0.0	25	32.9	
50–75% of the time	0	0.0	18	23.7	
90–100% of the time	0	0.0	19	25.0	
Maximum side effect intensity					
No side effects	2	100	13	17.1	
Minimal to mild	0	0.0	26	34.2	
Moderate to marked	0	0.0	27	35.5	
Severe to intolerable	0	0.0	10	13.2	
Maximum side effect burden					
No side effects	2	100	18	23.7	
Minimal to mild	0	0.0	32	42.1	
Moderate to marked	0	0.0	22	28.9	
Severe to intolerable	0	0.0	4	5.3	
Exited because of intolerance	6	16.7	23	26.7	0.2330
At least 1 serious adverse event	0	0.0	2	2.3	1.0000
At least 1 psychiatric serious adverse event	0	0.0	0	0.0	

[a] Sums do not always equal N because of missing values. Percentages are based on available data.

noteworthy that although the U.S. Food and Drug Administration warns of the emergence of suicidal ideation as a hazard following initiation of antidepressant medication, several cases of suicidal ideation occurred as serious adverse events following the initiation of cognitive therapy in our study.

The remission rates we report here for cognitive therapy (either switch or augmentation) are different from those reported previously by Rush et al. (46) because we used different STAR*D samples. For the cognitive therapy switch remission rates, Rush et al. reported on all participants who received a switch to cognitive therapy, whereas in this article we focused only on those who were both willing to be randomly assigned to cognitive therapy switch or medication switch and were randomly assigned to one of these treatments (see Figure 1; we excluded 24 participants who were willing only to receive cognitive therapy as a switch or augmentation and two who were willing to accept any treatment except medication switch). Likewise, for the cognitive therapy augmentation remission rates, Rush et al. report on all participants who received cognitive therapy augmentation, whereas we focused only on those who were both willing to be randomly assigned to cognitive therapy augmentation or medication augmentation and were randomly assigned to one of these treatments (see Figure 1; we excluded 20 participants who were willing only to receive cognitive therapy as a switch or augmentation).

The outcomes for participants treated with cognitive therapy in this study are generally comparable to those reported by Scott (13) and Schatzberg et al. (17), although much less promising than those of Fava et al. (15). The latter reported that 12 of 19 patients who had not benefited from antidepressant medication responded to a form of cognitive behavior therapy that emphasized life style management and engagement in healthy, adaptive activities. Although it is plausible that differences in the emphasis of therapy could explain the better outcomes, differences in design (Fava et al. conducted a nonrandomized, single-site case series with a single expert therapist) and patient illness characteristics (Fava et al. excluded patients with medical and psychiatric comorbidities) seem more likely to account for the differences.

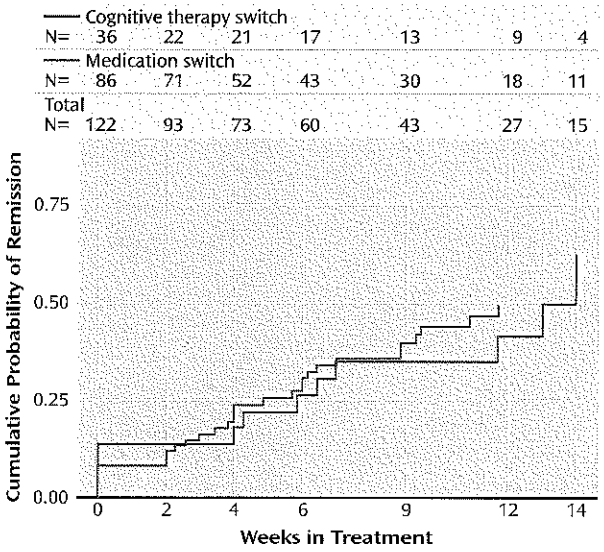
The greatest shortcoming of this study is the lack of statistical power to detect moderately sized between-group differences. This low power was a result of lower-than-ex-

TABLE 6. Outcome Measures for STAR*D Level 2 Participants Who Received Switch Treatments[a]

Measure[b]	Switch Option: Cognitive Therapy (N=36)		Switch Option: Medication (N=86)		p
	N	%	N	%	
Met remission criteria on Hamilton Rating Scale for Depression	9	25.0	24	27.9	0.6881
Quick Inventory of Depressive Symptomatology—Self-Rating (16-item)					
Met remission criteria	11	30.6	23	26.7	0.9032
Met response criteria	8	22.2	23	26.7	0.8390
	Mean	SD	Mean	SD	
Mean score at exit	9.1	5.4	9.1	5.0	0.9734
Change in score (%)	−15.6	40.7	−17.2	46.2	0.9040

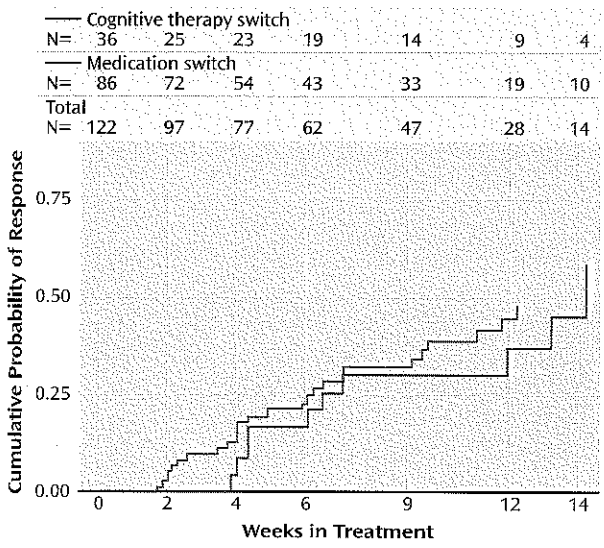
[a] Sums do not always equal N because of missing values. Percentages are based on available data.
[b] Adjusted for monthly household income.

FIGURE 4. Time to Remission and Cumulative Probability of Remission for STAR*D Level 2 Participants Receiving Switch Treatments, by Treatment Option[a]



[a] Log-rank=0.0067, p=0.9350.

FIGURE 5. Time to Response and Cumulative Probability of Response for STAR*D Level 2 Participants Receiving Switch Treatments, by Treatment Option[a]



[a] Log-rank=0.1103, p=0.7398.

pected numbers of patients agreeing to randomization strata that included both cognitive therapy and pharmacotherapy. The STAR*D investigators had expected that more patients would be at equipoise on the acceptability of second-step treatments. In fact, one of the most surprising findings of STAR*D overall was that only 1.5% of patients were willing to accept all seven of the second-step options (Figure 1). It was particularly surprising that only 26% of the patients were willing to accept assignment to cognitive therapy as either a switch or an augmentation strategy. These low numbers also limited the ability to control for imbalances in baseline characteristics.

The STAR*D investigators were experienced in designing studies of depression-focused psychotherapies, and the unexpectedly low acceptability of cognitive therapy was frankly at considerable variance with our earlier research experiences (see, for example, references 47–51). For example, even among more severely depressed inpatients, the Pittsburgh group (52) found that more than three-quarters of eligible patients accepted treatment with an intensive form of cognitive therapy alone instead of pharmacotherapy. Of particular relevance to the current study is the report of Schatzberg et al. (17), in which chronically depressed patients who did not respond to 12 weeks of therapy with either a form of cognitive therapy or nefazodone were permitted to switch to the other treatment. In that study, 88% of participants who did not respond to nefazodone accepted the switch to psychotherapy, and 95% of those who did not respond to psychotherapy accepted the switch to nefazodone.

Psychosocial interventions likewise are not commonly viewed as "unacceptable" alternatives to pharmacotherapy outside of research studies. In fact, surveys of patients' treatment preferences have consistently found that counseling and psychotherapy receive higher marks than pharmacotherapy (53–56). Thus, it may be that some aspects of the design of STAR*D inadvertently biased patients against accepting cognitive therapy as compared with a second

Patient Perspective

"Mr. N," age 47, white, and divorced, was diagnosed as having chronic major depression and dysthymia; he also suffered from a concurrent pain disorder. His chronic back problems (treated with benzodiazepines, muscle relaxants, and a morphine pump) followed a construction accident that made him economically dependent on disability insurance payments for the past 13 years. His marriage deteriorated after his accident; he and his wife divorced, and she had custody of their children. Mr. N's score on the Quick Inventory of Depressive Symptomatology-Self-Rating (QIDS-SR) at Level 1 baseline was 21 (he had severe depression, anhedonia, anxiety and agoraphobia, insomnia, poor concentration and attention, and thoughts of helplessness and hopelessness, and he denied suicidal ideation). His affect was blunted, and his speech was impoverished. His automatic negative thoughts revolved around the idea that "there is no help for me." This belief was reinforced by his experience of interpersonal loss, chronic pain, and chronic depression. The cognitive therapy treatment plan focused on building the therapeutic relationship, challenging his all-or-none belief that there was no help for him, using a chronic pain workbook to begin a pain management program, and focusing on the achievement of mastery experiences. His therapy attendance was sporadic, and his homework compliance was poor. His QIDS-SR scores at weeks 0, 2, 4, 6, and 12 of Level 2 were 14, 8, 15, 11, and 8, respectively, and he was categorized as a nonresponder to Level 2 cognitive therapy.

"Mrs. X," age 58, white, and married, worked with her husband as a property manager. Her depressive episode followed a conflict with her boss at work that generated thoughts of inadequacy, helplessness, and hopelessness. Her father had been emotionally abusive, and she compensated by "having to be perfect to please him." In cognitive therapy, the therapist focused on her perfectionist beliefs and her tendency to overfunction in the workplace and in her marriage. For example, she believed that her husband's "lack of initiative" placed an extra burden on her, citing as evidence that she was "never satisfied with the way he does things" (and, as a result, he deferred to her to complete tasks to her satisfaction). The cognitive therapy treatment plan focused on her automatic negative thinking patterns, her perfectionist beliefs, and the impact her perfectionism had on her relationships. Over the course of therapy, she became less emotionally reactive and came to approach stressful situations as problems to be solved rather than as indicators of her inadequacy. This aided in her functioning at work and improved her relationship with her husband. She attended sessions regularly, did homework reliably, and was an excellent responder to cognitive therapy. Her QIDS-SR scores at weeks 0, 2, 4, 6, and 12 were 11, 10, 6, 5, and 7, respectively, and she was categorized as a responder/nonremitter in Level 2 cognitive therapy. She elected to enter naturalistic follow-up treatment after Level 2.

course of pharmacotherapy. For example, since the initial treatment in STAR*D was pharmacotherapy, patients who wanted to begin treatment with psychotherapy would very likely have opted not to enroll in the study. A second possible factor is the cost of study treatments. Whereas STAR*D provided the medications and most of the study-related sessions not covered by insurance, it was not possible for the study to reimburse participants for copayment charges for insurance-covered psychotherapy sessions. A third potential bias may have resulted from the need for patients to go to a different site to see a psychotherapist. If so, this is a real-world factor that may limit the utility of psychotherapy as a second-step option, given that referral to a provider at a different site is routine practice.

These were not the only factors that may have dampened patients' enthusiasm for receiving psychotherapy, however, because cognitive therapy was significantly more acceptable to participants who opted for augmentation than it was to those who opted for a treatment switch. Perhaps the potential fear of breaking the treatment alliance with the study physician biased some patients against accepting a switch to cognitive therapy. Not only did participants in the augmentation groups get to continue citalopram, they also maintained an ongoing therapeutic relationship with their study physician. Finally, because patients who were already participating in psychotherapy could be enrolled in STAR*D, a small number of otherwise eligible participants who wished to continue their current therapy may have declined the option of cognitive therapy with a study therapist. Unfortunately, since we did not systematically record the number and nature of these extra-protocol courses of therapy, it is not possible to determine whether or not this was a common occurrence.

Another limitation of the study is that the fidelity of the therapy was not independently evaluated, and, because not all of the therapists were highly experienced with cognitive therapy, it is possible that some participants did not receive an optimal course of therapy. Both of these limitations reflect the STAR*D investigators' decision to study the effectiveness of cognitive therapy under real-world conditions. That said, all study therapists were screened to ensure basic competence in cognitive therapy, and they received ongoing supervision—quality controls that probably surpass those generally found in clinical settings. Although it is not certain that expert therapists would have achieved better results with this difficult-to-treat patient population, there is evidence that therapist adherence is associated with better outcomes in cognitive therapy (57, 58). In two multicenter controlled studies (59, 60), site differences in cognitive therapy response suggest that thera-

pists' experience level may significantly affect outcomes, perhaps particularly for inpatients with more difficult-to-treat depression.

Our study examined only one form of psychotherapy. Other approaches, including interpersonal psychotherapy and the cognitive behavior analysis system of psychotherapy, may have yielded different results. Secondary analyses of the Treatment of Depression Collaborative Research Program suggest that interpersonal psychotherapy performed better than cognitive therapy among the subset of patients with more severe depressive symptoms (61, 62).

Finally, less than one-third of the patients remitted with any of the Level 2 treatments in STAR*D, which indicates that there is room for improvement in the treatment of depression. Future analyses will examine the impact of the STAR*D treatments on functioning and quality of life. Given that only about one-fourth of the patients treated with cognitive therapy completed the full 16-session protocol, it would be worthwhile to explore novel methods of facilitating mastery of therapy materials without increasing the number of therapy sessions. It would be useful in future research to determine whether concurrently starting psychotherapy and making changes in pharmacotherapy can result in higher remission rates. It would likewise be worthwhile in future research to study alternative methods of delivering therapy, such as greater use of telephone sessions and supplemental materials (e.g., self-help materials via print, Internet, video, or DVD modules), to determine whether the acceptability of psychotherapy can be improved.

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References

1. Depression Guideline Panel: Depression in Primary Care, vol 2: Treatment of Major Depression. Clinical Practice Guideline No 5. AHCPR Publication No 93-0551. Rockville, Md, US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, 1993
2. Williams JW, Rost K, Dietrich AJ, Ciotti MC, Zyzanski SJ, Cornell J: Primary care physicians' approach to depressive disorders: effects of physician specialty and practice. Arch Fam Med 1999; 8:58–67

3. Thase ME: Bipolar depression: issues in diagnosis and treatment. Harv Rev Psychiatry 2005; 13:257–271
4. Stimpson N, Agrawal N, Lewis G: Randomised controlled trials investigating pharmacological and psychological interventions for treatment-refractory depression: systematic review. Br J Psychiatry 2002; 181:284–294
5. Hollon SD, Jarrett RB, Nierenberg AA, Thase ME, Trivedi M, Rush AJ: Psychotherapy and medication in the treatment of adult and geriatric depression: which monotherapy or combined treatment? J Clin Psychiatry 2005; 66:455–468
6. Fava M, Rush AJ: Current status of augmentation and combination treatments for major depressive disorder: a literature review and a proposal for a novel approach to improve practice. Psychother Psychosom 2006; 75:139–153
7. Fava M, Rush AJ, Trivedi MH, Nierenberg AA, Thase ME, Sackeim HA, Quitkin FM, Wisniewski S, Lavori PW, Rosenbaum JF, Kupfer DJ: Background and rationale for the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study. Psychiatr Clin North Am 2003; 26:457–494
8. Rush AJ, Fava M, Wisniewski SR, Lavori PW, Trivedi MH, Sackeim HA, Thase ME, Nierenberg AA, Quitkin FM, Kashner TM, Kupfer DJ, Rosenbaum JF, Alpert J, Stewart JW, McGrath PJ, Biggs MM, Shores-Wilson K, Lebowitz BD, Ritz L, Niederehe G: Sequenced Treatment Alternatives to relieve Depression (STAR*D): rationale and design. Control Clin Trials 2004; 25:119–142
9. Trivedi MH, Rush AJ, Wisniewski SR, Nierenberg AA, Warden D, Ritz L, Norquist G, Howland RH, Lebowitz B, McGrath PJ, Shores-Wilson K, Biggs MM, Balasubramani GK, Fava M, STAR*D Study Team: Evaluation of outcomes with citalopram for depression using measurement-based care in STAR*D: implications for clinical practice. Am J Psychiatry 2006; 163:28–40
10. Rush AJ, Trivedi MH, Wisniewski SR, Stewart JW, Nierenberg AA, Thase ME, Ritz L, Biggs MM, Warden D, Luther JF, Shores-Wilson K, Niederehe G, Fava M: Bupropion-SR, sertraline, or venlafaxine-XR after failure of SSRIs for depression. N Engl J Med 2006; 354:1231–1242
11. Trivedi MH, Fava M, Wisniewski SR, Thase ME, Quitkin F, Warden D, Ritz L, Nierenberg AA, Lebowitz BD, Biggs MM, Luther JF, Shores-Wilson K, Rush AJ: Medication augmentation after the failure of SSRIs for depression. N Engl J Med 2006; 354:1243–1252
12. Friedman ES, Thase ME: Cognitive-behavioral therapy for depression and dysthymia, in Textbook of Mood Disorders. Edited by Stein DJ, Kupfer DJ, Schatzberg AF. Washington, DC, American Psychiatric Publishing, 2006, pp 353–371
13. Scott J: Chronic depression: can cognitive therapy succeed when other treatments fail? Behavioural Psychotherapy 1992; 20:25–36
14. Thase ME, Friedman ES, Howland RH: Management of treatment-resistant depression: psychotherapeutic perspectives. J Clin Psychiatry 2001; 62(suppl 18):18–24
15. Fava GA, Savron G, Grandi S, Rafanelli C: Cognitive-behavioral management of drug-resistant major depressive disorder. J Clin Psychiatry 1997; 58:278–282
16. McPherson S, Cairns P, Carlyle J, Shapiro DA, Richardson P, Taylor D: The effectiveness of psychological treatments for treatment-resistant depression: a systematic review. Acta Psychiatr Scand 2005; 111:331–340
17. Schatzberg AF, Rush AJ, Arnow BA, Banks PL, Blalock JA, Borian FE, Howland R, Klein DN, Kocsis JH, Kornstein SG, Manber R, Markowitz JC, Miller I, Ninan PT, Rothbaum BO, Thase ME, Trivedi MH, Keller MB: Chronic depression: medication (nefazodone) or psychotherapy (CBASP) is effective when the other is not. Arch Gen Psychiatry 2005; 62:513–520
18. Friedman EF, Thase ME, Biggs MM, Carmin C, Hollon SD, Kornblith SJ, Petersen T, Veenstra G, Wisniewski SR, Rush AJ: The implementation of cognitive therapy in STAR*D. Cognit Ther Res 2004; 28:819–833
19. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Washington, DC, American Psychiatric Association, 1994
20. Hamilton M: A rating scale for depression. J Neurol Neurosurg Psychiatry 1960; 23:56–62
21. Hamilton M: Development of a rating scale for primary depressive illness. Br J Soc Clin Psychol 1967; 6:278–296
22. Rush AJ, Trivedi MH, Ibrahim HM, Carmody TJ, Arnow B, Klein DN, Markowitz JC, Ninan PT, Kornstein S, Manber R, Thase ME, Kocsis JH, Keller MB: The 16-item Quick Inventory Of Depressive Symptomatology (QIDS), Clinician Rating (QIDS-C), and Self-Report (QIDS-SR): a psychometric evaluation inpatients with chronic major depression. Biol Psychiatry 2003; 54:573–583
23. Rush AJ, Bernstein IH, Trivedi MH, Carmody TJ, Wisniewski S, Mundt JC, Shores-Wilson K, Biggs MM, Woo A, Nierenberg AA, Fava M: An evaluation of the Quick Inventory of Depressive Symptomatology and the Hamilton Rating Scale for Depression: a Sequenced Treatment Alternatives to Relieve Depression trial report. Biol Psychiatry 2006; 59:493–501
24. Trivedi MH, Rush AJ, Ibrahim HM, Carmody TJ, Biggs MM, Suppes T, Crismon ML, Shores-Wilson K, Toprac MG, Dennehy EB, Witte B, Kashner TM: The Inventory of Depressive Symptomatology, Clinician Rating (IDS-C) and Self-Report (IDS-SR), and the Quick Inventory of Depressive Symptomatology, Clinician Rating (QIDS-C) and Self-Report (QIDS-SR) in public sector patients with mood disorders: a psychometric evaluation. Psychol Med 2004; 34:73–82
25. Wisniewski SR, Rush AJ, Balasubramani GK, Trivedi MH, Nierenberg AA: Self-rated global measure of the frequency, intensity, and burden of side effects. J Psychiatr Pract 2006; 12:71–79
26. Wisniewski SR, Eng H, Meloro L, Gatt R, Ritz L, Stegman D, Trivedi M, Biggs MM, Friedman E, Shores-Wilson K, Warden D, Bartolowits D, Martin JP, Rush AJ: Web-based communications and management of a multi-center clinical trial: the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) project. Clin Trials 2004; 1:387–398
27. Lavori PW, Rush AJ, Wisniewski SR, Alpert J, Fava M, Kupfer DJ, Nierenberg A, Quitkin FM, Sackeim HA, Thase ME, Trivedi M: Strengthening clinical effectiveness trials: equipoise-stratified randomization. Biol Psychiatry 2001; 50:792–801
28. Shaw BF: Specification of the training and evaluation of cognitive therapists for outcome studies, in Psychotherapy Research: Where We Are and Where We Should Go. Edited by Williams JBW, Spitzer RL. New York, Guilford, 1984, pp 173–189
29. Jarrett RB, Kraft D, Doyle J, Foster BM, Eaves GG, Silver PC: Preventing recurrent depression using cognitive therapy with and without a continuation phase: a randomized clinical trial. Arch Gen Psychiatry 2001; 58:381–388
30. Linn BS, Linn MW, Gurel L: Cumulative Illness Rating Scale. J Am Geriatr Soc 1968; 16:622–626
31. Miller MD, Paradis CF, Houck PR, Mazumdar S, Stack JA, Rifai AH, Mulsant B, Reynolds CFI: Rating chronic medical illness burden in geropsychiatric practice and research: application of the cumulative illness rating scale. Psychiatry Res 1992; 41: 237–248
32. Zimmerman M, Mattia JI: The reliability and validity of a screening questionnaire for 13 DSM-IV axis I disorders (the Psychiatric Diagnostic Screening Questionnaire) in psychiatric outpatients. J Clin Psychiatry 1999; 60:677–683
33. Rush AJ, Zimmerman M, Wisniewski SR, Fava M, Hollon SD, Warden D, Biggs MM, Shores-Wilson K, Shelton RC, Luther JF, Thomas B, Trivedi MH: Comorbid psychiatric disorders in depressed outpatients: demographic and clinical features. J Affect Disord 2005; 87:43–55

34. Rush AJ, Giles DE, Schlesser MA, Fulton CL, Weissenburger JE, Burns CT: The Inventory for Depressive Symptomatology (IDS): preliminary findings. Psychiatry Res 1986; 18:65–87
35. Rush AJ, Gullion CM, Basco MR, Jarrett RB, Trivedi MH: The Inventory of Depressive Symptomatology (IDS): psychometric properties. Psychol Med 1996; 26:477–486
36. Rush AJ, Carmody TJ, Reimitz PE: The Inventory of Depressive Symptomatology (IDS): Clinician (IDS-C) and Self-Report (IDS-SR) ratings of depressive symptoms. Int J Methods Psychiatr Res 2000; 9:45–59
37. Fava M, Alpert JE, Carmin CN, Wisniewski SR, Trivedi MH, Biggs MM, Shores-Wilson K, Morgan D, Schwartz T, Balasubramani GK, Rush AJ: Clinical correlates and symptom patterns of anxious depression among patients with major depressive disorder in STAR*D. Psychol Med 2004; 34:1299–1308
38. Novick JS, Stewart JW, Wisniewski SR, Cook IA, Manev R, Nierenberg AA, Rosenbaum JF, Shores-Wilson K, Balasubramani GK, Biggs MM, Zisook S, Rush AJ: Clinical and demographic features of atypical depression in outpatients with major depressive disorder: preliminary findings from STAR*D. J Clin Psychiatry 2005; 66:1002–1011
39. Khan AY, Carrithers J, Preskorn SH, Lear R, Wisniewski SR, Rush AJ, Stegman D, Kelley C, Kreiner K, Nierenberg AA, Fava M: Clinical and demographic factors associated with DSM-IV melancholic depression. Ann Clin Psychiatry 2006; 18:91–98
40. Mundt JC: Interactive voice response systems in clinical research and treatment. Psychiatr Serv 1997; 48:611–612
41. Kobak KA, Greist JH, Jefferson JW, Mundt JC, Katzelnick DJ: Computerized assessment of depression and anxiety over the telephone using interactive voice response. MD Comput 1999; 16:64–68
42. Endicott J, Nee J, Harrison W, Blumenthal R: Quality-of-Life Enjoyment and Satisfaction Questionnaire: a new measure. Psychopharmacol Bull 1993; 29:321–326
43. Ware J Jr, Kosinski M, Keller SD: A 12-Item Short-Form Health Survey: construction of scales and preliminary tests of reliability and validity. Med Care 1996; 34:220–233
44. Mundt JC, Marks IM, Shear MK, Greist JH: The Work and Social Adjustment Scale: a simple measure of impairment in functioning. Br J Psychiatry 2002; 180:461–464
45. Fisher L, Dixon D, Herson J, Frankowski R, Hearron M, Peace K: Intention-to-treat in clinical trials, in Statistical Issues in Drug Research and Development. Edited by Ke P. New York, Marcel Dekker, 1990
46. Rush AJ, Trivedi MH, Wisniewski SR, Nierenberg AA, Stewart JW, Warden D, Niederehe G, Thase ME, Lavori PW, Lebowitz BD, McGrath PJ, Rosenbaum JF, Sackeim HA, Kupfer DJ, Luther J, Fava M: Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR*D report. Am J Psychiatry 2006; 163:1905–1917
47. Rush AJ, Beck AT, Kovacs M, Hollon SD: Comparative efficacy of cognitive therapy and pharmacotherapy in the treatment of depressed outpatients. Cognit Ther Res 1977; 1:17–37
48. Thase ME, Simons AD, Cahalane J, McGeary J, Harden T: Severity of depression and response to cognitive behavior therapy. Am J Psychiatry 1991; 148:784–789
49. Thase ME, Friedman ES, Berman SR, Fasiczka AL, Lis JA, Howland RH, Simons AD: Is cognitive behavior therapy just a "nonspecific" intervention for depression? a retrospective comparison of consecutive cohorts treated with cognitive behavior therapy or supportive counseling and pill placebo. J Affect Disord 2000; 57:63–71
50. Keller MB, McCullough JP, Klein DN, Arnow B, Dunner DL, Gelenberg AJ, Markowitz JC, Nemeroff CB, Russell JM, Thase ME, Trivedi MH, Zajecka J: A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression. N Engl J Med 2000; 342:1462–1470
51. Hollon SD, DeRubeis RJ, Shelton RC, Amsterdam JD, Salomon RM, O'Reardon JP, Lovett ML, Young PR, Haman KL, Freeman BB, Gallop R: Prevention of relapse following cognitive therapy vs medications in moderate to severe depression. Arch Gen Psychiatry 2005; 62:417–422
52. Thase ME, Dubé S, Bowler K, Howland RH, Myers JE, Friedman E, Jarrett DB: Hypothalamic-pituitary-adrenocortical activity and response to cognitive behavior therapy in unmedicated, hospitalized depressed patients. Am J Psychiatry 1996; 153: 886–891
53. Drugs vs talk therapy: 3,079 readers rate their care for depression and anxiety. Consum Rep 2004; 69(10):22–29
54. Gum AM, Arean PA, Hunkeler E, Tang LQ, Katon W, Hitchcock P, Steffens DC, Dickens J, Unutzer J: Depression treatment preferences in older primary care patients. Gerontologist 2006; 46: 14–22
55. Jaycox LH, Asarnow JR, Sherbourne CD, Rea MM, LaBorde AP, Wells KB: Adolescent primary care patients' preferences for depression treatment. Adm Policy Ment Health 2006; 33:198–207
56. Lowe B, Schulz U, Grafe K, Wilke S: Medical patients' attitudes toward emotional problems and their treatment: what do they really want? J Gen Intern Med 2006; 21:39–45
57. Bryant MJ, Simons AD, Thase ME: Therapist skill and patient variables in homework compliance: controlling an uncontrolled variable in cognitive therapy outcome research. Cognit Ther Res 1999; 23:381–399
58. Shaw BF, Elkin I, Yamaguchi J, Olmsted M, Vallis TM, Dobson KS, Lowery A, Sotsky SM, Watkins JT, Imber SD: Therapist competence ratings in relation to clinical outcome in cognitive therapy of depression. J Consult Clin Psychol 1999; 67:837–846
59. DeRubeis RJ, Hollon SD, Amsterdam JD, Shelton RC, Young PR, Salomon RM, O'Reardon JP, Lovett ML, Gladis MM, Brown LL, Gallop R: Cognitive therapy vs medications in the treatment of moderate to severe depression. Arch Gen Psychiatry 2005; 62: 409–416
60. Jacobson NS, Hollon SD: Cognitive-behavior therapy versus pharmacotherapy: now that the jury's returned its verdict, it's time to present the rest of the evidence. J Consult Clin Psychol 1996; 64:74–80
61. Elkin I, Gibbons RD, Shea MT, Sotsky SM, Watkins JT, Pilkonis PA, Hedeker D: Initial severity and differential treatment outcome in the National Institute of Mental Health Treatment of depression Collaborative Research Program. J Consult Clin Psychol 1995; 63:841–847
62. Klein DF, Ross DC: Reanalysis of the National Institute of Mental Health Treatment of Depression Collaborative Research Program General Effectiveness Report. Neuropsychopharmacology 1993; 8:241–251

Article

Systems Training for Emotional Predictability and Problem Solving (STEPPS) for Outpatients With Borderline Personality Disorder: A Randomized Controlled Trial and 1-Year Follow-Up

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Objective: Systems Training for Emotional Predictability and Problem Solving (STEPPS) is a 20-week manual-based group treatment program for outpatients with borderline personality disorder that combines cognitive behavioral elements and skills training with a systems component. The authors compared STEPPS plus treatment as usual with treatment as usual alone in a randomized controlled trial.

Method: Subjects with borderline personality disorder were randomly assigned to STEPPS plus treatment as usual or treatment as usual alone. Total score on the Zanarini Rating Scale for Borderline Personality Disorder was the primary outcome measure. Secondary outcomes included measures of global functioning, depression, impulsivity, and social functioning; suicide attempts and self-harm acts; and crisis utilization. Subjects were followed 1 year posttreatment. A linear mixed-effects model was used in the analysis.

Results: Data pertaining to 124 subjects (STEPPS plus treatment as usual [N=65]; treatment as usual alone [N=59]) were analyzed. Subjects assigned to STEPPS plus treatment as usual experienced greater improvement in the Zanarini Rating Scale for Borderline Personality Disorder total score and subscales assessing affective, cognitive, interpersonal, and impulsive domains. STEPPS plus treatment as usual also led to greater improvements in impulsivity, negative affectivity, mood, and global functioning. These differences yielded moderate to large effect sizes. There were no differences between groups for suicide attempts, self-harm acts, or hospitalizations. Most gains attributed to STEPPS were maintained during follow-up. Fewer STEPPS plus treatment as usual subjects had emergency department visits during treatment and follow-up. The discontinuation rate was high in both groups.

Conclusions: STEPPS, an adjunctive group treatment, can deliver clinically meaningful improvements in borderline personality disorder-related symptoms and behaviors, enhance global functioning, and relieve depression.

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The treatment of patients with borderline personality disorder is challenging (1, 2). The use of medication has increased, but while several drugs have proven useful, their benefit has been modest (3–4). A range of psychotherapies has been developed and several have garnered empirical support (5–12), including dialectical behavioral therapy (5–7, 12), mentalization-based therapy (8, 9), cognitive behavioral therapy (10), schema-focused therapy (11), and transference-focused therapy (12).

In 1995, Blum et al. developed Systems Training for Emotional Predictability and Problem Solving (STEPPS) based on a program introduced by Bartels and Crotty (13). STEPPS is a group treatment that combines cognitive behavior elements and skills training with a systems component for individuals with whom a patient regularly interacts (14, 15). STEPPS is easily learned and efficiently delivered by therapists of varying educational and professional backgrounds. The program supplements—but does not replace—a patient's ongoing treatment (e.g., medication, individual therapy, case management). Data from two uncontrolled studies have supported its use (16, 17). STEPPS is used in the United States (18) and was introduced in the Netherlands in 1998. By 2005, nearly 400 Dutch therapists were trained in its use (18).

In the present study, we report results of a 20-week randomized controlled trial and a 1-year follow-up. Outpatients with borderline personality disorder were randomly assigned to STEPPS plus treatment as usual or treatment as usual alone. We hypothesized the following: 1) STEPPS plus treatment as usual would result in greater improve-

This article is featured in this month's AJP Audio and is discussed in an editorial by Dr. Silk (p. 413).

ment in borderline traits, social functioning, global functioning, and mood relative to treatment as usual alone; 2) STEPPS plus treatment as usual would result in fewer suicidal and self-harm acts and the use of fewer crisis resources relative to treatment as usual alone; and 3) gains resulting from STEPPS plus treatment as usual would be maintained during the follow-up.

Method

Subjects

Subjects with DSM-IV (19) borderline personality disorder were recruited from the University of Iowa inpatient and outpatient psychiatric services (N=92); clinicians and mental health centers in eastern Iowa (N=35); advertisements (N=29); word of mouth (N=8); and unspecified methods (N=8). We excluded subjects who 1) did not speak English; 2) had a psychotic or primary neurological disorder; 3) were cognitively impaired; 4) had current (past month) substance abuse or dependence; or 5) participated in STEPPS previously. Subjects were required to designate a mental health professional and a friend or relative to serve as system members. The purpose was to ensure that an independent mental health professional could be reached in a crisis and that a friend or relative could participate in the systems component of STEPPS. The designated individual was taught how to respond to the subject's dysfunctional thoughts or behaviors. Subjects were not required to have recent suicidal or self-harm behavior. Subjects gave written informed consent according to procedures approved by the University of Iowa Institutional Review Board.

Assessments

The diagnosis of borderline personality disorder was established using the Structured Interview for DSM-IV Personality (20). The Structured Clinical Interview for DSM-IV (SCID) (21) assessed current and lifetime DSM-IV axis I disorders. Efficacy assessments included the Zanarini Rating Scale for Borderline Personality Disorder (22) to assess affective disturbance, cognitive disturbance, impulsivity, and disturbed relationships; the Borderline Evaluation of Severity Over Time (18) to assess thoughts, feelings, and behaviors associated with borderline personality disorder; the Positive and Negative Affect Schedule (PANAS) (23) to assess positive and negative dispositions; the Beck Depression Inventory (24); the Symptom Checklist-90-Revised (25); the Barratt Impulsiveness Scale (version 11a) (26); and the Social Adjustment Scale (27). Suicide and self-harm behaviors, medication usage, physician visits, other therapies, and crisis contacts were also assessed.

Primary outcome was the Zanarini Rating Scale for Borderline Personality Disorder total score. Zanarini Rating Scale for Borderline Personality Disorder subscales were used as secondary efficacy measures. Other secondary measures included the rater-administered Clinical Global Impression (CGI) Improvement and Severity scales (28), patient CGI self-rating (28), Global Assessment Scale (29), Beck Depression Inventory (24), Symptom Checklist-90-Revised (25), Barratt Impulsiveness Scale (26), and Social Adjustment Scale (27). The CGI and Global Assessment Scales were used in part because of their demonstrated utility in medication studies of borderline personality disorder (30, 31). Secondary outcome measures also included crisis variables (hospitalizations, emergency department visits, and crisis phone calls), suicide attempts, and self-harm acts.

To achieve reliability on interview measures, raters were trained by Nancee Blum, who also provided ongoing supervision. Excellent diagnostic agreement was achieved (kappa=1.0 for borderline personality disorder). The intraclass correlation coefficient was 0.96 for the Zanarini Rating Scale for Borderline Personality Disorder total and 0.58 for the CGI severity ratings.

In addition to screening and baseline evaluations, subjects were assessed at weeks 4, 8, 12, 16, and 20. The Client Satisfaction Questionnaire-8 (32) was administered at week 20.

Treatment Assignment

Subjects were assigned by coin toss to either the STEPPS plus treatment as usual group or treatment as usual alone group. Whenever eight to 12 subjects were assigned to STEPPS plus treatment as usual, they were notified that a group would begin. Groups began a mean of 6.5 (SD=6.6) weeks after random assignment. Eight treatment cohorts were recruited between 2002 and 2006.

STEPPS Program

STEPPS is a manual-based group treatment program for outpatients with borderline personality disorder that combines cognitive behavioral elements with skills training; it does not include individual therapy. The program involves 20 2-hour weekly sessions with two co-facilitators who follow a detailed lesson plan. Participants receive a packet of materials each week, including an agenda and homework assignments. STEPPS is systems-based in that family members, significant others, and health care professionals are educated about borderline personality disorder and instructed how best to interact with their relative or friend with the disorder. Participants are urged to share their notebooks and lesson materials with system members.

The STEPPS program has the following three main components: 1) psychoeducation about borderline personality disorder; 2) emotion management skills training; and 3) behavior management skills training. The first component teaches subjects to replace misconceptions about borderline personality disorder with an awareness of the thoughts, feelings, and behaviors that define it and to identify their own schemas (i.e., cognitive filters) that drive their behaviors. The disorder is also reframed as an emotional intensity disorder, which patients find preferable to borderline personality disorder. The second component teaches the following skills to better manage the cognitive and emotional effects of borderline personality disorder: distancing, communicating, challenging, distracting, and problem management. The third component teaches the following behavioral skills, which subjects are encouraged to master: goal setting, healthy eating behaviors, sleep hygiene, regular exercise, leisure activities, health monitoring (e.g., medication adherence), avoiding self-harm, and interpersonal effectiveness. A session-by-session description is provided in Table 1.

Sessions have the look and feel of a seminar. Participants sit at a conference table facing a board. There is a short break between the first and second hours. Each weekly session is organized around a particular skill. Some skills require more than one session to teach. In addition to the use of a board and printed materials, the program is facilitated by poetry, songs, art work, and relaxation exercises. Participants are encouraged to bring materials or artwork to reinforce the skills and themes of the meetings.

Participants are asked to monitor their thoughts, feelings, and behaviors over the course of the program; this enables them to become aware of and to monitor improvements in the intensity and frequency of their emotional episodes. They are introduced to the Emotional Intensity Continuum, a 1- to 5-point scale using the metaphor of pots on a burner. At level 1, there is no heat under the pot; at level 5 the pot is boiling over. This allows participants to recognize early warning signs of an impending outburst. New skills become the tools to prevent the heat from getting too hot, thereby reducing the chance that the pot will boil over. With this and other metaphors, abstract concepts are made more concrete and understandable. As participants progress, they are asked to

TABLE 1. Session-by-Session Description of Systems Training for Emotional Predictability and Problem Solving (STEPPS) for Outpatients With Borderline Personality Disorder

Session	Description
Session 1	Introduction of participants and co-facilitators. Completion, scoring, and recording of the Borderline Evaluation of Severity Over Time (BEST) scale. Review guidelines for participating in STEPPS program. Review concept of borderline personality disorder, including diagnostic criteria and introduction of Emotional Intensity Disorder as an alternate "diagnostic" label. Identification of reinforcement team (members of support system with whom they choose to share information about borderline personality disorder, the skills they are learning, and how the team can reinforce what they've learned). Each group member identifies his or her specific goals (e.g., personal, social, educational/vocational).
Session 2	Completion of the BEST. (From this point forward, participants complete the BEST prior to each subsequent session.) Completion of schema questionnaire and education about schemas (cognitive filters) in borderline personality disorder.
Session 3	Description of distancing from emotional intensity, and relaxation breathing; each subsequent session begins with a different relaxation exercise.
Sessions 4 and 5	Introduction to the Emotional Intensity Continuum. These two sessions also teach the communicating of feelings, physical sensations, thoughts, filters, behaviors, and action urges more accurately. Beginning with session 5, the relaxation exercise is followed by a review of each participant's use of the Emotional Intensity Continuum and specific STEPPS skills.
Sessions 6–8	Teach the challenging of maladaptive filters by identifying common cognitive distortions and replacing them with more accurate and functional alternative thoughts.
Sessions 9 and 10	Teach distracting behaviors and positive affirmations to reduce emotional intensity.
Sessions 11 and 12	Teach the management of problems using specific problem solving paradigms.
Session 13	Identify problematic lifestyle behaviors (eating, sleeping, exercise, etc.) and discuss the need for balance. Participants complete a questionnaire to identify areas of difficulty. Each participant identifies a problem area on which to work.
Session 14	Specific goals are set for one previously identified problematic behavior, which are worked on in the remaining weeks.
Session 15	Healthy eating and sleep behaviors are reviewed.
Session 16	Healthy exercise, leisure, and physical health behaviors are reviewed.
Session 17	Skills to reduce self-harm behaviors are taught. Participants use the Emotional Intensity Continuum to identify antecedents to self-harm and other abusive behaviors.
Sessions 18 and 19	Discussion of interpersonal boundaries and solicitation of relationships.
Session 20	Comparison of initial and termination schema (i.e., cognitive filters) questionnaire. Evaluation of the group's progress and use of skills. Celebration of completion.

monitor the new skills employed to manage their emotional intensity. Patients gradually become more aware of emotional triggers that may lead to outbursts.

Participants are encouraged to continue with ongoing concomitant treatment. Those participating in individual therapy are asked to familiarize their therapist with STEPPS, thereby enabling all members of the treatment team to employ a consistent approach and terminology. Participants are encouraged to show a copy of the handouts to their therapist and to review their homework assignments during their individual sessions.

A 2-hour evening session is held for family members or significant others as part of the program. These individuals are educated about borderline personality disorder and how best to respond to their relative or friend with the disorder. STEPPS attendees are encouraged to share their lessons with their individual therapist and significant others. This constitutes the systems component of the program.

STEPPS was administered by two of the authors of the present study (Ms. Blum and Mr. St. John). Adherence to the manual was rated on a 5-point scale, with a score of 5 denoting excellent adherence (unpublished data of Donald W. Black, 2002). A score of 4 (good) or higher was considered acceptable. Two Ph.D.-level psychologists who were not involved with the randomized controlled trial but familiar with STEPPS rated 43 randomly selected videotaped sessions. The mean adherence score was 4.4 (SD=0.8).

Additional information about the STEPPS program may be found at www.steppsforbpd.com. The website contains a summary of the program, literature references, author information, and contact instructions.

Treatment as Usual

Subjects assigned to either STEPPS plus treatment as usual or to treatment as usual alone were encouraged to continue their usual care, including individual psychotherapy, medication, and case management. Subjects received no instructions or advice about other pharmacologic or psychotherapeutic treatments. Subjects assigned to treatment as usual alone could not attend any STEPPS group until they completed the 20-week trial.

Follow-Up

At the end of the 20-week treatment period, subjects entered a 1-year follow up. Assessments were made at months 1, 3, 6, 9, and 12. These included the Borderline Evaluation of Severity Over Time, Beck Depression Inventory, PANAS, CGI severity and improvement ratings, Global Assessment Scale, and Social Adjustment Scale. Data on crisis variables, medication use, psychotherapy visits, suicide attempts, and self-harm acts were also collected.

Statistical Analysis

Subjects with at least one postbaseline assessment were included in the analyses. To test for treatment group imbalances, baseline demographic characteristics and clinical variables were compared using Pearson's chi-square tests or Student's t tests.

A linear mixed-effects model was used for primary and secondary outcomes. Each subject's trajectory of scores from baseline to week 20 was summarized with a subject-specific intercept and slope, thus allowing STEPPS efficacy to be tested by examining the difference between the mean slopes of the two groups. To adjust for possible bias from informative right censoring (which occurs, for

TABLE 2. Baseline Social, Demographic, and Clinical Characteristics of 124 Outpatients With Borderline Personality Disorder, by Treatment Assignment

Characteristic	Treatment Assignment: STEPPS Plus Treatment as Usual (N=65)		Treatment Assignment: Treatment as Usual Alone (N=59)		All Subjects (N=124)	
	N	%	N	%	N	%
Gender						
Female	52	80	51	86	103	83
Male	13	20	8	14	21	17
Race/ethnicity						
Caucasian	62	95	55	93	117	94
African American	1	2	2	3	3	2
Other	2	3	2	3	4	3
Marital status						
Never married	27	42	23	39	50	40
Married/living together	21	32	20	34	41	33
Divorced/separated	17	26	16	27	33	27
Education						
<High school	2	3	4	7	6	5
High school	10	15	15	25	25	20
Some college	38	59	27	46	65	52
College degree	9	14	11	19	20	16
Graduate degree	6	9	2	3	8	6
Employment						
Employed	28	43	20	34	48	39
Disabled	18	28	14	24	32	26
Other (e.g., student)	19	29	25	42	44	35
Past psychiatric hospitalization[a]	38	69	30	75	68	72
Prior suicide attempts	47	72	44	75	91	73
Prior self-harm	45	69	44	75	89	72
Current individual therapy	41	63	32	54	73	59
Current major depressive disorder	44	68	46	78	90	73
	Mean	SD	Mean	SD	Mean	SD
Age (years)	31.4	8.8	31.6	10.3	31.5	9.5
Psychotropic medications	3.0	2.5	2.7	2.1	2.9	2.3
Lifetime DSM-IV axis I disorders	4.8	2.4	5.0	2.6	4.9	2.5
DSM-IV personality disorders	3.1	1.7	3.7	1.9	3.4	1.8
DSM-IV borderline personality disorder criteria	7.6	1.3	7.7	1.2	7.6	1.2

[a] Total N=95 (55 in STEPPS plus treatment as usual, 40 in treatment as usual alone).

example, when subjects with more favorable response are more likely to be assessed), last assessment time was used as a covariate for intercepts and slopes. For the primary outcome variable (Zanarini Rating Scale for Borderline Personality Disorder total), last assessment time was not related to baseline score (intercept) or level of improvement (slope), and therefore this adjustment had little effect on the test of STEPPS efficacy. To ensure that a significant baseline difference with respect to avoidant personality disorder did not confound the test of STEPPS efficacy, the disorder was used as a covariate for intercepts and slopes. Avoidant personality disorder was associated with baseline severity (intercept) for the primary outcome but not level of improvement (slope), an adjustment that had little effect on the test of STEPPS efficacy.

Group differences were also tested across the 1-year follow-up. A repeated measures analysis of variance (ANOVA) model was used to compare group changes from week 20 with week 72 (1-year follow-up). By utilizing the correlation of subjects' responses over time, this model accommodates subjects with incomplete data. The correlation of subjects' responses was assumed to have a first-order autoregressive structure, which assumes that the correlation of a subject's responses decreases as the time between the assessments increases. For this analysis, week 20 was considered the baseline.

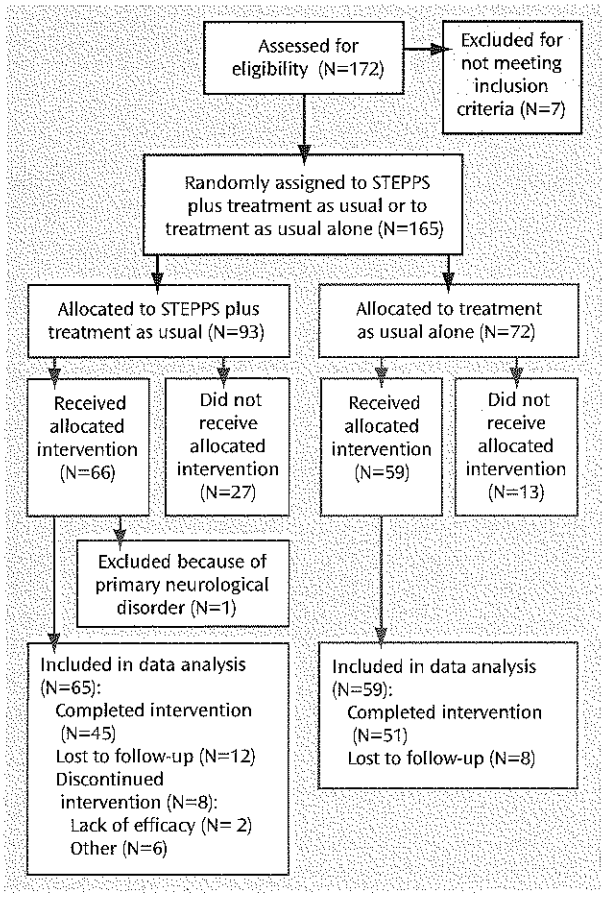
Groups were compared on the use of crisis services throughout the treatment and follow-up periods. For these variables, subjects were asked to report utilization during the last month. For each subject, we counted the number of follow-up months (n) and number of months for which each crisis service (hospitalizations, emergency department visits, and crisis calls) was utilized (y). Assuming a binomial model (y is a binomial random variable with parameters n and p) with logistic link function, we tested whether the probability of monthly utilization (p) differed for the groups. Using the Cox proportional hazards model, the study groups were compared on times to first suicide attempt and self-harm act.

Statistical analyses were carried out using SAS (33). The linear mixed-effects and repeated measure models were fit using the MIXED procedure; the binomial models were fit using the NLMIXED procedure; and the Cox proportional hazards model was fit using the PHREG procedure. All tests were performed using a two-sided significance level of p=0.05.

Results

One hundred seventy-two men and women 18 years and older were screened; 165 were enrolled and randomly assigned to STEPPS plus treatment as usual or treatment as usual alone. One hundred twenty-five subjects received the allocated interventions. Of these, data from 124 were analyzed (Figure 1). (One subject was excluded because of a primary neurological disorder.) The groups were balanced on baseline demographic and clinical variables (Table 2), except avoidant personality disorder was more frequent in the treatment as usual alone group (66% versus 45%; χ^2=5.8, df=1, p=0.016).

FIGURE 1. Consort Diagram of Patient Flow in the Randomized Controlled Trial



Forty-five (69%) subjects assigned to STEPPS plus treatment as usual and 51 (86%) subjects assigned to treatment as usual alone completed the week 20 assessment (χ^2=5.2, df=1, p=0.022). Baseline variables—age, gender, severity (Borderline Evaluation of Severity Over Time), and depression (Beck Depression Inventory)—were not predictive of having at least one postbaseline assessment or early discontinuation. Subjects completed a mean of 4.2 (SD=1.3) assessments, with no significant differences between treatment conditions (Mann-Whitney test: χ^2=1.6, df=1, p=0.213). Overall, 82 (66%) subjects were assessed at least once during the 1-year follow-up. During follow-up, the mean number of assessments was 3.0 (SD=1.6) for STEPPS plus treatment as usual recipients and 2.8 (SD=1.3) for treatment as usual alone recipients (Mann-Whitney test: χ^2=0.4, df=1, p=0.549). STEPPS recipients attended a mean of 12.9 (SD=5.4) group treatment sessions.

Assessment of Efficacy: Treatment Period

STEPPS plus treatment as usual recipients improved from baseline through week 20 on primary and secondary outcome measures (Table 3). The mean rate of change for the STEPPS plus treatment as usual group was significantly greater relative to the treatment as usual alone group for the Zanarini Rating Scale for Borderline Personality Disorder total and all four subscales, CGI severity and improvement ratings, Global Assessment Scale, Borderline Evaluation of Severity Over Time (thoughts/feelings subscale), Barratt Impulsiveness Scale, PANAS (negative affectivity subscale), Beck Depression Inventory, Symptom Checklist-90-Revised (depression, psychoticism, and global severity subscales), and Social Adjustment Scale (social/leisure subscale and total score). For other outcomes, improvement observed in the STEPPS plus treatment as usual group was greater than the treatment as usual alone group, but differences were not statistically significant.

Effect sizes for the STEPPS program at 20 weeks represent group differences in mean improvement divided by the pooled standard deviations at baseline. While some assessment scales were reverse-coded (lower scores more favorable), we report all effect sizes in a positive direction. For the Zanarini Rating Scale for Borderline Personality Disorder total, estimated effect size was 0.84, indicating a large effect of the STEPPS program on the primary outcome. For secondary outcome measures, effect size estimates ranged from 0.12–1.09. Generally, those of 0.50 and greater were statistically significant.

Figure 2 shows estimated means over the treatment period for the primary and selected secondary outcomes. Improvements for the STEPPS plus treatment as usual group appear to be monotonic and roughly linear. Improvements for the treatment as usual alone group appear mostly confined to the first half of the treatment period.

Subjects randomly assigned to STEPPS plus treatment as usual had greater change in CGI severity and improvement ratings relative to those randomly assigned to treatment as usual alone. Using each subject's last observation within the treatment period, those randomly assigned to STEPPS plus treatment as usual were more likely to be rated "very much" or "much" improved (40.0% versus 5.1%; χ^2=21.0, df=1, p<0.001); subjects' own global self-ratings showed similar results, with 58.5% of STEPPS plus treatment as usual recipients rating themselves as "very much" or "much" improved, compared with 22.0% for those assigned to treatment as usual alone (χ^2=16.9, df=1, p<0.001). STEPPS plus treatment as usual recipients were more likely to reach the clinically relevant Global Assessment Scale cutoff (>60) (18.5% versus 5.1%; χ^2=5.2, df=1, p=0.023).

Assessment of Efficacy: 1-Year Follow-Up

There were no statistically significant group differences across the 1-year follow-up (Table 4), suggesting that treatment period gains attributed to STEPPS were maintained. Because not all subjects were assessed through the follow-up period, these analyses were less powerful than the primary analyses through week 20.

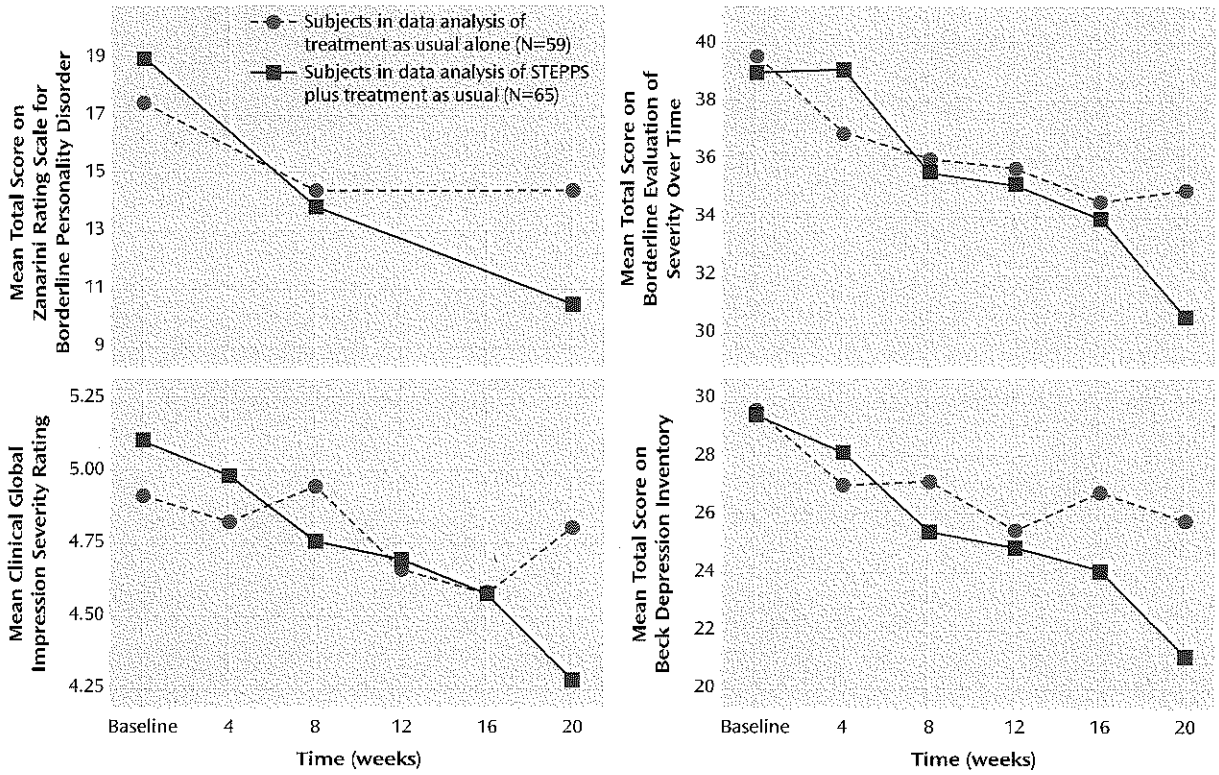
Using each subject's last observation within the follow-up period, those subjects randomly assigned to STEPPS

TABLE 3. Primary and Secondary Outcome Measures in Outpatients With Borderline Personality Disorder Randomly Assigned to STEPPS Plus Treatment as Usual or Treatment as Usual Alone

	Treatment Assignment								
	STEPPS Plus Treatment as Usual (N=65)		Treatment as Usual Alone (N=59)[a]		Analysis of Difference in Rate of Change				
Outcome Measure	Mean	SD/SE[b]	Mean	SD/SE[b]	F	df	p	Effect Size[c]	SE
Primary measure									
Zanarini Rating Scale for Borderline Personality Disorder (total score)					11.0	1, 89	0.001	0.84	0.25
Baseline	18.9	6.8	17.3	7.0					
Week 20	9.8	1.0	13.4	1.0					
Secondary measures									
Affective subscale[d]					7.6	1, 89	0.007	0.70	0.25
Baseline	10.8	2.7	10.1	2.8					
Week 20	3.9	0.4	4.9	0.4					
Cognitive subscale[d]					5.1	1, 89	0.027	0.51	0.23
Baseline	6.1	2.3	6.2	2.2					
Week 20	2.0	0.3	3.0	0.3					
Impulsivity subscale[d]					6.9	1, 89	0.010	0.65	0.25
Baseline	5.0	2.1	4.3	2.0					
Week 20	1.9	0.3	2.3	0.3					
Disturbed relationships subscale[d]					5.1	1, 88	0.026	0.61	0.27
Baseline	6.0	2.0	5.8	2.0					
Week 20	2.2	0.3	3.2	0.3					
CGI severity rating					14.1	1, 398	<0.001	0.75	0.20
Baseline	5.1	0.8	4.9	0.9					
Week 20	4.4	0.1	4.7	0.1					
CGI improvement rating					11.6	1, 277	<0.001	1.09	0.32
Baseline	3.8	1.0	4.0	1.1					
Week 20	2.7	0.2	3.8	0.2					
CGI patient self-rating					9.0	1, 254	0.003	0.90	0.30
Baseline	3.6	1.3	3.7	1.4					
Week 20	2.4	0.2	3.3	0.2					
Global Assessment Scale					12.1	1, 84	<0.001	0.65	0.19
Baseline	39.7	11.2	39.6	11.4					
Week 20	50.5	1.6	43.5	1.6					
Thoughts/feelings[e]					4.9	1, 379	0.027	0.51	0.23
Baseline	23.1	6.6	23.6	7.7					
Week 20	18.7	1.0	20.6	1.1					
Negative behaviors[e]					0.3	1, 375	0.578	0.12	0.22
Baseline	9.3	3.3	9.6	4.3					
Week 20	8.2	0.5	7.9	0.5					
Positive behaviors[e]					2.6	1, 368	0.110	0.41	0.26
Baseline	8.5	2.7	8.6	2.8					
Week 20	10.1	0.4	9.3	0.4					
Total score[e]					3.5	1, 364	0.063	0.47	0.25
Baseline	39.0	9.7	39.8	12.6					
Week 20	31.8	1.7	34.1	1.8					
Positive affectivity (PANAS)					0.6	1, 374	0.440	0.15	0.19
Baseline	21.6	9.3	22.3	7.9					
Week 20	23.4	1.1	22.4	1.1					
Negative affectivity (PANAS)					4.3	1, 376	0.038	0.43	0.21
Baseline	28.9	9.4	29.9	9.0					
Week 20	23.6	1.2	26.1	1.2					
Beck Depression Inventory					4.6	1, 377	0.033	0.50	0.23
Baseline	29.0	11.6	29.7	15.0					
Week 20	22.0	2.0	25.8	2.0					
Barratt Impulsiveness Scale					9.0	1, 80	0.004	0.54	0.18
Baseline	80.6	12.6	77.4	12.8					
Week 20	72.7	1.8	76.8	1.8					
Sympton Checklist-90-Revised Global Severity Index[f]					4.8	1, 78	0.031	0.44	0.20
Baseline	16.0	7.2	16.8	6.0					
Week 20	12.5	1.0	14.9	1.1					
Social Adjustment Scale total score[f]					3.5	1, 80	0.065	0.43	0.23
Baseline	27.8	5.0	28.2	5.0					
Week 20	24.6	0.8	26.3	0.8					

[a] Estimated mean and standard error from linear mixed-effects model adjusted for last assessment time and avoidant personality disorder. All subjects with postbaseline assessment contributed to the estimation of baseline and week 20 means.
[b] Standard deviation was used at baseline, and standard error was used at week 20.
[c] Effect size is estimated as the group difference in week 20 mean improvement divided by the pooled standard deviation at baseline.
[d] From the Zanarini Rating Scale for Borderline Personality Disorder.
[e] From the Borderline Evaluation of Severity Over Time scale.
[f] To facilitate the reporting of significant digits, we scaled this measure by multiplying item means by 10.

FIGURE 2. Mean Primary and Secondary Outcome Measure Scores[a]



[a] The Zanarini Rating Scale for Borderline Personality Disorder was obtained at baseline, week 8, and week 20. The Borderline Evaluation of Severity Over Time, CGI ratings, and Beck Depression Inventory were obtained at baseline and weeks 4, 8, 12, 16, and 20.

plus treatment as usual were still more likely to be rated "very much" or "much" improved (40.0% versus 15.6%; χ^2= 5.5, df=1, p=0.019). However, subjects' global self-ratings were not significantly different during the follow-up, with 55.1% of STEPPS plus treatment as usual recipients rating themselves "very much" or "much" improved, compared with 43.8% of those assigned to treatment as usual alone (χ^2=1.0, df=1, p=0.318). Within the follow-up period, subjects in STEPPS plus treatment as usual were still more likely to reach the Global Assessment Scale score cutoff (>60) (28.0% versus 9.7%; χ^2=3.9, df=1, p=0.049).

Medication and Individual Psychotherapy

Ninety percent of subjects reported at least one psychotropic medication at baseline. Antidepressants were reported by 42 (65%) of the STEPPS plus treatment as usual recipients and 33 (56%) of the treatment as usual alone group (χ^2=1.0, df=1, p=0.323). Psychotropic usage significantly decreased during the 20-week treatment period for both groups (from 2.9 to 1.3 medications per subject), but there was no group difference in level of change (Mann-Whitney test: χ^2=0.1, df=1, p=0.782). Thus, medication usage did not confound study results. Additionally, 63% of STEPPS plus treatment as usual subjects and 54% of treatment as usual alone subjects were receiving individual psychotherapy at baseline. These percentages remained relatively static during the 20-week treatment period.

Indirect Indicators of Efficacy

Subjects were asked to report crisis care utilization within the last month. Because subjects varied in their number of assessments, we report utilization statistics in terms of the number of months per year in which utilization occurred. Thus, for example, we can distinguish a subject with three utilizations over 3 months (i.e., 12 months per year with utilization) from a subject with three utilizations over 6 months (i.e., 6 months per year with utilization). Overall, 35 (28.2%) subjects had at least one hospitalization during the treatment period or follow-up. Subjects randomly assigned to STEPPS plus treatment as usual averaged 1.13 months per year during which hospitalization occurred, and subjects randomly assigned to treatment as usual alone averaged 1.24; the difference was not significant (binomial test: p=0.670). In addition, 43 (34.7%) subjects had at least one emergency department visit during the treatment period or follow-up. Subjects randomly assigned to STEPPS plus treatment as usual averaged 0.97 months per year with at least one emergency department visit, and subjects randomly assigned to treatment as usual alone averaged 1.52; the difference was significant (binomial test: p=0.040). Finally, 60 (48.4%) sub-

TABLE 4. Follow-Up Comparison of Outcome Measures in Outpatients With Borderline Personality Disorder Randomly Assigned to STEPPS Plus Treatment as Usual or Treatment as Usual Alone

	Treatment Assignment						
	STEPPS Plus Treatment as Usual (N=65)		Treatment as Usual Alone (N=59)		Analysis		
Outcome Measure	Mean[a]	SE	Mean[a]	SE	F	df	p
CGI severity rating					0.1	1, 761	0.759
Week 20	4.3	0.1	4.8	0.1			
1 year	4.4	0.2	4.9	0.2			
CGI improvement rating					1.4	1, 616	0.240
Week 20	2.7	0.2	3.9	0.2			
1 year	3.1	0.2	3.8	0.3			
CGI patient self-rating					3.6	1, 572	0.058
Week 20	2.4	0.2	3.3	0.2			
1 year	2.8	0.3	2.7	0.4			
Global Assessment Scale					0.1	1, 427	0.743
Week 20	50.0	1.6	43.0	1.6			
1 year	53.0	2.0	47.1	2.7			
Thoughts/feelings[b]					2.4	1, 718	0.121
Week 20	18.3	1.1	20.9	1.1			
1 year	20.5	1.4	18.8	2.1			
Negative behaviors[b]					0.1	1, 714	0.783
Week 20	7.9	0.5	8.0	0.5			
1 year	7.9	0.7	7.5	1.0			
Positive behaviors[b]					0.3	1, 704	0.587
Week 20	9.9	0.4	9.4	0.4			
1 year	10.2	0.6	9.1	0.8			
Total score[b]					0.7	1, 700	0.410
Week 20	31.3	1.8	34.5	1.8			
1 year	33.0	2.3	32.4	3.4			
Positive affectivity (PANAS)					0.2	1, 710	0.687
Week 20	23.5	1.3	23.0	1.3			
1 year	25.1	1.7	26.0	2.5			
Negative affectivity (PANAS)					0.1	1, 713	0.750
Week 20	23.4	1.3	26.2	1.3			
1 year	25.8	1.8	27.4	2.6			
Beck Depression Inventory					0.5	1, 712	0.462
Week 20	22.1	2.0	25.3	2.0			
1 year	24.0	2.6	23.4	3.8			
Social Adjustment Scale total score[c]					0.8	1, 415	0.371
Week 20	25.2	0.8	26.2	0.8			
1 year	24.3	1.0	27.1	1.5			

[a] Estimated mean if groups were balanced on avoidant personality disorder and last visit time (hence the week 20 mean estimates will differ somewhat from those presented in Table 3). All subjects with follow-up assessment (N=50 for STEPPS plus treatment as usual, N=32 for treatment as usual alone) contributed to the estimation of week 20 and week 72 means.
[b] From the Borderline Evaluation of Severity Over Time scale.
[c] To facilitate the reporting of significant digits, we scaled this measure by multiplying item means by 10.

jects made at least one crisis call during the treatment period or follow-up. Subjects randomly assigned to STEPPS plus treatment as usual averaged 2.49 months per year during which at least one crisis call was made, and subjects randomly assigned to treatment as usual alone averaged 2.31; the difference was not significant (binomial test: p=0.603).

Suicide attempt and self-harm data were available for 108 of the 124 subjects. Suicide attempts were reported by 24 subjects (22.2%), and self-harm acts were reported by 56 (45.2%) subjects during treatment and follow-up. Nearly all who attempted suicide (88%) also reported self-harm acts. Among those who attempted suicide, the median number of attempts was 1.75 per year, and the mean was 2.60. Among those who reported acts of deliberate self-harm, the median number of acts was 9.8 per year, and the mean was 16.6. Using the Cox proportional hazards model, treatment group was not associated with time to first suicide attempt (χ^2<0.1, df=1, p=0.994) or first self-harm act (χ^2<0.1, df=1, p=0.902).

Client Satisfaction Questionnaire-8 total scores at week 20 were significantly higher for the STEPPS plus treatment as usual group relative to the treatment as usual alone group (t=4.7, df=71, p<0.001), with means of 28.2 (SD=4.9) and 22.6 (SD=5.2), respectively, indicating greater satisfaction.

Discussion

STEPPS plus treatment as usual was superior to treatment as usual alone in the treatment of outpatients with borderline personality disorder across a spectrum of illness-specific and global measures. These results are en-

Patient Perspective

"Jenny," a 43-year-old married, Caucasian woman, was referred to the research study by her psychiatrist. She had a history of physical and emotional abuse in childhood, repetitive self-harm (mainly cutting and head banging), and multiple non-serious suicide attempts. She had been psychiatrically hospitalized more than 200 times, and she had from 5 to 10 admissions annually in recent years. She was taking nefazodone, quetiapine, gabapentin, and carbamazepine for symptom management and was engaged in individual psychotherapy. She screened positive for recurrent major depression, posttraumatic stress disorder, past panic disorder, and past anorexia nervosa in addition to her borderline personality disorder.

Jenny was randomly assigned to the active treatment arm and attended all 20 STEPPS sessions, despite having to drive a considerable distance and experiencing financial, marital, and school-related stressors. Her reinforcement team consisted of her psychiatrist and therapist but eventually expanded to include other members of the group. She gradually became less symptomatic. For example, her Borderline Evaluation of Severity Over Time score fell from 50 at baseline to 17 at week 20. Instead of near monthly hospitalizations, there were only three during the STEPPS program, two during the following year, and none during the past year. Likewise, there was one non-serious suicide attempt during the program and none during the following 2 years, a record for her.

With STEPPS, Jenny learned new emotion and behavior management skills. When she reached a "5" on the Emotional Intensity Continuum (indicating that she felt out of control), the group facilitators and members helped her identify the cognitive filters and related distorted thoughts that were triggered; she was then encouraged to choose and implement a skill to reduce her emotional intensity. Social undesirability, for example, was a strong cognitive filter that often led to acts of self-harm. In response, Jenny learned to use the skills of distancing and distracting to decrease her emotional intensity and to use the skill of communicating her thoughts to others and accepting feedback. As the group progressed, she was able to challenge her cognitive distortions more effectively and respond to stressful situations in a more positive way.

Jenny has since completed her schooling and is employed as a part-time school teacher and mental health advocate. She uses her STEPPS skills on a daily basis: "Although I often feel like hurting myself, I rarely act out....It's much easier for me to bring myself down to a lower intensity level, often without the help of others."

couraging because they suggest that a relatively brief adjunctive program can deliver clinically meaningful benefits to persons with this disorder and improve their quality of life. STEPPS now joins several other treatment programs supported by empirical evidence and is a reminder that earlier pessimism regarding the treatment of borderline personality disorder was misplaced (5–12).

This treatment program helped subjects to better understand their personality disorder and gave them skills to cope with it. It may also have provided social support, hope, and therapeutic alliance, which are common factors that may be responsible for benefit from many forms of therapy (34–36). Further, our test of STEPPS employed features of an effectiveness study suggesting that STEPPS provides "real-world" benefit. For example, subjects were allowed to take psychotropic medication or receive individual therapy and case management.

STEPPS led to broad-based improvements that included the affective, cognitive, impulsive, and disturbed relationship domains assessed by the Zanarini Rating Scale for Borderline Personality Disorder; it also had a robust antidepressant effect. Impulsivity, as measured by the Barratt Impulsiveness Scale, was significantly reduced, as were negative thoughts and feelings and negative affectivity, the latter findings indicating that STEPPS recipients were less likely to feel hopeless and helpless or to have negative self-impressions. These changes reflect the emphasis of the program in that subjects are taught to regulate their intense emotions and maladaptive behaviors. Importantly, improvements were generally maintained during the follow-up, suggesting that subjects learned new skills that they used beyond the treatment period to enhance their quality of life. Nonetheless, there was regression in some scores during the follow-up for STEPPS recipients. Without the support and structure of the group, mild regression may be inevitable in some persons.

Subjects assigned to STEPPS plus treatment as usual had moderate to high levels of satisfaction with the program based on their Client Satisfaction Questionnaire-8 scores, findings congruent with our preliminary data (16). Of course, these ratings were obtained from subjects who completed the treatment study, and those who did not may have been less satisfied.

We were unable to confirm our a priori hypotheses regarding a reduction in suicidal and self-harm acts during the 20-week treatment or follow-up, although there were no suicides. Additionally, while there was less crisis utilization among those individuals receiving STEPPS, only the reduction of emergency department visits was statistically significant. It may be that a positive effect on these behaviors requires more than a 20-week program or that more intensive follow-up is needed. To this end, we have developed an adjunctive program designed to follow STEPPS, which we plan to investigate. Reductions in crisis utilization, suicide attempts, and self-harm acts reported by other researchers have generally followed at least 12 to 18 months of active treatment (6–10). In addition, unlike some studies (5, 6), we did not require subjects to be sui-

cidal at intake, and the low base rate of suicidal behaviors may have made it difficult to show a treatment effect.

There are several methodological limitations. First, we experienced a relatively high discontinuation rate. High drop-out rates are the bane of borderline personality disorder treatment trials. Bateman and Fonagy (8, 9) claimed a rate of only 12%, as did Linehan et al. (6) in their recent dialectical behavioral therapy trial, yet substantially higher rates have been reported by others. Verheul et al. (7) reported that 34 of 58 subjects (59%) assigned to dialectical behavioral therapy or treatment as usual dropped out. While we encouraged patients to remain in the study, we neither sought a commitment nor made a systematic attempt to reduce nonattendance. Most subjects assigned to STEPPS plus treatment as usual were not regular attendees of our clinic, and lack of "clinic loyalty" may have contributed to dropping out. Additionally, for some subjects, travel to Iowa City for the program, particularly during winter months, may have played a role. Subjects assigned to treatment as usual alone only had to complete periodic assessments, often conducted by telephone. While we intended to conduct blind assessments, we found it nearly impossible to maintain blindness. The convergence of both rater- and patient-administered scales suggests that this may not have been an important deficiency.

Another concern is the possible confounding of results by psychotropic medication. Zanarini (4) noted that nearly all patients treated for borderline personality disorder receive psychotropic medication. This was true of our subjects. Yet, there were no differences between groups indicating that results favoring STEPPS plus treatment as usual were not because of medication. Similarly, individual psychotherapy did not appear to confound the results.

The paucity of men and minorities does not allow firm conclusions about the effectiveness of STEPPS in these groups. Nor does the study design allow conclusions about the effectiveness of STEPPS relative to other manual-based treatment programs. Additionally, the fact that we did not seek subjects with recent suicidal or self-harm behaviors limits comparison with studies that have actively recruited such persons (5, 6, 10).

Additional trials of STEPPS by independent research groups and testing STEPPS in other patient populations should be considered. Future studies should also address premature discontinuation and develop strategies to minimize this limitation.

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References

1. Paris J: Social Factors in Personality Disorders: A Biopsychosocial Approach to Etiology and Treatment. New York, Cambridge University Press, 1996
2. American Psychiatric Association: Practice Guidelines for the Treatment of Patients With Borderline Personality Disorder. Am J Psychiatry 2001; 158(suppl 1):1–52
3. Soloff PH: Psychopharmacology of borderline personality disorder. Psychiatr Clin North Am: 2000; 23:169–191
4. Zanarini MC: Update on pharmacotherapy of borderline personality disorder. Curr Psychiatry Rep 2004; 6: 66–70
5. Linehan MM, Armstrong HE, Suarez A, Allmon D, Heard HL: Cognitive-behavioral treatment of chronically parasuicidal borderline patients. Arch Gen Psychiatry 1991; 48:1060–1064
6. Linehan MM, Comtois KA, Murray AM, Brown MZ, Gallop RJ, Heard HL, Korslund KE, Tutek DA, Reynolds SK, Lindenboim N: Two year randomized controlled trial and follow up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. Arch Gen Psychiatry 2006; 63:757–766
7. Verheul R, Van den Bosch LMC, Koeter MWJ, De Ridder MAJ, Stijnen T, Van den Brink W: Dialectical behavior therapy for women with borderline personality disorder: 12-month randomized clinical trial in the Netherlands. Br J Psychiatry 2003; 182:135–140
8. Bateman A, Fonagy P: Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. Am J Psychiatry 1999; 156:1563–1569
9. Bateman A, Fonagy P: Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. Am J Psychiatry 2001; 158:36–42
10. Davidson K, Norrie J, Tyrer P, Gumley A, Tata P, Murray H, Palmer S: The effectiveness of cognitive behavior therapy for borderline personality disorder: results from the Borderline Personality Disorder Study of Cognitive Therapy (BOSCOT) trial. J Person Disord 2006; 20:450–465
11. Giesen-Bloo J, van Dyck R, Spinhoven P, van Tilburg W, Dirksen C, van Asselt T, Kremers I, Nadort M, Arntz A: Outpatient psychotherapy for borderline personality disorder-randomized trial of schema-focused therapy vs transference-focused therapy. Arch Gen Psychiatry 2006; 63:649–658
12. Clarkin JF, Levy KN, Lenzenweger MF, Kernberg OF: Evaluating three treatments for borderline personality disorder: a multiwave study. Am J Psychiatry 2007; 164:922–928
13. Bartels N, Crotty T: A Systems Approach to Treatment: The Borderline Personality Disorder Skill Training Manual. Winfield, Ill, EID Treatment Systems, Inc, 1992
14. Blum N, Bartels N, St. John D, Pfohl B: STEPPS: Systems Training for Emotional Predictability and Problem Solving: Group Treat-

ment for Borderline Personality Disorder. Coralville, Iowa, Blum's Books, 2002
15. Black DW, Blum N, Pfohl B, St. John D: The STEPPS group treatment program for outpatients with borderline personality disorder. J Contemp Psychotherapy 2004; 34:193–210
16. Blum N, Pfohl B, St. John D, Monahan P, Black DW: STEPPS: A cognitive behavioral systems based group treatment for outpatients with borderline personality disorder: a preliminary report. Compr Psychiatry 2002; 43:301–310
17. Freije H, Dietz B, Appelo M: Behandling van de borderline persoonlijk heidsstoornis met de vers: de vaardigheidstraining emotionele regulatiestoornis. Direct Therapies 2002; 4:367–378
18. Van Wel B, Kockmann I, Blum N, Pfohl B, Black DW, Heesterman W: STEPPS group treatment for borderline personality disorder in the Netherlands. Ann Clin Psychiatry 2006; 18:63–67
19. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Washington, DC, American Psychiatric Publishing, 1994
20. Pfohl B, Blum N, Zimmerman M: Structured Interview for DSM-IV Personality (SIDP-IV). Washington, DC, American Psychiatric Publishing, 1997
21. Spitzer RL, Williams JBW, Gibbon M: Structured Clinical Interview for DSM-IV. New York, New York State Psychiatric Institute, Biometrics Research, 1994
22. Zanarini MC, Vujanovic AA, Parachini EA, Boulanger JL, Frankenburg FR, Hennen J: Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD): a continuous measure of DSM-IV borderline psychopathology. J Person Disord 2003; 17:233–242
23. Watson D, Clark LA: The PANAS-Manual for the Positive and Negative Affect Schedule—Expanded Form. Iowa City, University of Iowa, 1994
24. Beck AT: Depression Inventory. Philadelphia, Philadelphia Center for Cognitive Therapy, 1978
25. Derogatis LR: SCL-90-R Administration, Scoring, and Procedures Manual II. Towson, Md, Clinical Psychometric Research, 1983
26. Barratt E: Anxiety and impulsiveness related to psychomotor efficiency. Percept Mot Skills 1959; 9:191–198
27. Weissman MM, Bothwell S: Assessment of Social Adjustment by Patient Self-Report. Arch Gen Psychiatry 1976; 33:1111–1115
28. Guy W: ECDEU Assessment Manual for Psychopharmacology. Washington, DC, United States Department of HEW Publications, 76–338, 1976, pp 217–222
29. Endicott J, Spitzer RL, Fleiss JL, Cohen J: The Global Assessment Scale: a procedure for measuring overall severity of psychiatric disturbance. Arch Gen Psychiatry 1976; 33:766–771
30. Cowdry RW, Gardner DL: Pharmacotherapy of borderline personality disorder: alprazolam, carbamazepine, trifluoperazine, and tranylcypromine. Arch Gen Psychiatry 1988; 45:111–119
31. Benedetti F, Sforzini L, Colombo C, Maffei C, Smeraldi E: Low-dose clozapine in acute and continuation treatment of severe borderline personality disorder. J Clin Pychiatry 1998; 59:103–107
32. Attkisson CC, Greenfield TK: The UCSF Client Satisfaction Questionnaire (CSQ) Scales: the Client Satisfaction Questionnaire-8, in Psychological Testing: Treatment Planning and Outcome Assessment, 2nd edition. Edited by Maruish ME. Hillsdale, NJ, Erlbaum, 1999
33. SAS: SAS/STAT User's Guide: Version 8. Cary, NC, SAS Institute, Inc, 1999
34. Gabbard GO: Do all roads lead to Rome? New findings on borderline personality disorder. Am J Psychiatry 2007; 164:853–855
35. Frank JD, Frank JB: Persuasion and Healing: A Comparative Study of Psychotherapy. Baltimore, Johns Hopkins Press, 1991
36. Wampold BE: The Great Psychotherapy Debate: Models, Methods, and Findings. Mahwah, NJ, Lawrence Erlbaum Associates Publishers, 2001

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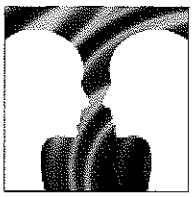

Service users' experiences of a therapeutic group programme in an acute psychiatric inpatient unit

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Psychiatric nurses have been facilitating therapeutic groups in acute psychiatric inpatient units for many years; however, there is a lack of nursing research related to this important aspect of care. This paper reports the findings of a study which aimed to gain an understanding of service users' experiences in relation to therapeutic group activities in an acute inpatient unit. A qualitative descriptive study was undertaken with eight service users in one acute psychiatric inpatient unit in Ireland. Data were collected using in-depth semi-structured interviews and analysed using Burnard's method of thematic content analysis. Several themes emerged from the findings which are presented in this paper.

Keywords: acute care, group work

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Introduction and background

Acute psychiatric inpatient units have been described as places that are fraught with difficulty with little therapeutic care offered (Sainsbury Centre for Mental Health 1998, O'Donovan & Gijbels 2006). Studies have indicated that service users believe they are dreary, de-skilling, anti-therapeutic and are likely to promote institutionalization (Mental Health Commission 2006). Furthermore, psychiatric nursing practice within these units has been found to be 'therapeutically superficial' (Hummelvoll & Severinsson 2001).

Psychiatric nurses have been facilitating therapeutic groups in acute inpatient units for many years in an attempt to overcome some of these problems. Anecdotal evidence suggests that these groups range from anxiety management groups, relapse prevention groups, recovery groups, discussion groups and relaxation groups. Indeed involving service users in groups has been identified as one way of optimizing service user treatment while maximizing staff resources and containing costs (Potter *et al.* 2004).

An electronic search of CINAHL, PubMed and PsycINFO was undertaken using the key terms groups, group therapy, group programme and therapeutic group which were combined with nursing and psychiatric nursing. All papers that referred to groups facilitated solely by other professionals such as Doctors and Psychologists were not included in the review.

In reviewing the literature, drawing comparison between the studies proved difficult. First, the studies were undertaken in a variety of different settings and involved a variety of psychological treatments. In particular, most of the literature refers to group therapy. Group therapy implies that a psychological therapy is offered in a group format; however, many of the groups facilitated by nurses in the acute setting are not categorized as 'group therapy' but rather the groups aim to have a therapeutic element. Additionally, much of the research is dated with little

European focus on this aspect of nursing care in recent years. In the current climate of service user dissatisfaction with the lack of therapeutic care offered in acute inpatient units and with the drive towards cost-effective treatments it was deemed timely to explore service users' experiences of therapeutic groups offered in acute inpatient units.

Therapeutic groups are an important component of therapeutic nursing care in acute psychiatric inpatient units and have been highlighted by service users as something that is needed (Thomas *et al.* 2002). Offering support in all forms is an essential component of the nurse patient relationship (Horberg *et al.* 2004, Shattell *et al.* 2007). Therapeutic groups are one such way support can be offered. Indeed because of the acclaimed busyness of the acute units, where nurse have claimed not enough time is available for one-to-one support (Hem & Heggen 2004), group interventions may offer an alternative.

The mental health nursing literature indicates that the focus on group work facilitation dates back to the mid to late 1980's when a number of small research projects mainly with an educational focus were published (Watkins 1984, Briggs 1985, Reynolds & Cormack 1985, Burnard 1986, Ellis & Watson 1987); few studies have been published since. Since then there is some evidence of psychiatric nurses evaluating group programmes, although the evidence is quite ad hoc.

Over the past three decades, studies involving group therapy have been conducted in North America, Asia and Europe focussing on the aspects of the curative process in group psychotherapy that inpatients perceive to be efficacious (Maxmen 1973, Butler & Fubriman 1980, Schaffer & Dreyer 1982, Leszcz *et al.* 1985, Colign *et al.* 1991). From these studies inpatients expressed similar perceptions of the important therapeutic factors. These included cohesion, catharsis, self-understanding, altruism and universality (Hsiao *et al.* 2004). Studies have also evaluated specific types of group therapy. In a systematic review of group-based cognitive behaviour therapy for individuals with psychosis, Lawrence *et al.* (2006) found that cognitive behaviour therapy was more effective than treatment as usual in reducing levels of social anxiety. Indeed further studies have evaluated the effect of cognitive behaviour therapy groups on anxiety (Dodd & Wellman 2000) and depression (Iqbal & Bassett 2008) and demonstrated positive results. A more recent study by Macinnes & Lewis (2008) evaluated a group which aimed to reduce self-stigma among people with enduring mental health problems using a combination of cognitive therapy and psychoeducation in the inpatient setting. It was found that the group produced significant reduction in stigma. It is important to highlight that many of these studies did not involve nurse delivered programmes.

Hsiao *et al.* (2004) conducted a qualitative study exploring Chinese inpatients views on what aspects of nurse-led structured therapy groups worked to help their psychological and interpersonal problems. They found that helpful therapeutic factors valued by service users included group cohesiveness, universality, interpersonal learning-output and installation of hope while identification was considered the least helpful therapeutic factor (Hsiao *et al.* 2004). While this study was conducted in China, where the culture may be different to that of Europe and North America, these findings are similar to those conducted in the 1970s and 1980s (Maxmen 1973, Kapur *et al.* 1988).

Further studies have involved evaluations of therapeutic groups in a variety of settings. Harms & Benson (2003) examined clients' experiences of a community group which was facilitated by nurses. The findings indicated that the participants experienced the group as an anxiety-provoking event especially in the early stages. Additionally, they reported being bored and verbally attacked by other group members.

Some studies of therapeutic groups have elicited positive results such as one by Webster & Austin (1999). They evaluated a psychoeducation programme which aimed to promote health-related hardiness, which was described as the person's ability to resist illness when under stress. Their findings suggested that individuals described positive changes in thoughts, feelings and behaviours following participation in the psychoeducational group.

Leung & Arthur (2004) explored clients and facilitators experiences of participating in a Hong Kong self-help group. The facilitators included psychiatric nurses, social workers and occupational therapists. It was reported that clients had positive experiences of the group. They suggested the group allowed for friendship development, open communication, genuine sharing, support and encouragement, and provided a warm and caring atmosphere. It is important to highlight that the group-evaluated in this study used facilitators from different professional backgrounds.

In summary, no studies were found that reported upon service users' experiences of therapeutic group programmes in the acute inpatient setting. Studies have been undertaken to identify the effectiveness of group therapy and have explored individual groups facilitated by nurses, however, in some of these studies (Leung & Arthur 2004), it was not only psychiatric nurses who were facilitating the group but other professionals also. There is some evidence to suggest that nurses are facilitating therapeutic group programmes in inpatient units; however, there is currently little evidence to support this practice. This study aims to add to this limited body of evidence by aiming to gain an understanding of service users' experiences of a nurse-led therapeutic

Table 1
Group programme

Group title	Aim of group
News and views	Aim is to enable clients to interact with each other, improve communication/interpersonal relationships and maintain orientation in the here and now.
Relaxation	Aim is to provide an environment in order to reduce stress, insomnia, generalized anxiety and fatigue. It may also contribute to improved concentration, memory and energy levels.
Women's group	Aim is to discuss issues pertinent to women and explore ideas, worries and promote problem solving discussion.
Solutions for wellness	Aim is to promote a healthier way of living through education, open discussion and promotion of positive change in current lifestyle.
Manage your mood	Aim is to give clients the opportunity to share their experiences and explore coping strategies within a supportive and educational framework.
Recreation group	Aim is to motivate clients, help clients focus on particular tasks, improve concentration and contribute to a sense of achievement.
Anxiety management	Aim is to give clients the opportunity to share their experiences and explore coping strategies within a supportive and educational framework.
Confidence building group	Aim is to explore current issues around self-esteem and confidence and provide various tools in order to improve confidence.
Out and about (re-socialization group)	Aim is to promote and maintain independent functioning by maintaining social contact with everyday living.
Staying well group (relapse prevention)	Aim is to prevent relapse, empower clients to reduce their breakdowns or the severity of them and thus reduce the need for subsequent admission to hospital.

group programme in an acute psychiatric inpatient unit. This understanding may help in the development of group programmes in inpatient units by providing an insight into service user's experiences and needs in relation to this aspect of care.

Methodology

A qualitative descriptive approach was adopted in this study which was undertaken in one acute psychiatric inpatient unit in Ireland. Qualitative description aims to provide a comprehensive summary of events in everyday terms (Sandelowski 2000), allowing service user's experiences to be heard as they tell it. The unit where the study was undertaken provides care and treatment for approximately 50 people. The unit has a nurse therapy department with two full time psychiatric nurses facilitating therapeutic and recreational groups. One of the researchers was involved in the delivery of the programme; however, this researcher was not involved in data collection. The overall aim of the programme was to aid recovery by providing service users with a medium for expression and emotional catharsis and to provide support and education in relation to coping skills. The unit also has an occupational therapy (OT) department, also with two full time staff facilitating educational and recreational groups. The recreational groups offered in both departments possess similar aims; however, the therapeutic and educational groups differ in their focus, with the nurse-led groups providing support and exploring coping skills whereas the OT-led groups are concerned with assisting individuals to return to doing activities they did prior to admission. This study was concerned only with the group programme run by the two nurses. Table 1 outlines the types and aims of each of the groups facilitated in the nurse therapy department at the time the study was undertaken.

Sample

The sample was recruited through the distribution of information leaflets to those attending the programme by the facilitators of the groups. Those who were interested in participating in the study and met the inclusion criteria were asked to contact the researchers. The inclusion criteria outlined that participants had to be over 18 years of age, within 1 week of discharge, admitted to the acute unit for a minimum of 2 weeks and had attended a minimum of four groups per week Twenty individuals expressed interest in participating in the study; however, a number were excluded because of the acuity of their mental distress. Therefore, purposeful sampling was undertaken, whereby the sample was purposefully selected based on the needs of the study and consisted of eight service users. Data collection was ceased after eight service users were interviewed as the same issues arose repeatedly throughout the interviews. Within the programme offered, an average of eight people attend each group, with an average of 20 different people a day and 35 different people per week attending the programme. No distinction was made between which groups the participants attended as the overall aim of the programme was the same. Of the 10 groups on offer in the department, the participants had attended an average of 8.25 different groups at least twice.

The sample consisted of five women and three men. One was aged between 18 and 25 years, four between 25 and 35 years, one between 35 and 55 and two between 55 and 65 years. All participants were Caucasians and of Irish nationality. At the time the research was undertaken, this was the only ethnicity in the unit. All but one participant was in paid employment. Two participants had been admitted to the unit for the first time and the remainder were re-admissions. All participants were voluntary at the time of interview; however, two participants were detained involuntarily when initially admitted. When asked about their main area of difficulty, one participant stated they suffered from schizophrenia, two from eating disorders, one bipolar disorder, one post-natal depression, two depressions and one participant a combination of alcohol dependence and depression.

Data collection and analysis

Data were collected over a period of 6 weeks using in-depth semi-structured interviews, which were tape recorded and guided by an interview schedule (Table 2). Data collection was undertaken by a researcher who had no involvement in the delivery of the group programme. All interviews lasted between 20 and 45 min. The schedule was piloted with one service user, while no questions were changed following the pilot interview it was decided to give participants the interview schedule prior to the interview to allow them time to reflect upon the questions. Data were transcribed verbatim and analysed using Burnard's (1991) method of thematic content analysis. Categorization themes were developed from the raw data, patterns were then sought for to connect the categories which then evolved into themes. The trustworthiness of the research was enhanced through the use of a decision trail which was presented to the co-researcher at all stages of the research process. It was also enhanced during the interviews by summarizing the participant responses and allowing them the opportunity to clarify or correct any statements. Finally, the data were analysed independently by both researchers in keeping with Burnard's (1991) method of analysis.

Table 2
Interview schedule

What do therapeutic groups mean to you?
○ What do you think therapeutic groups are about?
○ Do you feel it is an important aspect of care? If yes why? If no, why not?
○ Describe the groups you have attended during your stay here?
○ What was the most beneficial group, why, in what way?
○ What was the least beneficial group, why, in what way?
○ How have the groups made you feel?
○ What type of effects have the groups had on you?
What are your views on the type of groups offered here?
○ What do you think of the structure of the programme, i.e. times, types of groups?
○ What do you think about the content of the groups?
○ What do you think about the facilitators' style of facilitation?

Ethical issues

Ethical approval for this study was gained from the local Teaching Hospitals Ethical Committee. Informed consent was obtained by providing an information leaflet to all participants outlining the nature of the study and their involvement in it. Those who volunteered to partake in the study were advised that their participation was voluntary and they were free to withdraw at any time. They were asked to sign a consent form prior to the interview and were asked if they understood the nature of the proposed research. The service user's Consultant and/or Primary nurse decided on the person's ability to give informed consent. Participants were informed that they would be given time if needed at the end of the interview to reflect and ventilate any adverse feelings with the researcher. Finally, participants were informed that they could contact a psychiatric nurse counsellor who had agreed to provide counselling to any participant who experienced any adverse effects. None of the participants availed of this. Data transcripts and recordings were kept confidential to the principle and co-investigator and the individual participants. All data were coded to ensure confidentiality.

Findings

Four themes emerged from the findings. These themes highlighted the value service users placed on the programme, the benefits they gained, the unhelpful aspects they experienced and the factors that influenced their participation. Fictitious names are used in the presentation of findings to protect the anonymity of the participants.

Personal gains: I have that too!

All participants reported that the therapeutic group programme was an important aspect of their care and impacted upon their recovery. They provided many descriptions of what they gained from participating in the programme. They described feeling supported, understood and a decreased sense of isolation.

The overall experience

The participants reported that the programme had an effect on their mental health, by helping improve their mood,

helping them not to focus too much on their personal difficulties and improving their overall mental health.

> There is a sense of well-being . . . having gone through the group programme.
>
> It takes me out of my own head, stops me always thinking about myself and my own problems. (Valerie)
>
> Overall it has taken me out of my depression. I have changed my negativity. (Charles)

The participants described the value they placed on having the programme as part of their care. It was viewed as being an important aspect of recovery and highly beneficial.

> I would still be here only for the groups, without a doubt I would still be here. . . . I found them very beneficial. (Gina).
>
> There are very few ways to get better in here but the groups are one of them. (Valerie)

The participants demonstrated a good understanding of the purpose of the group programme. Individual participants suggested that it helps develop communication skills and allows for the opportunity to explore thoughts and feelings.

> . . . group therapy is about communicating with other people who may have the same problems as you . . . its a chance to explore that and how they feel about it . . . group therapy is a sharing of similar problems. (Charles).

Interaction: relating to others

The opportunity to relate to others was highlighted by many participants as the most important aspect of the programme. They outlined that by attending the programme they learned to empathize with others, learned from the achievements and mistakes of those in the programme, and were provided with the opportunity to reflect.

Extracts illustrating this are outlined below:

> It's not just about keeping occupied, it's about talking about how you are feeling, you can relate to others around you. Like people can say 'yeah I have that too', even though there are different people here with different problems, I can relate to them. (Rebecca)
>
> I can see similarities with people about my problems. My problems can be so similar or they can be totally different but I can empathise with the problems people have and how they could relate to me. (James)
>
> I can see that other people are struggling like me, I can see that I am not on my own. Even if I don't interact much, I take it all in. I listen to how other people cope with their problems and sometimes I say 'oh yeah, that might help me too'. I can relate to some people there. (Valerie)

Normalization

Many participants reported that attending the groups allowed them to realize that other people had similar problems which decreased their sense of isolation. This was illustrated by Gina and Nathan:

> You meet other patients in the smoking room, but nobody ever spoke about why they were here but in the group you realised they suffered from panic attacks as well and it kind of made you feel more normal. (Gina)
>
> There are people here with the same illness as me and they would open up in the group and that would lead me to open up in the group, or I might open up first and then it encourages others to open up. It's helpful to hear from others with similar problems. (Nathan)

Helpful content

Many of the participants reported that specific groups aided their recovery because of the content. In particular, the confidence group, relaxation group and the formal information given during the group were deemed valuable. They differed in opinion regarding the type of group that was most helpful. It was suggested that the discussion groups directly impacted on their recovery, while the activity groups were a means to pass time, both were deemed important.

The confidence group was highly regarded by many participants. They commented on how their mental health problems have influenced their confidence, they described the group as helping them to build their confidence and described noticing a change in their confidence levels since attending. The confidence group is 'good because I have lost a lot of confidence and I need it in my job because I have a team at work and I need to be a leader, give direction. At the moment I don't feel I can do that, its making me realise bits and pieces, being assertive again' (Sarah).

The relaxation group was also described by many participants as invaluable as it achieved what it set out to achieve. One participant stated it 'sets you up for the day, you drag yourself to it and feel much better afterwards' (Valerie). Various other groups were seen as helpful by individual participants, Nathan and Gina reported that the 'staying well' group helped them prepare for discharge and learn how to cope more efficiently. Other individual groups were described as being beneficial as they helped the participants to open up, share their feelings and develop coping strategies.

> The women's group was great, it was non-directive, you had half your life story told before you realised it so it was brilliant. (Gina)

Overall, their satisfaction with the group greatly depended on the content being discussed.

Unhelpful aspects

The participants highlighted that sometimes they gained little from their experiences in the group, this was due to content. It was not identified by the participants which groups they were referring to. Individual participants reported that sometimes the content of the group was not relevant to their situations and that often the content was very basic and repetitive.

> When it doesn't relate to me. There was a half hour group yesterday and I got nothing out of it, (the topic) wasn't relevant to me. (James)
>
> Sometimes they are talking down to you. Its like we don't know anything, they tell us stuff that we already know and it's like being in a class room . . . I've been here 3 times and the content of the group is always the same, it's a bit repetitive. I've been here 9 weeks; the groups are now repeating themselves. (Valerie)

Some of the participants suggested that the groups should focus more on specific illnesses, such as eating disorders. Additionally, they reported that more information on diagnosis and specific mental health problems was needed to aid recovery.

Influencing factors

Many participants highlighted that what they gained from the group depended on their mental health at the time. This was primarily affiliated to being low in mood:

> If I was in very low form I would come out going 'oh God', I was just sitting in the room to pass time to be honest, but if I was in good form I got a lot more out of the groups. (Gina)
>
> I know when I came in I was down and when you get down its hard to get yourself up out of bed and go to a group. You could be drowsy from the medication in the morning but you get up out of bed. (Nathan)
>
> When I was down I wouldn't express myself but now that I am well I would. (Nathan)

Their mental health also affected their attendance:

> When I came in I was elated so the groups were excellent but then as time went on I got more depressed so I found the groups harder to attend. (Gina)

Further participants suggested that the benefits they gained depended to a degree on who attended the group, the age of the group members, the similarities in problems among members and the facilitation style of the group leader. It was highlighted that the greater the homogeneity within the group the more beneficial the group. It was also highlighted that facilitators need to be patient, fair and allow all members of the group the opportunity to speak and be heard.

Discussion

The findings as described suggest that the participants had a very positive experience of the group programme being offered. They reported many benefits and valued the programme as part of their recovery. The main benefit reported by participants was being provided with the opportunity to relate to others regardless of what a person's main problem was. They also reported how being able to relate to people helped them feel 'normal'. These findings are similar to those studies previously conducted on group therapy in acute inpatient units (Hsiao *et al.* 2004, Leung & Arthur 2004). The participants reported that there was a need for both discussion and activity-based groups, this reflects the ideas of Garrick & Ewashen (2001) who reported that a holistic approach incorporating both are needed to promote recovery and well-being.

The most beneficial group as described by the participants was the 'confidence group'. This group reportedly benefited most participants because of their reported low confidence. According to the World Health Organization (2007) confidence is almost always reduced in people with mental health problems, in particular depressive disorders. It has also been suggested that the process of being admitted to a psychiatric unit could also affect confidence (Faulkner 2004). It is recommended therefore that groups which aim to increase confidence should become an essential part of programmes in acute units.

Very few aspects of the group programme were seen as unhelpful by the participants. One participant highlighted that the content of the groups was too basic and believed the facilitators 'talked down' to them. This acute unit covers a large geographical region, with urban, sub-urban and rural areas. Its clientele come from a variety of backgrounds and educational levels. Running group programmes that need to take into account wide ranging abilities can be difficult as suggested by Benson (1996). It may be possible to overcome this by carefully selecting the participants for each group taking into account their educational background and level of mental distress. Some participants highlighted that groups needed to focus more on specific illnesses and more information should be provided on diagnosis and different types of mental health problems. These findings are similar to those of Shattell *et al.* (2007), Thomas *et al.* (2002), who found that service users felt that reference material, education and information would enhance recovery.

The participants reported that their mental health affected their attendance and participation in the groups. In particular, when they were low in mood they found it difficult; however, they also reported that it was important for them to try to motivate themselves. It is well documented how depression in particular can affect motivation (Krupp & Fogel 1997). The participants reported that the benefits of the group largely depended on who attended the group. Indeed group cohesion is an important aspect of group process which has been highlighted in early studies by Leszcz *et al.* (1985), Kapur *et al.* (1988), Maxmen (1973). Furthermore, the facilitation style of the nurse was deemed to be important. Whitaker (2000) suggested that the (nurse) facilitator should create a climate in which anxiety levels are controlled to a sufficient degree to allow participants to attend to the aims of the group. The inability to achieve this may indicate a lack of knowledge and skills in conducting and maintaining groups. This study highlights the importance of nurse facilitators being equipped with adequate knowledge and skills in order to carry out groups competently and therapeutically.

There are limitations to this study and as such the findings need to be interpreted with caution. This was a small scale study with only eight participants. It was undertaken in only one acute inpatient unit and therefore the findings are contextually bound. As previously mentioned, most responses from the participants were positive in nature. This could be related to the fact that the interviews took place while they were inpatients which could have impacted upon the findings. It was highlighted in the participant information leaflet that their responses would not affect their treatment in any way and that data were confidential; however, it is still possible that the participants were reluctant to make negative comments because of the possible repercussions.

Conclusion

The findings suggested that this group programme is quite effective and appears to be achieving its aims. The participants' experiences highlighted how it was important for them to relate to others, feel supported and be understood, which was facilitated through the group programme. Reported mental health benefits were also outlined such as an improvement in mood, confidence and overall well-being.

Many factors need to be considered when implementing group programmes. The needs of service users need to be considered with evolving group programmes based on need offered. There needs to be emphasis on providing generic groups on issues that effect many people with mental health problems such as confidence building, informational support and emotional support, with service user-led groups being initiated. Nurse facilitators need to be equipped with the knowledge and skills necessary to facilitate groups, understanding the impact they can have on group cohesion and understanding the difficulties which may arise, such as those presented in this study. A balance in the type of groups offered is evidently needed and while discussion groups are of the utmost importance, there is also a need for activity-based groups.

This area of psychiatric nursing practice has been given little attention by researchers and a body of evidence is needed. It is recommended that further larger scale studies in this area are needed using both qualitative and quantitative methodology to provide an evidence base for practice. This aspect of care is deemed an important component in recovery by service users and thus needs to be valued by nurses and other healthcare professionals. Further studies could also compare service users' experiences of both nurse-led and OT-led groups to gain a more comprehensive overview. Further research should also include service users who did not attend the group programme to compare their experiences of care.

In light of current dissatisfaction with therapeutic care in acute inpatient units, similar programmes such as the one described in this paper, which could be cost-effective, need to be developed and reported upon in the literature. Finally, greater focus on the teaching of group facilitation skills to psychiatric nursing students is needed to equip them with the skills needed to plan and implement programmes such as the one described in this paper.

References

Benson J. (1996) *Working More Creatively with Groups*. Routledge, London.

Briggs K. (1985) Group facilitator skills: how can they be learned? *Nurse Education Today* **5**, 143–146.

Burnard P. (1986) Learning about groups. *Nurse Education Today* **6**, 116–120.

Burnard P. (1991) A method of analyzing interview transcripts in qualitative research. *Nurse Education Today* **11**, 461–466.

Butler T. & Fubriman A. (1980) Patient perspective on curative process. A comparison of day treatment and out-patient psychotherapy groups. *Small Group Behaviour* **11**, 371–388.

Sainsbury Centre for Mental Health (1998) *Acute Problems: A Survey of the Quality of Care in Acute Psychiatric Wards*. The Sainsbury Centre for Mental Health, London.

Colign S., Hoencamp E., Snijders H.J.A., *et al.* (1991) A comparison of curative factors in different types of group psychotherapy. *International Journal of Group Psychotherapy* **41**, 365–378.

Dodd H. & Wellman N. (2000) Staff development, anxiety and relaxation techniques: a pilot study in an acute psychiatric inpatient setting. *Journal of Psychiatric and Mental Health Nursing* **7**, 443–448.

Ellis R. & Watson C. (1987) Experiential learning: the development of communication skills in a group therapy setting. *Nurse Education Today* **7**, 215–221.

Faulkner A. (2004) Strategies for surviving acute care. In: *Acute Mental Health Nursing* (eds Harrison, M., Howard, D. & Mitchell, D.), pp. 78–89. Sage, London.

Garrick D. & Ewashen C. (2001) An integrated model for adolescent inpatient group therapy. *Journal of Psychiatric and Mental Health Nursing* **8**, 165–171.

Harms S. & Benson A. (2003) The clients experience of the community group: implications for nurse facilitators. *Journal of Psychiatric and Mental Health Nursing* **10**, 49–56.

Hem M.H. & Heggen K. (2004) Rejection – a neglected phenomenon in psychiatric nursing. *Journal of Psychiatric and Mental Health Nursing* **11**, 55–63.

Horberg U., Brunt D. & Axelsson A. (2004) Client's perceptions of the client-nurse relationships in local authority psychiatric services: a qualitative study. *International Journal of Mental Health Nursing* **13**, 9–17.

Hsiao F.H., Lin S.M., Liao H.Y., *et al.* (2004) Chinese inpatients subjective experiences of the helping process as viewed through examination of a nurses focused, structured therapy group. *Journal of Clinical Nursing* **13**, 886–894.

Hummelvoll J.K. & Severinsson E.I. (2001) Imperative ideals and the strenuous reality: focusing on acute psychiatry. *Journal of Psychiatric and Mental Health Nursing* **8**, 17–24.

Iqbal S. & Bassett M. (2008) Evaluation of perceived usefulness of activity scheduling in an inpatient depression group. *Journal of Psychiatric and Mental Health Nursing* **15**, 393–398.

Kapur R., Miller K. & Mitchell G. (1988) Therapeutic factors within in-patient and out-patient psychotherapy groups: implications for therapeutic techniques. *British Journal of Psychiatry* **152**, 229–233.

Krupp B. & Fogel B. (1997) Motivational impairment in psychiatric and mental illness. *Psychiatric Annals* **27**, 34–38.

Lawrence R., Bradshaw T. & Mairs H. (2006) Group cognitive behavioural therapy for schizophrenia: a systematic review of the literature. *Journal of Psychiatric and Mental Health Nursing* **13**, 673–681.

Leszcz M., Yalom I.D. & Norden M. (1985) The value of inpatient psychotherapy: patient's perceptions. *Interpersonal Journal of Group Psychotherapy* **35**, 411–433.

Leung J. & Arthur D.G. (2004) Clients and facilitators experiences of participating in a Hong-Kong self-help group for people recovering from mental illness. *International Journal of Mental Health Nursing* **13**, 232–241.

Macinnes D. & Lewis M. (2008) The evaluation of a short group programme to reduce self-stigma in people with serious and enduring mental health problems. *Journal of Psychiatric and Mental Health Nursing* **15**, 59–65.

Maxmen J.S. (1973) Group psychotherapy as viewed by hospitalised patients. *Archives of General Psychiatry* **28**, 404–408.

Mental Health Commission (2006) *The Views of Adult Users of the Public Sector Mental Health Services*. Stationary office, Dublin.

O'Donovan A. & Gijbels H. (2006) Understanding psychiatric nursing care with non-suicidal self harming patients in acute psychiatric admission units: the views of psychiatric nurses. *Archives of Psychiatric Nursing* **20**, 186–192.

Potter M.L., Williams R.B. & Costanzo R. (2004) Using nursing theory and a structured psychoeducational curriculum with inpatient groups. *Journal of the American Psychiatric Nurses Association* **10**, 122–128.

Reynolds W. & Cormack D.F.S. (1985) Clinical teaching of group dynamics: an evaluation of a trial clinical teaching programme. *Nurse Education Today* **5**, 101–108.

Sandelowski M. (2000) Focus on research methods: whatever happened to qualitative description? *Research in Nursing and Health* **23**, 334–340.

Schaffer J.B. & Dreyer S.F. (1982) Staff and in-patients perceptions of change mechanisms in group psychotherapy. *American Journal of Psychiatry* **139**, 127–128.

Shattell M.M., Starr S.S. & Thomas S.P. (2007) Take my hand, help me out': mental health service recipient's experience of the therapeutic relationship. *International Journal of Mental Health Nursing* **16**, 274–284.

Thomas S., Shattell M. & Martin T. (2002) What's therapeutic about the therapeutic milieu? *Archives of Psychiatric Nursing* **3**, 99–107.

Watkins P.N. (1984) The value of training groups in the professional development of psychiatric student nurses: an appraisal. *Nurse Education Today* **4**, 76–79.

Webster C. & Austin W. (1999) Health-related hardiness and the effect of a psycho-educational group on client's symptoms. *Journal of Psychiatric and Mental Health Nursing* **6**, 241–247.

Whitaker D.S. (2000) Theory building, theory-use and practice in group psychotherapy. *Group Analysis* **33**, 559–573.

World Health Organization (2007) *International Statistical Classification of Diseases and Health Related Problems*, 10th edn. WHO, Geneva.

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Review

Psychological interventions for alcohol misuse among people with co-occurring depression or anxiety disorders: A systematic review

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ABSTRACT

Objective: Depression, anxiety and alcohol misuse frequently co-occur. While there is an extensive literature reporting on the efficacy of psychological treatments that target depression, anxiety or alcohol misuse separately, less research has examined treatments that address these disorders when they co-occur. We conducted a systematic review to determine whether psychological interventions that target alcohol misuse among people with co-occurring depressive or anxiety disorders are effective.
Data sources: We systematically searched the PubMed and PsychINFO databases from inception to March 2010. Individual searches in alcohol, depression and anxiety were conducted, and were limited to 'human' published 'randomized controlled trials' or 'sequential allocation' articles written in English.
Study selection: We identified randomized controlled trials that compared manual guided psychological interventions for alcohol misuse among individuals with depressive or anxiety disorders. Of 1540 articles identified, eight met inclusion criteria for the review.
Data extraction: From each study, we recorded alcohol and mental health outcomes, and other relevant clinical factors including age, gender ratio, follow-up length and drop-out rates. Quality of studies was also assessed.
Data synthesis: Motivational interviewing and cognitive–behavioral interventions were associated with significant reductions in alcohol consumption and depressive and/or anxiety symptoms. Although brief interventions were associated with significant improvements in both mental health and alcohol use variables, longer interventions produced even better outcomes.
Conclusions: There is accumulating evidence for the effectiveness of motivational interviewing and cognitive behavior therapy for people with co-occurring alcohol and depressive or anxiety disorders.

Contents

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1. Introduction

Epidemiological surveys consistently indicate that depressive, anxiety and alcohol use disorders frequently co-occur (Farrell et al., 2001; Grant et al., 2004; Kessler et al., 2003). Studies conducted in the United States and Australia have found that individuals with alcohol dependence are three to four times more likely to have a concurrent affective or anxiety disorder compared to the general population (Degenhardt et al., 2001; Grant et al., 2004). Even higher rates of comorbid disorders are found within treatment settings. In a large population study, 32.8% of participants with alcohol use disorders who sought treatment were found to have comorbid depression and 33.4% were found to have a comorbid anxiety disorder (Grant et al., 2004). Such high rates are problematic as co-occurring alcohol, depressive and anxiety disorders have been associated with a broad range of negative outcomes, including more severe depressive and anxiety symptoms and suicidal ideation, poorer social functioning and increased service utilization (Sullivan et al., 2005). In terms of treatment outcomes, while individuals with and without comorbid conditions improve, those with co-occurring conditions continue to drink more, have poorer physical and mental health outcomes, and display poorer functioning following treatment (Mills et al., 2009).

Psychological treatments for unipolar depression, anxiety and alcohol use disorders have separately been shown to be effective. Meta-analyses examining randomized controlled trials (RCTs) of cognitive behavior therapy (CBT) for adult unipolar depression, anxiety or alcohol disorders have found that CBT is superior to waitlist and untreated controls, as well as pharmacotherapy (Dobson, 1989; Gloaguen, 1989; Hofmann and Smits, 2008; Magill and Ray, 2009; Norton and Price, 2007; Stewart and Chambless, 2009). During the last 30 years, there has been a significant paradigm shift from the dichotomous concept of 'normal drinking' versus an 'alcohol use disorder' to the concept of a spectrum of hazardous to harmful drinking, delineated as 'alcohol misuse' (Saunders and Lee, 2000). Two meta-analytic reviews have found evidence for the efficacy of brief (often one session) motivational interviewing (MI) interventions for alcohol misuse, with one finding a medium effect in non-treatment seeking populations and a small to moderate effect in treatment seekers (Hettema et al., 2005; Moyer et al., 2002).

Although there have been numerous trials examining the effectiveness of psychological interventions for unipolar depression, anxiety disorders and alcohol misuse separately, relatively few have been conducted for individuals with depressive or anxiety disorders and comorbid alcohol misuse. Nevertheless, a number of recent reviews have demonstrated the effectiveness of psychological interventions for co-occurring substance misuse and unipolar depression (assessed via diagnostic interview or ratings/questionnaires with cut-off scores indicative of a clinical disorder), dysthymia or anxiety disorders. Hesse (2009) reported that integrated psychological treatments that combine treatment for substance use disorders and co-occurring depression or dysthymia into one program had superior outcomes in terms of the percentage of days abstinent compared with treatment for substance use disorder alone. Similarly, Hides et al. (2010) found support for the efficacy of CBT over no treatment control conditions among patients with co-occurring unipolar depression or dysthymia and substance misuse (including alcohol). Baillie and Sannibale (2007) reviewed clinical trials for co-occurring anxiety and substance use disorders and concluded that standard care for substance use had the best outcomes for those with more than moderate substance dependence in five of the six studies reviewed.

No previous studies have systematically examined the efficacy of psychological interventions for patients with unipolar depression, dysthymia or anxiety disorders and co-occurring alcohol misuse specifically (rather than substance misuse per se). This is important because treatment may be differentially effective according to the type of substance misuse. Baker et al. (2009a), for example, found brief interventions were effective for alcohol misuse but only somewhat effective for cannabis misuse in people with severe mental disorders. In this article, we systematically review the evidence

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from RCTs of psychological intervention for co-occurring alcohol misuse among people with unipolar depression, dysthymia or anxiety disorders and provide recommendations for clinical management and future research.

2. Method

The study search protocol included RCTs of psychological interventions for co-occurring alcohol misuse among people with mood or anxiety disorders. Inclusion and exclusion criteria were established prior to the literature search. Included studies were required to employ diagnostic criteria for mood (unipolar depression or dysthymia) or anxiety disorders; to utilize a treatment manual and to report data on alcohol use outcomes. Psychological interventions were operationalized as non-pharmacological treatments for either alcohol misuse alone or alcohol misuse and mood or anxiety disorders.

During March 2010, a systematic literature search was conducted using the PubMed (ISI) and PsychINFO (CSA) databases. Individual searches in alcohol, depression and anxiety (search terms: depression, major depression, depressive disorder, anxiety, anxiety disorders, dysthymia, affective disorders, mood disorders) and treatment (search terms: treatment and therapy) were conducted, and were limited to 'human' published 'randomized controlled trials'(RCTs) or 'sequential allocation' articles written in English (so as to maximize methodological quality). Sequential allocation refers to the allocation of participants to treatment groups as they sequentially arrive in a treatment trial, allowing the trial to remain as balanced as possible throughout the recruitment process (Atkinson, 2002). It was included in our search strategy as it was considered to be a potentially sound method of treatment allocation, compatible with randomization. No date limits were placed on the searches. The alcohol, depression, anxiety and treatment searches produced a total of 1540 papers. By reviewing the titles, abstracts and reference lists, one author (LT) identified 34 potentially relevant studies. Two authors (AB and SH) then independently reviewed these articles in full, and identified eight RCTs to be included in the literature review. Inpatient studies with samples of participants with a variety of disorders and a larger proportion of patients with psychotic disorders compared to affective disorders were not included in the review. The full study selection process is shown in Fig. 1.

In addition to the narrative systematic review, effect sizes for alcohol use, depression and anxiety outcomes were compared between studies and between treatment conditions. Effect sizes were not compared for mental health outcomes due to heterogeneity in the patient samples used in the studies. One author (AB) extracted means and standard deviations of occasions of alcohol use per day, days of alcohol use per week/month, days of heavy drinking, percentage of days abstinent from drinking, depression severity ratings and anxiety severity ratings from each article (when available), which were then independently checked by a second author (SH). Cohen's *d* paired standardized mean differences were computed comparing alcohol, depression and anxiety variables at baseline and immediately following treatment (or equivalent timepoint for control conditions) using Comprehensive Meta-Analysis. Calculating a pooled effect size (combining the study effect sizes of the 8 studies), which would usually occur during a meta-analysis was inappropriate, due to considerable heterogeneity in the clinical characteristics of participants, and the type of treatment and measures used.

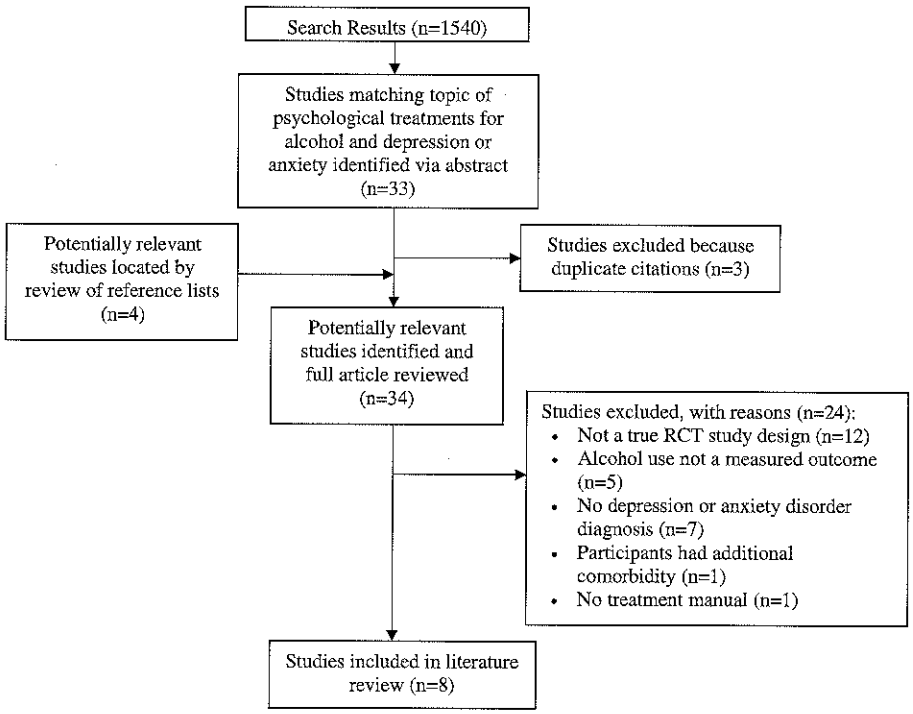

Fig. 1. Study selection process.

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Table 1
Summary of depression and alcohol use outcomes from RCTs among samples with affective disorders and alcohol problems.

Study	Sample	Diagnoses (%)	Entry criteria depression/ anxiety and alcohol	Design	Results	Clinical significance of results	Methodological limitations	PEDro Scale quality rating (items v and vi blank)	Composite score (total 9)
Baker et al. (2009a, 2009b) Australia Comorbid depression and alcohol misuse	N=284, Outpatients Male=53.0% Mean age=45 Participation rate: 284/433 (65.6%); 149 (34.4%) refused	DSMIV (SCID): 76% lifetime MD 77% lifetime AUD	BDI>16 At least 4 standard drinks per day for men, 2 for women Concurrent medication (61%) and substance use (13% used cannabis at least weekly) not excluded	BI 1×60 minute session alone or plus 9 60 minute sessions of MI/CBT depression, alcohol or integrated focus. Psychologists delivered manual guided intervention. Follow up 18 wks after baseline: 238/284 (84%). Collateral reports verified self-reported alcohol consumption.	Percentage of treatment sessions attended: 86% for the BI; 16% none; 28% 1–4; 17% 5–8; 39% 9–10. Of those offered 10 sessions, mean no. of sessions attended was 5.76, with no differences between conditions. Depression: significant reduction for all conditions, no differences between conditions; trend for integrated focus to be more effective than single focus. Alcohol: 10 sessions more effective than BI; integrated more effective than single focused; for men, alcohol focus more effective than depression focus.	Mean BDI change score for integrated vs. single focus condition was 11.5 vs. 8.2. Alcohol: 10 sessions associated with 22.9 vs. 10.8 drinks per week reduction and 1.3 vs. 0.6 reduction in drinking days. Integrated focus associated with reduction in 1.83 vs. 0.9 drinking days reduction. Men reported mean drinking reduction of 4.6 vs. 0.34 drinks per day in alcohol vs. depression focus. Thus, BI and extended treatment helpful for depression. Integrated or alcohol focus best for men, integrated focus best for women.	Only short-term outcome reported. 14% of sample were still in treatment at 18-week follow-up.	111?--10111	5
Kay-Lambkin et al. (2009) Australia Comorbid depression and alcohol and/or cannabis misuse	N=97, Outpatients Male=46.0% Mean age=35 Participation rate: 97/116 (83.6%); 19 (16.4%) refused	DSMIV (SCID-RV) 100.0% lifetime MD AUD Not reported	BDI>16 At least 4 standard drinks per day for men, 2 for women (n=52/97 met alcohol criteria; 53.6%); or at least weekly use of cannabis (69/97; 71.1%) Concurrent medication not excluded (% not reported)	BI 1×60 minute session alone or plus 9 60 minute sessions of MI/CBT psychologist or computer-delivered MI/CBT (with brief weekly input from a psychologist). Manual guided. Follow up 12 ms: 41/52 (78.9%)	Percentage of treatment sessions attended: 87% for the therapist-delivery group, mean of 9/10 sessions; 76.1% for the computer-delivery condition, mean of 8/10 sessions. Depression: significant reduction for all conditions; MICBT more effective than BI. Alcohol: Significant reduction for all conditions, no differences between conditions.	% Improved at 12 months: Depression (%BDI <17): BI (30.4%); psychologist (50%); computer (63%). Alcohol (>49% improvement in alcohol consumption): BI (53.8%); psychologist (82.4%); computer (73.3%). Thus, BI helpful for depression and alcohol problems, with additional improvement following longer intervention.	Use of only one therapist. Small sample (97) of whom 52 met alcohol entry criteria. Therapy adherence and fidelity not rated. Reliance on self-report measures.	1111--11111	9

Markowitz et al. (2008) USA Comorbid dysthymic disorder and AUD	N = 26 Outpatients Male = 69.0% Mean age: 38 Participation rate: Not stated. Ss were excluded from a concurrent trial of psychotherapy for dysthymic disorder without substance use (Markowitz et al., 2005).	DSMIV (SCID-NP) 100% primary dysthymic disorder; 54% current MD; 77% dysthymic disorder with early onset; 77% Axis II disorder. AUD (lifetime): 77% dependence; 23% abuse.	Primary DSMIV dysthymic disorder with early onset (before age 21), Score > 13 on HAM-D; GAF < 61; and DSMIV alcohol abuse secondary to dysthymic disorder. Concurrent psychoactive medications and substance abuse or dependence excluded except for cannabis abuse (% not reported).	16–18 50-min sessions over 16 wks manual guided IPT-D vs. BSP delivered individually by therapists with MSW or PhD degrees. Post-treatment assessment at wk 16: 18/44 (40.9%). Breathalyzer verified alcohol consumption.	43% of IPT and 42% of BSP Ss failed to complete tx. Mean no. of sessions not reported. Depression improved significantly for the sample as a whole. IPT significantly better than BSP on BDI at 16 wks. High% of Ss reported abstinence in the month before tx.	BDI: IPT: 18.9 (pre); 8.9 (16 wk). BSP: 25.1 (pre); 20.1 (16 wk). ES: −1.38 vs −0.64. Mean% days abstinent: IPT 40.4% (pre); 47.0% (16 wk). BSP: 32.1% (pre); 49.7% (16 wk). ES: 0.21 vs 0.54.	Small sample. High level of baseline abstinence. High level of tx dropout. No follow-up. Therapy adherence deemed adequate; fidelity ratings not reported.	1111–10111	8
Hulse and Tait (2002) Australia Psychiatry inpatients with alcohol misuse	N = 120 Voluntary psychiatry inpatients Male = 54.2% Mean age: 32 Participation rate: 120/144 (83.3%) of those who met the study criteria and were asked to join the study.	DSMIV (from hospital records) 62.5% mood 15.8% anxiety 10.0% psychotic 11.7%% other AUDIT Hazardous 28.3% Harmful 42.5% Dependent 29.2%	New inpatients on psychiatric wards. AUDIT score > 7, SADQ score < 30 Concurrent substance abuse not reported.	45 minute individually delivered MI following a template by nurses or clinical psychologists vs. information package. 6/12 follow-up: 83/120 (69.2%)	Both conditions reduced alcohol consumption significantly. The MI condition had a significantly greater change in weekly alcohol consumption and a greater proportion was improved. Mental health outcomes not reported.	The difference in alcohol consumption per week between conditions was just over 3 drinks per week, which the authors describe as clinically meaningful.	Subjects had non-severe mental disorders admitted to general hospital units and included multiple disorders. The intervention cannot be separated from psychiatric tx. No therapy adherence or fidelity ratings. Large loss to follow-up. Reliance on self-report measures.	1120–10111	6
Santa Ana et al. (2007) USA Psychiatry inpatients with SUD	N = 101 60 voluntary and 41 non-voluntary non-psychotic psychiatry inpatients Male = 62.4% Mean age: 37 Participation rate: 101/211 (47.8%) met inclusion criteria.	DSMIV (interview not specified): 78.2% MD/mood 13.9% Bipolar 3% Schizoaffective 2% Borderline Alcohol dependence 67%	Current DSMIV SUD and Axis I disorder other than dementia or psychosis	2 × 120 minute group MI sessions following manual vs. 2 × 120 minute therapist attention activity control group conducted by a psychologist. 1/12 follow-up: 97/101 (96%); 3/12 follow-up 87/101 (86%) Collateral interviews verified self-report.	No difference between conditions in proportion attending aftercare or attaining abstinence. MI had more favorable drinking outcomes at 1- and 3-months. Mental health outcomes not reported.	At 3-months MI groups reported more aftercare attendance (mean of 21.1 vs. 10.7 occasions), fewer standard drinks (mean 117.3) vs. control condition (262.3) and a lower proportion binge drinking (34.1% vs. 55.8%).	Use of only one therapist. Alternate group assignment following initial randomization.	1101–11011	7
Schade et al. (2005) Netherlands Comorbid agoraphobia or	N = 96 65 from an inpatient clinic and 31 from an outpatient clinic for alcohol	DSMIV (SCID-I/P): 66.6% social phobia 7.3% agoraphobia 26% both Alcohol dependence 100%	DSMIV diagnosis of alcohol dependence and comorbid agoraphobia or social phobia Concurrent	Alcohol tx program alone (if an inpatient, group sessions for 25 h a week over 12–16 weeks, plus	Average no. of sessions attended was 9. 15/47 (31.9%) used fluvoxamine. Significant improvement in	32 wks: Improvement on Fear Qr total mean from 40.1 to 32.7 in the 27% and 38% in alcohol treatment vs.	Optional fluvoxamine included in tx condition but unrelated to outcome.	1110–11111	8

(continued on next page)

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Table 1 (*continued*)

Study	Sample	Diagnoses (%)	Entry criteria depression/ anxiety and alcohol	Design	Results	Clinical significance of results	Methodological limitations	PEDro Scale quality rating (items v and vi blank)	Composite score (total 9)
social phobia and alcohol dependence	dependence Male = 67.7% Mean age: 42 Participation rate: 96/157 (61.1%). Of 157 interviewed, 31 were excluded, 30 refused.		substance abuse allowed, medication excluded.	weekly follow-up for up to 32 weeks; if an outpatient weekly individual or group tx for 10 weeks) vs. alcohol treatment program combined with anxiety tx comprising manual guided CBT (12 weekly 60-min individual sessions) and optional SSRI. CBT was conducted by experienced therapists. Follow-up: 16 wks: 84/96, (87.5%); 24 wks: 74/96 (77.1%); 32 wks: 64/96 (66.7%). CDT levels on blood checked self-report validity.	anxiety outcomes for both conditions, significantly better improvement in the anxiety tx group. No difference in relapse or abstinence between intervention conditions.	44.1 to 21.9 in alcohol and anxiety tx respectively. Days heavy drinking (last mth) fell from 14.8 at baseline to 7.7 in the alcohol tx condition and from 19.5 to 5.9 in the alcohol and anxiety tx condition. 32 wks: Abstinence 27% and 38% in alcohol tx vs. alcohol respectively. Days heavy drinking (last mth) fell from 14.8 at baseline to 7.7 in the alcohol tx condition and from 19.5 to 5.9 in the alcohol and anxiety tx condition.			
Toneatto (2005) Canada Comorbid agoraphobia and alcohol dependence	N = 14 outpatients Male = 42.9% Mean age: 41 Participation rate: 14/19 completed treatment (73.7%) and were included in the study.	DSM-IIIR (SCID): Panic disorder with agoraphobia and alcohol dependence 100% Lifetime MD (35.7%) Lifetime dysthymia (35.7%) Lifetime social phobia (28.6%) Axis II (50%)	DSM-IIIR Panic disorder with agoraphobia and alcohol dependence Concurrent substance dependence excluded; medication not stated	10 individual sessions of either cognitive therapy (addressing dysfunctional cognitions mediating the alcohol and anxiety problems) vs. behavior therapy (5 sessions treating alcohol dependence and 5 treating the anxiety problems). Manual guided. Therapists not described.	Mean no. of sessions attended not reported. 5/19 dropped out before session 3. Both conditions equally successful in reducing alcohol consumption and anxiety at post-treatment and 1-year follow-up.	5/14 (36.8%) met low risk drinking criteria and 3/14 (21.4%) met medium risk drinking criteria at both post-treatment and follow-up. 6/13 (46%) were improved on several clinical dimensions of anxiety at post-treatment and 4/12 (33%) at follow-up.	Small sample size. Self-reported outcomes.	1121--?0011	5

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Randall et al. (2001) USA Comorbid social phobia and alcohol dependence	N = 93 Outpatients Male = 69.0% Mean age:38 Participation rate: Of 187 screened, 110 met inclusion criteria, 17 of these were later excluded from analysis, leaving 93/110 (84.5%).	DSMIII-R (SCID): Social phobia and alcohol dependence 100%	DSMIII-R Social phobia and alcohol dependence Concurrent substance dependence excluded except for cannabis; medication not stated.	Follow up 1 year: 12/14 (85.7%) 12 individual sessions of CBT over a maximum of 14 weeks focusing on alcohol problems only (60 mins per session) alcohol problems plus social phobia, 'dual' (90 mins per session). Manual guided. Conducted by clinical psychologists. Follow-up at 3 mth intervals for 9 mths after tx. Breathalyzer and collateral reports verified self-reports.	Average no. of sessions attended was 8. Both groups improved significantly from baseline on all alcohol outcome measures, with the alcohol only group significantly superior to the dual condition at 3-mth follow-up on all 3 drinking variables Both conditions significantly improved on all social anxiety measures and BDI, with no differences between groups.	Authors state that amount of improvement on social anxiety scores was modest (around 20% from baseline scores) and average post-treatment scores indicated significant impairment. % days heavy drinking reduced from around 50% at baseline to around 12% for the alcohol condition and 25% for the dual condition.	Social phobia plus alcohol condition received more treatment and less review of homework material in order to achieve equivalent time discussing alcohol problems. Only data of the first follow up were reported.	1171–71011	6

Physiotherapy Evidence Database (PEDro) quality rating items: (i) eligibility criteria were specified; (ii) participants allocated randomly to groups; (iii) allocation concealed; (iv) groups similar at baseline on main prognostic signs; (vii) blinding of assessors who measured at least one key outcome; (viii) adequacy of follow-up; (ix) intent-to-treat analysis; (ix) between group statistical comparison of outcomes; (xi) study gives both point estimates and variability for an outcome [64]. A score of 1 = meets criteria, 0 = does not meet criteria, and ? = unclear from manuscript whether study meets criteria or not. Two PEDro items regarding blinding of subjects (item v) and blinding of treatment providers (item vi) were not scored, as blinding is not feasible in this type of psychological intervention study. Composite score from PEDro quality ratings (range = 0–9).

PE: psychoeducation.
MI: motivational interview.
SI: standard psychiatric interview.
IPT-D: interpersonal psychotherapy adapted for dysthymic disorder.
BSP: brief supportive psychotherapy.
CBT: cognitive-behavior therapy.
AUD: alcohol use disorder.
SUD: substance use disorder.
Dep: depression.
MD: major depression.
ES: effect size.
BDI: Back Depression Inventory.
SCID: Structured Clinical Interview for DSM.
SCID-RV: Structured Clinical Interview for DSM, Research Version.
SCID-NP: Structured Clinical Interview for DSM, Non-patient Version.
SCID- I/P: Structured Clinical Interview for DSM, Patient Version.
Mth: month.
SSRI: selective serotonin reuptake inhibitor.
Wk: weeks.
AUDIT: Alcohol Use Disorders Identification Test.
SDQ: Severity of Alcohol Dependence Questionnaire.
CDT: Carbohydrate-deficient transferring (CDT).

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The quality of the studies was assessed using the validated Physiotherapy Evidence Database (PEDro) scale (Centre for Evidence-Based Physiotherapy, 2009). PEDro scores are calculated by assessing whether a study has (i) specified participant eligibility criteria; (ii) allocated participants randomly to groups; (iii) concealed allocation; (iv) used groups similar at baseline on main prognostic signs; (v) employed blinding of assessors who measured at least one key outcome; (vi) had adequate follow-ups; (vii) used intent-to-treat analysis; (viii) employed between group statistical comparison of outcomes; and (ix) given both point estimates and variability for outcomes (Centre for Evidence-Based Physiotherapy, 2009). Consistent with the recent study by Spring et al. (2009), two items regarding blinding of subjects and therapists were not scored in the present review, as these were not feasible for the interventions studied. Two raters (AB and SH) independently rated the eight RCTs on the PEDro scale and reached consensus on the ratings (maximum score of 9).

3. Results

3.1. Trials of psychological interventions

Eight RCTs have reported alcohol use outcomes following manual-led psychological interventions for alcohol misuse among people with mood or anxiety disorders. These comprise two trials among samples with depression, one in a sample with dysthymia, two among inpatient samples with mixed diagnoses, one in a sample with social phobia, one in a sample with social phobia or agoraphobia and one in a sample with agoraphobia or panic disorder. Details of these studies and PEDro scores are provided in Table 1, including the percentage of each sample meeting diagnostic threshold or entry criteria on questionnaire measures.

3.2. Alcohol misuse among people with mood disorders

3.2.1. Alcohol misuse and depression

Kay-Lambkin et al. (2009) reported the results of a RCT designed to evaluate computer- versus therapist-delivered psychological treatment among 97 people with comorbid depression and substance misuse, over half of whom had alcohol misuse. All participants received an initial integrated session comprising MI and case formulation for depressive symptoms and substance use problems, followed by random assignment to one of three treatments: no further treatment (brief intervention); nine further sessions of MI and CBT delivered by a psychologist (therapist condition); or nine further sessions of MI/CBT therapy delivered by a computer (with brief 10–15 minute weekly input from a psychologist). As detailed in Table 1, all treatment conditions were associated with a significant reduction in alcohol consumption as well as symptoms of depression, with greater benefits observed among the longer treatment conditions. Conclusions that can be drawn from this study are limited by its small sample size and absence of therapy adherence and fidelity ratings.

Baker et al. (2009b) extended this work to compare the effectiveness of integrated brief intervention to single-focused (depression versus alcohol) and integrated MI/CBT among 284 people with co-occurring depression and alcohol misuse. As seen in Table 1, superior alcohol use outcomes for CBT relative to brief interventions were found, but depression and global functioning outcomes were equivalent at 18 weeks follow up. Gender differences between alcohol- and depression-focused treatments were reported, with males responding better to alcohol-focused and females better to depression-focused treatment over the short-term. Both genders responded to integrated intervention which was found to be superior to single focused treatment in terms of depression and days drinking. The authors suggested that stepped care approaches are worthy of further investigation. In stepped-care approaches, all patients receive low intensity treatment (e.g., brief integrated interventions) as a first step, progress is monitored, and patients who do not respond sufficiently are stepped-up to receive a treatment of higher intensity and/or longer duration. The lack of long-term follow-up in this study is a limitation (but is currently underway) and only partial recovery (as seen in Table 1) was achieved by many participants, indicating that a stepped care approach in which treatment is delivered until an improvement threshold is reached, may be helpful.

3.2.2. Alcohol misuse among people with dysthymia

Markowitz et al. (2008) conducted a small pilot study (N = 26) comparing 16 weeks of interpersonal psychotherapy (IPT) with 16 weeks of brief supportive psychotherapy among people with co-occurring dysthymic disorder and alcohol abuse or dependence. While depressive symptoms improved significantly within each condition at 6 months follow up, IPT achieved significantly better outcomes than brief supportive psychotherapy on this measure, with a large versus moderate effect size. Conversely, brief supportive psychotherapy and IPT had moderate and small effect sizes respectively, for the percentage of days abstinent from alcohol. Results were thus not encouraging regarding the effectiveness of either IPT or brief supportive psychotherapy for co-occurring dysthymia and alcohol misuse. There are numerous limitations to this study, including the small sample size, a high level of abstinence at baseline, high treatment dropout and the absence of longer term follow-up.

3.2.3. Alcohol misuse among mixed psychiatric inpatient samples

Hulse and Tait (2002) assessed the effectiveness of a 45-minute single session template-guided MI compared to an information package control (safer alcohol consumption patterns and normative feedback) among 120 hospitalized psychiatric patients (mainly mood and anxiety disorders) with (non-dependent) alcohol misuse. Both groups reported significant reductions in alcohol use at 6 months. The MI condition was significantly better than the information condition in terms of lowering weekly alcohol consumption, as well as the proportion of drinkers who improved. The authors concluded that brief interventions, particularly MI, are effective in reducing alcohol consumption among people with mental disorders. There were a number of limitations to this study, listed in Table 1, the most serious being the large loss to follow-up. The results reported were limited to the 69% of subjects retained at 6 months and planned analyses of the 12 month data were abandoned due to the high level of attrition (53% were followed up at 1 year).

Santa Ana et al. (2007) compared the effectiveness of a group MI consisting of two 2-hour sessions with an attention

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control group condition among 101 non-psychotic inpatients (over three quarters with depression) in a psychiatric hospital. Outcomes assessed included the level of aftercare attendance and alcohol consumption at 1 month follow up. There were no differences between conditions in terms of the proportion of people attending aftercare or the rate of abstinence (50.0% for MI vs. 34.9% control). However, there were benefits of MI in terms of number of aftercare attendances, number of standard drinks consumed and fewer participants reporting binge drinking (see Table 1). The main limitations of the study were the use of one therapist (possible confounding due to therapist effects), the lack of treatment fidelity ratings as well as the alternate randomization of groups following the initial randomization. The authors concluded that the study provides preliminary evidence of the effectiveness of MI in enhancing aftercare attendance and reducing drinking.

3.3. Alcohol misuse among people with anxiety disorders

3.3.1. Alcohol misuse and social phobia

Randall et al. (2001) randomly assigned 93 people with comorbid social phobia and alcohol dependence to either 12 individual sessions of CBT focusing on alcohol or both conditions ('dual' condition). As described in Table 1, the latter condition received more time in therapy and less homework than the alcohol focused condition. Both conditions were associated with significant reductions in alcohol and significant, albeit modest, improvements in anxiety at 3 months post treatment. The alcohol condition was associated with better outcomes on three alcohol indices compared to the dual condition. The short-term nature of the follow-up limits the conclusions that can be drawn from the study, as it is possible that there may have been delayed improvement in the 'dual' condition. The authors suggested that consideration be given to the staging of treatments, rather than simply treating both disorders (Randall et al., 2001). They recommended that while it is important to treat comorbid disorders, the order in which this should be done and the degree of integration (versus adjunctive or parallel approaches) should be the subject of further study.

Schade et al. (2005) randomly assigned 96 abstinent individuals with alcohol dependence and comorbid agoraphobia or social phobia to either inpatient or outpatient treatment as usual for alcohol use, or to usual alcohol treatment plus parallel CBT for anxiety (12 weekly 60-min individual sessions) and optional pharmacotherapy (a selective serotonin reuptake inhibitor [SSRI]). The additional therapy was significantly better in terms of improving anxiety symptoms, but no difference between conditions on alcohol use outcomes were found at follow up. Limitations of the study include the inclusion of inpatients and outpatients with mixed phobias, as well as the inclusion of optional SSRIs in treatment.

3.3.2. Alcohol misuse and panic disorder/agoraphobia

Toneatto (2005) conducted a small pilot trial in which 14 people with comorbid alcohol dependence and agoraphobia were randomly assigned to either behavior therapy or cognitive therapy. Both treatments consisted of 10 individually administered sessions of cognitive therapy focused on dysfunctional cognitions mediating the alcohol and anxiety conditions, or sessions of behavior therapy focused on the treatment of alcohol dependence in the first five sessions and then anxiety for the remainder of treatment. Both interventions were equally effective in reducing drinking and anxiety symptoms at 12 months follow up. Interestingly, anxiety symptoms significantly improved during the five alcohol-focused sessions of the behavior therapy condition, leading Toneatto (2005) to conclude that brief behavior therapy might be an effective treatment for this specific comorbidity. Although this study was limited by its small sample size and reliance on self-report measures, the integrated nature of the treatments (addressing both alcohol and anxiety problems) and the initial focus on alcohol in the behavioral condition supports a staged approach.

3.3.3. Comparison of effect sizes for changes in alcohol use and depression/anxiety symptoms immediately following treatment

Hulse and Tait (2002) did not measure outcome variables immediately after treatment and were excluded from the analysis. The seven remaining studies for alcohol use outcomes are compared in Fig. 2. All conditions demonstrate standardized mean differences in the expected direction (decrease for occasions of use/average number of drinking days/heavy drinking days and increase in percentage days abstinent following treatment). Several conditions resulted in large changes of at least one standard deviation, including the therapist-delivered MI/CBT for people with depression (Kay-Lambkin et al., 2009), group MI for mixed psychiatric samples (Santa Ana et al., 2007), parallel CBT for alcohol and anxiety (Schade et al., 2005) and targeted alcohol focused CBT (Randall et al., 2001) for people with anxiety disorders. These large changes in alcohol outcome were found despite the likelihood of the presented effect sizes being underestimates of the true population effect size. Most other treatment conditions generated approximately half a standard deviation of change, including the brief interventions. Standardized mean differences for depression and anxiety severity scores, when reported, are compared in Fig. 3. There were large decreases of over one standard deviation in depression severity scores in several studies. Decreases in anxiety severity scores were smaller, although tended to show decreases in similar magnitude to the alcohol use variables.

3.3.4. Limitations of psychological intervention trials

PEDro scale scores ranged from 5 to a maximum of 9 for the studies analyzed, with the most common limitations (4/8 studies) being: failure to obtain more than 85% of subjects initially allocated to groups at follow-up; lack of intention to treat analysis (3/8 studies); lack of clarity regarding concealment of allocation (3/8 studies); and dissimilar baseline characteristics (3/8 studies). In addition, as Table 1 shows, the studies suffered from a number of other methodological limitations including: short-term follow-up (4/8 studies); recruitment of heterogeneous samples with different mental disorders (3/8 studies, one of which recruited both inpatients and outpatients); reliance on self-reported alcohol consumption (3/8 studies); and small sample sizes (2/8 studies). Among the mood studies, there was variability in the use of diagnostic interviews versus symptom severity ratings with diagnostic cut-off scores to determine eligibility for inclusion in the study. While the anxiety studies all included diagnostic assessments of both anxiety and alcohol misuse, samples included mixed anxiety diagnoses. Nevertheless, the eight RCTs reviewed above

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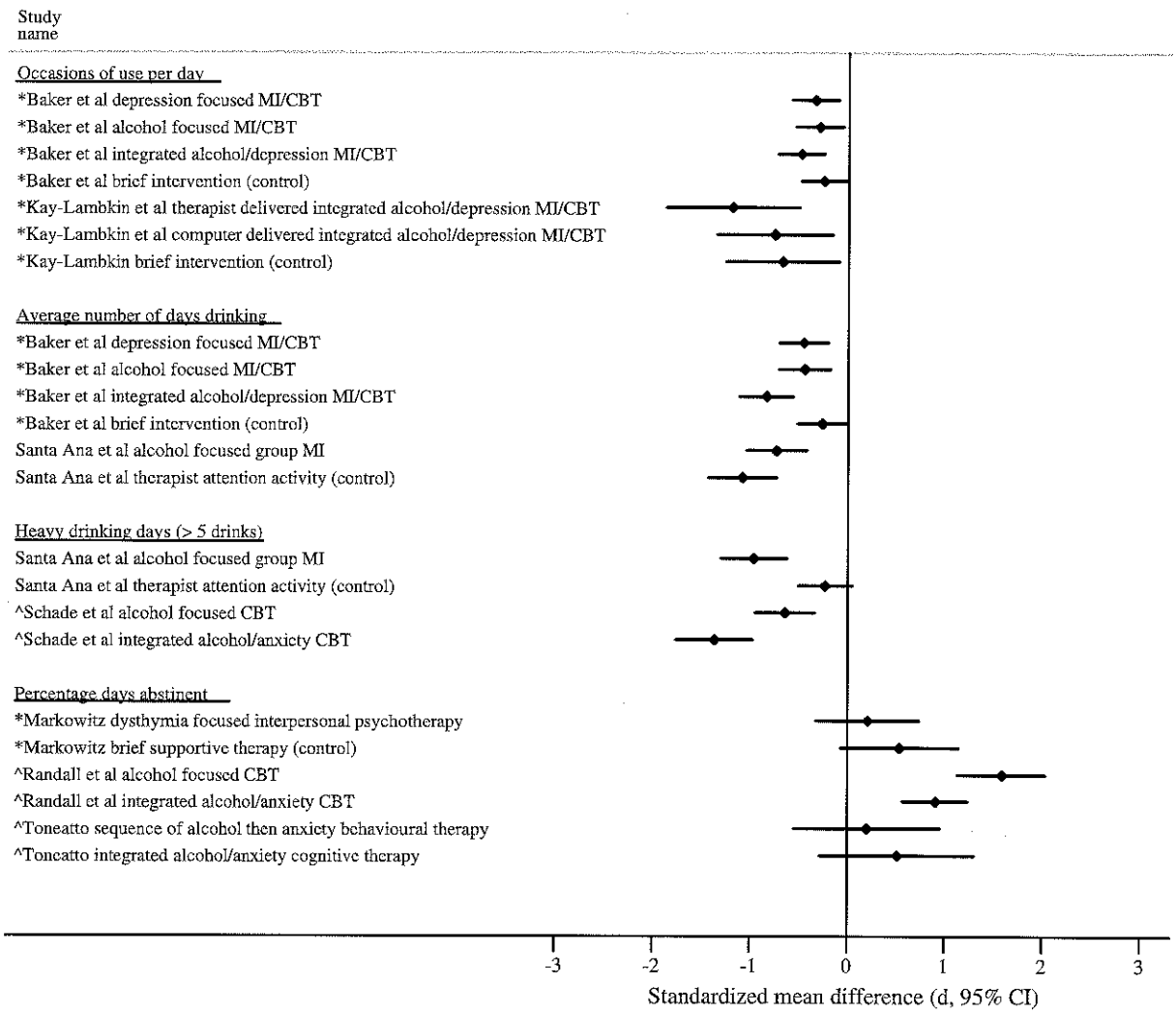

Fig. 2. Paired standardized mean difference (Cohen's *d*, ± 95% CI) comparing baseline vs. immediate post treatment alcohol outcome variables, stratified by alcohol outcome measure. A negative mean difference represents a decrease in scores from pre- to post-treatment. A positive mean difference represents an increase in scores from pre- to post-treatment. * denotes study examining comorbid alcohol/depressive disorder sample. ^ denotes study examining comorbid alcohol/anxiety disorder sample. Unmarked studies involved mixed affective disorder samples. CBT: cognitive behavioral therapy. MI: motivational interviewing.

provide unique information about people with comorbid mood/anxiety disorders and alcohol misuse and the effects of manual guided treatment.

3.4. Summary of findings of psychological intervention trials and suggestions for further research

3.4.1. Alcohol misuse and depressive disorders

Overall, two studies suggest that co-occurring depression and alcohol misuse are responsive to psychological treatment, including brief integrated MI interventions and longer duration CBT of up to ten sessions (Baker et al., 2009b; Kay-Lambkin et al., 2009). Additional benefits of the longer over brief integrated interventions were seen on both depression and alcohol outcomes, with both studies suggesting that stepped care is worthy of further investigation. When stepping up to a longer intervention, integrated CBT interventions appear to be suitable for both men and women (Baker et al., 2009b) and can be delivered effectively by a therapist or a computer (Kay-Lambkin et al., 2009). IPT and brief supportive psychotherapy, based on the results of one study, are yet to demonstrate effectiveness in both mood and alcohol use domains. The brief integrated MI intervention and CBT in the trials conducted by Kay-Lambkin et al. (2009) and Baker et al. (2009b) were delivered by psychologists in research clinics, and further research is required to determine if these interventions can effectively be translated into practice in real world clinical settings. Heather (1995; 1996) has pointed out that the effectiveness of brief interventions among treatment seekers, often delivered by counselors, may not generalize to non-treatment seekers who may receive brief interventions in a general health care setting. In addition, as the sample included in Kay-Lambkin et al.'s (2009) study comprised of cannabis users as well as problem drinkers, a direct comparison of brief integrated intervention and computer therapy among participants with comorbid depression and alcohol misuse is required.

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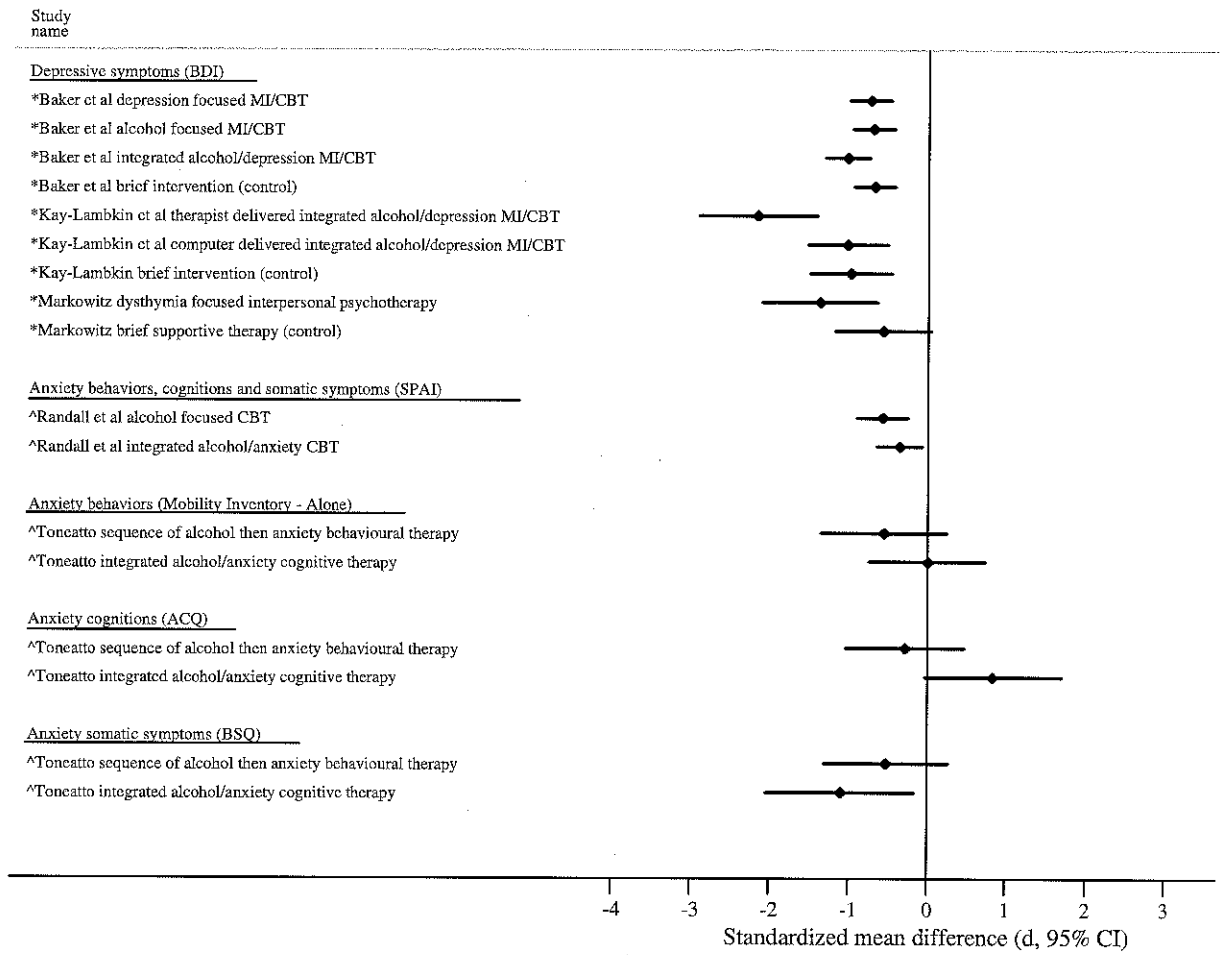

Fig. 3. Paired standardized mean difference (Cohen's *d*, ± 95% CI) comparing baseline vs. immediate post treatment depression and anxiety outcome variables. A negative mean difference represents a decrease in scores from pre- to post-treatment.* denotes study examining comorbid alcohol/depressive disorder sample. ^ denotes study examining comorbid alcohol/anxiety disorder sample. ACQ: Agoraphobic Cognitions Questionnaire; BSQ: Body Sensations Questionnaire (Chambless et al., 1984). BDI: Beck Depression Inventory (Beck, 1993). CBT: cognitive behavioral therapy. Mobility Inventory (Chambless et al., 1985). MI: motivational interviewing. SPAI: Social Phobia and Anxiety Inventory (Turner et al., 1989).

Individual (Hulse and Tait, 2002) and group (Santa Ana et al., 2007) MI among psychiatric hospital inpatients, primarily with depression, have been shown to be effective in reducing alcohol consumption at follow-up. However, the results were modest in the study by Hulse and Tait (2002) and replication is needed. It is possible that inclusion of nurses as therapists may have weakened the results and further investigation of the influence of therapist characteristics in the effectiveness of MI in psychiatric settings is warranted. The Santa Ana et al. (2007) study had good outcomes with the inclusion of inpatients with alcohol dependence, suggesting that the exclusion of inpatients with alcohol dependence in the study by Hulse and Tait (2002) is not indicated and indeed, may have resulted in a floor effect (i.e., reduced the likelihood of potentially greater improvements in drinking being observed).

3.4.2. Alcohol misuse and anxiety disorders

As with comorbid depression and alcohol misuse, existing studies suggest that co-occurring anxiety disorders and alcohol misuse are responsive to psychological treatment, including brief behavioral interventions focusing on alcohol (Toneatto, 2005). Two of the three studies recommended a stepped or staged approach to treatment (Randall et al., 2001; Toneatto, 2005), indicating a need for future studies on stepped care. While the study by Schade et al. (2005) found a significant reduction in anxiety symptoms among a mixed sample of participants with social phobia and agoraphobia, the level of anxiety reduction in the social phobia group was modest in comparison to studies comprised mostly of participants with agoraphobia (Schade et al., 2005; Toneatto, 2005). This suggests that replication of these studies with larger unmixed samples of subjects is needed. It is possible that different anxiety disorders respond differentially to alcohol- versus anxiety-focused or integrated interventions. As no studies have yet compared the effectiveness of anxiety, alcohol and integrated focused interventions, research targeting groups with specific anxiety disorders would clearly be informative. Such studies could potentially allow an evaluation of a stepped approach to further intervention among those who require treatment in the anxiety and/or alcohol domain. The possibility of gender differences in treatment outcomes among individuals

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with comorbid anxiety and alcohol misuse is also worthy of investigation, as differential treatment effects by gender were found in one study of co-occurring depression and alcohol misuse (Baker et al., 2009b). As pointed out by Randall et al. (2001), there is also a need to investigate the effectiveness of different levels of integrated treatment, for example, comparing the effectiveness of one practitioner versus more than one practitioner within a service providing integrated treatment for co-existing disorders. Given its effectiveness for co-occurring depression and alcohol misuse, the role of computer-delivered treatment for co-occurring anxiety and alcohol problems is also worthy of investigation.

3.4.3. Retention in treatment and follow-up

As seen in Table 1, completion of available treatment sessions is uncommon and follow-up attendance diminishes markedly with time. It is possible that participants discontinue treatment when they reach a desired level of improvement, hence adopting an informal stepped care approach. Ongoing measurement of mental health symptoms and alcohol consumption across the study period, as well as participants' expectations of treatment, would thus be informative, and should include both quantitative and qualitative data. In addition to MI for behavior change, MI focused on increasing treatment attendance may also be helpful for some. On the other hand, it is possible that among samples with co-occurring problems, a return to a strictly defined 'non-clinical' level of depression, dysthymia, anxiety or alcohol consumption might be an unrealistic expectation during the typical timeframe of clinical trials. The common clinical picture of an isolated, unemployed individual, with few resources may mean that any stepped care approach may be more successful over the longer term, with later improvement evident as social, vocational and other functioning improves.

Together, these findings indicate that MI/CBT for co-occurring alcohol misuse among people with depressive or anxiety disorders has strong effectiveness. However, there remains room for improvement in the magnitude of change achieved. Contingency management, where patients are rewarded for desirable behavior (e.g., abstinence), has demonstrated effectiveness among populations with co-occurring disorders (Tidey et al., 2002; Tracy et al., 2007), and provides one potential avenue for enhancing the effectiveness of CBT and improving attendance at treatment and follow-up.

4. Conclusions

This review highlights the limited research available to inform psychological treatment approaches for co-occurring alcohol misuse and depression or anxiety disorders. While this review may have been improved by conducting a more complete search of the literature (e.g., by accessing unpublished and/or non-English language studies), there is evidence that psychological interventions (MI/CBT) are effective for treating co-occurring mood or anxiety disorders and alcohol misuse. Even brief interventions appear to be effective, although longer interventions are associated with greater improvements in mood and alcohol use outcomes. Further research should include larger, more homogeneous samples with more frequent follow-up assessments over longer periods of time.

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Conflict of interest

Dan Lubman has received speaker honoraria from Astra Zeneca, Bristol Myers Squibb, Eli Lilly, Janssen, and Pfizer. All other authors declare that they have no conflicts of interest.

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References

Atkinson, A.C., 2002. The comparison of designs for sequential clinical trials with covariate information. J. R. Stat. Soc. 165, 349–373.
Baker, A., Turner, A., Kay-Lambkin, F.J., Lewin, T.J., 2009a. The long and the short of treatments for alcohol or cannabis misuse among people with severe mental disorders. Addict. Behav. 34, 852–858.
Baker, A.L., Kavanagh, D.J., Kay-Lambkin, F.J., Hunt, S.A., Lewin, T.J., Carr, V.J., Connolly, J., 2009b. Randomized controlled trial of cognitive–behavioural therapy for coexisting depression and alcohol problems: short-term outcome. Addiction 105, 87–99.
Baillie, A., Sannibale, C., 2007. Anxiety and drug and alcohol problems. In: Baker, A., Velleman, R. (Eds.), Clinical Handbook of Co-existing Mental Health and Drug and Alcohol Problems. Routledge, London, pp. 197–217.
Beck, A.T., 1993. Beck Depression Inventory. Psychological Corporation, San Antonio, TX.
Centre for Evidence-Based Physiotherapy, 2009. PEDro Scale. Centre for Evidence-Based Physiotherapy, Sydney.
Chambless, D.L., Caputo, G.C., Bright, P., Gallagher, R., 1984. Assessment of fear in agoraphobia: the body sensations questionnaire and the agoraphobic cognitions questionnaire. J. Consult. Clin. Psychol. 61, 248–260.
Chambless, D.L., Caputo, G.C., Jasin, S.E., Gracely, E.J., Williams, C., 1985. The Mobility Inventory for agoraphobia. Behav. Res. Ther. 23, 35–44.
Degenhardt, L., Hall, W., Lynskey, M., 2001. Alcohol, cannabis and tobacco use among Australians: a comparison of their associations with other drug use and use disorders, affective and anxiety disorders, and psychosis. Addiction 96, 1603–1614.
Dobson, K.S., 1989. A meta-analysis of the efficacy of cognitive therapy for depression. J. Consult. Clin. Psychol. 57, 414–419.
Farrell, M., Howes, S., Bebbington, P., Brugha, T., Jenkins, R., Lewis, G., Marsden, J., Taylor, C., Meltzer, H., 2001. Nicotine, alcohol and drug dependence and psychiatric comorbidity: results of a national household survey. Br. J. Psychiatry 179, 432–437.
Gloaguen, V., 1989. A meta-analysis of the effects of cognitive therapy in depressed patients. J. Affect. Disord. 49, 59–72.
Grant, B., Stinson, F.S., Dawson, D.A., Chou, P., Dufour, M.C., Compton, W., Lamb, R., Fletcher, B., Pickering, R.P., Kaplan, K., 2004. Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders. Arch. Gen. Psychiatry 61, 807–816.
Heather, N., 1995. Interpreting the evidence on brief interventions for excessive drinkers: the need for caution. Alcohol Alcohol. 30, 287–296.
Heather, N., 1996. The public health and brief interventions for excessive alcohol consumption: the British experience. Addict. Behav. 21, 857–868.
Hesse, M., 2009. Integrated psychological treatment for substance use and co-morbid anxiety or depression vs. treatment for substance use alone. A systematic review of the published literature. Biomed. Cent. Psychiatry 9, 6.
Hettema, J., Steele, J., Miller, W.R., 2005. A meta-analysis of research on motivational interviewing treatment effectiveness (MARMITE). Annu. Rev. Clin. Psychol. 1, 91–111.
Hides, L., Samet, S., Lubman, D.I., 2010. Cognitive behaviour therapy (CBT) for the treatment of co-occurring depression and substance use: current evidence and directions for future research. Drug Alcohol Rev. 29, 508–517.
Hofmann, S.G., Smits, J.A., 2008. Cognitive-behavioral therapy for adult anxiety disorders: a meta-analysis of randomized placebo-controlled trials. J. Clin. Psychiatry 69, 621–632.
Hulse, G.K., Tait, R.J., 2002. Six-month outcomes associated with a brief alcohol intervention for adult in-patients with psychiatric disorders. Drug Alcohol Rev. 21, 105–112.

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Kay-Lambkin, F.J., Baker, A., Lewin, T.J., 2009. Computer-based psychological treatment for comorbid depression and substance use problems: a randomised controlled trial of clinical efficacy. Addiction 104, 378–388.
Kessler, R.C., Berglund, P., Demler, O.V., Jin, R., Koretz, D., Merikangas, K.E., Rush, J.A., Walters, E.E., Wang, P.S., 2003. The epidemiology of major depressive disorder: results from the national comorbidity survey replication (NCS-R). JAMA 289, 3095–3105.
Magill, M., Ray, L.A., 2009. Cognitive–behavioral treatment with adult alcohol and illicit drug users: a meta-analysis of randomized controlled trials. J. Stud. Alcohol Drugs 70, 516–527.
Markowitz, J.C., Kocsis, J.H., Bleiberg, K.L., Christos, P.J., Sacks, M., 2005. A comparative trial of psychotherapy and pharmacotherapy for "pure" dysthymic patients. J. Affect. Disord. 89, 167–175.
Markowitz, J.C., Kocsis, J.H., Christos, P., Bleiberg, K., Carlin, A., 2008. Pilot study of interpersonal psychotherapy versus supportive psychotherapy for dysthymic patients with secondary alcohol abuse or dependence. J. Nerv. Ment. Dis. 196, 468–474. doi:10.1097/NMD.0b013e31817738f1.
Mills, K.L., Deady, M., Proudfoot, H., Sannibale, C., Teesson, M., Mattick, R., Burns, L., 2009. Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings. National Drug and Alcohol Research Centre, University of Sydney, Sydney.
Moyer, A., Finney, J.W., Swearingen, C.E., Vergun, P., 2002. Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations. Addiction 97, 279–292.
Norton, P.J., Price, E.C., 2007. A meta-analytic review of adult cognitive–behavioral treatment outcome across the anxiety disorders. J. Nerv. Ment. Dis. 195, 521–531.
Randall, C.L., Thomas, S., Thevos, A.K., 2001. Concurrent alcoholism and social anxiety disorder: a first step toward developing effective treatments. Alcohol. Clin. Exp. Res. 25, 210–220.
Santa Ana, E.J., Wulfert, E., Nietert, P.J., 2007. Efficacy of group motivational interviewing (GMI) for psychiatric inpatients with chemical dependence. J. Consult. Clin. Psychol. 75, 816–822.
Saunders, J.B., Lee, N.K., 2000. Hazardous alcohol use: its delineation as a subthreshold disorder and approaches to its diagnosis and management. Compr. Psychiatry 41, 95–103.
Schade, A., Marquenie, L., Van Balkom, A., Koeter, M., De Beurs, E., Brink, W., Van Dyck, R., 2005. The effectiveness of anxiety treatment on alcohol-dependent patients with a comorbid phobic disorder: a randomized controlled trial. Alcohol. Clin. Exp. Res. 29, 794–800.
Spring, B., Howe, D., Berendsen, M., Mcfadden, H.G., Hitchcock, K., Rademaker, A.W., Hitsman, B., 2009. Behavioral intervention to promote smoking cessation and prevent weight gain: a systematic review and meta-analysis. Addiction 104, 1472–1486.
Stewart, R.E., Chambless, D.L., 2009. Cognitive–behavioral therapy for adult anxiety disorders in clinical practice: a meta-analysis of effectiveness studies. J. Consult. Clin. Psychol. 77, 595–606.
Sullivan, L.E., Fiellin, D.A., O'connor, P., 2005. The prevalence and impact of alcohol problem in major depression: a systematic review. Am. J. Med. 118, 330–341.
Tidey, J.W., O'neill, S.C., Higgins, S.T., 2002. Contingent monetary reinforcement of smoking reductions, with and without transdermal nicotine, in outpatients with schizophrenia. Exp. Clin. Psychopharmacol. 10, 241–247.
Toneatto, T., 2005. Cognitive versus behavioral treatment of concurrent alcohol dependence and agoraphobia: a pilot study. Addict. Behav. 30, 115–125.
Tracy, K., Babuscio, T., Nich, C., Kiluk, B., Carroll, K.M., Petry, N.M., Rounsaville, B.J., 2007. Contingency management to reduce substance use in individuals who are homeless with co-occurring psychiatric disorders. Am. J. Drug Alcohol Abuse 33, 253–258.
Turner, S., Beidel, D., Dancu, C., Stanley, M., 1989. An empirically derived inventory to measure social fears and anxiety: the Social Phobia and Anxiety Inventory. Psychol. Assess. 1, 35–40.

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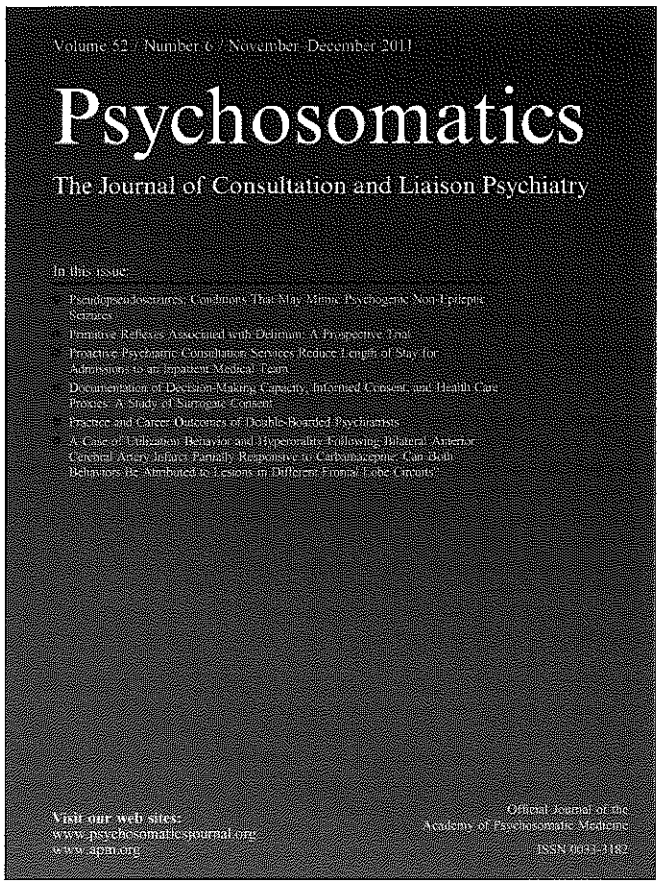

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Original Research Reports

Proactive Psychiatric Consultation Services Reduce Length of Stay for Admissions to an Inpatient Medical Team

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Background: *Some studies suggest intensive psychiatric consultation services facilitate medical care and reduce length of stay (LOS) in general hospitals.* **Objective:** *To compare LOS between a consultation-as-usual model and a proactive consultation model involving review of all admissions, rapid consultation, and close follow-up.* **Methods:** *LOS was compared in an ABA design between a 33-day intervention period and 10 similar control periods, 5 before and 5 after the intervention, on an internal medical unit. During the intervention period, a staff psychiatrist met with the medical team each weekday, reviewed all admissions, provided immediate consultation as needed, and followed all cases throughout their hospital stay.* **Results:** *Time required for initial case review was brief, 2.9 ± 2.2 minutes per patient (mean ± S.D.). Over 50% of admissions had mental health needs: 20.3% were estimated to require specialist consultation to avoid potential delay of discharge. The consultation rate for the intervention sample was 22.6%, significantly greater than in the control sample, 10.7%. Mean LOS was significantly shorter in the intervention sample, 2.90 ± 2.12 versus 3.82 ± 3.30 days, and the fraction of cases with LOS > 4 days was significantly lower, 14.5% versus 27.9%. A rough cost benefit analysis was favorable with at least a 4.2 ratio of financial benefit to cost.* **Conclusions:** *Psychiatric review of all admissions is feasible, indicates a high incidence of mental health barriers to discharge, identifies more necessary consultations than typically requested, and results in earlier consultation. A proactive consultation model can reduce hospital LOS.*

(Psychosomatics 2011; 52:513–520)

Substantial evidence suggests that appropriate psychiatric consultation services in general hospitals can improve medical care and decrease length of stay (LOS). Twenty to 40% of patients in general hospitals have psychiatric diagnoses.[1–3] Most research finds that patients with psychiatric diagnoses have longer LOS.[4–7] Studies with different approaches demonstrate that early psychiatric consultation is associated with early discharge.[8–10] Some studies[11–13] demonstrate that intensive psychiatric consultation services in general hospitals can reduce LOS. One large, elegantly designed and controlled study[14] failed to find a reduction in LOS, but identified patients by questionnaire screening and provided only one visit from a consultation psychiatrist. While it is established that psychiatric consultation services are essential in general hospitals, it is unclear whether more intensive or differently organized psychiatric consultation services can further facilitate medical care and reduce LOS.

This trial was designed to test the feasibility and effectiveness of a "proactive" model of psychiatric consultation. In this model, a staff attending psychiatrist met each weekday with an internal medical hospital team, reviewed all admissions with the team to identify any

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mental health issues, initiated appropriate psychiatric consultation immediately, and continued to work closely with the team to assist with any mental health care required. Thus, the intervention was intended to identify the need for psychiatric consultation more broadly, assure more rapid completion of the consultation, and insure consultation recommendations were carried out effectively.

METHODS

Study Design

This quasi-experimental trial compared outcomes on a specific internal medicine unit during an intervention period using the proactive consultation model with outcomes during control periods before and after the intervention. The intervention group consisted of all cases admitted and discharged within the 33-day intervention period in the fall of 2008. The control group consisted of all cases admitted and discharged during five similar 33-day periods prior to the intervention period and five similar 33-day periods after the intervention period. All intervention and control periods started on a Monday and ended on a Friday. The control periods were separated from each other by 3 days and from the intervention period by 14 days. Patients admitted on the last day of a 33-day sample period were excluded from both intervention and control groups. Patients admitted to the medical team but transferred to other teams were omitted from both intervention and control groups. Patients admitted and discharged on a weekend, who would not have received the intervention, were also omitted from both intervention and control groups. The internal medicine unit used for the study was a service assigned to receive admissions of patients from the hospital primary medicine clinic, distinguished by a relatively high turnover and short LOS. The study was approved by the Institutional Review Board of the Yale University School of Medicine, which also determined that informed consent from individual patients in the study was not required.

Intervention

During the intervention period, a staff attending psychiatrist (P.C.Z. or P.H.D.) met with the medical team each weekday morning and reviewed each new admission. If necessary, the psychiatrist reviewed the medical record or briefly examined the patient to clarify any aspects of the history. The goal of the review was to ascertain any active psychiatric problems and potential barriers to discharge. This initial screening was usually completed on the second day in hospital, after the medical team had completed its initial assessment (preliminary observations had indicated that this was more efficient than review on the day of admission). In the case of weekend admissions, the assessment was performed on the first working day after the weekend, as the psychiatrist was present on regular workdays and not the weekends. If psychiatric issues were identified, the psychiatrist and medical team decided among the following options: (1) management with full psychiatric consultation, (2) management by the medical team with informal discussion with the psychiatric consultant, or (3) referral to outpatient psychiatric services only. In the case of the first option, a formal psychiatric consultation was initiated immediately and generally completed on that day, and the psychiatrist continued to provide any necessary care. In the case of the second option, any suggestions regarding the mental health care of the patient were formulated and transmitted to the medical team immediately, and the psychiatrist remained available for any further discussion if needed. In the case of the third option, the psychiatrist made any required recommendations about appropriate psychiatric referral. The staff psychiatrist was assisted by the regular psychiatric consultation service in performing the initial and follow up consultation.

Control Treatment

During the control periods, all cases received care as usual: consultations were performed by the psychiatric consultation team when requested by the medical service, and follow-up consultation visits were performed until psychiatric issues were judged resolved and the consultation team signed off.

Outcome Measures

The primary outcome measure was LOS. The following intervention-related data were also collected: psychiatrist time spent for initial screening; decision regarding need for consultation; psychiatrist time spent for initial and follow up consultation; time between admission and completion of initial screening/consultation; psychiatric needs identified at initial screening and whether they were judged likely to affect LOS. Identified psychiatric needs were tabulated as issues related to: substance abuse, mood/anxiety disorders, psychotic disorders, delirium/dementia, suicidal attempt/suicidal ideation, or other need. Time spent for screening and for consultation included time spent by the consultant psychiatrist and time spent by the regular consultation service. After discharge, the psychia-

trist(s) involved in a particular case recorded their impressions as to whether consultation reduced LOS. At the conclusion of the project, the qualitative impressions of members of the medical team and consultant psychiatrists were solicited regarding the services provided during the intervention period.

Statistical Methods

Proportions were compared with χ^2 tests and means were compared with *t*-tests. The a priori hypothesis was that LOS between intervention and control groups would differ from each other. LOS distribution was found to be non-normal (Kolmogorov-Smirnov test, $P < 0.01$), and variance differed between intervention and control groups (F test on variance ratio, $P < 0.01$). A negative binomial model is appropriate for count data when the variance of the observations is larger than the mean,[15] and was used to estimate the effect of the intervention on group means (SAS PROC GENMOD, with logarithmic link function, with a two-level group variable as predictor, intervention versus control). Pre- and post-control groups were compared with the intervention group in a model with a three-level group variable, intervention versus pre-control versus post-control, followed by specific contrasts of pre- versus intervention and post- versus intervention. Analyses were completed using Statview version 5.0.1 and SAS ver. 9.1.3 (SAS Institute, Inc., Cary, NC).

Fiscal Calculations

Financial advantages were analyzed from the perspective of benefit and cost to the hospital, did not include professional fee transactions, and focused on LOS reduction assuming that the hospital bore the full cost of the intervention. Our analysis was based on the value of the annualized saved days (the difference between mean LOS in the control and intervention groups multiplied by the number of patients in the intervention group) minus the cost of the psychiatrists' time (including full indirects and blended salaries of the two providers). The saved days had value as expense reduction ($400 per day) and revenue enhancement ($997 per day if the saved day could be filled by a new patient). The annualized cost fully loaded (indirect rate of 56%) of 0.25 full-time equivalents (FTE) psychiatrist time was estimated to be $56,550.

RESULTS

The intervention group consisted of 62 admissions and the control group consisted of 531 admissions (257 admitted in the pre-control period, and 274 in the post-control period). The intervention and control groups did not differ in age (53.6 ± 19.9 versus 53.3 ± 17.9 years, respectively) or gender (59.8% versus 56.5% male). In the 59 cases with a completed assessment, the time required for review was brief, 2.9 ± 2.2 min (mean ± standard deviation) per case (in three cases it was not possible to complete the assessment). A significant fraction of cases, 50.8% had psychiatric problems requiring treatment, consultation, or referral: 20.3% were judged to require psychiatric consultation to avoid potential delay of discharge, 5.1% judged to require psychiatric consultation for issues not likely to affect discharge, 10.2% judged to have psychiatric problems manageable by the medical team without requiring a formal consultation, and 15.2% judged to have psychiatric problems manageable by referral to outpatient psychiatric care without further intervention in the hospital. Of all identified psychiatric problems, the most common were related to substance abuse (43%), mood/anxiety disorders (30%), psychotic disorders (13%), suicidal attempt/ideation (7%), and delirium/dementia (7%). Of psychiatric problems judged to require formal psychiatric consultation in order to avoid potential delay of discharge, problems related to substance abuse were again the most common (38%), followed by mood/anxiety disorders (31%), psychotic disorders (13%), suicidal attempt/ideation (12%), and delirium/dementia (6%).

The consultant, together with the team, decided to initiate formal psychiatric consultation in 22.6% of the admissions during the intervention period, which is significantly greater than the rate of psychiatric consultation requested in the control period, 10.7% (χ^2 test, $P < 0.01$; see Table 1, Figure 1a). Separate analysis of the pre- and post-control groups indicated a consultation rate of 9.3% and 12.0%, respectively. Both of these are significantly different from the intervention period rate (χ^2 test, $P < 0.01$ and $P = 0.03$). Consultations were completed earlier during the intervention period than during the control period, 1.44 ± 0.88 versus 3.02 ± 2.78 days, a significant difference (*t*-test, unequal variances assumption, $P < 0.01$; see Table 1, Figure 1b).

Mean LOS was shorter in the intervention group, 2.90 ± 2.12 days, than in the pre- and post-control groups, 3.81 ± 3.01 and 3.66 ± 3.92 days, respectively, (see Table 1, Figure 1c, Figure 2). While this difference

TABLE 1. Comparison of Intervention and Control Groups

	Control, pre	Intervention	Control, post	Control, pre + post
Number of cases	257	62	274	531
Consultations/100 cases	9.3% (24)*	22.6% (14)	12.0% (33)*	10.7% (57)*
Consultation latency (days)	3.52 ± 3.01*	1.44 ± 0.88	2.64 ± 2.58*	3.02 ± 2.78*
LOS (days)	3.81 ± 3.01*	2.90 ± 2.12	3.66 ± 3.92*	3.82 ± 3.30*
% LOS > 4 days (# cases)	27.6% (71)*	14.5% (9)	28.1% (77)*	27.9% (148)*

LOS = length of stay.
* Significantly different from intervention, $P < 0.05$.

is significantly different by *t*-test, with ($P = 0.03$) and without the assumption of equal variance ($P < 0.01$), a *t*-test may be inappropriate for non-normally distributed data. A more sophisticated two-level model assuming a negative binomial distribution offered a good fit to the data (deviance = 558.8, degrees of freedom 591, ratio of 0.95 where 1 indicates good fit). This model indicated a significant difference between control and intervention groups ($\chi^2 = 6.38$, df = 1, $P = 0.01$). A three-level model was used to compare the intervention group and the pre- and post-control groups: the model indicated a statistically significant effect of group ($\chi^2 = 6.38$, df = 2, $P = 0.04$), and statistically significant differences in the contrasts of intervention with pre-control group ($\chi^2 = 5.93$, df = 1, $P = 0.02$), and intervention with post-control group ($\chi^2 = 5.78$, df = 1, $P = 0.02$). The difference between the pre- and post-control groups was not significant.

The reduction in mean LOS was accompanied by a decrease in the proportion of cases with LOS greater than 4 days in the intervention group, 14.5%, compared with the pre-control group, 27.6% ($\chi^2 = 4.57$, df = 1, $P = 0.03$) and compared with the post-control group, 28.1% ($\chi^2 = 4.90$, df = 1, $P = 0.03$; Figure 1d). Alternatively, the relative risk for length of stay greater than four days was roughly half when the intervention was compared with the pre-intervention and post-intervention periods (RR = 0.53, 95% CI: 0.28–0.99 and RR = 0.52, 95% CI: 0.27–0.97). The distributions of LOS for intervention and control cases are shown in Figure 2. The comparison suggests that the intervention had its chief effect in decreasing the number of cases with LOS > 4 days.

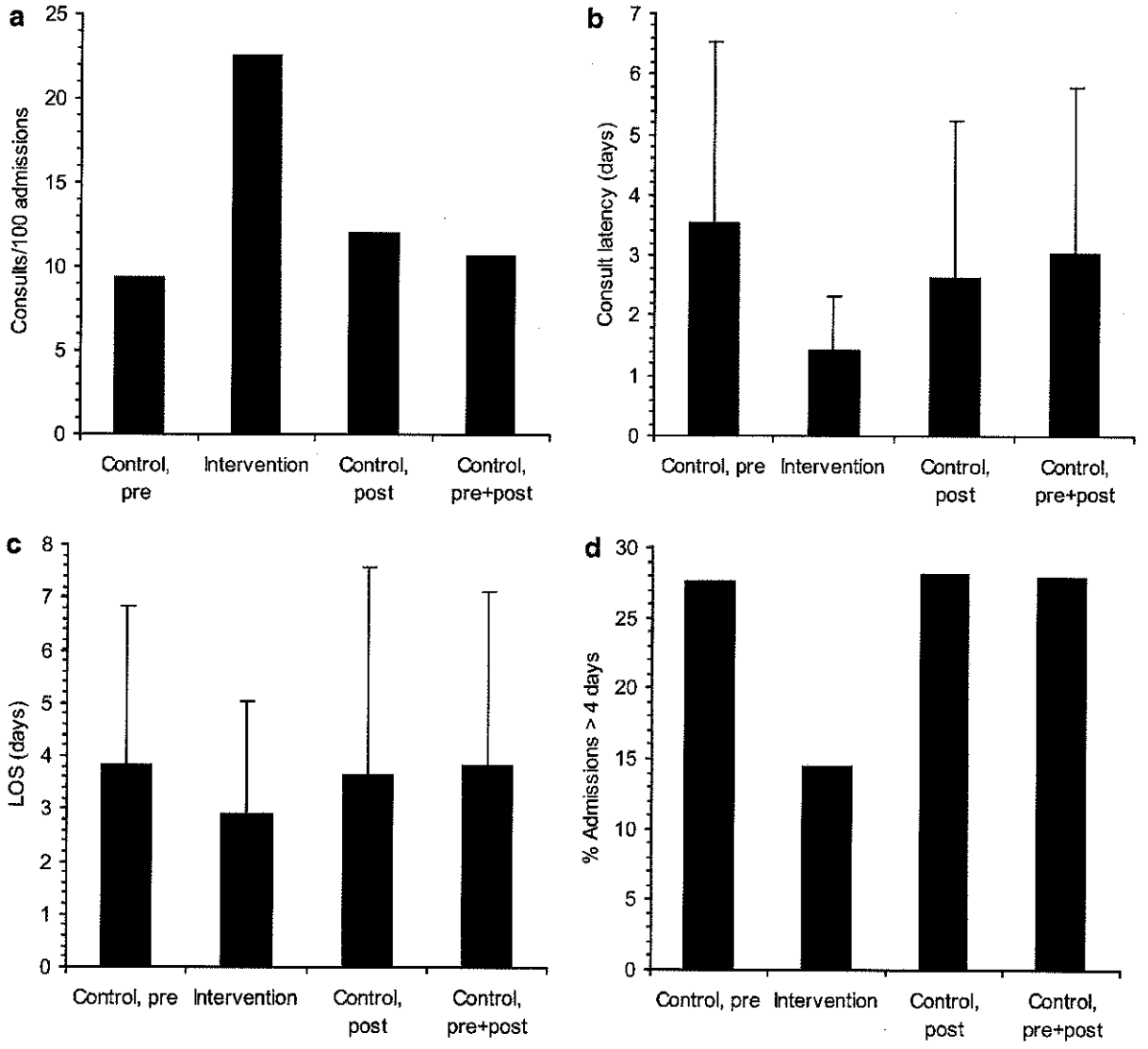
In 11 cases (16.7%), the consultant psychiatrist(s) judged retrospectively that consultation likely had a significant effect on LOS. These 11 cases were: optimization of anxiety treatment permitting more effective treatment of pain or respiratory symptoms (three cases), recommendations regarding substance abuse treatment or detoxification (three cases), quicker recognition and transfer to inpatient psychiatric unit (two cases), and one case each of adjustment of psychiatric medications causing physical symptoms (falls), improved treatment for delirium, and clarification of medical versus psychiatric diagnosis between (depression versus sleep apnea). The chief qualitative feedback from the consultant psychiatrists was to note the usefulness of early involvement in cases with behavioral factors affecting discharge, allowing earlier treatment of the patient, and earlier formation of appropriate discharge plans. The chief qualitative feedback from the medical team was an appreciation of the ease of communication when the psychiatrist was present daily. Team members also appreciated the ability to discuss cases and receive advice even on patients not receiving a formal consultation.

The total hours involved in initial case review and consult completion was estimated at 38.7 hours of physician time during the 5-week intervention period (15.0 hours in meeting with medical team, 3.0 hours in case review, and 20.7 hours in performing extra consultations and follow-up compared with baseline period), which would translate into 0.19 FTE clinical time, for a total estimated effort of 0.25 FTE. The total saving in LOS represented 57.0 days during the 5-week intervention period (0.92 times 62 cases), annualized to 593.2 saved days. Annualized cost of physician time was $56,550, which was the only direct cost associated with the intervention. Annualized financial benefit of saved days was $237,286 for cost avoidance alone and $591,436 for revenue enhancement alone (the full benefit of the revenue enhancement assumes vacated beds are filled immediately), resulting in an estimated minimum ratio of benefit to cost of 4.2, which could range as high as 14.7 if the full revenue enhancement were realized.

DISCUSSION

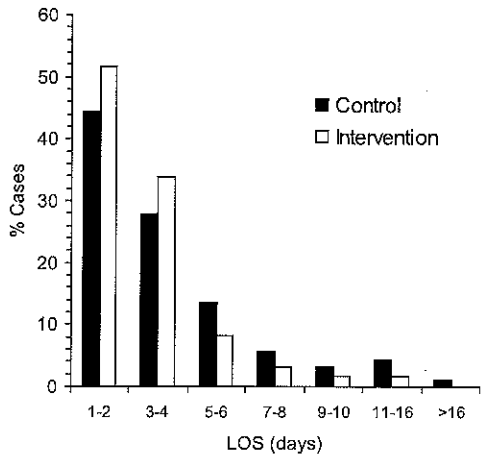
These results suggest that a proactive model for hospital psychiatric consultation is feasible and effective. Total

FIGURE 1. **Comparison of Outcome Measures between Intervention and Control Groups. (a) Number of Consultations per 100 Admissions during Control and Intervention Periods. (b) Consultation Latency, as Days between Admission and Performance of Consultation, during Control and Intervention Periods (Mean ± Standard Deviation). (c) LOS in Days during Control and Intervention Periods (Mean ± Standard Deviation). (d) Percentage of Admissions with LOS > 4 Days during Control and Intervention Periods.**



time required for screening of all admissions was manageable, averaging roughly 3 minutes per patient. Such screening identifies a larger fraction of cases needing psychiatric consultation than usual consultation requests, and identifies these cases earlier in the admission: during the control periods, about 11% of patients received a psychiatric consultation, with a mean latency of 3.5 days, while during the intervention period, 23% of patients received a consultation, with a mean latency of 1.4 days. Such expanded, prompt consultation cases reduced LOS, compared with a control period without this intervention. Examination of the distribution of LOS during the intervention period indicates that the major effect of the intervention was to reduce the fraction of patients with longer LOS. During the intervention, the proportion of patients with LOS greater than 4 was 14.5%, compared

FIGURE 2. Distribution of LOS during Control and Intervention Periods. LOS = Length of stay.



with 27.9% during control periods. This suggests that roughly 13% of patients had treatable psychiatric issues capable of delaying discharge, consistent with the retrospective impressions of the participating psychiatrists, who identified 17% of patients where prompt psychiatric care appeared to affect LOS. These results also emphasize that delay of discharge of even 13% of admissions has a notable effect on mean LOS, at least on this type of high turnover medical unit. At least three factors may have contributed to the effect observed on LOS: general case review, early consultation, and effective intervention and follow up.

First, general review of all cases with a psychiatrist disclosed a high rate of psychiatric problems, 50.9% of total cases. Many (20.4% of total cases) were judged as capable of affecting discharge. Our results are complementary to studies indicating a high rate of psychiatric diagnoses in medical inpatients. Our screening was intended to identify patients with behavioral health problems, not just those related to a specific psychiatric diagnosis. Accordingly, consultations were performed at a higher rate in the intervention period than in control period, 22.6% versus 10.7%. The baseline rate of consultation on this unit is already much higher than the rate of consultation in most other medical units in our hospital, which is about 4%. Many studies show consultation rates in academic medical centers of 4% or less.[16,17] Frequently, consultation requests are placed for issues such as psychological support (40% in one study[18]), not likely to affect discharge. It is clear that psychiatric consultation is greatly underused in typical hospital practice, and many patients with behavioral health issues capable of delaying discharge are not identified in this setting.

Second, consultations were completed earlier in admission during the intervention than control periods, an average of 1.44 days versus 3.02 days after admission. This reflects the case review process, which was generally done on the second day in the hospital, compared with the usual care model of awaiting a request from the medical team. Our results are consistent with other studies indicating that initiating discharge planning work for all patients upon admission can reduce LOS compared with awaiting primary physician request. For example, Boone and colleagues found that automatic early social work consultation decreased LOS by approximately 1.2 days in orthopedic unit patients.[19] Systematic discharge planning starting within 1 day of admission, as opposed to usual care, reduced LOS 0.8 days on a medical unit.[20] Our results are also consistent with research indicating that consultation requests arrive often too late to be maximally useful.[9] Data from other sectors of our research suggest that among patients with complex, chronic, multisystem diseases an individual problem may not only worsen in the hospital course but spawn new problems in a cascading manner.[21]

Finally, since the psychiatrist met daily with the team, treatment recommendations could be transmitted and enacted effectively. Continuing close contact with the team permitted the rapid detection of failure of a suggested treatment, or the failure to implement a suggested treatment, as well as the detection of new psychiatric problems. The proactive psychiatrist also offered substantial informal consultation and aid to the medical team. Such interaction may have added to the effect on LOS, but our study was not designed to measure time spent in this type of assistance.

While a more precise fiscal calculation would have included an analysis of each patient including rates of reimbursement, specific diagnosis-related group, method of payment (case rate versus per diem) and other relevant financial details, it is clear from this rough estimate that the savings (cost avoidance alone) are clearly substantial. These metrics do not consider other possible financial benefits of associated costs such as a reduction in denied days and constant companion use. The results suggest a very conservative estimate of at least a 4-fold ratio between the fiscal benefits and costs of the intervention, and likely much higher.

Our finding agrees with certain other studies of the effect of psychiatric consultation on LOS. In the founding years of consultation psychiatry, Billings and colleagues[11,22] compared all patients referred to the new Psychiatric Liaison Service in a general hospital in 1 year with

all patients referred in the preceding year: mean LOS was approximately 5 days shorter with the intervention. Likely, this represents a comparison of psychiatric consultation versus minimal or no consultation. Levitan and Kornfeld (1981) performed psychiatric consultations with all female patients admitted for femur fracture surgical repair: median LOS was approximately 12 days shorter than in the treatment as usual group in the preceding year.[12] Strain and colleagues (1991) studied patients over 65 admitted for hip fracture surgical repair in two different hospitals with a control population of similar patients in the preceding year: mean LOS was improved by about 2 days in both institutions.[13] Slaets and colleagues (1997) studied the effect of a multidisciplinary psychogeriatrics consultation intervention in patients over 75 admitted to a hospital internal medicine unit: LOS was reduced by 5.1 days compared with a parallel control group.[23] These studies test the effect of proactive, general screening and prompt consultation.

Other studies have not found psychiatric consultation to affect LOS. In a carefully designed randomized controlled trial, the largest and most systematic study carried out to date, Levenson and coworkers[14] did not find an effect of psychiatric consultation on LOS. All patients admitted to a general medical service scoring above threshold on a composite instrument measuring anxiety, depression, confusion, or pain received a single standard psychiatric consultation. There was no significant decrease in mean LOS in the intervention group versus either concurrent or preceding period comparison groups receiving usual care. Our study differed from this study in screening methodology, intervention implementation, and clinical setting. Our screening was intended to include all psychiatric issues that might affect LOS, some of which might not be indicated by a general screening instrument. Our psychiatrist met with the medical team regularly to ensure that consultation recommendations were implemented and newly emerging psychiatric problems efficiently detected. Levenson et al.[14] expressed concerns about whether teams acted effectively on recommendations from a single unrequested consultation. Finally, our study was performed on a particular internal medical unit rather than on multiple hospital units of different types, greatly increasing the odds of finding a statistically significant change. The unit used in this study admitted patients from the hospital primary care clinic, which has a high rate of clients with state insurance and of mental health issues, and the unit has a shorter LOS than most units in the hospital.

Two other studies using a generalized screening instrument[24,25] did not find a statistically significant improvement in LOS following increased consultation services (the latter study did find an improvement in LOS in patients over 65). A randomized controlled trial of psychiatric consultation for patients identified by a psychiatric disorder screen failed to show a significant benefit in inpatient or outpatient costs.[26] Hengeveld (1988) did not detect a change in LOS in a small study based on cases with a suprathreshold score on a questionnaire measuring depression.[27] It may be relevant that all of these studies used screening instruments rather than individual clinical assessments.

Strengths of the study include the well defined, discrete nature of the intervention, the ABA design, and an adequately sized control group. Although the before, during, and after comparisons are not as strong as a randomized controlled design, they lend compelling support to the findings. A strength and a weakness is the limitation of the intervention to one specific type of hospital unit, an internal medical unit with high patient turnover. Limitation to one type of unit increases the statistical power of the study, but decreases our ability to assert that these findings can be generalized to other settings. During the study, the medical team was aware that additional consultation services were in place and intended to reduce LOS. It cannot be determined how much of the shortened LOS could be due to expectation bias or nonspecific effects of the intervention. Finally, the study is necessarily preliminary, being small in size and restricted to one academic institution. More research using a randomized controlled design and multiple settings are required to demonstrate the conclusions our study suggests.

Our results do offer suggestions for hospital-based psychiatric consultation practice. The medical team valued the easy communication possible with a daily meeting with a consultation psychiatrist, and also reported benefitting from informal discussion of cases without formal consultation. Consultation-liaison (C-L) services may consider assigning a specific psychiatrist to a specific team. An embedded psychiatrist would reduce the delay in providing psychiatric expertise through both formal and informal consultation. Such a psychiatrist can also help educate staff in problem recognition and treatment, a liaison role. In the present study, consultant psychiatrists noted the usefulness of early identification of mental health factors relevant in discharge planning. C-L services can help in organizing discharge planning done by other services.

In the early work on the cost effectiveness of C-L psychiatry, the question was whether psychiatric services could reduce LOS and costs. It is now accepted that psychiatric consultation is essential to the modern hospital, and few large

general hospitals do not have access to some form of psychiatric consultation. We believe the relevant hypotheses for research can now be more specific: how should hospital psychiatric services be organized and what specific interventions are needed for which patients. Our results echo the analysis proposed by Kathol et al. (2009) in arguing that future consult services will be proactive, will be specific in their interventions, and will be multidisciplinary.[28] Furthermore, our study suggests that such services can pay for themselves in increasing efficiency, reducing costs, and allowing more revenue generating opportunities without increasing costs. The need for psychiatric consultation services, from both fiscal and medical perspective, is no longer at issue: the issue is what kinds of services, when, by whom, and how much.

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Disclosure: The authors disclosed no proprietary or commercial interest in any product mentioned or concept discussed in this article.

References

1. Silverstone PH: Prevalence of psychiatric disorders in medical inpatients. J Nervous Mental Dis 1996; 184:43–51
2. Wancata J, Windhaber J, Bach M, et al: Recognition of psychiatric disorders in nonpsychiatric hospital wards. J Psychosom Res 2000; 48:149–155
3. Hansen MS, Fink P, Frydenberg M, et al: Mental disorders among internal medical inpatients: prevalence, detection, and treatment status. J Psychosom Res 2001; 50:199–204
4. Fulop G, Strain JJ, Fahs MC, et al: A prospective study of the impact of psychiatric comorbidity on length of hospital stays of elderly medical-surgical inpatients. Psychosomatics 1998; 39: 273–280
5. Saravay SM: Psychiatric interventions in the medically ill. Outcome and effectiveness research. Psychiatr Clin North Am 1996; 19:467–480
6. Zolneirek CD: Non-psychiatric hospitalization of people with mental illness: systematic review. J Adv Nurs. 2009; 65:1570–1583
7. Bourgeois JA, Kremen WS, Servis ME, et al: The impact of psychiatric diagnosis on length of stay in a university medical center in the managed care era. Psychosomatics 2005; 46:431–439
8. Bourgeois JA, Wegelin JA: Lag time in psychosomatic medicine consultations for cognitive disorder patients: association with length of stay. Psychosomatics 2009; 50:622–625
9. Kishi Y, Meller WH, Kathol RG, et al: Factors affecting the relationship between the timing of psychiatric consultation and general hospital length of stay. Psychosomatics 2004; 45:470–476
10. Lyons JS, Hammer JS, Strain JJ, et al: The timing of psychiatric consultation in the general hospital and length of hospital stay. Gen Hosp Psychiatry 1986; 8:159–162
11. Billings EG, McNary WS, et al: Financial importance of general hospital psychiatry to hospital administrator. Hospitals 1937; 11: 40–44
12. Levitan SJ, Kornfeld DS: Clinical and cost benefits of liaison psychiatry. Am J Psychiatry 1981; 138:790–793
13. Strain JJ, Lyons JS, Hammer JS, et al: Cost offset from a psychiatric consultation-liaison intervention with elderly hip fracture patients. Am J Psychiatry 1991; 148:1044–1049
14. Levenson JL, Hamer RM, Rossiter LF: A randomized controlled study of psychiatric consultation guided by screening in general medical inpatients. Am J Psychiatry 1992; 149:631–637
15. McCullagh P, Nelder JA: Generalized linear models. London; New York: Chapman and Hall/CRC, 1989
16. Huyse FJ, Herzog T, Lobo A, et al: Consultation-liaison psychiatric service delivery: results from a European study. Gen Hosp Psychiatry 2001; 23:124–132
17. Wallen J, Pincus HA, Goldman HH, et al: Psychiatric consultations in short-term general hospitals. Arch Gen Psychiatry 1987; 44:163–168
18. Katon W, Von Korff M, Lin E, et al: Distressed high utilizers of medical care : DSM-III-R diagnoses and treatment needs. Gen Hosp Psychiatry 1990; 12:355–362
19. Boone CR, Coulton CJ, Keller SM: The impact of early and comprehensive social work services on length of stay. Soc Work Health Care 1981; 7:1–9
20. Farren EA: Effects of early discharge planning on length of hospital stay. Nursing Economics 1991; 9:25–30
21. Sells D, Sledge WH, Wieland M, et al: Cascading crises, resilience, and social support within the onset and development of multiple chronic conditions. Chronic Illness 2009; 5:92–102
22. Billings EG: Value of psychiatry to the general hospital. Hospitals 1941; 15:30–34
23. Slaets JP, Kauffmann RH, Duivenvoorden HJ, et al: A randomized trial of geriatric liaison intervention in elderly medical inpatients. Psychosom Med 1997; 59:585–591
24. Camus V, Viret C, Porchet A, et al: Effect of changing referral mode to C-L psychiatry for noncognitively impaired medical inpatients with emotional disorders. J Psychosom Res 2003; 54:579–585
25. de Jonge P, Latour CH, Huyse FJ: Implementing psychiatric interventions on a medical ward: effects on patients' quality of life and length of hospital stay. Psychosom Med 2003; 65:997–1002
26. Gater RA, Goldberg DP, Evanson JM, et al: Detection and treatment of psychiatric illness in a general medical ward: a modified cost-benefit analysis. J Psychosom Res 1998; 45:437–448
27. Hengeveld MW, Ancion FA, Rooijmans HG: Psychiatric consultations with depressed medical inpatients: a randomized controlled cost-effectiveness study. Int J Psychiatry Med 1988; 18:33–43
28. Kathol RG, Kunkel EJ, Weiner JS, et al: Psychiatrists for medically complex patients: bringing value at the physical health and mental health/substance-use disorder interface. Psychosomatics 2009; 50:93–107

EXHIBIT 6

Description of Services Provided by Rushford Center, Inc.

Rushford
A Hartford HealthCare Partner

Adult
Community Support Services
Meriden

Funded by the Department of Mental Health & Addiction Services (DMHAS), individuals enter the program in a variety of ways: family and self-referrals, referrals from hospitals, social services and other community providers.

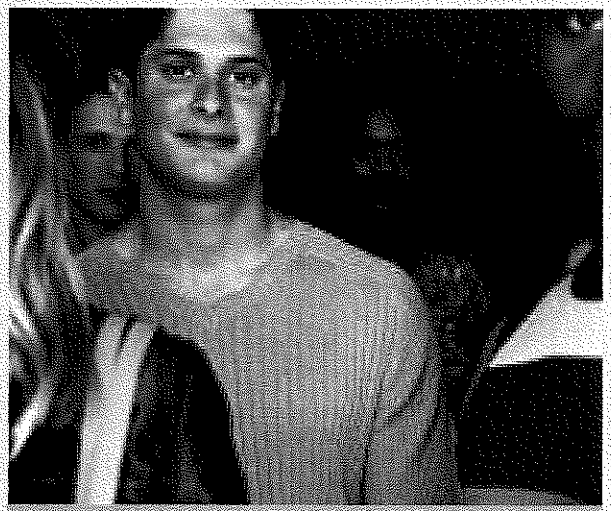
COMMUNITY SUPPORT SERVICES

This program assists people with mental illness and/or addiction disorders to achieve independence. This means helping to improve their ability to live in the community with the least intervention from formal services and to make their own decisions to the greatest extent possible. The decision to receive community support services is voluntary, goal driven and participant directed.

Services are provided in a flexible manner to meet a participant's changing wants, needs and resources. Case managers provide assistance to individuals in order to obtain a full range of mental health services and/or encourage additional decisions about how to improve their quality of life.

Services offered include:

- Treatment Coordination
- Employment and Housing Assistance
- Homeless Outreach
- AIDS Education and Outreach
- SAGA Case Management Services
- Social Club (Friendship Club) to assist persons with mental health disorders achieve maximum independence through the exploration and the development of daily living skills.



MERIDEN
883 Paddock Avenue
Meriden, CT 06450
(203) 630-5220

ACCREDITED BY THE JOINT COMMISSION

www.rushford.org

To make an appointment, please contact our Access Center at 888-203-2916.

Rushford
A Hartford HealthCare Partner

Adult
Partial Hospital Program

Individualized Structured Day Treatment Program for Adults

Rushford provides individualized care that offers people coping with mental illness and/or an addiction disorder a route to recovery that is specifically tailored to their needs.

PARTIAL HOSPITALIZATION PROGRAM (PHP)

A highly structured group treatment program for adults who suffer from psychiatric or co-occurring psyhciatric and substance abuse disorders. Individuals attend the PHP program 5 days per week, from 9 a.m. - 2 p.m. Various group treatment methodologies are provided to help support clients for effective and safe transition into the community following hospitalization. Clients who require stabilization from crisis, short-term emotional disorders, or periodic relapse, with the intention of averting an inpatient hospitalization, also attend PHP.

INTENSIVE OUTPATIENT PROGRAM (IOP)

A step-down treatment program from the PHP program, and/or to provide support services to individuals who do not require treatment on a daily basis. Groups operate 3 days per week, (M, W, F) from 9 a.m. - 12:30 p.m.

Transportation, if needed, is provided for individuals who reside in Meriden and Wallingford.

MORE INFORMATION

For client referral and intake information, please contact:

Kerry Carli, MSW
Intake Coordinator/Liaison
Rushford
203-630-5264

CRISIS HOTLINE - 1.800.567.0902

MERIDEN
883 Paddock Avenue
Meriden, CT 06450
(203) 630-5264

ACCREDITED BY THE JOINT COMMISION

www.rushford.org

For more information, please contact Kerry Carli at (203) 630-5264

Rushford
A Hartford HealthCare Partner

Adult Mental Health Services

Meriden

HOURS OF OPERATION

Mondays - Fridays, 8 a.m. to 8 p.m., Crisis Hotline available 24 hours a day, 7 days a week.

OUTPATIENT SERVICES

For adults ages 18 and older who may be experiencing mental health issues.
Services provided:

- Individual Therapy
- Group and Family Therapy
- Dual Diagnosis Treatment

CRISIS EVALUATION & STABILIZATION SERVICES

1-800-567-0902

A 24-hour, seven-day-a-week crisis program and hotline to address emergency mental health and substance abuse issues. Licensed clinicians monitor all phone calls and provide emergency and mobile assessment services. Five respite care beds are available to adult clients who meet established criteria.

COURT DIVERSION

Rapid assessment and referral to clinical services for incarcerated persons or those at risk for incarceration with mental health and/or substance abuse disorders

DUAL DIAGNOSIS PARTIAL HOSPITAL PROGRAM (DDPHP)

A structured, integrated therapeutic program for clients who have co-occurring substance abuse and mental health disorders not requiring inpatient hospitalization. The program provides more intensive therapy than a traditional outpatient setting.

DUAL RECOVERY TREATMENT PROGRAM (DRTP)

An intensive outpatient program for individuals coping with co-occurring mental health and substance abuse disorders. DRTP provides short-term treatment for patients in the acute phase of their illness and periodic care for severe, prolonged disorders.

INTENSIVE OUTPATIENT PROGRAMS

Highly structured treatment programs for adults who suffer from co-occurring mental health and substance abuse disorders.

LATINO SERVICES

Services for Spanish speaking clients in need of substance abuse and mental health treatment including outpatient and rehabiliation services.

PARTIAL HOSPITAL PROGRAMS

Treatment programs that are more intensive than traditional outpatient programs for adults who suffer from co-occurring psychiatric and substance abuse disorders.

OLDER ADULT SERVICES

A program serving older adults (50+) who have a primary mental health diagnosis and active substance abuse issues that negatively impact their relationships, health and/or quality of life.

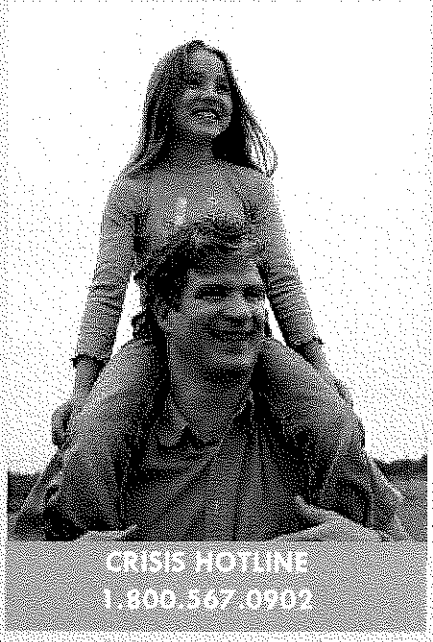


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EXHIBIT 7

Excerpts from the Hartford HealthCare Behavioral Health Network Balanced Scorecard Initiative

Hartford HealthCare

00121

Behavioral Health Network
2011 Balanced Scorecard Initiative

Strategy Council Progress Report
July 8, 2011

Evaluate and re-design Behavioral Health practices and processes across the system to enhance quality and value of the service line.

Balanced Scorecard Measure

Review of behavioral health operations, assess best practices by level of care, and determine initiatives that will improve the quality & contribution margin of services system-wide.

Today's Report will:

✓ Briefly review the process we have used.

✓ Highlight the progress each of our 7 workgroups have made to date.

✓ Focus on the decisions and actions needed from the Strategy Council to continue our work.

Hartford HealthCare

Process Used to Implement Initiative

Steering Committee:

Steve Larcen – Hank Schwartz – Annetta Caplinger

Jeff Walter – Mike Balkunas – Cindy Russo

Program Inventory Completed:

✓Operating Revenues of $141 million (excludes research and training).

✓ Contribution margin of $37 million

✓ Best practices reviewed for all levels of care

March Retreat – Completed SWOT and Identified Priority Areas

7 Workgroups Implemented: Over 50 volunteers from the system

✓ Executive Sponsor & Workgroup Leaders identified.

✓ Develop action plans to implement initiatives & timetable.

✓ Determine contribution margin improvement expected in 2012 & 2013

Behavioral Health Network - Workgroups

Workgroup	Executive Sponsor/Workgroup Leader
1. Increase Intra System Referrals	Annetta Caplinger/Olga Dutka
2. Consolidation of Inpatient Services	Steve Larcen/Mike Balkunas
3. Improved Inpatient Operations	Steve Larcen/ Ellen Blair, Sharon Hinton
4. Improved PHP/IOP Operations	Jeff Walter/David Klein
5. Improved Outpatient Operations	Mike Balkunas/Kathy Ulm
6. Implement System-wide EMR & Clinical Workflows	Hank Schwartz/Brain Jaworowski
7. Unified Business Environment	Jeff Walter/Paul Maloney

Hartford HealthCare

Consolidation of Inpatient Services

Determine feasibility of the consolidation of inpatient services between MMC and HOCC. Determine capital costs, expected improvement in operations and clinical benefits of this consolidation. Address needed connections to community services and develop strategy for community and regulatory support.

Recommendations:

1. Establish second inpatient unit adjacent to HOCC current unit. Single unit preferable.
2. Current capacity (6 Beds MMC, 22 Beds HOCC) preserved with total 32 beds at HOCC.
3. Referrals outside network retained in network with increased real capacity – estimate 130 additional admissions.
4. Increase managed care rates at HOCC comparable to MMC/NH rates for behavioral health (inpatient and outpatient).

Hartford HealthCare

Improved Inpatient Operations

Determine clinical staffing patterns, operating processes and program designs that contribute to best quality and improved contribution margins.

Initial action steps recommended to implement this initiative:

1. Identify similarities and differences in existing unit programs.
2. Identify and analyze staffing patterns for best practices that support quality and efficiency.
3. Standardize reporting of data for staffing ratios, productivity and acuity across HHC.
4. Process map work flow and evaluate for best practices that promote quality and efficiency.
5. Evaluate clinical programming for best practices that promote quality, safety and potential program growth.

Implement System-wide EMR & Clinical Workflows

EMR implementation used to design standardized clinical documentation processes, utilizing best practices in the system. This will accelerate the implementation, and realize improvements in clinical processes. A common EMR (with managed care components) will also increase management information for all entities on quality, reduced managed care denials, and improved compliance monitoring resources as external compliance requirements also increase. This goal will also support the HHC BSC for establishing a quality and data infrastructure for BH.

Initial action steps recommended to implement this initiative:

1. EMR business case was completed and presented to HHC IT Steering Committee in May. Contract currently being negotiated.
2. Process for design of common clinical workflows and documentation will start with ambulatory care, to be completed by December 2011. Inpatient completed by end of FY 2012.
3. Initial sub-groups formed to focus on comprehensive review of the assessment process, clinical and regulatory standards, and best practices at each member.

EXHIBIT 8

Excerpts of Minutes from the Hartford HealthCare Board of Directors Meeting

Excerpts of Minutes from The Hospital of Central Connecticut Board of Directors Meeting

Copy of the MidState Medical Center Board of Directors Resolution Approving this Application

Excerpts from the May 15, 2012 MidState Medical Center Board of Directors meeting recommending the filing of this CON Application

HARTFORD HEALTHCARE CORPORATION
BOARD OF DIRECTORS
MINUTES OF MEETING OF NOVEMBER 29, 2011

The Board of Directors of Hartford HealthCare Corporation ("HHC") met on November 29, 2011 in the Board Room of Hartford Hospital.

Directors present were: Ramani Ayer, William A. Conway, M.D., Nancy Dean, John Dillaway, Laura Estes, David Hyman, DDS, Elliot Joseph, John Manning, Lawrence McGoldrick, Didier Michaud-Daniel, Elsa Nunez, Steven Preston (via conference telephone), William Trachsel, and Jennifer Smith Turner.

Director excused was: Brian MacLean.

Invited guests present were: James Blazar, Michele Bush, Daphne Carter, Tracy Church, Jeffrey Flaks, Stephen Larcen, Ph.D. (business meeting only), Thomas Marchozzi, Gail Marcus, Rocco Orlando, M.D., Karl Kellner (McKinsey & Company, educational session only), James Stanford (McKinsey & Company, educational session only), and Jeffrey Walter (business meeting only).

- **Consolidation of MidState Psychiatric Beds into The Hospital of Central Connecticut**

A Certificate of Need ("CON") is required to change healthcare services in Connecticut. Mr. Larcen stated that the total access to psychiatric beds by the community would be increased, which should offset any CON concerns about the consolidation. Mr. Larcen summarized the potential impact of the behavioral health initiative to the system.

Upon motion duly made and seconded, it was unanimously

VOTED: To approve the consolidation of inpatient psychiatric beds from MidState into HOCC, whereby MidState will seek to terminate its existing service of six (6) beds and HOCC will seek to increase its service of inpatient psychiatric beds from twenty-four (24) to thirty-two (32) beds, as presented in the written resolution submitted to the Board in advance.

RESOLUTION
HARTFORD HEALTHCARE CORPORATION
BOARD OF DIRECTORS

CERTIFICATE OF NEED
NOVEMBER 29, 2011

WHEREAS, the addition or termination of certain health care services in the State of Connecticut requires approval under Connecticut law known as the Certificate of Need ("CON") process;

WHEREAS, pursuant to Section 3.0 (n) of the Third Amended and RestatedBylaws of Hartford HealthCare Corporation ("HHC"), as duly adopted by the Board of Directors (the "Board") on April 4, 2011, the HHC Board has the power to approve the services offered by its subsidiaries, including the filing of any application for a CON with the State of Connecticut;

WHEREAS,MidStateMedicalCenter ("MidState") is a direct subsidiary of HHC;

WHEREAS, The Hospital of Central Connecticut ("HOCC") is an indirect subsidiary of HHC, through HOCC's corporate parent, the Central Connecticut Health Alliance, Inc. ("CCHA");

WHEREAS, pursuant to Section 2.2 (k) of the corporate Bylaws of each of MidState and HOCC, as duly adopted by the Boards of each of them, and as further approved by the Board of HHC, HHC reserves the power to approve the spectrum of services offered by each of MidState and HOCC and the introduction or termination of any service, including the filing of any application for a CON;

WHEREAS,MidState currently operates six (6) of the eight (8) inpatient psychiatric beds for which it presently has CON approval;

WHEREAS, HOCC currently operates twenty-two (22) of the twenty-four (24) inpatient psychiatric beds for which it presently has CON approval;

WHEREAS, the affiliation of CCHA/HOCC with HHC has determined, through the integration plan and process,that it is in the best interests of MidState, HOCC and HHC that the inpatient psychiatric beds at MidState and HOCC be consolidated to optimize the cost-benefits and maximize the efficiencies of healthcare services in the system; and

WHEREAS, the HHC Behavioral Health Network Steering Committee has separately determined, as part of a 2011 HHC BalancedScorecard initiativeunder the"Financial Strength" pillar,that it is in the best interests of MidState, HOCC and HHC that the inpatient psychiatric

beds at MidState and HOCC be consolidated to optimize the cost- benefits and maximize the efficiencies of healthcare services in the system.

NOW, THEREFORE, BE IT:

RESOLVED, that the Board of Directors of HHC hereby authorizes and approves the consolidation of inpatient psychiatric beds between MidState and HOCC;

FURTHER RESOLVED, that MidState shall seek to terminate its service of inpatient psychiatric beds;

FURTHER RESLOVED, that HOCC shall seek to increase its service of inpatient psychiatric beds from twenty-four (24) to thirty-two (32) beds; and

FURTHER RESOLVED, that management of HHC, MidState and HOCC shall undertake all acts as necessary, prudent and appropriate to effectuate the purposes of this Resolution, including, but not limited to, the filing of any Certificate of Information or CON with the Office of Health Care Access of the State of Connecticut.

implications of the budget deficit and debt will have on health care. The only certainty is there will be less money for the hospital. We will continue to monitor the situation.

Behavioral Health – Mr. Silvia provided an overview of the plan to consolidate MidState's inpatient psychiatric beds with HOCC's. The membership and attributes of Hartford HealthCare's Behavioral Health Network were reviewed. It is Connecticut's largest behavioral health network accounting for $141 M in operating revenue and 27% of the inpatient bed admissions. The network offers a full array of inpatient and outpatient programs with over 200,000 outpatient visits annually. The reasons to consolidate were discussed. The resources to operate such a small unit at MidState are limited which impacts the amount of programs that can be offered. Access to other programs and facilities is also limited and it negatively impacts MidState's financial performance. The consolidation options were reviewed. They included consolidating the service at the MidState campus, providing the service at the Bradley campus or two options for moving the beds to the New Britain campus (1st floor renovation for two units costing $1.9 million or a single 32-bed unit on the 3rd floor costing $4.8 million). It was determined that the best option would be to consolidate the beds into a single unit at the New Britain campus. The benefits of the consolidation were reviewed and include improved access, reduced outmigration and hold times, increased access to enhanced programming and the potential to develop specialized programs. The pro forma shows a benefit for both hospitals. The loss at MidState would be reduced by $565,000 and with an ADC of 25.6 out of 32 beds, there would be an increase to HOCC's contribution margin of $1 million. The timeline going forward includes filing a letter of intent with OHCA later this month. A CON will be required because we would be terminating the service at MidState and increasing the number of beds at HOCC. Facility changes will also have to be made at HOCC. E3 is currently being used by Dr. Luciano's practice and W-3 is where the Department of Medicine is located.

ACTION *It was motioned, seconded and passed to approve the consolidation of the MidState/HOCC inpatient psychiatric beds creating a 32-bed inpatient psychiatric unit located on the 3rd floor of HOCC's New Britain campus.*

Physician Press Ganey Summary – Dr. Hanks reviewed the physician Press Ganey scores for 2011 and promised to e-mail a copy of the comprehensive survey report to the Board. There was concern about the survey results in 2007 and actions were taken to improve our results. Beginning in 2009 we have seen a remarkable turnaround in our scores and have been nationally recognized by Press Ganey for our improvements. The Satisfaction Scores and Engagement Scores were reviewed in comparison to 2009. Dr. Hanks also provided a comparative overview between 2009 and 2011 in regard to the number of respondents, the total number of participants in the database, the number of systems and hospitals in the database as well the number of questions and number of ranked questions in the survey. He also reviewed the differences in the individual question results from 2009 to 2011. Scores increased from 2009 in all of the survey categories: Overall Facility Rating (79.6 to 82.5 - 98th to 96th percentile rank), Quality of Patient Care (81.7 to 82.5 – 99th to 98th percentile rank), Ease of Practice (79.2 to 81.3 – 95th to 86th percentile rank), Summary Assessments (82.2 to 85.5 – no change from 99th percentile rank), Communication and Collaboration (69.4 to 73.4 – 84th to 93rd percentile rank) and Final Assessments (85.7 to 89.4 – 96th to 99th percentile rank). The increases in the overall satisfaction national ranking from 2007 (53rd percentile) to 2011 (98th percentile) and overall engagement ranking from 2007 (54th percentile) to 2011 (96th percentile) were reviewed. Dr. Hanks also reviewed the questions scoring under the 70th percentile as well as the questions with a mean score of under 70 for 2011. Committees have been established to target the areas where we are under performing based on the responses to the questions and write-in comments. The groups will develop and implement action plans to address the issues identified. The physicians will be surveyed again in 2013.

2012 Board and Board Committee Dates – Mr. Silvia referred the Board to the list of Board and Board Committee dates for 2012 located on page 45 of the information mailed to the Board prior to the meeting.

7. FINANCIAL REPORT

Carolyn Freiheit reviewed the new financial report format and stated it was implemented to provide consistency in reporting financial results across the system. HOCC's operating margin for October was $1 million. The result was equal to budgeted projections and $475,000 less than FY 11. Discharges were below budget by 6.4%. The Med/Surg area saw the most significant decrease in activity primarily because of the economy and a statewide downward trend in activity. Total inpatient and outpatient surgeries were under budget by 83 cases. A review of the Statement of Operations shows that bad debts are at $1.1 M compared to $1.3 M budgeted. Operating

MIDSTATE MEDICAL CENTER

Resolutions of the Board of Directors
Proposed for adoption at May 15, 2012 Meeting

WHEREAS, the addition or termination of certain health care services in the State of Connecticut requires approval under Connecticut law known as the Certificate of Need ("CON") process; and

WHEREAS, MidState currently operates six (6) of the eight (8) inpatient psychiatric beds for which it presently has CON approval; and

WHEREAS, The Hospital of Central Connecticut at New Britain General and Bradley Memorial ("HOCC"), is one of the hospital entities in the health care delivery system administered by Hartford HealthCare Corporation ("HHC"), the parent company of MidState; and

WHEREAS, HOCC currently operates twenty-two (22) of the twenty-four (24) inpatient psychiatric beds for which it presently has CON approval; and

WHEREAS, the Board of Directors of HHC has determined that it is in the best interests of MidState and HOCC that the inpatient psychiatric beds at MidState and HOCC be consolidated to optimize the cost-benefits and maximize the efficiencies of healthcare services in the system; and

WHEREAS, this Board deems it to be advisable and in MidState's best interest to terminate the provision of inpatient psychiatric services which it is currently providing in its 6-bed inpatient unit, and to collaborate with HOCC to have at least ten (10) beds available at HOCC wherein patients from the MidState service area would receive preferential inpatient admission to the HOCC inpatient psychiatric unit.

NOW, THEREFORE, it is hereby

RESOLVED, that the Board recommends that MidState seek to terminate its service of inpatient psychiatric beds in conjunction with its plan to secure preferential admission status at HOCC for up to ten (10) patients from MidState's service area that require inpatient psychiatric services; and further

RESOLVED, that the Board recommends that MidState file a CON with the State of Connecticut for such purpose; and further

RESOLVED, that the CEO of MidState is authorized to relay such recommendations to HHC as required under the Bylaws; and further

RESOLVED, that any officer or member of the management of MidState is authorized and empowered to take or cause to be taken any and all such acts as are deemed necessary, prudent and appropriate to effectuate the purposes of the preceding resolutions; and further

RESOLVED, that all actions previously taken by any officer or member of the management of MidState in furtherance of any of the foregoing resolutions be, and the same hereby are, ratified and approved in all respects.

MIDSTATE MEDICAL CENTER
BOARD OF DIRECTORS
May 15, 2012
7:30 a.m. – Board Room

PRESENT: Christopher W. Beale, Irfan Chughati MD, Bruce C. Eldridge, Lucille Janatka, Lewis Levin MD, Joseph E. Mirra, James L. Pellegrino, Marcia B. Proto, James N. Smith, Richard A. Smith MD, Giovanna T. Weller; also attending: Ralph Becker, Harold P. Kaplan MD, Cindy Russo, and Betsey DuBois

ABSENT: Carl Grant, Chris Ulbrich, Rajani Nadkarni MD

GUESTS: Steven Hanks MD, Valerie Dillon-Weed, Richard Stys

1. **Call to Order**: Bruce C. Eldridge, Chairman of the Board, called the meeting to order at 7:30 a.m.

4. **Board Approvals:**

a. HHC CON – Behavioral Health Changes – Dr. Hanks and Ms. Russo reviewed the proposed CON application to close MidState's six-bed inpatient psych unit and transfer that patient population to HOCC, which is building a new 32-bed unit to replace its current 22-bed unit. HOCC, with its larger unit, can provide a variety of group therapies, and MidState will have a preferential referral relationship for up to ten patients needing inpatient psychiatric services. Rushford, physicians, and advocacy groups are supportive of this plan. Patient transfer and ED flow are being addressed. A CON is necessary to terminate the service. A suggestion was made to promote the plan to the media. A motion was made, seconded, and it was

VOTED: To recommend to HHC the filing of a CON to terminate MidState's inpatient psych services (Copy of resolution attached to permanent minutes)

EXHIBIT 9

Copy of MidState Medical Center Communication Plan

MidState Medical Center
A Hartford HealthCare Partner

MidState Medical Center
Communication Plan for Closing of Inpatient Psychiatry Unit

Purpose: To inform all internal and external stakeholders of the closing of MidState Medical Center's inpatient psychiatry unit and provide information to patients and families regarding transportation services available, ensuring that outpatient follow-up care will be transitioned back to their local community

Communications	Target Date
Internal - Staff Communicate closing at General Management meeting Release talking points to managers for staff education Disseminate a CEO letter via an all-user email blast announcing the official closing and time line of project	Immediately following CON approval
External – Physicians Distribute an electronic CEO letter to all MidState affiliated physicians announcing the official closing and time line of project	Immediately following CON approval
External – Community/Public Secure a story in Record-Journal that announces closing and provides details on how the transportation service will be provided Send press release to local media in primary service area as appropriate Post press release on the homepage of MidState Medical Center's website Send letters to health and human service agencies that detail how patients will be transferred, what they can expect, and how transportation service will be provided (i.e. Community Health Center, local health departments, etc.) Create an information sheet to distribute to patients in ED being transferred to HOCC that details transportation service	Within two weeks following CON approval Begin distribution immediately following change

EXHIBIT 10

Resumes and Curriculum Vitae for Key Administrative and Clinical Personnel Related to this Proposal
MidState Medical Center
The Hospital of Central Connecticut
Rushford Center

LUCILLE ANDOLINA JANATKA, FACHE

P. O. Box 940
Woodbury, Connecticut 06798
203.405.3452

PROFESSIONAL EXPERIENCE:

1999 - Present **President/Chief Executive Officer**
MidState Medical Center
Meriden, Connecticut 06451

Responsible for executive oversight and all aspects of MidState Medical Center, an acute care hospital with 144 licensed beds and net revenue of approximately $182,000,000. MidState consistently ranks in the top ten percent in customer satisfaction, measured by Press Ganey. Compared to 31 hospitals in Connecticut, MidState has been in the top ten hospitals, maintaining a margin of three-to-four percent consistently for ten years.

MidState Medical Center has received the following recognition:

- *2000 Connecticut Award For Excellence - Nutmeg Award (Organizational Excellence)*
- *2001 Excellence Award for Values Integration: Sodexho Healthcare Services; and listed in Modern Healthcare Magazine (12-17-01)*
- *2003 Connecticut Breakthrough Quality Award (only hospital in State to receive this business award)*
- *One of the Best 25 Medium Companies to Work for in America - 2005*
- *Connecticut Nurses Association Excellence in the Workplace Award - 2006*
- *2010 Hospital & Health Networks "Most Wired" for information technology systems*
- *2011 Massachusetts Excellence Award (state-level Baldrige award)*

1995 - 1999 **Chief Operating Officer**
Waterbury Hospital
Waterbury, Connecticut 06708

Responsible for all hospital operations at this 360-bed acute care teaching facility; implemented a redesign plan that achieved $10 million savings in operating expenses; negotiated sale of dialysis business for $2 million above offering price; developed joint venture with rehabilitation agency, increasing net revenues by $500,000; participated in planning stages of merging outpatient cancer services operating at two hospitals, into new independent LLC.

1992 - 1995 **Vice President, Operations**
Hospital of St. Raphael
New Haven, Connecticut 06511

Accountable for all Clinical and Support Services in 500-bed teaching tertiary care hospital; hospital-wide program coordination for cancer services, JCAHO requirements, union negotiations, and

Engineering/Maintenance, Construction Management, Environmental Health and Safety departments.

1990 - 1992 **Vice President, Administration**
Greenwich Hospital
Greenwich, Connecticut 06830

Responsible for operation of all clinical departments, Environmental Services, Engineering, construction programs, Materials Management, Laundry, Safety and Security; directed construction of 600-car ($6.8 million) parking garage; coordinated plan, design, and construction of cancer center and medical offices ($15 million); participated in development of master plan for renovation and expansion of entire hospital.

1986 - 1990 **Senior Vice President**
Meriden-Wallingford Hospital
Meriden, Connecticut 06450

Responsible for operation of both clinical and non-clinical departments; coordinated purchase and operation of walk-in center, industrial medicine services program, physical therapy services; changed physician referral patterns, increased market share with $1 million new revenue to hospital; developed new Women's Health Center; physician recruitment; participated in planning, strategy, and implementation of merger with competitor hospital.

1982 - 1986 **Vice President for Patient Care Services**
Meriden-Wallingford Hospital
Meriden, Connecticut 06450

Areas of responsibility included Division of Nursing, Anesthesia, Operating Room, Emergency Department, Continuing Care/Social Services, OB clinics, Hospice, Infection Control, SurgiCenter, and labor relations; decentralized Nursing Division; instituted walk-in program for non-emergent care through the Emergency Department; key member of negotiating team for all union contracts.

EDUCATION: MSN Degree, Boston College, School of Arts and Sciences, Chestnut Hill, Boston, Massachusetts

BSN Degree, St. Anselm College
Manchester, New Hampshire

PROFESSIONAL ASSOCIATIONS:

- Fellow of the American College of Health Care Executives 1987-present.
- Connecticut Women in Health Care Management 1988-present

PERSONAL AWARDS:

- 2003 Strong, Smart & Bold Award – Girls, Inc., Meriden, CT
- 2005 Regent's Award – American College of Healthcare Executives

Lucille Janatka, FACHE
203-405.3452

P. O. Box 940
Woodbury, Connecticut 06798

- 2006 Women in Leadership – Women & Families Center, Meriden, CT
- 2008 Athena Award – Quinnipiac Chamber of Commerce, Wallingford, CT
- 2009 Top 25 Women in Healthcare – Modern Healthcare Magazine
- 2009 CT Women's Hall of Fame
- 2011 Women in Business Award – Hartford Business Journal, Hartford, CT

COMMUNITY ACTIVITIES:

- Senior Vice President, Hartford Healthcare Corp.
- Rushford Centers, Inc. – Board of Directors
- Eastern Rehabilitation Network – Board of Directors
- Meriden Imaging Partners – Board of Directors
- City of Meriden CEDS Committee
- Meriden Economic Development Corporation (MEDCO)
- Hartford Hospital - Corporator
- Naugatuck Savings Bank - Corporator

6/13/11

CINDY L. RUSSO, MS, FACHE

20 Frances Court
Cheshire, CT 06410
(203) 699-9948 Residence
(203) 694-8321 Office
clrusso@snet.net

EDUCATION:

Masters of Science in Management, concentration in Health Care Administration; Hartford Graduate Center, Hartford, CT (1994)

Bachelor of Science in Nursing, Minor in Psychology; Western Connecticut State University, Danbury, CT (1980)

PROFESSIONAL EXPERIENCE:

(2001-Present) **MidState Medical Center**, Meriden, CT
144 bed community hospital, member of Hartford Healthcare with six satellite locations, 10,000 admissions and 55,000 emergency department visits annually and operating revenues of $200M.

Senior Vice President, Operations (2009- Present)
Responsibilities: Accountability and authority for overall operations. Guides the development and implementation of strategic plan. Reports to and acts on behalf of the CEO in her absence.

Vice President, Patient Care Services/CNO (2007- 2009)
Responsibilities: Assuring the delivery of quality patient care through strategic planning, setting objectives, determining resource needs and compliance with regulatory agencies.

President/CEO MidState VNA & Hospice (2005- 2007)
Responsibilities: Accountable for all administrative functions necessary to carry out the objectives of $3M homecare agency while assuring delivery of comprehensive quality health care services.

Director Clinical Services (2001- 2006)
Responsibilities: Managed operations and financial performance for Nursing Administration and clinical support departments such as; Pharmacy, Rehabilitation Services, Respiratory Therapy, Social Work Services, Case Management, IV Therapy, Infection Control and Risk Management. Accountable for compliance with regulatory standards and oversight of collective bargaining agreements.

(1997-2001) **Yale University Health Services and Health Plan,** New Haven, CT
Director of Internal Medicine and Urgent Care
Responsibilities: Coordinate day to day management, systems and operations of the Internal Medicine, Medical Sub-specialties and Urgent Care Departments.

(1994- 1997) **Masonic Geriatric HealthCare Center,** Wallingford, CT
Director for Ambulatory Services and Acute Care Unit
Responsibilities: Coordinate, evaluate, and direct the operations of the Integrated Care Team for the Ambulatory Care and Acute Medical Hospital Unit.

(1980-1994) **Waterbury Hospital Healthcare Center**, Waterbury, CT
Registered Nurse (1980-1987)
Patient Care Manager (1988-1994)

(1987) **Bristol Hospital**, Bristol, CT
Assistant Patient Care Manager

CERTIFICATIONS:

Fellow, American College of HealthCare Executives (2009)

Nursing Administration Advanced, Board Certified, American Nurses Credentialing Center (2004)

PROFESSIONAL AFFILIATIONS:

- American College of Healthcare Executives
- Connecticut Association of HealthCare Executives
- Connecticut Hospital Association; Hospital Oversight Task Force, Committee on Hospital Finance and Primary Care Sub-Committee
- American Organization of Nurse Executives; Patient Care Delivery Model Task Force, Nominating Committee, Chapter President.
- Connecticut League of Nurses; Board of Directors
- National League for Nurses; NCLEX test reviewer
- Nursing Spectrum; New England Region Advisory Board
- Sigma Theta Tau
- Sacred Heart University; Advisory Board, Adjunct Faculty
- Western Connecticut State University; Advisory Board

Ralph Becker, Vice President of Finance & Chief Financial Officer, MidState Medical Center and The Hospital of Central Connecticut

Professional Biography

Ralph Becker has been the Vice President of Finance and Chief Financial Officer at MidState Medical Center since 1985. In 2011, he also took on the role of Chief Financial Officer at The Hospital of Central Connecticut, another hospital part of the Hartford HealthCare system. Prior to that, he was a Senior Consultant with the health care practice of Ernst & Young in Hartford, from 1981 until 1985. He held various positions in Medicare Reimbursement at Blue Cross/Blue Shield of Connecticut, between 1974 and 1981. Becker received his Bachelor of Science degree in Business Administration from Norwich University in Northfield, Vermont, and his Masters of Business Administration (Finance) degree from the University of New Haven.

Christine Scully
143 Farms Village Road
Rocky Hill, CT 06067
860-257-8836

EXPERIENCE

1979 – Present **MidState Medical Center, Meriden CT**

2011- Present Director, Behavioral Health, Patient Safety & Regulatory Compliance, Laboratory & Corporate Compliance

Compliance Liaison for Hartford Healthcare overseeing compliance activities at MidState. Provides oversight and leadership to MMC Laboratory Services, a contracted service through Clinical Laboratory Partners.

2009 -Present Director of Behavioral Health, Patient Safety & Regulatory Compliance.

Responsible for effectively leading the delivery of patient care, program development, growth management, financial performance and quality improvement for Inpatient Psychiatry and the Acute Behavioral Health Unit in the ED. Participates in daily patient rounds to facilitate patient care and assist with a smooth transition to outpatient care. Builds cohesive relationships with internal and external customers and ancillary departments. Develops and manages departmental budgets.

2008-Present Director, Patient Safety & Regulatory Compliance

The Director of Regulatory Compliance, Patient Safety is responsible for managing and directing the hospital wide activities related to Continuous Survey Readiness and Patient Safety. Directs ongoing, organization wide collection of information about deficiencies and opportunities for improvement related to regulatory and accreditation requirements. Collaborates with educational services to ensure appropriateness & effectiveness of related patient safety orientation and training programs.

2005 - 2007 Performance Improvement Consultant- Quality Improvement Office

1995 – 2004	CQI Facilitator- Quality Improvement Office of MidState Medical Center and also The Curtis Home, Meriden, CT.
1979 – 1995	Medical Technologist- Laboratory –Assistant Supervisor of the Blood Bank & Generalist performing laboratory testing in all areas.

EDUCATION

University of Connecticut
Masters in Public Health 1994

University of Hartford
BS in Health Science 1986

PROFESSIONAL ORGANIZATIONS/ CERTIFICATION

- National Association of Healthcare Quality- Certified Healthcare Quality Professional (CPHQ)
- Connecticut Association of Healthcare Quality – Board President 2011-2012
- American College of Healthcare Executives- Member status
- Healthcare Compliance Association – Member status
- American Society of Professionals in Patient Safety – Member status
- Girls Incorporated, Board President 2011-2013
- Green Belt, Six Sigma
- Certificate, Outcomes Management
- State Baldrige Examiner, CQIA

Richard H. Anderson, M.D.

RESUME

Office Address:
237 Hall Ave.
Wallingford, CT 06492
Phone: 203-269-6512

Home address:
267 South Main
Wallingford, Ct 06492
Phone: 203-265-4701

Licensure: Connecticut 22285

Certification: Board certified in psychiatry, 1987

Speciality: Psychiatry

Experience:

1981-present	Private practice in Psychiatry, Wallingford, Ct
1984-1986	Chief of Psychiatry, Veterans Memorial Medical Center, Meriden, Ct
1981-1983	Director of Psychiatry, Kaiser-Permante Health Plan, East Hartford, CT

Education:

1987-1981	University of Connecticut Health Center, Farmington, CT --Resident, Psychiatry; Chief Resident, 1980-1981 --Inpatient Psychiatry; Outpatient Psychiatry --Included couples therapy, family therapy Child Psychiatry --Led two groups; one for infertile couples

Richard H. Anderson, M.D.

Page 2.

1973-1977	University of South Alabama Medical School Mobile, AL --M.D., 1977 --Fourth year psychiatric rotation at Mass. Mental Health Center, Boston, MA
1972-1973	Harvard University, Cambridge, MA --Special student; premed courses
1968-1972	Harvard University, Cambridge, MA --B.A., English Literature --Graduated Magna cum laude

Hospital Affiliation: Veterans Memorial Medical Center, Meriden, CT.

Seminars:

Chief Residency Seminar, Tarrytown, N.Y., June, 1980

Basic Medical Hypnosis, Columbia University College of Physicians and Surgeons October, 1980

Personal:

Born: March 5, 1950 in Atlanta, GA.

Height: 5'7" Weight: 150 lbs.

Married, 1977; 2 children

Professional Associations:

American Psychiatric Association
Connecticut State Medical Society
New Haven County Medical Society

CLARENCE J. SILVIA

The Hospital of Central Connecticut
100 Grand Street
New Britain, CT 06050
Telephone – Business: (860) 224-5723

EMPLOYMENT HISTORY

CENTRAL CONNECTICUT HEALTH ALLIANCE, NEW BRITAIN, CT (1995 – PRESENT)
President (2010 to Present)
Senior Vice President, Operations (1995 to 2010)

THE HOSPITAL OF CENTRAL CONNECTICUT, NEW BRITAIN, CT (2006 MERGER OF BRADLEY MEMORIAL HOSPITAL AND NEW BRITAIN GENERAL HOSPITAL),
President and CEO (2010 – Present)
Chief Operating Officer (1995 to 2010)

Central Connecticut Health Alliance is the parent company of an integrated system of health care entities. The Alliance includes The Hospital of Central Connecticut which is a 414-bed acute care general hospital with two campuses, Central Connecticut Senior Health Services, with two skilled nursing facilities and two assisted living communities and a home care, behavioral health and rehabilitation division. In my role as President of the parent company, I serve as the President and CEO of The Hospital of Central Connecticut responsible for clinical and support services. In addition, I serve as the President of Central Connecticut Senior Health Services.

Major Achievements

- Together with Senior Administration, Board and Medical Staff successfully negotiated a Memorandum of Understanding for CCHA to become part of the Hartford Health care Corporation.
- Responsible for the coordination and completion of the merger between Bradley Memorial Hospital and New Britain General Hospital into The Hospital of Central Connecticut.
- Consolidation of all clinical and support services between the two campuses.
- Together with Senior Administrative Staff, achieved an average operating margin of 2% over the last 2 years.
- Responsible for the development and establishment of outpatient diagnostic centers, including an outpatient MRI Center.
- Worked with the Medical Staff in the development and establishment of new programs and services: vascular center, wound care center, primary angioplasty.
- Implemented a dashboard for the Board which includes financial, operating, human resources, quality and safety measures and benchmarks.
- Achieved a 4% bottom line in the senior care division the last 2 years.
- Developed a strategic plan in conjunction with the Medical Staff, Board and key constituents and a process for monitoring and updating the plan.

EMPLOYMENT HISTORY – CONTD.

BRADLEY MEMORIAL HOSPITAL AND HEALTH CENTER, SOUTHINGTON, CT
(1986 – 2006)
President and Chief Executive Officer (1993 to 2006)

Executive Vice President (1986 to 1993)

Bradley Memorial Hospital and Health Center was an 84-bed acute care general hospital. As President and CEO, I was responsible for the operations of the hospital and reported directly to the Board of Directors. I also served as President of a number of the subsidiary corporations which include a 130-bed nursing home, two assisted living communities, a women's health center and an occupational health program.

As Executive Vice President, I served as Chief Operating Officer for the hospital and was also responsible for the planning activities of the hospital and its subsidiaries.

Major Achievements

- Responsible for the coordination and completion of the affiliation between Bradley Memorial Hospital and New Britain General Hospital and the establishment of the Central Connecticut Health Alliance.
- Responsible for the successful Certificate of Need application for a 130-bed nursing home, the subsequent construction and operation of the facility.
- Development of a 90-bed assisted/independent living community and a 90-bed Alzheimer's assisted living community
- The establishment of new programs and services: MRI, hyperbaric therapy, PET scanning, occupational medicine program.
- Recruitment of primary care and specialist physicians to the community.

MANCHESTER MEMORIAL HOSPITAL, MANCHESTER, CT (1979 – 1986)
Vice President – Professional Services (1983 to 1986)
Manchester Memorial Hospital is a 303-bed not-for-profit acute care general hospital. As Vice President, I was responsible for the management and coordination of the Laboratory, Emergency Service, Radiology, Pharmacy, Physical Therapy, Quality Assurance, Respiratory Therapy, Epidemiology and Ambulatory Surgery Departments.

Assistant Hospital Director (1980 to 1983)
Managed and developed operating plans for the Laboratory, Central Sterile Supply, Cardiology, Management Engineering, EEG and Ambulatory Surgery Departments.

Director of Management Engineering (1980)
Management Engineer (1979)

EDUCATION

- M.B.A., Health Systems, University of Connecticut, Storrs, Connecticut, 1979
  Honors: Beta Gamma Sigma, Business and Management Society

- B.S., Chemistry, University of Connecticut, Storrs, Connecticut, 1977
  Honors: Summa Cum Laude, Phi Beta Kappa, Phi Lamda Epsilon

PROFESSIONAL ACTIVITIES

- Board Member, United Way of Southington (2006 – Present)
- Board Member, Connecticut Hospital Association (Secretary of the Board, 1995 – 1998)
- Board Member, Southington Chamber of Commerce (1999 – 2001)
- Board Member, Community Mental Health Affiliates (1990 – 1996, Chairman, 1993 – 1996)
- Member, Town of Southington Emergency Medical Services Committee
- Board Member, Manchester Road Race Committee

The Hospital of Central Connecticut
100 Grand St.
New Britain Connecticut 06050
(860)224-5900 x 2656
e-mail mbalkunas@thocc.org

Michael E Balkunas MD

Experience

Medical Director of Psychiatry and Behavioral Health Research
The Hospital of Central Connecticut
February 2006 - present
Supervise all aspects of clinical research. Serve as principal investigator for all studies. Liaison with research sponsors. Manage clinical research staff. Prepare annual budget. Develop collaborative interdepartmental research programs.

Chief of Psychiatry and Behavioral Health
The Hospital of Central Connecticut
December 2004 - present
Responsible for all administrative and clinical aspects of psychiatric and behavioral health services including adult inpatient unit, emergency department crisis team, consultation and liaison team, psychiatric research, and multiple outpatient programs. Formulate annual budget, improve and develop clinical programs, recruit clinical staff, liaison with all departments in the general hospital. Direct consultation-liaison service, inpatient psychiatric unit, quality improvement and peer review processes. Prepare for JCAHO surveys. Implement resident and physician assistant education programs. Serve on Hospital Operations Group, Staff Executive Committee, Committee on Performance Improvement, Pharmacy and Therapeutics Committee, Community Access to Care Committee and Pain Control Performance Improvement Committee. Member of Physician Standards Hospital Initiative. Lead Initiative on Revenue and Cost Analysis for all hospital departments.

Chief and Chairman of Psychiatry/Assistant Professor of Psychiatry
Memorial Health University Medical Center/
Mercer School of Medicine
August 2003 – November 2004
Provide leadership, organization, management and strategic direction for all psychiatric education, research and related clinical programs. Manage the Psychiatric Group of the Coastal Empire. Create new department of psychiatric billing and collections. Serve on Medical Executive and related committees. Assist in development of innovative funding strategies.

Director of Psychiatric Education
Memorial Health University Medical Center/
Mercer School of Medicine
August 2003 – November 2004
Develop and maintain all psychiatric educational programs for house staff, medical students, physician assistants and pharmacy students. Design research studies and promote academic activities. Establish psychiatric library and conference center.

Vice Chairman of Psychiatry
Memorial Health University Medical Center/
Mercer School of Medicine
July 2002 – August 2003
Assist chairman in all aspects of management of Department of Psychiatry including clinical, academic, business and regulatory programs.

Medical Director- Inpatient Psychiatry
Memorial Health University Medical Center Health/
Mercer School of Medicine
July 2002 – August 2003
Responsible for all phases of clinical care for 64 inpatient psychiatric beds including a 10 bed medical–psychiatry unit. Develop treatment protocols, policies and procedures, quality improvement and adherence to JCAHO standards. Liaison with community providers. Recruit clinical staff.

Director of Consultation Liaison Service
Memorial Health University Medical Center/
Mercer School of Medicine
November 2002 – November 2004
Supervise and provide psychiatric consultations to a 500 bed university medical center. Supervise and teach residents, medical students, physician assistants and pharmacy students. Liaison with all clinical departments.

Chairman of Clinical Committee
Savannah Area Behavioral Health Collaborative
July 2002 – November 2004
Develop all clinical programs for outpatient public mental health clinics serving citizens of Chatham County. Organize system into a comprehensive continuum of care. Assist in preparation of business plans and strategic direction. Advise on construction of new outpatient mental health center.

General Psychiatrist
Private Practice in Savannah GA
March 1999 – August 2003
Owner/ President of solo practice with 700- 800 patients ranging in age from 4 to 95. Attending duties at two area hospitals. Treatment of adolescents in residential care, adult psychiatric patients, patients with developmental disabilities and patients in medical psychiatry unit.

Psychiatric consultant to area hospitals, nursing homes and group homes. Manager of billing and collections department.

Staff Psychiatrist
Charter Savannah Behavioral Health System- Savannah GA
July 1996 – March 1999
Treatment of children, adolescents, adults and geriatric patients in both inpatient and outpatient settings. Educate staff and develop treatment protocols. Help create innovative public inpatient and outpatient treatment programs.

Medical Director
Charter Beaufort Counseling Center- Beaufort SC
July 1996 – March 1999
Responsible for all clinical matters pertaining to the operation of outpatient psychiatric center including supervision of all therapists and ancillary staff. Initiate contracts with area mental health providers and organize region wide system of continuum of care.

Education

Doctor of Medicine 1992
State University of New York- Stony Brook

Bachelor of Arts- Psychology 1982
New York University

Training

Chief Resident in Psychiatry 1995 to 1996
University Hospital, Stony Brook, NY

Resident in Psychiatry 1993 to 1996
University Hospital, Stony Brook, NY
Create psychiatric education program for School of Social Work. Maintain and improve outpatient ECT program. Recruit house staff and serve as liaison to clinical departments.

Intern in Medicine 1992 to 1993
University Hospital, Stony Brook, NY

Clinical Trials

Schizophrenia

A 24-week, Multicenter, Double-blind, Randomized, Parallel-group, Dose Ranging Study of the Efficacy and Safety of Oral Doses of AVE1625 5, 10 and 30mg and Placebo on Top of an Established Treatment Regimen of Either Olanzapine, Risperidone/Paliperidone, Quitiapine, or Arpiprazole Monotherapy in the Treatment of Cognitive Impairment on Schizophrenia. Investigator. Sponsor: Sanofi-Aventis.

A Multicenter, Randomized, Placebo-controlled, Double-blind, Parallel-group Phase IIb Proof of Concept Study with 3 Oral Dose Groups of AZD3480 during 12 Weeks Treatment of Cognitive Deficits in Patients with Schizophrenia. Investigator. Sponsor: AstraZeneca.

A Randomized, Multicenter, Double-blind, Parallel Group Study to Compare the Effects of Bifeprunox and Quetiapine on Weight Changes in Stable Schizophrenia Patients. Investigator. Sponsor: Solvay Pharmaceuticals

Predicting Response to Risperidone Treatment Through Identification of Early-onset of Antipsychotic Drug Action in Schizophrenia. Investigator. Sponsor: Eli Lilly.

A Multicenter, Double-Blind Study on the Effects of Aripiprazole on Overweight Patients Treated with Olanzapine for Schizophrenia or Schizoaffective Disorder. Investigator. Sponsor: Bristol-Myers Squibb.

A Multicenter, Open-label, Flexible-dose, Parallel group Evaluation of the Cataractogenic Potential of Quetiapine Fumarate (Seroquel) and Risperidone (Risperdal) in the Long-term Treatment of Patients with Schizophrenia or Schizoaffective Disorder. Investigator. Sponsor: AstraZeneca.

A Multicenter, Randomized, Double-blind, Fixed-dose, Efficacy and Safety Trial of Farampator (Org 24448) (250 and 500 mg b.i.d.) vs. Placebo as Augmentation Therapy in Schizophrenic Subjects Currently Receiving Risperidone. Investigator. Sponsor: Organon.

Olanzapine Versus Aripiprazole in the Treatment of Acutely Ill Patients with Schizophrenia. Investigator. Sponsor: Eli Lilly.

Efficacy of High Dose Olanzapine in a Controlled, Fixed Dose- response Trial for the Treatment of Schizophrenia and Schizoaffective Disorder. Sub-Investigator. Sponsor: Eli Lilly.

A Phase III Double-Blinded placebo controlled study of M100907 for psychosis. Sub-investigator. Sponsor: Hoechst Marion Rousse.

A Comparison of the Effects of Quetiapine and Haloperidol in Schizophrenic Patients with a History of and Demonstrated, Partial Response to Conventional Antipsychotic Treatment. Sub-investigator. Sponsor: AstraZeneca.

Bipolar

A Three-week, Double-blind, Multicenter, Placebo-controlled Study Evaluating the Efficacy and Safety of Add-on Oral Ziprasidone in Subjects with Acute Mania Treated with Lithium or Divalproex. Investigator. Sponsor: Pfizer Pharmaceuticals.

A Phase III, Randomized, Placebo-controlled, Double-blind Trial Evaluating the Safety and Efficacy of Sublingual Asenapine vs. Olanzapine and Placebo on Inpatients with Acute Manic episodes. Investigator. Sponsor: Pfizer/Organon.

A Multi-center, Randomized, Parallel-group, Double-blind, Phase III Comparison of the Efficacy and Safety of Quetiapine Fumarate (oral tablets 400 mg to 800 mg daily in divided doses) to Placebo When Used As Adjunct to Mood Stabilizers (Lithium or Divalproex) in the Maintenance of Bipolar I Disorder in Adult Patients. Sub-Investigator. Sponsor: AstraZeneca.

Generalized Anxiety Disorder

A Multicenter, Randomized, Double-blind, Parallel-group, Placebo-controlled, Active-controlled Study of the Efficacy and Safety of Sustained-release Quetiapine Fumarate (SEROQUEL) Compared with Placebo in the Treatment of Generalized Anxiety Disorder (Gold Study) Investigator. Sponsor: AstraZeneca.

An Eight-Week, Multicenter, Randomized, Double-blind, Placebo-controlled Study, with Escitalopram as an Active Control, to Evaluate the Efficacy, Safety and Tolerability of a Saredutant 100 mg Dose Once Daily, in Patients with Generalized Anxiety Disorder. Investigator. Sponsor: Sanofi-Aventis.

A Randomized, Double-blind, Placebo and Active Comparator Controlled, Parallel-group Safety and Efficacy Study of OROS® Alprazolam in Adults with Generalized Anxiety Disorder. Sub-Investigator. Sponsor: Jazz Pharmaceuticals.

A Long-Term, Open-label, Safety and Efficacy Study of OROS Alprazolam in Adults with Generalized Anxiety Disorder (GAD) Sub-Investigator. Sponsor: Jazz Pharmaceuticals.

A Multi-center, Randomized, Placebo-controlled, Double-blind Study to Assess the Safety and Tolerability of Oral Ocinaplon in Patients with GAD and to Compare Effects of Ocinaplon 30 mg and Ocinaplon 60 mg to Placebo. Sub-Investigator. Sponsor: DOV Pharmaceuticals.

Major Depressive Disorder

A Double-Blind, Randomized, Placebo-Controlled Study Examining the Safety, Efficacy and Tolerability of SEP-225289 in Subjects with Major Depressive Disorder (including Atypical and Melancholic Features). Investigator. Sponsor: Sepracor

An Eight-Week, Double-blind, Placebo-controlled study to Evaluate the Efficacy, Safety, and Tolerability of Saredutant 100 mg Once Daily in Combination with Escitalopram 10 mg Once Daily in Patients with Major Depressive Disorder. Investigator. Sponsor: Sanofi-Aventis.

Duloxetine Versus Placebo in Patients with Major Depressive Disorder (MDD): Assessment of Energy and Vitality in MDD. Investigator. Sponsor: Eli Lilly.

An Eight-week, Double-blind, placebo-controlled, Multicenter Study with Escitalopram (10 mg qd) as Positive Control, Evaluating the Efficacy, Safety, and Tolerability of a Fixed Dose of SR58611A (350 mg q12) in Outpatients with Major Depressive Disorder (MDD). Investigator. Sponsor: Eli Lilly.

Social Anxiety Disorder

A Randomized, Double-blind Comparison of LY686017, Paroxetine, and Placebo in the Treatment of Social Anxiety Disorder. Investigator. Sponsor: Eli Lilly.

Insomnia

A Parallel III, Randomized, Double-blind, Placebo-controlled, Parallel-group, Multicenter, Outpatient Study to Assess the Efficacy and Safety of Doxepin HCl in Elderly Patients with Primary Sleep Maintenance. Investigator. Sponsor: Somaxon Pharmaceuticals.

Migraine

Study TRX109013, A Randomized, Double-blind, Double-dummy, Placebo-controlled, Crossover Study to Evaluate the Efficacy of TREXIMA (Sumatriptan + Naproxen Sodium) versus Butalbital-containing Combination Medications (BCM) for the Acute Treatment of Migraine When Administered During the Moderate-Severe Phase of the Migraine

Presentations

March 2008 *Delirium and Dementia in the medically ill*
Internal Medicine Resident Lecture, The Hospital of Central CT

Jan 2008 *Depression and Anxiety in the medically ill*
Internal Medicine Resident Lecture, The Hospital of Central CT

June 2007 *Neuroleptic Malignant Syndrome in a patient with Lewy Body Dementia*
Medical Grand Rounds, The Hospital of Central CT

April 2007 *Substance Abuse Disorders*
Internal Medicine Resident Lecture, The Hospital of Central CT

Nov 2006 *Top 10 in Psychiatry*
Internal Medicine Resident Lecture, The Hospital of Central CT

Sept 2006 *Treatment of Bipolar Depression*
Department of Psychiatry & Behavioral Health, The Hospital of Central CT

May 2006 *Clinical & Practical Tips in Psychiatry*
Internal Medicine Resident Lecture, The Hospital of Central CT

Oct 2005 *Psychiatry 2005*
Internal Medicine Resident Lecture, The Hospital of Central CT

March 2005 *Evidence Based Treatment of Depression*
Medical Grand Rounds, The Hospital of Central CT

July 2003-July 2004 *Psychiatry Clerkship Lecture Series*
Schizophrenia and other Psychotic Disorders
Mood Disorders
Anxiety Disorders
Substance Abuse Disorders
The Dementias
Personality Disorders
Biological Therapies in Psychiatry
Memorial Health University Medical Center
Mercer School of Medicine, Savannah, Georgia

June 2002 *Late life Depression*
Jewish Education Alliance, Savannah, Georgia

Feb 2002 *Remission as a goal in the treatment of Major Depressive Disorder*
Lecture to Primary Care Providers, Savannah, Georgia

April 2001 *Treatment of Depression and Anxiety in the Primary Care Patient*
Lecture to Primary Care Providers, Savannah, Georgia

July 1996-March 1999 *Clinical Staff Education Series*
Biological Therapies in Psychiatry
Schizophrenia
Transference and Counter Transference
Bipolar Disorder
Charter Savannah Behavioral Health System, Savannah, Georgia

Licenses

Connecticut

Honors

Outstanding Resident of the Year 1996

Special Interests

Integrated Healthcare Systems
Neuropsychiatry
Care of the chronically ill

Certifications

Diplomat of The American Board of Psychiatry and Neurology General Adult Psychiatry May 1999

Diplomat of The American Board of Psychiatry and Neurology Psychosomatic Medicine April 2008

Professional Memberships

American Psychiatric Association

American Society of Clinical Psychopharmacology

Connecticut State Medical Society

American Society of Addiction Medicine

American College of Physician Executives

CURRICULUM VITAE

Pamela J Salvatore
761 Marion Avenue
Plantsville, CT 06479
860-919-3313

EXPERIENCE

3-2011 to present	Director Outpatient and Inpatient Psychiatry and Behavioral Health and Crisis. Continue to Practice as an APRN in the outpatient substance abuse program since July 2009.
2002 – Present	Hospital of Central Connecticut, New Britain, CT Director for the Inpatient Psychiatric Unit and Crisis team. Responsible for overseeing the management of the units including fiscal and service excellence, quality patient care, providing inservices and education to the staff in both areas. Participated in case conferences and business meetings with the physician group. Oversight in the orientation of all new staff members. Super user and educational role in teaching CPI skills, new cerner program, bar coding, etc. Work closely with the physicians to determine appropriateness of care, smooth transition to outpatient care and quality improvements. Instituted objective tools to measure depression, and severity of illness. Had clinical experiences for individual and group experiences in the outpatient department. Also experienced clinical with an APRN in a private practice setting. Board Certified Psychiatric Mental Health Nurse Practitioner since March 2009. Practicing APRN in the HCC outpatient substance abuse program prescribing since July 2009.
1997 – 2002	Special projects including a year with information systems, education department, chart reviews, admitting liaison, patient care audits, infection control, and staff nurse on a telemetry unit.
1992 – 1997	Senior hospital administrative supervisor responsible for performance appraisals, hiring and disciplinary activities, payroll, budget, schedules, staff meetings, running mock Dr Quicks, attending and instructing for mock and real disasters.
1991 – 1992	Temporary position with the Education department to oversee the orientation of New graduate nurses.

1986 – 1991	Assistant Nurse Manager for E2 and then N2. Responsible for QI activities, performance appraisals, schedules, discipline, in-services, and staff meetings. This was in the absence of a Nurse Manager. Both units were surgery and surgical oncology.
1983 – 1986	Staff nurse on many patient care units including orthopedics, oncology, medicine and peritoneal dialysis.

EDUCATION

Saint Joseph College
MSN – Adult Psychiatric Mental Health Nurse Practitioner
Board Certified 2008

Saint Joseph College
BSN 1983

PROFESSIONAL ORGANIZATIONS/ CERTIFICATION

American Psychiatric Nursing Association

Sigma Theta Tau International

American Organization of Nurse Executives

American Nurses Credentialing Center
Certified Psychiatric Mental Health Nurse Practitioner

Wound care certified nurse

JEFFREY L. WALTER
442 E. Carriage Drive
Glastonbury, CT 06033
(860) 430-9143

PROFESSIONAL EXPERIENCE:

PRESIDENT AND CEO
Rushford Center Inc., Middletown, CT
1979 to Present

VICE PRESIDENT - BEHAVIORAL HEALTH NETWORK
Hartford Health Care Corporation
1998 to Present

DIRECTOR OF PROGRAM DEVELOPMENT
Windham Area Community Action Program, Inc.
Danielson, CT
1975-1979

EDUCATIONAL BACKGROUND:

MASTERS in
HUMAN SERVICES ADMINISTRATION
Antioch University
Keene, NH 1981

BACHELOR OF ARTS AND SCIENCES
University of Connecticut
Storrs, CT 1974

PROFESSIONAL AFFILIATIONS:

1st Vice-Chairman, BOARD OF DIRECTORS
National Council for Community Behavioral Healthcare

President-Elect, Middletown, CT Rotary Club

PAST PRESIDENT
Connecticut Association of Substance Abuse Agencies
Connecticut Community Providers Association
Advanced Behavioral Health, Inc.
Congregation Adath Israel

MEMBER
American College of Addiction Treatment Administrators

CO-CHAIR
Connecticut Behavioral Health Partnership Oversight Council

MEMBER
Connecticut Medicaid Care Management Oversight Council

JEFFREY L. WALTER

AREAS OF EXPERTISE:

* Healthcare policy development with an emphasis on private sector delivery of publicly funded behavioral health services; authored plan for new statewide, managed addiction treatment system; a leading proponent of the application of managed care technology to the publicly-funded mental health and addiction services fields.

* Development, management, vision and direction for comprehensive mental health and addiction prevention and treatment services organization; state-level policy development and advocacy; legislative advocacy.

* Involvement with human service-related state departments; proven reputation and cooperative working relationship with a wide variety of state agencies.

* Close working relationships within the business community; past Chamber Board member and chair of Chamber's Prevention Committee; advisor to corporate leaders and executives in solving workplace problems related to substance abuse.

* Strategic planning, needs assessment, and organizational development expertise applied at state, community and organizational levels.

SUMMARY OF ACCOMPLISHMENTS:

* Leadership in the development and ongoing implementation of Connecticut's Medicaid carve-out of behavioral health benefits for children, adults and families.

* Twenty-seven years experience developing and leading an innovative, highly respected non-profit behavioral health care organization with a $28 million budget and 500 employees.

* Leadership in numerous statewide provider trade associations.

* Founding member of the first statewide preferred provider network of non-profit mental health and addiction treatment providers.

* Founder and past chairman of innovative workplace prevention program within the Middlesex County Chamber of Commerce.

* Helped develop a statewide behavioral health managed care organization and served as Vice President for Operations from 1998 to 2004.

Kathleen Whelan-Ulm MA, LADC

4 Madaket Ct
Guilford, CT 06437
(203) 238-6806 (W) (203) 457-8757 (H)

Professional Experience

2011 to Present

Rushford Center Inc.
Meriden, CT 06450

Vice President of Mental Health services

Full authority for the efficient and effective delivery of clinical and community support services, supervision of a team of Managers and Director. Responsible for the development of business opportunities and program initiatives that advance organizational priorities and address unmet consumer and community needs.

2007 to 2011

Rushford Center Inc.
Meriden, CT 06450

Vice President of Behavioral Health Services

Full authority for the efficient and effective delivery of clinical, and community support services; supervision of a team of Associate and Director level managers. Responsible for the development of business opportunities and program initiatives that advance organizational priorities and address unmet consumer and community needs.

1997 - 2007

Rushford Center Inc.
Middletown, CT 06457
Director of Addiction Services

Full authority for program development and operation of clinical services in all Residential and Outpatient Programs, including Detox and Dual Diagnosis, Utilization Management and Assessment Center activities; supervision of a team of clinical managers to ensure efficient, quality care of clients and client/staff safety; compliance with annual budget; achievement outcomes in compliance with JCAHO and DMHAS standards, and recruiting of appropriately credentialed staff. Programs are located at five sites in Middlesex, Hartford and New Haven Counties.

1997

Rushford Center Inc.
Middletown, CT 06457
Director of Outpatient Treatment Services

Full authority for operation of Partial Hospitalization Program, Dual Partial Hospitalization Program, MISA (Mentally Ill Substance Abuser) Program, and Outpatient Clinic; responsible for the delivery of efficient, quality care of clients and client/staff safety. Duties include: assigning caseloads, supervising staff of Clinical Managers and Interns to ensure clients achieve individualized treatment goals, facilitating team meetings, scheduling, monitoring outcomes in compliance with JCAHO and DMHAS standards, monitoring compliance with annual budget and supervising management of supplies, equipment and other material.

1989 to 1997

Rushford Center Inc.
Middletown, CT 06457
Coordinator of Residential Treatment Services

Full authority for operation of Intensive and Halfway House Programs. Responsible for 24 hour delivery of efficient, quality client care and client/staff safety. Duties include: Assigning caseloads, supervising staff of six counselors and interns to insure clients achieve individualized treatment goals, leading team meetings, scheduling, monitoring outcomes in compliance with JCAHO standards, monitoring compliance with annual budget and supervising management of supplies, equipment and other material.

1985 to 1989

Kathleen Whelan-Ulm

Rushford Center Inc.
Middletown, CT 06457
Alcoholism Counselor

Management of caseload; individual and group counseling sessions, assessment of problems with related treatment plans, utilization of DAP system for documenting progress notes, discharge planning, correspondence with outside agencies, participation in team review, facilitation of aftercare program.

1981 to 1985

Parkview Medical Recovery Center
New Haven, CT

Assistant Food Service Supervisor

Trained as a dietary aide. Responsible as a cook, including pre-prep and preparation of meals for 120 patients; training and supervision of dietary aides, utility workers. Became responsible for training and supervising all dietary personnel. Also provided menu planning for regular and therapeutic diets; patient consultations, and did ordering, scheduling and general maintenance of the department.

1980 to 1981

Shirley Frank Foundation
New Haven, CT

Floor Manager, Detox Aide

As Floor Manager, responsible for assisting patients as needed, insuring promptness to and from completion of work assignments, meals, meetings and completion of admission and discharge forms. As Detox Aide, taking and recording of vital signs, room preparation for admissions, provide supportive care and comfort as needed for all patients.

Education

1997

Southern Connecticut State University
Master of Marriage and Family Therapy

1991 to 1993

Gestalt Training, Theory and Practicum

1986 to 1987

Charter Oak College
BA Psychology

Additional Professional Experience and Education

2011 - Present

Leadquest Leadership Program

2003 - Present

Women and Families Board of Directors - Treasurer

1994 – Present

Manchester Community College Advisory Council

1992 - Present

Board Member of the Connecticut Certification Board - Secretary

1993 - 1998

Board of Directors, Domestic Violence Services, N. Haven, CT

1992 -1996

Case Presentation Method - Evaluator for oral exam for CT Alcohol and Drug Certification Process

1992 -1998

Certified Trainer in Total Quality Management

1992 - Present

Achieved Certification by the State of CT as a Clinical Supervisor for Alcohol and Drug Abuse Counseling

1990

	Kathleen Whelan-Ulm Rutgers University - Summer School of Addiction Services
1989	State Certification as Alcohol and Drug Counselor
1985, 2000, 2006	New England School of Alcoholism

EXHIBIT 11

IRS Determination Letters, MidState, The Hospital of Central Connecticut and Hartford HealthCare

Internal Revenue Service
District Director

Department of the Treasury

P. O. Box 2508
Cincinnati, OH 45201

Date: MAR 12 1999

Person to Contact:
Ruth Ohmer 31-03159
Customer Service Specialist
Telephone Number:
877-829-5500
Fax Number:
513-684-5936
Federal Identification Number:
06-0646715
Accounting Period Ends
September 30

Midstate Medical Center
435 Lewis Ave.
Meriden, CT 06451-2101

Dear Sir or Madam:

This is in response to your Certificate Of Amendment dated September 29, 1998, requesting a name change to your organization. We have updated our records to reflect this change..

In June 1923, we issued a determination letter that recognized your organization as exempt from federal income tax under section 101(6) of the Internal Revenue Code of 1939 (now section 501(c)(3) of the Internal Revenue Code of 1986). That determination letter is still in effect.

We classified your organization as a publicly supported organization, and not a private foundation, because it is described in sections 509(a)(1) and 170(b)(1)(A)(iii) of the Code. This classification was based on the assumption that your organization's operations would continue as stated in the application. If your organization's purposes, character, method of operations, or sources of support have changed, please let us know so we can consider the effect of the change on the organization's exempt status and foundation status.

Your organization is required to file Form 990, Return of Organization Exempt from Income Tax, only if its gross receipts each year are normally more than $25,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of the organization's annual accounting period. The law imposes a penalty of $20 a day, up to a maximum of $10,000, when a return is filed late, unless there is reasonable cause for the delay.

As of January 1, 1984, your organization is liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of $100 or more the organization pays to each of its employees during a calendar year. There is no liability for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Organizations that are not private foundations are not subject to the excise taxes under Chapter 42 of the Code. However, these organizations are not automatically exempt from other federal excise taxes. If you have any questions about excise, employment, or other federal taxes, please let us know.

Donors may deduct contributions to your organization as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to your organization or for its use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

Midstate Medical Center
06-0646715

Your organization is not required to file federal income tax returns unless it is subject to the tax on unrelated business income under section 511 of the Code. If your organization is subject to this tax, it must file an income tax return on Form 990-T, Exempt Organization Business Income Tax Return. In this letter, we are not determining whether any of your organization's present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

Because this letter could help resolve any questions about your organization's exempt status and foundation status, you should keep it with the permanent records of the organization.

If you have questions, please call us at the telephone number shown in the heading of this letter.

Sincerely,

C. Ashley Bullard
District Director

Internal Revenue Service
Director, Exempt Organizations

Date: JUN 26 2007

The Hospital of Central Connecticut
at New Britain General and
Bradley Memorial
C/O Wiggin and Dana LLP
One Century Tower
PO Box 1832
New Haven, CT 06508
ATTN: Melinda Agsten

Department of the Treasury
P.O. Box 2508
Cincinnati, Ohio 45201

Person to Contact - ID#:
Gwen Shaw - 75078
Contact Telephone Numbers:
877-829-5500 Phone
513-263-3756 FAX
Federal Identification Number:
06-0646768

Dear Sir or Madam:

By our determination dated January, 1937, you were held to be exempt from Federal Income Tax under the provisions of section 501(c)(3) of the Internal Revenue Code.

You recently furnished us information that New Britain General Hospital merged with Bradley Memorial Hospital and Health Center Inc on October 1, 2006. New Britain General Hospital which was the surviving organization changed it name to The Hospital of Central Connecticut at New Britain General and Bradley Memorial. Based on the information submitted, we have determined that the merger does not affect your exempt status. The organization will continue using Employer Identification Number 06-0646768.

Please let us know about any further changes in the character, purposes, method of operation, name or address of your organization.

If you have any questions regarding this matter, please contact the person whose name and telephone number appear in the heading of this letter.

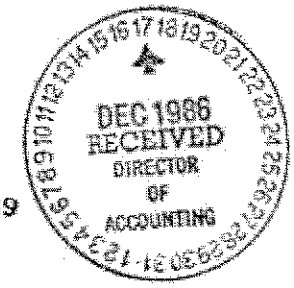
Sincerely,

Robert Choi
Director, Exempt Organizations
Rulings and Agreements

Internal Revenue Service

Department of the Treasury

Washington, DC 20224



Person to Contact: Mr. Cossin

Telephone Number: (202) 566-3969

Refer Reply to: OP:E:EO:R:4

Date: 11 DEC 1986

Hartford Health Care
Corporation
80 Seymour Street
Hartford, CT 06115

Employer Identification Number: 22-2672834
Key District: Brooklyn
Accounting Period Ending: September 30
Foundation Status Classification: 509(a)(3)

Dear Applicant:

Based on information supplied and assuming your operations will be as stated in your application for recognition of exemption, we have determined you are exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code.

We have further determined that you are not a private foundation within the meaning of Code section 509(a), because you are an organization described in the section of the Code shown above.

If your sources of support, or your purposes, character, or method of operation change, please let your key district know so that office can consider the effect of the change on your exempt status and foundation status. Also, you should inform your key District Director of all changes in your name or address.

Unless specifically excepted, beginning January 1, 1984, you must pay taxes under the Federal Insurance Contributions Act (social security taxes) for each employee who is paid $100 or more in a calendar year. You are not required to pay tax under the Federal Unemployment Tax Act (FUTA).

Since you are not a private foundation, you are not subject to the excise taxes under Chapter 42 of the Code. However, you are not automatically exempt from other federal excise taxes. If you have questions about excise, employment, or other federal taxes, contact your key District Director.

Donors may deduct contributions to you as provided in Code section 170. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522.

You are required to file Form 990, Return of Organization Exempt Income Tax, only if your gross receipts each year are normally more th $25,000. If your gross receipts are not normally more than $25,000 we that you establish that you are not required to file Form 990 by compl Part I of that Form for your first tax year. Thereafter, you will not required to file a return until your gross receipts normally exceed th $25,000 minimum. For guidance in determining if your gross receipts a "normally" not more than the $25,000 limit, see the instructions for t Form 990. If a return is required, it must be filed by the 15th day of the fifth month after the end of your annual accounting period. There a penalty of $10 a day, up to a maximum of $5,000, when a return is fil late, unless you establish, as required by section 6652(d)(1), that the failure to file timely was due to reasonable cause.

You are not required to file federal income tax returns unless you subject to the tax on unrelated business income under Code section 511. you are subject to this tax, you must file an income tax return on Form 990-T, Exempt Organization Business Income Tax Return. In this letter w are not determining whether any of your present or proposed activities are unrelated trade or business as defined in section 513.

Please show your employer identification number on all returns you file and in all correspondence with the Internal Revenue Service.

We are informing your key District Director of this ruling. Because this letter could help resolve any questions about your exempt status and foundation status, you should keep it in your permanent records.

If you have any questions about this ruling, please contact the pers whose name and telephone number are shown in the heading of this letter. For other matters, including questions concerning reporting requirements, please contact your key District Director.

Sincerely yours,

Milton Cerny

Milton Cerny
Chief, Exempt Organizations
Rulings Branch

EXHIBIT 12

Schedule of Capital Costs - The Hospital of Central Connecticut

Schedule of Capital Costs – The Hospital of Central Connecticut

Inpatient Psychiatry Renovation of Pavilion Building E/W 3

Relocation of 22 beds from W1 to new 32 bed unit on 3 East/West. Estimate includes major renovation to W3 for conversion to Psychiatric Unit and more minimal renovation to E3 due to structure of existing walls. New MEP infrastructure and distribution required to support 2010 code. All exterior windows would be upgraded to safety windows with integral blinds. All finishes and fixtures would be upgraded to tamper proof/suicide proof safety fixtures.

$ 389,040	- A/E Design Cost
$ 75,000	- Abatement Estimate
$3,728,300	- Construction Costs ($3,242,000) plus 15% Contingency ($486,300)
$ 522,000	- Furniture, equipment and IT @ $45SF x 11,600SF (program space)
$ 30,000	- In-House Labor Costs
$4,744,340	- Total Cost Estimate for 12,385SF ($343 SF) program & MEP space. Note: roof costs N/A in SF. Cost per SF actually less when MEP work is considered

13 Months- E/W3 Construction Duration Estimate

EXHIBIT 13

Financial Attachment I
MidsState Medical Center
The Hospital of Central Connecticut
Hartford HealthCare

MidState Medical Center **Attachment A**

12. C (i). Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY 2011 Actual Results	FY2013 Projected W/out CON	FY2013 Projected Incremental	FY2013 Projected With CON	FY2014 Projected W/out CON	FY2014 Projected Incremental	FY2014 Projected With CON	FY2015 Projected W/out CON	FY2015 Projected Incremental	FY2015 Projected With CON
NET PATIENT REVENUE										
Non-Government	$105,680,433	$125,700,000	($222,000)	$125,478,000	$133,000,000	($461,000)	$132,539,000	$139,500,000	($480,000)	$139,020,000
Medicare	$70,035,314	$74,700,000	($342,000)	$74,358,000	$73,800,000	($698,000)	$73,102,000	$74,900,000	($714,000)	$74,186,000
Medicaid and Other Medical Assistance	$20,754,012	$24,700,000	($291,000)	$24,409,000	$25,700,000	($588,000)	$25,112,000	$26,300,000	($594,000)	$25,706,000
Other Government	$285,677	$300,000		$300,000	$300,000		$300,000	$300,000		$300,000
Total Net Patient Patient Revenue	$196,755,436	$225,400,000	($855,000)	$224,545,000	$232,800,000	($1,747,000)	$231,053,000	$241,000,000	($1,788,000)	$239,212,000
Other Operating Revenue	$14,584,411	$7,800,000		$7,800,000	$8,000,000		$8,000,000	$8,200,000		$8,200,000
Revenue from Operations	$211,339,847	$233,200,000	($855,000)	$232,345,000	$240,800,000	($1,747,000)	$239,053,000	$249,200,000	($1,788,000)	$247,412,000
OPERATING EXPENSES										
Salaries and Fringe Benefits	$99,625,726	$104,400,000	($828,000)	$103,572,000	$107,000,000	($1,720,000)	$105,280,000	$112,000,000	($1,789,000)	$110,211,000
Professional / Contracted Services	$1,503,048	$1,700,000		$1,700,000	$1,800,000		$1,800,000	$1,900,000		$1,900,000
Supplies and Drugs	$22,136,153	$23,500,000	($306,000)	$23,194,000	$24,200,000	($639,000)	$23,561,000	$25,000,000	($664,000)	$24,336,000
Bad Debts	$7,875,420	$10,200,000	($51,000)	$10,149,000	$10,900,000	($106,000)	$10,794,000	$11,700,000	($113,000)	$11,587,000
Other Operating Expense	$57,466,387	$69,100,000		$69,100,000	$72,500,000		$72,500,000	$75,600,000		$75,600,000
Subtotal	$188,606,734	$208,900,000	($1,185,000)	$207,715,000	$216,400,000	($2,465,000)	$213,935,000	$226,200,000	($2,566,000)	$223,634,000
Depreciation/Amortization	$12,845,628	$14,300,000		$14,300,000	$14,900,000		$14,900,000	$15,300,000		$15,300,000
Interest Expense	$2,222,925	$4,200,000		$4,200,000	$4,200,000		$4,200,000	$4,200,000		$4,200,000
Lease Expense				$0			$0			$0
Total Operating Expense	$203,675,287	$227,400,000	($1,185,000)	$226,215,000	$235,500,000	($2,465,000)	$233,035,000	$245,700,000	($2,566,000)	$243,134,000
Gain/(Loss) from Operations	$7,664,560	$5,800,000	$330,000	$6,130,000	$5,300,000	$718,000	$6,018,000	$3,500,000	$778,000	$4,278,000
Plus: Non-Operating Revenue	$455,490	$900,000		$900,000	$950,000		$950,000	$1,000,000		$1,000,000
Revenue Over/(Under) Expense	$8,120,050	$6,700,000	$330,000	$7,030,000	$6,250,000	$718,000	$6,968,000	$4,500,000	$778,000	$5,278,000
FTEs	1061.7	1078.2	-6.4	1071.8	1086.4	-12.8	1073.6	1092.2	-12.8	1079.4
Discharges	10,235	10,358	(102)	10,256	10,555	(204)	10,351	10,754	(204)	10,550

Incremental assumptions: Half year impact in FY2013 due to renovation timing

Other incremental assumptions:	Between 2011-2013	2014	2015
Gross Revenue all payers	12%	6%	6%
Net Revenue			
Medicare	5%	2%	2%
Medicaid	0%	1%	1%
Non government	9%	4%	4%
Expenses	7%	4%	4%

The Hospital of Central Connecticut

12. C (i). Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY 2011 Actual Results	FY2013 Projected W/out CON	FY2013 Projected Incremental	FY2013 Projected With CON	FY2014 Projected W/out CON	FY2014 Projected Incremental	FY2014 Projected With CON	FY2015 Projected W/out CON	FY2015 Projected Incremental	FY2015 Projected With CON
NET PATIENT REVENUE										
Non-Government	$182,472,674	$188,714,078	327,052	$189,041,130	$197,371,733	$680,268	$198,052,001	$205,625,594	$707,479	$206,333,073
Medicare	$137,749,529	$135,484,122	837,900	$136,322,022	$133,515,456	$1,709,316	$135,224,772	$133,507,089	$1,743,502	$135,250,591
Medicaid and Other Medical Assistance	$59,380,843	$53,806,732	354,507	$54,161,239	$54,018,333	$716,104	$54,734,437	$54,599,778	$723,265	$55,323,043
Other Government	$3,713,418	$3,443,747		$3,443,747	$3,449,811		$3,449,811	$3,456,197		$3,456,197
Total Net Patient Patient Revenue	$383,316,464	$381,448,679	$1,519,459	$382,968,138	$388,355,333	$3,105,688	$391,461,021	$397,188,658	$3,174,246	$400,362,904
Other Operating Revenue	$9,455,325	$11,756,862		$11,756,862	$11,030,979		$11,030,979	$10,305,096		$10,305,096
Revenue from Operations	$392,771,789	$393,205,541	$1,519,459	$394,725,000	$399,386,312	$3,105,688	$402,492,000	$407,493,754	$3,174,246	$410,668,000
OPERATING EXPENSES										
Salaries and Fringe Benefits	$205,321,750	$199,080,093	$800,907	$199,881,000	$207,627,114	$1,665,886	$209,293,000	$218,112,478	$1,732,522	$219,845,000
Professional / Contracted Services	$11,127,118	$12,007,464		$12,007,464	$12,259,621		$12,259,621	$12,517,073		$12,517,073
Supplies and Drugs	$51,694,261	$49,142,078	158,922	$49,301,000	$50,963,441	$330,559	$51,294,000	$52,909,219	$343,781	$53,253,000
Bad Debts	$1,140,529	$8,941,834	55,082	$8,996,916	$9,569,398	116,775	$9,686,173	$10,282,970	$123,781	$10,406,751
Other Operating Expense	$73,232,593	$83,694,620		$83,694,620	$77,995,206		$77,995,206	$70,967,176		$70,967,176
Subtotal	$342,516,251	$352,866,089	$1,014,912	$353,881,000	$358,414,781	$2,113,219	$360,528,000	$364,788,917	$2,200,084	$366,989,000
Depreciation/Amortization	$18,679,687	$20,306,392	$118,609	$20,425,000	$23,209,783	$237,217	$23,447,000	$24,230,783	$237,217	$24,468,000
Interest Expense	$837,138	$2,073,000		$2,073,000	$2,418,000		$2,418,000	$2,784,000		$2,784,000
Lease Expense		$0		$0	$0		$0	$0		$0
Total Operating Expense	$362,033,076	$375,245,480	$1,133,520	$376,379,000	$384,042,564	$2,350,436	$386,393,000	$391,803,700	$2,437,301	$394,241,000
Gain/(Loss) from Operations	$30,738,713	$17,960,061	$385,939	$18,346,000	$15,343,748	$755,252	$16,099,000	$15,690,054	$736,946	$16,427,000
Plus: Non-Operating Revenue	$26,025	$6,300,000		$6,300,000	$6,300,000		$6,300,000	$6,300,000		$6,300,000
Revenue Over/(Under) Expense	$30,764,738	$24,260,061	$385,939	$24,646,000	$21,643,748	$755,252	$22,399,000	$21,990,054	$736,946	$22,727,000
FTEs	2,172.00	2,269.20	9.00	2,276.30	2,266.51	18.00	2,280.70	2,266.51	18.00	2,280.70

*Volume Statistics:
Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

12. C (i). Please provide one year of actual results and three years of ***Total Hospital Health System*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Hospital Health System: Description	FY 2011 Actual Results	FY2013 Projected W/out CON	FY2013 Projected Incremental	FY2013 Projected With CON	FY2014 Projected W/out CON	FY2014 Projected Incremental	FY2014 Projected With CON	FY2015 Projected W/out CON	FY2015 Projected Incremental	FY2015 Projected With CON
NET PATIENT REVENUE										
Non-Government	$772,119,000	$905,814,000	$105,052	$905,919,052	$936,354,000	$219,268	$936,573,268	$966,523,000	$227,479	$966,750,479
Medicare	$618,923,000	$726,092,000	$495,900	$726,587,900	$750,573,000	$1,011,316	$751,584,316	$774,755,000	$1,029,502	$775,784,502
Medicaid and Other Medical Assistance	$219,775,000	$257,829,000	$63,507	$257,892,507	$266,522,000	$128,104	$266,650,104	$275,109,000	$129,265	$275,238,265
Other Government	$5,171,000	$6,067,000	$0	$6,067,000	$6,271,000	$0	$6,271,000	$6,473,000	$0	$6,473,000
Total Net Patient Patient Revenue	$1,615,988,000	$1,895,802,000	$664,459	$1,896,466,459	$1,959,720,000	$1,358,688	$1,961,078,688	$2,022,860,000	$1,386,246	$2,024,246,246
Other Operating Revenue	$187,975,000	$198,351,000	$0	$198,351,000	$207,378,000	$0	$207,378,000	$218,098,000	$0	$218,098,000
Revenue from Operations	$1,803,963,000	$2,094,153,000	$664,459	$2,094,817,459	$2,167,098,000	$1,358,688	$2,168,456,688	$2,240,958,000	$1,386,246	$2,242,344,246
OPERATING EXPENSES										
Salaries and Fringe Benefits	$1,047,834,000	$1,101,432,000	($27,093)	$1,101,404,907	$1,146,623,000	($54,114)	$1,146,568,886	$1,191,150,000	($56,478)	$1,191,093,522
Professional / Contracted Services	$58,095,000	$62,836,000	$0	$62,836,000	$65,349,000	$0	$65,349,000	$67,963,000	$0	$67,963,000
Supplies and Drugs	$228,530,000	$247,178,000	($147,078)	$247,030,922	$257,065,000	($308,441)	$256,756,559	$267,348,000	($320,219)	$267,027,781
Bad Debts	$35,420,000	$67,553,000	$4,082	$67,557,082	$64,457,000	$10,775	$64,467,775	$62,109,000	$10,781	$62,119,781
Other Operating Expense	$299,728,000	$443,029,000	$0	$443,029,000	$448,356,000	$0	$448,356,000	$449,741,000	$0	$449,741,000
Subtotal	$1,669,607,000	$1,922,028,000	($170,088)	$1,921,857,912	$1,981,850,000	($351,781)	$1,981,498,219	$2,038,311,000	($365,916)	$2,037,945,084
Depreciation/Amortization	$81,701,000	$96,961,000	$118,609	$97,079,609	$102,635,000	$237,217	$102,872,217	$110,101,000	$237,217	$110,338,217
Interest Expense	$6,487,000	$11,676,000	$0	$11,676,000	$17,841,000	$0	$17,841,000	$25,564,000	$0	$25,564,000
Lease Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Operating Expense	$1,757,795,000	$2,030,665,000	($51,480)	$2,030,613,520	$2,102,326,000	($114,564)	$2,102,211,436	$2,173,976,000	($128,699)	$2,173,847,301
Gain/(Loss) from Operations	$46,168,000	$63,488,000	$715,939	$64,203,939	$64,772,000	$1,473,252	$66,245,252	$66,982,000	$1,514,946	$68,496,946
Plus: Non-Operating Revenue	$11,068,000	$16,645,000	$0	$16,645,000	$16,705,000	$0	$16,705,000	$16,789,000	$0	$16,789,000
Revenue Over/(Under) Expense	$57,236,000	$80,133,000	$715,939	$80,848,939	$81,477,000	$1,473,252	$82,950,252	$83,771,000	$1,514,946	$85,285,946
FTEs	11986	12272	2.6	12274.6	12306	5.2	12311.2	12312	5.2	12317.2
Discharges	76,191	76,351	117	76,468	76,945	234	77,179	77,407	234	77,641

Incremental assumptions: Half year impact in FY2013 due to renovation timing

Other incremental assumptions:	Between 2011-2013	2014	2015
Gross Revenue all payers	12%	6%	6%
Net Revenue			
Medicare	5%	2%	2%
Medicaid	0%	1%	1%
Non government	9%	4%	4%
Expenses	7%	4%	4%

Hartford Healthcare - Total system impact - Attachment FA C support **Attachment C Support**

12. C (i). Please provide one year of actual results and three years of ***Total Hospital Health System*** projections of revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY2013 HOCC Incremental	FY2013 MidState Incremental	FY2013 HHC Incremental	FY2014 HOCC Incremental	FY2014 MidState Incremental	FY2014 HHC Incremental	FY2015 HOCC Incremental	FY2015 MidState Incremental	FY2015 HHC Incremental
NET PATIENT REVENUE									
Non-Government	327,052	($222,000)	$105,052	$680,268	($461,000)	$219,268	$707,479	($480,000)	$227,479
Medicare	837,900	($342,000)	$495,900	$1,709,316	($698,000)	$1,011,316	$1,743,502	($714,000)	$1,029,502
Medicaid and Other Medical Assistance	354,507	($291,000)	$63,507	$716,104	($588,000)	$128,104	$723,265	($594,000)	$129,265
Other Government			$0			$0			$0
Total Net Patient Patient Revenue	$1,519,459	($855,000)	$664,459	$3,105,688	($1,747,000)	$1,358,688	$3,174,246	($1,788,000)	$1,386,246
Other Operating Revenue			$0			$0			$0
Revenue from Operations	$1,519,459	($855,000)	$664,459	$3,105,688	($1,747,000)	$1,358,688	$3,174,246	($1,788,000)	$1,386,246
OPERATING EXPENSES									
Salaries and Fringe Benefits	$800,907	($828,000)	($27,093)	$1,665,886	($1,720,000)	($54,114)	$1,732,522	($1,789,000)	($56,478)
Professional / Contracted Services			$0			$0			$0
Supplies and Drugs	158,922	($306,000)	($147,078)	$330,559	($639,000)	($308,441)	$343,781	($664,000)	($320,219)
Bad Debts	55,082	($51,000)	$4,082	116,775	($106,000)	$10,775	$123,781	($113,000)	$10,781
Other Operating Expense			$0			$0			$0
Subtotal	$1,014,912	($1,185,000)	($170,088)	$2,113,219	($2,465,000)	($351,781)	$2,200,084	($2,566,000)	($365,916)
Depreciation/Amortization	$118,609		$118,609	$237,217		$237,217	$237,217		$237,217
Interest Expense			$0			$0			$0
Lease Expense			$0			$0			$0
Total Operating Expense	$1,133,520	($1,185,000)	($51,480)	$2,350,436	($2,465,000)	($114,564)	$2,437,301	($2,566,000)	($128,699)
Gain/(Loss) from Operations	$385,939	$330,000	$715,939	$755,252	$718,000	$1,473,252	$736,946	$778,000	$1,514,946
Plus: Non-Operating Revenue			$0			$0			$0
Revenue Over/(Under) Expense	$385,939	$330,000	$715,939	$755,252	$718,000	$1,473,252	$736,946	$778,000	$1,514,946
FTEs	9.00	-6.4	2.6	18.00	-12.8	5.2	18.00	-12.8	5.2
Discharges (A)	219	(102)	117	438	(204)	234	438	(204)	234

Incremental assumptions: Half year impact in FY2013 due to renovation timing

Other incremental assumptions:	Between 2011-2013	2014	2015
Gross Revenue all payers	12%	6%	6%
Net Revenue			
Medicare	5%	2%	2%
Medicaid	0%	1%	1%
Non government	9%	4%	4%
Expenses	7%	4%	4%

(A) MidState discharge values are based on 6 month actual FY 2012 experience which reflect a LOS increase of 60% in Medicaid patients due to delays in outplacing patients with long term needs

EXHIBIT 14

Financial Attachment II
MidsState Medical Center
The Hospital of Central Connecticut

MidState Medical Center **Attachment A Support**

13.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

00181

Type of Service Description	INPATIENT
Type of Unit Description:	DISCHARGES
# of Months in Operation	6

FY 2013 - 6 MONTH	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$1,134,000**									
Total Facility by Payer Category:										
Medicare		$24,889	27	$672,000	$330,000		$23,000	$319,000	$362,000	($43,000)
Medicaid		$25,395	43	$1,092,000	$801,000			$291,000	$554,000	($263,000)
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			70	$1,764,000	$1,131,000	$0	$23,000	$610,000	$916,000	($306,000)
Commercial Insurers		$16,000	23	$368,000	$193,000			$175,000	$157,000	$18,000
Uninsured		$14,889	9	$134,000	$42,000	$45,000	$28,000	$19,000	$61,000	($42,000)
Total NonGovernment			32	$502,000	$235,000	$45,000	$28,000	$194,000	$218,000	($24,000)
Total All Payers		$22,216	102	2,266,000	1,366,000	45,000	51,000	804,000	1,134,000	(330,000)

13.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

00182

Type of Service Description	INPATIENT									
Type of Unit Description:	DISCHARGES									
# of Months in Operation	12									
FY 2014	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross Revenue Col. 2 * Col. 3	Allowances/ Deductions	Charity Care	Bad Debt	Net Revenue Col.4 - Col.5 -Col.6 - Col.7	Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	Gain/(Loss) from Operations Col. 8 - Col. 9
Total Incremental Expenses:	**$2,359,000**									
Total Facility by Payer Category:										
Medicare		$26,389	54	$1,425,000	$727,000		$47,000	$651,000	$753,000	($102,000)
Medicaid		$26,919	86	$2,315,000	$1,727,000			$588,000	$1,152,000	($564,000)
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			140	$3,740,000	$2,454,000	$0	$47,000	$1,239,000	$1,905,000	($666,000)
Commercial Insurers		$16,957	46	$780,000	$416,000			$364,000	$327,000	$37,000
Uninsured		$15,778	18	$284,000	$97,000	$90,000	$59,000	$38,000	$127,000	($89,000)
Total NonGovernment			64	$1,064,000	$513,000	$90,000	$59,000	$402,000	$454,000	($52,000)
Total All Payers		$23,549	204	4,804,000	2,967,000	90,000	106,000	1,641,000	2,359,000	(718,000)

13.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description	INPATIENT
Type of Unit Description:	DISCHARGES
# of Months in Operation	12

FY 2015 **FY Projected Incremental** Total Incremental Expenses: **$2,453,000** **Total Facility by Payer Category:**	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare		$27,981	54	$1,511,000	$797,000		$50,000	$664,000	$783,000	($119,000)
Medicaid		$28,535	86	$2,454,000	$1,860,000			$594,000	$1,198,000	($604,000)
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			140	$3,965,000	$2,657,000	$0	$50,000	$1,258,000	$1,981,000	($723,000)
Commercial Insurers		$17,978	46	$827,000	$448,000			$379,000	$340,000	$39,000
Uninsured		$16,722	18	$301,000	$105,000	$95,000	$63,000	$38,000	$132,000	($94,000)
Total NonGovernment			64	$1,128,000	$553,000	$95,000	$63,000	$417,000	$472,000	($55,000)
Total All Payers		$24,966	204	5,093,000	3,210,000	95,000	113,000	1,675,000	2,453,000	(778,000)

The Hospital of Central Connecticut

13.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description: INPATIENT
Type of Unit Description: DISCHARGES
# of Months in Operation: 6

FY 2013 - 6 MONTH **FY Projected Incremental** Total Incremental Expenses: **$1,078,438** **Total Facility by Payer Category:**	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare		$13,319	84	$ 1,118,780	$ 280,880		$ -	$ 837,900	$ 372,371	$ 465,529
Medicaid		$15,123	85	$ 1,285,442	$ 930,935		$ -	$ 354,507	$ 427,842	$ (73,335)
CHAMPUS/TriCare		$0	0	$ -	$ -		$ -	$ -	$ -	$ -
Total Governmental			169	$ 2,404,222	$ 1,211,815	$ -	$ -	$ 1,192,407	$ 800,214	$ 392,193
Commercial Insurers		$18,330	41	$ 751,519	$ 451,976		$ 28,013	$ 271,530	$ 250,133	$ 21,397
Uninsured		$9,378	9	$ 84,399	$ 56,890	$ -	$ 27,069	$ 440	$ 28,091	$ (27,651)
Total NonGovernment			50	$ 835,918	$ 508,866	$ -	$ 55,082	$ 271,970	$ 278,224	$ (6,254)
Total All Payers		$14,795	219	$ 3,240,140	$ 1,720,681	$ -	$ 55,082	$ 1,464,377	$ 1,078,438	$ 385,939

13.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description: INPATIENT

00184

Type of Unit Description:	DISCHARGES
# of Months in Operation	12

FY 2014 **FY Projected Incremental** Total Incremental Expenses: **Total Facility by Payer Category:**	(1) **$2,233,661**	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare		$14,118	168	$ 2,371,813	$ 662,497		$ -	$ 1,709,316	$ 771,255	$ 938,061
Medicaid		$16,030	170	$ 2,725,138	$ 2,009,034		$ -	$ 716,104	$ 886,148	$ (170,044)
CHAMPUS/TriCare		$0	0	$ -	$ -		$ -	$ -	$ -	$ -
Total Governmental			338	$ 5,096,951	$ 2,671,531	$ -	$ -	$ 2,425,420	$ 1,657,403	$ 768,017
Commercial Insurers		$19,430	82	$ 1,593,220	$ 970,172		$ 59,933	$ 563,115	$ 518,076	$ 45,039
Uninsured		$9,940	18	$ 178,925	$ 121,705	$ -	$ 56,842	$ 378	$ 58,182	$ (57,804)
Total NonGovernment			100	$ 1,772,145	$ 1,091,877	$ -	$ 116,775	$ 563,493	$ 576,258	$ (12,765)
Total All Payers		$15,683	438	$ 6,869,096	$ 3,763,408	$ -	$ 116,775	$ 2,988,913	$ 2,233,661	$ 755,252

13.C(ii). Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description	INPATIENT
Type of Unit Description:	DISCHARGES
# of Months in Operation	12

FY 2015 **FY Projected Incremental** Total Incremental Expenses: **$2,313,520** **Total Facility by Payer Category:**	(1)	(2) Rate	(3) Units	(4) Gross Revenue Col. 2 * Col. 3	(5) Allowances/ Deductions	(6) Charity Care	(7) Bad Debt	(8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7	(9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total	(10) Gain/(Loss) from Operations Col. 8 - Col. 9
Medicare		$14,965	168	$ 2,514,121	$ 770,619		$ -	$ 1,743,502	$ 798,829	$ 944,673
Medicaid		$16,992	170	$ 2,888,646	$ 2,165,381		$ -	$ 723,265	$ 917,830	$ (194,565)
CHAMPUS/TriCare		$0	0	$ -	$ -		$ -	$ -	$ -	$ -
Total Governmental			338	$ 5,402,767	$ 2,936,000	$ -	$ -	$ 2,466,767	$ 1,716,659	$ 750,108
Commercial Insurers		$20,595	82	$ 1,688,814	$ 1,040,843		$ 64,687	$ 583,284	$ 536,599	$ 46,685
Uninsured		$10,537	18	$ 189,661	$ 130,152	$ -	$ 59,094	$ 415	$ 60,262	$ (59,847)
Total NonGovernment			100	$ 1,878,475	$ 1,170,995	$ -	$ 123,781	$ 583,699	$ 596,861	$ (13,162)
Total All Payers		$16,624	438	$ 7,281,242	$ 4,106,995	$ -	$ 123,781	$ 3,050,466	$ 2,313,520	$ 736,946

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

August 7, 2012

VIA FAX ONLY

Ms. Barbara A. Durdy
Director, Business Development
MidState Medical Center
435 Lewis Ave.
Meriden, CT 06451

RE: Certificate of Need Application, Docket Number 12-31775-CON
MidState Medical Center
Proposal to Terminate Inpatient Behavioral Health Services

Dear Ms. Durdy:

On July 18, 2012, the Office of Health Care Access ("OHCA") received your Certificate of Need application filed on behalf of MidState Medical Center ("MMC" or "Applicant"), for the termination of the hospital's inpatient behavioral health services. OHCA has reviewed the CON application and requests the following additional information pursuant to General Statutes §19a-639a(c):

1) On page 3 of the CON application the legal notice states that the "inpatient psychiatric services" will be terminated and that "quality alternative access to inpatient psychiatric services" will be included in MMC's proposal. The legal notice does not refer to behavioral health services that would also include services for substance abuse. Please clarify the range of services that the Applicant proposes to terminate.

2) Provide a time line for the proposal. Specify the anticipated date of termination for the behavioral health inpatient services.

3) Was the expansion of behavioral health services at MMC considered prior to the decision to terminate the program? What were the main factors that resulted in the decision to terminate the program at MMC and expand services at The Hospital of Central Connecticut ("HoCC")?

4) Has MMC completed any community surveys or made other inquiries to determine the willingness of area residents to travel to HoCC to receive inpatient behavioral health services? If yes, please provide a discussion of the results. If not, explain how MMC has determined that area residents would be supportive of the proposal.

5) Are there any circumstances where the proposed "preferential admission status" beds at HoCC will be used for non-MMC referred patients? If so, please provide an example.

6) Please describe the patients that were discharged from MMC's behavioral health unit in FY 2011. At a minimum, summarize by sex, race, age group (18-44, 45-64, 65 and older), town of residence, primary payer, primary diagnosis and discharge status (e.g., home, another inpatient program, etc.).

7) Table 2 on page 10 of the CON application lists behavioral health patient transfers from MMC's Emergency Department to other acute care facilities. Of 223 transfers during Fiscal Year (FY) 2011, there was only one patient transferred to HoCC. Explain why the number of patients transferred to HoCC was lower than the number transferred to other listed facilities.

8) Provide a revised version of Table 2 that only includes patients 18 years of age and older. Report separately the transfers made in FYs 2009, 2010, and 2011.

9) Report the number of ED patients that were admitted to MMC's existing behavioral health unit in FYs 2009, 2010, and 2011. Provide a breakdown of these admissions that categorizes the primary reason for admission by the following: behavioral health, substance abuse, or those patients with comorbidities.

10) Report the number of transfers of behavioral health patients from the ED to other facilities due to the lack of an inpatient bed at MMC for FYs 2009, 2010, and 2011.

11) Report the complete calculation used to determine the resulting additional capacity of 155 MMC inpatient admissions given on page 11 of the CON application.

12) Provide how direct cost per day was computed for inpatient behavioral health care at MMC and at HoCC.

13) Provide a description of the services or therapies currently available at HoCC for inpatient behavioral health patients that are not currently available at MMC.

14) What additional services or therapies will be added to those listed above that will be available at HoCC after the expansion of the inpatient unit?

15) Please answer the following questions concerning the transportation between MMC and HoCC:
    a) How will MMC inform patients and their families of the availability of transportation assistance from MMC to HoCC campus?
    b) Through which account will the transportation costs be paid?
    c) Under what conditions would a person be unable to use public transportation and therefore qualify for hospital-provided transportation between the MMC and HoCC?
    d) How long will MMC maintain the transportation assistance?

16) On page 15 of the CON application it states that the Master Facilities Plan for MMC is currently under development. When will the Master Facilities Plan be available? How will MCC utilize the six beds currently used for inpatient behavioral health services, if the proposal is approved?

17) Question 2c of the CON application asked that the Applicant provide information on each provider to whom the Applicant proposes to transfer or refer clients. In response, the Applicant reported only the average occupancy rate for HoCC. However, Table 2 on page 10 listed numerous other providers, such as the Institute of Living, Saint Francis Hospital and Medical Center St. Vincent's Hospital and Masonicare. The combined number of patients transferred in FY 2011 to these facilities was 162. Please provide information on additional service providers that may receive transfers from MMC.

18) Question 2d requested that any special populations that utilize the services be identified and to explain how these patients would continue to access this service after the service location closes. Please readdress the question, as the response provided on page 18 of the CON application reported two populations that MMC does not admit as inpatients.

19) It was stated on page 20 of the CON application that MMC has recently experienced an increase in illness severity on the inpatient unit and longer than normal wait times for available beds for patients at State facilities. Please expand on this statement with supporting information or documentation. How does the lack of beds at a State facility affect MMC's inpatient unit? What effect will the illness severity and longer wait times have on the expanded inpatient unit at HoCC?

20) Explain the services that MMC currently provides on an outpatient basis for persons requiring behavioral health treatment. Include where the services are provided and the capacity of each program.

21) Discuss the services that Rushford currently provides to residents of the greater Meriden area, including the capacity of each program. How will Rushford enhance these community-based services?

22) Specifically describe how MMC and Rushford will work together to enhance community-based services.

23) Explain why there is a clear public need for the proposal. Provide evidence that demonstrates this need.

In responding to the questions contained in this letter, please repeat each question before providing your response. Paginate and date your response, i.e., each page in its entirety. Information filed after the initial CON application submission (i.e. completeness letter, late file submissions, and the like) must be numbered sequentially from the Applicant document preceding it. As the current submission for the application concludes with page 186, please begin with the completeness response with page 187. Reference Docket Number: 12-31775-CON and submit one (1) original and six (6) hard copies of your response in its entirety, including any

supporting documentation. Submit a scanned copy of your response in Adobe format, an electronic copy in MS Word format and any worksheets in MS Excel, including all attachments, on CD.

Sincerely,

Laurie K. Greci

Laurie K. Greci
Associate Research Analyst

Brian A. Carney

Brian A. Carney
Associate Research Analyst

Copy (faxed): Claudio Capone, Director, Hospital of Central Connecticut
Karen Goyette, Vice President, Hartford HealthCare Corporation

****
*** TX REPORT ***
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TRANSMISSION OK

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Barbara Durdy

FAX: 203 694 7601

AGENCY: MidState Medical Center

FROM: Laure Greci

DATE: 8/7/2012 **TIME:**

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: Completeness for 12-31775-CON
Proposal to Terminate IP BH Services

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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*** TX REPORT ***
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TRANSMISSION OK

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RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Claudio Capone

FAX: 860 224 5740

AGENCY: Hosp of Central CT

FROM: Laura Greci

DATE: 8/7/2012 **TIME:**

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: Completeness ltr for 12-31775-CON Proposal of MidState Med Ctr to Terminate IP BH Services

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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*** TX REPORT ***
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TRANSMISSION OK

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RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Karen Goyette

FAX: 860 545 2127

AGENCY: Hartford HealthCare Corp

FROM: Lauric Greci

DATE: 8/7/2012 **TIME:**

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: Completeness ltr for 12-31775-CON
Proposal of MidState Med Ctr to
Terminate IP BH Services

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greci, Laurie

From: Barbara Durdy <Bdurdy@midstatemedical.org>
Sent: Wednesday, August 08, 2012 11:15 AM
To: Greci, Laurie
Subject: Re: 12-31775-CON Word Doc Version of Completeness Letter dated 8/7/2012

thank you Laurie!

>>> "Greci, Laurie" <Laurie.Greci@ct.gov> 8/8/2012 10:48 AM >>>
Barbara,

For your convenience I have attached the Word version of the completeness letter your received via fax yesterday.
Any problems with it, just let me know!

Laurie

Laurie K. Greci
Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

STATE OF CONNECTICUT
HOUSE OF REPRESENTATIVES

CHRISTOPHER G. DONOVAN
SPEAKER OF THE HOUSE

August 6, 2012

Commissioner Jewell Mullen
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Re: Certificate of Need Application of MidState Medical Center, Docket No. 12-31775-CON

Dear Commissioner Mullen:

We are writing in reference to MidState Medical Center's recent application for a certificate of need to terminate its inpatient behavioral health services. Under the proposal, MidState would close the six beds it currently maintains on site in Meriden, in exchange for 10 beds at the Hospital of Central Connecticut in New Britain, which will be expanded to include 32 beds total.

We want to acknowledge MidState's efforts to respond to concerns we have raised in the past and its recent work to reach out to us and other stakeholders. While we recognize MidState's need to adapt to the changing healthcare landscape, the proposal raises concerns about both patient access to services and the ability of families to support patients in crisis and be part of their continuum of care.

In 2007, MidState filed a CON application, which included a request to terminate inpatient psychiatric services and transfer patients in need of these services to the Institute of Living in Hartford and other facilities. In 2008 OHCA denied this provision of the application because it did not find evidence that community need for these services had diminished. To the contrary, OHCA referenced strong evidence to support the need for an inpatient psychiatric unit at MidState, writing in its decision that "an individual requiring routine inpatient psychiatric care will be better served by receiving their treatment closer to home, where matters pertaining to patient support from family members and the establishment of appropriate aftercare treatment can be better achieved." As part of its denial, OHCA advised MidState to maintain psychiatric inpatient services consisting of no less than 8 licensed beds. It is our understanding that MidState currently maintains only six inpatient psychiatric beds.

We have a variety of additional concerns about the proposal, including the barriers it creates for families without transportation and the disruption to care as patients are transitioned from inpatient services in New Britain to outpatient services in Meriden and surrounding communities. One of the great features of

having inpatient psychiatric services available right in Meriden is the accessibility of the unit to families whose loved ones are in crisis. Families who may not have access to a car can conveniently access the hospital using public transportation. This allows family members to focus on the needs of the patient during a very stressful time and support caseworkers as they facilitate the healing process.

We are particularly concerned because New Britain is located in a different catchment area and clients may be seeing different psychiatrists and clinicians when they return home to Meriden. Both families and service providers report that there is a strong sense of community in the way services are currently structured through the MidState unit: patients have consistent access to their individual doctors and there are many opportunities for families to remain involved as service needs change. We all know how important a strong support system is to recovery and we are concerned that the vital role families and friends play will be reduced if MidState's unit is moved out of town.

Finally, MidState is our nonprofit community hospital and its mission is to serve the needs of the community. OHCA reinforced this in its 2008 decision. Based on our conversations with families and mental health providers over the years, we have developed a deep appreciation for the role of family, friends and community in the recovery process. We believe it is imperative that our community's mental health needs are served within the community, which is why we do not support the CON application as currently written.

We appreciate your consideration of these concerns and the opportunity to make them a part of the public record. We would also respectfully request that OHCA hold a public hearing on this proposal. We would be happy to meet with you or representatives of OHCA to discuss this matter.

Sincerely,

Christopher G. Donovan
Speaker of the House

Catherine F. Abercrombie
State Representative

CC: Deputy Commissioner Lisa A. Davis, Department of Public Health
Kimberly Martone, Director of Operations, Office of Health Care Access
Lucille Janatka, President and CEO, MidState Medical Center

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

August 15, 2012

The Honorable Christopher G. Donovan
Speaker of the House
State of Connecticut
Legislative Office Building, Suite 4100
Hartford, CT 06106

Re: Certificate of Need
MidState Medical Center, Docket Number: 12-31775-CON
Proposal to Coordinate with its Hartford Healthcare Affiliate to Offer Inpatient Behavioral Health Services at The Hospital of Central Connecticut

Dear Speaker Donovan:

On August 13, 2012, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for the proposal by MidState Medical Center to coordinate with its Hartford Healthcare Affiliate to offer inpatient behavioral health services at The Hospital of Central Connecticut.

I welcome and appreciate your comments regarding this matter. I have forwarded your letter to DPH's Office of Health Care Access ("OHCA"). Your letter will be made part of OHCA's formal record of the CON application docket. Please be advised, once a decision has been rendered it will be posted and available on OHCA's website at http:// www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone at (860) 418-7029.

Sincerely,

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

LAD:KRM:bko

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

August 15, 2012

The Honorable Catherine F. Abercrombie
State Representative
State of Connecticut
Legislative Office Building, Suite 4100
Hartford, CT 06106

Re: Certificate of Need
MidState Medical Center, Docket Number: 12-31775-CON
Proposal to Coordinate with its Hartford Healthcare Affiliate to Offer Inpatient Behavioral Health Services at The Hospital of Central Connecticut

Dear Representative Abercrombie:

On August 13, 2012, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for the proposal by MidState Medical Center to coordinate with its Hartford Healthcare Affiliate to offer inpatient behavioral health services at The Hospital of Central Connecticut.

I welcome and appreciate your comments regarding this matter. I have forwarded your letter to DPH's Office of Health Care Access ("OHCA"). Your letter will be made part of OHCA's formal record of the CON application docket. Please be advised, once a decision has been rendered it will be posted and available on OHCA's website at http:// www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone at (860) 418-7029.

Sincerely,

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

LAD:KRM:bko

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
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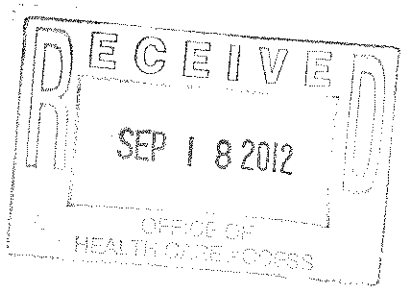
SHIPMAN & GOODWIN LLP®

COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com



September 18, 2012

Laurie K. Greci
Associate Research Analyst
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

RE: Certificate of Need Application, Docket Number 12-31775-CON
MidState Medical Center
Proposal to Terminate Inpatient Behavioral Health Services
Certificate of Need Completeness Letter Responses

Dear Ms. Greci:

On behalf of MidState Medical Center ("MidState"), enclosed please find the original and six hard copies of MidState's responses to your Certificate of Need Completeness Letter dated August 7, 2012 for Docket Number: 12-31775-CON. As requested, I have also included a CD with the electronic version of the enclosed documents and materials.

Please do not hesitate to contact me at 860-251-5104 if you have any questions.

Sincerely,

Joan W. Feldman

JWF/tb

Enclosures

1) On page 3 of the CON application the legal notice states that the "inpatient psychiatric services" will be terminated and that "quality alternative access to inpatient psychiatric services" will be included in MidState's proposal. The legal notice does not refer to behavioral health services that would also include services for substance abuse. Please clarify the range of services that the Applicant proposes to terminate.

   Current inpatient psychiatric services offered at MidState do not include treatment for substance abuse. Patients who need substance abuse treatment are referred to facilities specializing in these services.

2) Provide a time line for the proposal. Specify the anticipated date of termination for the behavioral health inpatient services.

   Subject to approval by OHCA, MidState will terminate its inpatient behavioral health service upon the completion of the THOCC expansion of its inpatient unit. The expansion will not take place prior to obtaining OHCA's approval and is expected to take approximately 9 months.

3) Was the expansion of behavioral health services at MidState considered prior to the decision to terminate the program? What were the main factors that resulted in the decision to terminate the program at MidState and expand services at The Hospital of Central Connecticut ("THOCC")?

   Yes. The Hartford HealthCare Behavioral Health Network as described in the Application conducted a thorough review of all behavioral health resources within the System in order to determine how and where behavioral health services could be provided in the most effective and efficient manner, including expanding the MidState program and relocating the services at THOCC to MidState. THOCC was ultimately selected as the inpatient hub for Central Connecticut because of the size of its program, higher volume of ED referrals, and the availability of an expanded array of clinical services and the diverse expertise of its behavioral health clinicians. By locating the consolidated program on THOCC's campus, a state-of-the art psychiatric facility could be developed to better serve the region.

4) Has MidState completed any community surveys or made other inquiries to determine the willingness of area residents to travel to THOCC to receive inpatient behavioral health services? If yes, please provide a discussion of the results. If not, explain how MidState has determined that area residents would be supportive of the proposal.

   MidState did not conduct a survey of area residents as it is often difficult to get reliable findings through such surveys. However, as part of its bi-annual community needs assessment, MidState conducted focus groups with community-based health and human service providers. Focus group participants discussed the need for more accessible and affordable outpatient mental health services, especially for youth and adolescents. The need to increase opportunities for individual counseling was noted, as well as the need

for more family services that focus on crisis prevention instead of crisis intervention. In response to the community needs assessment and as part of this proposal, MidState and Rushford have made several enhancements to community based outpatient services. Please see response to Question #21.

MidState did meet with community stakeholders, patient advocacy groups and other constituents in regard to this proposal. In particular, the decision was discussed very early on with the Commissioner of DMHAS.

Specifically, MidState discussed this proposal with community leaders including the Mayor Rohde of Meriden, Mayor Dickinson of Wallingford, Probate Court Judge Mahon (Meriden), Probate Court Judge Wright (Wallingford), and patient advocacy groups including NAMI-CT, Connecticut Legal Rights Project, Connecticut Behavioral Health Partnership, Regional Mental Health Board, Mental Health Association of Connecticut, and Catchment Area Council. In addition, leadership from MidState and THOCC met with State and local representatives, medical staff and community physicians, union leadership, local police departments and ambulance services in order to allow all stakeholders in the community an opportunity to comment and provide feedback.

Patients on MidState's inpatient unit were surveyed regarding the potential transportation needs of family members. Based on the feedback from patients and from the community, MidState and THOCC developed a transportation assistance plan to ensure a family-centered approach to delivering this service. MidState and THOCC understand the importance of family participation in a patient's care plan and are committed to providing the necessary support for this participation to continue. Transportation will be provided to patients who need such assistance as discussed below.

It should be noted that historically, geriatric behavioral health patients requiring inpatient care have been routinely transferred from the ED at MidState to Masonicare, located in Wallingford, CT. Masonicare and THOCC are equal distance from MidState (both facilities are approximately 9 miles from MidState). MidState has not received any negative feedback from patients or families indicating that a hardship or inconvenience resulted from the transfer of their loved one to the Masonicare facility.

One additional significant benefit of the proposed expansion of services at THOCC is that approximately 150 additional patients who previously were receiving care at facilities that were of greater distance from Meriden will now be able to receive their inpatient care closer to their community once THOCC unit is expanded.

5) Are there any circumstances where the proposed "preferential admission status" beds at THOCC will be used for non-MidState referred patients? If so, please provide an example.

There are no circumstances anticipated where MidState patients would not have "preferential admission status" to 10 beds on the THOCC inpatient unit.

6) Please describe the patients that were discharged from MidState's behavioral health unit in FY 2011. At a minimum, summarize by sex, race, age group (18-44, 45-64, 65 and older), town of residence, primary payer, primary diagnosis and discharge status (e.g., home, another inpatient program, etc.).

Please see Exhibit 1 attached.

7) Table 2 on page 10 of the CON application lists behavioral health patient transfers from MidState's Emergency Department to other acute care facilities. Of 223 transfers during Fiscal Year (FY) 2011, there was only one patient transferred to THOCC. Explain why the number of patients transferred to THOCC was lower than the number transferred to other listed facilities.

THOCC joined the System in February 2011. Prior to that time, certain existing referrals patterns were in place and were based upon established relationships that preceded the affiliation of the Applicants.

8) Provide a revised version of Table 2 that only includes patients 18 years of age and older. Report separately the transfers made in FYs 2009, 2010, and 2011.

Please see Exhibit 2 attached

9) Report the number of ED patients that were admitted to MidState's existing behavioral health unit in FYs 2009, 2010, and 2011.Provide a breakdown of these admissions that categorizes the primary reason for admission by the following: behavioral health, substance abuse, or those patients with co morbidities.

Please see Exhibit 3 attached.

As presented in Exhibit 3, the range of behavioral health diagnoses admitted to MidState's inpatient unit is broad thereby making specialized group therapy sessions impractical. All but two of the patients admitted to MidState during FY09, FY 10 and FY 11 had a primary diagnosis relating to a behavioral health problem. The two patients identified in 2009 as having a primary diagnosis related to alcohol abuse or alcohol withdrawal were admitted to manage psychiatric medications.

Behavioral health patients admitted to MidState, not unlike medical patients with chronic conditions, routinely have co-morbid conditions associated with their mental illness (for example: diabetes, obesity, high cholesterol, hypertension, anemia, etc). Almost all of the behavioral health patients admitted had at least one underlying co-morbid condition.

10) Report the number of transfers of behavioral health patients from the ED to other facilities due to the lack of an inpatient bed at MIDSTATE for FYs 2009, 2010, and 2011.

MidState does not track the number of patients transferred from the ED to other facilities due to lack of an inpatient bed. However, during FYs 2009, 2010 and 2011, MidState consistently maintained an average daily census of 5 or higher. Therefore, on most days the unit was full.

Patient Transfers from MidState ED

	FY 2009	FY 2010	FY 2011
Pediatric	55	60	49
Geriatric	84	70	65
All Other	179	118	109
Total Transfers	318	248	223

As presented in the table above, approximately 50% of the patient transfers were either pediatric or geriatric patients and not appropriate for admission at MidState. However; patients can also be transferred for a multitude of other reasons, such as severity of illness, violent tendencies, patient preference, patient gender, or the patient's condition would not fit the current therapeutic milieu on the unit.

11) Report the complete calculation used to determine the resulting additional capacity of 155 MidState inpatient admissions given on page 11 of the CON application.

Incremental discharges are calculated as follows:

Bed Days Available	Occupancy	Projected Patient Days	ALOS	# cases
1460	85%	1,241	8	155

12) Provide how direct cost per day was computed for inpatient behavioral health care at MidState and at THOCC.

The direct cost per day at both MidState and THOCC were calculated using the same cost methodology.

Direct cost per day for MidState was developed using the cost accounting module within the EPSI decision support software. Total direct costs were then divided by total patient days to arrive at the average direct cost per day.

The cost of care per day at THOCC was based on total direct cost of the inpatient psychiatric unit during FY 2011 divided by the total patient days for that unit.

Direct costs for the proposed newly expanded unit at THOCC includes additional staffing costs to accommodate the incremental volume.

The Applicants believe that this proposal offers a cost-effective solution benefitting payors and consumers alike.

13) Provide a description of the services or therapies currently available at THOCC for inpatient behavioral health patients that are not currently available at MidState.

THOCC has specialized group therapy sessions related to specific diagnoses or treatment needs. These include dialectic behavioral therapy (DBT), cognitive behavioral therapy (CBT) and individual supportive therapy for all patients experiencing psychosis. MidState, due to its size, does not offer similar services as it is difficult to assimilate a group of patients with similar treatment needs.

14) What additional services or therapies will be added to those listed above that will be available at THOCC after the expansion of the inpatient unit?

Currently, there are no plans to add additional services or therapies. However, the design of the THOCC proposed unit will permit the physical separation of patients based on clinical acuity or diagnosis, and expansion of the scope of therapeutic activities, including occupational therapy. The unit will also feature a quiet/activity room which will enable clinicians to de-escalate patients to avoid the use of seclusion and restraint. The ability to tailor services to a patient's specific needs is less achievable on a unit of MidState's size.

THOCC currently employs three psychiatrists to provide care for THOCC's inpatient behavioral health services. Dr. Michael Balkunas, Chief of Psychiatry, and Dr. Christopher Yergen, both have advanced training and expertise in treatment of individuals with psychosomatic disorders. Dr. Balkunas and Dr. Mihai Caratas both also specialize in the treatment of substance abuse and are conversant in Spanish. All three psychiatrists provide office-based treatment for individuals with opiod dependence.

15) Please answer the following questions concerning the transportation between MidState and THOCC:

a) How will MidState inform patients and their families of the availability of transportation assistance from MidState to THOCC campus?

MidState and THOCC will provide informational written materials describing transportation assistance for each patient and his/her family to receive in the MidState ED and upon inpatient admission at THOCC. Personnel at both facilities

will discuss visitation hours at THOCC and other aspects of family involvement in treatment with loved ones as appropriate. At these discussion points, and at any time thereafter, it will be determined if loved ones need assistance with transportation.

b) Through which account will the transportation costs be paid?

The cost associated with transportation assistance will be provided for in MidState's operating budget.

c) Under what conditions would a person be unable to use public transportation and therefore qualify for hospital-provided transportation between the MidState and THOCC?

Examples of conditions that would preclude the use of public transportation include but are not limited to the following:

Public transportation schedule, inclement weather, infirmity or advanced age.

Taxi vouchers will be utilized at times when bus schedules conflict with a family member's attendance at meetings or visiting hours or at any time public transportation does not adequately meet the needs of patients and families.

d) How long will MidState maintain the transportation assistance?

MidState and THOCC intend to maintain the transportation assistance program as long as needed to serve the community.

16) On page 15 of the CON application it states that the Master Facilities Plan for MidState is currently under development. When will the Master Facilities Plan be available? How will MCC utilize the six beds currently used for inpatient behavioral health services, if the proposal is approved?

MidState anticipates that its Master Facilities Plan will be completed during FY13. The recommendations in this plan may influence the future use of the vacated space.

17) Question 2c of the CON application asked that the Applicant provide information on each provider to whom the Applicant proposes to transfer or refer clients. In response, the Applicant reported only the average occupancy rate for THOCC. However, Table 2 on page 10 listed numerous other providers, such as the Institute of Living, Saint Francis Hospital and Medical Center St. Vincent's Hospital and Masonicare. The combined number of patients transferred in FY 2011 to these facilities was 162. Please provide information on additional service providers that may receive transfers from MidState.

One of the main benefits resulting from this proposal is the significant reduction in the number of patients that will need to be transferred to facilities outside of the community.

MidState routinely transfers behavioral health patients to providers with whom there is an established referral relationship. The providers with whom MidState has a referral relationship are included in Table 2, page 10 of the CON Application. Additional considerations in patient placement are patient preference and bed availability.

18) Question 2d requested that any special populations that utilize the services be identified and to explain how these patients would continue to access this service after the service location closes. Please readdress the question, as the response provided on page 18 of the CON application reported two populations that MidState does not admit as inpatients.

There are no special populations of patients currently utilizing inpatient behavioral health services at MidState.

19) It was stated on page 20 of the CON application that MidState has recently experienced an increase in illness severity on the inpatient unit and longer than normal wait times for available beds for patients at State facilities. Please expand on this statement with supporting information or documentation. How does the lack of beds at a State facility affect MidState's inpatient unit? What effect will the illness severity and longer wait times have on the expanded inpatient unit at THOCC?

The length of stay of patients greater than 21 days was reviewed for FY 10, FY 11 and FY 12 YTD. The table below lists the number of patients who remained on the MidState inpatient unit for greater than 21 days. The length of stay ranged from 24 – 67 days among the 25 patients listed below.

Fiscal Year	# of patients w/ LOS > 21 days	# of patients who were discharged to a state facility
2010	7	1
2011	5	1
10 Months	13	3

If a patient were to remain hospitalized for 67 days, capacity would be reduced by 9 patients, assuming an ALOS of 6-7 days.

The impact of patients with long lengths of stay is likely to be less noticeable at THOCC because it is a much larger unit. The additional capacity provided by the addition of four (4) inpatient beds at THOCC is expected to further mitigate the impact of any long lengths of stay.

20) Explain the services that MidState currently provides on an outpatient basis for persons requiring behavioral health treatment. Include where the services are provided and the capacity of each program.

MidState does not currently provide outpatient behavioral health services. Outpatient behavioral health services for the MidState community are provided by Rushford Center, Inc. and by community physicians and community health centers.

21) Discuss the services that Rushford currently provides to residents of the greater Meriden area, including the capacity of each program. How will Rushford enhance these community-based services?

OUTPATIENT SERVICES - MERIDEN
Capacity - 1200

Outpatient Clinic provides counseling to individuals 18 and over who have severe and persistent mental illness and are designed to assist the client to achieve goals related to such areas as psychological or social functioning, self-esteem, coping abilities, or opportunities in the vocational, social, or educational realms. Service modalities include group and individual therapy, as well as medication management. Frequency and duration of clinical contact are arranged to meet the needs of the individual. All persons receive a preliminary assessment to determine the appropriateness for treatment, level of care needed, and a disposition to the appropriate treatment group. Treatment plans are reviewed and updated regularly, and clinicians are provided clinical supervision on a weekly or as-needed basis. Rushford also contracts with the State of CT Court Support Services Division to work with clients who are on probation and need mental health services.

OUTPATIENT SERVICES - WALLINGFORD
Capacity 20

This service is funded by the town of Wallingford to serve any residents who are un-insured or under insured needing short term intervention to resolve stressors in their lives. We offer individual and group counseling and assistance with determining their eligibility for health care benefits

PHP/IOP
Capacity - 30

The Partial Hospitalization Program (PHP) provides 20 hours of care per week to patients with profound or disabling mental health conditions. Treatment is individualized, intensive, and comprehensive and employs an interdisciplinary approach. The Intensive Outpatient Program (IOP) provides a step-down in care from the PHP and runs three days per week. For both programs the client needs to be capable of regularly following and attending the program detailed in the treatment

plan. Also, the client's primary DSM-IV diagnosis must be in one of the following categories: Schizophrenia Spectrum Disorders; Delusional Disorder; Psychotic Disorder, NOS; Mood Disorders.

Community Supports Program/Recovery Pathways
Capacity - 398

Case managers use motivational interviewing, skills building, coaching, counseling, and modeling to assist the client in learning new skills. The Community Supports Program (CSP) is for clients who need more intensive case management (at least three meetings/month). Recovery Pathways (RP) is for clients who have fewer case management needs (generally only one meeting/month). The goal is to provide an integrated approach to develop a collaborative plan to achieve goals and monitor the ongoing services. Some of these services include financial supports, entitlements, housing, and client education.

LATINO SERVICES
Capacity - 250

Services are provided by an integrated group of professionals entirely dedicated to the delivery of culturally sensitive services to the Spanish-speaking population. Therapeutic approach is multidisciplinary where medication management, therapy, and case management (for those who qualify) are combined. Individual therapy is a short-term therapeutic approach with the main focus on assessing the client's needs and/or providing some extra support when needed. Group therapy addresses issues such as depression, anger management, basic coping skills, and relapse prevention (from substance abuse). Latino case managers work collaboratively with employment specialists (from Kuhn Employment Services) assisting Latino clients to become part of the workforce.

SUBSTANCE ABUSE
Capacity - 180

The Intensive Outpatient Program (IOP) provides structured, flexible-stay group therapy and drug education groups well as an introduction to a 12-step program. Treatment services help individuals develop the skills and confidence they need to cope successfully with the problems caused by substance abuse while offering the advantages of working and living at home.

Relapse prevention services groups are held day or evening, one or two times per week as needed. This service helps the individual to understand relapse as a process that begins before picking up a drink or drug, to recognize warning signs and high-risk situations, and to take effective actions to prevent relapse.

CRISIS STABILIZATION PROGRAM

The crisis stabilization program, funded primarily by DMHAS through state and federal grants plus a small portion of funding from insurance revenues for client service delivery, is a coordinated crisis response service for residents of Meriden and Wallingford. A telephone hotline operates 24/7 and is answered by trained mental health counselors and licensed clinicians as part of a collaborative with River Valley Services. The Respite Program has 10 beds and is designed to avoid visits to the emergency department or for further psychiatric stabilization to avoid re-hospitalization. Mobile Crisis coverage provides risk and psychological assessment of clients in the community and clients who arrive at the Paddock Avenue site seeking assistance, also part of a collaborative with RVS. Community Outreach/Education provides community education and information sessions to police, nurses, residential care settings, and other community groups, and also provides debriefing for Rushford staff and community members following traumatic events. The MidState Medical Center Acute Behavioral Unit is funded by a separate contract with MidState Medical Center. A psychologist or LCSW provides emergency evaluation and placement of behavioral patients in the Emergency Department 17 hours/day, seven days/week.

CAREER DEVELOPMENT SERVICES (KUHN)
Capacity - 120

Staffing includes six employment specialists (including one bilingual) and one support specialist. The goal of the program is to place individuals in competitive jobs that meet their interests and needs within their own community. Services include vocational planning, job-seeking skills training, and placement follow-up support.

FRIENDSHIP CLUB
Capacity - 88

The Friendship Club is a social rehabilitation program for adults who live with chronic mental health issues. The Club is a place where members feel comfortable and safe. More importantly, the Friendship Club is a community of individuals who want to achieve more in their lives. The program offers various opportunities to learn valuable skills, participate in peer support groups, attend recreational out trips, and develop lifetime social connections. Social rehabilitation staff members assist in goal planning and give support in personal and financial matters.

NEXT STEP
Capacity - 4

The Next Step program has four certificates that expand and contract per the size of the families. All housing issues are handled through J.D. Almelia, while case management is handled through Rushford housing staff. All housing decisions (who to house, who to discharge, etc.) are made through a committee comprised of area providers who meet on the last Wednesday of every month.

PILOTS (MERIDEN)
Capacity - 17

The Pilots program has 17 certificates (14 one-bedroom apartments and three two-bedroom apartments). Clients must be chronically homeless per the HEARTH ACT definition and must be DMHAS-eligible. Apartment sizes are static and do not change as the family size changes (funding is per the above unit distribution).

For both Pilots and Shelter Plus Care (see below), all clients are assigned a housing specialist (case manager). Participation with mental health services is optional. The case manager handles all housing paperwork (leases, contracts, etc.) and serves as a liaison between the client and the landlord. For fiscal reasons, all the Pilots and Shelter Plus Care certificates have been combined into the same grant.

SHELTER PLUS CARE
Capacity - 22

The Shelter Plus Care program has 22 certificates (three efficiencies, 14 one- bedroom apartments, three two-bedroom apartments, and two three-bedroom apartments). Clients must be chronically homeless per the HEARTH ACT definition and must be DMHAS-eligible. Apartment sizes are static and do not change as the family size changes (funding is per the above unit distribution).

LIA CASE MANAGEMENT
Capacity - 15

Rushford staff members work with Rushford clients not in case management to establish and maintain medical and SNAP benefits, collaborate with DSS and Social Security to ensure client benefits, and maintain appropriate records on clients as established by law.

HOMELESS OUTREACH
Capacity - 30

Homeless outreach staff members identify and establish contact with the population in the community that is either literally/chronically homeless or at immediate risk of losing their housing. Services include assistance with obtaining and maintaining benefits and safe and stable housing, and teaching skills to sustain safe and stable housing. Outreach/case management personnel work closely with other community providers to help insure that the needs of their clients are met.

CAMP STREET (TRANSITIONAL LIVING PROGRAM)
Capacity - 6

Camp Street is a six-bed facility to transition male clients coming out of Dutcher Hall at CVH back into the community. The length of stay is between six to nine months, up to a possible 12 months. Staffing is 24 hours/day, seven/days a week with a staffing ratio of 3:1. Clients work with the CSP/RP Model, individual recovery plans (IRPs), and life skills curriculum and receive mental health and substance abuse treatment and medication management at Rushford Center.

COMMUNITY BASED INITIATIVE PROGRAM (CBI)
Capacity - 26

CBI (Community Based Initiative) is a 24-hour Community Supports Program which provides services for up to 26 DMHAS clients who are diagnosed with a chronic mental illness. Program clients reside in their own apartments in one of two buildings and carry their own lease. There are on-site staff apartments at both buildings. The purpose of the program is to teach all program clients the skills necessary for them to maintain their own apartments.

JAIL DIVERSION PROGRAM
Capacity - 75

The jail diversion program provides rapid assessment and referral to clinical services for persons with mental health diagnoses in the Meriden and Wallingford area. Clients can be in pre-arraignment lock-up, out on bond, or on a promise to appear, and are usually seen at the courthouse in Meriden. Community re-integration for sentenced persons is facilitated through collaboration with the Department of Corrections, police departments, court systems throughout the state, probation/parole, and other community providers.

As described above, Rushford maintains a significant array of outpatient programs for the MidState service area. Rushford in cooperation with MidState, plans to enhance these community-based services in the following manner:

1) **Create a community- based alternative to inpatient psychiatric hospitalization:**

   Rushford will provide access to its existing 10-bed Crisis Stabilization/Respite unit at 883 Paddock Avenue, Meriden for patients in the Partial Hospital Program (PHP), also located at the Paddock site. This will allow Rushford to provide ambulatory care services with 24-hour support for lower-risk clients who may otherwise require inpatient hospitalization. This option will be available, based on appropriate clinical criteria, for patients in the MidState ED and for patients on the expanded THOCC inpatient unit. It is estimated that 50 additional patients per year would be served in this setting. These admissions would account for 500 patient days at an anticipated average length of stay of 10 days.

2) **Increase the number of clients connected with Primary Care in the MidState community and Psychiatric Services at Rushford in order to provide enhanced coordination of care, increase early intervention with the hope of reducing relapses or deterioration.**

3) **Establish a Behavioral Health Proactive Management Team at MidState:**

Through its contract with Rushford, MidState will establish a behavioral health intervention team to provide proactive management of co-morbid psychiatric and/or substance abuse conditions based on a standardized model. The BIT is comprised of a psychiatrist, nurse practitioner, and licensed social worker. The team reviews all medical/surgical hospital inpatient and ED admissions and identifies patients who may be at risk of, or experiencing psychiatric or substance use disorders. The team conducts assessments on these patients and makes referrals, as appropriate, to behavioral health services.

22) Specifically describe how MidState and Rushford will work together to enhance community-based services.

The Hartford HealthCare Behavioral Health Network is committed to developing a fully integrated network for the delivery of behavioral health services in Central Connecticut.

Hartford Healthcare's Behavioral Health Network (BHN) currently includes the psychiatric services of MidState Medical Center, The Hospital for Central Connecticut, The Institute of Living, Natchaug Hospital and Rushford Center, Inc. As stated in question 20 herein, MidState does not provide outpatient services while other members in the BHN do provide community-based care and treatment.

Behavioral Health Leaders from each of the entities of the BHN meet twice a month to discuss strategy and operations for both inpatient and outpatient behavioral healthcare provided by the System. With input from each entity, strategies are developed to improve care across the continuum, which are then implemented by project teams. In FY 2012, eight (8) project teams were tasked with enhancing inpatient and outpatient community based services. Another team is focused on strategies to strengthen the PHP/IOP programs throughout the System to improve access.

Leadership from Rushford, MidState and THOCC will be included in a monthly forum that will monitor operations and transitions of care between the two acute care hospitals. This group will also focus on utilizing our community resources and network partners to create enhanced outpatient services.

In addition, the role of Rushford's Community Liaison will be expanded to provide onsite contact with clients hospitalized at THOCC to plan and expedite discharges back to the community on a timely and coordinated basis.

Please see response to Question # 21 above for specific examples of how MidState, THOCC and Rushford will work together toward this end.

23) Explain why there is a clear public need for the proposal. Provide evidence that demonstrates this need.

The healthcare needs of the public are best addressed when care is highly coordinated, efficiently delivered and is of high quality. When healthcare services are delivered in this manner, they provide a great value to the residents of the State.

To ensure the long-term stability of the health care system in Connecticut, providers must engage in responsible and innovative planning of services or their ability to remain vibrant and thrive in the community is jeopardized.

Currently, the delivery system for behavioral health services in Central Connecticut is fragmented and not efficiently provided. Fragmented, poorly coordinated care leads to higher admission and readmission rates and longer lengths of stay. Through the alignment of System resources and the oversight of the BHN, this proposal will improve the Applicants' ability to provide high quality, cost-effective, personalized and coordinated care for the residents of Central Connecticut.

Exhibit 1

Response to Completeness Question # 6

MidState Medical Center
Certificate of Need Application DN12-31775-CON
Proposal to Terminate Inpatient Behavioral Health Services
Completeness Question # 6

MidState Medical Center
FY 2011 Discharges from
Inpatient Behavioral Health Unit
by Race

Description	Discharges
African American / Black	23
Asian	2
Hispanic or Latino	66
Other	7
White	184
	282

MidState Medical Center
FY 2011 Discharges from
Inpatient Behavioral Health Unit
by Gender

Gender	Discharges
Female	155
Male	127
	282

MidState Medical Center
FY 2011 Discharges from
Inpatient Behavioral Health Unit
by Age Group

Age Group	Discharges
18-44	162
45-64	109
65+	11
	282

MidState Medical Center
FY 2011 Discharges from
Inpatient Behavioral Health Unit
by Primary Payer

Payer	Discharges
Commercial	68
Medicaid	117
Medicare	85
Uninsured	12
	282

MidState Medical Center
FY11 Inpatient Behavioral Health Discharges by Town

Norwalk	1	Newington	1
Shelton	1	East Haven	1
Bristol	1	Hamden	3
East Hartford	1	North Branford	2
Columbus	1	New Britain	4
Clinton	1	Waterbury	4
Cromwell	1	Berlin	1
Durham	1	North Haven	2
Old saybrook	1	Southington	6
Beacon Falls	1	Middletown	6
East Berlin	1	Cheshire	9
Naugatuck	1	Wallingford	39
Colchester	1	Meriden	182
New Haven	1	Brooklyn	1
Hartford	1	Other States	6
		Grand Total All Towns	282

MidState Medical Center
Certificate of Need Application DN12-31775-CON
Proposal to Terminate Inpatient Behavioral Health Services
Completeness Question # 6

MidState Medical Center
FY 2011 Discharges from
Inpatient Behavioral Health Unit
by Primary Diagnosis

Description		Discharges
292.11	DRUG IND PSY DIS W/DELUSIONS	2
295.3	PARANOID SCHIZ-UNSPEC	3
295.32	PARANOID SCHIZ-CHRONIC	2
295.34	PARANOID-CHR/EXACERB	16
295.7	SCHIZOAFFECTIVE-UNSPEC	44
295.72	SCHIZOAFFECTIVE-CHRONIC	3
295.74	SCHIZOAFF-CHR/EXACER	1
295.9	SCHIZOPHRENIA NOS-UNSPEC	2
295.92	SCHIZOPHRENIA NOS-CHR	1
296.2	MDD, SINGLE EPISODE, NOS	6
296.22	MDD, SINGLE EPISODE-MOD	3
296.23	MDDSINGLE EPISODE-SEVERE	7
296.24	MDD-SEV W PSYCH	5
296.32	RECURRENT MDD-MOD	14
296.33	RECURRENT MDD-SEVERE	65
296.34	RECURRENT MDD-SEV PSYCH	21
296.4	BAD, MANIC-UNSPEC	5
296.44	BAD-SEV W PSYCH	1
296.5	BID, DEPR-UNSPEC	13
296.52	BID, DEPRESSED-MOD	2
296.53	BID, DEPRESS-SEVERE	9
296.54	BID, DEPRESS SEV W PSYCH	9
296.6	BID, MIXED-UNSPEC	4
296.8	BIPOLAR DISORDER UNSPEC	7
296.81	ATYPICAL MANIC DISORDER	1
296.82	ATYPICAL DEPRESS DISORD	2
296.89	BIPOLR DISORDR OTHER	4
296.9	UNSPEC EPISD MOOD DISOR	7
297.9	PARANOID STATE NOS	1
298.9	PSYCHOSIS NOS	4
300.3	OBC DISORDER	1
300.4	DYSTHYMIC DISORDER	2
309	ADJUSTMNT DIS W/DEPRESD MOOD	3
309.28	ADJUST DIS-MIX ANX AND DEPRESD	1
311	DEPRESSIVE DISORDER NEC	9
780.97	ALTERED MENTAL STATUS	1
V65.2	PERSON FEIGNING ILLNESS	1
		282

MidState Medical Center
FY 2011 Discharges from
Inpatient Behavioral Health Unit
by Discharge Status

Discharge Disposition	Discharges
Acute Care Hospital	3
Home Routine	250
Home with Home Care	13
Inpatient Psychiatric Facility	9
Skilled Nursing Facility	7
	282

Exhibit 2

Response to Completeness Question # 8

MidState Medical Center
FY 2011 Transfers of Behavioral Health Patients
Patients Age 18 and Older
Emergency Department to Other Acute Care Facilities

Hospital	FY09 Transfers	FY10 Transfers	FY11 Transfers	Distance (miles) to MidState	Time of Travel to MidState
Hartford Hospital / Institute of Living	41	23	29	22	26 mins.
Natchaug Hospital	8	11	6	46	57 mins.
THOCC		1	1	9	18 mins.
Saint Francis Hospital & Medical Center	79	23	35	24	28 mins.
St. Vincents Hospital	33	46	42	38	47 mins.
Yale-New Haven Hospital	11	3	6	24	28 mins.
Waterbury Hospital	1		1	17	23 mins.
Hospital of Saint Raphael			1	23	29 mins.
University of Connecticut Medical Center	12	6		15	28 mins.
Connecticut Valley Hospital		4	2	10	20 mins.
Masonicare	30	27	29	9	12 mins.
Sharon Hospital	10	10	5	60	1 hour, 21 mins.
Hebrew Healthcare	25	19	12	25	34 mins.
Silver Hills	6	10	3	55	1 hour, 8 mins.
Greater Bridgeport Mental Health	1	1		39	48 mins
Manchester Memorial Hospital	5	3	1	27	34 mins.
Connecticut Mental Health Care - New Haven	1			24	28 mins.
Capital Region		1		23	30 mins
Stamford Hospital			1	61	1 hour, 16 mins.
	263	188	174		

Exhibit 3

Response to Completeness Question # 9

MidState Medical Center

Admissions from the MidState Emergency Department to Inpatient Behavioral Health Unit by Principal Diagnosis

PRIMARY ICD9 DIAGNOSIS	PRIMARY ICD9 DIAGNOSIS DESC	Treatment Behavioral Health / Substance Abuse	Dual Diagnosis	FY09 CASES	FY10 CASES	FY11 CASES
296.33	RECURRENT MDD-SEVERE	Behavioral Health	n/a	22	52	54
295.7	SCHIZOAFFECTIVE-UNSPEC	Behavioral Health	n/a	41	34	44
296.34	RECURRENT MDD-SEV PSYCH	Behavioral Health	n/a	13	16	19
295.34	PARANOID-CHR/EXACERB	Behavioral Health	n/a	2	6	15
296.5	BID, DEPR-UNSPEC	Behavioral Health	n/a	10	8	12
296.32	RECURRENT MDD-MOD	Behavioral Health	n/a	23	0	10
296.53	BID, DEPRESS-SEVERE	Behavioral Health	n/a	4	5	8
296.54	BID, DEPRESS SEV W PSYCH	Behavioral Health	n/a	3	2	8
296.23	MDDSINGLE EPISODE-SEVERE	Behavioral Health	n/a	10	6	7
296.9	UNSPEC EPISD MOOD DISOR	Behavioral Health	n/a	2	7	7
296.2	MDD, SINGLE EPISODE, NOS	Behavioral Health	n/a	8	4	6
296.8	BIPOLAR DISORDER UNSPEC	Behavioral Health	n/a	15	4	6
296.4	BAD, MANIC-UNSPEC	Behavioral Health	n/a	3	0	4
296.6	BID, MIXED-UNSPEC	Behavioral Health	n/a	2	4	4
296.89	BIPOLR DISORDR OTHER	Behavioral Health	n/a	6	8	4
298.9	PSYCHOSIS NOS	Behavioral Health	n/a	6	8	4
311	DEPRESSIVE DISORDER NEC	Behavioral Health	n/a	14	11	4
295.72	SCHIZOAFFECTIVE-CHRONIC	Behavioral Health	n/a	1	1	3
296.24	MDD-SEV W PSYCH	Behavioral Health	n/a	5	1	3
292.11	DRUG IND PSY DIS W/DELUSIONS	Behavioral Health	n/a	0	0	2
295.3	PARANOID SCHIZ-UNSPEC	Behavioral Health	n/a	6	2	2
295.32	PARANOID SCHIZ-CHRONIC	Behavioral Health	n/a	3	6	2
295.9	SCHIZOPHRENIA NOS-UNSPEC	Behavioral Health	n/a	2	1	2
296.22	MDD, SINGLE EPISODE-MOD	Behavioral Health	n/a	10	1	2
296.52	BID, DEPRESSED-MOD	Behavioral Health	n/a	2	0	2
300.4	DYSTHYMIC DISORDER	Behavioral Health	n/a	1	0	2
309	ADJUSTMNT DIS W/DEPRESD MOOD	Behavioral Health	n/a	0	0	2
295.74	SCHIZOAFF-CHR/EXACER	Behavioral Health	n/a	5	6	1
295.92	SCHIZOPHRENIA NOS-CHR	Behavioral Health	n/a	1	0	1
296.44	BAD-SEV W PSYCH	Behavioral Health	n/a	1	7	1
296.81	ATYPICAL MANIC DISORDER	Behavioral Health	n/a	2	0	1
296.82	ATYPICAL DEPRESS DISORD	Behavioral Health	n/a	4	3	1
297.9	PARANOID STATE NOS	Behavioral Health	n/a	0	0	1
300.3	OBC DISORDER	Behavioral Health	n/a	0	0	1
309.28	ADJUST DIS-MIX ANX AND DEPRESD	Behavioral Health	n/a	0	0	1
780.97	ALTERED MENTAL STATUS	Behavioral Health	n/a	0	0	1
V65.2	PERSON FEIGNING ILLNESS	Behavioral Health	n/a	0	0	1
291.81	ALCOHOL WITHDRAWAL	Behavioral Health	n/a	1	0	0
294.8	OTHER PERSIS MEN DIS CLASS EL	Behavioral Health	n/a	1	0	0
295.6	RESIDUAL SCHIZ UNSPEC	Behavioral Health	n/a	2	0	0
295.62	RESIDUAL SCHIZ-CHR	Behavioral Health	n/a	3	0	0
296.21	MDD, SINGLE EPISODE-MILD	Behavioral Health	n/a	1	0	0
296.3	RECURRENT MDD-UNSPEC	Behavioral Health	n/a	7	4	0
296.31	RECURRENT MDD-MILD	Behavioral Health	n/a	0	1	0
296.41	BAD, MANIC-MILD	Behavioral Health	n/a	1	0	0
296.42	BAD, MANIC-MODERATE	Behavioral Health	n/a	2	0	0
296.43	BAD, MANIC SEVERE	Behavioral Health	n/a	0	1	0
296.55	BID, DEPRESS-PART REMISS	Behavioral Health	n/a	0	2	0
296.62	BID, MIXED-MOD	Behavioral Health	n/a	5	0	0
296.63	BID, MIXED-SEVERE	Behavioral Health	n/a	0	2	0
296.64	BID-SEV W PSYCH BEHAV	Behavioral Health	n/a	2	5	0
297.1	DELUSIONAL DISORDER	Behavioral Health	n/a	2	1	0
298.1	EXCITATIVE TYPE PSYCH	Behavioral Health	n/a	0	1	0
300.01	PANIC DISORDER WO AGORA	Behavioral Health	n/a	0	1	0
303.01	AC ALCOHOL INTOX-CONT	Behavioral Health	n/a	1	0	0
309.81	POSTTRAUM STRESS DISORDER	Behavioral Health	n/a	1	1	0
312.34	INTERMIT EXPLOSIV DISORD	Behavioral Health	n/a	0	1	0
572.2	HEPATIC ENCEPHALOPATHY	Behavioral Health	n/a	0	1	0
648.43	MENTAL DISORDER-AP	Behavioral Health	n/a	1	5	0
648.44	MENTAL DISORDER-PP	Behavioral Health	n/a	0	1	0
969.4	POIS-BENZODIAZEPINE TRAN	Behavioral Health	n/a	1	0	0
				258	230	248

00208 (9/18/12)

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

October 1, 2012

Via Fax and Regular Mail

Barbara A. Durdy
Director, Business Development
MidState Medical Center
435 Lewis Avenue
Meriden, CT 06451

RE: Certificate of Need Application; Docket Number: 12-31775-CON
MidState Medical Center, the Hospital of Central Connecticut, and Hartford HealthCare Corporation
Termination of Inpatient Behavioral Health Services at MidState Medical Center

Dear Ms. Durdy:

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 determined that the above-referenced application has been deemed complete as of September 28, 2012.

If you have any questions regarding this matter, please feel free to contact me at (860) 418-7032.

Sincerely,

Laurie K. Greci

Laurie K. Greci
Associate Research Analyst, DPH/OHCA

Copy: Claudio Capone, Director, Strategic Business Planning & Physician Relations, The Hospital of Central Connecticut
Karen Goyette, Vice President, Strategic Planning & Business Development, Hartford HealthCare Corporation

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3066
RECIPIENT ADDRESS	912038947601
DESTINATION ID	
ST. TIME	10/01 14:54
TIME USE	00'18
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Barbara Durdy

FAX: 203 694 7601

AGENCY: MidState Med Ctr

FROM: Laurie Greci

DATE: 10/1/2012 TIME: 2:45

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Re: 12-31775-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3067
RECIPIENT ADDRESS	98602245740
DESTINATION ID	
ST. TIME	10/01 14:55
TIME USE	00'20
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Claudio Capone

FAX: 860 224 5740

AGENCY: NOCC

FROM: Laurie Greci

DATE: 10/1/2012 TIME: 2:45

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: RE: 12-31775-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3068
RECIPIENT ADDRESS	98605452127
DESTINATION ID	
ST. TIME	10/01 14:56
TIME USE	00'23
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Karen Goyette

FAX: 860 545 2127

AGENCY: Hartford HealthCare

FROM: Laurie Greci

DATE: 10/1/2012 TIME: 2:45

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: RE: 12-31775-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

TO: Kevin Hansted, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: October 10, 2012

RE: Certificate of Need Application; Docket Number: 12-31775-CON
MidState Medical Center
Proposal to Terminate Inpatient Behavioral Health Services

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 34038
Hartford, Connecticut 06134-0308
www.ct.gov/dph

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

October 12, 2012

Ms. Barbara A. Durdy
Director, Business Development
MidState Medical Center
435 Lewis Ave.
Meriden, CT 06451

RE: Certificate of Need Application, Docket Number 12-31775-CON
MidState Medical Center
Proposal to Terminate Inpatient Behavioral Health Services

Dear Ms. Durdy:

With the receipt of the completed Certificate of Need ("CON") application information submitted by MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation ("Applicants") on September 28, 2012, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Applicants:	MidState Medical Center The Hospital of Central Connecticut Hartford HealthCare Corporation
Docket Number:	12-31775-CON
Proposal:	Termination of Inpatient Behavioral Health Services at MidState Medical Center

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: November 7, 2012

Time: 3:00 p.m.

Place: Four Points by Sheraton Meriden
275 Research Parkway, Meriden, Connecticut 06450

The Applicants are designated as party in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in the *Record Journal* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association
Claudio Capone, Director, Hospital of Central Connecticut
Karen Goyette, VP, Strategic Planning & Business Development

KRM:bc: lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

October 12, 2012 Requisition # 40028

Record Journal
11 Crown Street
Box 915
Meriden, CT 06450-0914

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Monday, October 15, 2012.** Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Brian Carney or Laurie Greci at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:BC:LKG:lmg

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-639
Applicant(s):	MidState Medical Center The Hospital of Central Connecticut Hartford HealthCare Corporation
Town:	Meriden
Docket Number:	12-31775-CON
Proposal:	Termination of Inpatient Behavioral Health Services at MidState Medical Center with no capital expenditure
Date:	November 7, 2012
Time:	3:00 p.m.
Place:	Four Points by Sheraton Meriden 275 Research Parkway, Meriden, Connecticut

Any person who wishes to request status in the above listed public hearing may file a written petition no later than October 30, 2012 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001.

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Friday, October 12, 2012 11:08 AM
To: Greer, Leslie
Subject: Re: Hearing Notice 12-31775-CON

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

PLEASE NOTE: New Department of Labor guidelines allow web base advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Friday, October 12, 2012 10:58 AM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice 12-31775-CON

To Whom It May Concern,
Please run the attached hearing notice in the Record Journal no later than October 15, 2012. For billing purposes, please refer to requisition #40028. Please call me if you have any questions.

Thank you,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca
Please consider the environment before printing this message

Greer, Leslie

From: Laurie <Laurie@graystoneadv.com>
Sent: Friday, October 12, 2012 4:55 PM
To: Greer, Leslie
Subject: FW: Hearing Notice 12-31775-CON
Attachments: 12-31775np Record Journal.doc

Your legal notice is all set to run as follows:

Meriden Record, 10/15 issue - $170.88

Thanks,
Laurie Miller

Graystone Group Advertising
2710 North Ave., Ste 200, Bridgeport, CT 06604
Ph: 203-549-0060, ext 319, Fax: 203-549-0061,Toll free: 800-544-0005
email: laurie@graystoneadv.com
www.graystoneadv.com

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Friday, October 12, 2012 10:58 AM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notice 12-31775-CON

To Whom It May Concern,
Please run the attached hearing notice in the Record Journal no later than October 15, 2012. For billing purposes, please refer to requisition #40028. Please call me if you have any questions.

Thank you,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

October 23, 2012

Ms. Barbara A. Durdy
Director, Business Development
MidState Medical Center
435 Lewis Ave.
Meriden, CT 06451

RE: Certificate of Need Application, Docket Number 12-31775-CON
MidState Medical Center, The Hospital of Central Connecticut and
Hartford HealthCare Corporation
Proposal to Terminate Inpatient Behavioral Health Services at MidState Medical Center
Request for Prefile Testimony

Dear Ms. Durdy:

The Office of Health Care Access ("OHCA") will hold a public hearing on Wednesday, November 7, 2012, at 3:00 p.m. at the Four Points by Sheraton, 275 Research Parkway, Meriden, Connecticut, regarding the Certificate of Need ("CON") application identified above. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29 (e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation (together herein known as "Applicants") must submit prefiled testimony to OHCA no later than **12:00 p.m.** on **Friday, November 2, 2012.**

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Please contact Laurie Greci at (860) 418-7032 or Brian Carney at (860) 418-7014, if you have any questions concerning this request.

Sincerely,

Kevin Hansted, Esq.
Hearing Officer

Greer, Leslie

From: Martone, Kim
Sent: Thursday, November 01, 2012 12:01 PM
To: Greer, Leslie; Olejarz, Barbara; Greci, Laurie; Hansted, Kevin
Subject: Fw: Behavioral Health Beds at Midstate

----- Original Message -----
From: Judy Hurlbert [mailto:david.hurlbert@gmail.com]
Sent: Thursday, November 01, 2012 11:24 AM
To: Martone, Kim
Subject: Behavioral Health Beds at Midstate

Thank you for taking the time to hear the public regarding the closure of the Mental Health Unit at Midstate Hospital. As a member of CAC 10 of the Regional Mental Health Board and the RVS advisory board I would urge you to take seriously the impact this closure would have on the population of Meriden and Wallingford. You must know that we already suffer from an access problem for those with serious psychiatric disabilities. There is frequently a short window of opportunity for those with a mental health disability to agree to treatment . Further complicating the issue with a drive to an unfamiliar hospital would drastically reduce the chances of that client receiving help. Convenient access is vital to not only treating folks with these illnesses but containing the increased use and cost of emergency room visits and incarceration. These are some of our most vulnerable citizens who already have to deal with societal stigma, prejudice from insurance companies in obtaining medication and generally 25 year shorter life span because of their illness. Please don't make treatment access harder for them. Thank you for listening . Judy Hurlbert

CONNECTICUT LEGAL RIGHTS PROJECT, INC.

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Kevin Hansted – Hearing Officer	Kirk W. Lowry and Jan VanTassel
COMPANY: OHCA	DATE: 11/1/2012
FAX NUMBER: (860) 418-7053	TOTAL NO. OF PAGES INCLUDING COVER: 29
PHONE NUMBER: (860) 418-7032	SENDER'S REFERENCE NUMBER: Dkt# 12-31775-CON
RE: MidState CON	YOUR REFERENCE NUMBER: Dkt# 12-31775-CON

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

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

October 31, 2012

IN THE MATTER OF:

An Application for a Certificate of Need
Filed pursuant to Section 19a-638 by

Mid State Medical Center

Petition to Intervene With Full Procedural Rights

Docket No. 12-31775-CON

Termination of Inpatient Behavioral Health Services

Petition to Intervene With Full Procedural Rights

Pursuant to General Statutes § 4-177a(b) and Regs., Conn. State Agencies § 19a-643-38, the Connecticut Legal Rights Project petitions the Office of Health Care Access to intervene with full procedural rights in the above-captioned matter. Granting this petition to intervene will allow the Connecticut Legal Rights Project to carry out its responsibilities to the State of protecting the legal rights of persons who are eligible for services from the Department of Mental Health and Addiction Services (DMHAS). The proposed intervention is in the interest of justice, and the proposed intervention will not impair the orderly conduct of the proceedings.

1. The Connecticut Legal Rights Project

The Connecticut Legal Rights Project, Inc. (CLRP) is a private non-profit legal services organization created by consent decree filed on

October 24, 1989 in *Doe v. Hogan*, Case No.: H88-239 (EBB). (Consent Decree attached as Exhibit A.) The purpose of the lawsuit was to remedy denial of effective access to the courts as guaranteed by the First and Fourteenth Amendments for psychiatric inpatients in the State of Connecticut. CLRP is incorporated in the State of Connecticut as a nonprofit legal services organization with its main office located in Beers Hall on the campus of Connecticut Valley Hospital (CVH). Pursuant to the provisions of the Consent Order, CLRP staff provide on-site legal services for treatment-related matters at all DMHAS facilities with full access to residents, their living environments and staff. Moreover, CLRP staff regularly conduct informational sessions and meet with key administrators to discuss systemic issues and operational concerns. While CLRP initially served only inpatient clients, the Consent Order anticipated the closure of state hospitals, which occurred in 1995 (Fairfield Hills) and 1996 (Norwich), and authorized CLRP to represent clients in the community. Therefore, CLRP conducts outreach and intake in a range of community locations throughout the state, including outpatient service providers, psychosocial clubs, soup kitchens and shelters. CLRP currently has five attorneys and eight paralegal advocates who are managed by an executive director and legal director. One attorney and one paralegal are assigned on a part time

basis to represent clients in the Greater Meriden region on matters related to their treatment, community integration and civil rights.

In addition, CLRP's attorneys have been actively involved in numerous advisory, planning, policy and oversight entities evaluating the state's mental health system and developing recommendations for improving its scope, efficiency and operations. These include, but are not limited to, the Governor's Blue Ribbon Commission on Mental Health, the Community Mental Health Strategy Board, the Mental Health Block Grant Planning Council, and the Mental Health Transformation Grant Oversight Council. This diverse experience provides a policy context to the casework that CLRP's lawyers and paralegals handle on a daily basis and enriching our understanding of the implications of the Mid State proposal on clients and the overall state system of care.

CLRP's Executive Director is attorney Jan VanTassel whose address is 1000 Silver Street, P.O. Box 351, Beers Hall, 2nd Floor, Middletown, Connecticut 06457.

2. The Connecticut Legal Rights Project and Clients that it Represents will be Affected by the Termination of Inpatient Behavioral Health Services at Mid State Medical Center

CLRP's clients will be directly affected by the termination of inpatient behavioral health services at Mid State Medical Center. The most obvious

impact will be on access to inpatient care in the region, barriers to visits and interaction with family, friends and natural supports, and challenges presented to the continuity of care when inpatient treatment is provided at a facility that is not part of the Meriden-Wallingford community. While all of these can be addressed on paper, it is not possible to measure the real chilling effect that they have on a patient's experience. The additional time, stress and planning involved in visiting a person at a facility even just ten miles away is not simply a matter of distance. Anyone who has had personal experience struggling to visit a loved one understands this reality. The Mid State proposal has already become a topic of concern and source of anxiety for many CLRP clients in the Meriden region. In speaking with clients about the proposed closure of the Mid State inpatient beds, it is apparent that many of them regard the proposed closure as an abandonment of them, particularly in the context of the medical center's prior actions. Mid State Medical Center was originally authorized to operate ten psychiatric beds, four of which were "swing beds" also available to meet the demand for med-surg patients. In fact, those four were used almost exclusively by med-surg patients, even though there was also demand for inpatient psych beds. Five years ago when Mid State applied to close the inpatient psych beds, OHCA denied the request and

ordered Mid State to operate eight inpatient psych beds. Despite documented demand, they never did so. They did follow through with increasing the emergency room beds for psychiatric stabilization, but to many people in recovery this sends a message that they are to be segregated and excluded from options available to other patients. One individual commented that he doubted that the community would be so complacent about the bed closure if the beds served persons with other illnesses.

While Mid State met with many advocacy groups, there has not been a meaningful effort to obtain input and suggestions from people in recovery and address their concerns directly. Nor are there any specific proposals to expand access to community services, including peer support and in-home respite, or emergency room supports. Mid State may claim that this is a 'bold and innovative' proposal, but that is not reflected in the document.

3. CLRP Petitions to Participate as an Intervenor with Full Procedural Rights

The Connecticut Legal Rights Project petitions to participate as an intervenor with full procedural rights. CLRP has specific responsibility to represent DMHAS clients pursuant to the Consent Order, providing a

unique perspective based on more than twenty years of representing clients throughout the state's mental health treatment system. CLRP's testimony can inform and enrich the decision-making process by presenting information on the challenges that our clients have encountered accessing services at all levels of care, and analysis, based on that experience and legal mandates including the Americans with Disabilities Act.

The gridlock at all levels of the mental health system was identified as a major problem in the Blue Ribbon Commission Report issued in July, 2002. Several contributing factors were cited, including:

-Spending on publicly funded community based services has not kept pace with the influx of new client groups entering the system.

*Cost cutting efforts by private sector managed care companies are reducing access to services and forcing people to seek care in the public system.

-Absence of appropriate community services has caused gridlock in the hospital beds making it difficult to discharge those no longer in need of hospitalization and equally difficult to admit people who need acute inpatient psychiatric care.

-A growing number of Connecticut general hospitals have cut back and are considering further reductions in their psychiatric services

because they are no longer able to afford the financial drain of supporting such services.

The relative cost per bed at Mid State as compared to HOCC is startling, and the corporation's desire to address this disparity is understandable. However, it is not clear that this is the only solution to the problem, nor is it the most appropriate in terms of community access to services. More conversation regarding options, including those which would explore truly innovative approaches to preventive and early intervention services as part of the system of care, need to be considered.

For these reasons, we believe that OHCA would benefit from CLRP's participation as an intervenor with full procedural rights.

Respectfully submitted,

Connecticut Legal Rights Project by:

Jan VanTassel, Executive Director

And,

Kirk W. Lowry, Legal Director
Connecticut Legal Rights Project
1000 Silver Street, P.O. Box 351
Beers Hall, 2nd Floor
Middletown, CT 06457

(860) 262-5017
Fax (860) 262-5035
klowry@clrp.org

Certification of Mailing

I hereby certify that above Petition to Intervene has been deposited in the United States Mail on this 31st day of October 2012 to:

Commissioner Dr. Jewell Mullen, MD, MPH, MPA
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134

And to:

Attorney Joan Feldman, Esq.
Shipman & Goodman
One Constitution Plaza
Hartford, CT 06103-1919
Attorney for MidState Medical Center

Kirk W. Lowry

Connecticut Legal Rights Project, Inc.
P.O. Box 351, Silven Street
Middletown, CT 06457

FILED

Oct 24 8 56 AM '89

CLERK
U.S. DISTRICT COURT
HARTFORD, CONN

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

LINDA DOE, ET AL. : CIVIL NO. H88-239 (EBB)

v. :

MICHAEL F. HOGAN, ET AL. : OCTOBER 19, 1989

CONSENT ORDER

WHEREAS, plaintiffs filed this action on May 5, 1988 alleging the defendants failed to provide the plaintiffs with effective access to the courts as guaranteed by the First and Fourteenth Amendments of the United States Constitution; and

WHEREAS, the plaintiffs believe it is in the best interests of all the parties to settle this lawsuit; and

WHEREAS, defendants, without admitting liability, believe it is in the best interests of all parties to settle this lawsuit; and

WHEREAS, all parties consider the terms and conditions of this Order to be a fair, just, and reasonable settlement of this action;

NOW THEREFORE IT BE ORDERED, ADJUDGED, AND DECREED, AS FOLLOWS:

I. DEFINITIONS:

1. "Plaintiffs" shall include the named plaintiffs and the members of the plaintiff class as defined in paragraph 6 of this Consent Order.

2. "Defendants" shall include the named defendants, their successors in office, their agents, employees and assigns.

Attachment A

3. "DMH" means the Connecticut Department of Mental Health.

4. "Legal Assistance Program" means the legal assistance program as described in this Consent Order.

5. "Patient" shall mean any indigent person who resides in a DMH inpatient facility, whether as a result of a voluntary admission, involuntary commitment, emergency commitment, or as a result of involvement with the criminal justice system.

II. CLASS ACTION

6. This case is certified as a class action consisting of all present and future indigent patients of inpatient facilities funded or operated by the Connecticut Department of Mental Health who are or will be in need of legal assistance regarding their admission, treatment, environmental conditions, discharge, and other hospital-related rights under state or federal law or policy.

7. Notice of the Consent Order, as approved by the Court, shall be given to all class members as follows:

a. A notice shall be given to each patient by placing a copy of attached Exhibit A on his or her bed no later than November 10, 1989.

b. Thereafter, all future class members shall receive notice of this decree by receiving a copy of a DMH Patient Handbook which shall include a description of the Legal Assistance Program as outlined in part IV of this Consent Order.

III. GENERAL PROVISIONS

8. Defendants shall establish and maintain an advocacy program for indigent patients of in-patient DMH facilities in accordance with Section IV of this Consent Order.

9. In entering into this Consent Order, State officials do not admit any violation of law and this Consent Order may not be used as evidence of liability in any other civil proceeding.

10. Any violation of provisions of this Consent Order does not create a private right of action. This Consent Order is enforceable only by the parties.

11. The parties agree that this Consent Order is a final judgment in the above-captioned case.

12. The parties reserve the right to withdraw consent in the event that this order is not approved by the Court in its entirety.

13. This Consent Order shall be applicable to and binding upon all the parties, their officers, employees, their agents, assigns and successors.

14. Plaintiffs reserve the right to file a motion for costs and attorneys' fees subsequent to the signing of this order.

IV. LEGAL ASSISTANCE PROGRAM

A. INTRODUCTION

15. The creation of the Legal Assistance Program pursuant to this Order is intended to be a component of a broader legal advocacy system and is intended to supplement, not supplant, these existing services. To the maximum extent possible, these existing services will be coordinated with the Legal Assistance Program and integrated into the broader legal and other advocacy system for all DMH clients.

B. PURPOSE

16. The purpose of the Legal Assistance Program is to ensure that clients of the DMH and especially patients of its inpatient facilities have effective access to the system of justice by providing them with independent advocates and attorneys to protect and enforce their rights and entitlements.

C. SCOPE AND AUTHORITY

17. The Legal Assistance Program has the authority to serve any individual regarded as mentally ill and indigent in the State of Connecticut in accordance with the provisions of paragraphs 18 and 19 of this Agreement. However, consistent with its programmatic priorities and resources, the Program must provide advocacy assistance, including legal advocacy, to all indigent patients of DMH inpatient facilities. These facilities include Fairfield Hills Hospital, Connecticut Valley Hospital, Norwich Hospital, Whiting Forensic Institute, Cedarcrest Hospital, Greater Bridgeport Community Mental Health Center and Connecticut Mental Health Center. The Program must ensure that adequate advocacy services are offered to patients of inpatient facilities before it may provide assistance to other indigent mentally ill individuals.

18. The Legal Assistance Program has the authority to provide advocacy assistance, including legal advocacy, to indigent persons regarded as mentally ill in the State of Connecticut. However, consistent with its priorities and resources, the Program must provide assistance to patients of Department inpatient facilities regarding their admission, treatment, environmental conditions, discharge, and other hospital-related rights under state or federal law or policy. To the extent resources

permit or are available, it may offer its services on noninstitutional issues clearly related to a person's admission or discharge. The Legal Assistance Program shall not provide services, excluding services related to counseling and referral, in non-civil rights cases in connection with claims for damages against the State of Connecticut or any of its officers, departments, employees, boards or commissions; however, the legal assistance program staff may provide legal services and representation in such non-civil rights cases if the staff has attempted unsuccessfully to refer the case to a minimum of three qualified attorneys. In such cases, Legal Assistance Program staff shall maintain documentation of their efforts to refer the case, which shall be available to the Attorney General's Office upon request.

19. The Program shall seek to refer to, or arrange for assistance to be provided by, private attorneys or other public interest organizations on general legal disputes (e.g., wills, divorces, land transactions) with parties other than the State, or any of its officers, departments, employees, boards or commissions, its agents or employees. No program funds shall be used to provide legal services on such general legal issues, except in extraordinary or rare situations and where (1) no other specific resources are available; and (2) the situation is directly or indirectly related to the patient's admission, discharge, course of treatment. The extraordinary circumstances which would permit legal services on a general legal issue are to be directly or indirectly linked to treatment issues such that the resolution of the legal issue would affect the resolution of the particular treatment issue.

20. The design, establishment, operation, and administration of the Program shall insure the independence of Program staff in the provision of legal assistance to their clients. The Program shall perform its functions consistent with the Rules of Professional Conduct, and other applicable rules of legal practice. Subject to the provisions of paragraphs 18 and 19, the professional judgment of Program staff shall be exercised solely for the benefit of its clients, and the desires of any other person or entity shall be disregarded when they would either conflict with the interests of the client or impair the independent judgment of the Program.

21. The establishment, governance, funding, and operation of the Legal Assistance Program will be free from any conflict of interest, to the maximum extent possible, which might arise in its relationship with the State of Connecticut, its public agencies, private mental health agencies funded by the state, and other statewide private, professional, or service organizations involved in provision of mental health care. The funding of the Program by the defendants should be undertaken in a manner which recognizes and minimizes the conflict of interest inherent in its support of the Program.

D. ACTIVITIES

22. The Legal Assistance Program will have the capacity to provide information and referral, advice counseling, individual and group representation, and education to its clients. The Program is not intended to displace or supplant DMH's responsibility to investigate and resolve internally allegations of abuse or neglect.

23. (A) To the extent appropriate and when consistent with the Rules of Professional Conduct, Program staff will attempt to resolve most issues informally,

through discussions with hospital staff, negotiations with clinical supervisors and institutional administrators, and resort to the DMH's internal complaint procedure. In order to facilitate communication and promote early resolution of issues affecting patients rights and program implementation, the DMH and the Legal Assistance Program shall conduct regular meetings on the following basis: Both the Commissioner or his designee and the Program's Board of Directors, as well as the Program's Director, shall meet twice a year to discuss mental health policy issues and other issues affecting the relationship between the Department and the Program. A senior staff person from the Legal Assistance Program may meet regularly with the superintendent of each facility to discuss implementation of the program, including any problems that may arise with respect to program access to patients and records. Staff may also discuss, where appropriate, concerns regarding specific policies or program clients. The Program shall seek the input and advice of the Department of Mental Health prior to adopting policies, changing policies and proposing legislative initiatives unless the Program's Board of Directors determines that prior discussions with the Department of Mental Health would compromise the interests of the Program or the Program's clients. Internal policies of the Program shall not be subject to this requirement. If the Program's Board of Directors makes such a determination, the Program shall give notice to the Department of Mental Health of the basis for its decision, without revealing the nature of the policy. The Department of Mental Health may thereafter challenge the appropriateness of such a determination.

(B) In the event that the Program intends to seek judicial relief against t defendants, whether in their official or individual capacity, without first having attempted informal resolution of the particular issue(s) involved, the Program will give reasonable notice under the circumstances of that intention to the DMH or the Attorney General's Office prior to seeking such relief. The Program shall give notice to the Attorney General's Office of any judgment obtained on behalf of any person who has received or is receiving any form of state assistance and shall provide notice of the institution of suit on every occasion when the Program has knowledge that any party is a recipient of any form of state funding or is a health care facility licensed under Conn. Gen. Stat. S 19a-490 et seq. or is an individual licensed under Conn. Gen. Stat. S-19a-14. State funding shall include receipt of a state grant, contract subsidization, loan or any similar benefit but shall not include specific financial assistance to an individual for basic life support unless notice to the State is specifically required by law.

(C) The Legal Assistance Program may attend, on behalf of a client, regula hospital meetings, treatment team meetings, or portions of such meetings, where the patient has a right to attend or is permitted to attend.

(D) To the extent appropriate, the Program may also represent clients in formal proceedings, if any, concerning admission, releases, medications, treatment, and the enforcement of other related rights. The Program shall not, however represent clients in court proceedings for which legal counsel is otherwise provided by statute, such as proceedings subject to the provisions of Conn. Gen. Stat. SS 17-178, 17-183, 17-192, 17-205d or 17-257s.

24. The DMH will provide regular and reasonable access to the patients, living environments, client meetings, and staff of its inpatient facilities for the Legal Assistance Program. Such access will include reasonable unimpeded contact with patients, without unreasonable disruption of any facility or patient treatment, e.g., scheduled meetings, group therapy, to provide information concerning legal rights and the availability of services under the Program. Contact with hospital staff shall not unduly impede the performance of their duties as determined by the appointing authority.

25. Prior to the commencement of the Legal Assistance Program, the DMH will inform all hospital staff, and new administrative and treatment staff thereafter, of the purpose and activities of the Legal Assistance Program and will facilitate a cooperative relationship between its staff and the Program. The Legal Assistance Program shall recognize the importance of consulting with hospital treatment staff so as not to unnecessarily disrupt the course of treatment. The Program shall similarly endeavor to develop a cooperative relationship with the DMH and its staff which will promote the effective access to the Program's clients.

26. The Legal Assistance Program shall act consistently with state and federal laws protecting confidential information concerning individuals regarded as mentally ill. The DMH will provide prompt and reasonable access to such confidential information consistent with all applicable state and federal laws without unreasonable disruption of any facility or patient treatment with the consent of the patients, his/her guardian, or if the patient is incompetent and lacks a guardian, with the approval of the

Commissioner of Mental Health or his designee. Under Connecticut law, all persons admitted to a mental health facility are presumed to be competent, unless otherwise determined by a court of competent jurisdiction.

E. STAFFING

27. The Legal Assistance Program will be staffed primarily by attorneys and paralegal advocates, with appropriate secretarial and administrative support. The Program will primarily rely on advocates to provide routine assistance to patients. The Program may include law students, consumers of mental health services, and others, as appropriate.

28. All Program staff will be qualified by training, experience, and personal commitment to serve individuals regarded as mentally ill who reside in inpatient facilities of the Department of Mental Health. Program staff will be adequately trained in the laws and policies of the State of Connecticut and the United States which affect mentally ill individuals. Advocates must be supervised by lawyers who have overall responsibility for their activities, and staff lawyers will be supervised by the director or supervising attorney of the Program.

29. The Legal Assistance Program will be phased-in over four years in accordance with paragraph 38 of this Order. The staffing in the fourth year will be a minimum of three patient advocates/paralegals, two attorneys, a director (who may also be an attorney) and two secretaries. The Program, in consultation with its Board of Directors, will retain flexibility regarding staffing, so long as its actions are not inconsistent with the minimal

staffing level in this Consent Order, and in particular, paragraph 31 of this Consent Order and so long as the consent of the Commissioner is first obtained if the staffing is done through the use of independent contractors, rather than the use of employees of the Program.

30. The DMH will provide, on an ongoing basis, appropriate space for a central office and will enter into an agreement with the Legal Assistance Program for the use of such space pursuant to Conn. Gen. Stat. § 17-210a(m). The initial agreement will be for a period of three years, subject to the DMH's reservation of the right to terminate for reasons unrelated to the operation of the Program upon the giving of one year's notice, and will provide space located in Beers Hall, 2nd floor, Connecticut Valley Hospital which contains 13 offices and a conference room. The conference room will be available to other Connecticut Valley Hospital personnel upon request and advance notice. Eleven of the thirteen offices will be furnished with a desk, file cabinet, chair, telephone and local telephone service for each of the Program staff included in the consent order (up to 11 staff members). Inkind support includes ongoing office supplies, copying, postage, utilities and janitorial services. If it is necessary for the Department of Mental Health to move the Legal Assistance Program, the Department of Mental Health will provide appropriate office space for eleven equipped offices in conformance with the space standards established by the Department of Public Works, as well as inkind services described above, and if the Program continues to want to be located in a central office, the DMH shall make all reasonable efforts to provide a central location in the State. Should the Legal Assistance Program elect to

move out of Department of Mental Health space when such space is available, the program will be responsible for all rental costs and support costs and the Department's responsibility for providing inkind support shall cease. Field sites will be located at Norwich Hospital, Fairfield Hills Hospital, and, in the event it is necessary for the DMH to move the central office from Connecticut Valley Hospital, at Connecticut Valley Hospital. Field sites will include a locked room, desk, chair, locked file cabinet and telephone services. At Greater Bridgeport Mental Health Center, Connecticut Mental Health Center, Whiting Forensic Institute, Cedarcrest Hospital, and Connecticut Valley Hospital, an interview room will be provided and will contain a desk, chair, locked file cabinet and telephone service. At locations other than the central office, the DMH will ensure privacy and confidentiality at all times when Program staff are providing client services at each site.

The amount of DMH inkind services and the estimated value of such services is as follows:

Year 1 (based on 8-month contribution) -

Office supplies, copying, postage	$ 840
Office space	78,000
Furniture	1,333
Utilities	20,000
Janitorial	1,800
DMH Total In-Kind	$101,973

Year 2

Office supplies, copying, postage	$ 3,024
Office space	117,000
Furniture	2,100
Utilities	40,000
Janitorial	4,500
DMH Total In-kind	$166,624

Year 3	
Office supplies, copying, postage	$ 4,536
Office space	117,000
Furniture	600
Utilities	50,000
Janitorial	6,300
DMH Total In-kind	$178,436
Year 4	
Office supplies, copying, postage	$ 5,292
Office space	117,000 *
Furniture	600
Utilities	50,000
Janitorial	6,300
DMH Total In-kind	$179,192 *
Four-Year Total	
Office supplies, copying, postage	$ 13,692
Office space	429,000
Furniture	4,633
Utilities	160,000
Janitorial	18,900
Four-Year DMH Total In-Kind	$626,225

* or appropriate value, based on Department of Public Works Space Standards in the event it is necessary for the Department of Mental Health to relocate the program.

The value of inkind services shall not exceed the fourth year total of $179,192, or such other appropriate value based on public works space standards in the event that the Department of Mental Health needs to relocate the program, and shall not exceed the amount for each individual category as indicated above. Notwithstanding the $179,192 limitation, the Department of Mental Health will provide full janitorial services and utility service so long as the Legal Assistance Program is located in a Department of Mental Health facility, and in subsequent years, the level of inkind

services for office supplies, copying, furniture and postage shall remain equivalent to that of year four.

31. By the conclusion of year four, and continuing thereafter, the Program will ensure that an attorney or advocate is available at least three days per week at Fairfield Hills Hospital, Connecticut Valley Hospital, Norwich Hospital, Whiting Forensic Hospital and Cedarcrest Hospital. At Greater Bridgeport Community Health Center and the Connecticut Mental Health Center, a Program attorney or advocate shall be available at least twice a week.

F. STRUCTURE AND DEVELOPMENT

32. In order to promote prompt and effective resolution of advocacy issues affecting its clients, the organization of the Legal Assistance Program shall generally correspond to the administrative structure of the Department of Mental Health in each region.

33. (A) The representatives for the parties agree that, in order to facilitate development of an effective legal assistance program, a qualified legal assistance program from outside Connecticut may be utilized during the start up period of the first year to perform the functions stated below.

(B) The Center for Public Representation in Northhampton, Massachusetts shall initially be awarded the contract as provider for the Legal Assistance Program, on the condition that it shall select a director and assist in training, and initial organization, for not more than 12 months, at which time the Legal Assistance Program shall be constituted as an independent nonprofit Connecticut corporation in accordance with the provisions of subparagraph (C) below. The director shall manage the Legal Assistance Program under the auspices of the Center for Public Representation during the period of the initial provider contract. The contract award with the Center for Public

Representation shall provide for an extension of time to manage the Program for longer than twelve months in case of extraordinary circumstances. In the event that the Center for Public Representation is unable to enter into an agreement to provide such services, then there shall be an award to a new nonprofit Connecticut corporation, to be set up in accordance with subparagraph (C) below.

(C) The Legal Assistance Program corporation shall be a new nonprofit corporation with the capacity to provide the services and to meet the obligations of the program set forth in this Agreement. It must have, or demonstrate the capacity to develop, reasonable expertise and experience in serving institutionalized persons with mental disabilities. There shall be three incorporators of the nonprofit corporation. The plaintiffs and defendants shall each select one incorporator. The third incorporator shall be selected by consensus of the two selected by the parties. The initial Board of Directors of the nonprofit corporation shall be appointed by the incorporators and shall be comprised of three persons with substantial experience and reputation in the creation of institutional legal advocacy systems for persons regarded as mentally ill or other similarly qualified persons. The initial Board members shall adopt bylaws for the corporation. In the event of a conflict between the terms of such bylaws and terms of this Agreement, the terms of this Agreement shall control.

34. The Program will retain sufficient flexibility and discretion to modify the program design, development schedule, and the allocation of staff to specific offices if new information indicates modifications are appropriate. Notwithstanding the foregoing, no modification may be made of the Program's scope and authority, as specified in

Part IV C of this Agreement or the Program's funding, as specified in Part IV G of this Agreement. The duties and obligations of the defendants under this Agreement shall not be modified without the consent of the defendants.

35. The parties agree that this Agreement will be adopted by the court as a final judgment in the above-captioned case. The court shall retain jurisdiction during the four year phase-in. The terms and conditions of this Agreement shall not be construed or interpreted as an admission by, or a finding that the State of Connecticut or any of its officers, departments, employees, boards or commissions have violated any provisions of the law or Constitution of the United States or the State of Connecticut.

36. The Program shall be operated under a contract with the Department of Mental Health, with reasonable reporting and review requirements. The contract is subject to the audit clause requirement of Conn. Gen. Stat. § 7-396a, and the standard contract provisions required for all state contracts.

37. The Legal Assistance Program shall report monthly to the DMH, utilizing the standard mental health information system required of all grant-fund services, and shall furnish the DMH the following information on a quarterly basis:

Number of attorneys and advocates whose services were provided

(FTE if not full-time)

Number of hours of legal services and advocate services

Cost per hour (total of money expended divided by the total hours of service)

Cost of provider overhead

Number of residents receiving services in the quarter, by type of service provided (i.e. — federal benefits, grievance, any other), at

each facility and the average number of hours each resident receives in legal services.

Any information which the DMH deems necessary to evaluate the efficiency and effectiveness of the program and the manner in which the funds of the programs are expended and which is reasonable and non-privileged.

G. FUNDING

38. Subject to the provisions of paragraphs 18 and 19 of this Agreement, the Department of Mental Health will fund all necessary expenses of the Legal Assistance Program up to the maximum annual amount specified in the following schedule:

First year of Program operation	-	$ 90,000.
Second year of Program operation	-	$209,000.
Third year of Program operation	-	$327,600.
Fourth and subsequent years of Program operation (plus reasonable cost of living adjustments in subsequent years, if such adjustments are appropriated by the Legislature and received by DMH for the following DMH accounts: Personal Services, Other Expenses, Mental Health Services Grants and Employment Opportunities Grants.)	-	$397,200.

39. The DMH reserves the right to reduce or withhold contract payment in the event the Program provider materially breaches the contract between the DMH and the provider.

40. To the extent that the population of these inpatient facilities is decreased through transfer of patients to community alternatives, funding for the Legal

Assistance Program should not decrease but the priorities of the Program may be adjusted concomitantly to reflect the needs of these Department clients, consistent with the provisions of Part IV C of this Agreement.

41. In the event that the Program receives funds or assets other than those provided by the DMH pursuant to its contract with the Program, the funding obligation of the DMH specified in paragraph 38 of this Order shall be reduced as follows: for any calendar year in which the Program receives funds or assets, other than those provided by the DMH pursuant to its contract with the Program, in excess of $350,000.00, the funding obligation of the DMH specified in paragraph 38 of this Order shall be reduced by $1.00 for every $2.00 of such funds or assets in excess of $350,000.00. In the event that such a reduction cannot be fully realized in the calendar year in which such funds or assets are received, such reduction shall be applied to the funding obligation of the DMH in the following year(s). The DMH may waive the provisions of this section.

The ceiling on outside contributions provided for in this section shall be increased for any calendar year in the same proportion by which the Northeast Consumer Price Index for the preceding year exceeds the Northeast Consumer Price Index as published by the Bureau of Labor Statistics for the calendar year in which this Judgment is entered. For purposes of this paragraph, the term "Northeast Consumer Price Index" shall be the "Northeast Urban Consumer Price Index for all Urban Consumers," issued by the Bureau of Labor Statistics of the United States Department of Labor. If, at the time adjustment of the ceiling is required, such Northeast Consumer Price Index is no longer issued, the adjustment shall be made by utilizing such other index as is then

generally recognized and accepted for similar determination of the cost of living variations.

Additionally, if for any calendar year the annual inpatient admissions for the preceding year exceeded the annual inpatient admissions for the calendar year in which this Judgment is entered by 25% (twenty-five percent) or more, the ceiling on outside contributions will be adjusted upwards to maintain the same ratio of the amount of the ceiling on outside contributions to annual inpatient admissions which exists for the year in which this judgment is entered.

H. MONITORING AND EVALUATION

42. The Board shall provide ongoing advice on program design, development, and implementation issues, and shall select the director of the Program after consulting with the attorneys for the parties in the event that a) The Center for Public Representation in North Hampton, Massachusetts is not initially awarded the contract as provider for the Legal Assistance Program or b) when the initial program director vacates the position.

43. The Board shall report to the representatives for parties annually on the activities, progress and status of the Legal Assistance Program.

44. Nothing in this agreement or the court order to be issued pursuant thereto shall preclude either party from moving the court for an order modifying or terminating the same based on existing law at the time of the motion.

45. The parties agree that their attorneys will meet no later than the beginning of the program's fourth year of operation to discuss the following two matters: (1)

the use of non-DMH funds by the Program to provide legal services beyond those authorized in Part IV C of this Order; (2) the location of the Program's offices and the desirability of maintaining one central office versus multiple offices for the Program. In the event the parties thereafter agree that this Order should be modified with respect to either or both of these matters, or with respect to any other matter as to which the parties mutually agree, this Order may, with the consent of the Court, be modified to reflect the terms mutually agreed upon by the parties.

PLAINTIFFS

BY:

Martha Stone
Connecticut Civil Liberties
Union Foundation
32 Grand Street
Hartford, CT 06106

Philip D. Tegeler
Connecticut Civil Liberties
Union Foundation
32 Grand Street
Hartford, CT 06106

DEFENDANTS

Michael F. Hogan
Commissioner of Mental Health

BY: CLARINE NARDI RIDDLE
DEPUTY ATTORNEY GENERAL
(ACTING ATTORNEY GENERAL)

Richard J. Lynch
Assistant Attorney General

Thomas J. Ring
Assistant Attorney General
P.O. Box 120
Hartford, CT 06101

So Ordered:

United States District Court Judge

Date

A True Copy
ATTEST:
KEVIN F. ROWE
Clerk, U.S. District Court

Paul C. Horton, M.D. 240 Pomeroy Ave., Suite 205 • Meriden, CT 06450

FAX

Date 11-1-12

Number of pages including cover sheet 7

To Mr. Kevin Hansted

Fax # 860-418-7053

From Paul C. Horton, M.D.

Phone (203) 235-2505

Fax # (203) 235-2506

REMARKS: ☐ Urgent ☐ For your review ☐ Reply ASAP ☐ Please comment

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November 1, 2012

Mr. Kevin Hamsted, Hearing Officer
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Mr. Hamsted,

Please find enclosed my statement regarding the MidState Hospital/NBGH proposal. I hope you will select me as an intervenor and give me enough time to raise the truly pertinent quality care issues.

Sincerely,

Paul C. Horton, M.D.

MidState Hospital wants to jettison its inpatient psychiatric unit to New Britain General Hospital. This proposal should be denied:

1. Psychiatric services are an indispensable and crucial component of the delivery of modern day hospital medical care. For example, recently, among acute care hospitals in the Hartford Healthcare system, MidState doctors were rated by their patients in the 39th percentile for "courtesy and respect," in the 29th percentile for careful listening," and in the 15th percentile for "explaining things." It is perhaps no coincidence that a general hospital administration which has decided to jettison its psychiatric services in one of the most psychiatrically needy communities in the State would be found wanting in patient satisfaction scores. After all, psychiatry is first and foremost – but not only – about relationship skills, ie. empathy, compassion and understanding. MidState needs more and better psychiatric presence, not the hostile-take-over kinds of care that have characterized the machinations of the Elmcrest/CVH/Rushford crowd over the last couple of decades. Yes, the strictly-for-profit types are good at wresting control from those psychiatrists who are doing their jobs in the trenches, but what happens when the "customer" – formerly the "patient" – has a say in the matter? A robust, inpatient psychiatric service provides essential medical expertise and an atmosphere that assures patients will be afforded a total treatment program, one that respects their dignity as human beings and does not treat them as objects to be poked, prodded, split open or dismissed as not medically "profitable." Getting rid of the inpatient psychiatric service at MidState sends a message that the emotional and mental illness needs of patients in the Meriden area are not important or, at least, not as important as other less labor intensive and more financially profitable medical services. Unfortunately, MidState Hospital appears to value maximal profits first since it does not seek to build its own "premier" and much needed psychiatric facility, but rather desires to "outsource" its mentally ill patients.

2. Jettisoning psychiatric services will not only undermine the provisions of enlightened, humane treatment to the total spectrum of MidState Hospital patients, it will send a message to psychiatrists – already in critically short supply nationally – that Meriden and surrounding communities do not value and do not want or need young psychiatrists to establish private practices in their communities. When we had a robust 20 bed inpatient unit at Memorial Hospital on Paddock Avenue, the Meriden/Wallingford community and surrounding towns had 14 psychiatrists in private practice, many of whom treated children, adolescents and their families; we often had as many as 24 patients on our inpatient unit, and we were able to admit and treat "in house" our own mentally ill patients, an option that has been stripped

from the private practice psychiatrist at MidState in the hospital's efforts to downsize and eliminate full-service psychiatric care to the Meriden community and surrounding area. Since the downsizing began, we are left with only three full-time psychiatrists with offices in Meriden, all of whom are approaching retirement age. Indeed, the MidState Certificate of Need Application even acknowledges the mess that psychiatry is in in the Meriden area, thanks, in no small measure, to the machinations of this hospital administration. I quote from the MidState CON: "Currently, the delivery system for behavioral health services in Central Connecticut is fragmented and not efficiently provided. Fragmented, poorly coordinated care leads to higher admission and readmission rates and longer lengths of stay." How will Meriden attract new psychiatrists if MidState Hospital is allowed to say, in effect, that we do not need and do not want intensive *psychiatric* participation and input and if private practice psychiatrists cannot be directly involved in the treatment of their mentally ill patients in the hospital setting? Moreover, it is very concerning and upsetting to patients and their families to have to travel halfway across the state to find a psychiatrist and/or to have to forfeit their relationship and trust in the referring psychiatrist to someone who has to start from scratch in treating them and who is pressured by the insurance company – almost always successfully – to discharge patients before they are ready.

3. The New Britain General Hospital plan is a **bad** plan. When the psychiatric Director of NBGH met this summer with the psychiatrists who are on the MidState Staff, including myself, to describe the purported advantages of shipping our patients over to New Britain, he said several things that were very concerning to me, a psychiatrist with over 40 years of experience. Provided that NBGH actually keeps its end of the bargain, the plan, as I understand it, is that NBGH will provide 10 beds for the treatment of our psychiatric patients. They will be "evaluated" by a psychiatrist whose sole job is to prescribe medications, and then these patients will be turned over to lesser qualified persons to receive "Cognitive Behavioral Therapy" and its cousin, "Dialectical Behavior Therapy." Thereafter, the psychiatrist will not be actively involved with the ongoing treatment process other than to prescribe and monitor the medication regimen. Although this modus operandi has become predominant, it does not and will not work. First the effective prescription of powerful psychotropic medications used on an inpatient, locked-ward service requires that the psychiatrist be actively, directly and continuously involved in the diagnosis and care of his/her patient and that the psychiatrist knows in detail, and with nuance, the psychological,

emotional, and cognitive effects of what he is prescribing. Psychiatric intervention is not and should never be a "second-hand" job, especially, when one considers the expertise and insight that only a psychiatrist can bring to the table when diagnosing and treating a mentally ill patient. But what is happening increasingly in hospitals around the state is the use of psychiatrists as mere pill-pushers, writing prescriptions for patients they barely know and have only cursorily evaluated, and, then, turning them over to non-M.D.'s for their on-going followup. Indeed, I am fed up with new patients showing up in my office with fistfuls of prescriptions some of which are addictive and/or powerful drugs given to them by hospital doctors eager to discharge them prematurely in order to roll-over for some insurance company and/or for a greedy hospital administration that wants to provide a semblance of mental care on the cheap. In a related matter, it is now becoming standard practice in the emergency room for patients who are a danger to themselves and/or others being evaluated and discharged without direct psychiatric assessment. Just a few months ago, I sent an angry, paranoid, intoxicated man to the hospital on a Physician's Emergency Certificate which should have resulted in him being admitted to the inpatient unit for further evaluation and treatment. Instead, he was discharged from the emergency room without having seen a psychiatrist and without a meaningful follow-up plan. The patient left the emergency room and immediately assaulted his employer and family members and was arrested. This was totally unnecessary and I understand that a lawyer for the patient is now involved. Indeed, many times in the past several years, I have seen emergency staff employees – not psychiatrists – discharge children and adolescents who are a danger to themselves and/or others, overriding a Physician's Emergency Certificate in the process. This dilatantist approach to psychiatric treatment should not be tolerated and, whether the psychiatric unit at MidState stays at MidState or is transferred to NBGH, there should be safeguards against this dangerous practice.

The Clinical Director at NBGH has assured us that the "therapists" on the inpatient unit will be skilled at "Cognitive Behavior Therapy" (CBT). However, – and this is extremely important – CBT does *not* work with the major mentally ill. At a recent Harvard symposium it was stated that there is not even one controlled study in the literature that shows that CBT works with the *major* mentally ill. This superficial poke-at-it approach to the major mentally ill is laughable at best and tragic at worst. In fact, there is no substitute for the role of the seasoned psychiatrist in the diagnosis, treatment, and management of these difficult individuals. Bear in mind, hardly anybody gets admitted to a psychiatric

hospital anymore unless he or she has a blatant, major mental illness such as Schizophrenia, Bipolar Disorder, Delusional Disorder or some other crippling condition.

4. Finally, one of the most disturbing flaws in the current NBGH proposal is that no provisions have been made for the treatment of the already overwhelming number of psychiatrically needy children and adolescents in the Meriden area who, in some cases, are in desperate *need* of psychiatric inpatient evaluation and treatment. When the Director of NBGH was asked why their proposal did not service this fragile and growing population of patients, he tersely responded, "There's no money in it!" Any proposal that does not problem solve in this critical area is not one that should be taken seriously for its "devotion" to the betterment of psychiatric services for *our* mentally ill patients. Such an egregious oversight cannot be tolerated. Why the Office of Healthcare Access permits this is a puzzle that needs immediate address.

In summary, 1) MidState should not be allowed, in its pursuit of profits, to shuffle off its responsibilities to psychiatric patients in Central CT; 2) The NBGH psychiatric unit is not the right place for our patients to be sent; 3) The impact of eliminating psychiatric inpatient services from MidState Hospital will not only have negative effects on the quality of care given throughout MidState Hospital but moreover, will damage the quality of both inpatient and outpatient psychiatric services by making the Meriden area unattractive to younger psychiatrists, who are badly needed; and, 4) The current NBGH proposal does not adequately address the psychiatric needs, especially the *inpatient* needs, of children and adolescents.

Paul C. Horton, M.D.
Diplomate of the American Board
of Psychiatry and Neurology

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2011-2012

Paul Chester Horton, MD

campaign, 1987-88. Mem. Am. Psychol. Assn. (divs. clin. psychology and child clin. psychology), Assn. for Advancement Behavior Therapy, Phi Kappa Phi. Republican. Presbyterian.

HORNBEIN, THOMAS FREDERIC, anesthesiologist; b. St. Louis, Nov. 6, 1930; s. Leonard and Rosalie (Bernstein) Hornbein; m. Gene Schwartz (div. 1968); children: Lia, Lynn, Cari, Andrea, Robert; m. Kathryn Mikesell, Dec. 24, 1971; 1 child, Melissa. BA, U. Colo.; MD, Wash. U. Diplomate Am. Bd. Anesthesiology. Intern King County Hosp., Seattle; resident in anesthesiology Wash. U., St. Louis, USPHS postdoctoral residency, instr. anesthesiology div., 1960—61; asst. prof. U. Wash., Seattle, 1963—67, assoc. prof., 1967—70, prof. anesthesiology, physiology and biophysics, 1970—2002, prof. emeritus, 2002—. Vice chmn. dept. anesthesiology U. Wash., Seattle, 1972—74, asst. chmn. rsch., 1974—77, chmn., 1979—93, rsch. affiliate Primate Ctr., 1980; bd. dirs. Colo. Ctr. for Alternative Medicine and Physiology, 2003—. Author: Everest the West Ridge, 1966 (rated #1 Outside Mag., 2003). Mem. bd. trustees Little Sch., Bellevue, Wash., 1982—89; bd. dirs. Colorado Ctr. Alt. Medicine and Physiology, 2003. Served to lt. comdr. USN, 1961—63. Recipient George Norlin award, U. Colo., Denver, 1970, Alumni Centennial Symposium award, 1975, Disting. Tchg. award, U. Wash., 1982. Fellow: AAAS; mem.: Inst. of Medicine, Soc. Acad. Anesthesia Chmn., Assn. Univ. Anesthetists (treas. 1969—72, pres. 1974—75), Am. Soc. Anesthesiologists (Rovenstine lectr. 1989), Am. Physiol. Soc. (editor 1967—73), Alpha Omega Alpha, Phi Beta Kappa. Avocation: mountain climbing. Office: U Wash Sch Medicine Dept Anesthesiology PO Box 356540 Seattle WA 98195-6540 Business E-Mail: hornbein@u.washington.edu.

HORNBERGER, ROBERT HOWARD, retired psychologist; b. Trenton, NJ, Jan. 26, 1933; s. Jennings Howard and Leah Margaret (Lewis) H.; m. Anne Deshon Lyman, June 11, 1958; children: Lynn Diane, Todd Lyman. BA, Amherst Coll., Mass., 1954; MA, PhD, U. Iowa, Iowa City, 1957. Instr. to assoc. in med. psychology U. Nebr. Coll. Medicine, Omaha, 1958-62; staff psychologist Nebr. Psychiat. Inst., Omaha, 1958-62; chief psychologist Drs. Young, Wigton & Aita, Omaha, 1962-65; dir. Eastern Maine Guidance Ctr., Bangor, 1965-68; assoc. dir. The Counseling Ctr., Bangor, 1968-69; lectr. in psychology U. Maine, Orono, 1966-69; dir. psychology tng. VA Med. Ctr., Gainesville, Fla., 1969-81; asst. to assoc. adj. prof. U. Fla., Gainesville, 1969-2000; staff psychologist VA Med. Ctr., Gainesville, 1981-2000; ret., 2000. Bd. advisors Fla. Mental Health Inst., Tampa, 1987-95; psychologist pvt. practice, Gainesville, 1976-85, 90-98; dir. endowment fund, The Mountain Retreat & Learning Ctrs., Highlands, N.C., 2002-07, chair 2006-07, dir. SoftReal Corp., Clearwater, Fla., 2001-04; pres. Gainesville chpt. UNA-USA, 2003-2005, 2007; pres. Fla. Dvsn. UNA-USA, 2009-10. Contbr. articles to profl. jours. Founder, 1st pres. Sugarfoot Cmty. Improvement Assn., 1972; pres. Mental Health Assn. Alachua County, Gainesville, 1981, Mental Health Assn. Fla., Tallahassee, 1987, Planned Parenthood Nebr., Omaha, 1963; comdr. Gainesville Power Squadron, 1995-96; pres. Unitarian-Universalist Chs. Omaha, 1963, Unitarian-Universalist Chs. Gainesville, 1972, 1987-88. Mem. Fla. Psychol. Assn. (pres. north ctrl. Fla. chpt. 1996). Democrat. Unitarian Universalist. Avocations: sailing, bridge, bicycling, travel, dance. Home: 4056 NW 23rd Cir Gainesville FL 32605-2683 Home Phone: 352-378-3541. Personal E-mail: bobhornberger@cox.net.

HORNE, BENJAMIN DAVIES, epidemiologist; s. David Hughes and Barbara Alice Horne; m. Carolyn Joy Walsman (div.). BSc, Brigham Young U., 1996; MPH, U. Utah, Salt Lake City, 1998, MStat, 2002, PhD, 2005. Epidemiologist, cardiovasc. dept. Intermountain Med. Ctr., Salt Lake City, 1999—2005, dir. cardiovasc. and genetic epidemiology, 2005—. Mem. Ch. Jesus Christ Latter-day Saints, Salt Lake City, 1971—. Fellow, Am. Heart Assn., 2004—06; John D. Morgan fellow, Deseret Found., 2004. Fellow: Am. Coll. Cardiology; mem.: SAR (pres. Utah soc. 2006—09). Office: Intermountain Med Ctr 5121 S Cottonwood St Salt Lake City UT 84157-7000 Office Phone: 801-507-4708. Office Fax: 801-507-4792.

HORNYKIEWICZ, OLEH, retired biochemical pharmacologist; b. Sychow, Ukraine, Nov. 17, 1926; MD, U. Vienna, 1951. Lectr. pharmacological inst. U. Vienna, 1964, head dept. biochem. pharmacology, 1976, prof. emeritus Inst. Brain Rsch., 1992—; prof. dept. pharmacology U. Toronto, 1968—76. Sci. adv. Michael J. Fox Found. Parkinson's Rsch. Author: Classics of World Science, Vol. 9, 2003; co-author: The Pharmacology of Psychotherapeutic Drugs, 1969; contbr. articles to profl. jours. Recipient Gold Medal for rsch., Canadian Parkinson's Disease Assn., 1970, Wolf Found. prize in medicine, Israel, 1979, Ludwig Wittgenstein prize, Austrian Rsch. Found., 1993, Austrian Medal Sci. & Art, 2008. Achievements include first to discover that lack of the neurotransmitter dopamine causes Parkinson's disease; development of L-dopa, a drug to treat Parkinson's disease, 1960. Office: Ctr Brain Rsch U Vienna Spitalgasse 4 A-1090 Vienna Austria Office Phone: 431 4277 62872. •

HOROHO, PATRICIA DALLAS, career military officer, nurse; b. Ft. Bragg, NC, 1960; d. F. Paul Dallas. BS, U. NC, Chapel Hill, 1982; MS, U. Pitts.; grad., Army Command and Gen. Staff Coll.; MS in Nat. Resource Strategy, Indsl. Coll. Armed Forces. RN. Advanced through ranks to lt. gen. US Army, 2011; staff nurse multi-svc. specialty ward and staff & head nurse level III emergency dept. Evans Army Cmty. Hosp., Ft. Carson, Colo.; nurse counselor 1st recruiting brigade, northeast Harrisburg and Pitts. Recruiting Batallions, Pa.; head nurse Womack Army Med. Ctr., Ft. Bragg, NC; chief nurse, hosp. comdr. 249th Gen. Hosp., Ft. Gordon, Ga.; asst. br. chief, Army Nurse Corps Br. US Total Army Pers. Command, Alexandria, Va.; asst. dep. healthcare mgmt. policy Office of Asst. Sec. of Army, Pentagon, Washington, DC; dep. comdr. nursing, comdr. Dewitt Health Care Network, Ft. Belvoir, Va., 2004—06; dep. comdr. nursing Walter Reed Army Med. Ctr. and North Atlantic Regional Med. Command, Washington; comdr. Walter Reed Health Care Sys., Washington, 2007—08, Madigan Army Med. Ctr., Tacoma, 2008—09, Western Regional Med. Command, Ft. Lewis, Wash.; dep. surgeon gen. US Army, 2010—11, surgeon gen., 2011—, chief Nurse Corps, 2010—11; comdr. US Army Medical Command, Ft. Sam Houston, Tex., 2011—. Affiliate faculty Pacific Luth. U. Sch. Nursing, Tacoma, 2009—. Decorated Disting. Svc. medal US Army, Legion Merit, Two Oak Leaf Clusters, Meritorious Svc. medal, Six Oak Leaf Clusters, Army Commendation medal, Three Oak Leaf Clusters, Army USO, 2009; named a Nurse Hero, American Red Cross and Nursing Spectrum, 2002; named one of The Great 100 in the State of NC, 1993. Achievements include being the first woman to become surgeon general of the United States Army, 2011. Office: US Army Office Surgeon General 5109 Leesburg Pike Rm 682 Falls Church VA 22041-8012 •

HOROVITZ, LEN, internist, pulmonologist; BS in Biology summa cum laude, Brown U., 1972; MD, NYU Sch. Med., 1976. Intern Mt. Sinai Med. Ctr., 1976—77, resident, Lenox Hill Hosp., 1977—80, fellow, 1980—82, attending physician, 1982—; cons. physician Manhattan Eye, Ear & Throat Hosp., 1996—. Office: 47 E 77th St Rm 201 New York NY 10021 Office Phone: 212-744-3001. Office Fax: 212-744-2303.

HOROWITZ, MARK D., rheumatologist, educator; MD, NE Ohio U., 1983. Diplomate Am. Bd. Internal Medicine, Am. Bd. Internal Medicine-rheumatology. Resident internal medicine Mt. Sinai Hosp., 1984—86, fellow internal medicine, fellow rheumatology, 1987—89, clin. instr. medicine-rheumatology Mt. Sinai Med. Ctr. Office: Mount Sinai Medical Center 21 E 90th St New York NY 10128-0654 Office Phone: 212-860-3077. Office Fax: 212-410-7410. E-mail: mark.horowitz@mssm.edu.

HOROWITZ, STEVEN F., cardiologist; MD, NY Med. Coll., 1972. Diplomate in internal medicine and cardiovasc. disease Am. Bd. Internal Medicine. Resident in medicine Beth Israel Med. Ctr., 1972—76; resident in cardiology, fellow in medicine Mt. Sinai Hosp., NYC, 1976—79; attending physician cardiovasc. disease Beth Israel Med. Ctr., NYC, 1988—2002; dir. cardiology Stamford Hosp., Conn., 2003—. Clin. prof. medicine and nuc. medicine Albert Einstein Coll. Medicine. Home: 250 Rosedale Ave White Plains NY 10605 Office: PO Box 9317 Shelburne and W Broad St Stamford CT 06904-9317 E-mail: shorowitz@stamhealth.org. •

HORTOBÁGYI, TIBOR, neuropathologist; b. Budapest, Hungary, Sept. 25, 1965; s. Tibor Hortobágyi and Éva Görög; m. Juliana Molnar, June 28, 1997; children: Tibor, Julianna, Katica, Piroska, Csenge, Viola. MD, Albert Szent-Györgyi Med. U., Szeged, Hungary, 1991; PhD, Semmelweis U. Budapest, 2001. Rsch. fellow Ludwig Maximilians U., Munich, 1998—2001; sr. lectr. U. Szeged, 2001—02; specialist registrar King's Coll. Hosp. & Inst. of Psychiatry, London, 2003—08, vis. sr. rsch. fellow, 2007—08; sr. clin. lectr. Inst. Psychiatry, London, 2008—; assoc. prof. dept. pathology U. Debrecen, Hungary, 2010—. Fellow: Royal Coll. Pathologists (Eng.); mem.: European Neuropathological Soc. (EFN 2007). Achievements include research in mechanisms of secondary injury in brain trauma and stroke; neuronal death in neurodegenerative disorders; characterization and description of novel brain tumor subtypes. Office: Dept Pathology University Debrecen Debrecen H 4032 Hungary Office Fax: 02078480988. Business E-Mail: tibor.hortobagyi@kcl.ac.uk, hortobagyi@med.unideb.hu.

HORTOLÀ, POLICARP, biologist, researcher; b. Badalona, Catalonia, Spain, Sept. 13, 1958; m. Consol Bádenas, Jan. 25, 1986; 1 child, Conrad. MSc in Biol. Scis., U. Barcelona, Spain, 1987; PhD, Rovira i Virgili U., Tarragona, Spain, 2001. Herbarium asst. Bot. Inst. Barcelona, 1989—90; asst. biologist biochemistry svc. of the clinic hosp. U. Barcelona, 1990—92, lab. technician dept. cell biology and path. anatomy, 1992—94, lab. technician dept. stratigraphy and palaeontology, 1997—99; freelance sci. cons. biomolecular archaeology Barcelona, 1995—97; CSIC fellow prehistory Rovira i Virgili U., Tarragona, Catalonia, Spain, 2000—01, sr. rschr., lectr. prehistory, 2002—. Author: (non-fiction book) Datación por Racemización de Aminoácidos, 1998; author: (with others) Homínidos: las primeras ocupaciones de los continentes, 2005, Entendre la ciència des de dins o si més no intentar-ho, 2006; contbr. chapters to books, articles to profl. jours. With artillery corps bugler Spanish Army, 1979—80. Recipient Doctorate Special Prize, Rovira i Virgili U., 2002. Achievements include research in erythrocyte morphology in bloodstains; discovery of erythrocyte morphologies in mammalian bloodstains; founded science of haemotaphonomy. Office: Rovira i Virgili Univ Prehistory 35 Catalunya Ave Tarragona Catalonia ES-43002 Spain Office Phone: 34 977 558 648. Office Fax: 34 977 558 386. Business E-Mail: policarp.hortola@urv.cat.

HORTON, PAUL CHESTER, psychiatrist; b. Cin., Jan. 29, 1942; s. Paul Chester, Sr. and Elizabeth Pauline (Rice) Horton; children: Paul Andrey, Alexander Robert. BA, U. Minn., 1964, MD, 1968. Diplomate Am. Bd. Psychiatry and Neurology. Rotating intern U. Cin., 1969; resident in psychiatry Yale U., New Haven, 1972; staff psychiatrist Guidance Clinic of Camden County, West Collingswood, NJ, 1972-74, Milford (Conn.) Family and Child Guidance Clinic, 1974-77; mem. faculty Sch. Medicine Yale U., New Haven, 1974-76; pvt. practice Meriden, Conn., 1974—; cons. psychiatrist Child Guidance Clinic Ctrl. Conn., Meriden, 1980—94, med. dir., 1994—98. Mem. faculty U. Conn. Sch. Medicine, Farmington, 1978—79; cons. Caring for Children, San Francisco, 1989—; psychiat. cons. schs. including Bristol Meriden Pub. Schs., 1999—; reviewer Am. Jour. Psychiatry, 1980—; assoc. dir., divsn. psychiatry Midstate Hosp., Meriden, Conn. Author: Solace, 1981, paperback edit., 1983, Japanese edit., 1985; sr. editor: The Solace Paradigm, 1988; contbr. articles to profl. jours. Active Big Bros. Orgn., Mpls., 1964—68. Lt. comdr. USN, 1972—74. Mem.: Meriden Wallingford Med. Assn., Am. Psychiat. Assn. (life), Gridiron Club. Office: 240 Pomeroy Ave Ste 205 Meriden CT 06450 Office Phone: 203-235-2505. Personal E-mail: phortonmd@aol.com.

HORTOVA, KATERINA, cell biologist, educator; b. Pelhřimov, Czech Republic, Feb. 17, 1974; d. Tomas Komarek and Zdenka Komrskova; m. Timothy Paul Hort; 1 child, Catherine Elizabeth Hort. RNDr, Charles U., Prague, PhD, 2001. Cert. in biology Charles U., 2000, in devel. biology Charles U., 2001. Lab technician Jessop Hosp., IVF Clinic, Sheffield, England, 2000—01; postdoc. fellow dept. immunology U. Buffalo, 2001—02, postdoc. assoc., dept. microbiology, 2001—02; asst. prof., dept. cell biology, faculty sci. Charles U., Prague, Czech Republic, 2002—, rsch. asst. Mem. dept. zoology Internat. Soc. Behaviour Ecology. Recipient K. Bratanov Family award, Varna, Bulgaria, 2000, Best Abstract award, Congress on Reproductive Immunology, Rhodes, Greece, 2003, Best Poster award, European Congress Reproductive Immunology ...

tive Immunology, Internat. Soc. Andrology. Achievements include research in unique sperm behaviour of Rodents, dynamics of cytoskeleton in sperm and influence of environmental factors on reproduction of mammals, esp. sperm capacitation. Office Phone: 00420221951852. Business E-Mail: hortova@natur.cuni.cz.

HORUZSKO, ANATOLIJ, medical researcher; b. Pinsk, Belarus, Oct. 10, 1953; s. Pavel Horuzsko and Anna Joskevich; m. Vera Ponik-Dobos, Mar. 30, 1981; children: Julia Szonja, Daniel David. MD (hon.), Pediat. Med. Sch., Leningrad, Russia, 1976; PhD in immunology and allergy, Inst. of Exptl. Medicine, Russian Acad. of Sci., Leningrad, Russia, 1980; MD, Semmelweis U. of Medicine, Budapest, Hungary, 1986; PhD in clin. immunology and allergy, Hungarian Acad. of Sci., Budapest, Hungary, 1987. Lectr., sr. lectr. Pediatric Med. Sch., Leningrad, Russia, 1979—86, sr. lectr. Nat. Inst. of Hematology and Blood Transfusion, Budapest, Hungary, 1986—92; non-clin. scientist, grade 1 Nat. Inst. for Med. Rsch., London, 1992—95; sr. rsch. scientist Med. Coll. of Ga., Augusta, 1995—98, instr., 1998—2002, asst. prof., 2002—06, assoc. prof., 2006—. Author: (over 40 studies) Dealing With Issues In Transplantation Medicine And Immunobiology. Recipient Prize of George Soros, George Soros Found., 1988, Internat. Rsch. award, Wellcome Trust, U.K., 1992—95, Internat. Human Frontier Sci. Program Orgn., Strasbourg, France, 1998, Internat. Union Against Cancer, Geneva, Switzerland, 1999, Roche Organ Transplantation Rsch. Found., Switzerland, 2001. Mem.: European Fedn. for Immunogenetics (assoc.), Hungarian Soc. for Immunology (assoc.), Brit. Soc. for Immunology (assoc.), AAAS (assoc.), Am. Assn. of Immunologists (assoc.). Office: Med Coll of Ga 1410 Laney Walker Blvd Augusta GA 30912-2015 Personal E-mail: horuzsko@netzero.net. Business E-Mail: ahoruzsko@mcg.edu.

HORVITZ, HOWARD ROBERT, biologist, educator; b. Chgo., May 8, 1947; s. Oscar and Mary Horvitz; m. Martha Constantine-Paton, May 2, 1993; 1 child, Alexandra. BS in Math. and Economics, MIT, 1968; MA in Biology, Harvard U., 1972, PhD in Biology, 1974; MD (hon.), U. Rome, 2004. Postdoc. fellow MRC Lab. Molecular Biology, Cambridge, England; asst. prof. biology MIT, Cambridge, Mass., 1978—81, assoc. prof., 1981—86, prof., 1986—, career devel. assoc. prof. biology, Whitehead Inst., 1982-85, Whitehead prof. biology, 1990-2000, David H. Koch prof. biology, 2000—, founding mem. McGovern Inst. Brain Rsch., 2001—. Advisor dept. biochemistry and molecular biology Harvard U., 1984—90; co-organizer Gordon Conf. Devel. Biology, 1985; mem. sci. adv. bd. Hereditary Disease Found., 1987—93; investigator Howard Hughes Med Inst., 1988—; neurobiologist, geneticist Mass. Gen. Hosp., Boston, 1989—; mem. sci. adv. bd. Jane Coffin Childs Meml. Fund for Med. Rsch., 1989—97; mem. sci. rev. com. Amyotrophic Lateral Sclerosis (ALS) Assn., 1990—95; mem. adv. bd. Umea Ctr. Molecular Pathogenesis, Sweden, 1993—96, WHO Spl. Programme Rsch. & Tng. in Tropical Diseases; chair devel. biology rev. com. Swedish Found. Strategic Rsch., 1996; cons. sci. adv. bd. Idun Pharms., Inc., 1993—, Axys Pharms. Inc., 1998—2002, GenPath Pharms., 2003—, Novartis Inst. Biomed. Rsch., 2003—; mem. med. adv. bd. Gairdner Found., 2007—; mem. adv. coun. Nat. Ctr. Human Genome Rsch., NIH. Author (with others): The Role of Intercellular Signals: Nav., Encounter, Outcome, 1979, Genetic Maps, 1980, Nematodes as Biol. Models, 1980, Devel. of the Nervous Sys., 1981, Repair and Regeneration of the Nervous Sys., 1982, The Nematode Caenorhabditis elegans, 1988; mem. edit. bd.: Jour. Neurogenetics, 1982—88, Jour. Neurosci., 1984—89, Devel. Biology, 1985—95, Devel., 1986—93, Genes and Devel., 1986—98, Cell, 1987—99, Trends in Genetics, 1987—, Neuron, 1987—90, The New Biologist, 1989—92, Genetic Analysis: Techniques and Applications, 1990—95, Current Opinion in Neurobiology, 1990—, Current Biol., 1992—95, Annual Rev. Genetics, 1993—97, Cell Death & Differentiation, 1994—, Invertebrate Neurosci., 1994—, Neurobiology of Disease, 1994—2000, Jour. Exptl. Therapeutics and Oncology, 1995—, Cancer Rsch., 1995—2000, Procs. of the NAS, 1997—2001, Jour. Cell Biology, 1997—2000, Genome Biology, 1999—; contbr. articles to profl. jours. Recipient Rsch. Career Devel. award, NIH, 1981—86, Spencer award in neurobiology, Columbia U., 1986, Louisa Gross Horwitz prize, 2000, Warren Triennial prize, Mass. Gen. Hosp., 1986, US Steel Found. award in molecular biology, 1988, Method to Extend Rsch. in Time award, NIH, 1991, V.D. Mattia award, Roche Inst. Molecular Biology, 1993, Hans Sigrist award, 1994, Charles A. Dana award for pioneering achievements in health and edn., Inst. Medicine NAS, 1995, Ciba-Drew award for biomed. sci., 1996, Rosenstiel award, Brandeis U., 1998, Passano award for the advancement med. sci., 1998, Alfred P. Sloan Jr. prize, GM Cancer Rsch. Found., 1998, Gairdner Found. Internat. award, 1999, Paul Ehrlich & Ludwig Darmstaedter prize, Germany, 2000, Segerfalk award, 2000, March of Dimes prize in devel. biology, 2000, Charles-Leopold Mayer prize, French Acad. Scis., 2000, Bristol-Myers Squibb award for Disting. Achievement in Neuroscience, 2001, Genetics prize, Peter Gruber Found., 2002, Am. Cancer Soc. medal of honor, 2002, Wiley prize in biomed. scis., 2002, Nobel Prize in physiology/medicine, 2002, Alfred G. Knudson award, Nat. Cancer Inst., 2005, Centennial medal, Harvard U., 2005, Killian Faculty Achievement award, MIT, 2006; Woodrow Wilson fellow, 1968. Fellow: AAAS, Am. Acad. Microbiology, Am. Acad. Arts & Scis.; mem.: NAS, Am. Philos. Soc., Physiological Soc. London, Helminthological Soc. Washington, Am. Soc. Cell Biology (mem. exec. com.), Soc. Neurosci., Soc. Nematologists, Soc. Devel. Biology, Genetics Soc. America (membership com. 1984—86, bd. dirs. 1990—96, v.p. 1994, pres. 1995), Am. Assn. Cancer Rsch., Inst. Medicine. Jewish. Achievements include patents in field. Office: MIT Dept Biology Rm 68 425 77 Massachusetts Ave Cambridge MA 02139-4307 Office Phone: 617-253-4671. Office Fax: 617-253-8126. Business E-Mail: horvitz@mit.edu. •

HORWICH, ARTHUR L., biologist, educator; b. 1951; AB in Biomed. Scis., Brown U., Providence, 1972, MD, 1975. Postdoc. molecular biology/virology Salk Inst. Biol. Studies, La Jolla, Calif.; intern, resident pediat. Yale U. Sch. Medicine, dir. Horwich Lab, 1984—, now Sterling Prof. genetics and pediat.; attending physician, med. genetics and pediat. Yale-New Haven Hosp., 1988—; investigator Howard Hughes Med. Inst., Chevy Chase, Md., 1990—. Assoc. editor Cell, Molecular Cell, mem. edit. bd. Jour. Cell Biology, Structure. Recipient Hans Neurath award, Protein Soc., 2001, Stein & Moore award, 2006, Basil O'Connor Rsch. award, Albert Lasker

Paul C. Horton, M.D. 240 Pomeroy Ave., Suite 205 • Meriden, CT 06450

FAX

Date 11-1-12

Number of pages including cover sheet 7

To Mr. Kevin Hansted

Phone

Fax # 860-418-7053

From Paul C. Horton, M.D.

Phone (203) 235-2505

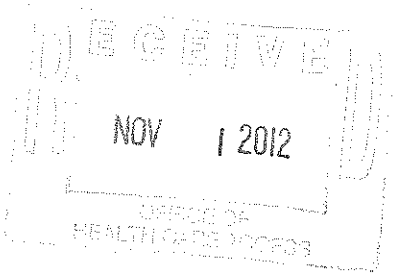
Fax # (203) 235-2506

REMARKS: ☐ Urgent ☐ For your review ☐ Reply ASAP ☐ Please comment

I noticed a misspelling in your name.

Paul C. Horton, M.D.
240 Pomeroy Avenue, Suite 205
Meriden, Connecticut 06450

Telephone (203) 235-2505
Facsimile (203) 235-2506
phortonmd@aol.com



November 1, 2012

Mr. Kevin Hansted, Hearing Officer
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Mr. Hansted,

Please find enclosed my statement regarding the MidState Hospital/NBGH proposal. I hope you will select me as an intervenor and give me enough time to raise the truly pertinent quality care issues.

Sincerely,

Paul C. Horton, M.D.

Greer, Leslie

From: Greci, Laurie
Sent: Friday, November 02, 2012 9:36 AM
To: Olejarz, Barbara; Carney, Brian; Hansted, Kevin
Cc: Martone, Kim; Riggott, Kaila; Greer, Leslie
Subject: FW: public officials re:12-31775-CON

Attendees for the MidState Medical Center hearing to be held on Wednesday, Nov. 7.

From: Barbara Durdy [mailto:Bdurdy@midstatemedical.org]
Sent: Thursday, November 01, 2012 3:32 PM
To: Greci, Laurie
Subject: public officials

Laurie,
As of today we have 3 public officials who will speak in favor of our proposal…

Representative Rick Lopes
Senator Terry Gerratano
Mayor Dickinson – Wallingford

Thanks
Barbara

Greer, Leslie

From: Carney, Brian
Sent: Friday, November 02, 2012 9:28 AM
To: bdurdy@midstatemedical.org; 'ccapone@thocc.org'; 'karen.goyette@hhchealth.org'
Cc: Riggott, Kaila; Greer, Leslie; Greci, Laurie; Hansted, Kevin
Subject: Petition for Intervenor Status
Attachments: 31775 MidState Intervenor 1.pdf; 31775 MidState Intervenor 2.pdf; 31775 MidState Intervenor 2a.pdf

Ms. Barbara Durdy
MidState Medical Center

Barbara,

Please see the two attached petitions for intervenor status - the third file corrects a misspelling.

If you (the applicants) wish to respond to either of these requests for intervenor status, please file by Monday, November 5, 2012, close of business.

Thanks,

Brian A. Carney, MBA
Department of Public Health
Office of Health Care Access
410 Capitol Ave.
Hartford, CT 06134-0308
Phone: 860-418-7014
Fax: 860-418-7053

cc: Claudio Capone, The Hospital of Central Connecticut
Karen Goyette, Hartford HealthCare Corporation

SHIPMAN & GOODWIN LLP®

COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

November 2, 2012

VIA HAND DELIVERY
Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308

Re: **Termination of Inpatient Behavioral Health Services at MidState Medical Center; Docket No. 12-31775-CON**

Dear Ms. Martone:

Enclosed please find the Notice of Appearance form regarding the matter referenced above. If you have any questions, please do not hesitate to contact me.

Sincerely yours,

Joan W. Feldman

Enclosure

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

IN RE: MIDSTATE MEDICAL CENTER, THE HOSPITAL OF CENTRAL CONNECTICUT AND HARTFORD HEALTHCARE CORPORATION- TERMINATION OF INPATIENT BEHAVIORAL HEALTH SERVICES AT MIDSTATE MEDICAL CENTER	:	**DOCKET NO. 12-31775-CON**
	:	**November 2, 2012**

NOTICE OF APPEARANCE

Please enter the appearance of Shipman & Goodwin LLP on behalf of the Applicants in the above-referenced matter.

Respectfully Submitted,

MidState Medical Center
The Hospital of Central Connecticut
Hartford HealthCare Corporation

By: 

Joan Feldman, Esq.
jfeldman@goodwin.com
Of Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103-1919
Tel: 860-251-5104
Fax: 860-251-5211
Their Attorney

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

IN RE: MIDSTATE MEDICAL CENTER, THE HOSPITAL OF CENTRAL CONNECTICUT AND HARTFORD HEALTHCARE CORPORATION- TERMINATION OF INPATIENT BEHAVIORAL HEALTH SERVICES AT MIDSTATE MEDICAL CENTER	:	**DOCKET NO. 12-31775-CON**
	:	**November 2, 2012**

Accompanying this cover sheet is the pre-filed testimony of Lucille Janatka, Elliot Joseph, Clarence Silvia, and John S. McIntyre, M.D. in connection with and in support of the above-captioned application.

Respectfully Submitted,

MidState Medical Center
The Hospital of Central Connecticut
Hartford HealthCare Corporation

By: _____

Joan Feldman, Esq.
jfeldman@goodwin.com
Of Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103-1919
Tel: 860-251-5104
Fax: 860-251-5211
Their Attorney

Enclosure

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

IN RE: MIDSTATE MEDICAL CENTER, THE HOSPITAL OF CENTRAL CONNECTICUT AND HARTFORD HEALTHCARE CORPORATION- TERMINATION OF INPATIENT BEHAVIORAL HEALTH SERVICES AT MIDSTATE MEDICAL CENTER	:	**DOCKET NO. 12-31775-CON**
	:	**November 2, 2012**

PRE-FILED TESTIMONY OF ELLIOT JOSEPH ON BEHALF OF HARTFORD HEALTHCARE CORPORATION AS AN APPLICANT

Good day, Deputy Commissioner Davis, Attorney Hansted and staff of the Office of Health Care Access ("OHCA"). My name is Elliot Joseph and I am the President and Chief Executive Officer of Hartford HealthCare ("System"), the parent and sole corporate member of MidState Medical Center ("MidState") and The Hospital of Central Connecticut ("HOCC"). I am thankful for this opportunity to speak before you today and provide you with additional perspective in connection with the decision by the Applicants to significantly enhance HOCC's inpatient behavioral health unit and improve access for MidState area residents who need inpatient behavioral health care.

Over the last several years, I have appeared before you on a number of occasions in connection with various requests relating to Hartford HealthCare's development of an integrated healthcare delivery system. During these proceedings, I have discussed with you our efforts to create a strong and advanced integrated healthcare delivery system. More particularly, I have conveyed to you our objectives to accomplish System-wide integration so that we may enhance quality and achieve cost efficiencies, all of which is essential under health care reform.

To date, we have made considerable progress toward clinical and operational integration, and as a result of those efforts, we have realized significant economic efficiencies. We have also made

significant progress in sharing clinical expertise throughout the System to improve access to our most advanced services and technologies. This proposal is yet another example of our efforts to integrate and coordinate clinical practice within the System and to promote and advance best practices and high quality services. This work has been critical to keeping our community hospitals relevant and thriving, and it is my firm belief, that without taking these steps to address redundancies and achieve cost savings, our System member hospitals would be experiencing financial difficulties today.

Key to our success and ability to enhance quality, obtain new technologies and achieve cost efficiencies has been our ability to coordinate System-wide strategic planning. One fundamental aspect of the System-wide strategic planning process is the assessment of System strengths and weaknesses in our service lines. Once our strengths are identified, our focus is to further enhance those strengths, and once our weaknesses are identified, our focus is to address those weaknesses.

With respect to our efforts to assess our strengths and weaknesses in behavioral health, the System has developed a team of providers to evaluate and coordinate behavioral health services for the purpose of enhancing access and quality and achieving greater efficiencies throughout the System. With the team's assistance, we have determined that given HOCC's size, proximity to MidState, and range and scope of services, MidState patients would be better served if they received their inpatient behavioral health services at HOCC. While some in the MidState community may view this plan as a loss or a takeaway, they are mistaken. What we propose is a gain or an enhancement to the MidState community in that MidState patients will be given preferential access to ten (10) beds on HOCC's newly designed and renovated inpatient behavioral health unit. The System, if this proposal is approved, is willing to make a four million ($4,000,000) dollar investment in behavioral health care in order to expand and enhance the HOCC inpatient behavioral health unit and directly benefit MidState-area residents. In today's healthcare market, there are undoubtedly

few hospitals or healthcare systems in the State, let alone the nation, making this type of investment in behavioral health. However, I must be clear that this project only makes sense if the Application is approved.

In closing, by leveraging the resources of the System, this proposal strengthens the delivery system for behavioral health services in Central Connecticut. In addition, for the reasons described in the Application and further elaborated on in our testimony today, this proposal ensures the delivery of the highest quality inpatient behavioral health services to our patients. I hope that you will agree that this proposal allows for many benefits to patients including increased access to inpatient services and the transformation of a delivery system that is broken and fragmented to a delivery system which is well coordinated, integrated and patient focused. As the State's largest provider of behavioral health services, we are committed to stabilizing and enhancing behavioral health services. However, we must be able to make the necessary strategic changes that we believe are essential to stabilizing and enhancing such services. Thank you once again.

I adopt the foregoing pre-filed testimony as my own.

Elliot Joseph, President and CEO
Hartford HealthCare Corporation

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

IN RE: MIDSTATE MEDICAL CENTER, THE HOSPITAL OF CENTRAL CONNECTICUT AND HARTFORD HEALTHCARE CORPORATION- TERMINATION OF INPATIENT BEHAVIORAL HEALTH SERVICES AT MIDSTATE MEDICAL CENTER	:	**DOCKET NO. 12-31775-CON**
	:	**November 2, 2012**

PRE-FILED TESTIMONY OF CLARENCE SILVIA ON BEHALF OF THE HOSPITAL FOR CENTRAL CONNECTICUT AS AN APPLICANT

Good Morning, Deputy Commissioner Davis, Attorney Hansted and staff of the Office of Health Care Access ("OHCA"). My name is Clarence Silvia and I am the President and Chief Executive Officer of The Hospital of Central Connecticut ("HOCC"). As you may know, HOCC is both a subsidiary of Hartford HealthCare ("System") and an affiliate of MidState Medical Center ("MidState"). I am here today to publicly express HOCC's strong commitment to serving MidState area patients with inpatient behavioral health care needs.

As discussed by Mr. Joseph and Ms. Janatka, the decision to close the MidState inpatient behavioral health unit was not made by MidState alone. Rather, it was a decision made by a team of System behavioral health experts and leadership charged with determining and recommending the best practices for the delivery of behavioral health services. Given the obvious size differences between the MidState and HOCC inpatient units, the range and depth of clinical expertise on the HOCC unit, the ability to develop more individualized treatment plans for patients on the HOCC unit (which we are

required by law to do)[1], and HOCC's lower cost structure, the decision to close the MidState inpatient behavioral health unit and increase the size of the HOCC unit by ten (10) beds was an obvious choice for all involved.

My main purpose in testifying today is to make it very clear that HOCC and the HOCC behavioral health clinical team, including Dr. Balkunas, the Chief of our Department of Psychiatry, have been fully engaged and involved in the analysis and planning process and we are in full support of this proposal. Put simply, our Hospital and clinical team are fully committed to giving MidState area patients the best inpatient behavioral health care services possible, including working with community providers to establish comprehensive community-based discharge plans. As part of that commitment, we are prepared to do the following:

- Make a four million dollars ($4,000,000) capital contribution to expand and renovate the HOCC inpatient behavioral health unit making available no less than ten (10) inpatient beds to MidState patients and increasing current capacity for MidState patients by four (4) beds;
- Inform MidState area residents upon admission of the transportation assistance that we can offer them. We want to make certain that there are no barriers to family and loved ones visiting the patient at HOCC. HOCC will coordinate and MidState will fund the transportation services. Bus vouchers and taxi vouchers for those who cannot take public transportation will be available to those who need it;
- MidState area residents who are admitted either through the MidState or HOCC emergency departments will be timely admitted to the unit if inpatient admission is warranted. If the patient is admitted through MidState, the patient will be transported to HOCC by either MidState with licensed clinical staff or an ambulance depending upon the patient's condition;
- MidState area residents will be discharged back to their providers in the catchment area where they reside. In the event that the patient does not have a community provider, referrals will be made to community providers in the patient's catchment area;

[1] See Medicare Conditions of Participation at 42 C.F.R. § 482.43.

- The psychiatrists on the MidState medical staff, are all invited and welcome to apply to join our medical staff; and
- HOCC will offer MidState inpatient behavioral health unit staff preferential hiring for any vacant positions available on our expanded inpatient behavioral health unit to the extent that a MidState employee chooses to leave MidState and is properly qualified.

This is not the first time MidState and HOCC have collaborated as System members. MidState and HOCC have collaborated on many clinical and operational initiatives, such as vascular surgery, bariatric surgery and neurology. We currently share one Chief Financial Officer for both hospitals. We believe that this type of collaboration is essential to the communities we serve. If hospitals can collaboratively plan and implement improvements in the delivery of health care services, quality and efficiencies stand to improve. I must also point out that HOCC has successfully replicated this proposal as it relates to the transfer of patients in need of inpatient behavioral health care from our Bradley campus to our New Britain campus without any of the problems identified by those who oppose this Application.

Accordingly, I encourage you to approve this Application because it is not only in the best interests of the patients, but it also represents best practice for our patients. I firmly believe that once the HOCC unit renovation is complete, patients will want to choose the HOCC unit over the MidState unit. I very much thank you for this opportunity to speak before you today.

I adopt the foregoing pre-filed testimony as my own.

Clarence Silvia, President and CEO
The Hospital of Central Connecticut

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

IN RE: MIDSTATE MEDICAL CENTER, THE HOSPITAL OF CENTRAL CONNECTICUT AND HARTFORD HEALTHCARE CORPORATION- TERMINATION OF INPATIENT BEHAVIORAL HEALTH SERVICES AT MIDSTATE MEDICAL CENTER	:	**DOCKET NO. 12-31775-CON**
	:	**NOVEMBER 2, 2012**

PRE-FILED TESTIMONY OF LUCILLE JANATKA ON BEHALF OF MIDSTATE MEDICAL CENTER AS AN APPLICANT

Good day, Deputy Commissioner Davis, Attorney Hansted and staff of the Office of Health Care Access ("OHCA"). My name is Lucille Janatka and I am the President and Chief Executive Officer of MidState Medical Center (the "Hospital" or "MidState"). I am very grateful for this opportunity to be here today to tell you why the above- referenced Application to terminate inpatient behavioral health services at MidState should be approved by OHCA.

As the President and CEO of the Hospital, it is my duty to judiciously lead the Hospital so that it may fulfill its mission and vision long into the future. As I understand OHCA's role, it is not too dissimilar to mine. Pursuant to OHCA's statutory authority, OHCA is responsible for overseeing and coordinating health system planning for the State, monitoring health care costs, and implementing and overseeing health care reform as enacted by the General Assembly.[1]

I am similarly charged with the responsibility to allocate the Hospital's resources in the most effective and efficient manner, manage the Hospital's costs, and plan for its

[1] Connecticut General Statutes Section 19a-613.

future, all the while responding to the rapid fire changes arising from state and federal health care reform. These responsibilities sometimes require difficult choices, ones that are not always well received by all interested parties. Nevertheless, I must lead based on what I believe is in the best interests of the Hospital and the community, not only for the short term, but also the long term.

It is important that OHCA understand that this proposal to close the MidState inpatient behavioral health unit was not made out of convenience, was not motivated for fiscal reasons alone, and was not made due to either a disregard for or a lack of commitment to those individuals in our community with behavioral health care needs. Quite the contrary, MidState's Application to terminate the inpatient behavioral health unit is based first and foremost upon an honest and thorough assessment of MidState's inpatient behavioral health program. In conducting such an assessment, MidState cannot ignore the fact that its affiliate, The Hospital of Central Connecticut ("HOCC"), given its size, service capacity, and lower costs, is the preferred provider of choice for inpatient behavioral health services, not MidState. Put differently, as the treatment needs of inpatient behavioral care patients become more complex, it has become clear to MidState that it cannot deliver the same level of behavioral health services that HOCC's larger and more specialized unit can offer to our patients.

While I recognize that some do not desire change and some do not appreciate the differences between what we have and what we could have for our behavioral health patients, that alone cannot be a determinative factor for denial of this Application, no matter how passionate the resistance or how loud the voices in opposition may be. In this instant case, change is what is necessary and change is what is in the best interests of those

who may need inpatient behavioral health services in the future. Moreover, I must point out that the rationale for this proposal and the proposal itself is no different than the proposals for the regionalization of other health care services in our community. For example, decisions to regionalize inpatient pediatrics and invasive cardiology have been made in order to provide the very best care available for patients, the same rational which is the basis for our proposal.

This Application must be based on the merits alone and there is no question that what we are proposing will: (1) increase inpatient behavioral health bed capacity and access for MidState area patients by four (4) inpatient beds for a total of ten (10) beds; (2) enhance the scope and depth of inpatient behavioral health services for patients from the MidState service area community; (3) offer a significantly lower cost structure for more sophisticated services than that currently offered by MidState[2]; and (4) support our patients in their return to their community with enhanced supportive outpatient services. As you heard from Mr. Joseph, Hartford HealthCare is committed to System-wide strategic planning so that all System members can thrive and flourish in the most challenging of times, all the while enhancing quality and access for all our patients.

Finally, I must also assure our employees on the MidState inpatient behavioral health unit that there will be no loss of jobs if this proposal is approved by OHCA. Staff affected by the closure of the MidState unit will have several options. The staff can remain at MidState and be provided with another position wherein they will receive the necessary training to perform their new role; or if they choose to remain in behavioral health, they

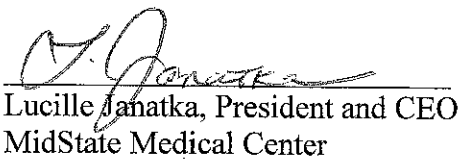
[2] See pages 0024-0025 of the Application for a discussion of the lower cost structure at HOCC.

will be giving preferential hiring at HOCC for a position on the newly expanded inpatient behavioral health unit in accordance with their specific qualifications.

As the President and CEO of MidState, this proposal is a demonstration of my stewardship and fiduciary duty to the Hospital, the patients, the employees and community. It is my firm belief that MidState should devote its resources to areas wherein it can provide the most exceptional of services for its patients. Inpatient psychiatry is not one of those areas. Accordingly, I respectfully request that OHCA approve this Application and trust that my interests and commitment for these patients are no less than any other patient.

Clarence Silvia, the President and CEO of HOCC, will describe the improvements that will be made to the HOCC inpatient behavioral health unit should this Application be approved, along with the commitment by his staff to work with Meriden outpatient community providers to coordinate the patient's return to the Meriden community. Dr. John S. McIntyre, our expert, will provide testimony as to why he believes that this Application is in the best interests of the behavioral health patients needing inpatient admission and why such a decision is consistent with best practices in connection with inpatient behavioral health treatment. I thank you for this time to state my position and look forward to your questions.

I adopt the foregoing pre-filed testimony as my own.



Lucille Janatka, President and CEO
MidState Medical Center

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

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	:	**November 2, 2012**

PRE-FILED TESTIMONY OF JOHN S. MCINTYRE, M.D.
ON BEHALF OF THE APPLICANTS

Good day, Deputy Commissioner Davis, Attorney Hansted and staff of the Office of Health Care Access ("OHCA"). My name is John S. McIntyre, M.D. and I am a board certified psychiatrist, with thirty (30) years of experience as a practicing psychiatrist, and the former President of the American Psychiatric Association. I have attached my resume to my pre-filed testimony so that OHCA can easily reference my credentials, along with a summary of my professional experience to date. I am very pleased to be here today on behalf of the Applicants to share with OHCA and those in attendance my enthusiasm and support for this Application and the reasons why I believe that this Application is, without doubt, in the best interests of MidState Medical Center ("MidState") area patients requiring inpatient behavioral health care.

Given my professional work on both a national and international level, and the regular opportunity that I have had to confer with clinicians, researchers and academicians, throughout the country, I have the good fortune of being regularly informed regarding the latest developments in behavioral health care, including new

developments with respect to emerging care delivery models and best practices for inpatient behavioral health care.

However, in this instant case, I do not believe that one necessarily needs to be an expert to see the benefits to the MidState proposal. In fact, if you conduct a purely academic cost to benefit analysis comparing the benefits of the MidState proposal with the status quo, you will see that the MidState proposal offers MidState area patients the following benefits: (1) more specialized treatments due to patient critical mass (e.g, group therapy with patients with similar issues, cognitive behavioral therapy, and dialectical behavioral therapy); (2) a more therapeutic milieu given the enhanced diversity of the patient population and patient critical mass; (3) a newly renovated unit that will offer the patients both greater privacy and greater opportunity for social interaction with other patients on the unit; (4) a broader spectrum of clinicians who can offer more specialized care; and (5) a more coordinated discharge planning process that will return the MidState area patients back to the community with supportive services from providers from the same MidState area community in which the patient resides.

Based upon the foregoing factors alone, I am confident that patients and family alike, if given the choice between the proposal and maintaining the status quo, (while fully understanding the differences), would choose the MidState proposal. There are of course some who are critical of the proposal because it will arguably be a burden to the patient and family to travel nine miles (from MidState) to receive these inpatient services from HOCC. This perceived or actual inconvenience has little bearing on what is actually in the patient's best interests or that which will achieve the best outcomes for the

patient. Few would disagree that traveling nine (9) miles to be in a modern, large unit with sophisticated and individualized services is worth any perceived or actual inconvenience. In fact, we know there are many MidState area patients, including behavioral health patients, who are treated at facilities that are located more than (9) miles away. MidState has never heard this to be an inconvenience for those patients; rather patients appreciate being cared for at a facility that can best meet their needs.

Moreover, there are significant differences between the MidState unit and the HOCC unit. While the MidState unit is effective at stabilizing patients in acute crisis through medication management, the HOCC unit offers a broader range of treatments, including a combination of psychopharmacology and other therapies, such as cognitive behavioral therapy and dialectical behavioral therapy. Regardless of whether MidState operates a six (6) or ten (10) bed unit, the reason that MidState cannot provide the same scope of therapies and staff that the HOCC unit can is simply because of MidState's size. When it comes between choosing between the two facilities, my opinion is that patients should receive treatment at the facilities that are most capable of comprehensively addressing most of the patients' needs. In this case, it is without question, HOCC. To not focus on what is best for the patient is not only an injustice to the patient, but also to the community at large.

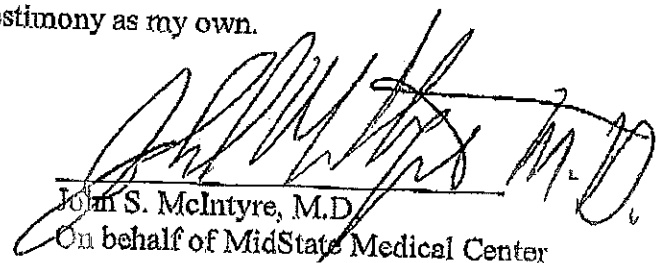
In today's challenging health care environment, hospital providers must act responsibly to secure the best care for their patients at the lowest cost. Sometimes this requires the realization that other providers can do it better. It is my professional opinion that MidState, given its size and depth, cannot deliver the same level of care that

a larger and more sophisticated behavioral health unit like HOCC can deliver. While there is little doubt that the small inpatient unit at MidState has served the community well for decades, the MidState community is at a critical point in time wherein if quality is to be enhanced, this Application to close the MidState unit and expand the HOCC unit should be approved.

I have seen hospitals throughout the country decide that it is simply not best practice to operate a small inefficient inpatient behavioral health unit. Some hospitals have chosen to close the units and others have done what MidState is proposing to do. The question remains, how should MidState best leverage its resources. Some may suggest that MidState should fully staff up to eight (8) beds on its unit. While that is a possibility, I believe this is not the best option in that it will not provide the critical mass or the diversity in staff and patients that MidState would need in order to deliver individualized care and implement best practices. MidState is most fortunate to be part of a System that has the resources to invest in the enhancement of HOCC's behavioral health unit. The HOCC unit as you have heard is fully committed to servicing MidState area patients and providing them with priority admission to ten (10) of the additional beds that will be added to the HOCC unit if this Application is approved. In other words, this proposal will benefit both MidState area patients and HOCC patients alike.

In this period of intense health care reform, providers must not be prevented from taking steps to respond to market forces and needs. If the proposal is not approved, it is my opinion that MidState area residents will be disadvantaged and be shortchanged from receiving the care that they deserve.

I adopt the foregoing pre-filed testimony as my own.



John S. McIntyre, M.D.
On behalf of MidState Medical Center
Hartford HealthCare Corporation
The Hospital of Central Connecticut

Curriculum Vitae

JOHN STANISLAUS McINTYRE, M.D.

Private Practice of Psychiatry
Behavioral Health Systems Consultation
Forensic Psychiatry

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jmcintyre@unityhealth.org

Clinical Professor of Psychiatry
University of Rochester
601 Elmwood Avenue
Rochester, NY 14642

Personal Data
Married, four children
Citizenship: United States

Home Address
205 Grosvenor Road
Rochester, NY 14610
(585) 244-6992

EDUCATION

1963 A.B., Mathematics, University of Notre Dame, Notre Dame, Indiana

1967 M.D., Medicine, University of Rochester School of Medicine and Dentistry (President of Student Council, 1966-67)

TRAINING

1967-68 Intern in Medicine, Department of Medicine, University of Kentucky Medical Center, Lexington, KY

1968-69 Assistant Resident, Department of Psychiatry, University of Rochester Medical Center, Rochester, NY

1971-73 Associate Resident and Resident in Psychiatry, Department of Psychiatry, University of Rochester Medical Center, Rochester, NY

MILITARY SERVICE

1969-71 Major, U.S. Army Medical Corps, Ft. Campbell, KY

PROFESSIONAL HOSPITAL AND ADMINISTRATIVE APPOINTMENTS

Unity Health System (St. Mary's Hospital and Park Ridge Hospital)

Vice President for Behavioral Health, 2000-2006
Chair, Department of Psychiatry and Behavioral Health, 1997-2006
Medical Executive Committee, 1997-2006
Chair, Ethics Committee, 1998-present
Vice President, Physician Organization, 1999-present
St. Mary's/Park Ridge Integration Committee, 1996-97
Co-Chair, Gala Committee, 2002-2004

St. Mary's Hospital

Chair, Department of Psychiatry, 1992-97
Chair, Division of Psychiatry, 1979-92
Chair, Ethics Committee, 1995-98
Vice President, Physician Organization, 1995-97
Physician Organization/Capitation Committee, 1994-98
President, Medical and Dental Staff, 1987-88
President-Elect, Medical and Dental Staff, 1985-87
Secretary, Medical and Dental Staff, 1981-85
Medical Board, 1981-90, 1993-98 **(Chair, 1987-88)**
Ethics Committee, 1992-98
Chair, Quality Assurance Committee, 1985-87
Chair, By-Laws Committee, 1983-85
Medical Staff, 1977-99

Park Ridge Hospital

Chair, Department of Psychiatry, 1997-2006
Medical Staff, 1982-present

Private Practice of Psychiatry, Rochester, NY

Full-time, 1977-92, 2006 - present
Part-time, 1973-77, 1992-2006

Westfall Associates, Rochester, NY

Board of Directors, 1987-99

Other

Psychiatric Consultant, DePaul Clinic, 1977-84
Psychiatric Consultant, Westside Health Services, 1973-76
Psychiatric Consultant, Western State Hospital, Hopkinsville, KY, 1970-71

ACADEMIC APPOINTMENTS

University of Rochester School of Medicine and Dentistry

Clinical Professor of Psychiatry, 1991-present
Clinical Associate Professor of Psychiatry, 1978-91
Clinical Assistant Professor of Psychiatry, 1977-78
Assistant Professor of Psychiatry, 1973-77
Instructor, 1972-73

Academic Assignments/Committees

Co-Chair, John Romano Legacy Committee, 1994-present
Credentials Committee, Department of Psychiatry, 1992-99
50th Anniversary Committee, Department of Psychiatry, 1994-97
Director, Service II (Department of Psychiatry), 1974-77
Director, Psychiatric Clerkship, 1973-77
Multiple Department of Psychiatry Committees, 1973-78
Including: Clinical and Community Services Steering Committee, Residency Education, Residency Selection, Central Records, Intake (Chair)
Multiple Medical School Committees and Assignments, 1973-78
Including: Utilization Review, Curriculum, House Officer Advisor, Interview Medical School Applicants

Academic Activities

American Board of Psychiatry and Neurology, Examiner
American Journal of Psychiatry, Reviewer, 1981-present
Hospital & Community Psychiatry, Reviewer, 1980-present
Archives of General Psychiatry, Reviewer, 1993-present

RESEARCH ACTIVITIES

Principle Investigator, Substance Abuse and Mental Health Services Administration (SAMHSA)

3 year Grant, $1,200,000, 2002-2005
Meeting the Mental Health Service Needs of Older Adults

4 year Grant, $1,292,300, 1998-2002 PRISM -e
Document and Evaluate Mental Health Substance Abuse Services for Older

Adults In Primary Care
Chair, National Multi-site Steering Committee, 1999-2000

Principal Investigator, New York State Department of Health Grant, $217,058,
1995-98 Dissemination Strategies for Major Depression Practice Guideline

Chair, Practice Research Network Steering Committee, American Psychiatric Association 1994-present

LICENSES AND BOARD CERTIFICATIONS

New York State (1969) and Kentucky (1970)
Diplomat of the National Board of Medical Examiners, July 1968
Diplomat, American Board of Psychiatry and Neurology, May 1975

MEMBERSHIP IN NATIONAL & INTERNATIONAL ACADEMIC & PROFESSIONAL ORGANIZATIONS

American Psychiatric Association, Distinguished Life Fellow (1972 – present)

President, 1993-94
Board of Trustees, 1987-89, 1990-present, (**Chair, 1993-94**)
President-Elect, 1992-93
Vice President, 1990-92
Speaker of the Assembly of District Branches, 1988-89
Speaker-Elect of the Assembly, 1987-88
Recorder of the Assembly, 1986-87
Parliamentarian of the Assembly, 1996-97, 2002-2003, 2010-2011
Steering Committee on Practice Guidelines, 1990-present (Chair 1990-2009)
Chair, Clinical and Public Health Committee, DSM-5, 2012 - present
Council on Quality Improvement, 1999-2009
Chair, Work Group on Practice Parameters, 1990
Joint Reference Committee, 1986-88, 1989-90, 1992-93 (**Chair, 1992-93**, Vice Chair, 1987-88)
APA Membership Committee, 1979-90, (**Chair, 1983-88**)
Ethics Appeals Board, 1989-90
Executive Compensation Advisory Committee, 1988-95
Assembly Budget Committee, 1986-88, (**Chair, 1987-88**)
Assembly Executive Committee, 1981-92, (**Chair, 1988-89**)
Assembly Membership Committee, 1978-87, (**Chair, 1979-87**)
Assembly Planning Committee, 1984-88
Assembly Rules Committee, (**Chair, 1989-92**)
Representative, Genesee Valley District Branch, 1978-81
Deputy Representative, Genesee Valley District Branch, 1975-78
Joint Commission Public Affairs, 1988-93
Committee on Alcoholism, 1987-90
Budget Committee, 1989-90
Ad Hoc Committee on Legislation Affecting Quality Care, 1989-92
Distinguished Service Awards Committee, 1993-95
Strategic Planning Committee, 1993-96
Task Force on Pay for Performance, (**Chair, 2006 – 07**)
Insurance Review Committee, 2006-2011

World Psychiatric Association

Zonal Representative, Zone 2 (U.S.) 2011 – present
WPA Board 2011-present
Section on Quality Assurance, 1997-present, **Co-chair**, 1999-2000, **Chair**, 2000-present

American Medical Association, 1975-present

Council on Medical Service 2007 – present
Senior Delegate, American Psychiatric Association, 2003-2010
Delegate, American Psychiatric Association, 1998-present
Section Council on Psychiatry, 1994-present, **Chair** 2003-2009
Physician Consortium on Performance Improvement (PCPI), Executive Committee, 2011-present
Physician Consortium Performance Improvement (PCPI), Work Group Chair, Major Depressive Disorder, 2010 - present
American Medical Association/Specialty Society Practice Parameters Partnership, 1990-2003

American Psychiatric Foundation, Board of Directors, 2000-2006

Corporate Advisory Council Committee, 2000-2003
Nominating Committee, 2001-2003, Chair, 2004-2006
Grant Review Committee, 2000-2006
Investment Committee, 2002-2004

American Psychiatric Institute for Research and Education

Steering Committee, Practice Research Network, **Chair, 1990-2004**
Scientific Advisory Committee, Practice Research Network, 1999-2004

American Psychiatric Political Action Committee, Board of Directors 2001-present

Founding Chair, 2001-2003

Corporation for the Advancement of Psychiatry

Board of Directors, 1994-2000

Psychiatrists' Mutual Insurance Company

Board of Directors, 1986-96 (**Chair** 1994-96)

National Alliance on Mental Illness

National Alliance for the Mentally Ill, 1989-present
National Alliance for the Mentally Ill - APA Liaison, 1994-2005
Outcomes Roundtable Steering Committee (NAMI/Johns Hopkins), 1994-99
Outcomes Roundtable Communications Task Force, 1995-99
National Advisory Council Stigma Campaign, 1996-2000

American Academy of Clinical Psychiatrists, 1990-present
Board of Directors, 1995-97

***American College of Psychiatrists,* (Fellow) 1994-present**
Long Range Planning Committee, 1996-2000
Committee on Dean Award, 2000-2003
Membership Committee, 2004- 2007
Nominating Committee, 2010-present

***Pacific Rim College of Psychiatrists* (Fellow)**, 1994-present

American Academy of Psychiatrists in Alcoholism and Addictions, 1990-present

American Society of Addiction Medicine, 2001-2008

Compeer, National Advisory Board, 1990-1996

Graduate Medical Education National Advisory Council (GMENAC), Study Update Panel for Psychiatry, 1990

Academy of Psychosomatic Medicine (Fellow), 1989-present

Royal Society of Medicine, 1988-1998

World Federation for Mental Health, 1988-present

American Association for the History of Medicine, 1986-present

American Orthopsychiatric Association (Fellow), 1985-present

American Academy of Psychiatry and the Law, 1982-present

Association of Directors of Undergraduate Education in Psychiatry, 1975-77

MEMBERSHIP IN LOCAL & STATE ACADEMIC/PROFESSIONAL ORGANIZATIONS

NYS Drug Utilization and Review Committee 2008 – present

Psychiatric Advisory Committee to the Commissioner of New York State Office of Mental Health 1980-86

New York State Psychiatric Association, 1972-present
President, 1984-86
Vice President, 1981-84
Secretary, 1980-81
Council Member, 1975-90
Committees: Executive (**Chair**), Council Reorganization (**Chair**), Insurance, Medicaid, Nominating, Editorial

Genesee Valley District Branch - APA, 1972-present
President, 1981-83
President-Elect, 1979-81
Representative, 1978-81
Deputy Representative, 1975-78

Council Member, 1972-present

New York State Medical Society, 1975-present
Committee for Physicians' Health, 1999-present, (**Chair**), 1999-2009
Delegate, **House of Delegates**, 1998-present
Task Force on Stress Management Education, 2002
Medical Education Scientific Foundation, 2001-2008, 2011-present
Mannix Award Committee, 2002 - 2008
Committee on Psychiatric Medicine, 1984-2001

Monroe County Medical Society, 1975-present
Board of Directors, 1998-present, 1981-84
Delegate to MSSNY, 1998-present
Vice President, 1983-84
Practice Guideline Steering Committee/Quality Collaborative, 2005-present, (**Chair 2006 – present)**
Assistant Treasurer, 1981-83
Executive Committee, 1981-84
Budget Committee, 1981-84
Chronic Illness & Aging Committee, 1982-92 (**Chair, 1985-87**)
Editorial Committee (Bulletin), 1982-84

Rochester Academy of Medicine, 1976-present
Board of Directors, 2003 – present
President Elect, 2006 – 2007
President, 2007 – 2008

Rochester Individual Practice Association
Board of Directors, 1987-93
Peer Review Committee, 1985-89
Special Studies Committee (**Chair, 1987-89**)

MEMBERSHIP IN LOCAL & STATE COMMUNITY SERVICE ORGANIZATIONS

Coordinated Care Services, Inc., Board of Directors, 2000-2009 (Vice Chair, 2007 – 2009)
Evaluation and Services Research Committee, 2005-2011, **Chair 2006-2009**

Community Services Board, County of Monroe (Mental Health Board), 1979-84, 2009-present
*Mental Health Committee*1978-84

Mental Health Association, 1987-present, **Board of Directors** 2007 – present
Geriatric Alliance, **Chair** 2007 –present
Program Committee 2007 – present
Diversity Committee 2008 -present

Rochester NAMI, *1989 – present,* ***Board of Directors 2009 – present***

New York Care Coordination Project, Steering Committee, 2003 – 2011, 2011 – present

Systems Integration Committee, Rochester, NY, 1993-2003

St. Johns' Home, **Board of Directors, 2007 – present**

***Camp DayDreams*, Board of Directors, 2000 - present**

Medicaid Managed Care Mental Health Subcommittee, New York State Department of Health, 1995-1998

Monroe County Behavioral Health Care Committee, *1996-98*
Health Systems Agency, Review and Planning Council, 1981-88

St. Thomas More Church, Rochester, NY
Parish Council, 1976-80 (President, 1977-78, 1979-80)
Human Development Committee (Chairman), 1974-79
Religious Education Teacher, 1974-78
Eucharistic Minister, 1980-present
Planning Committee, 1996-1997
Health Committee, 2004 -2009

Catholic Youth Organization, Basketball Coach, 1979-86

Notre Dame Club of Rochester, Board of Directors, 1993-1997
Schools Committee, 1994 - present

HONORS AND AWARDS

- Commendation, San Francisco Board of Supervisors, May 1980
- Honorary Member, Puerto Rico Medical Society, 1982
- Dr. Ramon Fernandez Marina Award, Puerto Rico, April 1992
- Honorary Fellow, Puerto Rico District Branch, APA, 1992
- Special Award, Genesee Valley Psychiatric Association, June 1992
- Distinguished Service Award, American Academy of Clinical Psychiatrists, October 1993
- Special Award, Korean Neuropsychiatric Association, Seoul, Korea, October 1993
- George Ginsberg Award, New York State Psychiatric Association, December 1993
- Notre Dame Award of 1994, Rochester, NY, April 1994
- Special Award, Association of Korean American Psychiatrists, Philadelphia, PA, May 1994
- Exemplary Psychiatrist Award, National Alliance for the Mentally Ill Philadelphia, PA, May 1994
- Community Service Award, Compeer, Rochester, NY, June 1994
- John Romano Award, Mental Health Association, Monroe County, May 1995
- Presidential Award, National Association of Music Therapy, November 1995
- Seton Ball Honoree, Rochester, New York, November 1995
- President's Advocacy Award, Mid-Atlantic Region, National Association for Music Therapy, Rochester NY, March 1996
- Special Award, Assembly of the American Psychiatric Association, Washington D.C., November 1996
- Alpha Omega Alpha (AOA), 1998
- Best Doctors in America, 1998, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009
- Compeer Silver Star Award, October 1998
- American Psychiatric Association Presidential Award, 1999
- National Alliance for the Mentally Ill Rochester, Special Award, April 2002
- Edward Mott Moore Award, Monroe County Medical Society, Rochester, NY, May 2002
- Award of Merit, Rochester Academy of Medicine, Rochester, NY, May, 2003

- Special Recognition, Compeer, Rochester, NY, April 21, 2004
- Presidential Commendation, American Psychiatric Association, May 2004
- Lifetime Achievement Award, New York State Alcohol and Substance Abuse Providers, March 2006
- Distinguished Service Award, American Psychiatric Association, May 2006
- Harold Berson Award, American Psychiatric Association , May 2007
- Warren Williams Award, American Psychiatric Association, May 2007
- Presidential Commendation, American Psychiatric Association, May 2009
- Distinguished Service in Psychiatry, American College of Psychiatrists, 2011

PRACTICE GUIDELINE PROJECT, AMERICAN PSYCHIATRIC ASSOCIATION

From 1989 - 2009 Chair of APA Practice Guideline Steering Committee which is responsible for developing the process of guideline development, and steering the writing, review, approval and dissemination of each guideline. The following Practice Guidelines were approved and published during this time.

1. Practice Guideline for Eating Disorders, *American Journal of Psychiatry*, February 1993.

2. Practice Guideline for Major Depressive Disorder in Adults, *American Journal of Psychiatry*, April 1993.

3. Practice Guideline for Treatment of Patients with Bipolar Disorder, *American Journal of Psychiatry*, December 1994.

4. Practice Guideline for Psychiatric Evaluation of Adults, *American Journal of Psychiatry*, November 1995.

5. Practice Guideline for Treatment of Patients with Substance Use Disorders, Alcohol, Cocaine, Opioids, *American Journal of Psychiatry*, November 1995.

6. Practice Guideline for Treatment of Patients with Nicotine Dependence, *American Journal of Psychiatry,* October 1996.

7. Practice Guideline for the Treatment of Patients with Schizophrenia, *American Journal of* Psychiatry, April 1997.

8. Practice Guideline on Alzheimer's disease and Related Dementias, *American Journal of* Psychiatry, May 1997.

9. Practice Guideline for the Treatment of Patients with Panic Disorder, *American Journal of Psychiatry*, June 1998.

10. Practice Guideline for the Treatment of Patients with Delirium, *American Journal of Psychiatry*, May 1999.

11. Practice Guideline for Eating Disorders, (Revision) *American Journal of Psychiatry*, January 2000.

12. Practice Guideline for Major Depressive Disorder in Adults, (Revision) *American Journal of Psychiatry*, April 2000.

13. Practice Guideline for the Treatment of Patients with HIV/AIDS, *American Journal of Psychiatry*, November 2000.

14. Practice Guideline for the Treatment of Patients with Borderline Personality Disorder, *American Journal of Psychiatry*, October 2001.

15. Practice Guideline for the Treatment of Patients with Bipolar Disorder, *American Journal of Psychiatry*, April 2002.

16. Practice Guideline for the Assessment on Treatment of Patients with Suicidal Behaviors, *American Journal of Psychiatry*, November 2003

17. Practice Guideline for the Treatment of Patients with Schizophrenia, *American Journal of Psychiatry*, (Revision) February 2004

18. Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder, *American Journal of Psychiatry*, November, 2004

19. Practice Guideline for Psychiatric Evaluation of Adults, (Revision) *American Journal of Psychiatry*, May, 2006.

20. Practice Guideline for Eating Disorders, (Revision) *American Journal of Psychiatry*, May, 2006.

21. Practice Guideline for Treatment of Patients with Substance Use Disorders, Alcohol, Cocaine, Opioids, (Revision) *American Journal of Psychiatry*, May, 2006.

22. Practice Guideline for Treatment of Patients with Nicotine Dependence (Revision), *American Journal of Psychiatry,* May, 2006.

23. Practice Guideline for the Treatment of Obsessive-Compulsive Disorder, *American Journal of Psychiatry,* July 2007

24. Practice Guideline on Alzheimer's disease and Related Dementias (Revision), *American Journal of Psychiatry*, October, 2007

25. Practice Guideline for the treatment of Patients with Panic Disorder, (Revision), *American Journal of Psychiatry*, January, 2009

PUBLICATIONS

A. Peer Reviewed Journals

1. Leavell U, Farley C, McIntyre J. "Cutaneous changes in a patient with carbon monoxide poisoning." *Archives of Dermatology*, 1969, 99:429-431.

2. McIntyre J, Romano J. "Is there a stethoscope in the house – and is it used?" *Archives of General Psychiatry*, 1977, 34:1147-51.

3. McIntyre J. "Mania—The common symptom of several illnesses." *Post Graduate Medicine*, 1979, 66:145-149.

A. *Peer Reviewed Journals continued*

4. McIntyre J. Report of the Speaker-Elect. *American Journal of Psychiatry*, 1988, 145:1344-46.

5. McIntyre J. Report of the Speaker of the Assembly. *American Journal of Psychiatry*, 1989, 146:1379-1381.

6. McIntyre J. Talbott J. "Developing practice parameters." *Hospital and Community Psychiatry*, 1990, 41:1103-05.

7. McIntyre J. "Private Practice: What will its future be in psychiatry?" *The Clinical Psychiatry Quarterly*, 1990, 13:9.

8. McIntyre J. "Practice guidelines & the psychiatrist." *The Clinical Psychiatry Quarterly*, 1991, 14:21.

9. Zarin DA, Pincus HA, McIntyre JS. "Practice guidelines." *American Journal of Psychiatry* 1993, 150:175-177.

10. McIntyre J. "The time is now." *American Journal of Psychiatry*,1993,150:1298-1301.

11. McIntyre J. "My viewpoint." *Music Therapy Perspectives*, 1994, 12:134-135.

12. McIntyre J. "Our heritage, Our future." *American Journal of Psychiatry*, 1994, 151:1257-1261.

13. McIntyre J. Obituary. John Romano, M.D. *Journal of the American Medical Association*, December 14, 1994, 272:22.

14. Zarin DA, Kuzneski J, Pincus HA, McIntyre, JS, "The Role of Practice Guidelines in the Financing of Mental Health Care" *Harvard Review of Psychiatry* 2(6):347-9, 1995

15. McIntyre J."John Romano" Images in psychiatry. *American Journal of Psychiatry*, July 1995, 152:1065.

16. Nickels M., McIntyre J. "A Model for Psychiatric Services Primary Care Settings." *Psychiatric Services,* 1996, 47:522-526.

17. West JC, Zarin DA, Pincus HA, McIntyre JS, "Characteristics of psychiatric patients." *Psychiatric Services* 1996, 47: 577.

18. McIntyre JS, Zarin DA, Pincus HA. "The role of Psychotherapy in the treatment of Depression." *Archives of General Psychiatry* 1996, 53: 291-293.

19. West JC, Zarin DA, Pincus HA, McIntyre JS, "Treatments Provided to Psychiatric Patients." *Psychiatric Services* 1996, 47: 693.

20. Yager J, Pincus H, Zarin D, McIntyre J. "Practice guidelines and psychiatric education: Potential implications." *Academic Psychiatry* 1997, 21:226-233.

21. Zarin DA, Seigle L, Pincus HA, McIntyre JS. "Evidence-Based Practice Guidelines." *Psychopharmacology Bulletin* 1997, 33:641-646.

22. Zarin DA, Pincus HA, West JC, McIntyre JS. "Practice- Based Research in Psychiatry."*American Journal of Psychiatry* 1997, 154:1199-1208.

23. Zarin DA, Pincus HA, Peterson BS, West JC, Suarez AP, Marcus MA, McIntyre JS. "Characterizing Psychiatry with Findings from the 1996 National Survey of Psychiatric Practice." *American Journal of Psychiatry* 1998, 155:397-404.

24. Pincus HA, Zarin DA, Tanielian TL, Johnson JL, West JC, Pettit AR, Marcus SC, Kessler RC, McIntyre JS. "Psychiatric Patients and Treatments in 1997." *Archives of General Psychiatry* 1999, 56:441-449.

25. Olfson M, Zarin DA, Mittman BS, McIntyre JS. "Is Gender a Factor in Psychiatrists' Evaluation and Treatment of Patients with Major Depression?" *Journal of Affective Disorders*, 2001, 63:149-157.

26. McIntyre JS. "Usefulness and Limitations of Treatment Guidelines in Psychiatry." *World Psychiatry*, 2002, 1:3:186-189.

27. McIntyre JS. Editorial. "A New Subspecialty." *Am J Psychiatry* 2002, 159:l2:1961-1963.

28. Bartels SJ, Coakley E, Zubritsky C, Ware JH, Miles KM, Arean PA, Chen H, Oslin DW, Llorente MD, Costantino G, Quijano L, McIntyre JS, Linkins KW, Oxman TE, Maxwell J, Levkoff SE, for the PRISM-E Investigators. "Improving Access to Geriatric Mental Health Services: A Randomized Trial Comparing Treatment Engagement in Integrated and Enhanced Referral Care for Depression, Anxiety and At-risk Alcohol Use." Am J Psychiatry, 161:8:1455-1462, 2004.

29. Dianan T, Holt R, Kohen D, Thakore J, Haddad P, Baxter R, Peet M, Gough S, Leonard B, McIntyre J, Paton C, Peveler R. "Schizophrenia and Diabetes" 2003 Expert Consensus, British Journal of Psychiatry, 184: s112-s114, April 2004

30. Gaebel W, Weinmann S, Sartoriou N, Rutz W, McIntyre J. "Schizophrenia Practice Guidelines – An International survey and Comparision "British Journal of Psychiatry, 187:248-255, 2005

31. Krahn DD, Bartels SJ, Coakley E, Oslin DW, Chen H, McIntyre J, Chung H, Maxwell J, Ware JH, Levkoff SE. PRISM-E: Comparison of Integrated Care and Enhanced Specialty Referral Models in Depression Outcomes. Psychiatric Services 2006; 57, 959-965.

32. Duffy F, Narrow W, West J, Fochtmann L, Kahn D, Suppes T, Oldman J, McIntyre J, Manderscheid R, Sirovatka P, Regier D. "Quality of Care Measures for the treatment of Bipolar Disorder." Psychiatric Quarterly. Volume 76. Number 3, Fall 2005, 213-230.

33. Perlman BB, Vaz C, McIntyre JS, Heller KS, O'Mara M, Griepp A. "Predicting the Cost and Length of Stay of Psychiatric Inpatients: Chart versus Administrative Data" Submitted for publication.

B. BOOK

Evidence-Based Behavioral Health Practices for Older Adults. Edited by Levkoff, S., Chen, H., Fisher, J., McIntyre, J. Springer Publishing Company, Inc., 2006, New York

C. BOOK CHAPTERS

1. McIntyre J. "Emerging clinical issues. The clinicians view." Allies and Adversaries. R Schreter, S Sharfstein, C Schreter (Eds). American Psychiatric Press, Inc. 1994, 10:163-168.

2. McIntyre J, Vergare M. "History of psychiatry in America." Section Editor, Foreword and Afterword. Review of Psychiatry Volume 13. J Oldham, M Riba (Eds). American Psychiatric Press, Inc. 1994, 57:121-122.

3. McIntyre JS, Zarin D, Pincus H. "Practice guidelines and outcomes research." Outcomes Assessment in Clinical Practice. LI Sederer, B Dickey (Eds). Williams & Wilkins, 1995, 139-145.

4. Zarin D, West JC, Pincus HA, McIntyre JS. "The American Psychiatric Association psychiatric research network." Outcomes Assessment in Clinical Practice. LI Sederer, B Dickey (Eds). Williams & Wilkins, 1995, 146-156.

5. Zarin DA, McIntyre JS, Pincus HA, Seigle L. "Practice guidelines in psychiatry and a psychiatric practice research network." The Textbook of Psychiatry, Third Edition. R Hales, S Yudofsky, JA Talbott (Eds). American Psychiatric Press, 1999, 1655-1665.

6. McIntyre JS, Zarin DA, Pincus HA. "Practice guidelines in psychiatry and a psychiatric practice research network." Psychiatry in the New Millennium, S Weissman, M Sabshin, H Eist (Eds). American Psychiatric Press, 1999, 143-162.

7. McIntyre JS, Zarin DA, Charles SC. Introduction. Practice Guidelines for the Treatment of Psychiatric Disorders, Compendium 2000, American Psychiatric Association, 2000, xiii-xvi.

8. McIntyre JS. "Depression and practice guidelines." Human Psychopharmacology. John Wiley & Sons, Ltd., Baffins Lane, Chichester, UK, 2001, Vol. 16:1, 115-118.

9. McIntyre JS, Charles SC. Introduction. Practice Guidelines for the Treatment of Psychiatric Disorders, Compendium 2002, APPI, Washington, DC, 2002, xi-xiv.

10. McIntyre JS, Charles SC. First MB. Introduction. Quick Reference to the American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders, Compendium 2002. APPI, Washington, DC, 2002, xi-xiii.

11. McIntyre JS, Charles SC. Introduction. Practice Guidelines for the Treatment of Psychiatric Disorders, Compendium 2004, APPI, Washington, DC, 2004, xi-xiv.

12. McIntyre JS, Charles SC. First MB. Introduction. Quick Reference to the American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders, Compendium 2004. APPI, Washington, DC, 2004, xi-xiii.

13. McIntyre JS, Charles SC. Introduction. Practice Guidelines for the Treatment of Psychiatric Disorders, Compendium 2006. APPI, Washington, DC, 2006, xi-xiv.

14. McIntyre JS, Charles SC. First MB. Introduction. Quick Reference to the American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders, Compendium 2006. APPI, Washington, DC, 2006, xi-xiii.

15. Oldham JM, McIntyre, JS. The Role of Quality Care, Disparities in Psychiatric Care, Clinical and Cross-Cultural Perspectives. Ed. Ruiz P and Primm A. Lippincott, Williams and Williams, 2009, Baltimore, MD.

16. McIntyre KM, Norton JR, McIntyre JS. The Psychiatric Interview, Comprehensive Textbook of Psychiatry, ed. Sadock B, Sadock V, Ruiz P, Lippincott, Williams and Williams, 2009, Philadelphia, PA.

17. McIntyre JS. Practice Guidelines in Psychiatry, Comprehensive Textbook of Psychiatry, ed Sadock B, Sadock V, Ruiz P, Lippincott, Williams and Williams, 2009, Philadelphia, PA.

D. PSYCHIATRIC NEWS COLUMNS, NEWSLETTER ARTICLES, LETTERS

1. McIntyre J. "APA Constitution." *The Bulletin* (NYSPA), 1977, 19(6):68.

2. McIntyre J. "Stress and the professional." *The Bulletin* (MCMS), 1980, 38(1):6-8.

3. McIntyre J. "On mental health: Proper diagnosis by psychiatrists." Letter to the Editor, *New York Times*, January 12, 1985.

4. McIntyre J. "Equal access to fellowship process for FMGs: An interview with John McIntyre, MD." *FMG Psychiatrists Newsletter*, April 1987, 2:1.

5. McIntyre J. "Work begins on practice guidelines." *Psychiatric News*, November 16, 1990.

6. McIntyre J. "Steering Committee on practice guidelines." *Psychiatric Research Report*, March 1991, 6(1):3.

7. McIntyre J. "Practice guidelines." *Psychiatric News*, April 1991, 41-43.

8. McIntyre J. "Position Paper on psychiatric education." *Residency Training Newsletter*, 1991, 17(1):4.

9. McIntyre J. "Views on IMGs, private practice, roles of women." *Menninger Alumni Association Newsletter*, January 1992, 39(1):2.

10. McIntyre J. "The future of APA." *Newsletter of the Association of Women Psychiatrists*, January 1992, 10:1.

11. McIntyre J. "APA's practice guidelines: A look behind the scenes." *Area II Bulletin*, January-February 1992.

12. McIntyre J. "The future of psychiatry." *Quebec and Eastern Canada District Branch Newsletter*, February 1992.

13. McIntyre J. "Our future." *The American Academy of Psychiatrists in Alcoholism & Addictions Newsletter*, February 1992, 7(1):4, 12.

14. McIntyre J. Pincus H. "Asserting professional values." *Psychiatric Times*, August 1992.

15. McIntyre J. "Four point plan for health care reform." *Psychiatric News*, April 16, 1993.

16. McIntyre J. "Looking to the years ahead." *Psychiatric News*, June 4, 1993.

17. McIntyre J. "Some highlights of APA's annual meeting." *Psychiatric News*, June 18, 1993.

18. McIntyre J. "Taking root in Flower City." *Psychiatric News*, July 2, 1993.

19. McIntyre J. "'Our heritage, Our future': Our sesquicentennial." *Psychiatric News*, July 16, 1993.

20. McIntyre J. "Listen to clinicians." *Psychiatric News*, August 6, 1993.

21. McIntyre J. "Collaborating with advocacy groups." *Psychiatric News*, August 20, 1993.

22. McIntyre J. "Changes in health care, medical education." *Psychiatric News*, September 3, 1993.

23. McIntyre J. "Mental illness awareness week: It works." *Psychiatric News*, September 17, 1993.

24. McIntyre J. "Our historic opportunity." *Psychiatric News*, October 1, 1993.

25. McIntyre J. "Our warm colleagues in Iceland." *Psychiatric News*, October 15, 1993.

26. McIntyre J. "Further reflections on health care reform." *Psychiatric News*, November 5, 1993.

27. McIntyre J. "Our colleagues north of the border." *Psychiatric News*, November 19, 1993.

28. McIntyre J. "Our future is indeed bright." *Psychiatric News*, December 3, 1993.

29. McIntyre J. "Learning from colleagues in the orient." *Psychiatric News*, December 17, 1993.

30. McIntyre J. "Notes on music and voting." *Psychiatric News*, January 7, 1994.

31. McIntyre J. "Don't throw that couch out." *Psychiatric News*, January 21, 1994.

32. McIntyre J. "In touch with everyday concerns." *Psychiatric News*, February 4, 1994.

33. McIntyre J. "APA's best sesquicentennial ever!" *Psychiatric News*, February 18, 1994.

34. McIntyre J. "Psychiatry and religion: A visit to Utah." *Psychiatric News*, March 4, 1994.

35. McIntyre J. "Practice research network: Pilot stage." *Psychiatric News*, March 18, 1994.

36. McIntyre J, Flynn L. "The Rip Van Winkle of psychiatry." Letter to the Editor, *The Wall Street Journal*, March 30, 1994.

37. McIntyre J. "Harnessing our network power." *Psychiatric News*, April 1, 1994.

38. McIntyre J. "Professional values and managed care." *Psychiatric News*, April 15, 1994.

39. McIntyre J. "A model psychiatry department." *Psychiatric News*, May 6, 1994.

40. McIntyre J. "My glory was I had such friends." *Psychiatric News*, May 20, 1994.

41. Messina J, McIntyre J. Institutional treatment for patients with serious mental illness—The present and the future." *The Bulletin, Monroe County Medical Society*, May/June 1995.

42. McIntyre J. "Group psychotherapy: Time to take a new look." Clinical Currents. *Psychiatric News*, April 21, 1995.

43. McIntyre JS, Hirschfeld R, Zarin, DA. "Treatment of bipolar disorder." Audio Tape *ACP-Psychiatric Update*, Vol 15, Number 9, 1995.

44. McIntyre J. "Practice guidelines." *Psychiatric Times*, August 1995.

45. McIntyre JS, Zarin DA. "Practice guideline for major depressive disorder in adults." *Directions in Psychiatry*, The Hatherleigh Co., Ltd., 1995.

46. McIntyre J. "Deep blue, understanding the illness of depression " Supplement to Wolfe Community Newspapers, April 22, 1996.

47. McIntyre JS. Book Review Comments. The New Music Therapist's Handbook, S. Hanser. Berklee Press, Boston, MA, 1999.

48. McIntyre JS. "The American Psychiatric Association Practice Guideline Project." *Psychiatric Times*, 2003, 110-111.

49. McIntyre JS. "Practice guidelines: process and promise" Article - The NYSPA Report *Mental Health News*, Vol. 6:2, Spring 2004.

50. McIntyre, JS. "Culture, Ethnicity and Mental Illness", Bulletin, Monroe County Medical Society, April 2007

51. McIntyre, JS. "Physician Stress: Seven Steps for Effective Coping", Bulletin, Monroe County Medical Society, November, 2008

VISITING PROFESSORSHIPS, NAMED LECTURES, KEYNOTE ADDRESSES

1. Visiting Professor, Cleveland Clinic, Cleveland, OH, September 9-10, 1992
2. Southern Psychiatric Association, Keynote Address, Hot Springs, VA, October 1, 1992 "The Future of Psychiatry"
3. Mental Illness Awareness Coalition, Keynote address, Buffalo, NY, October 3, 1992 "Equal Access to Mental Health"
4. Visiting Professor, Pennsylvania State University, Hershey, Pennsylvania, February 11-12, 1993
5. American Psychiatric Association Annual Meeting, President-elect Address, San Francisco, CA, May 23, 1993 "The Time Is Now"
6. Visiting Professor, Ohio State University, Columbus, OH, September 22, 1993
7. Ian Gregory Lecture, Ohio State University, Columbus, OH, September 22, 1993 "Practice Guidelines and Practice Research Network"
8. Hospital and Community Psychiatry Institute, Presidential Address, Baltimore, MD, October 9, 1993 "The Future of Psychiatry"
9. Compeer, Inc., Annual Conference, Keynote Speaker, Rochester, NY, October 29, 1993 "Compeer and Health Care Reform"
10. National Association for Music Therapy, Toronto, Canada, October 31, 1993 "Spectrum of Psychiatric Treatments"
11. George Ginsberg Lecture, Albany Medical Center Hospital and College, Albany, NY, December 1, 1993 "The Future of Psychiatry as a Medical Specialty"
12. Frederick Weniger Lecture, University of Pittsburgh, Pittsburgh, PA, April 15, 1994 "The Practice of Psychiatry, Directions for the Future"
13. American Psychiatric Association Annual Meeting, Presidential Address, Philadelphia, PA, May 22, 1994 "Our Heritage Our Future"
14. New York State Office of Mental Health, Keynote Address, "Public/Private Partnerships: New Models of Care." Albany, NY, June 23, 1994 "The Future of Psychiatric Services"
15. 10th Anniversary Alliance for the Mentally Ill of Buffalo and Erie County, Keynote Speaker, Buffalo, NY, October 15, 1994 "Mental Health Care, Past, Present and Future"
16. American Group Psychotherapy Association Annual Meeting, Keynote Speaker, Atlanta, GA, February 16, 1995 "Practice Guidelines and Mental Illness"
17. Visiting Professor, University of Louisville, Louisville, KY, June 5, 1997
18. Invited Lecturer, Symposium, Institute on Psychiatric Services, San Francisco, CA, October 5, 1998 "Primary Care and Psychiatry"
19. Mental Health Association, Mental Health Forum, Keynote Speaker, Rochester, NY, April 14, 1999 "Bio/Psycho/Social Model in Identification and Treatment of Mental Health Disorders in Older Persons"
20. National Alliance for the Mentally Ill Rochester, Keynote Speaker, Rochester, NY, April 9, 2002.

INTERNATIONAL PRESENTATIONS

1. Ramon Fernandez Marina Lecture, Puerto Rico District Branch, San Juan, Puerto Rico, April 1992 "Biopsychosocial Model: Agenda for the '90's"

2. Icelandic Psychiatric Society, Reykjavik, Iceland, September 15, 1993 "State of Psychiatry"

3. Canadian Psychiatric Association Annual Meeting, Winnipeg, Manitoba, Canada, September 29, 1993 "American Psychiatric Association and Canadian Psychiatric Association"

4. Canadian Psychiatric Association, Winnipeg, Manitoba, Canada, September 30, 1993 "Practice Research Network"

5. Chiba Psychiatric Medical Center, Tokyo, Japan, October 20, 1993 "Major Psychiatric Issues"

6. International Congress of Korean Psychiatrists, Keynote Speaker, Seoul, Korea, October 22, 1993 "Practice Guidelines and the Future of Psychiatry".

7. Royal College of Psychiatrists, Cork, Ireland, July 7, 1994 "One Hundred and Fifty Years of Psychiatry in America"

8. Western Canada District Branch, Victoria, British Columbia, April 21, 1995 "The Future of Psychiatry"

9. Washington State Psychiatric Association, Vancouver, British Columbia, April 22, 1995 "Practice Guidelines, A Practice Research Network and The Future of Psychiatry"

10. 1995 World Congress of the World Federation for Mental Health, Dublin, Ireland, August 17, 1995 "Professional and Advocacy Organizations Working Together"

11. World Psychiatric Association, Regional Conference, Prague, The Czech Republic, September 22, 1995 "Quality Assurance - A United States Perspective"

12. Icelandic Psychiatric Association, Reykjavik, Iceland, September 25, 1995 "Psychiatry and Clinical Research A New Approach"

13. Ontario District Branch, Toronto, Canada, January 26, 1996 "The Future of Clinical Research"

14. World Psychiatric Association Xth Congress, Madrid, Spain, August 24, 1996 "Practice Guidelines in Psychiatry"

15. World Psychiatric Association Xth Congress, Madrid, Spain, August 26, 1996 "Quality Assurance, the US Perspective"

16. World Psychiatric Association Xth Congress, Madrid, Spain, August 27, 1996 "The Future of Psychiatry -Evidence Based Diagnosis and Treatment"

17. World Psychiatric Association Xth Congress, Madrid, Spain, August 28, 1996 "Music Therapy and Mental Health"

18. American Psychiatric Association/Societa Italiana di Psichiatria Meeting, Borgo Monastero, Italy, April 11, 1997 "Quality Assurance and Practice Guidelines"

19. XI World Congress of Psychiatry, Hamburg, Germany, August 7, 1999 "Evidence-Based Psychiatry: An International Overview of Psychiatric Practice Guideline Projects"

20. XI World Congress of Psychiatry, Hamburg, Germany, August 7, 1999, Trends in Psychiatric Practice for the Next Century, "What's Really Going on in Psychiatry: Findings from the APA Practice Research Network"

21. XI World Congress of Psychiatry, Hamburg, Germany, August 8, 1999, Quality Assurance in Mental Health Care, "Practice Guidelines and Quality Assurance"

22. XI World Congress of Psychiatry, Hamburg, Germany, August 9, 1999 "Managed Care and Quality Assurance in Psychiatry"

23. XI World Congress of Psychiatry, Hamburg, Germany, August 11, 1999 "Standards and Guidelines in Psychiatry: How Far are They Adaptable from One Society to Another"

24. XI World Congress of Psychiatry, Hamburg, Germany, August 11, 1999 "Psychiatric Practice Guidelines"

25. Royal College of Psychiatrists, World Psychiatric Association, London, England, July 11, 2001 "Dissemination of Practice Guidelines: Methods, Issues and Results"

26. XII World Congress of Psychiatry, Yokohama, Japan, August 27, 2002 "Diagnosis and Treatment in Schizophrenia"

27. XII World Congress of Psychiatry, Yokohama, Japan, August 28, 2002 "Diagnosis and Treatment of Affective Disorders"

28. XII World Congress of Psychiatry, Yokohama, Japan, August 28, 2002 "A Practice Guideline as a Quality Improvement Tool - Major Depressive Disorder Guideline"

29. International Congress of Psychiatry, Florence, Italy, November 10-13, 2004 Symposium Chair "Quality Improvement"

30. International Congress of Psychiatry, Florence, Italy, November 10-13, 2004 "The American Psychiatric Association practice guideline project: status and challenges"

31. International Congress on Psychiatry, Athens, Greece, March 13, 2005 "Practice Guidelines as a Major Component of a Quality Improvement Initiative."

32. XIII World Congress on Psychiatry, Cairo, Egypt, September 10-15, 2005 "Practice Guidelines and Psychiatry, An International Perspective"

33. XIII World Congress on Psychiatry, Cairo, Egypt, September 12, 2005 "Physician Impairment with Mental Illness and/or Addiction"

34. International Congress, Havana, Cuba, March 28, 2006 "Integration of Primary Care and Psychiatry"

35. World Psychiatric Association Regional Congress, Istanbul Turkey, July 15, 2006 "Practice Guidelines as a Quality Improvement Initiatives/Recent Advances"

36. World Psychiatric Association Regional Congress, Istanbul Turkey, July 15, 2006 Chair, Symposium "Quality Improvement Initiatives"

37. World Psychiatric Association Regional Congress, Istanbul Turkey, July 15, 2006 "The Role of Person-Centered Planning in System Transformation in the Western New York Care Coordination Program"

38. IVX World Congress on Psychiatry, Prague, Czech Republic, September, 2008. Chair, Symposium on Quality Improvement Initiatives: From Research to System Reform.

39. IX World Congress on Psychiatry, Prague, Czech Republic, September, 2008. "From Research to Practice: Recent Initiatives in Practice Guidelines

40. The 3rd World Congress of Asian Psychiatry, Melbourne, Australia, August, 2011 "Practice Guidelines: New Directions and Challenges"

41. XV World Congress on Psychiatry, Buenos Aires, Argentina, September, 2011. "New Directions in the Development of Practice Guidelines"

LECTURES AND PRESENTATIONS AT NATIONAL MEETINGS, GRAND ROUNDS

42. "Present and Future of American psychiatry." Grand Rounds, VA Hospital, Canandaigua, NY, April 1, 1983.

43. "Fellowship aspirations." Component presentation, American Psychiatric Association Annual Meeting, New York, NY, May 2, 1983.

44. "Foreign medical graduates and the APA." American Psychiatric Association Annual Meeting, Dallas, TX, May 20, 1985.

45. "APA Fellowship process—Myth and reality" Workshop, Chair. American Psychiatric Association Annual Meeting, Dallas, TX, May 22, 1985.

46. "Mania in the elderly." Medical Society, State of New York, Annual Meeting, New York, NY, March 1986.

47. "The private practice of psychiatry—A model for survival." Medical Society, State of New York Annual Meeting, New York, NY, March 14, 1987.

48. "Practice in an IPA, treatment challenges and accountability." Psychiatry and Managed Care Systems—A Resource Symposium, Washington, DC, November 18, 1988.

49. "Overview of APA—Then and now." Public Affairs Institute, San Diego, CA, February 25, 1989.

50. "Directions in Psychiatric Services." Forum, Chairperson. American Psychiatric Association, Washington, DC, November 10, 1989.

51. "Psychiatry and managed care: Fantasy and reality." Department of Psychiatry Grand Rounds, New York University Medical Center, New York, NY, February 8, 1990.

52. "Managed care and the future of psychiatry." West Hudson District Branch, APA, Annual Meeting, Tuxedo, NY, April 20, 1990.

53. "Practice guidelines and psychiatry." American Psychiatric Association, Washington, DC, November 9, 1990.

54. "Practice guidelines, quality assurance, and psychiatry." Greater Houston Hospital Council, Houston, TX, February 9, 1991.

55. "Constraints of managed care on private practice." Regional meeting of the Tri-state Chapter of the American Association of Psychiatric Administrators, New York, NY, April 12, 1991.

56. "Practice guidelines and psychiatry." American Psychiatric Association Annual Meeting, New Orleans, LA, May 14, 1991.

57. "Subspecialization & psychiatry." Debate. American Psychiatric Association Annual Meeting, New Orleans, LA, May 14, 1991.

58. "Developing clinical criteria and standards for mental health." American Managed Care and Review Association's Managed Mental Health Conference, Washington, DC, June 14, 1991.

59. "Practice guidelines and the future of psychiatry." The Ohio Psychiatric Association, Cleveland, OH, October 6, 1991.

60. "The future of psychiatry." The New Hampshire Psychiatric Society, Concord, NH, October 10, 1991.

61. Psychiatry and the APA." California Psychiatric Association, Santa Barbara, CA, October 12, 1991.

62. "Practice guideline project." New York County District Branch Council, Arden Homestead, NY, October 19, 1991.

63. "Managing managed care." Hospital & Community Psychiatry Institute, Los Angeles, CA, October 21, 1991.

64. "A volunteer program as an adjunct to therapy" presentation with Bernice Skirboll). Hospital & Community Psychiatry Institute, Los Angeles, CA, October 22, 1991.

65. "Practice parameters and the psychiatrist." American Academy of Clinical Psychiatrists, New Orleans, LA, October 24, 1991.

66. "Managed care and health initiatives: the impact on the treatment of addictions and other psychiatric disorders." American Academy of Psychiatrists in Alcoholism and Addictions, Naples, FL, December 7, 1991.

67. "The future of psychiatry." Department of Psychiatry Grand Rounds, University of Chicago, Chicago, IL, January 6, 1992.

68. "Practice guidelines and psychiatry." Department of Psychiatry Grand Rounds, University of Louisville, Louisville, KY, January 9, 1992.

69. "The influence of practice parameters in psychiatry." San Diego Society of Psychiatric Physicians, San Diego, CA, January 16, 1992.

70. "The future of psychiatry." American Association of Directors of Psychiatric Residency Training, New Orleans, LA, January 18, 1992.

71. "Practice guidelines and psychiatry." Department of Psychiatry Grand Rounds, Bronx Lebanon Hospital, Bronx, NY, January 21, 1992.

72. "The future of psychiatry." The Bronx District Branch, Bronx, NY, January 22, 1992.

73. "The future of psychiatry." Department of Psychiatry Grand Rounds, Columbia University, New York, NY, January 24, 1992.

74. "Practice guidelines and psychiatry." New York University Grand Rounds Bellevue), Department of Psychiatry, New York, NY, January 30, 1992.

75. "Psychiatry and managed care." Manhattan Psychiatric Center Grand Rounds, New York, NY, January 31, 1992.

76. "Eating disorders and major depressive disorder—Emerging practice guidelines." Jefferson Medical College, Department of Psychiatry Grand Rounds, Philadelphia, PA, February 5, 1992.

77. "Psychiatry and the future." New York County District Branch, New York, NY, February 13, 1992.

78. "Psychiatry and the APA." Washington Psychiatric Society, Washington, DC, February 20, 1992.

79. "Review criteria and practice guidelines." American Managed Care and Review Association Annual Conference, Boston, MA, April 6, 1992.

80. "Rationale for practice guidelines." Tennessee Medical Society, Nashville, TN, April 10, 1992.

81. "Psychiatry and Society." Round Table Discussion. American Psychiatric Association Annual Meeting, Washington, DC, May 5, 1992.

82. "Update on practice guidelines in psychiatry." Forum. American Psychiatric Association Annual Meeting, Washington, DC, May 6, 1992.

83. "Can we afford to talk to patients?" American Psychiatric Association Annual Meeting, Washington, DC, May 7, 1992.

84. "Challenges for our field." Western New York Psychiatric Society, Buffalo, NY, May 16, 1992.

85. "Remarks." Brooklyn Psychiatric Society, Brooklyn, NY, May 17, 1992.

86. "Psychiatry in the '90's." Bronx Psychiatric Society, Bronx, NY, June 17, 1992.

87. "Crucial issues in psychiatry." Cleveland Psychiatric Society, Cleveland, OH, September 9, 1992.

88. "Practice guidelines and psychiatry." Cleveland Clinic, Cleveland, OH, September 10, 1992.

89. "History of practice guidelines in psychiatry." Methods Conference, American Psychiatric Association, Washington, DC, September 22, 1992.

90. "Major depressive disorder." Louisiana Psychiatric Association, San Destin, FL, September 27, 1992.

91. "Standards of clinical practice." Hospital & Community Psychiatry Institute, Toronto, Canada, October 26, 1992.

92. "Practice guidelines-an overview." Texas Society of Psychiatric Physicians, Dallas, TX, October 31, 1992.

93. "Psychiatry in the future." New Jersey Psychiatric Association, Newark, NJ, November 6, 1992.

94. "Practice guidelines." Discussion Group. American Psychiatric Association, Washington, DC, November 12, 1992.

95. "Roles of international medical graduates in American psychiatry." American Association of Psychiatrists from India, Long Island, NY, November 22, 1992.

96. "Practice guidelines." Hospital Psychiatry-Year 2000, Houston, TX, December 5, 1992.

97. "Practice guidelines and psychiatry." Special Presentation. Fifth Annual New York State Office of Mental Health Research Conference, Albany, NY, December 7, 1992.

98. "150 Years of service." Sesquicentennial Celebration, Mohawk Valley Psychiatric Center, Utica, NY, January 16, 1993.

99. "Development of practice guidelines in medicine." Department of Psychiatry, Penn State University, Hershey, PA, February 11, 1993.

100. "Practice guidelines in psychiatry." Department of Psychiatry, Penn State University, Hershey, PA, February 11, 1993.

101. "Major issues in psychiatry: Health care systems, ethics, subspecialization and recruitment." Department of Psychiatry, Penn State University, Hershey, PA, February 12, 1993.

102. "Outcome research and guidelines." University of New Jersey Medical School, Newark, NJ, March 3, 1993.

103. "Future of forensic psychiatry." Columbia University, New York, NY, April 22, 1993.

104. "Parameters of practice." Omstead State Hospital Grand Rounds, Durham, NC, April 23, 1993.

105. "Practice guidelines and practice research network." Duke University Grand Rounds, Durham, NC, April 23, 1993.

106. "Subsequent therapist, clinical, legal and ethical issues." Discussant, Symposium. American Psychiatric Association Annual Meeting, San Francisco, CA, May 24, 1993.

107. "Practice guidelines in psychiatry." American Psychiatric Association Annual Meeting, San Francisco, CA, May 25, 1993.

108. "Health care reform." President's Symposium. American Psychiatric Association Annual Meeting, San Francisco, CA, May 26, 1993.

109. "Forum on practice guidelines." Chair. American Psychiatric Association Annual Meeting, San Francisco, CA, May 27, 1993.

110. "The effect of health care reform." National Alliance for the Mentally Ill Annual Meeting, Miami, FL, July 23, 1993.

111. "Treatment of major depression- biopsychosocial approach." Mountain View Hospital Grand Rounds, Gadsden, AL, August 13, 1993.

112. "How should we develop behavioral practice guidelines and protocols." Behavioral Health Care Institute, San Francisco, CA, September 27, 1993.

113. "Expert knowledge-driven guidelines." Behavioral Health Care Institute, San Francisco, CA, September 27, 1993.

114. "Practice research network in psychiatry." American Academy of Clinical Psychiatrists, Chicago, IL, October 7, 1993.

115. "Practice guidelines and practice research network." Hospital and Community Psychiatry, Baltimore, MD, October 10, 1993.

116. "Healthcare reform." Interdisciplinary Panel, Hospital and Community Psychiatry, Baltimore, MD, October 11, 1993.

117. "Practice guidelines for the management of depression: the APA approach." Academy of Psychosomatic Medicine, New Orleans, LA, November 11, 1993.

118. "The future of psychiatry." Nebraska Psychiatric Society, Omaha, NE, November 16, 1993.

119. "Health care reform and mental health." Grand Rounds, St. Joseph's Center for Mental Health, Omaha, NE, November 17, 1993

120. "The future of psychiatry." New York State Capital District Branch, Albany, NY, November 30, 1993.

121. "Practice guidelines and practice research network." Grand Rounds, Albany Medical College, Albany, NY, December 1, 1993.

122. "Practicing with practice guidelines." The National Association of Psychiatric Health Systems, San Diego, CA, January 24, 1994.

123. "The future of psychiatry." Grand Rounds, University of Utah, Salt Lake City, UT, January 31, 1994.

124. "The future of psychiatry." Colorado Psychiatric Society, Denver, CO, March 23, 1994.

125. "The impact of health care reform on psychiatry." Area VII/ Arizona State Psychiatric Society, Tucson, AZ, April 10, 1994.

126. "Update on various APA programs." Nassau/Suffolk District Branches Joint Meeting, Woodbury, NY, April 26, 1994.

127. "A practice research network and the future of psychiatry." Minnesota Psychiatric Society Annual Banquet, Rochester, MN, April 30, 1994.

128. "Funding for public psychiatry: the national scene." Office of Mental Health Physician Management Conference, Albany, NY, May 9, 1994.

129. "History of Psychiatry in America." Symposium Co-chair. American Psychiatric Association Annual Meeting, Philadelphia, PA, May 23, 1994.

130. "Practice research network." American Psychiatric Association Annual Meeting, Philadelphia, PA, May 24, 1994.

131. Forum: "Update on practice guidelines," American Psychiatric Association Annual Meeting, Philadelphia, PA, May 24, 1994.

132. "Stigma and the celebrity." Presidential symposium Co-chair. American Psychiatric Association Annual Meeting, Philadelphia, PA, May 24, 1994.

133. "Practice guidelines." Workshop. American Psychiatric Association Annual Meeting, Philadelphia, PA, May 26, 1994

134. "The future of the practice of psychiatry." Yale University, New Haven, CT, June 3, 1994.

135. "Development and standardization of behavioral healthcare practice guidelines." The Behavioral Healthcare Outcomes & Guidelines Summit, Minneapolis, MN, June 18, 1994.

136. "DSM-IV and guidelines." Symposium. Collegium International Neurosycho-pharmacologium Congress, Washington, DC, June 29, 1994.

137. "The future of American psychiatry." Pine Rest Hospital, Grand Rapids, MI, August 8, 1994.

138. "APA's clinical outcomes research network: Improving the clinical and services delivery research base in psychiatry." Symposium. Institute on Hospital Community Psychiatry, San Diego, CA, October 1, 1994.

139. "Continuous quality improvement in psychiatry." Symposium. Institute on Hospital Community Psychiatry, San Diego, CA, October 3, 1994.

140. "Practice guidelines for the treatment of patients with bipolar disorder." Symposium, Institute on Hospital Community Psychiatry, San Diego, CA, October 3, 1994.

141. "Practice guidelines update and practice research network." Department of Psychiatry Grand Rounds, University of Rochester, Rochester, NY, October 19, 1994.

142. "Mental health outcomes assessment: Using patient outcomes to improve the quality of care." National Association for the Mentally Ill, Washington, DC, November 14, 1994.

143. "Practice guidelines for psychiatry and practice research networks." Grand Rounds, University of Kansas Medical Center, Wichita, KS, January 24, 1995.

144. "Psychiatrists and their patients: APA's National Psychiatric Research Network findings." Symposium Co-chair. American Psychiatric Association Annual Meeting, Miami, FL, May 22, 1995.

145. "Update on practice guidelines in psychiatry." Forum. American Psychiatric Association Annual Meeting, Miami, FL, May 23, 1995.

146. "A vision of the future of practice guidelines." Chair, Symposium. American Psychiatric Association Annual Meeting, Miami, FL, May 23, 1995.

147. "The role of the APA: professional and social issues." Symposium. American Psychiatric Association Annual Meeting, Miami, FL, May 23, 1995.

148. "How to move up in an organization." Symposium. American Psychiatric Association Annual Meeting, Miami, FL, May 24, 1995

149. "Psychiatric management." Chair, Symposium. American Psychiatric Association Annual Meeting, Miami, FL, May 24, 1995.

150. "Practice guidelines: the challenges ahead." The Behavioral Healthcare Outcomes, Guidelines and Report Card Summit, Minneapolis, MN, June 10, 1995.

151. "What is this thing called outcomes and why is it important in managed care?" National Alliance for the Mentally Ill, Washington, DC, July 21, 1995.

152. "The treatment of bipolar disorder - a guideline." National Depressive and Manic Depressive Association Annual Meeting, Chicago, IL, August 25, 1995.

153. "Using outcomes to improve care: Quality assurance of mental health and substance abuse treatment." Symposium Co-chair. Institute on Psychiatric Services, Boston, MA, October 6, 1995.

154. "Roles of social approaches in the concept of psychiatric management." Institute on Psychiatric Services, Boston, MA, October 7, 1995.

155. "Update on practice guidelines." Symposium Chair. Institute on Psychiatric Services, Boston, MA, October 9, 1995.

156. "A psychiatric research network and the future of psychiatry." American Academy of Clinical Psychiatrists, San Diego, CA, October 20, 1995.

157. "The future of psychiatry." Symposium Chair. St. Mary's Hospital, Rochester, NY, January 12, 1996

158. "Outcomes of managed care." Outcomes Roundtable. Tampa, Fl, April 29, 1996

159. "Update on practice guidelines - Alzheimers and Nicotine Dependence." Forum Chair. American Psychiatric Association, New York, NY, May 6, 1996

160. "Practice research network." Symposium Co-Chair. American Psychiatric Association, New York, NY, May 6, 1996

161. "Should APA promote standards?" Symposium Chair. American Psychiatric Association, New York, NY, May 7, 1996

162. "APA as advocate in the ABPN process." Workshop. American Psychiatric Association, New York, NY, May 7 1996.

163. "American Psychiatric Association - What next?" Symposium. American Psychiatric Association, New York, NY, May 7, 1996.

164. "Swimming with sharks - organization politics." Workshop. American Psychiatric Association, New York, NY, May 8, 1996.

165. "Outcomes - a partnership approach." Symposium. American Psychiatric Association. New York, NY, May 8, 1996.

166. "Career Directions: Practice management essentials for residents." New York, NY, May 10, 1996.

167. "Clinical controversies in the treatment of depression." Symposium Co-Chair. Syracuse, NY, May 18, 1996.

168. "The use of practice guidelines for managed care." University of South Florida, Mental Health Institute, Tampa, Florida, May 30, 1996.

169. "Psychiatry as primary care." 50th Anniversary Celebration of the University of Rochester, Rochester, NY, June 7, 1996.

170. "Practice guidelines for persons with mental illnesses." Behavioral Health Care Institute. Chicago, IL, June 14, 1996.

171. "Outcome measures and mental health." NYS Association of CMHC Annual Meeting. Saratoga Springs, NY, June 17, 1996.

172. "Primary care and psychiatry." Grand Rounds. Carolina Medical Center, Charlotte, NC, August 13, 1996.

173. "Outcomes and quality assurance." Forum. American Psychiatric Association, Workshop. Washington, DC, September 7, 1996.

174. "Working with patients, families and managed care." Symposium. American Academy of Clinical Psychiatrists, Ft. Lauderdale, FL, October 12, 1996

175. "Practice research network - key findings." Institute on Psychiatric Services, Chicago, IL, October 19, 1996.

176. "Review of practice guidelines: nicotine dependence, panic and related anxiety disorders, and schizophrenia." Symposium Chair. Institute on Psychiatric Services, Chicago, IL, October 22, 1996.

177. "Templates for guideline development." Institute for International Research, Atlanta, GA, November 4, 1996.

178. "Practice guidelines and psychiatry." Grand Rounds. VA Hospital, Canandaigua, NY, January 24, 1997.

179. "The effect of managed care on the treatment process." American Group Psychotherapy Association, New York, NY, February 21, 1997.

180. "Practical implementation of APA practice guidelines." Career Directions for Psychiatry Residents, San Diego, CA, May 15, 1997.

181. "Primary care and psychiatry." Symposium. American Psychiatric Association, San Diego, CA, May 18, 1997.

182. "Swimming with sharks: organization politics." Workshop. American Psychiatric Association, San Diego, CA, May 20, 1997.

183. "Music therapy -- an efficacious and effective modality of care." Symposium Chair. American Psychiatric Association, San Diego, CA, May 20, 1997.

184. "Research directions in psychiatry: advances in geriatric psychiatry: APA practice guidelines." San Diego, CA, May 21, 1997.

185. "Psychiatry, primary care and depression." Western New York Psychiatric Society, Buffalo, New York, October 16, 1997.

186. "Practice guidelines and managed care." State University of New York at Buffalo, Department of Psychiatry, Grand Rounds, Buffalo, New York, October 17, 1997.

187. "Swimming with sharks: organization politics," Workshop. Institute on Psychiatric Services, Washington, DC, October 25, 1997.

188. "What's really going on in psychiatry today?" Practice Research Network Update, Symposium. Institute on Psychiatric Services, Washington, DC, October 25, 1997.

189. "Review of APA practice guidelines." Workshop. Institute on Psychiatric Services, Washington, DC, October 26, 1997.

190. "Practice guideline implementation evaluation." Workshop. Institute on Psychiatric Services, Washington, DC, October 26, 1997.

191. "Challenges to the primary care provider in treatment of psychiatric illness." New York State Capital District Branch, Albany, NY, November 13, 1997.

192. "Practical implementation of APA practice guidelines." Pharmedica/Career Directions, Workshop. Toronto, Canada, May 28, 1998.

193. "What's really going on in psychiatry: APA PRN forum." American Psychiatric Association, Toronto, Canada, June 1, 1998.

194. Practicing evidence-based psychiatry: Major depressive disorders, Symposium. American Psychiatric Association, Toronto, Canada, June 2, 1998.

195. "Review of APA practice guidelines: delirium and HIV/AIDs." Forum Chair and Presentation. American Psychiatric Association, Toronto, Canada, June 3, 1998.

196. "PRN policy implication: practice profile of U.S. and Canadian psychiatrists." American Psychiatric Association, Toronto, Canada, June 3, 1998.

197. "Music therapy in psychiatric care." Symposium Chair and Presentation. American Psychiatric Association, Toronto, Canada, June 3, 1998.

198. "Primary care and psychiatry." Symposium Presentation. University of South Carolina, Hilton Head, South Carolina, September 26, 1998.

199. "Recent developments in practice guidelines for psychiatry." Symposium Presentation. University of South Carolina, Hilton Head, South Carolina, September 27, 1998.

200. "Characterizing psychiatry: findings from the APA's Research Network." Symposium. Institute on Psychiatric Services, San Francisco, CA, October 3, 1998.

201. "Meet the experts: sunny-side up." Workshop. Institute on Psychiatric Services, San Francisco, CA, October 4, 1998.

202. "Depression: present and future implications." Overview Presentation. Third Annual Spring Conference, Department of Psychiatry and Behavioral Health, Unity Health System, Rochester, NY, April 16, 1999.

203. "Practical implications of APA practice guidelines." Career Directions, Presenter. Washington, DC, May 13, 1999.

204. "Private practice is alive and thriving." Workshop Presenter. American Psychiatric Association, Washington, DC, May 17, 1999.

205. "What's really going on in psychiatry? The APA Practice Research Network." Forum Co-chair. American Psychiatric Association, Washington, DC, May 17, 1999.

206. "Practicing and measuring quality care for schizophrenia: schizophrenia and practice guidelines." Symposium Chair. American Psychiatric Association, Washington, DC, May 17, 1999.

207. "Update on the practice guideline for the treatment of patients with BPD." Forum Co-chair. American Psychiatric Association, Washington, DC, May 19, 1999.

208. "Practicing evidence-based psychiatry: bipolar disorder." Symposium Chair. American Psychiatric Association, Washington, DC, May 19, 1999.

209. "Music therapy in psychosocial care and pain management, music therapy: an overview." Symposium Chair. American Psychiatric Association, Washington, DC, May 19, 1999.

210. "Guidelines for the treatment of depression in primary care settings." IM/Psychiatry Grand Rounds. Akron General Medical Center, Akron, OH, September 29, 1999.

211. "Practice guidelines in primary care." Akron City Hospital, Akron, OH, September 29, 1999.

212. "Practice guidelines in mental health care." Internal Medicine Grand Rounds. Youngstown, OH, September 30, 1999.

213. "Practice guidelines & outcomes." Keynote Address. Forum Health, Youngstown, OH, September 30, 1999.

214. "Practice guidelines in mental health care." Psychiatry Grand Rounds. Akron General Medical Center, Youngstown, OH, October 1, 1999.

215. "Music therapy and medicine." Institute on Psychiatric Services, New Orleans, LA, October 29, 1999.

216. "What's really going on in psychiatry: update from the APA practice research network." Co-Chairperson. Institute on Psychiatric Services, New Orleans, LA, October 30, 1999.

217. "From Bach to blues: music therapy." Chairperson. Institute on Psychiatric Services. New Orleans, LA, October 31, 1999.

218. "Using practice guidelines to improve quality." Chairperson. Institute on Psychiatric Services. New Orleans, NY, October 31, 1999.

219. "Practical implications of APA practice guidelines." Career Directions. Chicago, IL, May 12, 2000.

220. "Music therapy and medicine: partnerships in care." American Psychiatric Association, Chicago, IL, May 15, 2000.

221. "Quality indicators in psychiatry." Symposium Co-chair. American Psychiatric Association, Chicago, IL, May 16, 2000.

222. "Development of treatment guidelines in the United States." American Psychiatric Association, Chicago, IL, May 16, 2000.

223. "Using Computers to guide clinical practice." Component Workshop. American Psychiatric Association, Chicago, IL, May 17, 2000.

224. "Music therapy: integrative medicine for the new Millennium." Symposium Co-chair. American Psychiatric Association, Chicago, IL, May 17, 2000.

225. "Update on practice guidelines for treatment of patients with bipolar personality disorder and HIV/AIDS." Component Workshop . Institute on Psychiatric Services, Philadelphia, PA, October 25, 2000.

226. "Quality indicators and practice guidelines." Symposium Co-chair. Institute on Psychiatric Services, Philadelphia, PA, October 27, 2000.

227. "What's really going on in psychiatry today?" Symposium Chair. Institute on Psychiatric Services, Philadelphia, PA, October 27, 2000.

228. "Practical issues on implementation of practice guidelines within State systems." New York State Office of Mental Health Meeting, Philadelphia, PA, October 27, 2000.

229. "Music therapy: integrative medicine for the mind, body and spirit." Co-chair. Institute on Psychiatric Services, Philadelphia, PA, October 28, 2000.

230. "Interfacing primary care and behavioral health." Canandaigua Veterans Hospital, Medical/Psychiatric Service Staff Conference, Canandaigua, NY, November 17, 2000.

231. "Methodological issues in the multi-site aging," Mental Health and Substance Abuse in Primary Care Initiative. Gerontological Society of America 53rd Annual Scientific Meeting, Washington, DC, November 20, 2000.

232. "Practical implementation of American Psychiatric Association Practice Guidelines." Career Directions, Presenter. New Orleans, LA, May 4, 2001.

233. "New findings on psychiatric practice: access and patterns of care." Symposium Co-chair. American Psychiatric Association, New Orleans, LA, May 7, 2001.

234. "Music therapy: integrated art and science in health care." Symposium Chair. American Psychiatric Association, New Orleans, LA, May 8, 2001.

235. "Using practice guidelines in residency training." Workshop Chair. American Psychiatric Association, New Orleans, LA, May 9, 2001.

236. "Update on practice guideline on borderline disorder." Presenter. American Psychiatric Association, New Orleans, LA, May 9, 2001.

237. "Practice guidelines, development and dissemination: methods, issues and results." New York State Office of Mental Health Best Practices Conference, Brooklyn, NY, June 12, 2001.

238. "Integrated behavioral health and primary care." New York State Council for Community Behavioral Healthcare. Saratoga Springs, NY, June 27, 2001.

239. "Update on practice guidelines: suicide management." Workshop. Institute on Psychiatric Services, Orlando, FL, October 12, 2001.

240. "New findings on psychiatric practice: quality, access and patterns of care." Chair. Institute on Psychiatric Services, Orlando, FL, October 12, 2001.

241. "Bipolar guidelines will make your practice better." Chair. Institute on Psychiatric Services, Orlando, FL, October 13, 2001.

242. "Acute treatment of depression: the initial step in long-term management." Postgraduate Institute for Medicine, Philadelphia, PA, January 12, 2002.

243. "Integration of mental health and substance abuse services in primary care for the elderly." American Psychiatric Association, Philadelphia, PA, May 20, 2002.

244. "Major depression: current guidelines, practices and effectiveness research." American Psychiatric Association, Philadelphia, PA, May 21, 2202.

245. "Integrated mental health services for the older adults in primary care: does it work?" National Alliance for the Mentally Ill Annual Convention, Cincinnati, OH, June 28, 2002.

246. "Update on practice guidelines: substance use disorders and suicidal behavior." Workshop. Institute on Psychiatric Services, Chicago, IL, October 9, 2002.

247. "Modern long-term treatment of chronic and recurrent major depression disorder." San Diego County Medical Society, San Diego, CA, October 16, 2002.

248. "Co-morbidity-sequential, concurrent or integrative treatment." Discussant. National Education Alliance for Borderline Personality Disorders, New York, New York, January 11, 2003.

249. "Western NY Care Coordination Program." Grand Rounds, Department of Psychiatry, University at Buffalo, Buffalo, NY, February 14, 2003.

250. "Personality disorder nomenclature should be deleted." Moderator. American Psychiatric Association Annual Meeting, San Francisco, CA, May 19, 2003.

251. "Working with organized medicine: the AMA and state medical societies." Forum, American Psychiatric Association Annual Meeting, San Francisco, CA, May 19, 2003

252. "Schizophrenia: current guidelines, practices and effectiveness research." Symposium. Co-Chair. American Psychiatric Association Annual Meeting, San Francisco, CA, May 19, 2003.

253. "Update on practice guidelines: post traumatic stress disorder/acute stress disorder." Workshop Chair. American Psychiatric Association Annual Meeting, San Francisco, CA, May 22, 2003.

254. "Compeer's role in the recovery process." Compeer International Conference, Rochester, NY, October 17, 2003.

255. "Practice guidelines and bipolar disorder." Chief Residents' Executive Leadership Program, Institute on Psychiatric Services, Boston, MA, October 29, 2003.

256. "President's commission on mental health." Symposium Discussant. Institute on Psychiatric Services, Boston, MA, October 31, 2003.

257. "WNY care coordination program." Grand Rounds. Presenter. Department of Psychiatry, University at Buffalo, Buffalo, NY, February 14, 2004.

258. "Treatment of long-term depression: striving toward a sustained response." Presenter. InraMed Scientific Solutions Conference, Atlanta, GA, March 27, 2004.

259. "Maintenance Treatment of Bipolar I Disorders." Presenter. Psychopharmacology Seminar, Northern NY District Branch of APA & Mohawk Valley Psychiatric Center, Utica, NY, April 1, 2004.

260. "Evidence-Based Psychotherapy." Forum Co-Chair, American Psychiatric Association Annual Meeting, New York, NY, May 3, 2004.

261. "Engaging the Homeless in Treatment Strategies and Results" American Psychiatric Association Annual Meeting, New York, NY, May 4, 2005.

262. "Treatment of Long-Term Depression: Striving Toward a Sustained Response" InraMed Scientific Solutions Conference, Boston, MA, May 22, 2004.

263. "Bringing Science Into the Office: Implementing Practice Guidelines for Substance Use Disorders in Everyday Practice" 8th Annual ASAP Conference, Rochester, NY, April 20, 2005.

264. "Keeping APA Practice Guidelines Current: Alzheimer's, Delirium, and Eating Disorders" Chair, Symposium, American Psychiatric Association Annual Meeting, May 21, 2005.

265. "Making it Happen: Implementing Practice Guidelines in Everyday Practice." Workshop, American Psychiatric Association, Atlanta, GA May 23, 2005.

266. "Psychiatric Management of Treatment Resistant Schizophrenia" Symposium Chair, American Psychiatric Association Annual Meeting, Atlanta, GA May 24, 2005.

267. "Clinical Decisions: Guidelines – Indicators – Algorithms." Workshop, American Psychiatric Association Annual Meeting, Atlanta, GA May 25, 2005.

268. "New Developments in Guidelines on MDD, Bipolar Disorder and Panic Disorder" American Psychiatric Association Annual Meeting, Toronto, Canada, May 22, 2006

269. "Making it Happen: Implementing the APA Practice Guideline for Major Depressive Disorder in Everyday Practice" Workshop, American Psychiatric Association Annual Meeting, Toronto, Canada, May 24, 2006

270. "Moving the Psychiatric Agenda in the House of Medicine" Workshop, American Psychiatric Association Annual Meeting, Toronto, Canada, May 24, 2006

271. "International Perspective on Quality Improvement Initiatives" Chair, American Psychiatric Association Annual Meeting, Toronto, Canada, May 25, 2006

272. "Advances in the Development and Implementation of Practice Guidelines" American Psychiatric Association Annual Meeting, Toronto, Canada, May 25, 2006

273. "Overview of APA Practice Guideline Project" Institute of Psychiatric Services, October 7, 2006

274. "Optimizing Depression Treatment: Clinical Applications of Measurement-Based Care, Co-Chair, Psychiatric Association Annual Meeting, San Diego, CA, May 21, 2007

275. "Dealing with Disaster Mental Health" Scientific and Clinical Report, Psychiatric Association Annual Meeting, San Diego, CA, May 21, 2007

276. "New APA Practice Guidelines on Dementia, Panic Disorder and OCD", Workshop Chair, American Psychiatric Association Annual Meeting, San Diego, CA, May 23, 2007

277. "Fostering Spiritual Values and Well-Being: The Need in Psychiatry" Scientific and Clinical Report, American Psychiatric Association Annual Meeting, San Diego, CA, May 23, 2007

278. "Patient Centered Practice Guidelines: The Challenge" American Psychiatric Association Annual Meeting, San Diego, CA, May 24, 2007

279. "The Treatment of Bipolar Disorder" University of Tennessee, Memphis Tennessee, October 26, 2007.

280. New APA Practice Guidelines: Major Depressive Disorder and Bipolar Disorder", Workshop Chair, American Psychiatric Association Annual Meeting, Washington D.C., May 7, 2008

281. "Transforming The Local Mental Health System: A Person Centered Program", Workshop Chair, American Psychiatric Association Annual Meeting, Washington D.C., May 8, 2008

282. "Stigma – Patient, Family and Provider Perspectives" University of Rochester, Rochester N.Y. November 4, 2009.

LOCAL PRESENTATIONS AVAILABLE UPON REQUEST

SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

Joan W. Feldman
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November 5, 2012

VIA HAND DELIVERY

Kevin Hansted, Esq.
Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308

Re: Objection to Paul C. Horton, M.D.'s Petition for Intervenor Status; Docket No. 12-31775-CON

Dear Attorney Hansted:

By this letter and on behalf of the Applicants in the above-referenced Application, I respectfully: (1) object to Paul C. Horton, M.D.'s ("Dr. Horton's") petition for Intervenor Status (the "Petition"); and (2) disagree with and respond to Dr. Horton's statements made in said Petition in the order that he set them forth in his Petition.

1. Objection to Dr. Horton's Petition for Intervenor Status:

Dr. Horton has failed to demonstrate how his participation at the hearing, as an Intervenor, will assist the Office of Health Care Access ("OHCA") in rendering a final decision concerning this Application as required by Section 19a-9-27(b)(4) of the Regulations of Connecticut State Agencies. Dr. Horton has provided OHCA with a series of unsubstantiated, inaccurate, emotional and false statements as a basis for his Petition, that should not become part of the evidence that OHCA considers to rule on this Application. Accordingly, we believe that a more appropriate avenue for Dr. Horton's participation is through the public portion of the upcoming hearing at which time OHCA may permit Dr. Horton's views to be heard.

2. Applicants' Responses to Dr. Horton's Statements:

The following sets forth the Applicants' specific responses to Dr. Horton's statements in his Petition for Intervenor Status:

Dr. Horton's Statements in Section 1 of His Petition: "It is perhaps no coincidence that a general hospital administration which has decided to jettison its psychiatric services in one of the most psychiatrically needy communities in the State would be found wanting in patient satisfaction scores....MidState needs more and better psychiatric presence, not the hostile-take-over kinds of care that have characterized the machinations of the Elmcrest/CVH/Rushford crowd over the last couple of decades....A robust, inpatient psychiatric service provides essential medical expertise and an atmosphere that assures patients will be afforded a total treatment program, one that respects their dignity as human beings and does not treat them as objects to be poked, prodded, split open or dismissed as not medically 'profitable.'"

Applicants' Response: MidState has not decided to "jettison" its psychiatric services as so disparagingly stated by Dr. Horton. Rather, MidState has decided to stabilize and enhance access and quality to inpatient behavioral health services as part of a Hartford HealthCare System-wide plan to reinvigorate and improve the delivery of inpatient behavioral health services in the Central Connecticut region. Dr. Horton's characterization of MidState's plan maligns MidState's intentions and more importantly, is not based upon any fact. Dr. Horton refers to "Elmcrest/CVH/Rushford" as the "hostile-take-over kinds of care", does nothing more than offer emotional rhetoric that maligns the reputations of behavioral health providers without providing any evidentiary value to OHCA. While MidState respects Dr. Horton's passion for his position, he should not be given Intervenor Status so he can voice his frustrations with the behavioral health system at large.

Dr. Horton's Statements in Section 2 of His Petition: "How will Meriden attract new psychiatrists if MidState Hospital is allowed to say, in effect, that we do not need and do not want intensive psychiatric participation and input and if private practice psychiatrists cannot be directly involved in the treatment of their mentally ill patients in the hospital setting? Moreover, it is very concerning and upsetting to patients and their families to have to travel halfway across the state to find a psychiatrist and/or to have to forfeit their relationship and trust in the referring psychiatrist to someone who has to start from scratch in treating them and who is pressured by the insurance company - almost always successfully - to discharge patients before they are ready."

Applicants' Response: There is no factual basis for the statement that MidState will not attract new psychiatrists to the area. Given Dr. Horton's earlier statement that MidState is in "one of the most psychiatrically needy communities in the State....", his subsequent statement that MidState would not be able to attract psychiatrists to the area if the MidState unit is closed is a non sequitur. Nevertheless, we believe that a stable, large, high quality unit at The Hospital of Central Connecticut ("HOCC") will do more to attract behavioral health providers to the area than the existing MidState unit is capable of doing. Moreover, as stated in HOCC's prefiled testimony of Clarence Silvia, all MidState affiliated psychiatrists will be welcome to apply for medical staff privileges at HOCC. With respect to his statement that patients and their families will have to travel halfway across the State, this statement is also false. The distance is approximately nine (9) miles and MidState will provide transportation support to families. Patients currently and regularly travel much greater distances for a variety of healthcare services.

Dr. Horton's Statement in Section 3 of His Petition: Dr. Horton states in reference to how patients are and will be treated at HOCC, "[t]hey will be 'evaluated' by a psychiatrist whose sole job is to prescribe medications, and then these patients will be turned over to lesser qualified persons to receive 'Cognitive Behavioral Therapy' and its cousin, 'Dialectical Behavior Therapy.' Thereafter, the psychiatrist will not be actively involved with the ongoing treatment process other than to prescribe and monitor the medication regimen. Although this modus operandi has become predominant, it does not and will not work."

Applicants' Response. This statement is nothing more than an inaccurate rant by Dr. Horton with respect to all of his frustrations regarding the delivery of behavioral health services everywhere. They unfairly distort and misrepresent the way in which treatment is provided by HOCC's inpatient psychiatrists. The HOCC psychiatrists are intensely involved in patient treatment and are not simply monitoring the medication regimen. Furthermore, Dr. Horton appears to be of the opinion that only a psychiatrist can be involved in the delivery of therapeutic treatment to patients. If a psychiatrist cannot practicably be in therapy with the patient 24/7, it does not follow that alternative providers and treatments cannot supplement a patient's treatment. Regardless of his own frustrations, Dr. Horton's statements are irrelevant to the Application and add no value to the issues under review by OHCA.

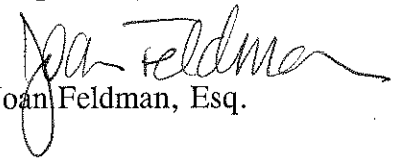
Dr. Horton's Statement 4 in His Petition: "Finally, one of the most disturbing flaws in the current NBGH proposal is that no provisions have been made for the treatment of the already overwhelming number of psychiatrically needy children and adolescents in the Meriden area who, in some cases, are in desperate need of psychiatric inpatient evaluation and treatment....Such an egregious oversight cannot

be tolerated. Why the Office of Healthcare Access permits this is a puzzle that needs immediate address."

Applicants' Response: This Application is not about whether or not the HOCC inpatient behavioral health unit should treat children. Thus, the statements provided by Dr. Horton in this regard are irrelevant to this Application. Notwithstanding, it should be noted that the Hartford HealthCare System's Institute of Living and Natchaug Hospital devote significant resources to providing inpatient behavioral health services to children. These inpatient services are specialized for children and thus, do not mix adults with children on their units.

In summary, the arguments made by Dr. Horton in his petition are not factually based, are irrelevant and will only serve as a distraction to OHCA in deciding the issues before it in this proceeding. Therefore, on behalf of the Applicants, I respectfully request that Dr. Horton not be granted Intervenor Status and that his testimony be heard at the public portion of the hearing only. In the alternative, if Intervenor Status is granted to Dr. Horton, I respectfully request that he not be granted the right to cross-examine the Applicants.

Respectfully Submitted,



Joan Feldman, Esq.

Certificate of Service

I hereby certify that a true and correct copy of the foregoing objection to petitioner's request for Intervenor Status was mailed via first class United States mail this 5th day of November 2012 to:

Connecticut Legal Rights Project
1000 Silver Street
P.O. Box 351
Beers Hall, 2nd Floor
Middletown, CT 06457
Attn: Jan VanTassel

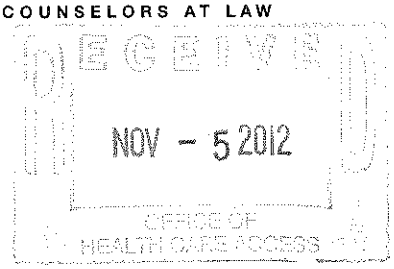
And to

Paul C. Horton, M.D.
240 Pomeroy Avenue, Suite 205
Meriden, CT 06450

Joan Feldman, Esq.

SHIPMAN & GOODWIN LLP®

COUNSELORS AT LAW



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Dear Attorney Hansted:

By this letter and on behalf of the Applicants in the above-referenced Application, I respectfully: (1) object to the Connecticut Legal Rights Project's ("CLRP's") petition for Intervenor Status (the "Petition"); and (2) disagree with and respond to CLRP's statements made in said Petition.

1. Objection to CLRP's Petition for Intervenor Status:

CLRP's stated purpose "is to ensure clients of [DMHAS] and especially patients of its inpatient facilities have effective access to the system of justice by providing them with independent advocates and attorneys to protect and enforce their rights and entitlements." See page 4 of *Doe v. Hogan*, Case No.: H88-239 (EBB), October 24, 1989 (the "Consent Decree"). As expressly stated in CLRP's own Petition, CLRP is responsible to the State for protecting the legal rights of DMHAS clients. The current Application before the Office of Health Care Access ("OHCA") has no bearing or effect on a patient's access to the justice system or their legal rights. Accordingly, CLRP has failed to present an interest that it is entrusted with protecting and that will

be affected by the current Application as required by Section 19a-9-27(b)(2) of the Regulations of Connecticut State Agencies.

CLRP has also failed to demonstrate how its participation at the hearing, as an Intervenor, will assist OHCA in rendering a final decision concerning this Application as required by Section 19a-9-27(b)(4) of the Regulations of Connecticut State Agencies. CLRP states that it plans on assisting OHCA by "presenting information on the challenges that [its] clients have encountered accessing services at all levels of care, and analysis, based on that experience and legal mandates including the Americans with Disabilities Act." Again, this Application has absolutely no effect, ramifications or connection to any legal mandates or rights such as the Americans with Disabilities Act (the "ADA").

The Applicants fully support and appreciate the CLRP's mission to ensure that its clients' legal rights are protected, including ensuring that its clients obtain equal and effective access to the justice system and are not denied access to facilities because of any disabilities in conformance with the ADA. However, because such mission and mandate is irrelevant to the Application at hand, CLRP's participation, as an Intervenor, will not assist OHCA in rendering a final decision in this matter. Rather, we believe that a more appropriate avenue for CLRP' participation is through the public portion of the upcoming hearing at which time OHCA may permit CLRP's position to be heard.

2. Applicants' Responses to CLRP's Statements:

CLRP Statement: "CLRP's clients will be directly affected by the termination of inpatient behavioral health services at MidState Medical Center ("MidState"). The most obvious impact will be on access to inpatient care in the region, barriers to visits and interaction with family, friends and natural supports, and challenges presented to the continuity of care when inpatient treatment is provided at a facility that is not provided at a facility that is not part of the Meriden-Wallingford community."

Applicants' Response: CLRP mistakenly views this Application as a loss or reduction in access to inpatient care. Quite the contrary, this Application will enhance access to inpatient behavioral health services or beds for MidState-area patients. Specifically, this Application will increase access to inpatient behavioral health care for these same patients as they will be given preferential access to ten (10) beds on The Hospital of Central Connecticut's ("HOCC's") newly designed and renovated inpatient behavioral health unit, resulting in an increase of four (4) staffed inpatient behavioral health beds. Not only does this Application offer an increase in access to inpatient behavioral health care, but it also results in an enhancement in such care through benefits such as: (a) more individualized treatment; (b) a newly renovated and expanded unit that will offer patients both

greater privacy and opportunity for social interaction with other patients on the unit; and (c) a broader spectrum of clinicians who can offer more specialized care.

Moreover, this Application does not present any barriers to patient visits since transportation support will be provided to those that need it. More specifically, MidState and/or HOCC staff, as applicable, will provide written materials to patients and family members describing the transportation assistance available for each patient and his/her family. HOCC and MidState staff will also personally discuss the visitation hours at HOCC and other aspects of family involvement in treatment with loved ones as appropriate. At these discussion points, and at any time thereafter, it will be determined if transportation assistance is required. The transportation assistance to and from HOCC and from MidState will be provided daily at convenient times through the use of taxi vouchers and/or hospital shuttles.

With respect to CLRP's statement that this Application will present challenges relating to continuity of care, this statement is false since services in the community and follow-up care will be enhanced (as described in greater detail below) and will be unaffected by the fact that HOCC is not located in either Meriden or Wallingford.

- Rushford Center Inc. ("Rushford") will work cooperatively with HOCC and MidState to arrange post discharge community-based care for MidState patients. Inpatients returning to the Meriden-Wallingford area will be provided direct and timely access to Rushford's continuum of care, including partial hospitalization, intensive outpatient care, individual and group therapy, medication management and community support services and programs. The discharge planning process is expected to begin within twenty-four (24) hours of admission to HOCC. Specifically, Rushford personnel will be concurrently notified of the admission of MidState patients to HOCC and will contact the HOCC inpatient behavioral health unit within twenty-four (24) hours to initiate discharge planning. In addition, Rushford will provide priority access at its Meriden outpatient center for discharged HOCC inpatients, including those in need of next-day appointments. Care coordination between MidState, HOCC and Rushford will be further facilitated by the exchange of electronic medical information between Hartford HealthCare system members.

- Rushford will also follow up with every MidState patient discharged from the inpatient unit at HOCC to ensure that there are no barriers to compliance with discharge plans or accessibility to services in the community. Focus on securing the appropriate community resources for behavioral health patients in the community will help to keep patients well and reduce the demand for inpatient services. In addition, MidState and Rushford will make every effort to connect patients presenting in the MidState emergency department or at Rushford Crisis Intervention Access Points with primary care providers in the

community for the purpose of promoting early intervention, prevention and self-management initiatives.

- Through its contract with Rushford, MidState will establish a behavioral health intervention team ("BIT") to provide proactive management of co-morbid psychiatric and/or substance abuse conditions based on a standardized model. The BIT is comprised of a psychiatrist, nurse practitioner, and licensed social worker. The team reviews all medical/surgical hospital inpatient and ED admissions and identifies patients who may be at risk of, or experiencing psychiatric or substance use disorders. The team conducts assessments on these patients and makes referrals, as appropriate, to behavioral health services.

- Leadership from Rushford, MidState and HOCC will be included in a monthly forum that will monitor operations and transitions of care between the two acute care hospitals. This group will also focus on utilizing our community resources and network partners to create enhanced outpatient services.

It is clear that CLRP's assertions are groundless and are nothing more than negative rhetoric as an attempt to undermine the Application. If CLRP read the Application and the representations therein, it could not in good conscience have made these statements. The Applicants believe that there will be greater continuity of care with this proposal than what currently exists.

CLRP Statement: "While Mid State [sic] met with many advocacy groups, there has not been meaningful effort to obtain input and suggestions from people in recovery and address their concerns directly."

Applicants' Response: This statement by CLRP is absolutely false. Over the last year, MidState has spent substantial time meeting with all interested parties, including government representatives and representatives from the behavioral health community for the sole purpose of discussing the proposal and obtaining the input from all interested parties. Specifically, MidState has conducted focus groups with community-based behavioral health providers and held meetings with community stakeholders, patient advocacy groups, the Commissioner of DMHAS, community and political leaders, probate judges, local police departments and ambulance services, local and medical staff physicians, and patients in MidState's inpatient behavioral health unit.

CLRP Statement: "A growing number of Connecticut general hospitals have cut back and are considering further reductions in their psychiatric services because they are no longer able to afford the financial drain of supporting such services."

Applicants' Response: This Application sets forth one of the few examples of a commitment to enhance inpatient behavioral health services in the State of Connecticut. The Applicants are proposing a $4,000,000 dollar investment in behavioral health care in order to expand and enhance HOCC's behavioral health unit, which will directly impact and benefit patients including, MidState-area patients. It is ironic that CLRP is opposing one of the few efforts in this State to invest in expanded and enhanced inpatient behavioral health services.

CLRP Statement: "The relative cost per bed at Mid State [sic] as compared to HOCC is startling, and the corporation's desire to address the disparity is understandable. However, it is not clear that this is the only or most appropriate solution to the problem...."

Applicants' Response: Given the relative difference in size between the MidState and HOCC units, it should not come at any surprise that the MidState unit is unable to achieve the same cost efficiencies that HOCC obtains. Interested parties may disagree that the decision to: (a) increase inpatient behavioral health bed capacity and access for MidState area patients by four (4) inpatient beds for a total of ten (10) beds; (b) enhance the scope and depth of inpatient behavioral health services for patients from the MidState service area community; (c) offer a significantly lower cost structure for more sophisticated services than that currently offered by MidState; and (d) support our patients in their return to their community with enhanced supportive outpatient services is the best solution. However, CLRP simply provides criticism without any direct or meaningful evidence.

Accordingly, because CLRP has offered no sound reasons for why this Application should not be approved and does not provide any additional evidence to OHCA in the consideration of this Application, CLRP's petition for Intervenor Status should be denied. In the alternative, if Intervenor Status is granted to CLRP, I respectfully request that CLRP not be granted the right to cross-examine the Applicants.

Respectfully Submitted,

Joan Feldman, Esq.

Certificate of Service

I hereby certify that a true and correct copy of the foregoing objection to petitioner's request for Intervenor Status was mailed via first class United States mail this 5th day of November 2012 to:

Connecticut Legal Rights Project
1000 Silver Street
P.O. Box 351
Beers Hall, 2nd Floor
Middletown, CT 06457
Attn: Jan VanTassel

And to

Paul C. Horton, M.D.
240 Pomeroy Avenue, Suite 205
Meriden, CT 06450

Joan Feldman, Esq.

Greer, Leslie

From: Hansted, Kevin
Sent: Tuesday, November 06, 2012 10:56 AM
To: Carney, Brian; Greci, Laurie; Greer, Leslie; Olejarz, Barbara
Subject: FW: CON Midstate Medical Center 12-31775. Request for Susan Duclos RN, CEN to be an Intervenor

FYI

Kevin T. Hansted
Staff Attorney / Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044

From: Susan Duclos [mailto:susiern59@aol.com]
Sent: Monday, November 05, 2012 4:06 PM
To: Hansted, Kevin
Cc: bdurdy@midstatemedical.org; ccapone@thocc.org; karengoyette@hhchealth.org
Subject: CON Midstate Medical Center 12-31775. Request for Susan Duclos RN, CEN to be an Intervenor

Rushford

- It was stated that DBT will be offered at HOCC and follow-up care will be provided by Rushford. There has, however, not been a DBT program at Rushford for many years. Patients are now being referred to Yale or IOL, depending on their insurance or transportation.

- CBT is offered at Midstate IPD through groups with our OT.

- It was stated that one-on-one visits with psychiatrists would be provided by Rushford, however very few patients see a Psychiatrist. Patients currently see the APRNs to prescribe their medications, however their goal is to put patients into groups not one-on-one treatment.

- Patients currently in the ABU that are restrained or require multiple IM psychiatric medications are often declined by other facilities. If IPD were to remain open, these patients would be able to be kept at MMC.

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Then it was said statistics are not currently being kept at MMC. However, the CSP clinicians have daily report sheets and bed search logs that discuss what bed searches have been done and what beds are available on IPD.

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In the CON it states we do not provide services for dual-diagnosed patients however a large majority of our patients are dual diagnosed.

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Approximately 1 patient in the last 8 months have been sent to HOCC.

•

As of approximately 2 weeks ago It was told to Deb Cabutis, LCSW that all patients to be presented on a bed search would now be through Dr. Nazarian to Dr. Balkunas conversation as opposed to the LCSW doing the search.

Responses to Midstate CON

It was stated that HOCC will provide a broader range of groups that are not available on IPD and that HOCC will provide patients and families with education to avoid repeat admissions.
MMC does provide psychiatric education regarding follow-up care to the patient and family using a multi-disciplinary treatment team including MMC inpatient psychiatry Rushford, crisis, the partnership and DMHAS . MMC also uses evidence-based pharmacology therapies and we also routinely employ the use of Clozapine for treatment resistant schizophrenia and injectable anti-psychotic medication for the chronically non-compliant patients. John Nazarian is in fact board certified in General and Addiction Psychiatry.

It was stated that HOCC would provide a quiet/activity room to enable de-escalation of patients to avoid seclusion and restraint.
MMC features private rooms to deescalate patients to avoid seclusion and restraint. Seclusion is against MMC policy.

HOCC proposes that Rushford, Natchaug and IOL made a priority for 2013 to manage dual-diagnosis conditions based on standardized protocols.
Why is it that Midstate cannot also provide standardized protocols for these conditions?

In regards to transports from MMC to HOCC, MMC stated that they would provide transportation via taxi vouchers and shuttles for immediate family members.
We are greatly concerned how long this program will be in place as the same promise was made on the CON for patients going to IOL. It is also very important the case mangers from Rushford, friends and clergy be in contact with the treatment team at HOCC. It is clear that the case managers at Rushford are able to provide continuity of care because of the proximity of MMC. It is important to maintain a support network of clergy and friends and HOCC makes no provision for this.

MMC anticipates that 10 staff positions will be impacted by the termination of IPD. They stated they would provide us with ample opportunities for employment

There was, however, no guarantee of HOCC providing such employment to displaced staff. In addition, MMC offered training to transition nurses into a different role at MMC but there are currently very few open positions listed on MMC's website.

MMC states that it has a MASTER FACILITIES PLAN to utilize the 6 beds that will be closed.
It is clear that Midstate had no present plan to utilize the 6 beds. There has been the potential of filling the 10 beds that could be available for INP by not transferring out the approximately 150 patients (number reached after excluding pediatric and geriatric patients) to other facilities.

HOCC states MMC will receive preferential access to up to 10 beds. The majority of the patients will come from MMC's ABU. They also stated that MMC CSP clinicians would contact IOL and Natchaug to get another bed within the system.
Natchaug does not have a Title 19 contract, which means they cannot take the majority of our patients.

It was stated Rushford will provide priority access for discharging HOCC inpatients.
We have a Rushford liaison that currently provides this service. It is important to not that Rushford routinely will discharge patients that are non-compliant with treatment and/or medications.

On August 7, 2012, Laurie Greci and Brian Carney, Associate Research Analysts, proposed specific questions to MMC. MMC was asked to respond whether the expansion of IPD was considered prior to termination of the unit.
As discussed in previous answers, MMC made 2 on-call beds for physicians. Additionally, chose not to post RN positions that were lost through attrition.

Has MMC done any community surveys to determine willingness of area residents to travel to HOCC and to explain how MMC determined that area residents would be in support of this proposal?
MMC clearly states they did not conduct surveys of area residents. Surveys were done with visitors for a brief amount of time, specifically addressing transportation issues. Where are these survey results? It also states MMC discussed with community leaders, probate judges and advocacy groups. In fact many of those people with whom MMC discussed this proposal, are opposed to the CON.
It was stated that patients on MMC's IPD were surveyed regarding transportation needs. As addressed before, it was family members that were surveyed, and not the patients.

Are there any circumstances where proposed "preferential admission status beds" at HOCC would be used for non-MMC patients. Their answer was there were no circumstances anticipated.
In reality, the same plan was in place with IOL, which did not come to fruition. Our patients did not get preferred admission status in IOL as was proposed several years ago because of the census at HHC's other hospitals.

Of 223 transfers in 2011, only 1 patient was transferred to HOCC? HOCC joined the system in 2011.
However, if that is the case, why is HOCC not listed on the current MMC bed search for Adults since that time?

Describe therapies available at HOCC not available at MMC.
We do have components of CBT offered by out Occupational Therapist and Nurses. MMC's response is that we do not provide individual supportive therapy for patients experiencing psychosis. This in fact is untrue.

What additional services will be available at HOCC after expansion? MMC's answer was that Dr. Balkunas and Dr. Caratas also specialized in substance abuse and are conversant in Spanish. It also states that 3 psychiatrists at HOCC provide office-based treatment for patient with opiod-dependence.

Dr. Nazarian also has office-based treatment. We routinely utilize the language line for patients that are not conversant in any non-English language, not just Spanish.

It asked about any special populations that utilize services that require them to be transferred and that we do not admit to MMC. MMC's answer was there are no special patient populations currently utilizing IPD.

We frequently have geriatric psychiatric patients on our unit that other facilities won't take due to their acuity or lack of beds.

We have an increase in the acuity and length of stay for patients going to state facilities. It also asks how the lack of beds at state facilities affect MMC's IPD and how having expanded services at HOCC will help this problem. Their response was that by having 4 additional inpatient beds at HOCC would mitigate the impact of length of stay.

The reality is when a patient is severely ill and requires state hospitalization it does not matter whether they are at HOCC or MMC. It is the responsibility of all hospitals to decrease the length of stay, including HOCC. In 2011 the average length of stay at MMC was 6.4 days and at HOCC was 8.7 days.

It was addressed that MMC and Rushford will work together to enhance community-based services.

Why could this not have been done at Midstate? They also stated that Rushford's community liaison plans to contact clients at HOCC to plan and expedite discharges back to the community.

If they have seen a need over these years, why have they not addressed or utilize the liaison and focus groups HHC's Behavioral Health Network meets twice a month to discuss strategies and operations. Why have they not focused on MMC in the past?

Greer, Leslie

From: Hansted, Kevin
Sent: Tuesday, November 06, 2012 10:56 AM
To: Olejarz, Barbara; Carney, Brian; Greci, Laurie; Greer, Leslie
Subject: FW: Intervenor Status

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-----Original Message-----
From: Susan Duclos [mailto:susiern59@aol.com]
Sent: Monday, November 05, 2012 4:10 PM
To: Hansted, Kevin
Subject: Intervenor Status

Dear Attorney Hansted,

Hard copies of my submission will be sent via the postal service as well as the emails

sent to Barbara Durdy, Claudio Capone, and Karen Goyette.

Please forgive my inexperience in this matter, as I am new to this process.

Susan Duclos RN, CEN

Greer, Leslie

From: Greci, Laurie
Sent: Tuesday, November 06, 2012 8:34 AM
To: susiern59@aol.com
Cc: jfeldman@goodwin.com; Carney, Brian; Greer, Leslie
Subject: Docket 12-31775-CON; Additional Documents
Attachments: 31775 MidState Objection to Petition - CLRP.pdf; 31775 MidState Objection to Petition - Horton.pdf

Dear Ms. Duclos:

Attached you will find two additional documents that have been entered into the docket (12-31775-CON) concerning the proposal of MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation to terminate inpatient behavioral health services at MidState Medical Center.

If you have any questions please feel free to contact me.

Laurie

Laurie K. Greci
Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

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CLRP has also failed to demonstrate how its participation at the hearing, as an Intervenor, will assist OHCA in rendering a final decision concerning this Application as required by Section 19a-9-27(b)(4) of the Regulations of Connecticut State Agencies. CLRP states that it plans on assisting OHCA by "presenting information on the challenges that [its] clients have encountered accessing services at all levels of care, and analysis, based on that experience and legal mandates including the Americans with Disabilities Act." Again, this Application has absolutely no effect, ramifications or connection to any legal mandates or rights such as the Americans with Disabilities Act (the "ADA").

The Applicants fully support and appreciate the CLRP's mission to ensure that its clients' legal rights are protected, including ensuring that its clients obtain equal and effective access to the justice system and are not denied access to facilities because of any disabilities in conformance with the ADA. However, because such mission and mandate is irrelevant to the Application at hand, CLRP's participation, as an Intervenor, will not assist OHCA in rendering a final decision in this matter. Rather, we believe that a more appropriate avenue for CLRP' participation is through the public portion of the upcoming hearing at which time OHCA may permit CLRP's position to be heard.

2. Applicants' Responses to CLRP's Statements:

CLRP Statement: "CLRP's clients will be directly affected by the termination of inpatient behavioral health services at MidState Medical Center ("MidState"). The most obvious impact will be on access to inpatient care in the region, barriers to visits and interaction with family, friends and natural supports, and challenges presented to the continuity of care when inpatient treatment is provided at a facility that is not provided at a facility that is not part of the Meriden-Wallingford community."

Applicants' Response: CLRP mistakenly views this Application as a loss or reduction in access to inpatient care. Quite the contrary, this Application will enhance access to inpatient behavioral health services or beds for MidState-area patients. Specifically, this Application will increase access to inpatient behavioral health care for these same patients as they will be given preferential access to ten (10) beds on The Hospital of Central Connecticut's ("HOCC's") newly designed and renovated inpatient behavioral health unit, resulting in an increase of four (4) staffed inpatient behavioral health beds. Not only does this Application offer an increase in access to inpatient behavioral health care, but it also results in an enhancement in such care through benefits such as: (a) more individualized treatment; (b) a newly renovated and expanded unit that will offer patients both

greater privacy and opportunity for social interaction with other patients on the unit; and (c) a broader spectrum of clinicians who can offer more specialized care.

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With respect to CLRP's statement that this Application will present challenges relating to continuity of care, this statement is false since services in the community and follow-up care will be enhanced (as described in greater detail below) and will be unaffected by the fact that HOCC is not located in either Meriden or Wallingford.

- Rushford Center Inc. ("Rushford") will work cooperatively with HOCC and MidState to arrange post discharge community-based care for MidState patients. Inpatients returning to the Meriden-Wallingford area will be provided direct and timely access to Rushford's continuum of care, including partial hospitalization, intensive outpatient care, individual and group therapy, medication management and community support services and programs. The discharge planning process is expected to begin within twenty-four (24) hours of admission to HOCC. Specifically, Rushford personnel will be concurrently notified of the admission of MidState patients to HOCC and will contact the HOCC inpatient behavioral health unit within twenty-four (24) hours to initiate discharge planning. In addition, Rushford will provide priority access at its Meriden outpatient center for discharged HOCC inpatients, including those in need of next-day appointments. Care coordination between MidState, HOCC and Rushford will be further facilitated by the exchange of electronic medical information between Hartford HealthCare system members.

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community for the purpose of promoting early intervention, prevention and self-management initiatives.

- Through its contract with Rushford, MidState will establish a behavioral health intervention team ("BIT") to provide proactive management of co-morbid psychiatric and/or substance abuse conditions based on a standardized model. The BIT is comprised of a psychiatrist, nurse practitioner, and licensed social worker. The team reviews all medical/surgical hospital inpatient and ED admissions and identifies patients who may be at risk of, or experiencing psychiatric or substance use disorders. The team conducts assessments on these patients and makes referrals, as appropriate, to behavioral health services.

- Leadership from Rushford, MidState and HOCC will be included in a monthly forum that will monitor operations and transitions of care between the two acute care hospitals. This group will also focus on utilizing our community resources and network partners to create enhanced outpatient services.

It is clear that CLRP's assertions are groundless and are nothing more than negative rhetoric as an attempt to undermine the Application. If CLRP read the Application and the representations therein, it could not in good conscience have made these statements. The Applicants believe that there will be greater continuity of care with this proposal than what currently exists.

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Applicants' Response: This statement by CLRP is absolutely false. Over the last year, MidState has spent substantial time meeting with all interested parties, including government representatives and representatives from the behavioral health community for the sole purpose of discussing the proposal and obtaining the input from all interested parties. Specifically, MidState has conducted focus groups with community-based behavioral health providers and held meetings with community stakeholders, patient advocacy groups, the Commissioner of DMHAS, community and political leaders, probate judges, local police departments and ambulance services, local and medical staff physicians, and patients in MidState's inpatient behavioral health unit.

CLRP Statement: "A growing number of Connecticut general hospitals have cut back and are considering further reductions in their psychiatric services because they are no longer able to afford the financial drain of supporting such services."

Applicants' Response: This Application sets forth one of the few examples of a commitment to enhance inpatient behavioral health services in the State of Connecticut. The Applicants are proposing a $4,000,000 dollar investment in behavioral health care in order to expand and enhance HOCC's behavioral health unit, which will directly impact and benefit patients including, MidState-area patients. It is ironic that CLRP is opposing one of the few efforts in this State to invest in expanded and enhanced inpatient behavioral health services.

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Applicants' Response: Given the relative difference in size between the MidState and HOCC units, it should not come at any surprise that the MidState unit is unable to achieve the same cost efficiencies that HOCC obtains. Interested parties may disagree that the decision to: (a) increase inpatient behavioral health bed capacity and access for MidState area patients by four (4) inpatient beds for a total of ten (10) beds; (b) enhance the scope and depth of inpatient behavioral health services for patients from the MidState service area community; (c) offer a significantly lower cost structure for more sophisticated services than that currently offered by MidState; and (d) support our patients in their return to their community with enhanced supportive outpatient services is the best solution. However, CLRP simply provides criticism without any direct or meaningful evidence.

Accordingly, because CLRP has offered no sound reasons for why this Application should not be approved and does not provide any additional evidence to OHCA in the consideration of this Application, CLRP's petition for Intervenor Status should be denied. In the alternative, if Intervenor Status is granted to CLRP, I respectfully request that CLRP not be granted the right to cross-examine the Applicants.

Respectfully Submitted,

Joan Feldman, Esq.

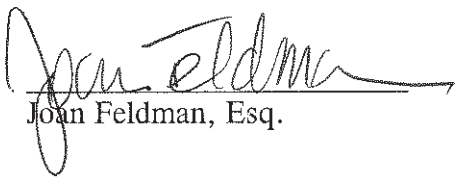
Certificate of Service

I hereby certify that a true and correct copy of the foregoing objection to petitioner's request for Intervenor Status was mailed via first class United States mail this 5th day of November 2012 to:

Connecticut Legal Rights Project
1000 Silver Street
P.O. Box 351
Beers Hall, 2nd Floor
Middletown, CT 06457
Attn: Jan VanTassel

And to

Paul C. Horton, M.D.
240 Pomeroy Avenue, Suite 205
Meriden, CT 06450



Joan Feldman, Esq.

SHIPMAN & GOODWIN LLP®

COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

November 5, 2012

VIA HAND DELIVERY

Kevin Hansted, Esq.
Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308

Re: Objection to Paul C. Horton, M.D.'s Petition for Intervenor Status; Docket No. 12-31775-CON

Dear Attorney Hansted:

By this letter and on behalf of the Applicants in the above-referenced Application, I respectfully: (1) object to Paul C. Horton, M.D.'s ("Dr. Horton's") petition for Intervenor Status (the "Petition"); and (2) disagree with and respond to Dr. Horton's statements made in said Petition in the order that he set them forth in his Petition.

1. Objection to Dr. Horton's Petition for Intervenor Status:

Dr. Horton has failed to demonstrate how his participation at the hearing, as an Intervenor, will assist the Office of Health Care Access ("OHCA") in rendering a final decision concerning this Application as required by Section 19a-9-27(b)(4) of the Regulations of Connecticut State Agencies. Dr. Horton has provided OHCA with a series of unsubstantiated, inaccurate, emotional and false statements as a basis for his Petition, that should not become part of the evidence that OHCA considers to rule on this Application. Accordingly, we believe that a more appropriate avenue for Dr. Horton's participation is through the public portion of the upcoming hearing at which time OHCA may permit Dr. Horton's views to be heard.

2. Applicants' Responses to Dr. Horton's Statements:

The following sets forth the Applicants' specific responses to Dr. Horton's statements in his Petition for Intervenor Status:

Dr. Horton's Statements in Section 1 of His Petition: "It is perhaps no coincidence that a general hospital administration which has decided to jettison its psychiatric services in one of the most psychiatrically needy communities in the State would be found wanting in patient satisfaction scores....MidState needs more and better psychiatric presence, not the hostile-take-over kinds of care that have characterized the machinations of the Elmcrest/CVH/Rushford crowd over the last couple of decades....A robust, inpatient psychiatric service provides essential medical expertise and an atmosphere that assures patients will be afforded a total treatment program, one that respects their dignity as human beings and does not treat them as objects to be poked, prodded, split open or dismissed as not medically 'profitable.'"

Applicants' Response: MidState has not decided to "jettison" its psychiatric services as so disparagingly stated by Dr. Horton. Rather, MidState has decided to stabilize and enhance access and quality to inpatient behavioral health services as part of a Hartford HealthCare System-wide plan to reinvigorate and improve the delivery of inpatient behavioral health services in the Central Connecticut region. Dr. Horton's characterization of MidState's plan maligns MidState's intentions and more importantly, is not based upon any fact. Dr. Horton refers to "Elmcrest/CVH/Rushford" as the "hostile-take-over kinds of care", does nothing more than offer emotional rhetoric that maligns the reputations of behavioral health providers without providing any evidentiary value to OHCA. While MidState respects Dr. Horton's passion for his position, he should not be given Intervenor Status so he can voice his frustrations with the behavioral health system at large.

Dr. Horton's Statements in Section 2 of His Petition: "How will Meriden attract new psychiatrists if MidState Hospital is allowed to say, in effect, that we do not need and do not want intensive psychiatric participation and input and if private practice psychiatrists cannot be directly involved in the treatment of their mentally ill patients in the hospital setting? Moreover, it is very concerning and upsetting to patients and their families to have to travel halfway across the state to find a psychiatrist and/or to have to forfeit their relationship and trust in the referring psychiatrist to someone who has to start from scratch in treating them and who is pressured by the insurance company - almost always successfully - to discharge patients before they are ready."

Applicants' Response: There is no factual basis for the statement that MidState will not attract new psychiatrists to the area. Given Dr. Horton's earlier statement that MidState is in "one of the most psychiatrically needy communities in the State....", his subsequent statement that MidState would not be able to attract psychiatrists to the area if the MidState unit is closed is a non sequitur. Nevertheless, we believe that a stable, large, high quality unit at The Hospital of Central Connecticut ("HOCC") will do more to attract behavioral health providers to the area than the existing MidState unit is capable of doing. Moreover, as stated in HOCC's prefiled testimony of Clarence Silvia, all MidState affiliated psychiatrists will be welcome to apply for medical staff privileges at HOCC. With respect to his statement that patients and their families will have to travel halfway across the State, this statement is also false. The distance is approximately nine (9) miles and MidState will provide transportation support to families. Patients currently and regularly travel much greater distances for a variety of healthcare services.

Dr. Horton's Statement in Section 3 of His Petition: Dr. Horton states in reference to how patients are and will be treated at HOCC, "[t]hey will be 'evaluated' by a psychiatrist whose sole job is to prescribe medications, and then these patients will be turned over to lesser qualified persons to receive 'Cognitive Behavioral Therapy' and its cousin, 'Dialectical Behavior Therapy.' Thereafter, the psychiatrist will not be actively involved with the ongoing treatment process other than to prescribe and monitor the medication regimen. Although this modus operandi has become predominant, it does not and will not work."

Applicants' Response. This statement is nothing more than an inaccurate rant by Dr. Horton with respect to all of his frustrations regarding the delivery of behavioral health services everywhere. They unfairly distort and misrepresent the way in which treatment is provided by HOCC's inpatient psychiatrists. The HOCC psychiatrists are intensely involved in patient treatment and are not simply monitoring the medication regimen. Furthermore, Dr. Horton appears to be of the opinion that only a psychiatrist can be involved in the delivery of therapeutic treatment to patients. If a psychiatrist cannot practicably be in therapy with the patient 24/7, it does not follow that alternative providers and treatments cannot supplement a patient's treatment. Regardless of his own frustrations, Dr. Horton's statements are irrelevant to the Application and add no value to the issues under review by OHCA.

Dr. Horton's Statement 4 in His Petition: "Finally, one of the most disturbing flaws in the current NBGH proposal is that no provisions have been made for the treatment of the already overwhelming number of psychiatrically needy children and adolescents in the Meriden area who, in some cases, are in desperate need of psychiatric inpatient evaluation and treatment....Such an egregious oversight cannot

be tolerated. Why the Office of Healthcare Access permits this is a puzzle that needs immediate address."

Applicants' Response: This Application is not about whether or not the HOCC inpatient behavioral health unit should treat children. Thus, the statements provided by Dr. Horton in this regard are irrelevant to this Application. Notwithstanding, it should be noted that the Hartford HealthCare System's Institute of Living and Natchaug Hospital devote significant resources to providing inpatient behavioral health services to children. These inpatient services are specialized for children and thus, do not mix adults with children on their units.

In summary, the arguments made by Dr. Horton in his petition are not factually based, are irrelevant and will only serve as a distraction to OHCA in deciding the issues before it in this proceeding. Therefore, on behalf of the Applicants, I respectfully request that Dr. Horton not be granted Intervenor Status and that his testimony be heard at the public portion of the hearing only. In the alternative, if Intervenor Status is granted to Dr. Horton, I respectfully request that he not be granted the right to cross-examine the Applicants.

Respectfully Submitted,

Joan Feldman

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Certificate of Service

I hereby certify that a true and correct copy of the foregoing objection to petitioner's request for Intervenor Status was mailed via first class United States mail this 5th day of November 2012 to:

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1000 Silver Street
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Attn: Jan VanTassel

And to

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240 Pomeroy Avenue, Suite 205
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P.O. Box 34048
Hartford, Connecticut 06134-0308

Re: Objection to The Connecticut Legal Rights Project, Inc.'s Petition for Intervenor Status; Docket No. 12-31775-CON

Dear Attorney Hansted:

By this letter and on behalf of the Applicants in the above-referenced Application, I respectfully: (1) object to the Connecticut Legal Rights Project's ("CLRP's") petition for Intervenor Status (the "Petition"); and (2) disagree with and respond to CLRP's statements made in said Petition.

1. Objection to CLRP's Petition for Intervenor Status:

CLRP's stated purpose "is to ensure clients of [DMHAS] and especially patients of its inpatient facilities have effective access to the system of justice by providing them with independent advocates and attorneys to protect and enforce their rights and entitlements." See page 4 of *Doe v. Hogan*, Case No.: H88-239 (EBB), October 24, 1989 (the "Consent Decree"). As expressly stated in CLRP's own Petition, CLRP is responsible to the State for protecting the legal rights of DMHAS clients. The current Application before the Office of Health Care Access ("OHCA") has no bearing or effect on a patient's access to the justice system or their legal rights. Accordingly, CLRP has failed to present an interest that it is entrusted with protecting and that will

be affected by the current Application as required by Section 19a-9-27(b)(2) of the Regulations of Connecticut State Agencies.

CLRP has also failed to demonstrate how its participation at the hearing, as an Intervenor, will assist OHCA in rendering a final decision concerning this Application as required by Section 19a-9-27(b)(4) of the Regulations of Connecticut State Agencies. CLRP states that it plans on assisting OHCA by "presenting information on the challenges that [its] clients have encountered accessing services at all levels of care, and analysis, based on that experience and legal mandates including the Americans with Disabilities Act." Again, this Application has absolutely no effect, ramifications or connection to any legal mandates or rights such as the Americans with Disabilities Act (the "ADA").

The Applicants fully support and appreciate the CLRP's mission to ensure that its clients' legal rights are protected, including ensuring that its clients obtain equal and effective access to the justice system and are not denied access to facilities because of any disabilities in conformance with the ADA. However, because such mission and mandate is irrelevant to the Application at hand, CLRP's participation, as an Intervenor, will not assist OHCA in rendering a final decision in this matter. Rather, we believe that a more appropriate avenue for CLRP' participation is through the public portion of the upcoming hearing at which time OHCA may permit CLRP's position to be heard.

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And to

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240 Pomeroy Avenue, Suite 205
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November 5, 2012

VIA HAND DELIVERY

Kevin Hansted, Esq.
Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308

Re: Objection to Paul C. Horton, M.D.'s Petition for Intervenor Status; Docket No. 12-31775-CON

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Applicants' Response: MidState has not decided to "jettison" its psychiatric services as so disparagingly stated by Dr. Horton. Rather, MidState has decided to stabilize and enhance access and quality to inpatient behavioral health services as part of a Hartford HealthCare System-wide plan to reinvigorate and improve the delivery of inpatient behavioral health services in the Central Connecticut region. Dr. Horton's characterization of MidState's plan maligns MidState's intentions and more importantly, is not based upon any fact. Dr. Horton refers to "Elmcrest/CVH/Rushford" as the "hostile-take-over kinds of care", does nothing more than offer emotional rhetoric that maligns the reputations of behavioral health providers without providing any evidentiary value to OHCA. While MidState respects Dr. Horton's passion for his position, he should not be given Intervenor Status so he can voice his frustrations with the behavioral health system at large.

Dr. Horton's Statements in Section 2 of His Petition: "How will Meriden attract new psychiatrists if MidState Hospital is allowed to say, in effect, that we do not need and do not want intensive psychiatric participation and input and if private practice psychiatrists cannot be directly involved in the treatment of their mentally ill patients in the hospital setting? Moreover, it is very concerning and upsetting to patients and their families to have to travel halfway across the state to find a psychiatrist and/or to have to forfeit their relationship and trust in the referring psychiatrist to someone who has to start from scratch in treating them and who is pressured by the insurance company - almost always successfully - to discharge patients before they are ready."

Applicants' Response: There is no factual basis for the statement that MidState will not attract new psychiatrists to the area. Given Dr. Horton's earlier statement that MidState is in "one of the most psychiatrically needy communities in the State....", his subsequent statement that MidState would not be able to attract psychiatrists to the area if the MidState unit is closed is a non sequitur. Nevertheless, we believe that a stable, large, high quality unit at The Hospital of Central Connecticut ("HOCC") will do more to attract behavioral health providers to the area than the existing MidState unit is capable of doing. Moreover, as stated in HOCC's prefiled testimony of Clarence Silvia, all MidState affiliated psychiatrists will be welcome to apply for medical staff privileges at HOCC. With respect to his statement that patients and their families will have to travel halfway across the State, this statement is also false. The distance is approximately nine (9) miles and MidState will provide transportation support to families. Patients currently and regularly travel much greater distances for a variety of healthcare services.

Dr. Horton's Statement in Section 3 of His Petition: Dr. Horton states in reference to how patients are and will be treated at HOCC, "[t]hey will be 'evaluated' by a psychiatrist whose sole job is to prescribe medications, and then these patients will be turned over to lesser qualified persons to receive 'Cognitive Behavioral Therapy' and its cousin, 'Dialectical Behavior Therapy.' Thereafter, the psychiatrist will not be actively involved with the ongoing treatment process other than to prescribe and monitor the medication regimen. Although this modus operandi has become predominant, it does not and will not work."

Applicants' Response. This statement is nothing more than an inaccurate rant by Dr. Horton with respect to all of his frustrations regarding the delivery of behavioral health services everywhere. They unfairly distort and misrepresent the way in which treatment is provided by HOCC's inpatient psychiatrists. The HOCC psychiatrists are intensely involved in patient treatment and are not simply monitoring the medication regimen. Furthermore, Dr. Horton appears to be of the opinion that only a psychiatrist can be involved in the delivery of therapeutic treatment to patients. If a psychiatrist cannot practicably be in therapy with the patient 24/7, it does not follow that alternative providers and treatments cannot supplement a patient's treatment. Regardless of his own frustrations, Dr. Horton's statements are irrelevant to the Application and add no value to the issues under review by OHCA.

Dr. Horton's Statement 4 in His Petition: "Finally, one of the most disturbing flaws in the current NBGH proposal is that no provisions have been made for the treatment of the already overwhelming number of psychiatrically needy children and adolescents in the Meriden area who, in some cases, are in desperate need of psychiatric inpatient evaluation and treatment....Such an egregious oversight cannot

be tolerated. Why the Office of Healthcare Access permits this is a puzzle that needs immediate address."

Applicants' Response: This Application is not about whether or not the HOCC inpatient behavioral health unit should treat children. Thus, the statements provided by Dr. Horton in this regard are irrelevant to this Application. Notwithstanding, it should be noted that the Hartford HealthCare System's Institute of Living and Natchaug Hospital devote significant resources to providing inpatient behavioral health services to children. These inpatient services are specialized for children and thus, do not mix adults with children on their units.

In summary, the arguments made by Dr. Horton in his petition are not factually based, are irrelevant and will only serve as a distraction to OHCA in deciding the issues before it in this proceeding. Therefore, on behalf of the Applicants, I respectfully request that Dr. Horton not be granted Intervenor Status and that his testimony be heard at the public portion of the hearing only. In the alternative, if Intervenor Status is granted to Dr. Horton, I respectfully request that he not be granted the right to cross-examine the Applicants.

Respectfully Submitted,

Joan Feldman

Joan Feldman, Esq.

Certificate of Service

I hereby certify that a true and correct copy of the foregoing objection to petitioner's request for Intervenor Status was mailed via first class United States mail this 5th day of November 2012 to:

Connecticut Legal Rights Project
1000 Silver Street
P.O. Box 351
Beers Hall, 2nd Floor
Middletown, CT 06457
Attn: Jan VanTassel

And to

Paul C. Horton, M.D.
240 Pomeroy Avenue, Suite 205
Meriden, CT 06450

Joan Feldman, Esq.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3110
RECIPIENT ADDRESS	918602625035
DESTINATION ID	
ST. TIME	11/06 09:51
TIME USE	01'57
PAGES SENT	12
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Kirk Lowry, Esq.

FAX: (860) 262-5035

AGENCY: CHRP

FROM: Laura Greci

DATE: 11/6/2012 TIME: 8:45 AM

NUMBER OF PAGES: 12
(including transmittal sheet

Comments: Objection to Petitions (Midstate hearing)
Re: 12-31775-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3111
RECIPIENT ADDRESS	912032352506
DESTINATION ID	
ST. TIME	11/06 09:53
TIME USE	07'55
PAGES SENT	12
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Kirk Lowry, Esq.

FAX: (860) 262-5035

AGENCY: CLRP

FROM: Laura Greci

DATE: 11/6/2012 TIME: 8:45 AM

NUMBER OF PAGES: 12
(including transmittal sheet

Comments: Objection to Re'Hans (Midstate hearing)
Re: 12-31775-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

RICK LOPES
24TH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 4000
HARTFORD, CT 06106-1591
HOME: 860-229-7721
CAPITOL: 860-240-8585
TOLL FREE: 1-800-842-8267
E-MAIL: Rick.Lopes@cga.ct.gov

MEMBER
BANKS COMMITTEE
FINANCE, REVENUE AND BONDING COMMITTEE
JUDICIARY COMMITTEE
PUBLIC SAFETY COMMITTEE

November 1, 2012

Commissioner Jewel Mullen, MD, MPH, MPA
State of Connecticut
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Dr. Mullen:

I am writing in full support of MidState Medical Center's proposed plan to close its inpatient psychiatric unit and transition patients to a larger unit at The Hospital of Central Connecticut.
The proposed plan is unique in that it takes advantage of the system strengths of Hartford Healthcare to actually increase the total number of inpatient psych beds by 4 beds to create a new, modern, larger unit here in New Britain. MidState would have first option on those additional 4 beds, so the effective capacity for regional inpatient mental health services for the Meriden population will be increased.

When MidState's unit is full, the patients are scattered all over the state, wherever an inpatient mental health bed is available. The expansion not only allows greater regional access for patients needing inpatient mental health care, it also allows for significant quality improvements and more continuity of care.

The new unit will take advantage of modern design for safety and privacy and the size will allow dedicated staffing to expand the repertoire of treatment modalities and subspecialty services provided. This proposal allows the delivery of health care services in our community to be provided in a more cost effective and sustainable manner.

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Rick Lopes MSW
State Representative

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

October 31, 2012

IN THE MATTER OF:

An Application for a Certificate of Need
Filed pursuant to Section 19a-638 by

Mid State Medical Center

Petition to Intervene With Full Procedural Rights

Docket No. 12-31775-CON

Termination of Inpatient Behavioral Health Services

Petition to Intervene With Full Procedural Rights

Pursuant to General Statutes § 4-177a(b) and Regs., Conn. State Agencies § 19a-643-38, the Connecticut Legal Rights Project petitions the Office of Health Care Access to intervene with full procedural rights in the above-captioned matter. Granting this petition to intervene will allow the Connecticut Legal Rights Project to carry out its responsibilities to the State of protecting the legal rights of persons who are eligible for services from the Department of Mental Health and Addiction Services (DMHAS). The proposed intervention is in the interest of justice, and the proposed intervention will not impair the orderly conduct of the proceedings.

1. The Connecticut Legal Rights Project

The Connecticut Legal Rights Project, Inc. (CLRP) is a private non-profit legal services organization created by consent decree filed on

October 24, 1989 in *Doe v. Hogan*, Case No.: H88-239 (EBB). (Consent Decree attached as Exhibit A.) The purpose of the lawsuit was to remedy denial of effective access to the courts as guaranteed by the First and Fourteenth Amendments for psychiatric inpatients in the State of Connecticut. CLRP is incorporated in the State of Connecticut as a nonprofit legal services organization with its main office located in Beers Hall on the campus of Connecticut Valley Hospital (CVH). Pursuant to the provisions of the Consent Order, CLRP staff provide on-site legal services for treatment-related matters at all DMHAS facilities with full access to residents, their living environments and staff. Moreover, CLRP staff regularly conduct informational sessions and meet with key administrators to discuss systemic issues and operational concerns. While CLRP initially served only inpatient clients, the Consent Order anticipated the closure of state hospitals, which occurred in 1995 (Fairfield Hills) and 1996 (Norwich), and authorized CLRP to represent clients in the community. Therefore, CLRP conducts outreach and intake in a range of community locations throughout the state, including outpatient service providers, psychosocial clubs, soup kitchens and shelters. CLRP currently has five attorneys and eight paralegal advocates who are managed by an executive director and legal director. One attorney and one paralegal are assigned on a part time

basis to represent clients in the Greater Meriden region on matters related to their treatment, community integration and civil rights.

In addition, CLRP's attorneys have been actively involved in numerous advisory, planning, policy and oversight entities evaluating the state's mental health system and developing recommendations for improving its scope, efficiency and operations. These include, but are not limited to, the Governor's Blue Ribbon Commission on Mental Health, the Community Mental Health Strategy Board, the Mental Health Block Grant Planning Council, and the Mental Health Transformation Grant Oversight Council. This diverse experience provides a policy context to the casework that CLRP's lawyers and paralegals handle on a daily basis and enriching our understanding of the implications of the Mid State proposal on clients and the overall state system of care.

CLRP's Executive Director is attorney Jan VanTassel whose address is 1000 Silver Street, P.O. Box 351, Beers Hall, 2nd Floor, Middletown, Connecticut 06457.

2. The Connecticut Legal Rights Project and Clients that it Represents will be Affected by the Termination of Inpatient Behavioral Health Services at Mid State Medical Center

CLRP's clients will be directly affected by the termination of inpatient behavioral health services at Mid State Medical Center. The most obvious

impact will be on access to inpatient care in the region, barriers to visits and interaction with family, friends and natural supports, and challenges presented to the continuity of care when inpatient treatment is provided at a facility that is not part of the Meriden-Wallingford community. While all of these can be addressed on paper, it is not possible to measure the real chilling effect that they have on a patient's experience. The additional time, stress and planning involved in visiting a person at a facility even just ten miles away is not simply a matter of distance. Anyone who has had personal experience struggling to visit a loved one understands this reality. The Mid State proposal has already become a topic of concern and source of anxiety for many CLRP clients in the Meriden region. In speaking with clients about the proposed closure of the Mid State inpatient beds, it is apparent that many of them regard the proposed closure as an abandonment of them, particularly in the context of the medical center's prior actions. Mid State Medical Center was originally authorized to operate ten psychiatric beds, four of which were "swing beds" also available to meet the demand for med-surg patients. In fact, those four were used almost exclusively by med-surg patients, even though there was also demand for inpatient psych beds. Five years ago when Mid State applied to close the inpatient psych beds, OHCA denied the request and

ordered Mid State to operate eight inpatient psych beds. Despite documented demand, they never did so. They did follow through with increasing the emergency room beds for psychiatric stabilization, but to many people in recovery this sends a message that they are to be segregated and excluded from options available to other patients. One individual commented that he doubted that the community would be so complacent about the bed closure if the beds served persons with other illnesses.

While Mid State met with many advocacy groups, there has not been a meaningful effort to obtain input and suggestions from people in recovery and address their concerns directly. Nor are there any specific proposals to expand access to community services, including peer support and in-home respite, or emergency room supports. Mid State may claim that this is a 'bold and innovative' proposal, but that is not reflected in the document.

3. CLRP Petitions to Participate as an Intervenor with Full Procedural Rights

The Connecticut Legal Rights Project petitions to participate as an intervenor with full procedural rights. CLRP has specific responsibility to represent DMHAS clients pursuant to the Consent Order, providing a

unique perspective based on more than twenty years of representing clients throughout the state's mental health treatment system. CLRP's testimony can inform and enrich the decision-making process by presenting information on the challenges that our clients have encountered accessing services at all levels of care, and analysis, based on that experience and legal mandates including the Americans with Disabilities Act.

The gridlock at all levels of the mental health system was identified as a major problem in the Blue Ribbon Commission Report issued in July, 2002. Several contributing factors were cited, including:

-Spending on publicly funded community based services has not kept pace with the influx of new client groups entering the system.

*Cost cutting efforts by private sector managed care companies are reducing access to services and forcing people to seek care in the public system.

-Absence of appropriate community services has caused gridlock in the hospital beds making it difficult to discharge those no longer in need of hospitalization and equally difficult to admit people who need acute inpatient psychiatric care.

-A growing number of Connecticut general hospitals have cut back and are considering further reductions in their psychiatric services

because they are no longer able to afford the financial drain of supporting such services.

The relative cost per bed at Mid State as compared to HOCC is startling, and the corporation's desire to address this disparity is understandable. However, it is not clear that this is the only solution to the problem, nor is it the most appropriate in terms of community access to services. More conversation regarding options, including those which would explore truly innovative approaches to preventive and early intervention services as part of the system of care, need to be considered.

For these reasons, we believe that OHCA would benefit from CLRP's participation as an intervenor with full procedural rights.

Respectfully submitted,

Connecticut Legal Rights Project by:

Jan VanTassel, Executive Director

And,

Kirk W. Lowry, Legal Director
Connecticut Legal Rights Project
1000 Silver Street, P.O. Box 351
Beers Hall, 2nd Floor
Middletown, CT 06457

(860) 262-5017
Fax (860) 262-5035
klowry@clrp.org

Certification of Mailing

I hereby certify that above Petition to Intervene has been deposited in the United States Mail on this 31st day of October 2012 to:

Commissioner Dr. Jewell Mullen, MD, MPH, MPA
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134

And to:

Attorney Joan Feldman, Esq.
Shipman & Goodman
One Constitution Plaza
Hartford, CT 06103-1919
Attorney for MidState Medical Center

Kirk W. Lowry

Connecticut Legal Rights Project, Inc.
P.O. Box 351, Silver Street
Middletown, CT 06457

RELATES TO Form 3023, Part II, #1
Exhibit 3

13

FILED

Oct 24 8 56 AM '89

CLERK
U.S. DISTRICT COURT
HARTFORD, CONN

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

LINDA DOE, ET AL. : CIVIL NO. H88-239 (EBB)

V. :

MICHAEL F. HOGAN, ET AL. : OCTOBER 19, 1989

CONSENT ORDER

WHEREAS, plaintiffs filed this action on May 5, 1988 alleging the defendants failed to provide the plaintiffs with effective access to the courts as guaranteed by the First and Fourteenth Amendments of the United States Constitution; and

WHEREAS, the plaintiffs believe it is in the best interests of all the parties to settle this lawsuit; and

WHEREAS, defendants, without admitting liability, believe it is in the best interests of all parties to settle this lawsuit; and

WHEREAS, all parties consider the terms and conditions of this Order to be a fair, just, and reasonable settlement of this action;

NOW THEREFORE IT BE ORDERED, ADJUDGED, AND DECREED, AS FOLLOWS:

I. DEFINITIONS:

1. "Plaintiffs" shall include the named plaintiffs and the members of the plaintiff class as defined in paragraph 6 of this Consent Order.

2. "Defendants" shall include the named defendants, their successors in office, their agents, employees and assigns.

Attachment A

3. "DMH" means the Connecticut Department of Mental Health.

4. "Legal Assistance Program" means the legal assistance program as described in this Consent Order.

5. "Patient" shall mean any indigent person who resides in a DMH inpatient facility, whether as a result of a voluntary admission, involuntary commitment, emergency commitment, or as a result of involvement with the criminal justice system.

II. CLASS ACTION

6. This case is certified as a class action consisting of all present and future indigent patients of inpatient facilities funded or operated by the Connecticut Department of Mental Health who are or will be in need of legal assistance regarding their admission, treatment, environmental conditions, discharge, and other hospital-related rights under state or federal law or policy.

7. Notice of the Consent Order, as approved by the Court, shall be given to all class members as follows:

a. A notice shall be given to each patient by placing a copy of attached Exhibit A on his or her bed no later than November 10, 1989.

b. Thereafter, all future class members shall receive notice of this decree by receiving a copy of a DMH Patient Handbook which shall include a description of the Legal Assistance Program as outlined in part IV of this Consent Order.

III. GENERAL PROVISIONS

8. Defendants shall establish and maintain an advocacy program for indigent patients of in-patient DMH facilities in accordance with Section IV of this Consent Order.

9. In entering into this Consent Order, State officials do not admit any violation of law and this Consent Order may not be used as evidence of liability in any other civil proceeding.

10. Any violation of provisions of this Consent Order does not create a private right of action. This Consent Order is enforceable only by the parties.

11. The parties agree that this Consent Order is a final judgment in the above-captioned case.

12. The parties reserve the right to withdraw consent in the event that this order is not approved by the Court in its entirety.

13. This Consent Order shall be applicable to and binding upon all the parties, their officers, employees, their agents, assigns and successors.

14. Plaintiffs reserve the right to file a motion for costs and attorneys' fees subsequent to the signing of this order.

IV. LEGAL ASSISTANCE PROGRAM

A. INTRODUCTION

15. The creation of the Legal Assistance Program pursuant to this Order is intended to be a component of a broader legal advocacy system and is intended to supplement, not supplant, these existing services. To the maximum extent possible, these existing services will be coordinated with the Legal Assistance Program and integrated into the broader legal and other advocacy system for all DMH clients.

B. PURPOSE

16. The purpose of the Legal Assistance Program is to ensure that clients of the DMH and especially patients of its inpatient facilities have effective access to the system of justice by providing them with independent advocates and attorneys to protect and enforce their rights and entitlements.

C. SCOPE AND AUTHORITY

17. The Legal Assistance Program has the authority to serve any individual regarded as mentally ill and indigent in the State of Connecticut in accordance with the provisions of paragraphs 18 and 19 of this Agreement. However, consistent with its programmatic priorities and resources, the Program must provide advocacy assistance, including legal advocacy, to all indigent patients of DMH inpatient facilities. These facilities include Fairfield Hills Hospital, Connecticut Valley Hospital, Norwich Hospital, Whiting Forensic Institute, Cedarcrest Hospital, Greater Bridgeport Community Mental Health Center and Connecticut Mental Health Center. The Program must ensure that adequate advocacy services are offered to patients of inpatient facilities before it may provide assistance to other indigent mentally ill individuals.

18. The Legal Assistance Program has the authority to provide advocacy assistance, including legal advocacy, to indigent persons regarded as mentally ill in the State of Connecticut. However, consistent with its priorities and resources, the Program must provide assistance to patients of Department inpatient facilities regarding their admission, treatment, environmental conditions, discharge, and other hospital-related rights under state or federal law or policy. To the extent resources

permit or are available, it may offer its services on noninstitutional issues clearly related to a person's admission or discharge. The Legal Assistance Program shall not provide services, excluding services related to counseling and referral, in non-civil rights cases in connection with claims for damages against the State of Connecticut or any of its officers, departments, employees, boards or commissions; however, the legal assistance program staff may provide legal services and representation in such non-civil rights cases if the staff has attempted unsuccessfully to refer the case to a minimum of three qualified attorneys. In such cases, Legal Assistance Program staff shall maintain documentation of their efforts to refer the case, which shall be available to the Attorney General's Office upon request.

19. The Program shall seek to refer to, or arrange for assistance to be provided by, private attorneys or other public interest organizations on general legal disputes (e.g., wills, divorces, land transactions) with parties other than the State, or any of its officers, departments, employees, boards or commissions, its agents or employees. No program funds shall be used to provide legal services on such general legal issues, except in extraordinary or rare situations and where (1) no other specific resources are available; and (2) the situation is directly or indirectly related to the patient's admission, discharge, course of treatment. The extraordinary circumstances which would permit legal services on a general legal issue are to be directly or indirectly linked to treatment issues such that the resolution of the legal issue would affect the resolution of the particular treatment issue.

20. The design, establishment, operation, and administration of the Program shall insure the independence of Program staff in the provision of legal assistance to their clients. The Program shall perform its functions consistent with the Rules of Professional Conduct, and other applicable rules of legal practice. Subject to the provisions of paragraphs 18 and 19, the professional judgment of Program staff shall be exercised solely for the benefit of its clients, and the desires of any other person or entity shall be disregarded when they would either conflict with the interests of the client or impair the independent judgment of the Program.

21. The establishment, governance, funding, and operation of the Legal Assistance Program will be free from any conflict of interest, to the maximum extent possible, which might arise in its relationship with the State of Connecticut, its public agencies, private mental health agencies funded by the state, and other statewide private, professional, or service organizations involved in provision of mental health care. The funding of the Program by the defendants should be undertaken in a manner which recognizes and minimizes the conflict of interest inherent in its support of the Program.

D. ACTIVITIES

22. The Legal Assistance Program will have the capacity to provide information and referral, advice counseling, individual and group representation, and education to its clients. The Program is not intended to displace or supplant DMH's responsibility to investigate and resolve internally allegations of abuse or neglect.

23. (A) To the extent appropriate and when consistent with the Rules of Professional Conduct, Program staff will attempt to resolve most issues informally,

through discussions with hospital staff, negotiations with clinical supervisors and institutional administrators, and resort to the DMH's internal complaint procedure. In order to facilitate communication and promote early resolution of issues affecting patients' rights and program implementation, the DMH and the Legal Assistance Program shall conduct regular meetings on the following basis: Both the Commissioner or his designee and the Program's Board of Directors, as well as the Program's Director, shall meet twice a year to discuss mental health policy issues and other issues affecting the relationship between the Department and the Program. A senior staff person from the Legal Assistance Program may meet regularly with the superintendent of each facility to discuss implementation of the program, including any problems that may arise with respect to program access to patients and records. Staff may also discuss, where appropriate, concerns regarding specific policies or program clients. The Program shall seek the input and advice of the Department of Mental Health prior to adopting policies, changing policies and proposing legislative initiatives unless the Program's Board of Directors determines that prior discussions with the Department of Mental Health would compromise the interests of the Program or the Program's clients. Internal policies of the Program shall not be subject to this requirement. If the Program's Board of Directors makes such a determination, the Program shall give notice to the Department of Mental Health of the basis for its decision, without revealing the nature of the policy. The Department of Mental Health may thereafter challenge the appropriateness of such a determination.

(B) In the event that the Program intends to seek judicial relief against th defendants, whether in their official or individual capacity, without first having attempted informal resolution of the particular issue(s) involved, the Program will give reasonable notice under the circumstances of that intention to the DMH or the Attorney General's Office prior to seeking such relief. The Program shall give notice to the Attorney General's Office of any judgment obtained on behalf of any person who has received or is receiving any form of state assistance and shall provide notice of the institution of suit on every occasion when the Program has knowledge that any party is a recipient of any form of state funding or is a health care facility licensed under Conn. Gen. Stat. S 19a-490 et seq. or is an individual licensed under Conn. Gen. Stat. S-19a-14. State funding shall include receipt of a state grant, contract subsidization, loan or any similar benefit but shall not include specific financial assistance to an individual for basic life support unless notice to the State is specifically required by law.

(C) The Legal Assistance Program may attend, on behalf of a client, regula hospital meetings, treatment team meetings, or portions of such meetings, where the patient has a right to attend or is permitted to attend.

(D) To the extent appropriate, the Program may also represent clients in formal proceedings, if any, concerning admission, releases, medications, treatment, and the enforcement of other related rights. The Program shall not, however represent clients in court proceedings for which legal counsel is otherwise provided by statute, such as proceedings subject to the provisions of Conn. Gen. Stat. SS 17-178, 17-183, 17-192, 17-205d or 17-257s.

24. The DMH will provide regular and reasonable access to the patients, living environments, client meetings, and staff of its inpatient facilities for the Legal Assistance Program. Such access will include reasonable unimpeded contact with patients, without unreasonable disruption of any facility or patient treatment, e.g., scheduled meetings, group therapy, to provide information concerning legal rights and the availability of services under the Program. Contact with hospital staff shall not unduly impede the performance of their duties as determined by the appointing authority.

25. Prior to the commencement of the Legal Assistance Program, the DMH will inform all hospital staff, and new administrative and treatment staff thereafter, of the purpose and activities of the Legal Assistance Program and will facilitate a cooperative relationship between its staff and the Program. The Legal Assistance Program shall recognize the importance of consulting with hospital treatment staff so as not to unnecessarily disrupt the course of treatment. The Program shall similarly endeavor to develop a cooperative relationship with the DMH and its staff which will promote the effective access to the Program's clients.

26. The Legal Assistance Program shall act consistently with state and federal laws protecting confidential information concerning individuals regarded as mentally ill. The DMH will provide prompt and reasonable access to such confidential information consistent with all applicable state and federal laws without unreasonable disruption of any facility or patient treatment with the consent of the patients, his/her guardian, or if the patient is incompetent and lacks a guardian, with the approval of the

Commissioner of Mental Health or his designee. Under Connecticut law, all persons admitted to a mental health facility are presumed to be competent, unless otherwise determined by a court of competent jurisdiction.

E. STAFFING

27. The Legal Assistance Program will be staffed primarily by attorneys and paralegal advocates, with appropriate secretarial and administrative support. The Program will primarily rely on advocates to provide routine assistance to patients. The Program may include law students, consumers of mental health services, and others, as appropriate.

28. All Program staff will be qualified by training, experience, and personal commitment to serve individuals regarded as mentally ill who reside in inpatient facilities of the Department of Mental Health. Program staff will be adequately trained in the laws and policies of the State of Connecticut and the United States which affect mentally ill individuals. Advocates must be supervised by lawyers who have overall responsibility for their activities, and staff lawyers will be supervised by the director or supervising attorney of the Program.

29. The Legal Assistance Program will be phased-in over four years in accordance with paragraph 38 of this Order. The staffing in the fourth year will be a minimum of three patient advocates/paralegals, two attorneys, a director (who may also be an attorney) and two secretaries. The Program, in consultation with its Board of Directors, will retain flexibility regarding staffing, so long as its actions are not inconsistent with the minimal

staffing level in this Consent Order, and in particular, paragraph 31 of this Consent Order and so long as the consent of the Commissioner is first obtained if the staffing is done through the use of independent contractors, rather than the use of employees of the Program.

30. The DMH will provide, on an ongoing basis, appropriate space for a central office and will enter into an agreement with the Legal Assistance Program for the use of such space pursuant to Conn. Gen. Stat. § 17-210a(m). The initial agreement will be for a period of three years, subject to the DMH's reservation of the right to terminate for reasons unrelated to the operation of the Program upon the giving of one year's notice, and will provide space located in Beers Hall, 2nd floor, Connecticut Valley Hospital which contains 13 offices and a conference room. The conference room will be available to other Connecticut Valley Hospital personnel upon request and advance notice. Eleven of the thirteen offices will be furnished with a desk, file cabinet, chair, telephone and local telephone service for each of the Program staff included in the consent order (up to 11 staff members). Inkind support includes ongoing office supplies, copying, postage, utilities and janitorial services. If it is necessary for the Department of Mental Health to move the Legal Assistance Program, the Department of Mental Health will provide appropriate office space for eleven equipped offices in conformance with the space standards established by the Department of Public Works, as well as inkind services described above, and if the Program continues to want to be located in a central office, the DMH shall make all reasonable efforts to provide a central location in the State. Should the Legal Assistance Program elect to

move out of Department of Mental Health space when such space is available, the program will be responsible for all rental costs and support costs and the Department's responsibility for providing inkind support shall cease. Field sites will be located at Norwich Hospital, Fairfield Hills Hospital, and, in the event it is necessary for the DMH to move the central office from Connecticut Valley Hospital, at Connecticut Valley Hospital. Field sites will include a locked room, desk, chair, locked file cabinet and telephone services. At Greater Bridgeport Mental Health Center, Connecticut Mental Health Center, Whiting Forensic Institute, Cedarcrest Hospital, and Connecticut Valley Hospital, an interview room will be provided and will contain a desk, chair, locked file cabinet and telephone service. At locations other than the central office, the DMH will ensure privacy and confidentiality at all times when Program staff are providing client services at each site.

The amount of DMH inkind services and the estimated value of such services is as follows:

Year 1 (based on 8-month contribution) -

Office supplies, copying, postage	$ 840
Office space	78,000
Furniture	1,333
Utilities	20,000
Janitorial	1,800
DMH Total In-Kind	$101,973

Year 2

Office supplies, copying, postage	$ 3,024
Office space	117,000
Furniture	2,100
Utilities	40,000
Janitorial	4,500
DMH Total In-kind	$166,624

Year 3	
Office supplies, copying, postage	$ 4,536
Office space	117,000
Furniture	600
Utilities	50,000
Janitorial	6,300
DMH Total In-kind	$178,436

Year 4	
Office supplies, copying, postage	$ 5,292
Office space	117,000 *
Furniture	600
Utilities	50,000
Janitorial	6,300
DMH Total In-kind	$179,192 *

Four-Year Total	
Office supplies, copying, postage	$ 13,692
Office space	429,000
Furniture	4,633
Utilities	160,000
Janitorial	18,900
Four-Year DMH Total In-Kind	$626,225

* or appropriate value, based on Department of Public Works Space Standards in the event it is necessary for the Department of Mental Health to relocate the program.

The value of inkind services shall not exceed the fourth year total of $179,192, or such other appropriate value based on public works space standards in the event that the Department of Mental Health needs to relocate the program, and shall not exceed the amount for each individual category as indicated above. Notwithstanding the $179,192 limitation, the Department of Mental Health will provide full janitorial services and utility service so long as the Legal Assistance Program is located in a Department of Mental Health facility, and in subsequent years, the level of inkind

services for office supplies, copying, furniture and postage shall remain equivalent to that of year four.

31. By the conclusion of year four, and continuing thereafter, the Program will ensure that an attorney or advocate is available at least three days per week at Fairfield Hills Hospital, Connecticut Valley Hospital, Norwich Hospital, Whiting Forensic Hospital and Cedarcrest Hospital. At Greater Bridgeport Community Health Center and the Connecticut Mental Health Center, a Program attorney or advocate shall be available at least twice a week.

F. STRUCTURE AND DEVELOPMENT

32. In order to promote prompt and effective resolution of advocacy issues affecting its clients, the organization of the Legal Assistance Program shall generally correspond to the administrative structure of the Department of Mental Health in each region.

33. (A) The representatives for the parties agree that, in order to facilitate development of an effective legal assistance program, a qualified legal assistance program from outside Connecticut may be utilized during the start up period of the first year to perform the functions stated below.

(B) The Center for Public Representation in Northhampton, Massachusetts shall initially be awarded the contract as provider for the Legal Assistance Program, on the condition that it shall select a director and assist in training, and initial organization, for not more than 12 months, at which time the Legal Assistance Program shall be constituted as an independent nonprofit Connecticut corporation in accordance with the provisions of subparagraph (C) below. The director shall manage the Legal Assistance Program under the auspices of the Center for Public Representation during the period of the initial provider contract. The contract award with the Center for Public

Representation shall provide for an extension of time to manage the Program for longer than twelve months in case of extraordinary circumstances. In the event that the Center for Public Representation is unable to enter into an agreement to provide such services, then there shall be an award to a new nonprofit Connecticut corporation, to be set up in accordance with subparagraph (C) below.

(C) The Legal Assistance Program corporation shall be a new nonprofit corporation with the capacity to provide the services and to meet the obligations of the program set forth in this Agreement. It must have, or demonstrate the capacity to develop, reasonable expertise and experience in serving institutionalized persons with mental disabilities. There shall be three incorporators of the nonprofit corporation. The plaintiffs and defendants shall each select one incorporator. The third incorporator shall be selected by consensus of the two selected by the parties. The initial Board of Directors of the nonprofit corporation shall be appointed by the incorporators and shall be comprised of three persons with substantial experience and reputation in the creation of institutional legal advocacy systems for persons regarded as mentally ill or other similarly qualified persons. The initial Board members shall adopt bylaws for the corporation. In the event of a conflict between the terms of such bylaws and terms of this Agreement, the terms of this Agreement shall control.

34. The Program will retain sufficient flexibility and discretion to modify the program design, development schedule, and the allocation of staff to specific offices if new information indicates modifications are appropriate. Notwithstanding the foregoing, no modification may be made of the Program's scope and authority, as specified in

Part IV C of this Agreement or the Program's funding, as specified in Part IV G of this Agreement. The duties and obligations of the defendants under this Agreement shall not be modified without the consent of the defendants.

35. The parties agree that this Agreement will be adopted by the court as a final judgment in the above-captioned case. The court shall retain jurisdiction during the four year phase-in. The terms and conditions of this Agreement shall not be construed or interpreted as an admission by, or a finding that the State of Connecticut or any of its officers, departments, employees, boards or commissions have violated any provisions of the law or Constitution of the United States or the State of Connecticut.

36. The Program shall be operated under a contract with the Department of Mental Health, with reasonable reporting and review requirements. The contract is subject to the audit clause requirement of Conn. Gen. Stat. § 7-396a, and the standard contract provisions required for all state contracts.

37. The Legal Assistance Program shall report monthly to the DMH, utilizing the standard mental health information system required of all grant-fund services, and shall furnish the DMH the following information on a quarterly basis:

Number of attorneys and advocates whose services were provided

(FTE if not full-time)

Number of hours of legal services and advocate services

Cost per hour (total of money expended divided by the total hours of service)

Cost of provider overhead

Number of residents receiving services in the quarter, by type of service provided (i.e. — federal benefits, grievance, any other), at

each facility and the average number of hours each resident receives in legal services.

Any information which the DMH deems necessary to evaluate the efficiency and effectiveness of the program and the manner in which the funds of the programs are expended and which is reasonable and non-privileged.

G. FUNDING

38. Subject to the provisions of paragraphs 18 and 19 of this Agreement, the Department of Mental Health will fund all necessary expenses of the Legal Assistance Program up to the maximum annual amount specified in the following schedule:

First year of Program operation	-	$ 90,000.
Second year of Program operation	-	$209,000.
Third year of Program operation	-	$327,600.
Fourth and subsequent years of Program operation (plus reasonable cost of living adjustments in subsequent years, if such adjustments are appropriated by the Legislature and received by DMH for the following DMH accounts: Personal Services, Other Expenses, Mental Health Services Grants and Employment Opportunities Grants.)	-	$397,200.

39. The DMH reserves the right to reduce or withhold contract payment in the event the Program provider materially breaches the contract between the DMH and the provider.

40. To the extent that the population of these inpatient facilities is decreased through transfer of patients to community alternatives, funding for the Legal

Assistance Program should not decrease but the priorities of the Program may be adjusted concomitantly to reflect the needs of these Department clients, consistent with the provisions of Part IV C of this Agreement.

41. In the event that the Program receives funds or assets other than those provided by the DMH pursuant to its contract with the Program, the funding obligation of the DMH specified in paragraph 38 of this Order shall be reduced as follows: for any calendar year in which the Program receives funds or assets, other than those provided by the DMH pursuant to its contract with the Program, in excess of $350,000.00, the funding obligation of the DMH specified in paragraph 38 of this Order shall be reduced by $1.00 for every $2.00 of such funds or assets in excess of $350,000.00. In the event that such a reduction cannot be fully realized in the calendar year in which such funds or assets are received, such reduction shall be applied to the funding obligation of the DMH in the following year(s). The DMH may waive the provisions of this section.

The ceiling on outside contributions provided for in this section shall be increased for any calendar year in the same proportion by which the Northeast Consumer Price Index for the preceding year exceeds the Northeast Consumer Price Index as published by the Bureau of Labor Statistics for the calendar year in which this Judgment is entered. For purposes of this paragraph, the term "Northeast Consumer Price Index" shall be the "Northeast Urban Consumer Price Index for all Urban Consumers." issued by the Bureau of Labor Statistics of the United States Department of Labor. If, at the time adjustment of the ceiling is required, such Northeast Consumer Price Index is no longer issued, the adjustment shall be made by utilizing such other index as is then

generally recognized and accepted for similar determination of the cost of living variations.

Additionally, if for any calendar year the annual inpatient admissions for the preceding year exceeded the annual inpatient admissions for the calendar year in which this Judgment is entered by 25% (twenty-five percent) or more, the ceiling on outside contributions will be adjusted upwards to maintain the same ratio of the amount of the ceiling on outside contributions to annual inpatient admissions which exists for the year in which this judgment is entered.

H. MONITORING AND EVALUATION

42. The Board shall provide ongoing advice on program design, development, and implementation issues, and shall select the director of the Program after consulting with the attorneys for the parties in the event that a) The Center for Public Representation in North Hampton, Massachusetts is not initially awarded the contract as provider for the Legal Assistance Program or b) when the initial program director vacates the position.

43. The Board shall report to the representatives for parties annually on the activities, progress and status of the Legal Assistance Program.

44. Nothing in this agreement or the court order to be issued pursuant thereto shall preclude either party from moving the court for an order modifying or terminating the same based on existing law at the time of the motion.

45. The parties agree that their attorneys will meet no later than the beginning of the program's fourth year of operation to discuss the following two matters: (1)

the use of non-DMH funds by the Program to provide legal services beyond those authorized in Part IV C of this Order; (2) the location of the Program's offices and the desirability of maintaining one central office versus multiple offices for the Program. In the event the parties thereafter agree that this Order should be modified with respect to either or both of these matters, or with respect to any other matter as to which the parties mutually agree, this Order may, with the consent of the Court, be modified to reflect the terms mutually agreed upon by the parties.

PLAINTIFFS

BY:

Martha Stone
Connecticut Civil Liberties
Union Foundation
32 Grand Street
Hartford, CT 06106

Philip D. Tegeler
Connecticut Civil Liberties
Union Foundation
32 Grand Street
Hartford, CT 06106

DEFENDANTS

Michael F. Hogan
Commissioner of Mental Health

BY: CLARINE NARDI RIDDLE
DEPUTY ATTORNEY GENERAL
(ACTING ATTORNEY GENERAL)

Richard J. Lynch
Assistant Attorney General

Thomas J. Ring
Assistant Attorney General
P.O. Box 120
Hartford, CT 06101

So Ordered:

United States District Court Judge

Date

A True Copy
ATTEST:

KEVIN F. ROWE
Clerk, U.S. District Court

TERRI CHYNA-ROBERTS

Paul C. Horton, M.D. 240 Pomeroy Ave., Suite 205 • Meriden, CT 06450

FAX

Date 11-6-12

Number of pages including cover sheet 4

To Atty. Kevin Hansted

Phone

Fax # 860-418-7053

From Paul C. Horton, M.D.

Phone (203) 235-2505

Fax # (203) 235-2506

REMARKS: ☐ Urgent ☐ For your review ☐ Reply ASAP ☐ Please comment

Paul C. Horton, M.D.
240 Pomeroy Avenue, Suite 205
Meriden, Connecticut 06450

Telephone (203) 235-2505
Facsimile (203) 235-2506
phortonmd@aol.com

November 6, 2012

Kevin Hansted, Esq.
Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS # 13HCA
P.O. Box 34048
Hartford, CT 06134

Re: Objection to Paul C. Horton, M.D.'s Petition for Intervenor Status:
Docket No. 12-31775-CON

Dear Attorney Hansted:

Regarding Attorney Feldman's attempt to disqualify me as an intervenor, a status I was granted in 2007, I think it is important to consider the following:

I am asking to do this because I think it is important that there be *seasoned* psychiatric input into the decision to close the MidState Psychiatric Unit and because I have been approached by responsible people in the community to stand up on this issue. I fear that without voices such as mine there will be, on the psychiatric side of the ledger, either young and relatively inexperienced – trendy if you will – psychiatric input and/or psychiatric input that is given by individuals who have a vested interest.

I settled in Meriden in 1974 after completing a tour of duty with the Navy. I was a LCDR in the Medical Corp – a fully trained psychiatrist – and took care of hundreds of sailors and Marines who were badly damaged by the Vietnam War. I continue to treat war casualties in my private practice. I have been in private practice in Meriden for 38

years and have had privileges at all of the Meriden hospitals – Veteran's Memorial, Meriden-Wallingford and MidState. I was consultant and/or Medical Director at Child Guidance Clinic for Central Connecticut for decades and, during the last decade, have been and continue to be a psychiatric consultant to the Meriden Board of Education and to several other school systems in Central Connecticut. I am in full-time private practice. I have been along-time contributor to the psychiatric literature and my work has been covered numerous times by the New York Times and many other prestigious publications, national and international. I could go on and on, but my point is that people, such as myself, *should* be consulted when big decisions are being made about psychiatric practice in our communities.

I am very concerned about the fact that there are so few child and adolescent beds available in Central Connecticut and believe that MidState should be compelled to address the greatest of all psychiatric needs as part of this proposal. When children and adolescents require inpatient care it should be as close to home as possible.

Attorney Feldman does not like my "emotionality" but, at a deeper level I suspect that she fears open discussion and exposure of the issues. She claims that I have no right or basis in fact to comment on the HOCC plan. I want to make this clear: During the summer of this year the psychiatric head of the proposed unit met, behind closed doors, with 10 or so of us psychiatrists who service the Meriden area, several of whom were not connected with the Rushford Program. What I report is what I heard *first hand* about the model of care being tendered by the man who will be responsible for implementing it. I know where he is coming from and I speak his language – something Attorney Feldman evidently cannot appreciate. What I objected to then, and object to now, is the model itself one that minimized and marginalized responsible *psychiatric* participation in favor of the delivery of services on the cheap. I *heard* it and I understand it. I have *witnessed* Rushford's operation for a number of years and I have found it to be reckless and irresponsible in far too many instances. And the reason for this poor practice is that relatively untrained and inexperienced people are given far too much leeway to wheel and deal with patients or, as they would have it, "customers." These service providers do not learn much because they have not labored in the intellectual vineyards, such as medical schools, from which good crops of mental health professionals are harvested.

So, I hope that I will be afforded fifteen minutes or so to speak to larger and deeper issues – not just those of profitability.

As far as Attorney Feldman's directive that I be relegated to the public hearing and confined to a three minute speech, I find that incredibly demeaning and totally unacceptable.

Respectfully,

P C Horton M D

Paul C. Horton, M.D.
Diplomate of the American Board
of Psychiatry and Neurology

PCH/gmc

Greer, Leslie

From: Greci, Laurie
Sent: Tuesday, November 06, 2012 12:16 PM
To: susiern59@aol.com
Cc: Greer, Leslie; Carney, Brian; Hansted, Kevin; Olejarz, Barbara
Subject: Ruling on Petition for Status at MidState Hearing concerning CON Docket 12-31775-CON
Attachments: 31775 Rulings.pdf

Importance: High

Dear Ms. Duclos,

Attached is the ruling on your request for status at the hearing concerning MidState's proposal to terminate inpatient behavioral health services.

Within the attachment you will also find the rulings for two additional intervenors.

I will also resend to you the .pdf of the docket for this Certificate of Need application along with directions to the location of the hearing, the tentative agenda, and the table of the record. This will be sent to you later this afternoon.

Regards,
Laurie

Laurie K. Greci
Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

November 6, 2012 VIA FAX ONLY

Kirk W. Lowry, Esq.
Legal Director
Connecticut Legal Rights Project, Inc.
1000 Silver Street, P.O. Box 351
Beers Hall, 2nd Floor
Middletown, CT 06457

RE: Certificate of Need Application Docket Number 12-31775-CON
MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation
Proposal to Terminate Inpatient Behavioral Health Services at MidState Medical Center

Dear Attorney Lowry:

Enclosed is the ruling by the Department Public Health's Office of Health Care Access on the Petition to Intervene with Full Procedural Rights by Connecticut Legal Rights Project, Inc. with OHCA on November 1, 2012.

If you have any questions concerning this matter, please contact me at (860) 418-7001.

Sincerely,

Laurie K Greci

Laurie K. Greci
Associate Health Care Analyst

Copy: Barbara Durdy, MidState Medical Center
Claudio Capone, The Hospital of Central Connecticut
Karen Goyette, Hartford HealthCare Corporation
Joan W. Feldman, Esq., Shipman and Goodwin, LLP
Paul C. Horton, M.D.
Susan Duclos, R.N.

IN THE MATTER OF:

A Certificate of Need Application by
MidState Medical Center, The Hospital of Central
Connecticut and Hartford HealthCare Corporation
Notice to Petitioner; re: Request for Status

Docket Number: 12-31775-CON
November 6, 2012

**RULING ON A PETITION FILED BY
CONNECTICUT LEGAL RIGHTS PROJECT, INC.
TO BE DESIGNATED AS AN INTERVENOR
WITH FULL RIGHTS OF CROSS-EXAMINATION**

By petition dated November 1, 2012, Connecticut Legal Rights Project, Inc. ("Petitioner") requested Intervenor status with full right of cross-examination in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") application of MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation ("Applicants") filed under Docket Number: 12-31775-CON. The CON application is for the termination of inpatient behavioral health services at MidState Medical Center.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with full rights of cross-examination for the hearing scheduled on November 7, 2012, 3:00 p.m., at the Four Points by Sheraton Meriden, 275 Research Parkway, Meriden, Connecticut. As an Intervenor with full rights of cross-examination, the Petitioner is allowed to participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 12-31775-CON and will be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicants until the issuance of a final decision by OHCA. As an Intervenor with full rights of cross-examination, the Petitioner may be cross-examined by the Applicants and the Petitioner has the right to cross-examine the Applicants.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

11/6/12
Date

Kevin T. Hansted
Hearing Officer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

November 6, 2012 VIA FAX ONLY

Paul C. Horton, M.D.
240 Pomeroy Avenue, Suite 205
Meriden, CT 06450

RE: Certificate of Need Application Docket Number 12-31775-CON
MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation
Proposal to Terminate Inpatient Behavioral Health Services at MidState Medical Center

Dear Dr. Horton:

Enclosed is the ruling by the Department Public Health's Office of Health Care Access on your Petition to Intervene that was filed with OHCA on November 1, 2012.

If you have any questions concerning this matter, please contact me at (860) 418-7001.

Sincerely,

Laurie K. Greci

Laurie K. Greci
Associate Health Care Analyst

Copy: Barbara Durdy, MidState Medical Center
Claudio Capone, The Hospital of Central Connecticut
Karen Goyette, Hartford HealthCare Corporation
Joan W. Feldman, Esq., Shipman and Goodwin, LLP
Kirk W. Lowry, Connecticut Legal Rights Project, Inc.
Susan Duclos, R.N.

IN THE MATTER OF:

A Certificate of Need Application by
MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation
Notice to Petitioner; re: Request for Status

Docket Number: 12-31775-CON
November 6, 2012

RULING ON A PETITION FILED BY PAUL C. HORTON, M.D. TO BE DESIGNATED AS AN INTERVENOR

By petition dated November 1, 2012, Dr. Paul C. Horton ("Petitioner") requested Intervenor status in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") application of MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation ("Applicants") filed under Docket Number: 12-31775-CON. The CON application is for the termination of inpatient behavioral health services at MidState Medical Center.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with limited rights for the hearing scheduled on November 7, 2012, 3:00 p.m., at the Four Points by Sheraton Meriden, 275 Research Parkway, Meriden, Connecticut. As an Intervenor with limited rights, the Petitioner is allowed to participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 12-31775-CON and will be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicants until the issuance of a final decision by OHCA. As an Intervenor with limited rights, the Petitioner may make a short presentation. The Applicants may cross-examine the Petitioner. The Petitioner is not permitted to cross-examine the Applicants.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

11/6/12
Date

Kevin T. Hansted
Hearing Officer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

November 6, 2012

VIA EMAIL ONLY

Susan Duclos, R.N.
susiern59@aol.com

RE: Certificate of Need Application Docket Number 12-31775-CON
MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation
Proposal to Terminate Inpatient Behavioral Health Services at MidState Medical Center

Dear Ms. Duclos:

Included is the ruling by the Department Public Health's Office of Health Care Access on your Petition to Intervene that was filed with OHCA on November 1, 2012.

If you have any questions concerning this matter, please contact me at (860) 418-7001.

Sincerely,

Laurie K. Greci

Laurie K. Greci
Associate Health Care Analyst

Copy: Barbara Durdy, MidState Medical Center
Claudio Capone, The Hospital of Central Connecticut
Karen Goyette, Hartford HealthCare Corporation
Joan W. Feldman, Esq., Shipman and Goodwin, LLP
Kirk W. Lowry, Connecticut Legal Rights Project, Inc.
Paul C. Horton, M.D.

IN THE MATTER OF:

A Certificate of Need Application by
MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation
Notice to Petitioner; re: Request for Status

Docket Number: 12-31775-CON
November 6, 2012

RULING ON A PETITION FILED BY SUSAN DUCLOS, R.N. TO BE DESIGNATED AS AN INTERVENOR

By petition dated November 5, 2012, Susan Duclos, R.N. ("Petitioner") requested Intervenor status in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") application of MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation ("Applicants") filed under Docket Number: 12-31775-CON. The CON application is for the termination of inpatient behavioral health services at MidState Medical Center.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with limited rights for the hearing scheduled on November 7, 2012, 3:00 p.m., at the Four Points by Sheraton Meriden, 275 Research Parkway, Meriden, Connecticut. As an Intervenor with limited rights, the Petitioner is allowed to participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 12-31775-CON and will be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicants until the issuance of a final decision by OHCA. As an Intervenor with limited rights, the Petitioner may make a short presentation. The Applicants may cross-examine the Petitioner. The Petitioner is not permitted to cross-examine the Applicants.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

11/6/12
Date

Kevin T. Hansted
Hearing Officer

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3117
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ST. TIME	11/06 13:06
TIME USE	02'57
PAGES SENT	7
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Joan Feldman, Esq

FAX: 860 251-5211

AGENCY: Shipman and Goodwin LLP

FROM: Laura K. Grech

DATE: 11/6/2012 TIME: 11:50 AM

NUMBER OF PAGES: 7
(including transmittal sheet

Comments: Ruling on Petitioners Status
Re: 12-31775-CON Hearing

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
****

TRANSMISSION OK

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DESTINATION ID	
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TIME USE	01'24
PAGES SENT	7
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Claudio Capone

FAX: (860) 224-5740

AGENCY: HOCC

FROM: Laurie K. Greci

DATE: 11/6/2012 TIME: 11:50 AM

NUMBER OF PAGES: 7
(including transmittal sheet

Comments: Rulings on Petitions for Stays
Re: 12-31775-CON Hearing

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3114
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DESTINATION ID	
ST. TIME	11/06 13:01
TIME USE	01'06
PAGES SENT	7
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Barbara Durkly
FAX: 203 674 7601
AGENCY: MMC
FROM: Laura K. Grech
DATE: 11/6/2012 TIME: 11:50 AM
NUMBER OF PAGES: 7
(including transmittal sheet

Comments: Rulings on Petitions for Stays
Re: 12-31775-CDN Hearing

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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*** TX REPORT ***
****

TRANSMISSION OK

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ST. TIME	11/06 12:59
TIME USE	01'45
PAGES SENT	11
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Kirk Lowry, Esq

FAX: (860) 262-5035

AGENCY: CHRP, Inc.

FROM: Laurie Greci

DATE: 11/6/2012 TIME: 11:25 AM

NUMBER OF PAGES: 12
(including transmittal sheet

Comments: Ruling on Petitions for Status at Hearing for 12-31775-CON and Additional Intervenor Request

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3122
RECIPIENT ADDRESS	912032352506
DESTINATION ID	
ST. TIME	11/06 14:46
TIME USE	07'01
PAGES SENT	12
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Paul Horton MD

FAX: (203) 235-2506

AGENCY: self

FROM: Laurie Greci

DATE: 11/6/2012 TIME: 1:40 P/M

NUMBER OF PAGES: 12
(including transmittal sheet

Comments: Ruling on Petitions for Status at Hearing for 12-31775-CON and Add'l Intervenor Request

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3121
RECIPIENT ADDRESS	918605452127
DESTINATION ID	
ST. TIME	11/06 14:37
TIME USE	02'00
PAGES SENT	11
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Karen Goyette

FAX: 860 545 2127

AGENCY: HHC

FROM: Laurie Greci

DATE: 11/6/2012 TIME: 1:25 PM

NUMBER OF PAGES: 11
(including transmittal sheet

Comments: Rulings on Status of Hearing
Re: 12-31775-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

November 6, 2012

The Honorable Rick Lopes, MSW
Representative
State of Connecticut
Legislative Office Building, Room 4000
Hartford, CT 06106-1591

Re: Certificate of Need
MidState Medical Center, Docket Number: 12-31775-CON
Proposal to Coordinate with its Hartford Healthcare Affiliate to Offer Inpatient Behavioral Health Services at The Hospital of Central Connecticut

Dear Representative Lopes:

On November 6, 2012, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for the proposal by MidState Medical Center to coordinate with its Hartford Healthcare Affiliate to offer inpatient behavioral health services at The Hospital of Central Connecticut.

I welcome and appreciate your comments regarding this matter. I have forwarded your letter to DPH's Office of Health Care Access ("OHCA"). Your letter will be made part of OHCA's formal record of the CON application docket. Please be advised, once a decision has been rendered it will be posted and available on OHCA's website at http:// www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone at (860) 418-7029.

Sincerely,

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

LAD:KRM:bko

Connecticut Department of Public Health

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410 Capitol Avenue, P.O. Box 34038
Hartford, Connecticut 06134-0308
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State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

RICK LOPES
24TH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
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MEMBER
BANKS COMMITTEE
FINANCE, REVENUE AND BONDING COMMITTEE
JUDICIARY COMMITTEE
PUBLIC SAFETY COMMITTEE

November 1, 2012

Commissioner Jewel Mullen, MD, MPH, MPA
State of Connecticut
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Dr. Mullen:

I am writing in full support of MidState Medical Center's proposed plan to close its inpatient psychiatric unit and transition patients to a larger unit at The Hospital of Central Connecticut.
The proposed plan is unique in that it takes advantage of the system strengths of Hartford Healthcare to actually increase the total number of inpatient psych beds by 4 beds to create a new, modern, larger unit here in New Britain. MidState would have first option on those additional 4 beds, so the effective capacity for regional inpatient mental health services for the Meriden population will be increased.

When MidState's unit is full, the patients are scattered all over the state, wherever an inpatient mental health bed is available. The expansion not only allows greater regional access for patients needing inpatient mental health care, it also allows for significant quality improvements and more continuity of care.

The new unit will take advantage of modern design for safety and privacy and the size will allow dedicated staffing to expand the repertoire of treatment modalities and subspecialty services provided. This proposal allows the delivery of health care services in our community to be provided in a more cost effective and sustainable manner.

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Rick Lopes MSW
State Representative

User, OHCA

From: JAMES SAYRE JR <jrsayre@snet.net>
Sent: Thursday, November 08, 2012 10:17 AM
To: User, OHCA
Subject: Termination of services at Midstate Midstate Medical Center

I am writing concerning the termination of inpatient behavioral health sevices at Midstate Medical Center (Docket #12-31775-CON). I planned to attend the public hearing yesterday, but I did not because of the weather conditions. I totally disagree with the move to New Britain Hospital. My brother has used the facility at Midstate several times and it would be a hardship to my family if it was moved to New Britain. When a person is having a breakdown, it is important that they be in a place they feel comfortable and where family members can support them. A bigger facility is not always better. All this just adds to the stress for the person being admitted. When my brother was a patient there in 2010, my family was so relieved there was a bed available at Midstate. My parents were both in their 80's and drove almost every day from Wallingford (his home also) to visit him. They could not drive to New Britain. I don't believe that providing transportation will solve all problems. It is still a considerable distance to travel. My family was pleased with the care received at Midstate. Please leave the services there.
Patricia and James Sayre

Greer, Leslie

From: Martone, Kim
Sent: Friday, November 09, 2012 1:53 PM
To: Hansted, Kevin; Carney, Brian; Greci, Laurie
Cc: Olejarz, Barbara; Greer, Leslie
Subject: FW: Testimony re: CON Application of MidState Medical Center, Docket No. 12-31775-CON
Attachments: Donovan-Abercrombie MidState Testimony to OHCA 110912.pdf

Kimberly R. Martone
Director of Operations
Office of Health Care Access
860-418-7029

From: Passaro, Cara [mailto:Cara.Passaro@cga.ct.gov]
Sent: Friday, November 09, 2012 1:36 PM
To: Martone, Kim
Subject: Testimony re: CON Application of MidState Medical Center, Docket No. 12-31775-CON

Hi Kim,

On behalf of Speaker Donovan and Rep. Abercrombie, attached please find testimony for the record related to MidState's CON application. Please let me know if you have any questions. I will forward a hardcopy to Deputy Commissioner Lisa Davis via interoffice mail.

Thanks,
Cara

Cara Passaro
Office of Speaker of the House Christopher Donovan
Legislative Office Building, Room 4100
300 Capitol Avenue
Hartford, CT 06106
Tel: 860-240-8794 or 800-842-8267
Cara.Passaro@cga.ct.gov

State of Connecticut

GENERAL ASSEMBLY
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

Testimony of Speaker of the House Christopher G. Donovan and State Representative Catherine F. Abercrombie

To Deputy Commissioner Lisa Davis, Office of Health Care Access concerning: CON Application of MidState Medical Center, Docket No. 12-31775-CON

November 9, 2012

Thank you for the opportunity to submit testimony on this important matter. As you know, under the proposal, MidState would close the six beds it currently maintains on site in Meriden, in exchange for 10 beds at the Hospital of Central Connecticut (HOCC) in New Britain, which will be expanded to include 32 beds total.

We want to acknowledge MidState's efforts to respond to concerns we have raised in the past and its recent work to reach out to stakeholders. While we recognize MidState's need to adapt to the changing healthcare landscape, the proposal raises concerns about both patient access to services and the ability of families to support patients in crisis and be part of their continuum of care.

In 2007, MidState filed a CON application, which included a request to terminate inpatient psychiatric services and transfer patients in need of these services to the Institute of Living in Hartford and other facilities. In 2008 OHCA denied this provision of the application because it did not find evidence that community need for these services had diminished. To the contrary, OHCA referenced strong evidence to support the need for an inpatient psychiatric unit at MidState, writing in its decision that "an individual requiring routine inpatient psychiatric care will be better served by receiving their treatment closer to home, where matters pertaining to patient support from family members and the establishment of appropriate aftercare treatment can be better achieved." As part of its denial, OHCA advised MidState to maintain psychiatric inpatient services consisting of no less than eight licensed beds. It is our understanding that MidState currently maintains only six inpatient psychiatric beds.

Previous discussions with officials at MidState led us to believe that the proposal included a guarantee that a certain number of HOCC beds would be available to patients transferred from MidState. At the hearing earlier this week, we learned that this is not the case. Thus, this proposal asks us to give up the existing six beds in Meriden, which are already inadequate, in exchange for longer travel times to HOCC, with no guarantee of immediate access to inpatient psychiatric care.

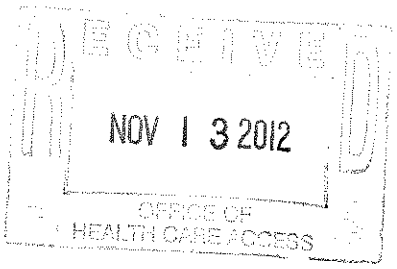
In addition to ensuring the maintenance of an adequate number of beds, we are concerned that this proposal will create barriers for families without transportation and will disrupt the care of patients transitioning from inpatient services in New Britain to outpatient services in Meriden and surrounding communities. One of the great features of having inpatient psychiatric services available right in Meriden is the accessibility of the unit to families whose loved ones are in crisis. Families who may not

have access to a car can conveniently access the hospital using public transportation. This allows family members to focus on the needs of the patient during a very stressful time and support caseworkers as they facilitate the healing process. On our congested roads, a roundtrip to HOCC and back to Meriden could easily exceed an hour—putting such a trip out of reach for many working families facing transportation challenges.

We are particularly concerned because New Britain is located in a different catchment area and clients may be seeing different psychiatrists and clinicians when they return home to Meriden. Both families and service providers report that there is a strong sense of community in the way services are currently structured through the MidState unit: patients have consistent access to their individual doctors and there are many opportunities for families to remain involved as service needs change. We all know how important a strong support system is to recovery and we are concerned that the vital role families and friends play will be reduced if MidState's unit is moved out of town.

Finally, MidState is our nonprofit community hospital and its mission is to serve the needs of the community. OHCA reinforced this in its 2008 decision. Meriden and Wallingford combined comprise over 100,000 residents and no urban community of that size should be without vital inpatient psychiatric services. Based on our conversations with families and mental health providers over the years, we have developed a deep appreciation for the role of family, friends and community in the recovery process. We understand that these services are expensive, but we must put patient care before the financial bottom line. We believe it is imperative that our community's mental health needs are served within the community, which is why we do not support the CON application as currently written.

We commend the work of your office and share your commitment to ensuring access to quality, affordable health care in our region and throughout our state and would be happy to answer any questions you may have regarding this proposal.



From:
Susan Duclos RN, CEM

page one of 17

to: Barbara Durdy
Claudio Capone
Karen Gayette
Dr Horton
Kirk Lowry
OHCA

November 10,2012

To whom it may concern,

Due to time constraints at the hearing for CON docket 12-31775, I was unable to present testimony that the RN's, social worker, and occupational therapist would like to address.

EXHIBIT 6 /MMC: Rushord's services do NOT include DBT groups, and have not for many years. In fact, the patients have to go to IOL or Yale for these services. Most DBT programs are 4-6 weeks, therefore HOCC would be unable to provide this service due to requiring decreased LOS.

EXHIBIT 8/MMC: our exhibit numbered pages 1 and 2 address a letter the Speaker of the House wrote August 6th to DPH confirming that OCHA denied MMC's CON to terminate inpatient psych services, and that OHCA referenced "strong evidence to support the need for an inpatient psych unit at Midstate." OHCA advised MMC to maintain no less than EIGHT licensed beds. We currently maintain 6 beds, and as I stated, 2 beds were made into on call physician rooms, and 2 beds were made into med-surg equipment rooms greater than a year ago.. These could have easily accommodated 4 additional beds, as in approximately 2002, we were a 10 bed unit. It also addresses in Exhibit 8 the downward trend of the need for med-surg beds statewide. IN fact., Pav A (which is the med-surg unit where our Psych unit is located), has frequently been closed this summer. We believe we could use those additional beds to expand psychiatric services in our community, for a much smaller cost than the projected expansion at HOCC of $4,744,340.

At MMC's Board of Director's Meeting on May 15th, it stated that MD's, Rushford,, and advocacy groups support this plan.In fact, CLRP, Chis Donovan, and State Rep Catherine Abercrombie among others do NOT support MMC's plan. Additionally, we have received unsoliciated letters from the community and other advocacy groups of the same opinion.

EXHIBT 10/MMC: lists resumes and CV's of key professional personnel. Surprisingly, it does NOT include our psychiatrist at MMC, who is also is a board-certified psychiatrist with a sub-specialty in Addiction. He in fact runs a private office in West Hartford for suboxone treatment., therefore he is equally as qualified as HOCC's Psychiatrists.

EXHIBIT 12/MMC: As addressed earlier the projected cost of an expanded unit at HOCC is well over $4 million dollars. MMC did not do any studies to project what the cost would be to open a larger unit at MMC. 4 of the beds I addressed earlier are "psych-safe beds", and would not cost anything to re-institute.

MMC addressed transportation provisions for close family members. Often our patients are estranged from their families, and their only support network are friends, sponsors, and clergy (to address their spiritual needs). Where is the provision for these other important members of a patient's support network? In addition, Rushford's caseworker's who know the patients intimately have a high case-load as it stands, and we feel this would provide an additional burden if they had to travel 18 miles round trip.

It is like comparing apples to oranges when stating that pediatric and cardiac catheterization labs are two examples of centralized care. For example, interventional radiologists ,cardio-thoracic surgeons, and specialized nursing care units are needed to provide treatment/care to these specialized populations. We at MMC used Evidenced-Based Guidelines and the team-approach in caring for our patients. It was also stated that Music therapy would be provided at HOCC, which is a service we have provided for many years. Our psychiatrist has the same board-certification as the MD's at HOCC. The RN's, OT, and LCSW are also licensed and have taken boards just as their staff at HOCC has. For a small unit. We have the highest % of Nightingale Award Winners for Excellence in Nursing at MMC. And in the short 4-5 months that MMC provided awards to staff for the excellent care they provide, and being mentioned by name in patient surveys, we have 3 RN's who have received this award!

Clarence Silva afforded priveleges to MD's at HOCC, yet when we inquired about being offered job opportunities at HOCC, we were told no special provisions would be made for us to obtain employment there if our unit closed.

HHC states our motto is "Caring, Excellence, Safety, and Integrity". I feel I have addressed the Caring and Excellence portion of HHC's motto. In regard to SAFETY, OurRN mandatory Safety Compliance education which is provided on-line, CLEARLY stated that our ABU and ER are the first and second most dangerous places to work at MMC.We have had several dangerous incidents in the past months, and MMC added "Code Silver" to our education ,which speaks to the necessary steps to take if a patient has a gun. We have seen our census and the acuity and violence of patients increase dramatically in the ABU. We greatly fear for for our safety, as well as the safety of patients ,visitors, and their families. WE feel that if HOCC cannot GUARANTEE provision to take these patients in the numbers they described, that there is a great potential for sentinel events. We are officially a 9 bed ABU, but often put up to 3 more additional pt's in ABU hallway, not to mention the patients waiting for beds in the ABU who are in the ER(which does not have psych-safe rooms)! If We could open up more beds upstairs on the inpatient unit, this would greatly decrease the potential for harm, and ensure appropriate initiation of therapy.

HOCC<HHC and MMC talk about the reduction in costs, but we say to you, "What is the cost of a human's life?"

EXHIBITS 1 and 2: Chris Donovan's letter to DPH which addresses valid concerns.

EXHIBITS 3 and 4:Unsolicitated letter[among many] to the psych unit at MMC, addressing from a patient's perspective the care at MMC and HOCC.

EXHIBITS 5 and 6:Letters to the Editor supporting keeping our Psych Unit open.

EXHIBITS7-13 are in reference to VMMC's original CON docket 92-567.

Exhibits 1 and 2 via fax to support our facts

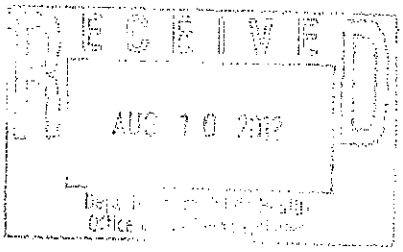
They address that VMMC intended to keep open the Psychiatry unit, that "VMMC INTENDS TO CONTINUE TO PROVIDE" these services, that no services be terminated, *that the proposed CON "SHOULD NOT IMPACT PHYSICAL ACCESS OF HEALTHCARE TO PERSONS RESIDING IN THE IMMEDIATE DOWNTOWN AREA".
Also Bill No. 5708 states if VMMC is non-compliant, the State of CT or City of Meriden can bring action in New Haven Superior Court.

Sincerely yours,
Susan Duclos RN, CEN
Representing staff of MMC

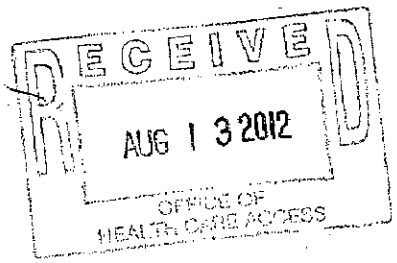
Staff Exhibit 1

STATE OF CONNECTICUT
HOUSE OF REPRESENTATIVES

CHRISTOPHER G. DONOVAN
SPEAKER OF THE HOUSE



August 6, 2012



Commissioner Jewell Mullen
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Re: Certificate of Need Application of MidState Medical Center, Docket No. 12-31775-CON

Dear Commissioner Mullen:

We are writing in reference to MidState Medical Center's recent application for a certificate of need to terminate its inpatient behavioral health services. Under the proposal, MidState would close the six beds it currently maintains on site in Meriden, in exchange for 10 beds at the Hospital of Central Connecticut in New Britain, which will be expanded to include 32 beds total.

We want to acknowledge MidState's efforts to respond to concerns we have raised in the past and its recent work to reach out to us and other stakeholders. While we recognize MidState's need to adapt to the changing healthcare landscape, the proposal raises concerns about both patient access to services and the ability of families to support patients in crisis and be part of their continuum of care.

In 2007, MidState filed a CON application, which included a request to terminate inpatient psychiatric services and transfer patients in need of these services to the Institute of Living in Hartford and other facilities. In 2008 OHCA denied this provision of the application because it did not find evidence that community need for these services had diminished. To the contrary, OHCA referenced strong evidence to support the need for an inpatient psychiatric unit at MidState, writing in its decision that "an individual requiring routine inpatient psychiatric care will be better served by receiving their treatment closer to home, where matters pertaining to patient support from family members and the establishment of appropriate aftercare treatment can be better achieved." As part of its denial, OHCA advised MidState to maintain psychiatric inpatient services consisting of no less than 8 licensed beds. It is our understanding that MidState currently maintains only six inpatient psychiatric beds.

We have a variety of additional concerns about the proposal, including the barriers it creates for families without transportation and the disruption to care as patients are transitioned from inpatient services in New Britain to outpatient services in Meriden and surrounding communities. One of the great features of

Legislative Office Building, Suite 4100, Hartford, CT 06106-1591 Phone: (860) 240-8500 Fax: (860) 240-8406

Staff Exhibit 2

having inpatient psychiatric services available right in Meriden is the accessibility of the unit to families whose loved ones are in crisis. Families who may not have access to a car can conveniently access the hospital using public transportation. This allows family members to focus on the needs of the patient during a very stressful time and support caseworkers as they facilitate the healing process.

We are particularly concerned because New Britain is located in a different catchment area and clients may be seeing different psychiatrists and clinicians when they return home to Meriden. Both families and service providers report that there is a strong sense of community in the way services are currently structured through the MidState unit: patients have consistent access to their individual doctors and there are many opportunities for families to remain involved as service needs change. We all know how important a strong support system is to recovery and we are concerned that the vital role families and friends play will be reduced if MidState's unit is moved out of town.

Finally, MidState is our nonprofit community hospital and its mission is to serve the needs of the community. OHCA reinforced this in its 2008 decision. Based on our conversations with families and mental health providers over the years, we have developed a deep appreciation for the role of family, friends and community in the recovery process. We believe it is imperative that our community's mental health needs are served within the community, which is why we do not support the CON application as currently written.

We appreciate your consideration of these concerns and the opportunity to make them a part of the public record. We would also respectfully request that OHCA hold a public hearing on this proposal. We would be happy to meet with you or representatives of OHCA to discuss this matter.

Sincerely,

Christopher G. Donovan
Speaker of the House

Catherine F. Abercrombie
State Representative

CC: Deputy Commissioner Lisa A. Davis, Department of Public Health
Kimberly Martone, Director of Operations, Office of Health Care Access
Lucille Janatka, President and CEO, MidState Medical Center

To: The Office of Health Care Access

As a former patient at the Midstate psychiatric unit, I am very concerned regarding the proposal to close it. At the time of my hospitalization I was first placed in the ER which has since been changed. I was given good care while there, but felt rather isolated and frightened. When I was admitted to the psychiatric unit the staff was extremely kind and caring with me, relieving all my fears and apprehension. The rooms are private and comforting, such as is with the rest of the hospital. Due to the size of this unit I believe the individual care I personally received was exactly what I needed. The therapy sessions were limited in size and easy to participate in.

In the short time I was treated at the Midstate psychiatry unit I felt extremely safe, secure and well cared for. The nurses were very professional and always available to speak with. Most patients there were similar to my situation, urgently in need of a place to be to get through a temporary but extremely rough time. The atmosphere was subdued and comforting, without commotion, yelling or screaming as I have experienced on other occasions. In a larger facility I know there would be a greater variety of extreme cases, persons with different and very severe needs, requiring much greater specialized attention. Nurse staff would undoubtedly have many patients to care for among them, resulting in a reduced level of care, very unlike the treatment Midstate now provides.

I have personally been to the Hospital of Central Connecticut in New Britain. It can not compare to the facility at Midstate. I was there with a close family member who resides in Bristol, requiring very needy urgent mental health care. The treatment he received at that time was appalling. He was placed on a stretcher in a common hallway in an area were another woman was constantly screaming and yelling for hours. M y family member was beyond terrified. He was saying anything after a while just to get himself released. He needed to be admitted as he had purposely taken extra medication, and had threatened suicide. After 6 hours passed he was finally able to speak with a nurse, and all he wished for at the time was to be released. A promise made to the nurse that he would not "do it again" was all he need to be sent on his way. Not at all comforting to the rest of his family who was very concerned for his safety at the time. As I reflect on this I am sure his experience and wait was due to lack of beds available, and perhaps an inadequate staff. If this is what lies ahead for those in need if this proposal is passed, I fear greatly for all those who require serious and proper care. I myself would never seek care at New Britain.

Most notably a large facility lacks the personal care one absolutely needs in a mental health care crisis. Group therapy sessions are less effective in a large setting. I have a close friend who attended a large psychiatric unit and witnessed many disturbing behaviors. She was terrified and it kept her from getting well. A large facility can in no way match the level Midstate currently provides.

Midstate's mental health care unit is a vital resource in this community. It is NOT inefficient as Ms Russo states in the Record Journal article. The cost of beds is mentioned. Why is there such a difference? If you reason it out, getting someone back on their feet timely and in a proper manner is most likely more cost effective in the long run. To continue to "recylce" a poor soul who has no other place to turn due to lack of PROPER care will cost much more in the long term. I urge the Office of Health Care Access to hear my plea and not close the Midstate unit. Citizens of this community deserve this valuable resource. The services provided here have, and will continue to, PROPERLY help many in the future.

Regards,

Linda Wiegert

Linda Wiegert

MidState subpar?

Editor:

We write in regard to your R-J article that was published on May 23 regarding the closure of the In-Patient Psych Unit at MidState Medical Center. We are in disagreement with Cindy Russo's statement concerning the events in 2007 and the treatment and care that the present patients are receiving. Why would the hospital continue to allow subpar care to occur? The hospital would not allow its employees to provide the care Russo refers to. First and foremost, the patients are receiving the highest quality care. The nurses are experienced and highly credentialed with many years of service. There is group therapy offered multiple times throughout each day. Patients sit in the emergency department and wait for bed placement even when there are empty beds available upstairs.

For how long is the hospital going to provide transportation to and from New Britain for patients' families? Where is the reimbursement for that type of service going to come from? Where is the guarantee that New Britain is going to retain and hold the additional ten (10) beds for the Meriden patients? How, and in what manner, is regionalization of psychiatric services better for the patients? What will post discharge care look like? Will patients be required to travel back to New Britain to receive that care? We would ask that the nurses who are being referred to in this article be interviewed. (*The writer is President, Connecticut Health Care Associates.*)

BARBARA SIMONETTA, RN, WALLINGFORD

MidState's move

Editor:

I am writing this letter to express my disappointment with MidState Medical Center in Meriden. While I understand that dollars must make sense when it involves a budget, there are times when a person's well-being must prevail. By this statement, I am referring to the move of the acute psychiatric ward currently at MidState to New Britain General Hospital.

I am an attorney that focuses a greater part of my practice to probate law. Because of this focus, I have had the distinct pleasure of representing clients at the acute unit. In the course of representing these persons, it is self-evident that this area of the state needs MidState's acute psychiatric unit to serve the local populace.

When persons are committed to the psychiatric unit, it is important that their family and friends are able to see them and support the patient's efforts towards mental recovery. By moving the patients to New Britain General, the family and friends may not be able to help these efforts due to the greater distance needed to see them. Furthermore, the personnel tending to these patients have always been courteous and professional in their behavior. The fact that I represent the patient, and not the hospital, has never left me feeling the need to cite the law in order to obtain documentation required to represent my client. These professionals are sorely needed for this part of the state as much as the psych unit is.

I implore MidState Medical Center to reevaluate any decisions to move the acute psychiatric unit to New Britain.

KEITH V. SITTNICK, BRANFORD

BARBARA PASTORE, WALLINGFORD

MidState and stigma

11-4-12

Editor:

I am very concerned about the Proposal to close the Psychiatric Treatment Unit at MidState Hospital. MidState Hospital is a community hospital. As such, there is an expectation that it cares for people within Meriden's community whenever possible, and in the patient's best interest.

People with a diagnosis of mental illness have long been victims of stigma. Is this another example of stigmatizing this population? Why is MidState Hospital proposing a plan that will require patients with mental illness to be treated outside their community? Is it possible that it is a matter of money? Is this in the patient's best interest? Leaders at MidState should look into their hearts and minds and ask themselves how they would feel if it were their own family member who was being sent to another hospital, away from their home, for treatment of this very painful illness.

GEORGE W. MELLOR, WALLINGFORD

Psychiatric unit

Editor:

I applaud Judge Brian Mahon's careful look at MidState Medical Center's proposal to close the psychiatric unit. Dr. Richard Anderson and the staff there have done an excellent job for many years caring for people in need. There are actually many beds available to expand MidState to a larger unit. Dr. Paul Horton is correct in saying that, sadly, this is really a financial decision. The bigger question is: why does the state of Connecticut not better reimburse the hospital for providing this important service? Costs to the state are actually much higher when psychiatric care is not provided. The health of folks in our area will certainly decline if this change is allowed to occur.

CLIFF DRECHSLER-MARTELL, MD, MERIDEN

3

MidState and money

Editor:

I am writing this letter as a citizen of Meriden. I think that it is a bad thing that they are going to close the psychiatric unit and make patients go to another town. It would be hard for my family to see me and give me support if I had to go somewhere else. The hospital has to think of how hard it would be for the families to go there, because some people walk or take the bus to get to the hospital. The staff at the psych unit are not inefficient. They really care about their patients and do special things for us to make us comfortable — and they teach us about our illness. I have talked to a lot of patients who are scared to write, but I am not because they have taken really good care of me every time. It does not seem like the hospital really cares about their patients and that they care about money only. Please keep the psych unit open for all of us who think that the staff there is great and who help us get better.

JENNY RODRIGUEZ, MERIDEN

Psych unit

Staff Exhibit 60

Editor:

As I write this letter, I am at MidState's psyc unit for depression. This is my 2nd time at this facility. After I arrived here, I read about it clos ing next year. I need to express how upset I am The state does not have enough facilities now for this disease. The unit is small, the nurses ar wonderful and are there for you the minute you need help. They are caring — and I notice I wil tell them how I feel, and the next thing I know a doctor will arrive in my room for a change of medicine or order a test. This disease is hard enough, and to have this unit close is disturbing It's perfect going to a small unit where the nurses know your name. I have been to larger facilities and have had to wait in line against the wall for one hour just to get my daily medications, and I think that's sad.

KIMBERLEE RUSSO, WALLINGFORD

Strange word

Editor:

Inefficient? Strange word to use for the closing of the psyche unit that has served this community so well for so many years. It was stated that patients could take advantage of group therapy at the Hospital of Central Connecticut, if transferred. In reality, daily group therapy has always been in place for its patients at MidState for many years. The staff of the psyche unit prides themselves on providing comprehensive education to both patients and family. One must ask whom this closing benefits the most — the hospital's financial outlook, or patients' care in the community?

MARYANN FAZZOLARI, SOUTHINGTON

MidState

Editor:

As a former member of the Meriden Community Provider Consortium board of directors, I am concerned about MidState Hospital's plan to discontinue services to the mentally disabled people of this community. The M.C.P.C., a forerunner of Rushford Services, was able to secure funds from the State of Connecticut to pay for the facilities at MidState. With a population of nearly 60,000, it is necessary for services to mentally ill citizens to receive local services. There is now a great need because of the broad use of illegal powerful drugs which affect the brain and the return of many veterans returning from the Middle East with psychological problems. So we need those services to remain in Meriden. The service at MidState is not one to keep a patient permanently housed, but only enough time to allow the patient to function in the community. To transfer the service to New Britain would pose a hardship not only on the patient but also to the families. Let us leave well-enough alone. No "foul play," please.

GERARD ROCCAPRIORE, MERIDEN

MidState: coordinate

Editor:

I have been practicing law in the Wallingford-Meriden area for nearly 12 years and have represented scores of individuals in probable cause and commitment hearings, the majority of which were patients at MidState. Many people have been weighing in on the plan to move the psychiatric beds out of MidState. I think that, given the unique nature of the attorney/client relationship and the conversations had and knowledge learned within that relationship, I'm compelled to add my voice to those who disapprove of this plan.

The clients I have represented over the years were benefited the most when their families and friends were part of their therapy. Transportation services notwithstanding, the level of interaction with family will decrease when the patients are moved out of the community which will likely result in longer hospital stays. Moreover, social workers and case managers will not have the intimate knowledge of the care providers in this community where the patient should ultimately return which will result in higher numbers of relapse.

It is not as simple as looking on a list of providers and sending off a referral. It is critical that the facility social worker know the staff of the service providers by name, what their specific roles are and their strengths and limitations. These patients' needs are extremely complex and their medications are powerful. I've come to believe that close, coordinated efforts reduce the number of admissions and decrease the length of hospital stays. If money is what's driving this plan, and I believe it is, MidState should focus its efforts on how to accomplish what it does now in a more cost effective manner without compromising the care of a vulnerable population.

ROBERT JAMES NACCARATO, WALLINGFORD

WHEREAS, the scope of the patient related services which will be relocated to the new physical plant from the existing East and West Campus' are identified in Attachment III, herein; and

WHEREAS, VMMC has indicated that it is intending to maintain six (6) "flex" beds to be used and staffed for either medical/surgical or psychiatric patients as the patient census needs dictate; and ↓ census bc ↑: 4 xtra rooms are call/equip. Room

WHEREAS, subsequent to the Phase I CON application filing, VMMC reduced it licensed bed capacity from 322 beds and 32 bassinets to 270 beds and 32 bassinets, as required pursuant to the Commission Order issued under Docket Number 92-521, which was the merger authorization for World War II Veterans' Memorial Hospital and Meriden-Wallingford Hospital; and

WHEREAS, as a result of current trends, the Co-Applicants are proposing to reduce VMMC's total existing licensed inpatient bed and bassinet compliment from two hundred seventy (270') beds and thirty-two (32) bassinets to ninety-two (92) beds and twelve 12 bassinets allocated as follows:

		Existing	Proposed
Adult Medical/Surgical		208	56
ICU/CCU		20	9
Step-down		(included in M/S)	12
Maternity		18	11
Psychiatry		24	4
	Sub-Total	270	92
Newborn Bassinets		32	12
	Total	302	104

;and

WHEREAS, VMMC plans to continue its current role as a community medical center by referring patients requiring tertiary-level services or specialty pediatric services to other institutions as appropriate; and

WHEREAS, through its Board of Directors, VMMC has established a Task Force on Alternative Use for the purpose of determining an alternative use of the West Campus that is acceptable to the community should the proposal under Docket Number 92-567 be authorized; and

WHEREAS, VMMC's traffic consultant, Greiner, Inc., concluded in a March, 1995 report that the Lewis Avenue corridor could satisfactorily accommodate the proposed development of the proposed new facility, provided various road and signal improvements were made to accommodate peak traffic levels during the holiday season; and

WHEREAS, the proposed capital expenditure includes an amount for off-site work, which would include improvements needed to surrounding roadways as a result of this project, such as the widening of the I-691 off-ramp to Lewis Avenue and the widening of Lewis Avenue between the I-691 off-ramp and on-ramp to the south and possible re-stripping of Kensington Avenue or signalization at the Colony street intersection; and

Staff Exhibit 8

WHEREAS, the Co-Applicants' modified proposal, as further modified herein, will allow VMMC to continue to maintain the cost-effectiveness of health care delivery in the region and this project will allow VMMC to provide these services in a more operationally efficient manner; and

WHEREAS, the Co-Applicants' modified proposal, as further modified herein, demonstrates a clear public need for the health care services that VMMC provides and intends to continue to provide in the proposed new physical plant; and

WHEREAS, the Co-Applicants' modified proposal, as further modified herein, appears to demonstrate that VMMC is technically, financially and managerially competent to provide efficient and adequate service to the public; and

WHEREAS, the Co-Applicants' modified proposal, as further modified herein, will allow VMMC to cover the proposed capital expenditure and incremental operating expenses associated with the proposed project, that are delineated in Attachment IV and Attachment VI, herein; and

WHEREAS, Attachment VI, herein, reflects projected revenues and expenses related to this project, as were filed by VMMC with the Commission, on June 22, 1995; and

WHEREAS, VMMC has a total licensed bed capacity of 270 beds, excluding newborn bassinets, however, its average daily census was only 122 for January - February, 1995; and

WHEREAS, the Co-Applicants' modified proposal, as further modified herein, is not anticipated to impact current utilization statistics as the projected decreases in inpatient utilization are anticipated to occur regardless of the implementation of this project and this project specifically addresses continuing shifts from inpatient to outpatient services; and

WHEREAS, the Co-Applicants' modified proposal, as further modified herein, will not significantly impact any teaching and research responsibilities; and

WHEREAS, the Co-Applicants' modified proposal, as further modified herein, presents no evidence concerning the proportionate number of patients of different types and physicians of different types, that differentiates VMMC from otherwise similar Hospitals; and

WHEREAS, the Co-Applicants' modified proposal, as further modified herein, demonstrates that VMMC has committed itself to making voluntary efforts in improving productivity and containing costs; and

WHEREAS, Section 4-177(c), C.G.S., provides that unless precluded by law, a contested case may be resolved by agreed settlement; and

WHEREAS, the Commission, Veterans Memorial Medical Center, Connecticut Health System, Inc., Meriden-Wallingford Community Corporation and Hartford Hospital wish to resolve their differences regarding this CON application.

NOW, THEREFORE, the Commission on Hospitals and Health Care ("Commission") and Veterans Memorial Medical Center ("VMMC"), Meriden-Wallingford Community Corporation ("MWCC") and Connecticut Health System, Inc. ("CHS"), all hereinafter referred to as the "Co-Applicants" and Hartford Hospital, a party to the proceeding, hereby stipulate and agree to the terms of settlement with respect to the Co-Applicants' modified request for a Certificate of Need ("CON"), pursuant to Section 19a-154 and 19a-155 of the Connecticut General Statutes ("C.G.S."), for the termination of VMMC's acute care hospital services at VMMC's East Campus located at 883 Paddock Avenue in Meriden, Connecticut and the termination of VMMC's acute care hospital services at VMMC's West Campus at One King Place in Meriden, Connecticut and the relocation of these services to a new acute care hospital physical plant to be constructed on Lewis Avenue in Meriden, Connecticut, at a capital expenditure of $70,000,000, which does not include net capitalized financing costs, plus $9,150,000 in net capitalized financing costs, for a total capital expenditure of $79,150,000, as follows:

1) The modified request of Veterans Memorial Medical Center ("VMMC"), Meriden-Wallingford Community Corporation ("MWCC") and Connecticut Health System, Inc. ("CHS"), all hereinafter referred to as the "Co-Applicants", for a Certificate of Need ("CON") for the termination of VMMC's acute care hospital services at VMMC's East Campus located at 883 Paddock Avenue in Meriden, Connecticut and the termination of VMMC's acute care hospital services at VMMC's West Campus at One King Place in Meriden, Connecticut and the relocation of these services to a new acute care hospital physical plant to be constructed on Lewis Avenue in Meriden, Connecticut, is hereby approved. The authorized physical plant must be used for the scope of services currently provided by VMMC under VMMC's acute care hospital license. The size and location of the Lewis Avenue site are described in more detail in Attachment I, herein.

2) The Co-Applicants' modified request for the construction of a new physical plant for VMMC's services, which contains a basement and three (3) stories and which totals 252,200 gross square feet ("GSF") of space is hereby modified and approved for the construction of a new physical plant for VMMC's services which contains a basement and no more than two (2) stories and which totals no more than 236,900 GSF. The Co-Applicants agree that a 3rd floor with square footage totaling 15,300 GSF of space will not be constructed. The authorized 236,900 GSF physical plant includes the requested medical office space for private physician offices which may be included on the two (2) stories above basement level and which totals no more than 41,400 GSF of space.

3) VMMC's total GSF, upon project completion at its Lewis Avenue site, shall not exceed the 236,900 GSF physical plant approved herein. VMMC may, however, continue to provide some existing services (as identified in Attachment II, herein) in leased or VMMC-owned space in various locations other than the Lewis Avenue site.

4) The scope of the project and the services which will be relocated to the new physical plant are identified in Attachment III, herein. No new or additional functions or services may be included and no services may be terminated, unless CON authorizations are first obtained, pursuant to Section 19a-154, C.G.S. The Co-Applicants agree that the scope of services, as outlined in Attachment III, herein, must be included in any final design drawings for the new physical plant.

Staff Exhibit 19

WHEREAS, on May 22, 1995, the presiding officer issued a ruling on Chiron's May 9, 1995 petition for reconsideration of the presiding officer's ruling on Chiron's petition for intervenor status; and

WHEREAS, on June 20, 1995, the Commission received, from Chiron, a motion for reconsideration of the presiding officer's ruling on Chiron's petition for declaratory ruling and on June 22, 1995, Chairman E. Cortright Phillips, acting as presiding officer, ruled on Chiron's motion for reconsideration; and

WHEREAS, Section 19a-153, C.G.S., sets forth the principles and guidelines to be considered by the Commission in its review of a CON application; and

WHEREAS, the Commission has reviewed the modified CON application pursuant to Sections 19a-154 and 19a-155, C.G.S., and has fully considered the principles and guidelines set forth in Section 19a-153, C.G.S., in its review; and

WHEREAS, the Co-Applicants' modified proposal, as further modified herein, will enable VMMC to meet the goals of the most recent State Health Plan that relate to health care services provided by the health care system in Connecticut; and

WHEREAS, the Co-Applicants' modified proposal, as further modified herein, is consistent with the goals and objectives that are contained in VMMC's mission statement and VMMC has indicated its intent to develop a long range plan; and

WHEREAS, the Co-Applicants' modified proposal, as further modified herein, appears to be financially feasible and appears to have no adverse impact on the Co-Applicants' financial condition and should allow for improvement of VMMC's financial condition due to the anticipated operational efficiencies inherent in the proposal; and

WHEREAS, the Co-Applicants' modified proposal, as further modified herein, is consistent with the interests of consumers of health care services and the payers for such services as this project will allow VMMC to realize significant net operating expense reductions and thus operate a significantly more cost-effective facility; and

WHEREAS, the Co-Applicants' modified proposal, as further modified herein, will allow VMMC to continue to offer the health care services it currently provides to the community, thereby maintaining the quality of health care delivery in the region; and

WHEREAS, the Co-Applicants' modified proposal, as further modified herein, will allow VMMC to maintain the current level of accessibility of health care delivery in the region it serves; and

WHEREAS, the Co-Applicants' modified proposal, as further modified herein, should not significantly impact the physical accessibility of health care to persons residing in the immediate downtown area where the West Campus is currently located as VMMC has demonstrated its intent to address transportation difficulties arising from this relocation of services and Special Act 95-4 requires VMMC to do so as a condition of purchase of the Lewis Avenue site; and

Staff Exhibit (11)

WHEREAS, a major emphasis of the modified proposal is to create a more outpatient care-oriented facility which would enable VMMC to achieve appropriate horizontal relationships between as many patient care functions as possible and which would have single bed rooms adapted to different levels of acuity and larger nursing units in a modular setting to increase VMMC's efficiency; and

WHEREAS, the Co-Applicants' modified proposal is for the construction of a new physical plant for VMMC's services, which contains a basement and three (3) stories and which totals 252,200 gross square feet ("GSF") of space ;and

WHEREAS, the proposed 252,200 GSF of space includes 41,400 GSF of space, on two (2) floors, which will be constructed as private physician office space and which will be leased to private physicians and physician groups once the building is completed; and

WHEREAS, of the proposed 252,200 GSF of space, 210,800 GSF is specific to VMMC's hospital operations and the proposed departmental allocation of this 210,800 is delineated in Attachment V, herein; and

WHEREAS, VMMC does currently provide various outpatient services at locations other than the East Campus and West Campus and VMMC intends to continue to provide various outpatient services at locations other than the proposed Lewis Avenue site (as identified in Attachment II, herein) in leased or VMMC-owned space.

WHEREAS, the new physical plant is proposed to be located on an approximately 50 acre site adjacent to Lewis Avenue and immediately north of Interstate 1-691 in Meriden Connecticut, as is hereinafter referred to as the "Lewis Avenue site"; and

WHEREAS, approximately 48 acres of the proposed 50 acre site is to be subdivided from a parcel currently owned by the State of Connecticut and previously occupied by the State Police; and

WHEREAS, VMMC currently has a right to purchase this site from the State of Connecticut for $1,000,000 via legislation by the Connecticut General Assembly passed in Special Act 95-4, as attached herein as Attachment I; and

WHEREAS, VMMC also has a right to purchase approximately 2.7 acres of land owned by Mr. John Simonetti for $250,000 which is part of the Lewis Avenue site and is related to the 60 foot wide strip of land running through the Lewis Avenue property where a railroad line had previously been located; and

WHEREAS, the Lewis Avenue site is accessible from both Interstates 91 and 691 and from downtown Meriden through local arteries and has been determined through geotechnical studies to be suitable for use for a medical facility; and

WHEREAS, VMMC is not requesting any additional health care functions or services as a result of this project or the termination of any health care function or service as a result of this project; and

Substitute House Bill No. 5708

SPECIAL ACT NO. 95-4

AN ACT CONCERNING AMENDMENTS TO SPECIAL ACTS 93-37 AND 94-16 CONCERNING THE CONVEYANCE OF A CERTAIN PARCEL OF STATE LAND IN THE CITY OF MERIDEN.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Special act 93-37, as amended by section 9 of special act 94-16, is amended to read as follows:

(a) AS USED IN THIS SECTION, "GRANTEE" MEANS VETERANS MEMORIAL MEDICAL CENTER, A SPECIALLY CHARTERED CONNECTICUT NONSTOCX CORPORATION. Notwithstanding any provision of the general statutes or any special act to the contrary, EXCEPT THE PROVISIONS OF SECTION 1 OF SPECIAL ACT 86-72, AS AMENDED BY SECTION 2 OF THIS ACT, the commissioner of public safety shall, not later than [June 30, 1995] DECEMBER 31, 1995, convey TO VETERANS MEMORIAL MEDICAL CENTER, BY QUITCLAIM DEED, subject to the approval of the secretary of the office of policy and management and the State Properties Review Board and at a cost of one million dollars, a parcel of land AND ALL IMPROVEMENTS THEREON located in the city of Meriden, which shall be used for the development and construction of a medical facility having the capability for the care and treatment of patients, including medical facilities for inpatient and outpatient care, medical offices, [clinics] and [laboratories] A LABORATORY and FOR ANY other legal uses. Said parcel of land has an area of [fifty] FORTY-EIGHT AND ONE-HALF acres, more or less, is located northerly of Interstate Route 691 (I-691) and generally between Lewis Avenue and Kensington Avenue, and westerly of the LEO J. MULCAHY COMPLEX, ALSO KNOWN AS THE State Police [Training] Facility WHICH FACILITY IS LOCATED on Colony Street in the city of Meriden and WHICH FORTY-EIGHT AND ONE-HALF ACRES OF LAND, MORE OR LESS, is more particularly bounded and described as follows:

[BEGINNING at a point at the northeasterly street line of Lewis Avenue at the intersection of land of the state of Connecticut (now known as I-691), thence bounded:

ATTACHMENT I
Staff's Exhibit 13

SUCH BURIALS OR REMAINS, UNTIL SUCH TIME AS AUTHORIZATION TO RESUME SUCH CONSTRUCTION ACTIVITY IS GIVEN BY THE CHIEF MEDICAL EXAMINER AND THE STATE ARCHAEOLOGIST, ALL IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF SECTION 10-388 OF THE GENERAL STATUTES;

(5) THE GRANTEE SHALL USE THE FACILITY DESCRIBED IN SUBSECTION (a) OF THIS SECTION IN ACCORDANCE WITH THE CERTIFICATE OF NEED FOR SUCH FACILITY WHICH IS GRANTED TO THE GRANTEE PURSUANT TO SECTIONS 19a-153, 19a-154 AND 19a-155 OF THE GENERAL STATUTES;

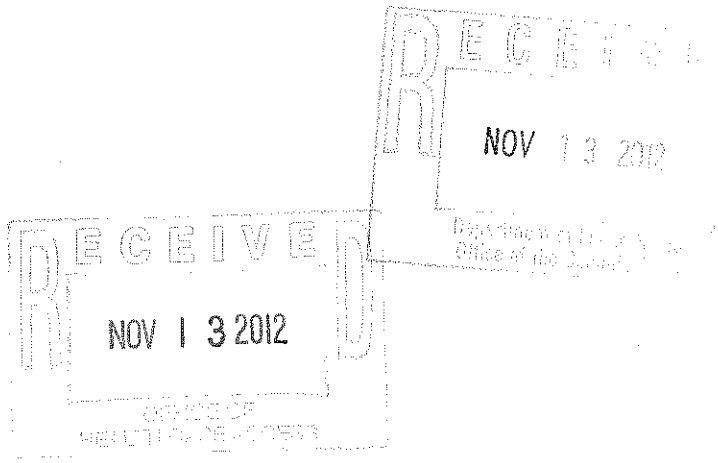
(6) FOR A PERIOD OF NOT LESS THAN TWENTY YEARS AFTER THE CONVEYANCE CONTEMPLATED UNDER THIS SECTION, THE GRANTEE SHALL CAUSE A PRIMARY CARE OR URGENT CARE PRESENCE TO BE MAINTAINED IN THE AREA COMMONLY KNOWN AS THE EAST SIDE OF THE CITY OF MERIDEN, AS APPROVED OR REQUIRED BY THE COMMISSION ON HOSPITALS AND HEALTH CARE; AND

(7) THE GRANTEE SHALL PROVIDE TRANSPORTATION SERVICE TO AND FROM THE FACILITY DESCRIBED IN SUBSECTION (a) OF THIS SECTION, FOR RESIDENTS OF THE ELDERLY HOUSING LOCATED AT 76 BUTLER STREET, 60 AND 80 HANOVER STREET AND 55 WILLOW STREET, IN THE CITY OF MERIDEN.

(f) THE STATE OF CONNECTICUT OR THE CITY OF MERIDEN, IF AGGRIEVED BY ANY NONCOMPLIANCE BY THE GRANTEE WITH ANY PROVISION OF SUCH DECLARATION OF RESTRICTIONS AND COVENANTS, OR ON BEHALF OF ANY PERSON, FIRM OR CORPORATION WHICH CLAIMS TO BE AGGRIEVED BY ANY SUCH NONCOMPLIANCE, MAY BRING AN ACTION IN THE SUPERIOR COURT FOR THE JUDICIAL DISTRICT OF NEW HAVEN. THE COURT MAY, IN ITS DISCRETION, ORDER PAYMENT OF DAMAGES TO SAID STATE OR CITY OR SUCH CLAIMANT OR INJUNCTIVE OR EQUITABLE RELIEF.

Sec. 2. Section 1 of special act 86-72 is amended to read as follows:

The commissioner of [administrative services] PUBLIC WORKS shall conduct a study of the state-owned land formerly occupied by the Connecticut State School for Boys to determine the location of the gravesites of any persons buried on such land. Upon determination of the location of such sites by said commissioner, he shall construct an appropriate monument at such location, erect a fence around such sites and take such other steps as he deems necessary to physically delineate the location of such sites. The area in which such sites are located shall be deemed to be an ancient burial place, as defined



September 5, 2012

Commissioner Jewell Mullen
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Re: Certificate of Need Application of MidState Medical Center, Docket No. 12-31775-CON

Dear Commissioner Mullen:

I am writing in reference to MidState Medical Center's recent application for a certificate of need to terminate its inpatient behavioral health services in Meriden. Under the proposal, MidState would utilize 10 beds at the Hospital of Central Connecticut (HOCC) in New Britain, which will be expanded to include 32 beds total.

I would like to recognize the efforts that MidState's President and CEO, Lucille Janatka and her professional team have made to reach out to stakeholders in the community. I recently had the opportunity to meet with Lucille and others who are working on the application and receive answers to some of my questions about the proposed changes in the delivery of behavioral health services in the Meriden community.

Despite that discussion, I am very concerned about Meriden residents' access to vital health services and potential barriers to family participation in the recovery process under the proposed changes. The proposal would move inpatient psychiatric services out of Meriden, creating significant transportation barriers to families seeking to participate in a loved one's treatment. MidState's application lays out a plan for addressing these transportation needs, but that plan lacks specificity and is relies largely on public bus transportation. Even though families from Meriden may be familiar with the bus system in the city, this plan promises to produce significant obstacles, as it will require families to make the roughly eighteen mile roundtrip to HOCC for meetings with clinicians as well as visiting hours, which are offered daily in two set one-hour time blocks.

In addition, the Regional Mental Health Board recently conducted a behavioral health needs assessment of our region. The assessment identified the accessibility of inpatient psychiatric beds as a barrier to the availability of high quality, consistent care in our community. The CON application proposes moving the small number of beds that are currently available at MidState out of the region entirely – which moves resources away from where need has been identified.

I firmly believe this proposal moves service availability in the wrong direction. Patients are best served by ensuring access to services right here in our community. Thank you for the opportunity to raise these

concerns and I would request that OHCA follow up on these issues as it works through the CON process. In addition, as a City Councilor, on behalf of my constituents, I would like to formally request that OHCA hold a public hearing on this proposal so that the public has an opportunity to submit their comments for the record.

Thank you for your attention to this matter.

Sincerely,

Hilda E Santiago

Hilda Santiago
Council Member
City of Meriden

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

AGENDA

PUBLIC HEARING

Docket Number: 12-31775-CON

MidState Medical Center, The Hospital of Central Connecticut, and Hartford HealthCare Corporation

Proposal to Terminate Inpatient Behavioral Health Services

November 7, 2012, at 3:00 p.m.

I. Convening of the Public Hearing

II. Applicants' Direct Testimony (10 minutes each)

III. Intervenors' (Full Procedural Rights) Direct Testimony (5 minutes each)

IV. Intervenors' (FPR) Cross-Examine Applicant(s)

V. Applicants' Cross-Examine FPR Intervenor(s)

VI. Remaining Intervenors' Direct Testimony (5 minutes each)

VII. Applicants' Cross-Examine Remaining Intervenor(s)

VIII. OHCA's Questions

IX. Public Comment (3 minutes per speaker)

X. Closing Remarks

XI. Public Hearing Adjourned

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Fax: (860) 418-7053

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

TABLE OF THE RECORD

APPLICANTS: **MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation**

DOCKET NUMBER: **12-31775-CON**

PUBLIC HEARING: **November 7, 2012 at 3:00 p.m.**

PLACE: **Four Points by Sheraton Meriden**
275 Research Parkway, Meriden, Connecticut

EXHIBIT	DESCRIPTION
A	Letters of support received prior to the submission of the Certificate of Need Application for MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation (Applicants), received in June and July, 2012. (2 pages)
B	Letter from MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation ("Applicants") dated July 17, 2012 enclosing the Certificate of Need for the termination of Inpatient Behavioral Health Services, received by the Office of Health Care Access ("OHCA") on July 18, 2012. (186 pages)
C	Letter of support from Senator Terry Gerratana dated July 6, 2012, received on July 10, 2012 and the Department of Public Health's response on July 24, 2012 in the matter of the CON application under Docket Number 12-31775.(2 pages)
D	OHCA's letter to the Applicants dated August 7, 2012 requesting additional information and/or clarification in the matter of the CON application under Docket Number 12-31775. (4 pages)
E	OHCA's email to the Applicants dated August 8, 2012 enclosing the word version of the completeness letter in the matter of the CON application under Docket Number 12-31775. (1 page)
F	Letter of concern from Speaker of the House Christopher Donovan and Representative Abercrombie dated August 6, 2012 and received on August 10, 2012 and the Department of Public Health's response dated August 15, 2012 in the matter of the CON application under Docket Number 12-31775. (4 pages)

G	Applicants' responses to OHCA's letter of August 7, 2012, dated September 18, 2012, in the matter of the CON application under Docket Number 12-31775, received by OHCA on September 18, 2012. (22 pages)
H	OHCA's letter to the Applicants dated October 1, 2012 deeming the application complete in the matter of the CON application under Docket Number 12-31775.(1 page)
I	Designation letter, dated October 10, 2012, designating Attorney Kevin Hansted as hearing officer in the matter of the CON application under Docket Number 12-31775. (1 page)
J	OHCA's request for legal notification in the *Record Journal* and OHCA's Notice to the Applicants of the public hearing scheduled for November 7, 2012 in the matter of the CON application under Docket Number 12-31775, dated October 12, 2012.(4 pages)
K	OHCA's letter to the Applicants dated October 23, 2012 requesting prefile testimony in the matter of the CON application under Docket Number 12-31775.(2 pages)
L	Email from Judy Hurlbert dated November 1, 2012 regarding the closure of the Mental Health Unit in the matter of the CON application under Docket Number 12-31775, received by OHCA on November 1, 2012.(1 page)
M	Petition from Paul C. Horton, M.D, dated November 1, 2012 requesting intervenor status in the matter of the CON application under Docket Number 12-31775, fax received by OHCA on November 1, 2012.(7 pages)
N	Facsimile letter from Paul C. Horton, M.D. dated November 1, 2012 correcting a misspelling in a prior fax in the matter of the CON application under Docket Number 12-31775, received by OHCA on November 1, 2012.(1 page)
O	Petition from the Connecticut Legal Rights Project dated October 31, 2012 requesting intervenor with full procedural rights in the matter of the CON application under Docket Number 12-31775, fax received by OHCA on November 1, 2012.(20 pages) Hardcopy received on November 6, 2012.
P	Email from OHCA to the Applicants dated November 2, 2012 enclosing the two requests for intervenor status in the matter of the CON application under Docket Number 12-31775, received on November 2, 2012.(1 page)
Q	Email from the Applicants dated November 2, 2012 listing the name of 3 public officials that plan to speak at the hearing in the matter fo the CON application under Docket Number 12-31775, received by OHCA on November 2, 2012.(1 page)
R	Letter from the Applicants to OHCA dated November 2, 2012 enclosing the Notice of Appearance of Shipman & Goodwin, LLP on behalf of the Applicants in the matter of the CON application under Docket Number 12-31775, received by OHCA on November 2, 2012. (2 pages)
S	Letter from the Applicants enclosing prefile testimony dated `November 2, 2012 in the matter of the CON application under Docket Number 12-31775, received by OHCA on November 2, 2012.(55 pages)

T	Petition from Susan Duclos, dated November 5, 2012 requesting intervenor status in the matter of the CON application under Docket Number 12-31775, email received by OHCA on November 5, 2012.(4 pages)
U	Letter from the Applicants to OHCA dated November 5, 2012 objecting to the Connecticut Legal Rights Project, Inc's Petiton for Intervenor Status in the matter of the CON application under Docket Number 12-31775, received by OHCA on November 5, 2012.(6 pages)
V	Letter from the Applicants to OHCA dated November 5, 2012 objecting to Paul C. Horton, M.D.'s Petiton for Intervenor Status in the matter of the CON application under Docket Number 12-31775, received by OHCA on November 5, 2012. (5 pages)
W	OHCA's Ruling on the Petition of Paul C. Horton, M.D. to be granted intervenor status with limited rights in the matter of the CON application under Docket Number 12-31775, dated November 6, 2012. (2 pages)
X	OHCA's Ruling on the Petition of Susan Duclos to be granted intervenor status with limited rights in the matter of the CON application under Docket Number 12-31775, dated November 6, 2012. (3 pages)
Y	OHCA's Ruling on the Petition of the Connecticut Legal Rights Project, Inc. to be granted intervenor status with full procedural rights in the matter of the CON application under Docket Number 12-31775, dated November 6, 2012. (2 pages)
Z	Letter from Dr. Paul C. Horton to OHCA dated November 6, 2012 responding to the Applicant's objection regarding request for intervenor status in the matter of the CON application under Docket Number 12-31775, received by OHCA on November 5, 2012 (3 pages)
AA	OHCA's email to Susan Duclos dated November 6, 2012 enclosing additional documents in the matter of the CON application under Docket Number 12-31775. (13 pages)
BB	Letter from Representative Rick Lopes dated November 1, 2012 in the matter of the CON application under Docket Number 12-31775. Received by OHCA on November 6, 2012. (1 page)

REGION II
REGIONAL MENTAL HEALTH BOARD, INC.

Good day Deputy Commissioner Davis, Attorney Hansted and staff members of the Office of Health Care Access. My name is Chantal DeArmitt and I am the Consumer Liaison for the Region II (South Central CT) Regional Mental Health Board. Both as a former Associate Administrator of a private psychiatric hospital and Assistant Manager at CT state hospitals, I have worked with, or on the behalf of, adults with psychiatric disabilities and their families for over 25 years. I have a very good understanding of consumer and family concerns regarding all aspects of hospitalization and treatment. Therefore, I respectfully ask that you give consideration to concerns I would like to bring to your attention about the proposed significant change in the provision of inpatient psychiatric services at MidState Medical Center.

- The anticipation of closing MidState's 6 psychiatric beds and transferring inpatient care to the Hospital of Central Connecticut is already having a negative impact on those who have been receiving care at MidState. These consumers and their families have nothing but praise for the caring treatment received and the long-time staff who work with them. Consumers with multiple admissions over a long period of time have established positive relationships with the professionals who work with them, and they are extremely apprehensive about getting the same quality and effectiveness of treatment with staff who do not know them. Building relationships and trust take time, and time is at a premium in today's hospital environment which favors short lengths-of stay. Transferring to distant hospitals already happens more often than anyone would like due to the number of beds being so few at MidState. There is no reason to think these transfers will not continue to occur; but at least if 10 beds were available at MidState, transportation issues would be much less of a barrier, as there would be less transfers.

- There is no guarantee that the 6 transferred beds and the 4 additional ones proposed at HOCC will, in fact, be available to residents of Meriden and Wallingford when needed. In fact, no assertion can honestly be made that there will be 10 beds reserved for these residents, because obviously, beds are generally assigned in the order in which the presenting person is accepted for admission, not just the clinical appropriateness of the admission or the severity of symptoms.

- The availability of transportation when wanted by family members or other support persons who do not have access to a car is going to be a problem, despite the assurance that means of transport will be made available. Although New Britain is not a very long distance from Meriden, it can be for residents in parts of Wallingford. Informative details about the transportation arrangements are not given in the proposal. Will desire to attend treatment sessions and have visits, and the distance from pick up points be taken into consideration for travel routes? Lack of transportation or enough income for gas to travel long distances on a regular basis for those who do have access to cars is already a serious problem for families and friends when their loved one is transferred from MidState to distant hospitals.

- I cannot stress enough the importance of the unique situation at MidState where the small unit, even if it expanded to 8 or 10 beds, allows for a more intensive experience with a great deal of one-to-one interaction with well-known, long-time staff that is provided with professionalism and compassion. This is an impossible situation to replicate at HOCC, if approved, with 32 beds. Will the staffing level on each shift be increased to accommodate an additional 10 beds?

  Finally, I am concerned about the stated assurance that discharge planning will be timely and appropriate and with our local providers, with service arrangements in place prior to discharge. Who will ultimately be responsible to guarantee that this will happen? It will be important for HOCC, MidState and Rushford to collaborate with Regional Boards II and IV to evaluate pertinent data and consumer and family satisfaction in our legislatively mandated Review & Evaluation process.

Thank you for your time and consideration.

Chantal DeArmitt, M.P.H

Chantal DeArmitt, M.P.H

Diane Frost – Peer Support Specialist/Case Manager

Dearest Committee Members:

I am living a full life, working and socializing, while living with mental illness. In 1995 I was in trouble. The critical piece bringing me back from the brink of a mental breakdown was the availability of a hospital bed. That is the key: opportunity to get well. If I couldn't have walked across the street to the psychiatric ward from my college dormitory in Washington, D.C., I could not be lucid and participate in society today.

Without that bed, my only opportunity to find the help I needed on a cold winter afternoon would have been lost. This is true for so many people fighting untreated, or improperly treated mental illnesses, such as bipolar and schizophrenia.

I finally admitted that I could no longer face my mental chaos alone after a valiant eighteen years and voluntarily admitted myself to The George Washington University psychiatric inpatient ward. The walk across the street to the hospital was the most needful thing I'd ever done for myself. The next seven days was a receipt of time and attention to my stabilization phase of illness that had been so

long denied. I am relieved to report that the hospital was my respite from world that had caused me nothing but stress and emotional pain.

Ladies and gentlemen, being a lone warrior isn't possible. Making a life for me and contributing to society with mental illness in the way only leads to failure upon an individual and a failure by society to help a valuable person. As incredible as my walk from my dormitory to the hospital was, a hospital bed the only answer to one more step to wellness.

Experiencing trauma upon trauma, the emergency room would have been the antithesis of the answer I needed that afternoon. When the ambulance sirens blare and the lights flash, passersby wonder who's in trouble now. Do I not deserve privacy and dignity?

I'm grateful that my arrival to the psychiatric bed that saved my life was not complicated and more overwhelming than my psychosis. A less direct route would most certainly have meant more strangers and more intrusive questions that I could not have dealt with on my own. I took responsibility for my well-being by handing it over to strange doctors and nurses. Today that trust placed in professionals should not be violated by walking through a maze at an at risk time.

Please spare us our crisis from becoming worse, waiting in triage, as we face our darkest day alone. The availability of beds at MidState Hospital will ensure that reaching out for help doesn't become harder than it is already. My mental health crisis was not a time during which I was capable of navigating the system from triage, to ambulance and finally hospital. Had I to jump through those hoops in such a defenseless state of mind, I may not have seen any options for myself and not be here to talk with you today. As a vulnerable person I needed ready support not deterrents to wellness.

My week in a hospital was the answer to my prayers. Believe it or not, the challenges of recovery should not be met with the obstacles of too many people places and things. Simply, if I hadn't of made it to an impatient bed, I wouldn't have made it. My fellow consumers who are trying to make life out of disorder need beds to recover in their own community.

I went to an Intensive Outpatient Program after my hospital discharge. The weeks inside that IOP were helpful. But, in the immediate crisis days of illness, proper diagnosis, stabilization and the achievement of freedom from illness' confines needs a hospital bed.

A hospital bed is the golden opportunity that individuals in the depths of mental health crises so urgently need to pick up scattered pieces of their lives and begin to function. Please allocate these hospital beds and open the pursuit of lifetime participation to ten people who may finally become well and whole at MidState.

Thank you, committee members for listening.

1. Who I am
    a. Credentials
    b. BA in psychology with major emphasis on learning behavior and economics as a minor field.
    c. Work history
        i. Psychiatric Aid at the IOL in 1968
        ii. MHA1 for the Department of Mental Health and Addiction Services for which I now draw a pension having retired in 2009
    d. Past status
        i. DMHAS retired
        ii. Employed as an employment support specialist part time
        iii. MEMBER
            1. CAC 10 who elected me as a Regional Board representative
                a. Serve on the Advocacy committee
            2. Region II 2nd vice president
                a. Serve on the executive committee
            3. 2 other boards and advisory boards.
2. Speaking to give a human presence to the facts presented here.
        i. Lived experience
            1. Hospitalization in 1977
                a. RN who leaned on the wall for r over 15 minutes not saying a word , while I sat and brooded not saying a word.
                b. I was discharged with the diagnosis of a Serious Mental Illness
        ii. 20 yeas later I was hired as a General Worker for DEMAS who was "judicially transparent" about my story as the work required of me.
        iii. Became a Mental Health Assistant 1 doing overtime on a locked inpatient ward.
        iv. 20 year gap before being hired by DMHAS included drinking excessively and habitually leading to homelessness and eventual recovery starting in 1982. There were several very responsible jobs but again a hospitalization.
3. 3 things I have learned through the above
    a. Nurses rule the ward
    b. Clinicians leave at the end of the day and the ward is essentially run by the direct care staff.
    c. The Head Nurse has a lot of decision making authority
4. Critical to in patient is:
    a. Who can you trust?
5. Relevant to HHC's desire:
    a. Non compliment with previous direct instructions

i. Hope to hear the spin on how that played out ~~over the years~~ over the last 4 years.

b. 34 million dollars was mentioned at previous meeting as being inplay.

6. Please conceder the option presented by a speaker in the snow storm meeting
   a. Comply with the board's previous instructions to expand services at Mid State and then take the money left and invest it there in the more and better service touted as the reason for change.
7. Personal take on consolidation and economies of scale.
   a. May work for selling soap or Fords, but in this crazy (kaleidoscopic) business I tell you as it was told to me
   b. **<u>The bottom line is ALWAYS, What is Best for the Sick and Suffering People who come to Us for Help.</u>**

i.

STATEMENT BY RICHARD B. SCHREIBER
IN PUBLIC HEARING BEFORE
THE CONNECTICUT OFFICE OF HEALTH CARE ACCESS
THURSDAY, DECEMBER 6, 2012
FOUR POINTS SHERIDAN,
MERIDEN, CONNECTICUT

Kimberly Martone, Kevin Hansted, members of the hearing panel, my name is Richard B. Schreiber. I reside in Branford, Connecticut. I am Treasurer of the Region II Regional Mental Health Board (RMHB II). I am commenting on Docket No. 12-31775-CON, an application by MidState Medical Center, The Hospital of Central Connecticut and Hartford Health Care to terminate behavioral health services at MidState Medical Center in Meriden and to expand behavioral health services at the Hospital of Central Connecticut in New Britain.

RMHB II is one of five regional boards in Connecticut. The commissioner of the Department of Mental Health and Addiction Services establishes the geographic boundaries of the regions to be served by each of the five boards. Region II includes Meriden. In compliance with Section 17a-479 of the Connecticut General Statutes, the aim of each mental health region is to establish a system of regionalized services for care and treatment of persons with psychiatric disabilities; also to provide other community mental health services for the maintenance of mental health and the prevention of psychiatric disabilities in addition to those services already available, and to recommend contracts to be made by the Commissioner of Mental Health and Addiction Services for services from providers of mental health services, including private agencies and other state or municipal agencies; and to provide or arrange for grants for demonstration and pilot programs, research, education and training.

RMHB II is a private non-profit agency incorporated in Connecticut. The board's duties are addressed in CGS Section 17a-484, and are carried out under contract with the Department of Mental Health and Addiction Services. Those duties include: to study the needs of the region and to develop plans for improved and increased mental health services; also to plan, and endeavor to stimulate and coordinate additional and expanded mental health services; as well as to review all applications for funds, make recommendations with respect thereto, and review and make specific recommendations concerning the annual budget of the region and state subsidies for regional mental health programs. The Region II board's duties are carried out in the 36-town section of south central Connecticut, which includes Meriden.

Region II is subdivided into 6 catchment areas. Carrying out the board's duties relies on information presented to it by catchment area councils within the region. Each town's chief executive appoints a member to the catchment area council. CGS Section 17a-483 asserts that each catchment area council is to study and evaluate the delivery of mental health services in its respective catchment area, and to make reports and recommendations to the regional mental health boards. Within Region II, Meriden is in CatchmentAreaNo.9.

I focus on the reach and mandate of the Regional Mental Health Board and of the Catchment Area Councils because there has been no finding brought to the board that

the bed accommodations at MidState are lacking or deficient in care, treatment or support for Region II's psychiatric patients. On the contrary, RMHB II has been a proponent for Midstate to reach its maximum bed requirements, as previously ordered.

In my view, applicants have made a case for the feasibility, or for the possibility, of the undertaking proposed, but they fall short in demonstrating conclusively that the affected community will be assured of continued access to affordable health care, and that safeguard procedures will be in place to avoid a conflict of interest in patient referral and, finally, that a need for such new arrangements exists.

Thank you.

NAMI Connecticut
National Alliance on Mental Illness
Find Help. Find Hope.

Testimony before the Office of Health Care Access
December 6, 2012
Re/ CON Application to terminate
inpatient psychiatric services at MidState Medical Center

Good afternoon, members of the Office of Health Care Access. My name is Daniela Giordano, and I am the Public Policy Director for Adults, State and National matters at the National Alliance on Mental Illness, Connecticut (NAMI CT). I am here today on behalf of NAMI CT to testify in regards to the Certificate of Needs application by MidState Medical Center, the Hospital of Central Connecticut (THOCC) and Hartford HealthCare Corporation to terminate inpatient psychiatric services at MidState and moving such services to the Hospital of Central Connecticut.

Thank you for the opportunity to testify before you today. We strongly support community-based access to mental health services and want to express concerns we have regarding the move of psychiatric services from MidState to THOCC. Our concerns are based on the principles of continuity of care and direct contact among hospital and community providers and among providers, clients, and families. We cannot comment on the merits of the proposal, we just want to make sure that it is done right, if it is done at all. The first concern relates to services moving not only from one catchment area to another, Catchment Area 9 to 19, but also from one region to another, Region 2 to Region 4. Pre-and Post- admission relationships with community providers and community services are crucial to the continuity of care and successful recovery of people facing complex challenges particularly when those challenges include persistent and severe mental illness and possibly co-morbid conditions. Receiving inpatient psychiatric services in one region and being discharged to another region may mean that treatment is being provided by different clinicians and staff members making adjustment and continuity more difficult.

Another concern regards the transportation of both clients and the members of clients' support systems, including family members. Patients admitted to MidState's acute behavioral health unit in the emergency department most likely will face a second transfer to the inpatient unit at THOCC, potentially increasing stress and anxiety in an already stressful emergency situation. It seems as though everyone agrees that support by family members and other loved ones is vital to people's successful stabilization, recovery, and discharge from the hospital, making transportation of this support system essential as well. Providing transportation assistance to only immediate family members who need it may not include all the people that

make an important difference in a client's recovery and thus present a gap in the best care possible.

The last major concern relates to the sufficient and increased access of beds to people being transferred from MidState. What happens if MidState transfers do not fill all of the ten beds one day but patients from other hospitals are awaiting admission and the next day a client from MidState needs inpatient care?

In conclusion, if this proposal was to be accepted, we would stress the importance of addressing the concerns laid out. Specifically, we would strongly recommend having planful, ongoing and collaborative relationships between the hospitals and community providers in both regions and catchment areas, including local mental health authorities and regional mental health boards. This should also include inpatient staff establishing direct relationships with Rushford and other community staff, such as visiting nurses as well as the establishment of regular discharge planning meetings and perhaps orientations to each others' programs. Access to transportation needed to be ensured and not only for immediate family members, but also other members of clients' support systems. Lastly, ready access to the increased number of beds needed to be assured as this is in the clients' best interest and seems to be a major point in the proposal.

Thank you for your time. I am happy to answer questions you may have.
Respectfully yours, Daniela Giordano

TESTIMONY BEFORE THE OFFICE OF HEALTH CARE ACCESS

November 7, 2012

Stephen W. Larcen, Ph.D.

Good afternoon, my name is Dr. Stephen Larcen, and I am the President & CEO of Natchaug Hospital and Windham Hospital, and lead the Behavioral Health Network for Hartford HealthCare.

I have been an advocate for improved access to behavioral health services for four decades. This application before you clearly does just that. The Keep the Promise Coalition was organized after the state closed Norwich and Fairfield Hills hospitals in the mid 90's to advocate for the promise of improved access to care in our communities and I have been active in support of this effort ever since. Our advocacy efforts resulted in funding for the CT Community Mental Health Strategy Board, and the Speaker appointed me to that Board in 2000. I worked with Lt. Governor Sullivan and some of the advocates here today on his cabinet which continued to advance community care initiates. And I currently serve as the Governor's appointee to the Behavioral Health Partnership Oversight Council. In 2010 I received a national award for my grassroots advocacy on improving access to behavioral health.

Hartford HealthCare kept that promise, and in 2000 invested over $5 million to build a new Natchaug Hospital to meet the unmet needs impacted by the closure of Norwich Hospital. Through our advocacy Natchaug was the first hospital in Connecticut to contract with DMHAS to meet the acute and intermediate care needs created by the closure of these state operated hospitals.

As CEO of a 57 bed psychiatric hospital, I know firsthand the clinical benefits when you can offer the individual treatment each client needs, have the critical mass to afford this individualized care, build the team with the expertise needed, and therefore be able to offer the specialized care our clients require. In fact, our primary referral sources are community hospital emergency rooms throughout our primary service area that also have psychiatric units, but because of their relatively small size often can't meet the individual needs of patients. These units **average 3-5 times the size of the MidState unit**. Our adult unit of 33 beds is comparable to the proposed 32 bed unit at HOCC. Access to the range of care,expertise and treatment will clearly improve for Midstate area clients with this proposed larger more specialized unit.

The MidState team does a great job within the limits of the scale of their program. In fact I have toured the behavioral health unit in the emergency department, it is state of the art, few hospitals in Connecticut

have such a well thought out and safe environment in the ED. MidState's investment in this unit was thoughtful and visionary, and a genuine effort to meet community need.

We have heard concerns about access to a program located 9 miles away. 65% of the adult patients treated at Natchaug come from emergency departments more than 9 miles away, including Manchester Hospital, Backus Hospital, Day Kimball Hospital, and in fact, our second largest referral source for adult psychiatric patients is Lawrence and Memorial 32 miles away. Some Midstate patients currently travel to facilities in Westport, New Haven and Hartford, and this expanded program 9 miles away will clearly improve access for many Midstate patients.

The Midstate unit is clearly too small to provide the range of clinical care required and too small to provide cost effective care, and this would be true whether it is 6 beds, 8 beds or 10 beds. It is the **smallest psychiatric unit in the state**. The typical psychiatric unit across the 19 community hospitals in Connecticut (excluding the five largest psychiatric programs in Hartford Hospital, St. Vincent's, Yale, St. Francis, and St. Raphael's) is **20 beds**. To require such a unit to continue to operate, when a more clinically optimal solution to meet the community need is offered, does not make sense, and is not a responsible use of limited healthcare resources.

Our Behavioral Health Network at Hartford HealthCare is committed to improve quality and client outcomes, improve access, and ensure efficiency in the delivery of care. To reach these goals we need to embrace new care delivery models, think out of the box, and leverage our limited resources to meet client and consumer needs. This is especially crucial with the lack of public reimbursement and advancing health care reform which require us to provide consumers value – that is good health outcomes and at reasonable cost.

Our network has improved access to care throughout the region, as other providers have limited or curtailed behavioral health services. When St. Francis sought to discontinue outpatient behavioral health services, our network assumed these programs. Again we kept the promise.

This investment of $4 million to construct a new 32 bed unit, state of the art, with improved clinical resources and facilities, is remarkable in the current climate. We know of no other provider investing $4 million in behavioral health in Connecticut. Again we kept the promise.

I remain convinced that this proposal is consistent with the goals and the criteria OHCA would use to ensure access, ensure financial viability of services, improve quality and avoid duplication of costs where feasible. I would urge the Department of Public Health, and OHCA to approve this application.

OHCA HEARINGS - EXHIBIT AND LATE FILE FORM

Applicant:	MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation
DN:	12-31775-CON
Hearing Date:	December 6, 2012 (continued from November 7, 2012
Time:	3:00 p.m.
Proposal:	Proposal to Terminate Inpatient Behavioral Health Services

OHCA Exhibit #	Description
1	How determine who get long Pick up times? How Paid for? TRANSPORT ATTEW Protocol
2	
3	
4	
5	

After Hours

No Sign up information was received for the Applicant.

PUBLIC HEARING
APPLICANT
SIGN UP SHEET

November 7, 2012
3:00 p.m.

Docket Number: 12-31775-CON
MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation
Proposal to Terminate Inpatient Behavioral Health Services

PRINT NAME	Phone	Fax	Representing Organization

	PRINT NAME	Representing
✓	Gary M. Grabko	2nd Vice-President Region II Mental Health Board
✓	Richard B. Schreiber	Treasurer, Region II Regional MH Board
✓ * Spoke at last mtg	Susan Duclos	self
✓	Sara Moody	self
✓	Jan Van Tassel	Keep the Promise Coalition
✓	Joan Cuttlla	Region 2 mental health
✓	Edelyn Bishop (Edelyn Bishop)	Reading letter on behalf of Mike Mamrosch.
✓ *	Bob Williams	Self
✓	Diane Frost	self
✓	Cliff Brechlin Martin	SELF + Meridy

PRINT NAME	Representing
GEORGE J. STASZEWSKI	SELF
* Hilda Santiago, Meriden City Councilor	self

* Public official

	PRINT NAME	Representing
✓	Michaela I. Fissel	Young Adults w/Behavioral health Diagnosis.
✓	Nicholas Marinelli	Central Connecticut State University
✓	Joyce Beck	Rexford
X	Daniela Giordano	NAMI-CT
✓	Dr. Hank Schwartz	Hartford Hospital - Institute of Living
✓	Ronald Gibbon	Mental health service access.
✓	Kathy Ulm	Rushford
✓	PAUL HORTON MD	self
X	Katrina S. Axelrod	Self
✓	Letha Deck	RMHB

PUBLIC HEARING

GENERAL PUBLIC

SIGN UP SHEET

December 6, 2012 (continued from November 7, 2012)
3:00 p.m.

Docket Number: 12-31775-CON
MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation
Proposal to Terminate Inpatient Behavioral Health Services

	PRINT NAME	Representing
✓	Michele R. Jaus	public
✓	Kris Brasch	public
✓	~~Nancy~~ NANCY M. SCHIAVONE	RUSHFORD CENTER MERIDEN CT (FRIENDSHIP CLUB)
✓	Chantal De Armitt	Region II Regional Mental Health Board
✓	Adrian Endorf	Midstate Inpatient Psych Unit

PUBLIC HEARING

INTERVENORS

SIGN UP SHEET

December 6, 2012 (continued from November 7, 2012)
3:00 p.m.

Docket Number: 12-31775-CON
MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation
Proposal to Terminate Inpatient Behavioral Health Services

PRINT NAME	Phone	Fax	Representing Organization
Kirk W. Lowry	(860)262-5017	(860)262-5035	CLRP - Intervenor
PAUL C. Horton MD	203-235-205	203 235-2506	Self.
Kristie M Barber	(860)262-5029	860 262-5028	Region II Regional Mental Health Board

✓ Deborah Strang

PUBLIC HEARING

APPLICANT

SIGN UP SHEET

December 6, 2012 (continued from November 7, 2012)
3:00 p.m.

Docket Number: 12-31775-CON
MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation
Proposal to Terminate Inpatient Behavioral Health Services

PRINT NAME	Phone	Fax	Representing Organization
✓ Gail McCormick			
~~Barbara Kaplan~~	2036948365		MidState
~~Maryanne Volkringer~~	~~2036948009~~		~~MidState~~
✓ DM Lombino MD	2036945772		MidState
✓ Carl Grant	2036059863		MidState

MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation

PRINT NAME	Phone	Fax	Representing Organization
JAMES N SMITH	860 621-6888		MIDSTATE

H

1

PUBLIC HEARING
GENERAL PUBLIC
SIGN UP SHEET

November 7, 2012
3:00 p.m.

Docket Number: 12-31775-CON
MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation
Proposal to Terminate Inpatient Behavioral Health Services

PRINT NAME	Representing
Bonnie Desjardins	staff ✓
Deb Labutis	staff ✓
~~Adrian Indorf~~	~~staff~~
Edelyn Bishop	staff ✓
Ronald Oblon	staff ✓ submit written

MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation

	PRINT NAME	Representing
✓	SEAN W. MOORE	GREATER MERIDEN CHAMBER OF COMM
✓	Marianne Fazzolari	retiree
might be late *	Michael Mamroush	pt.'s father
✓	J. Craig Allen MD	Rushford
✓	STEVEN HANKS, MD	HOCC/HHC
✓	Michael Balkans MD	HOCC/HHC
✓	~~Ken~~ Marc Nemeth	Self
	~~Judge~~ Brian Mahon	~~Meriden Probate Court~~
✓	Larry Giberton	Parent
✓	Jeffrey Walter	Rushford

MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation

	PRINT NAME	Representing
✓	Bruce Ellague	Self / Board Member Chairman
✓	James Geronimo	General Public / Governor's Youth Council United Way
✓	Richard Figlewski	General Public
✓	Stephen Knight	Self
✓	George McGoldrick	Self
✓	Chris Ulbrich	Self
	Dennis Lowell	Hunter's Ambulance
✓	Marcia Pinto	Self / CT Board Member League for Nursing
✓	Hal Kaplan Dr.	Self
✓	Larry McGoldrick	Self / Board Member Director HHC

MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation

	PRINT NAME	Representing
left	GERARD B ROCCAPRIORE	FORMER COMMUNITY PROVIDER CONCORTIUM
✓	Kristie Barber	Region II Regional Mental Health Board
✓	Barbara Simonetta	CHCA
✓	Melissa Pappas	aetna.
✓	Stephen LARCSW	NATCHAUG HOSPITAL
✓	Phil Wright, Jr., Judge	Wallingford Probate Court
✓	ARLINE J DUNLAP	Self

PUBLIC HEARING
ELECTED OFFICIALS
SIGN UP SHEET

November 7, 2012
3:00 p.m.

Docket Number: 12-31775-CON
MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation
Proposal to Terminate Inpatient Behavioral Health Services

PRINT NAME	Phone	Fax	Representing Organization
Judge Brian Mahon	203-238-1010	203-630-1930	Meriden Probate Court

PUBLIC HEARING
INTERVENORS
SIGN UP SHEET

November 7, 2012
3:00 p.m.

Docket Number: 12-31775-CON
MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation
Proposal to Terminate Inpatient Behavioral Health Services

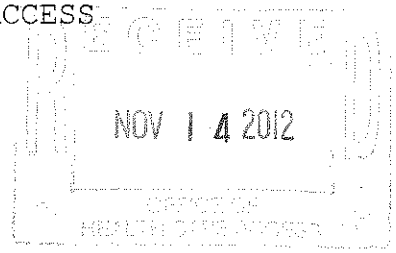
PRINT NAME	Phone	Fax	Representing Organization
Susan Duclos RN CEN	2036271743	203 626 5951	staff of In patient Psychiatry at Midstate Medical Center
Kirk W. Lowry	860 262 5071	860 262-5035	CLRP and Patient Community
Janet Van Tassel	8602625042	860 262 5035	CLRP & Patient Community

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS



MIDSTATE MEDICAL CENTER
THE HOSPITAL OF CENTRAL CONNECTICUT
AND
HARTFORD HEALTHCARE CORPORATION

PROPOSAL TO TERMINATE INPATIENT BEHAVIORAL HEALTH SERVICES

DOCKET NO. 12-31775-CON

NOVEMBER 7, 2012

3:22 P.M.

FOUR POINTS SHERATON
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MERIDEN, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

FOUR POINTS SHERATON
275 RESEARCH PARKWAY
MERIDEN, CONNECTICUT

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation, Proposal to Terminate Inpatient Behavioral Health Services, held at the Four Points Sheraton, 275 Research Parkway, Meriden, Connecticut, on November 7, 2012 at 3:22 p.m. . . .

MS. KIMBERLY MARTONE: -- signed up on the sign-up sheet, because we do go in order of the sign-up for the public hearing portion, okay? So it is located outside, and the individuals outside will bring the sign-up sheets up to us, as they are in order, when we start that portion of the hearing, okay?

And I also wanted to make sure that, due to the weather today, we really wanted to proceed with the hearing to hear all of you that were already here, but we are going to continue this hearing at a different date and

a different time, the public portion especially, so that anyone, who wasn't able to come today, we do fully hear their concerns, all right? And the Applicant will also be present at that hearing.

HEARING OFFICER KEVIN HANSTED: Good afternoon. Before we begin, I'd ask everyone to turn off their cell phones, or, if you're a doctor, please turn it on vibrate, in case you get an emergency call.

This public hearing before the Office of Health Care Access, identified by Docket No. 12-31775-CON, is being held on November 7, 2012 to consider the application of MidState Medical Center, The Hospital of Central Connecticut, and Hartford HealthCare Corporation to terminate inpatient behavioral health services.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes, the Uniform Administrative Procedures Act.

My name is Kevin Hansted, and I've been designated by Commissioner Jewel Mullen of the Department

of Public Health to serve as a Hearing Officer today in this matter.

I would like to thank everyone for coming today, especially given the weather conditions. I know how important this issue is to you and your community. It is OHCA's goal to arrive at the most appropriate conclusion by reviewing the application, by listening to the comments that people make today, and by following our statutory criteria.

Assisting me today with the public hearing are Kimberly Martone, Laurie Greci and Brian Carney. The hearing is being recorded by Post Reporting Services.

OHCA's mission is to insure that the citizens of Connecticut have access to a quality health care delivery system. I look forward to hearing from each of you today.

In order to conduct a fair public hearing, we have a few housekeeping items to go over. The way that we will proceed today is to first hear from each of the Applicants for a brief 10-minute overview of the project, followed by each Intervenor, with full rights of

participation.

The Intervenors will each have five minutes to provide testimony, and then they may Cross-Examine the Applicants. Following that, the Applicants may Cross-Examine the Intervenor.

The Cross-Examination of the Applicant only applies to Intervenors with full rights. Next, each Intervenor with limited rights of participation will have five minutes to provide testimony. Following each Intervenor, the Applicants may Cross-Examine the Intervenor. After this process has concluded, OHCA will question the Applicants and the Intervenors.

Out of deference to legislators and municipal officials, we will call them first, and then we will go to the public section of the sign-up sheets.

Each person, who wishes to speak, should write their name on the sign-up sheets, which have been provided out in the hallway. Again, please turn off all cell phones, so they don’t ring during anyone’s presentation.

Following the hearing, I will issue a

proposed final decision, in accordance with Connecticut General Statutes, Section 4-179. In making its decision, OHCA will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

The Applicants, MidState Medical Center, The Hospital of Central Connecticut, and Hartford HealthCare Corporation, have been designated as parties in this proceeding.

At this time, I would like all the individuals, who are going to testify on behalf of the Applicants and the Intervenors, to stand, raise your right hand, and be sworn in.

(Whereupon, the parties were sworn.)

HEARING OFFICER HANSTED: I would now ask the Applicants to make their presentation.

MR. KIRK LOWRY: Before that, could I lodge just a preliminary objection about the way that this occurred with the weather and all that issue? I just want to state an objection for the record, that some folks that I represent were told that the hearing was going to be

rescheduled, and many of them started to either go home, or were home, and were not able to make it here today, so, I think, once the hearing gets -- once there's notice that it's being cancelled, it has to be re-noticed adequately, so I just want to lodge the objection about lack of adequate notice for this hearing today.

HEARING OFFICER HANSTED: Thank you. You may proceed.

MS. JOAN FELDMAN: Good afternoon. As you can see from the room, many people are interested in this proceeding, and many people were able to get here today, without any difficulties, so we're very thankful that we are able to proceed with the hearing. Obviously, it's very important to all.

What you're going to hear from the folks that are testifying today is their remarks that hopefully will demonstrate for you the thoughtful effort that went into planning for this proposal, the careful coordination with community providers and members of Hartford HealthCare System, to come up with a proposal that we think actually stabilizes and enhances inpatient

behavioral health services in the Central Connecticut region, so we're very thankful for this opportunity.

You will be hearing, first, from Mr. Elliott Joseph. He's the President and CEO of Hartford HealthCare, to be followed by Lucille Janatka, who is the President and CEO of MidState Medical Center.

Mr. Clarence Silvia, who is the President and CEO of The Hospital of Central Connecticut, and our expert, Dr. Jack McIntyre, who will provide testimony with respect to the proposal. Thank you.

HEARING OFFICER HANSTED: Thank you.

MR. ELLIOTT JOSEPH: Thank you. Good afternoon. I'm Elliott Joseph, and I just have a few comments to make, in addition to my testimony that was submitted.

HEARING OFFICER HANSTED: Before you begin, we have received your pre-filed testimony. I just want to ask do you adopt that testimony?

MR. JOSEPH: I do, indeed.

HEARING OFFICER HANSTED: Thank you.

MR. JOSEPH: All right, thank you. I

appreciate you asking, because I was told to remember to say that at the end, and it's unlikely I would have actually remembered, so thank you.

HEARING OFFICER HANSTED: You're welcome.

MR. JOSEPH: Health care in our country is going through a much-needed and welcomed transformation, and some of it is painful and difficult to manage through, but it's exciting, and we're building what this country desperately needs, which are organized systems of care for people, who need health care in major ways in every community across the country.

This transformation is really trying to solve three problems in the health care industry simultaneously. First and foremost, we've built an incredibly fragmented, uncoordinated health care delivery system, particularly for those who suffer from serious problems, like mental health. This fragmented delivery system has to be built into a coordinated and integrated delivery system.

Second, we produce, as an industry across the country and here in Connecticut, remarkable variation

of the outcomes of care that we provide. There's just ample data that demonstrates that to be extraordinarily factual and unfortunate in these organized delivery systems that are being developed, like ours are aimed squarely at reducing variation and approving quality over time.

And the third thing that troubles our current health care system in America is it's too costly. It's unaffordable. No one can afford the cost that it currently requires, and we see nothing but increasing costs going forward.

So these are the three dilemmas of our delivery system in America. It's why we're all talking about health care. It's why the election was, in large part, focused around that, and it's about, then, turning our delivery system into what we call a fee for service oriented. The more you do, the more you get paid for industry, into one that delivers real value.

And, by value, we mean the inner section of high-quality and lower cost, because that's what's right. That's what's best to do for the people we serve,

for the patients, the communities, and the people who pay for this care.

And the vision of Hartford HealthCare, again, is completely aligned with this transformation. Our vision has two parts to it. One, it's to be most respected for excellence in patient care on a national level, and, secondly, to be most trusted for personalized coordinated care.

That vision statement requires us to reduce variation, and it requires us to coordinate the care of those patients, who need us, who rely upon us for their care, particularly those with chronic disease and difficult, complex clinical problems.

That's the vision, that's what we're aspiring to do, and everything we do leads us in that direction. Our model, the way we operate, we refer to as a geared model of care, and the gears are meant to illustrate to give us all a sense that keeping care local is where people want to get their care, and how we organize ourselves to insure that there's a thoughtful and deliberate access and movement of technology, sub-

specialization of care, and high-quality care in the local communities we serve is essential, and that is our geared model.

At the same time, we know that we can't do everything everywhere. There can't be a hospital every five miles from one another. There hasn't been. There shouldn't be.

Today, as you well know, pediatrics is a perfect example. Many hospitals no longer provide pediatric services, and the clinical arena goes on and on, where, because very clear reasons, the need for clinical expertise and clinical capability, the need for multi-disciplinary teams to treat children, who are sick in the example I'm using, the ability to consolidate services, so that we have more consistent outcomes of care, higher quality of care, is just a fact. The data supports the movement in this direction.

Most importantly, our application speaks to patient care, to quality. What we're proposing, and there is just no doubt about it, is better for the patients, who rely upon us, and we take that reliance as

an honor and a privilege of ours as we serve these communities.

In this particular application, it's been noted, and you'll hear from others a lot more familiar with mental health than I, the need for patients to have support groups with patients, who have similar situations, the need for these patients to have real depth and breadth of expertise that only comes from our ability to recruit and attract and retain providers with multi-disciplinary approaches to things, and deep expertise that requires scale and size to be able to attract really capable professionals to serve this vulnerable population.

Lastly, I just want to highlight a fact that I think is quite compelling, certainly for me anyway, and that is that Hartford HealthCare is, by far and away, in the State of Connecticut the largest provider of mental health services, the largest provider of mental health services in Connecticut.

We currently operate just about 25 percent of the inpatient beds in mental health across the entire state, 25 percent, and I think the most compelling part of

what we're proposing is we're actually proposing to expand that. We're actually expanding the amount of care we intend to provide.

I don't know everybody's plans, but I haven't seen anybody else expanding mental health and behavioral health to the degree that we're proposing here.

In fact, as you know, I mean the State, itself, has cut back significantly in this arena, and mostly everybody else has, as well, so we're very committed to this work.

We think it's vitally important to the communities we serve, and we think it fits very nicely and neatly into the way we think about developing organized systems of care for patients, who are most vulnerable and have the most complicated conditions and require breadth and depth of service to the be healthy.

So I thank you for the opportunity to submit my testimony and to offer these comments. Thank you.

HEARING OFFICER HANSTED: Thank you.

MS. LUCILLE JANATKA: Good afternoon,

Attorney Hansted and staff of Office of Health Care Access. My name is Lucille Janatka, and I'm the CEO and President of MidState Medical Center.

HEARING OFFICER HANSTED: Good afternoon.

MS. JANATKA: And I do adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

MS. JANATKA: Thank you. Specifically, it's my responsibility to insure that MidState will be able to continue to provide the high-quality services to the Meriden/Wallingford community now and well into the future.

I've been serving the community almost continuously since 1982, and I have a very good understanding of the issues in the health care needs. I'm also very conscious of how important our hospital is to the community, not only in the services we provide, but, also, as a major employer in our region.

To that end, we've made a commitment to insure that there's no job loss in this transition of services.

Nationally, I'm not going to go over Elliott's points, because he made them much better than I did, we have rapid change occurring. We have got to be flexible. We've got to really work together to collaborate and to insure that we can fulfill our mission.

What I would like to talk a bit about is just the treatment needs of the inpatient behavioral health patients and how much more complex it has become.

You will hear certainly more about this from our clinical experts, but it's clear to me that MidState can't deliver the same level of services, the same quality of care that HOCC larger and more specialized unit can, and they can deliver these services at a much lower cost.

Change is very difficult, and I realize that not everyone can appreciate the differences between what we have and what we could have for our behavioral health patients.

In coming to this decision and preparing our application, I met with many community members, physicians, industry leaders and state leaders. Their

concerns and suggestions were very helpful, and we incorporated them into our application. They actually helped us to make a much better application.

The decision to terminate the inpatient behavioral health services at MidState was based on the very best interests of our patients in the communities we serve.

MidState is very fortunate to be part of Hartford HealthCare, and I think, from Elliott's testimony you heard that we are working together with a fragmented system to insure that we have better coordination, higher quality and lower cost care in our state for the communities we all serve.

It requires us to be flexible. We have to be coordinated, and we have to be responsible for planning together. That's not just us in the system, but us as a state.

Finally, I want to talk a bit about trust. One of our values at MidState and Hartford HealthCare is integrity. Our values are actually integrity, caring, clinical excellence and patient safety, but I want to talk

a bit about trust, because I'm sure there are some members of our community that don't trust us and are concerned that we won't follow through on our commitments.

For example, in our application, and I'm sure that you are aware and we may have questions, we have preferential access to 10 beds at HOCC for our community. We've also talked about transportation assistance for those family members that are not able to get to their loved one and participate in care.

And I realize that, along with the responsibility of decision-making, comes accountability, and I want to be sure that MidState is accountable to the community and to the patients that we serve.

And I'd like to propose that if this application is approved, that MidState will work with the community and with our stakeholders, our patients to develop an Advisory Committee.

I'd like to insure that the actions that we intend to take, with the excellent outcomes that we believe will occur, that we are held accountable for that, and I will be happy to work with a community group to

insure that that takes place.

I respectfully request that OHCA approve this application and trust that my interest in the commitment for these patients are no less than any other patient that we serve.

Clarence Silvia, the President and CEO of Hospital of Central Connecticut, will describe the physical improvements that we've made to the Inpatient Behavioral Health Unit, should this application be approved, along with the commitment by his staff to work with Meriden outpatient community providers to coordinate the patients' return to the Meriden community, Wallingford community, or any of the communities that we serve at MidState.

Following that, Dr. John McIntyre, our expert, will provide testimony, as to why he believes this application is in the best interest of the behavioral health patients needing inpatient admission and why such decision is consistent with best practices in connection with inpatient behavioral treatment.

I want to thank you for this time that you

are taking to consider our position, and I look forward to your questions later on in the hearing.

HEARING OFFICER HANSTED: Thank you.

MR. CLARENCE SILVIA: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. SILVIA: My name is Clarence Silvia. I'm the President and CEO of Hospital of Central Connecticut, and I hereby adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

MR. SILVIA: And what I'd like to do is just summarize some of the key points in my pre-filed testimony that I think shows that the Hospital of Central Connecticut strongly supports and is committed to serving the inpatient behavioral health care needs of the MidState area patients.

First, Hospital of Central Connecticut is committed to spending four million dollars, four million dollars to renovate and expand our Inpatient Behavioral Health Unit, and we're going to add 10 beds to our existing compliment to serve the MidState inpatient needs.

Transportation, transportation is

extremely important for the community, enabling the families to be able to come and visit their loved ones and participate in the care, and we will be providing transportation assistance to any family members who need it.

Discharge, discharge to the MidState area community, we will be working collaboratively with Rushford. They will be onsite as part of the discharge process, discharging them to the various services in the MidState community, and, also, staff, as part of this application, we're going to be expanding our unit.

We're going to have additional positions that are going to be needed to be filled, and preference will be given to any MidState inpatient behavioral health staff, who are qualified to meet the positions that we're going to be posting.

And, so, with that, I just encourage you to approve this application, and I believe that we can better serve the inpatient behavioral health needs of our respective communities with the approval of this application. Thank you.

HEARING OFFICER HANSTED: Thank you.

MS. FELDMAN: Would we be able to use --

HEARING OFFICER HANSTED: Absolutely.

DR. JOHN McINTYRE: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. McINTYRE: My name is Dr. John McIntyre, and I adopt the pre-filed testimony as my own.

HEARING OFFICER HANSTED: Thank you.

DR. McINTYRE: I'm a clinical professor of psychiatry at the University of Rochester in Rochester, New York. I've had a private practice of psychiatry for over 30 years.

Before I go any further, I want to thank all those involved with today's hearing for arranging for weather that makes me feel like at home. (Laughter) This is a wonderful -- would be a wonderful day in Rochester, and I really appreciate the attention that you paid to some of the details here, making me feel more comfortable.

I'm a past President of the American Psychiatric Association, and I am the immediate past Chair of Psychiatry at Unity Health System in Rochester, New

York.

Two major areas that I have focused on in my career have been quality improvement and increasing access to quality mental health care.

I am delighted to be here today on behalf of the Applicants to share with the Office of Health Care Access and others in attendance my enthusiastic support for this application.

I have had the good fortune and opportunity over the past 20 years to visit over 60 or 70 inpatient psychiatric facilities in this country and internationally.

It is my conviction, based on this experience and knowledge of psychiatric services throughout this country and internationally, that the proposal we are discussing today will significantly improve the quality of care received by patients, who otherwise would be hospitalized for their psychiatric illnesses at MidState.

The major reason for this improvement and the quality of care is simply because of the size of the

psychiatric unit. A six-bed psychiatric unit, regardless of the expertise or dedication of staff -- and I can tell you that it's an excellent staff. I've met some of the staff and read a little bit more about their programs at MidState, and it's an excellent dedicated staff, but, despite that, they cannot offer the full range of treatment available to patients on units of 15 to 40 patients.

Now let's look at that a little bit more closely. There are three major non-financial reasons that smaller units, 10 beds or less, are not optimal.

Number one, patients with a mental illness, who require a hospitalization, have a wide range of psychiatric diagnoses. Some patients have a mood disorder. Some have dementia. Some have schizophrenia, or another psychotic illness.

Some have substance use disorder, and others may have one of several other disorders. On a six-bed unit, there is much less of a chance that several patients will have a similar diagnosis or presenting problem.

This makes certain therapies, like group therapy, less effective, especially in short-term units. For example, a young man, who has made a suicide attempt and abuses alcohol, and an elderly woman, with anxiety and mild dementia, will have a difficult time supporting each other and learning from each other, especially on a short-term unit.

Number two, small units have, of course, fewer staff, hence, there is not the opportunity to have staff with a range of special expertise. Staff may have special training in certain diagnoses, for example, mood or anxiety disorder, substance use disorders, or in certain treatments, for example, group therapy, cognitive, or behavioral therapy.

On the small unit, with a small number of staff, that expertise is, by very nature of the numbers, limited. On larger units, staff may bring to the unit a rich spectrum of special expertise and experiences that simply cannot be present on a small unit.

Number three, an important component of inpatient treatment is called milieu therapy. This is the

impact on patients. It's the total experience of the unit, as patients learn from each other and from staff how they come across to each other, and they begin to develop improved coping skills for dealing with daily challenges.

A unit of only six patients and a small number of staff cannot provide the rich, supportive and helpful milieu that a larger unit can provide.

Another factor that impacts the milieu is the physical state of the plant, itself, and you've already heard about the very significant upgrade at HOCC for the new unit, on moving it from the first floor to the third floor, and I've had the chance to visit the future site of that unit, as well as examining the plans in some detail of the unit, itself, and I can tell you that it is a first-class plan, and I think very significantly will improve the care, not only for patients, who would have been hospitalized at MidState, but, also, for patients, who would be hospitalized at HOCC, because the physical plant has very significantly improved in this new plan.

These are the three reasons that throughout the country small units are being phased out

where possible. Of course, at times, small units are the only option.

For example, in rural areas, where a large unit may be 60 or more miles away, you have to have a small unit, but, even in these places, folks recognize that a larger unit would be more optimal, in terms of the quality of care that could be delivered.

Of course, there is also the reality that small units are much more costly for a patient, but that is an issue that others have already addressed and is not the major focus of my presentation.

I have witnessed this type of consolidation in a number of locations throughout the country, including in my own department in Rochester, where we combined two inpatient psychiatric units that were seven miles apart into a single, more efficient and effective program.

The new combined inpatient service has flourished, and we have seen an enriched programming for the reasons just described. For example, in the new program in Rochester, the combined, the two hospitals that

combined their inpatient psych units, we were able now to have music therapy, dialectic behavior therapy, introduce family education involving National Alliance for Mental Illness, and many other innovations that we would not have been able to do on each unit by itself.

I also have to tell you, in terms of my experience, in terms of how some staff, as well as patients in the community, have received services at the hospital where we moved to the other hospital how they felt, and they were not happy, some of them, at the time that this occurred.

And I've had the chance to look over some of the presentation here that's coming here, in terms of feelings of both some professionals and patients and advocates. Very understandable.

In fact, I would have been disappointed in my program if folks didn't have that reaction, because you want to think that what you're doing and the care you're delivering is good, and people like it, and, of course, if you say, well, we're going to stop doing this, there's a natural reaction that that's not good.

However, I can tell you that over the course of, as soon as within six months to a year, almost every staff member, who was involved at the other hospital that was phased out and moved those beds to the other hospital, felt it was a positive thing to do, because they could see the improvements.

And I can say, also, that patients and families, by and large, were also fully supportive of it after the fact.

Certainly, family members having to travel up to an additional nine miles to visit patients is an issue that must be considered. Family involvement and treatment is very important and has to be encouraged and supported.

A plan for assistance with transportation for families who need it, as you have heard, has been developed, and I think, from my perspective as an outsider, it’s a very generous plan. For families that need it, providing taxi vouchers to get to the facility at HOCC I think is a marvelous idea.

I wish we had thought about that in

Rochester, when we were combining the two units, because it goes at the time of whatever the patients' families need to travel, etcetera.

I'm convinced that the vast majority of family members considering a tradeoff between the units being closer or being of high quality would choose the higher quality unit.

HEARING OFFICER HANSTED: Excuse me, Doctor. You have one more minute.

DR. McINTYRE: Okay.

HEARING OFFICER HANSTED: Thank you.

DR. McINTYRE: I was also going to say that, you know, now, 50 percent of the patients from the MidState from the emergency room go to other inpatient units, other than MidState, and some of these patients go a distance far greater than the nine miles. They go to other hospitals that are even more than the nine miles.

A couple of other things I will skip over. Let me just say, in closing, I want to comment that throughout this process I have been very impressed with the thoughtfulness and thoroughness of the staff in the

development of this application.

It's been clear to me that the primary goal of this is to prove the quality of care delivered to patients, who need inpatient psychiatric treatment.

I believe that this proposal clearly meets that goal, that the quality of care delivered to the psychiatric inpatients will be improved, and I urge you to approve this application. I'd be happy to answer any questions at the appropriate time. Thank you very much.

HEARING OFFICER HANSTED: Thank you, Doctor. Just a reminder, for those folks that just entered the room, there's a sign-up sheet outside. If you wish to present your opinion at today's hearing, please sign up, so we know to call you up at the end of the hearing. Thank you.

At this time, I'd ask Connecticut Legal Rights, which is the Intervenor with full rights, to present their opening statement.

MR. LOWRY: Thank you, Hearing Officer Hansted, other members from the Office of Health Care Access. My name is Kirk Lowry. I'm the Legal Director

for the Connecticut Legal Rights Project.

The Connecticut Legal Rights Project was incorporated in 1990 for the specific purpose of representing low income adults with severe and persistent mental illness on matters related to their treatment, recovery and civil rights.

The application filed by MidState Medical Center falls squarely within this mission of ours, however, I want to assure this body that CLRP has not pursued this matter unilaterally.

As attorneys, it is our ethical duty to represent the preferences of our clients, and I want to make it clear that CLRP did not become involved in this proceeding until persons directly affected by MidState's application to close the inpatient beds expressed their strong opposition to this proposal.

Their objections were thoughtful, well-reasoned, and, frankly, very persuasive. I will not speak for them, because they can speak far more eloquently for themselves, however, I do want to emphasize that the community relies upon the Office of Health Care Access to

assure that health care providers are responsive to the needs of the community and are held accountable.

MidState has not met its obligation to address the needs of the community or build a consensus with them. This is most prominently reflected in the hospital's failure to comply with OHCA's decision issued in 2008, which required them to operate at least eight inpatient psychiatric beds.

Despite the extensive paperwork submitted, this application raises as many questions as it answers. There are numerous questions about the assumptions made in the hospital's application, as well as the extent of their efforts to create and enhance innovative community-based services to prevent hospitalizations and strengthen the system of care in the region where it is located.

There are even questions regarding the need to spend millions of dollars renovating The Hospital of Central Connecticut when there may be sufficient space at MidState to meet the demand in that region.

Decisions of this import, which have a direct and irrevocable impact on the community,

particularly persons with behavioral health needs, demand a balancing of interest involved.

They are rarely black and white, and it's recognized that the health care delivery system continues to evolve, whether we like it or not.

However, in this case, the Applicant simply has not met the burden of demonstrating that the rationale for its proposal overrides the legitimate questions and concerns raised by the community.

The members that we have spoken to have clearly indicated that they want to continue to have inpatient psychiatric access at MidState, that both the travel and the lack of the access in their own community, both to themselves, their treatment, is going to be something that they just don't agree with and asked the Office of Health Care Access to, number one, make sure that MidState complies with the 2008 and provides at least eight beds at MidState, and, second, if there's going to be any expansion, that the expansion be at MidState.

What the patients tell us is that they like MidState, because it's small. Many of our clients

have been on large units, and they don't like them.

The large units are places that can foment disagreement, fights, the fights and arguments can lead to being restrained. That leads to involuntary medication and on and on to the different problems.

The smaller the unit, the smaller the patient/doctor ratio and the staff/doctor ratio, that's what they like, and they like having rooms to themselves, instead of doubling up or more.

So that's what they tell us, that's what we're here to express, and we look forward to, also, asking questions. Thank you.

HEARING OFFICER HANSTED: Thank you. Counsel, do you have any Cross-Examination for the Applicants today?

MR. LOWRY: Yes.

HEARING OFFICER HANSTED: You do. Okay. You may proceed with that at this point.

MR. LOWRY: Okay. Do you want me to ask questions of the panel and let them decide, or do you want me to pick a person and go that way? What's your

preference?

HEARING OFFICER HANSTED: I'll leave it up to you or your preference, Attorney Feldman.

MS. FELDMAN: Probably the former.

HEARING OFFICER HANSTED: The panel?

MS. FELDMAN: In terms of getting the best person to answer the question.

HEARING OFFICER HANSTED: That's fine.

MR. LOWRY: Okay. My first question is I would like to turn your attention to Exhibit G, page two of three, which is Exhibit 1 to your supplemental responses.

First, I'd like to just point out who the patients at MidState are demographically. On page two of three, it shows that eight percent of the patients are African-American and black, one percent Asian, and 23 percent Hispanic or Latino.

Was there any consideration by MidState or The Hospital of Central Connecticut to the impact on the racial, those racial-identified patients?

MS. FELDMAN: Can you clarify the

question?

MR. LOWRY: When you were making the decision to terminate inpatient psychiatric care, was there any consideration to the racial makeup, the sex makeup, or the income makeup, because, based on your submission on page 203, it looks like there's a disproportionately high amount of minorities, disproportionally high amount of females, and disproportionally high amount of low-income people.

Seventy-six percent are covered by Medicaid, Medicare, or uninsured.

MS. JANATKA: I will take that. Lucille Janatka. There was no attention or consideration. This is the population we serve. This is the population in our hospital, in our community, and we are very comfortable that Hospital of Central Connecticut also respects this population and will serve the population, as well.

MR. LOWRY: Did you consider the impact, the financial impact that it would have on 76 percent low-income population for terminating their community inpatient services?

MS. FELDMAN: Can you rephrase the question, because I'm not clear what you're asking.

MR. LOWRY: Whether the low-income aspect of their clients was considered before proposing to terminate the inpatient services in the community at MidState.

MS. JANATKA: No. No. We, again, serve all patients in all ways.

MR. LOWRY: On page 204 of that same Exhibit G, you identified the different diagnoses of the 282 people, who were discharged. Forty-four of those had schizoaffective of an unspecified type, three were schizoaffective chronic, 65, or 23 percent, were recurrent major depression severe.

My question is, in terminating the services in MidState in Meriden, did you consider the fact that this population, who are usually going from the emergency room up to inpatient care, correct?

MS. JANATKA: Yes. Some do do that.

MR. LOWRY: So my concern is and the concern that's been expressed to me is these are patients,

who are in a crisis at this time, and, usually, they will be going from the emergency room, and, to be in the emergency room, it has to be a very significant crisis.

I mean they've come either voluntarily, or they may come to the emergency room, because the police bring them there on a Physician's Emergency Certificate, or a Police Certificate, because they've been picked up, because the police feel they're a danger to self, or others, or greatly disabled, correct?

MS. FELDMAN: What is your question?

MR. LOWRY: My question is I'm trying to determine whether there was any consideration, as to before you decided to terminate these services in Meriden, about the very significant symptoms and suffering that people are in when they come to the emergency room, and then you're asking them to, oh, you can't stay here. You have to go to another hospital.

MS. JANATKA: All right, let me try to answer that the best I can. We are very skilled in our emergency department with an Acute Behavioral Health Unit that we were fortunate to be able to build in our last

construction project to, in fact, care for patients, who are acutely distressed.

All of our discussions were to improve care, to stabilize, to secure patients appropriately, to improve their care, as we, in fact, move them wherever they might go. We certainly do discharge patients to different venues.

MR. LOWRY: So let's just talk about those different venues, or those different options. Before someone goes to the emergency room, the different levels of care could include, number one, maybe going down from level of care down in acuity.

The next level of care would be partial hospitalization, correct?

MS. FELDMAN: That's a clinical question, and I'm not really sure what the point is, or what the question is, in fact, but if he would like a clinical person, like Dr. McIntyre, to respond to whether or not, if his question is people, who are in acute stage, presumably, everybody being admitted on an inpatient basis is in an acute stage, whether or not that's going to have

any bearing on their being admitted to HOCC versus MidState, we're happy to have Dr. McIntyre respond on a clinical level.

HEARING OFFICER HANSTED: Counsel, are you looking for a clinical answer, or are you looking for --

MR. LOWRY: I'm just looking for a structural -- a point, about what the different levels of care are underneath the emergency room.

Before someone decides that they need to go to the emergency room, where do they come from, from what different levels of care? I thought it would be helpful to understand the different levels of care under the emergency room, so where are these folks coming from, because it's important, as to discharge.

Do they go to inpatient, or do they go to Rushford, and then some other level of care? I think having an understanding of that, instead of just this isolated decision between the emergency room, and then inpatient care upstairs at MidState, is important.

HEARING OFFICER HANSTED: Understood.

MS. FELDMAN: I think Dr. Balkunas from

The Hospital of Central Connecticut can elucidate on how it works in the community, and how referrals are made to an inpatient facility, if that's, in fact, the question that is being presented. I'm not sure, still, what the question is.

COURT REPORTER: One moment, please.

HEARING OFFICER HANSTED: Is that acceptable to you? Do you think that will get you the answer you want?

MR. LOWRY: It might.

HEARING OFFICER HANSTED: Well let's try.

MR. LOWRY: Okay.

MS. FELDMAN: Do you want to come up to the podium, please, and just state your name and your position?

HEARING OFFICER HANSTED: Doctor, have you been sworn in already?

MS. FELDMAN: Yes.

HEARING OFFICER HANSTED: He has. Thank you.

DR. MICHAEL BALKUNAS: I'm Dr. Mike

Balkunas. I'm the Chief of Psychiatry and Behavioral Health at The Hospital of Central Connecticut.

The vast majority of patients that come to emergency rooms and are admitted to psychiatric units come, basically, from the street areas in and around the hospital.

Some patients will come from other levels of care, but the majority do come from usually places, where they're not being treated.

MR. LOWRY: So could you describe what the different levels of -- let me just ask the question. Maybe it will be easier to do it kind of yes and no.

Is partial hospitalization a level that's just under inpatient care?

DR. BALKUNAS: That's correct.

MR. LOWRY: And describe what partial hospitalization is.

DR. BALKUNAS: Partial hospitalization is a program several days a week, several hours a day, where patients will go in lieu of being on an inpatient unit.

MR. LOWRY: And who has partial in this

area?

DR. BALKUNAS: I believe Rushford has a partial hospitalization program.

MR. LOWRY: And what's the capacity of the partial at Rushford?

DR. BALKUNAS: I'm not sure. Capacity?

HEARING OFFICER HANSTED: Well let's not have someone testify. Why don't we reserve that question.

MR. LOWRY: I'll just state for the record that page 199 of Exhibit G there's a discussion of Rushford and their community capacity. Actually, it starts at page 195.

MS. FELDMAN: Again, I'd like to know what the question is.

MR. LOWRY: And partial at Rushford is a capacity of 30.

HEARING OFFICER HANSTED: Counsel, do you have a question?

MR. LOWRY: Yes.

HEARING OFFICER HANSTED: I don't want you to testify, as to what their documents say. The documents

can speak for themselves. If you have a question, just ask a direct question, so we can get a direct answer.

MR. LOWRY: So the next level after partial is crisis stabilization?

DR. BALKUNAS: Well intensive outpatient would be the next level down.

MR. LOWRY: And that's done by Rushford, correct?

DR. BALKUNAS: That's correct.

MR. LOWRY: And do you know what the capacity of that is at Rushford?

DR. BALKUNAS: No, I don't.

MR. LOWRY: And if the record states on page 195 that the respite program has 10 beds, you don't dispute that?

DR. BALKUNAS: No, but respite is a little bit different than partial hospitalization, which is different than inpatient. In terms of levels of care, inpatient, partial hospitalization, intensive outpatient. I see what you're saying, in terms of crisis. A respite bed, instead of inpatient, that could be considered a

level of care between inpatient and partial in some cases.

MR. LOWRY: All right and, then, after crisis stabilization and respite, what's the next level of care?

DR. BALKUNAS: Intensive outpatient.

MR. LOWRY: And people have intensive outpatient at Rushford, correct?

DR. BALKUNAS: Right.

MR. LOWRY: And do you know what the capacity of that is at Rushford?

DR. BALKUNAS: I don't.

MR. LOWRY: Is there a difference between intensive outpatient and outpatient?

DR. BALKUNAS: Yes. Intensive outpatient is more like a partial hospitalization program. It's generally four days a week and/or a few hours per day.

MR. LOWRY: And you said that many people come into the emergency room off the street, correct?

DR. BALKUNAS: That's correct.

MR. LOWRY: And, then, they go into the emergency room, correct?

DR. BALKUNAS: Correct.

MR. LOWRY: And how long is the average length of stay in the emergency room?

DR. BALKUNAS: It really varies, depending on how busy a particular emergency room is.

MR. LOWRY: And does it also depend on whether there's a bed in inpatient or in crisis stabilization?

DR. BALKUNAS: It can, yes.

MR. LOWRY: And, so, the more capacity there is in those other levels of care the less time a person would have to stay in the emergency room, correct?

DR. BALKUNAS: Perhaps. Part of the problem is the large majority of people coming to the emergency room, who were referred to the crisis unit in the emergency room, meaning the person who will work in the emergency room, these are people, who usually require inpatient care.

MR. LOWRY: And how does a person -- how does a physician decide whether to admit someone to the inpatient at HOCC or MidState versus to send them to a

non-hospital level of care, like partial, or intensive outpatient, or crisis stabilization, or respite?

DR. BALKUNAS: It depends on their acuity level. The common criteria we use are they suicidal with a plan, homicidal with a plan, psychotic, manic, delirious, demented, or otherwise unable to take care of themselves, and the statute for Connecticut basically says, if the patient is in imminent danger to self or others or gravely disabled, then that person would be admitted to an inpatient unit, either in your own unit, or, if you don't have a bed, unit in the area.

MR. LOWRY: And, so, those people, who are suicidal or danger to themselves or others, so suicidal, homicidal, or gravely disabled?

DR. BALKUNAS: Correct.

MR. LOWRY: So those people are the ones, who now we're going to be asking to go from MidState to a different hospital, that level of acuity?

DR. BALKUNAS: Yeah, at times, that's correct, but I guess what I will also offer is, currently, there are many people annually, who go from MidState ED to

other hospitals, because MidState does not have the capacity to admit them, so it's not unusual.

It's not unusual, actually, in any hospital system to send people from your own ED to surrounding hospitals, because you only have so much capacity.

MR. LOWRY: And how do those people get transferred, by ambulance?

DR. BALKUNAS: By ambulance, correct. As a matter of routine, they're often medicated before they even get into the ambulance, because we appreciate the clinical fact that they're uncomfortable, they may be psychotic, manic, suicidal, etcetera.

MR. LOWRY: How are they medicated? With what?

DR. BALKUNAS: Well, normally, we'll use drugs that are tranquilizer-type drugs, like Lorazepam. Sometimes the patients are psychotic. We can use anti-psychotic medications. It really depends on the clinical diagnosis of the patient.

MR. LOWRY: Do the patients have to be

restrained sometimes?

DR. BALKUNAS: Sometimes. That's not the norm, though, I should say.

MR. LOWRY: And what is, in your experience, the patients' experience that they've expressed to you about those trips?

DR. BALKUNAS: Well, to be completely frank, the patients, who are really ill, often don't even remember the trip, because they're so sick. The one thing that we do hear at the end of their stay is they're grateful for the care they received.

MR. LOWRY: People also get admitted both voluntarily and involuntarily to the emergency room, correct?

DR. BALKUNAS: That's correct. From the emergency room to the inpatient services, correct.

MR. LOWRY: And straight into the emergency room, too?

DR. BALKUNAS: Yes. Sometimes the police will pick them up, yes, that's correct.

MR. LOWRY: And the ways that someone can

come into the emergency room is by the police, or by family members, or voluntarily, correct?

DR. BALKUNAS: That is correct.

MR. LOWRY: And if they come in by the police, that's involuntary, and they are committed, based on a physician's emergency certificate?

DR. BALKUNAS: No. They're brought in by the police involuntarily, and, then, we assess them to see if we need to admit them somewhere involuntarily. It depends on their clinical status.

MR. LOWRY: Right. Have you ever had to -- you're at Hospital of Central Connecticut, correct?

DR. BALKUNAS: Correct.

MR. LOWRY: Okay. Let me ask a different question for someone else. I think I'm done. Thank you very much.

DR. BALKUNAS: You're welcome.

HEARING OFFICER HANSTED: Before you continue, counsel, Applicant, do you have any Redirect of this witness?

MS. FELDMAN: Lucille Janatka would like

to add to the response of Dr. Balkunas, in terms of explaining what happens in the MidState Emergency Room and the services that are provided there to stabilize patients, if that's okay.

HEARING OFFICER HANSTED: I'll allow that. I think that will be helpful.

MS. JANATKA: Thank you. I want to be sure that it's understood that MidState has an Acute Behavioral Health Unit that actually exists in our emergency department.

This unit is fully staffed, with psychiatric trained nurses and assistants and has the benefit of receiving care from our physicians to insure that they are being cared for and treated during the time they are being assessed for where they might need to go next.

I didn't want to leave that without being said. Thank you.

HEARING OFFICER HANSTED: Thank you.

MR. LOWRY: Okay. There's been discussion that one of the major factors for the termination of

services at MidState is the size and the cost.

What is the cost at MidState's inpatient unit, and what is the cost at The Hospital of Central Connecticut, and how is that done?

MS. FELDMAN: I think that's already in the testimony, in response to the completeness questions, but, if you would like some testimony regarding the size of the unit and cost effectiveness, Dr. Larcen from Natchaug Hospital, which is a member of the system, can provide some additional information, if that would be helpful.

HEARING OFFICER HANSTED: Why don't you provide that?

MS. FELDMAN: Okay, very good.

HEARING OFFICER HANSTED: Just so we can get it today.

MS. FELDMAN: Dr. Larcen, why don't you introduce yourself?

DR. STEVE LARCEN: Dr. Steve Larcen, President and CEO of Natchaug Hospital and Windham Hospital, and I'm not sworn in.

(Whereupon, Dr. Steve Larcen was sworn.)

DR. LARCEN: Your question is what is the relative cost of the care at each hospital? Is that your question?

MR. LOWRY: Let me just ask you a few questions about Natchaug first, since you're here.

DR. LARCEN: Go for it.

MR. LOWRY: So what is the capacity of inpatient psychiatric care at Natchaug?

DR. LARCEN: Natchaug has 57 beds. Thirty-three beds are an adult unit, which is similar to the proposed 32-bed unit that's being proposed here, and 24 beds are available for children and adolescents.

MR. LOWRY: And do you receive -- do you currently receive any patients from MidState?

DR. LARCEN: Yes.

MR. LOWRY: How many a year, approximately?

DR. LARCEN: I'd say about a dozen.

MR. LOWRY: Adults, children, or both?

DR. LARCEN: Probably mostly children, but

we probably have admitted adults, as well.

MR. LOWRY: Okay. My question is what is the cost of inpatient psychiatric care at MidState, and, first, tell me how you know what that is.

DR. LARCEN: Well I know from the application, and I know from our work earlier, we did a lot of studying the behavior health network and looking at the cost of the operation of every one of our behavioral health programs, and the cost of inpatient care at MidState was substantially higher than The Hospital of Central Connecticut, Natchaug Hospital, Hartford Hospital. It was the highest per-day cost within our system.

MR. LOWRY: What was that number?

DR. LARCEN: I don't recall exactly. I know that the documents we've provided here I believe it's $1,400 in direct costs.

MS. FELDMAN: It's in the application.

DR. LARCEN: I can open the application and read it back. You have it in front of you.

MS. FELDMAN: I can tell you, but you don't want to rely on my statement, but the information

was provided in the application.

HEARING OFFICER HANSTED: Page 25, counsel.

MS. FELDMAN: Attorney Hansted, the reason why I asked Dr. Larcen to step up to the podium was that I thought that it would be helpful for him to talk about his experience, in terms of managing costs and the relationship that the size of the unit has to the ability to manage those costs.

HEARING OFFICER HANSTED: I appreciate that, but I really want direct questions from counsel.

MS. FELDMAN: Okay.

HEARING OFFICER HANSTED: I want to move this along. We have a lot of the public here, and I want to give them ample opportunity to speak tonight.

MS. FELDMAN: Sure.

MR. LOWRY: So, on page 25, it says the cost of MidState is $1,421 per day, per bed.

DR. LARCEN: That’s correct.

MR. LOWRY: What makes up that cost?

DR. LARCEN: Principally, wages of the

staff to provide the care. There are some variable costs, such as supplies. It's not a fully-loaded cost. It doesn't include all the overhead. It basically is reflective of the operating cost of that program.

MR. LOWRY: So it comes down to a low doctor/patient and staff/patient ratio?

DR. LARCEN: Correct. And I might add requirements by CMS is to minimum types of professionals that a hospital unit requires. That's why Dr. McIntyre earlier mentioned that smaller units are so costly, because you have to meet the same requirements in a six-bed unit that you would in a 32-bed unit with respect to the leadership that CMS requires every psychiatric hospital program to have.

So, absolutely, if you have to have a medical director, nursing director, certain professional staff in a six-bed program and you have to have the same staff in a 32-bed program, it stands to reason that your efficiency is going to be much greater.

It doesn't necessarily speak to how many nurses per patient or how many doctors per patient, but it

does speak very directly to the clinical leadership that's required by CMS and the inefficiency of a small unit.

MR. LOWRY: Tell me why my common sense is wrong, when it tells me that a lower patient/doctor relationship is less effective in the inpatient psychiatric setting.

DR. LARCEN: Your intuition is wrong, because, as Dr. McIntyre testified, the variety of patient need is such and the importance of both the milieu and the group treatment that you cannot effectuate that when you only have five patients with very different needs.

So, you know, it would stand -- you're thinking, okay, smaller is better. Smaller is not better in this instance.

MR. LOWRY: Why not?

DR. LARCEN: Because, as Dr. McIntyre testified and my own experience, the range of patient need -- I'll give you a good example.

Sixty-five percent of Natchaug Hospital's patients come from distances greater than nine miles. They come from hospitals that already have psychiatric

units, well-run psychiatric units, units that are 18 and 20 beds, mind you, and smaller units, units with 12 and 15 patients, can't have the depth of staff, Dr. McIntyre testified to that, they can't have the range of modalities, and there are patients that they cannot effectually treat in these smaller units, and that's why they referred them to Natchaug Hospital.

So you find all over the state hospitals that are the smaller units have limitations on what they can provide to the patients.

MR. LOWRY: And isn't the main goal of psychiatric inpatient care to stabilize the patient, hopefully get them to accept medications, and get them discharged back home, or back to their level of care?

DR. LARCEN: Good question. The crisis stabilization part of what you're describing, that's correct, but, for many patients, they need more than that.

You have to engage them in the rehabilitation process. Dr. McIntyre, again, gave good testimony about the social skills and the rehabilitation aspect that's needed, as well.

And, so, if all you're doing is crisis stabilization of a very finite number of patients, that's one level of care, but most hospitals are doing more than that to insure that there's less likely a chance for readmission and that the reintegration back to the community is more effective.

So, yes, if all you're going to do is crisis stabilization, a smaller unit in theory can work. It's still very inefficient, and it's still not going to afford most patients what they need, and, for that very reason, hospitals all throughout eastern Connecticut that have psych units refer to our 32-bed unit, because we can do things for those patients that they cannot.

MR. LOWRY: And there's been discussion about DBT therapy, and my concern about that testimony is that my understanding is that that's a long-term therapy, and that the average length of stay in the emergency room here is six to eight days.

Is there any evidence-based documented studies about the effectiveness of DBT over six to eight days?

DR. LARCEN: I don't know the research, but you are correct. The DBT is a long-term treatment modality. There's no question about that. Initiating that in inpatient, getting the patient engaged around the importance of that treatment is a very important part of the inpatient care, so you're correct.

I don't know that there's any research, if Dr. McIntyre would be a better witness on that, but, without question, starting that treatment on inpatient, so it can be sustained in the community, is very important.

MR. LOWRY: And couldn't that just be started at MidState on a six-patient unit?

DR. LARCEN: I think that we already entered into evidence that the range of services that can be offered in what is the smallest unit in the State of Connecticut cannot meet the same range of expertise and services that a larger unit can give.

MR. LOWRY: Nothing further.

HEARING OFFICER HANSTED: Anything further? Nothing? Any Redirect?

MS. FELDMAN: I have nothing.

HEARING OFFICER HANSTED: Thank you.

MR. LOWRY: Okay. There's been concern about the testimony about the 10 beds and the preferential admission, so I'd like to have somebody answer that question.

MS. FELDMAN: What is the question?

MR. LOWRY: The question is will those beds be held open for patients from MidState, or will they be filled by someone, who is not from MidState, under any circumstances?

MS. FELDMAN: Okay. I'd like to ask Dr. Balkunas to respond to that question, please.

HEARING OFFICER HANSTED: Certainly.

MS. FELDMAN: If you can come up here? Thank you.

DR. BALKUNAS: We are firmly committed to allotting 10 beds to the patients from MidState.

MR. LOWRY: Okay, that doesn't answer my question. My question is will those beds be held open for patients from MidState, so that if there's only one patient from MidState, who has got one of those 10 beds,

will nine beds be held open, until another MidState patient comes to take bed number two, or will other patients from Stamford, Hartford, New Haven start backfilling those in?

DR. BALKUNAS: Well we've discussed this, actually, in detail, fully realizing that we need to be fair and honest, in terms of our plan.

The procedure will be as follows. If 10 beds are open and MidState has only one patient, we would admit that patient and subsequently contact MidState's emergency room to make sure that they don't have anybody that they think might need an inpatient psychiatric bed.

In the event that there's other patients, who have clinical need and need a bed, we would, of course, fill the bed.

MR. LOWRY: So there might be circumstances, then, once those beds are filled with other non-MidState patients, where another MidState patient could come, and there might not be one of those 10 beds immediately available.

DR. BALKUNAS: Just to further elaborate,

it may be that the bed is not immediately available, but the next day, on a 32-bed unit, you usually have four or five discharges per day, the next day the first patient discharged the MidState patient would get that bed.

MR. LOWRY: And how are those 10 beds going to be allocated on the unit? Are they segregated physically, or is it just a number out of the entire 32?

DR. BALKUNAS: It would be a number out of 32, because our intentions are to be able to possibly segregate populations, based on acuity, the idea being that perhaps one side of the unit would be people, who are very ill, and the other side of the unit would be people, who maybe improved somewhat and still need inpatient services.

MR. LOWRY: And are there two patients per room at Hospital of Central Connecticut?

DR. BALKUNAS: In some rooms. We have some single rooms, as well.

MR. LOWRY: But, at MidState, it’s only patient per room, correct?

DR. BALKUNAS: I believe that’s correct.

MR. LOWRY: And don't patients generally like that better?

DR. BALKUNAS: Well, you know, that's an interesting question. Sometimes the patients like it better, but sometimes they don't, because a depressed patient, who doesn't have a family, has no support, actually will, at times, make friends with some of the other patients on the unit and like the comfort of having someone else in their room.

A patient, who is possibly paranoid, may not want to have anyone in their room, so it really depends on the patient and their diagnosis.

MR. LOWRY: Okay, finally, I want to talk about the transportation issue. There's concern about how this is going to work. For starters, there's some mention in the submission that patients can take the bus.

The little bit of research that I've done I don't have any knowledge that there is a bus route from MidState to HOCC. Is that correct?

MS. JANATKA: I would like to answer that. Lucille Janatka. Yes, actually, there is a bus route that

does go between our hospitals, yes.

MR. LOWRY: Where is it at? Where is the bus stop?

MS. JANATKA: It stops right across the street at the Meriden Mall from MidState.

MR. LOWRY: And goes straight to HOCC?

MS. JANATKA: It goes directly to their campus, yes. However, I would like to state that, in our planning for transportation support and services, we have also discussed a variety of opportunities that we might be able to work with families on, and we feel that the taxi voucher would probably be the best one best suited to insuring that patients' families or loved ones can get to HOCC in a timely manner, according to whether there's treatment needs, or family planning, or just visiting patients.

So, actually, it is also one of the opportunities that I believe that we can use some help on with our community, as I had mentioned earlier, having an Advisory Committee to help us work out how we might actually communicate that and make that available to

patients. We'd like input on that particular topic.

MR. LOWRY: How are the taxi vouchers going to work, then?

MS. JANATKA: I don't have all the details at this point. This is something I would like to work out with more community input, but we are making the commitment. We have been very clear that we will support family members that need to be present at Hospital of Central Connecticut to visit their loved ones.

MR. LOWRY: And will people have to ask for it, or will it be kind of like a guarantee, or standing protocol, that, oh, your family member is at HOCC, we have a taxi voucher, and here it is, that it will be affirmatively offered, or will it be a program that people can just access?

MS. JANATKA: This will be discussed in the emergency department, when the need and the actual admission is determined, so that the patient and their family can have that discussion, and we can determine their need for transportation.

At HOCC, they will also participate with

families, and if there's a need for transportation from their end, they will also participate and insure that.

We had discussed having a brochure available, something that could be actually in writing and available to patients and their families, and, again, this is something we would like to develop as the time gets closer to us actually using it.

MR. LOWRY: I don't have any further questions.

HEARING OFFICER HANSTED: Thank you. Counsel, do you have any Cross of Connecticut Legal Rights?

MS. FELDMAN: No.

HEARING OFFICER HANSTED: Thank you. Is Dr. Horton in the room? Dr. Horton?

MS. SUSAN DUCLOS: Dr. Horton had intended on coming, however, we were notified at approximately 20 of 2:00 that there was a possibility of this hearing not happening.

By the way, I'm Susan Duclos, and I will be speaking on behalf of the staff at MidState. If you'd

like, I can have someone call him.

HEARING OFFICER HANSTED: No, that's not necessary. I just wanted to see if he is here tonight. He had not signed in.

MS. DUCLOS: I understand, from what I've read online, that he had requested to be an Intervenor, as well. I don't know if he plans on coming after office hours.

HEARING OFFICER HANSTED: Thank you. Perfect segue, Ms. Duclos.

MS. DUCLOS: Thank you.

HEARING OFFICER HANSTED: You are the next Intervenor. I would remind you that you have been granted limited rights as an Intervenor, which means that you do not have the right to Cross-Examine the Applicant.

MS. DUCLOS: Okay.

HEARING OFFICER HANSTED: So you now have five minutes to give your opening statement.

MS. DUCLOS: Okay and, then, I ask you to let me know when it's about a minute from the end of my speech.

HEARING OFFICER HANSTED: Absolutely.

MS. DUCLOS: If the clock has already begun ticking.

HEARING OFFICER HANSTED: Certainly.

MS. DUCLOS: Because I have a lot of information that I'd like to address. My name is, for the record, is Susan Duclos. I am an RN and a CEN, which is a Certified Emergency Nurse, employed at MidState Medical Center for the past 32 years and a psychiatric nurse for the past nine years.

In my pre-trial testimony, which I submitted, I would like to address the concerns of my colleagues, which are the nurses, social worker and occupational therapist that works at MidState Medical Center.

I'd particularly like to address some of the inconsistencies noted in MidState Medical Center's responses to the completion question and discuss our inpatient department's current range of services, transportation issues, and Rushford's current and proposed role.

In addition, I would also like to address MidState Medical Center's original CON, which is Docket No. 92-567, when they were formerly known as Veteran's Memorial Medical Center.

I am by no means an attorney, but I would like to share the views of our department through the eyes of a health care professional, and, also, if I may, submit letters to the editor, unsolicited letters from patients, and editorials in support of keeping our unit open.

So I would like to start by saying that I respectfully appreciate what Hartford Health Care Corporation, what Lucille Janatka and Dr. Balkunas at HCC are proposing on a fiscal standpoint, however, there are some discrepancies that I'd like to address.

Number one, I have a table that lists in 2011 the amount of transfers from behavioral health patients to other acute care facilities. I believe that, prior to me, it was asked how many patients went to Natchaug. The answer to that is eight. Natchaug is one of HHC's health care system.

The Institute of Living, as well, is part

of HHC, 33. The primary amount of patients that were sent to other facilities that were in it that were the largest amount were St. Vincent's Medical Center at 42, St. Francis Hospital at 42, and Masonicare at 45.

It was stated in I don't recall whose testimony that 25 percent of our patients that need extra care are provided by HOCC, HHC and MidState, so I'd like to submit that.

Also, I have responses to MidState's CON, and I am going to hope to speak quickly to get my five minutes in.

HEARING OFFICER HANSTED: Let me just interrupt you there.

MS. DUCLOS: Yes, please do.

HEARING OFFICER HANSTED: Did you want to submit those documents as exhibits today?

MS. DUCLOS: I would like to.

HEARING OFFICER HANSTED: Do you have an objection, counsel?

MS. FELDMAN: I haven't seen them.

MS. DUCLOS: I would be glad to. It was

right off the Certificate of Need answers, or it might have been in the original CON application, so I would be glad to share it with you.

HEARING OFFICER HANSTED: Do you have more than one copy?

MS. DUCLOS: I believe I might. It might take me some time, but I'm under the gun, if the clock is still running.

HEARING OFFICER HANSTED: No. I'll stop the clock for you. I want to get this settled.

MS. DUCLOS: I believe, if you look perhaps under the original CON or the answers --

MR. LOWRY: She's referring to page 10 of Exhibit B.

HEARING OFFICER HANSTED: Thank you.

MS. DUCLOS: Thank you. I appreciate that. Please let me know when I may continue.

HEARING OFFICER HANSTED: Okay, Ms. Duclos, that's already in the exhibits, since it's part of the application.

MS. DUCLOS: Okay.

HEARING OFFICER HANSTED: So you do not need to make that an exhibit today.

MS. DUCLOS: Okay. I will not make it an exhibit, however, I believe it answers your prior questions that were important, as to how many of HHC's patients go to HHC facilities.

MS. FELDMAN: That was not the testimony. I just want to clarify that.

HEARING OFFICER HANSTED: Thank you.

MS. DUCLOS: Okay. Duly noted. May I continue?

HEARING OFFICER HANSTED: You may.

MS. DUCLOS: Okay. It was also stated by Elliott Joseph that they have a vision of quality of care qualified professionals, etcetera. I find it very, very interesting to note that our psychiatrist, Dr. John Nazarian's resume or C.V. was not listed in the application for the CON.

It touted all of the psychiatrists and their articles at HOCC, and I find it interesting to note that Dr. Nazarian is a Board Certified psychiatrist with a

sub-specialty in addiction services and, in fact, has a private suboxone clinic in West Hartford, so he does have qualifications.

I would also like to address Lucille Janatka's responses, that she is a major employer in Meriden, which, indeed, she is. I've been there 32 years. Behind me are many qualified nurses. It was told to us that we would not be provided any special inclusion into being a part of the staff at HOCC.

In other words, if we were terminated as a unit, that we would not have any special preferential jobs at HOCC, however, I do recall reading somewhere on this CON that, in speaking about the psychiatrists, that they would be welcomed to be part of HOCC's staff.

HEARING OFFICER HANSTED: One more minute, Ms. Duclos.

MS. DUCLOS: Okay. I have one more minute left?

HEARING OFFICER HANSTED: One more minute.

MS. DUCLOS: Oh, well, then, let me just say that I would like to provide the responses to MidState

CON, and I'm wondering how I might go about doing that, because it addresses inconsistencies.

HOCC will provide a broader range of groups that are not available on IPD, and, indeed, we do provide psychiatric education using evidence-based practice, and we routinely use Clozapine, as they stated they do, and anti-psychotic medications.

A great concern is if we are closed, patients that are in the emergency department that are in need of restraints, or IM medications will not be accepted at other facilities, because they're deemed too acute, yet they'd be able to go on our unit.

It also states that the transportation issue and vouchers, which are for family members, however, we feel that it is important to incorporate the whole picture of having clergy, the case managers.

And sometimes people only have one friend. They need to be provided vouchers. It also states that they had no present plan, MidState had no present plan to utilize the six beds, with the potential of the ten beds, and I'd like to state for the record that, when I started

there 10 years ago, nine years ago, there were 10 available psych beds.

Two of those rooms are now equipment rooms. A year ago, two of the other potential rooms that we could use to expand our unit was made into doctor on-call rooms, therefore, negating the possibility of expanding our unit.

And, also, only one patient was transferred to HOCC. Debbie Labutis will testify to that. That's part of -- two. Two. I apologize. Two. It describes therapies at HOCC not available here.

We do have components of the CBT, and it was stated by MMC we do not provide individual supportive therapy for patients, who experience psychosis, and this is more than not the truth.

We have the luxury of having the time to spend one-on-one time for our patients.

Also, it was asked if there were any special populations that utilize services that require them to be transferred that we do not admit to MMC, and I would like to state for the record that we frequently have

geriatric psych patients on our unit that other facilities will not take.

It was addressed that an increase in acuity in like the safer patients are going to stay at facilities, and MidState's response by having four additional beds to 10, that HOCC would mitigate or impact the length of stay, however, it's interesting to note that our length of stay at MMC was 6.4 days. HOCC was 8.74 days.

What I would really like to address, since I really have no time --

HEARING OFFICER HANSTED: I'm going to stop you there. You mentioned that you wanted to submit a document.

MS. DUCLOS: I would.

HEARING OFFICER HANSTED: Okay, what is that document? Is that the document you were just reading off of?

MS. DUCLOS: No. In my original pre-trial testimony, what I felt very compelling to submit to you is Docket No. 92-567, which was the original CON for

Veteran's Memorial Medical Center to open the facility, now known as MidState Medical Center, at 435 Lewis Avenue, and I have taken out several of the pages, which state that --

HEARING OFFICER HANSTED: Okay, I'm going to stop you. Let me just stop you there. If you want to submit these documents as exhibits, submit them to my office by the end of this week.

MS. DUCLOS: I will.

HEARING OFFICER HANSTED: And, also, make sure that the Applicant and the other Intervenors receive copies of those, as well.

MS. DUCLOS: I would be glad to do that.

HEARING OFFICER HANSTED: Thank you. Counsel, do you have any Cross?

MS. FELDMAN: Excuse me. These documents that are going to be submitted, are these late files?

HEARING OFFICER HANSTED: They will be late files, yes, and you will have an opportunity to object.

MS. FELDMAN: Okay.

MS. DUCLOS: There's a great concern.

HEARING OFFICER HANSTED: Counsel, do you have any Cross of this Intervenor?

MS. FELDMAN: No, I do not.

HEARING OFFICER HANSTED: Okay. Thank you.

MS. DUCLOS: Thank you for your time.

HEARING OFFICER HANSTED: Okay. At this time, I'd like to ask any public officials that are in the room to please step forward. I understand we have a few.

MS. TERRY GERRATANA: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MS. GERRATANA: My name is State Senator Terry Gerratana. I serve in the 6th District, and I'm here today addressing this hearing on behalf of one of my hospitals that I have in my legislative district, and that's The Hospital of Central Connecticut.

I'm here today in support of the expansion of the psychiatric care for the central Connecticut area. When The Hospital of Central Connecticut approached me with their current proposal, I thought back to a time when

they took the initiative to establish both psychiatric care at the hospital and, then, subsequently, an outpatient clinic back in the 1970s, while I was working at the then New Britain General Hospital.

Mental illness and a comprehensive approach in care were limited and, in some cases, unheard of back then. I thought it was both brave and sound medical policy for our community.

Today, HOCC is part of Hartford Health Care, a regional collaboration of health care entities mainly in the central Connecticut area.

The proposal to consolidate inpatient behavioral health care on one campus makes sense. It will deliver better quality care, with enhancements to treatment and rehabilitation resources.

These will be possible in the proposed larger 32-bed unit and would otherwise not -- which would otherwise not exist in the small six-bed availability at MidState, in my opinion. I apologize. I'm coming down with a cold.

HEARING OFFICER HANSTED: That's okay.

MS. GERRATANA: I understand these enhancements will include many more modalities, such as CBT and, also, DBT, and, also, music and art therapy.

Rushford Center, another Hartford Health Care partner, will also continue to provide clinical assessments for all behavioral health patients in the MidState Emergency Department and will facilitate placement of patients to the HOCC inpatient unit, if necessary.

This insures that all aspects of outpatient, community and crisis care will remain at MidState and continue to serve the Meriden community.

I like the approach that Hartford Health Care is taking of fulfilling their mission, and this is a collaborative health care approach. It is a way to provide better access and services.

While this is much more comprehensive of an approach, it will also offer many more quality choices in care that smaller, individual entities cannot offer.

Now I did have some concerns when I had my discussions, and I've had a couple of discussions with The

Hospital of Central Connecticut. One of my concerns, of course, was about the employment status of the current employees at MidState.

I asked them what would happen to them. After meeting with both HOCC and MidState, I am sure that they will be able to continue working at MidState if they choose. MidState will continue to accept behavioral health patients in their ED, and these health care professionals will be needed to administer care. That is my understanding.

Additionally, these employees have expertise and training in either MedSurg or emergency care, so their skills could be utilized anywhere in an appropriate health care setting at MidState.

Now I also had another concern, and that was how the families and caregivers of behavioral health patients currently at MidState would be able to visit and have access to their loved ones if they are transferred to HOCC.

I have been assured that transportation arrangements, and, indeed, I did talk to the

administrators about the taxi vouchers as a way of offering transportation arrangements for these family members.

In fact, very often, of course, family members are an essential part of the recovery. Family therapy is an essential component of recovery with these patients.

I urge OHCA and the Department of Public Health to approve the Certificate of Need application proposed by MidState Medical Center, and I thank you for this opportunity to share my opinion and your time and your consideration today.

HEARING OFFICER HANSTED: Thank you, Senator.

MS. GERRATANA: You're welcome.

COURT REPORTER: One moment, please.

JUDGE BRIAN MAHON: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

JUDGE MAHON: I'm Judge Brian Mahon. I'm the Probate Judge for the Probate District of Meriden. I've served as a Judge in this community for the past

eight years, and I find that there is an overwhelming mental health need in our community.

I see cases in my office on a weekly basis of the elderly, the mentally ill, and I spend many hours at MidState Medical Center conducting hearings for commitments, as well as psych med hearings.

I find that the majority of patients that I see at MidState are people of lower socioeconomic steps in the community, and people, who are of particular need of community resources.

I find that the families that I deal with of these people are families, who are, many times, do not speak English, many times are under-educated and don't understand how they would be able to get to other communities for the visitation of their patients and help in the therapeutic sessions that the patients would receive.

I have real concerns about a community of 61,000, with no inpatient psychiatric unit within our community, and I think that I -- I don't know how many other cities, I think Meriden is the tenth largest city in

the state, how many other cities of our size do not have a psychiatric inpatient unit. I have a feeling that it's very few.

I also have a concern about the voucher system, about the taxi system, and people being able to get to New Britain from Meriden.

Also, I have a concern about the hearings. As I say, I conduct many hearings. If we move this unit to New Britain, you're going to take away some of my business, which I'm just kidding. I mean it's going to make my job easier, but I'm not interested in having my job any easier.

What happens is, when hearings are held, attorneys are appointed to represent the patients. There will be now out-of-town attorneys, who will be representing these patients in New Britain.

There will be an out-of-town Judge, who will be hearing the cases. One of the unique things of the Probate system in the State of Connecticut is we are a community-based system, and there is familiarity with me when I go into the hospital. Patients are, often times,

patients, who I have seen numerous times before.

I think the patients feel more familiar with me and with my decisions, and my feeling is that to move this is going to be really taking away from the community that I'm trying to serve. Thank you.

HEARING OFFICER HANSTED: Thank you, Judge. Are there any other public officials, who wish to speak here tonight? At this time, I'd just like to take a five-minute break.

(Off the record)

HEARING OFFICER HANSTED: Folks? As everyone can see, we have a lot of folks here tonight, so I just want to make the announcement that, if any of you need to leave that would normally be giving verbal testimony here this evening as a member of the public, you do have the option of submitting that testimony in writing to my office, so you do not have to stay this evening.

OHCA has some questions now, so we'll start. Laurie, would you like to start? Brian?

MR. BRIAN CARNEY: Sure. I'm Brian Carney, member of OHCA staff. I just have a couple of

questions for the Applicants, following along with what we were discussing before in testimony, about preferential admission status.

How often do you think that it will occur that MidState referral will not have the ability to be placed at The Hospital of Central Connecticut?

MS. FELDMAN: I'm going to ask Dr. Balkunas to answer that.

DR. BALKUNAS: I don't think it will happen terribly frequently, since our average daily census right now is about 18 or 19 patients, so we hope that it will happen infrequently.

MR. CARNEY: Any better information, as to could it happen once a week, once a month? It's just hard to tell at this point?

DR. BALKUNAS: It's so fluid, the unit, in terms of admissions and discharges. We get people, who have sometimes private room needs, because they have medical illnesses, or they're infected. It's really, you know, it would just be a complete guess on my part. I don't want to throw that out.

MR. CARNEY: Okay, but you did say that four or five discharges occur?

DR. BALKUNAS: On a 32-bed unit, you'd have about four or five discharges per day, yes.

MR. CARNEY: So, hopefully, the wait wouldn't be too much.

DR. BALKUNAS: Yes.

MR. CARNEY: Okay. Going along with the whole bed issue, how is it determined that 10 additional staff beds at the New Britain campus was the optimal number for this proposal?

DR. BALKUNAS: Well, in part, it's a space issue, as well, in our building. Our building is a rather old building. When we worked with the architect, the number we really came up with was 32.

In addition, that does add beds to the current compliment of the combined, the beds at MidState and The Hospital of Central Connecticut, which we thought was an excellent thing.

MS. FELDMAN: Brian, we can supplement that response. Dr. Larcen was part of the planning

process, too, and can provide more information to respond to your question, if that's okay.

MR. CARNEY: Okay, sure. And maybe I can just follow-up with could that be adjusted at some point in the future, based on the demand?

MS. FELDMAN: Okay, let Dr. Larcen.

DR. LARCEN: When we did the planning, we did a very careful review of every patient that was leaving the MidState ED for other facilities and looked at how many we thought would be retained and could be serviced and calculated the expected demand, and the four beds more than adequately covered that demand.

If you look in the application, it shows you how many incremental admissions we expect, and you can also see how that matches up against the number of patients that were referred out.

Obviously, the pediatric patients and the geriatric patients would most likely continue to be referred out, so it would just be the balance of the adult patients, so we made, I think, an aggressive approach to retaining those patients, plus allowing some growth.

MR. CARNEY: Thank you. Laurie?

MS. LAURIE GRECI: Laurie Greci, OHCA staff. Not a lot has been talked about here at the hearing about substance abuse or patients with comorbidity.

If you had a patient that was brought to the ED, now this is a question for the Applicant, of course, if you had a patient that was brought to the ED that was under the influence of alcohol and needed to be almost hospitalized or hospitalized, would that patient be allowed to be admitted to MMC, or would he or she be considered a psychiatric patient and be referred over to HOCC?

MS. FELDMAN: I'm going to ask Dr. Balkunas to respond.

DR. BALKUNAS: Given our experience at The Hospital of Central Connecticut, the sorts of patients that you're talking about fall into two major categories.

Patients that require relatively large doses of anxiolytic medications, so that they won't go into major withdrawal or delirium tremens from alcohol,

are routinely admitted to a medicine unit, since they need to be on a telemetry med.

Other patients that are in withdrawal from alcohol, but aren't as ill, can be managed on the psychiatric unit, which we routinely do, with oral anxiolytic medication.

MS. GRECI: Can someone from MidState Medical Center give an overview of the history of the psychiatric services inpatient, well, starting back with Veterans and Meriden/Wallingford up to current?

MS. FELDMAN: Is there a specific area that you want them to focus on, Laurie?

MS. GRECI: Well, yes. It would be the size and how the beds have been reduced, and, also, the populations that they have chosen to maintain treating versus the geriatric and the pediatrics going out.

MS. JANATKA: MidState Medical Center, as you all know, is the merger of two hospitals, and, at the time that MidState became MidState, we opened with six psychiatric beds.

We worked with a swing, initially a swing

opportunity with MedSurg, but that became very difficult, because, as you know, psychiatric beds need a very specific facility, so we did isolate the six beds and worked with the six beds.

When we went to OHCA to ask for an expansion of our Emergency Department and we planned the ABU, at that time, we were also planning to delete our beds. At that time, Christine Vogel had instructed us to go from six beds to eight beds, and, at the completion of our construction project, that was the plan, that we would move from six to eight beds.

Our construction project allowed us to increase beds in the facility, which, then, freed up the space to be able to go from six to eight, and that actually happened -- we completed our project in 2011.

In 2011, we also, or very shortly after, it might have been the end of 2010, and, then, the beginning of 2011, The Hospital of Central Connecticut came into our system, and, at that point in time, we began a major study of behavioral health services in our system, and it didn't seem appropriate at that time to change our

compliment, until we had a full survey done and had an understanding of what our needs were.

MS. FELDMAN: Ms. Greci, I just want to clarify. So there were several CONs that were referred to by one of the Intervenors. There was the original docket number, 92-567, which you have in your possession, which spoke about the swing bed, four psych beds, with six beds being swing beds.

What I think Mrs. Janatka just clarified is they committed to doing six beds, even though they were only required to do four. Back in 2007, when they went before OHCA with the request to terminate the unit at that particular point in time, I believe the Commissioner stated that they should continue to operate eight beds, and we believe that to actually be somewhat of an error, because, at that time, we were only operating six.

And there was a discrepancy in some of our attachments. One of our financial attachments said eight, but we were operating six, but, at that time, even though Mrs. Janatka was planning on doing the eight, even though it was six that we were operating and we'd only be

continuing six, there were changes within the system by way of HOCC becoming a member and the planning starting to be undertaken.

MS. GRECI: The geriatric patients, have you routinely always referred them out?

MS. JANATKA: Yes. We have always worked very closely with Masonic. They have a geriatric psych, geriatric psych unit, and our patients are well-cared for there.

MS. GRECI: I have a couple of questions, just to clarify some testimony that was provided, so it should be pretty quick.

The transportation, it said that there's a bus that goes from Meriden Mall to Hartford, I'm sorry, Central Connecticut. That would be if somebody was at the hospital. What about the balance of the city? Is there a bus system that people can get to New Britain from?

MS. JANATKA: The answer is yes, but let me speak to transportation, because it's been such an issue, and there seems to be still confusion about it, and I want to make it very clear, that we will be working

individually with patients and their families or loved ones, whomever is appropriate, to determine what is the best option for them?

It might be van service. If we find that there's a lot of need, maybe it's van, maybe it's shuttle, taxi voucher, I feel that, you know, we are making every effort to insure that we're going to meet the individual needs of the patients, including paying for this, as well.

Is there anything more I can say about transportation?

MS. GRECI: Just, you know, we're just trying to get all of the facts into the record.

MS. JANATKA: I understand. That's why I want to make sure.

MS. GRECI: Yeah. Just to clarify that people aren't going to just like live right across from the medical center.

MR. CARNEY: Who would determine who was appropriate?

MS. JANATKA: I think that determination needs to be at the time of the transfer and the admission

that is going to be planned at HOCC with the Emergency Department staff, the patient, and their significant other, a family member or person that's with them. That's when that discussion needs to take place.

Certainly, the discussion might also take place when the patient is at HOCC if there are transportation needs that are identified after they meet with us.

HEARING OFFICER HANSTED: I just have a question on transportation. I appreciate your testimony here tonight regarding the transportation, but I'm concerned that I still do not have anything concrete to exactly explain the protocol that will be used if these patients and their family members or whoever else it may be need this transportation.

MS. JANATKA: Would we be able to provide that to you in a late file?

HEARING OFFICER HANSTED: Absolutely.

MS. JANATKA: Would that be all right? Let's do that for you.

HEARING OFFICER HANSTED: Absolutely.

Thank you.

MS. GRECI: I'd like to address recidivism. How often do a lot of these patients require readmission to an inpatient in a given year? What kind of percentage are we looking at?

DR. BALKUNAS: We do track the number of readmissions over seven, 14, 30 days. I think each individual entity within the system has different data. It really depends on the patient's diagnosis, the two major groups. The patients with schizophrenia, or schizophrenic-like illnesses, as well as substance abuse patients, seem to come to the hospital, are readmitted most frequently.

That said, we all have pretty strong outpatient treatment programs, which mitigates against readmission, so our data on readmission is actually pretty good. It's pretty low.

MS. GRECI: Good. As Brian would like to say, when you say low, are you saying once every two years, once a year?

DR. BALKUNAS: The most recent data I have

for our facility over a 30-day period I think there was only two patients that came back to the hospital, which actually is pretty good.

MS. GRECI: There was some testimony provided from an Intervenor about too acute to transfer to a different facility. Can you comment on that, please?

DR. BALKUNAS: Well I can't speak to the experience of MidState's emergency room, but we routinely take all comers. Actually, and I'll make a point later in my public testimony, at our hospital, I run the inpatient unit. We pride ourselves on taking all patients, regardless of diagnosis.

The fact of the matter is the large majority of patients that we admit are very ill patients, patients, who may otherwise be in a State facility, to be frank, so this is what we do every day all the time. It's nothing unique, and there are certainly ways to calm patients before they transport.

MS. FELDMAN: Laurie, Lucille would like to speak about the stabilization process that occurs in the ED at MidState before patients --

MS. GRECI: That would have been one of my questions, so that would be wonderful. Thank you.

MS. FELDMAN: Okay.

MS. JANATKA: Okay. I want to try to address this as clearly as possible. We do have an Acute Behavioral Health Unit. It's a nine-bed unit. It's a locked unit in our Emergency Department.

They're private rooms, staffed with psychiatric staff. This unit really provides dignity, respect, safety and excellent crisis intervention and care for those patients that are so acutely ill that we need to stabilize them before they could go anywhere, whether it might be upstairs, or whether it might be to another facility.

Is there anything more that I can explain to you around that particular patient population?

MS. GRECI: I think, perhaps, maybe if you describe what you mean by stabilize, just for the record, so we understand what the clinical issues are.

MS. JANATKA: I need a clinician to do that.

DR. BALKUNAS: Well, basically, if you're talking about agitation, and I think that's what you're driving at, correct?

MS. GRECI: Um-hum.

DR. BALKUNAS: So there are agents, who use standard medications. Some of them are anti-psychotic medications. Some of them are anxiolytic medications, often a combination, where you can calm the large majority, if not, all patients if you need to to transport them, absolutely.

MS. GRECI: Another question I have, when patients do come to the ED, how often are they accompanied by a family member or a loved one, or how quickly do family members or loved ones be contacted to come to the ED?

DR. BALKUNAS: Well contacting a third party is routine. It's part of routine care for every single patient, not only to have somebody come, we need collateral information, because, often, the patients are so sick we can't get any good history from them.

So if they don't come with them, then we

immediately contact a family member to get more history. I can't give you numbers on exactly how many, in terms of percentages.

MS. GRECI: That's okay. Thank you.

HEARING OFFICER HANSTED: I just have a couple of follow-up questions. There's been some discussion here tonight about the priority beds for MidState patients, and, certainly, the Intervenors are concerned about that.

Has there been discussion among the Applicants regarding actually dedicating a certain amount of beds at HOCC for these patients?

DR. BALKUNAS: We've been meeting over many, many months as a group toward putting together this application, and really have discussed every facet, transfer process, transportation, etcetera.

The thing is, if you think about it, if you were to say we're going to dedicate 10 beds solely to MidState patients and not admit anyone else, then what you're doing is limiting access to other patients, who have critical needs.

But I think our process is a really excellent one. We will routinely call MidState's emergency room to see not only if they had someone in their ABU, but if there's somebody in the medical part of the emergency room, who they think may need an admission to Hospital of Central Connecticut.

If there is, a bed will be held for them, regardless of the fact that we may someone in our emergency room, who needs admission.

If they don't have any patients either in their ABU or who potentially would be admitted and we had someone in our emergency room, who really needed a bed, of course, we would admit them, and, then, the following day, given the fact that there are, on average, four to five discharges, the next day the MidState patient would be admitted and be given priority again.

The priority is where it needs to be, because of the clinical needs of the patients, but we're certainly not going to fill up all 10 beds with people from outside the Meriden/Wallingford area. I just don't see that happening.

HEARING OFFICER HANSTED: Okay. I appreciate your testimony. Are the Applicants at all willing to dedicate any specific number of beds to MidState patients? I'm not saying -- I understand there will be 10 new beds. Has there been any discussion, and are the Applicants willing to dedicate any of those beds to MidState?

DR. BALKUNAS: Well that's an interesting question. We didn't discuss dedicating a number smaller than 10 beds to MidState, but, for the same reason, that if you had another patients, who needed services, you have their unfilled bed, and, then, the sick patient in your emergency room, and you really don't want to keep people in the emergency room overnight if we can avoid it. That's really a goal of the whole system.

MS. FELDMAN: Attorney Hansted, to answer your question, we absolutely did consider that, but we were also considering the overall needs to the state and the community of all patients, and given the fact that with a larger unit we were very confidently expecting that there would be a significant amount of turnover on a daily

basis, that the amount of time that a MidState patient would have to potentially, but unlikely, have to wait to be transferred from what is essentially an inpatient unit in the ABU setting.

This is not your typical ED, you know, pod, where people are sort of waiting to get a bed. This is very much like an inpatient unit, so while they wait there, they are getting treatment, and it's very unlikely that they would not be in a bed within 24 hours, but if OHCA is to direct us and say that you wouldn't want us to, if there were no patients at the MidState ED waiting for a bed at HOCC, that you would want us to hold it versus giving a patient, who needs the bed, you know, we would, you know, certainly take that under consideration, but, at this point, we try to come up with approach that really made the most sense for the entire community and, most importantly, the MidState patients.

We're very confident that our proposal will provide a ready number of beds at any given time for MidState patients, so it's very unlikely that we're ever going to be in that situation, but, in the event that we

are, it's probably not going to be more than 24 hours before they're in a bed, and there are many hospitals in the state, where patients are waiting for beds much longer than 24 hours.

In fact, that's why the length of stay has gone up in many hospitals, because people are waiting for transfer to a long-term facility.

HEARING OFFICER HANSTED: Okay.

DR. BALKUNAS: Can I just add something, too?

HEARING OFFICER HANSTED: Sure.

DR. BALKUNAS: There will be times, I think, as well, where the patients from Meriden/Wallingford may exceed the 10 beds if there's a clinical need, and that would be fine, as well.

HEARING OFFICER HANSTED: Okay, thank you.

MS. MARTONE: I would just like to offer to the Applicant, if there's any additional evidence that you'd like to put forward to the office, in terms of insuring access to behavioral health services for the residents of your area, this would be your opportunity to

do that.

MS. FELDMAN: Right now?

MS. MARTONE: Yup.

MS. FELDMAN: Well I think, you know, in the application and in our responses to the completeness questions, we worked very hard and very thoroughly and carefully to be completely realistic, honest and transparent, in terms of our proposal.

There's absolutely no way to predict anything, anywhere, at any given time, so we did our best to estimate how we could cushion the needs for MidState patients.

Right now, at the MidState facility, there are six beds, and we are proposing that there be 10 beds, so we believe firmly that not only will there be increased access, but, more importantly, there will be enhanced quality for all the reasons that you've heard in the testimony provided by our clinicians, Dr. McIntyre, Dr. Balkunas and Dr. Larcen.

This is about quality and enhancing care and, also, stabilizing access in the community. So we

think our proposal speaks to that. If there's something, in particular, that we perhaps are missing, you know, we're certainly open to adjusting the proposal to reflect that.

HEARING OFFICER HANSTED: So it's the Applicant's position that the expansiveness of the program leads to better quality? Is that correct?

MS. FELDMAN: In part. I think we had several positions that we were taking, in terms of why we think this is absolutely an increased access and enhancement in care.

I think Dr. McIntyre, all the clinicians, once again, had testified that, with a larger unit, there's going to be more opportunities for patients to socially interact in a therapeutic way.

There's going to be more opportunities for patients to match up with specific staff, who suit their personalities and their specific needs. There's going to be actual increase in the number of clinicians, who are going to add the scope of expertise available to these patients.

So we are, in fact, saying that size does matter, in terms of the delivery of quality behavioral health care.

MS. MARTONE: That's building the size of it at HOCC.

MS. FELDMAN: Correct.

MS. MARTONE: Not at MidState.

MS. FELDMAN: Not at MidState, because even if we were to increase MidState's unit from six to 10, or 12, or 14, if you look at the units in the state, and I think Dr. Larcen can speak to this, also, most of the units in the state, I think the next largest, next smallest unit in the state is 14 beds, but most units are 22, 24 and up.

And, as you heard Dr. McIntyre state earlier, based on his experience nationally and internationally, the best practice is a larger unit.

He also testified to the fact that environment does matter. It does influence outcomes, in terms of how the patient does, and one of the articles that we attached in our application speaks to that

specific issue.

I don't know, Dr. Balkunas, if you want to speak more directly?

DR. BALKUNAS: Yeah. I just wanted to mention, too, just on the very concrete level, if you have a six-bed unit, you could have six patients with six different diagnoses. To be completely frank, it's incredibly difficult to give them any sort of appropriate care, so, on the 32-bed unit, you'll have clusters of patients with similar diagnoses, which allow you to specialize group therapy, etcetera, some of the therapies we spoke about, which are clearly the therapeutic modalities in inpatient psychiatric units in the entire United States.

This will give us the opportunity to have similar patients together, so we can really focus on their diagnosis throughout a day, you know, maybe have four or five groups just for substance abuse. You can't do that on a six-bed unit. It's impossible to do.

MS. FELDMAN: And, Kim, to answer your question, we believe, it's our opinion, based on our

experts, that we can't do it on a 10-bed unit at MidState or even a 14-bed unit. It is not best practice, hence the decision to put the resources that are, you know, that we're willing to commit to expanding and enhancing the HOCC unit, which will benefit not only the HOCC community, but the MidState community at the same time, and that was the decision that we made in our best judgment.

HEARING OFFICER HANSTED: What number of beds would make it a best practice?

MS. FELDMAN: We'll let Dr. McIntyre respond, because I think that's what --

HEARING OFFICER HANSTED: Absolutely.

MS. MARTONE: And if there's information that you could submit on that that you have on best practices for a unit that you have not already submitted?

MS. FELDMAN: Okay.

DR. McINTYRE: Generally, most folks, who have looked at this, feel that units have somewhere between 14, or I used the number 15 before, 15 and 40 are ideal sizes.

As you get larger than that, if you get up

to an 80-bed unit of something, that's not as effective, actually. You would get diminishing returns after a period of time, and what those larger units often do is they'll break them down into different wings, so if you have like, let's say, a service that has 80 beds, you may have two 40-bed wings that operate somewhat independently, so, once you get over 40 to 50 beds on a single unit, it does become less effective.

So the ideal is somewhere in between 14, 15 and 40, perhaps up to 50 beds.

MS. FELDMAN: In all due respect, MidState is not proposing to expand its unit, and there's no plan to do that, in terms of the discussion of, you know, would a 10-bed unit work? But it certainly was in the consideration and thought processes that were engaged in to come to this proposal.

DR. McINTYRE: One of the interesting things, in terms of the size of the unit that's been mentioned sort of peripherally here, but not centrally, is the ABU. I mean that unit, which has nine beds, essentially, is a powerful resource for patients in that

community, very powerful.

And I've got to tell you it is incredibly -- I've never seen a situation, in which an ABU has more beds than the inpatient service. It's always the other way around, that you have a smaller emergency than you do inpatient beds that are feeding it, so that resource of nine beds at MidState is a tremendous resource, as you heard, for treating, as well as assessing the needs of the persons, and, then, having to go to different places.

Remember, again, that when I looked at the figures, about 50 percent of patients from that unit go to other hospitals. They don't go upstairs to MidState. They go to other hospitals, and I believe that HOCC is the closest hospital that they can go to.

I think Middlesex was another one that was a little bit further away. Geography is a little bit beyond me at this point, but a lot of patients from MidState and the emergency room do not get admitted to MidState, so the idea, you know, why they have to go all the way to HOCC, rather than going upstairs, half of them don't now go upstairs, so that's a very important issue to

keep in mind.

That ABU is a marvelous resource for this community.

MS. FELDMAN: I also want to circle back to where we began our testimony, with Elliott Joseph talking about health care reform and the mandate that not only we have, but that OHCA has, to avoid duplication in services, so very much a part of this decision-making process was how could we be more efficient?

How could we best garner our services, and, at the same time, enhance the quality of services that we're providing, and we think the proposal before you does exactly that. And this proposal is a byproduct of an interdisciplinary group of folks with expertise from various behavioral health areas determining that this was, in fact, a win/win.

I think, you know, to the extent that Mr. Joseph can sort of speak to the issue of what he envisions for the system, in terms of his fiduciary duty, to deliver high-value, cost-effective services, we can, you know, explain to you why we decided not to for quality reasons

not to go from six, to 10, to 14, but, also, to avoid duplication.

HEARING OFFICER HANSTED: Before we get to him, I have one more question for the doctor, as long as we're on this subject. Excuse my ignorance on the clinical side of this, but if the hospital, if MidState were to start treating pediatric and adolescent patients in this regard, clinically speaking, could you expand the unit and treat them in groups that way, or are pediatrics and adolescents treated in a different manner than adults?

DR. McINTYRE: They are treated in a different manner, and we have found that you do need specialized units for kids and adolescents. In fact, in New York, and probably the same in Connecticut, having younger kids on an adult unit is not permissible, so you need to.

The other issue, and I think you're raising a very good point, and we have talked about that, in terms of preparing for this hearing, that this is a very significant need, in terms of child and adolescent services, that there's no question about that, and you're

not unique. It's a problem here. It's a problem many, many places, but neither the status quo, or expanding a small number of beds at MidState, or the application directly addresses that issue at this point in time.

So, you're right, there's a piece of this, in terms of child and adolescent services, certainly child services, especially, that I think need some further work, but that, I think, is not germane to the question at this point, in terms of whether or not the beds at MidState should come over to HOCC, because in neither case do we have specialized child beds.

I think it's a very valid issue for the future, and it may be that, in terms of resources available, again, as an outsider, my opinion would be that HOCC is going to be much better able to address those needs in the long-term than a small unit at MidState.

MS. FELDMAN: Attorney Hansted, if we could have Dr. Larcen respond to your specific question about adolescent care?

HEARING OFFICER HANSTED: Sure.

DR. LARCEN: Before I do that, though,

your earlier question, about is there best practice about the size of units, I think that, if you look at the practice here in Connecticut, you have the data in your files, as to what the typical psychiatric unit is in a general community hospital.

If you exclude the five largest hospital programs, Hartford Hospital, Yale, St. Francis, St. Vincent's -- I'm forgetting my fifth one. St. Raphael's, thank you. I forgot.

If you exclude those five, you have 19 hospitals that have psychiatric units. Both the median and the mode is 20 beds, so I think we have the data by actual practice in Connecticut what the size is. The size is in the twenties, and anything less than that is not practical.

And the few hospitals that are below that are all struggling and all two to three times the size of the hospital before us.

On the child and adolescent services within the state, there are six hospitals that provide child services within Connecticut right now, and, of

course, St. Raphael's and Yale are now one, so I guess you'd say five hospitals with two programs.

And I'm an active member of the Behavioral Health Partnership Oversight Council. We work with data on length of stay, recidivism, family engagement, and the data is persuasive that what we have done with the partnership is we have reduced the number of -- total number of days of care, and we have found a way to be more efficient in getting patients out into the community with the community services that they so often need.

So there's no evidence right now in Connecticut that we are under-bedded with respect to the pediatric services, and that was a problem that was raised before this Commission a number of years ago.

The partnership has made a difference. I'm sure you could get the data from them that would be supportive of that, and, certainly, we can provide it to you.

To have an adolescent unit, again, you're back to the economy of scale and the size. You'd be talking -- you're not talking five beds. You're talking

15 beds. You're talking 16 beds.

The Natchaug Adolescent Unit is 18 beds. Our combined child and adolescent is 24. You need that size. You need classrooms. You need activity space. You're talking about a completely different treatment environment.

It's not a matter of taking an acute general hospital and just having pediatric site beds. You're really talking about a complete comprehensive program that would be needed to do that, and, as I said, the data does not suggest that there is an unmet need in Connecticut right now, because of the work that we've done with the partnership. Thank you.

MR. JOSEPH: Thank you. I just want to underscore a couple of points, if I may. We are a not-for-profit, community-based organization. Hartford Health Care, The Hospital of Central Connecticut, MidState Medical Center, Natchaug, Rushford, the IOL, not-for-profit, community-based.

We're blessed by having community members, who sit on our Boards and advise us and govern us, people,

who live in these communities.

The decisions that we're making to build a sustainable delivery system in the communities that we serve, our Boards labor over these questions, of how do we build sustainable health systems?

It's not easy. We're instituting an enormous amount of change. The world is changing around us even more quickly than we can keep up with in the health care arena, and we're charged by the community, by the Board, who are community members, to make the changes necessary to create a sustainable delivery system.

When we find opportunities like this one, that from my point of view and from our point of view do three things, they improve quality, based on the clinical expertise you've heard from today, they actually lowered the cost of care and, in a certain way, they improve access, by adding more beds, those are homerun decisions for us.

Not to say that any of these decisions of change are easy, but when you're able to lower cost, improve access, improve quality, the answer becomes pretty

obvious for our Boards and for us, as we meander through these difficult decisions that we have to make.

I understand perfectly well the concerns that are being raised. They're legitimate, they're real, they're things that we have to be sure we've all thought through together.

This notion of nine miles between HOCC and MidState, to me, I know it's a very real issue for poor and vulnerable people in the local community, and we have to take those issues very seriously.

Beyond that, the notion that we would have an inpatient psych unit across Connecticut, no more than nine miles away from the next one, would be something that I don't think anybody would vote for.

The nine miles, to me, is manageable. I think we've made an incredible commitment you've heard a lot about today, in terms of transportation. We've made a fairly strong commitment of a four-million-dollar investment, and we've made a commitment to actually expand the number of beds.

That's all because we're a community-

based, not-for-profit organization. We're trying to do the right thing for the right reasons, and yet required to make the changes necessary to insure this remains sustainable and high-quality.

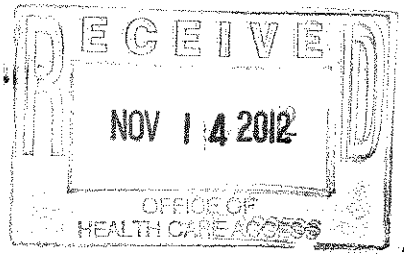
I know, when I think about my loved ones, who need behavioral health, who need mental health, who need substance abuse counseling, I want them to go to a facility that has the depth and breadth and the capability to care for them.

If I have to drive five or nine miles further away, that's not a hard decision for me. That's the way we've thought about this thing. So I just appreciate, again, the chance to express our thinking around what we're trying to do, why we're trying to do it, and, also, an understanding that the questions and the issues that are being raised at the hearing are vitally important for us to create an understanding of and do what we need to do to make sure that we continue to serve people. Thank you.

(Whereupon, the public comment portion of the hearing commenced.)

HEARING RE: OFFICE OF HEALTH CARE ACCESS
NOVEMBER 7, 2012

AGENDA



Department of Public Health
Office of Health Care Access
410 Capitol Avenue MS#13HCA
PO Box 340308
Hartford, Ct 06134-0308

Re:Docket number 12-31775-CON

November 7,2012

Dear Sir/Madam:

I come to you today as Vice President of the former Meriden Community Provider Consortium,the fore runner of Russford Services. From Middletown Connecticut Valley Hospital, we had at that time two major objectives. One objective was to re-locate all the patients from Meriden and Wallingford and to main stream them into society. This was accomplished with the new drugs available at that time and the dedication of our staff.

Second, we wanted to establish a Crisis Intervention facility. With State of Connecticut funding and co-operation from the then Meriden-Wallingford Hospital (now Midstate Medical Center) and our dedicated staff, this was complete as it now stands. Midstate Medical Center serves more than 100,000 people. It needs to have this Crisis Intervention program . The facil-ity has room to expand to a 15 bed unit and it should be done.

Respectfully submitted.

Gerard B. Roccapriore
P.O. Box 450
Meriden, CT 06450

Phone:203-235-2372

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

November 15, 2012

Ms. Barbara A. Durdy
Director, Business Development
MidState Medical Center
435 Lewis Ave.
Meriden, CT 06451

RE: Certificate of Need Application, Docket Number 12-31775-CON
MidState Medical Center
Proposal to Terminate Inpatient Behavioral Health Services
Continuation of Hearing

Dear Ms. Durdy:

The Office of Health Care Access ("OHCA") has scheduled a continuation of the hearing for the above Certificate of Need application that began on November 7, 2012.

Notice is hereby given of the continuation of the public hearing will commence on:

Date: December 6, 2012

Time: 4:00 p.m.

Place: Four Points by Sheraton Meriden
275 Research Parkway, Meriden, Connecticut 06450

Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in the *Record Journal* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association
Claudio Capone, Director, Hospital of Central Connecticut
Karen Goyette, VP, Strategic Planning & Business Development
Kirk Lowry, Esq., Connecticut Legal Rights Project, Inc.
Paul Horton, M.D.
Susan Duclos

KRM:bc: lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

November 15, 2012 Requisition # 40333

Record Journal
11 Crown Street
Box 915
Meriden, CT 06450-0914

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Monday, October 19, 2012.** Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:KR:lmg

Record Journal **November 15, 2012**
Notice of Public Hearing, Docket Number 12-31775-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-639
Applicant(s):	MidState Medical Center The Hospital of Central Connecticut Hartford HealthCare Corporation
Town:	Meriden
Docket Number:	12-31775-CON
Proposal:	Termination of Inpatient Behavioral Health Services at MidState Medical Center with no capital expenditure
Date:	December 6, 2012
Time:	3:00 p.m.
Place:	Four Points by Sheraton Meriden 275 Research Parkway, Meriden, Connecticut

Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3148
RECIPIENT ADDRESS	912036947601
DESTINATION ID	
ST. TIME	11/16 12:12
TIME USE	00'36
PAGES SENT	5
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: BARBARA DURDY

FAX: (203) 694-7601

AGENCY: MIDSTATE MEDICAL CENTER

FROM: LAURIE GRECI

DATE: 11/16/12 **TIME:**

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: DN: 12-31775-ON Continuation of Hearing

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Friday, November 16, 2012 10:49 AM
To: Greer, Leslie
Subject: Re: Hearing Notices

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

PLEASE NOTE: New Department of Labor guidelines allow web base advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: <Greer>, Leslie <Leslie.Greer@ct.gov>
Date: Friday, November 16, 2012 10:45 AM
To: ads <ads@graystoneadv.com>
Subject: Hearing Notices

Please post the three attached hearing notices by 11/19/12.

DN: 12-31775-CON	Record Journal	Requisition # 40333
DN: 12-31780-CON	The Advocate	Requisition # 40337
DN: 12-31781-CON	The News Times	Requisition # 40337

If you have any questions, please feel free to call me.

Thank you,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca
Please consider the environment before printing this message

Greer, Leslie

From: Greci, Laurie
Sent: Friday, November 16, 2012 1:58 PM
To: ccapone@thocc.org; karen.goyette@hhchealth.org; klowry@clrp.org; susiern59@aol.com
Cc: Greer, Leslie; Carney, Brian
Subject: 12-31775-CON Notice of Continuation of Public Hearing

Attached you will find a file containing the letter announcing the continuation date of the hearing for MidState Medical Center's Certificate of Need application for the termination of inpatient behavioral health services. The hearing has been schedule for December 6, 2012 at 4:00 p.m. at the Four Points by Sheraton in Meriden. Paul Horton, M.D. will receive his copy of the file by facsimile.

If you have any questions, please contact me.

Regards,

Laurie K. Greci

Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

November 15, 2012

Ms. Barbara A. Durdy
Director, Business Development
MidState Medical Center
435 Lewis Ave.
Meriden, CT 06451

RE: Certificate of Need Application, Docket Number 12-31775-CON
MidState Medical Center
Proposal to Terminate Inpatient Behavioral Health Services
Continuation of Hearing

Dear Ms. Durdy:

The Office of Health Care Access ("OHCA") has scheduled a continuation of the hearing for the above Certificate of Need application that began on November 7, 2012.

Notice is hereby given of the continuation of the public hearing will commence on:

Date: December 6, 2012

Time: 4:00 p.m.

Place: Four Points by Sheraton Meriden
275 Research Parkway, Meriden, Connecticut 06450

Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in the *Record Journal* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association
Claudio Capone, Director, Hospital of Central Connecticut
Karen Goyette, VP, Strategic Planning & Business Development
Kirk Lowry, Esq., Connecticut Legal Rights Project, Inc.
Paul Horton, M.D.
Susan Duclos

KRM:bc: lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

November 15, 2012 Requisition # 40333

Record Journal
11 Crown Street
Box 915
Meriden, CT 06450-0914

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Monday, October 19, 2012.** Please provide the following **within 30 days** of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:KR:lmg

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-639
Applicant(s):	MidState Medical Center The Hospital of Central Connecticut Hartford HealthCare Corporation
Town:	Meriden
Docket Number:	12-31775-CON
Proposal:	Termination of Inpatient Behavioral Health Services at MidState Medical Center with no capital expenditure
Date:	December 6, 2012
Time:	3:00 p.m.
Place:	Four Points by Sheraton Meriden 275 Research Parkway, Meriden, Connecticut

Please check OHCA's website at **www.ct.gov/ohca** for more information or call OHCA directly at (860) 418-7001.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3150
RECIPIENT ADDRESS	912032352506
DESTINATION ID	
ST. TIME	11/16 15:07
TIME USE	02'02
PAGES SENT	5
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Paul C. Horton, MD

FAX: (203) 235-2506

AGENCY:

FROM: Laurie Greci

DATE: 11/16/2012 TIME: 2:05 p.m.

NUMBER OF PAGES: 5
(including transmittal sheet

Comments: Notice of Continuation of Hearing for 12-31775-CON concerning MidState Med Ctr's proposal to terminate inpatient behavioral health services

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Facsimile Transmission

To: KEVIN HANSTED, HEARING OFFICER

Fax # 860-418-7053

Tel # _____

From:
Kristie Barber
Executive Director, Region II Regional Mental Health Board
Tel #860-262-5029 Fax: 860-262-5028

Date: 11/16/12

RE: INTERVENOR STATUS REQUEST

Number of Pages, including cover: 2

REGION II
REGIONAL MENTAL HEALTH BOARD, INC.

Date: November 16, 2012

Kevin Hansted
Hearing Officer
Department of Public Health
Office of Health Care Access
Faxed: 860 418-7053

RE: Certificate of Need Application, Docket Number 12-31775-CON
MidState Medical Center
Proposal to Terminate Inpatient Behavioral Health Services
Intervener Status Request

Dear Mr. Hansted,

I am requesting intervener status as Executive Director, on behalf of the Region II Regional Mental Health Board for the Certificate of Need Application for the proposal to close psychiatric beds at MidState Medical Center. The board's mission is legislatively mandated to review and evaluate the sufficiency, appropriateness, and quality of mental health services in south central Connecticut. Our mandate covers towns in the south central region which includes Meriden and Wallingford. Our board is concerned about the impact of this proposal on the needs of people with behavioral health disorders for whom we advocate and to assure that this proposal will not have a negative impact on these people. I have met with all of stakeholders in this process and the local legislators and I believe I have an informed and unique perspective on the matter to be decided.

I appreciate your consideration of my request for this status.

Sincerely,

Kristie Barber
Executive Director

P.O. Box 351, Middletown, CT 06457
Phone: (860) 262-5027 * Fax (860) 262-5028 * Email: southcentral@rmhb2.org
www.southcentralhealth.org

Greer, Leslie

From: Greci, Laurie
Sent: Monday, November 19, 2012 10:53 AM
To: ccapone@thocc.org; karen.goyette@hhchealth.org; klowry@clrp.org; susiern59@aol.com
Cc: Greer, Leslie; Carney, Brian
Subject: 12-31775-CON: MidState Medical Center Proposal to Terminate Inpatient Behavioral Health Services
Attachments: Continuation Notice for Hearing 31775 Revised.pdf

Attached to this email is a letter that corrects the time of the hearing to be held on December 6, 2012 from 4:00 p.m. to 3:00 p.m.

As always , please call me with any questions.

Regards,
Laurie

Laurie K. Greci
Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

November 19, 2012

Ms. Barbara A. Durdy
Director, Business Development
MidState Medical Center
435 Lewis Ave.
Meriden, CT 06451

RE: Certificate of Need Application, Docket Number 12-31775-CON
MidState Medical Center
Proposal to Terminate Inpatient Behavioral Health Services
Continuation of Hearing

Dear Ms. Durdy:

The Office of Health Care Access ("OHCA") has scheduled a continuation of the hearing that began on November 7, 2012.

Notice is hereby given that the continuation of the public hearing will commence on:

Date: December 6, 2012

Time: 3:00 p.m.

Place: Four Points by Sheraton Meriden
275 Research Parkway, Meriden, Connecticut 06450

The letter sent to you via email on November 16, 2012, listed the start time as 4:00 p.m. The hearing notice published in the *Record Journal* pursuant to General Statutes § 19a-639a (f) reported the start time as 3:00 p.m.

Sincerely,

Kimberly R. Martone
Director of Operations

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association
Claudio Capone, Director, Hospital of Central Connecticut
Karen Goyette, VP, Strategic Planning & Business Development
Kirk Lowry, Esq., Connecticut Legal Rights Project, Inc.
Paul Horton, M.D.
Susan Duclos, R.N.

KRM:bc: lmg

****
*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3156
RECIPIENT ADDRESS	912032352506
DESTINATION ID	
ST. TIME	11/19 12:09
TIME USE	01'24
PAGES SENT	3
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Paul C. Norton, MD

FAX: (203) 235-2506

AGENCY:

FROM: Laurie Greci

DATE: 11/19/2012 TIME: 11:05

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: Hearing Continuation Notice for 12-31775 changing start time from 4:00 pm to 3:00 p.m on 12/6/2012

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3157
RECIPIENT ADDRESS	912036947601
DESTINATION ID	
ST. TIME	11/19 12:33
TIME USE	00'26
PAGES SENT	3
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: BARBARA DURDY

FAX: (203) 694-7601

AGENCY: MIDSTATE MEDICAL CENTER

FROM: LAURIE GRECI

DATE: 11/19/12 **TIME:**

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: DN: 12-31775-CON Continuation of Hearing

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

(1)

PUBLIC HEARING
GENERAL PUBLIC
SIGN UP SHEET

November 7, 2012
3:00 p.m.

Docket Number: 12-31775-CON
MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation
Proposal to Terminate Inpatient Behavioral Health Services

PRINT NAME	Representing
Bonnie Desjardins	staff ✓
Deb Labutis	staff ✓
~~Adrian Indorf~~	~~staff~~
Edelyn Bishop	staff ✓
Ronald Oblon	staff ✓ submit written

MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation

PRINT NAME	Representing
SEAN W. MOORE	GREATER MERIDEN CHAMBER OF COMM
Marianne Fazzalari	retiree
Michael Mamroush	pt.'s father
J. Craig Allen MD	Rushford
STEVEN HANKS, MD	HOCC/HHC
Michael Balkans MD	HOCC/HHC
~~Kim~~ Marc Nemeth	Self
~~Judge Brian Mahen~~	~~Meriden Probate Court~~
Larry Giberton	Parent
Jeffrey Walter	Rushford

might be late

MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation

	PRINT NAME	Representing
✓	Bruce Edmonds	Self / Board Chairman member
✓	James Geronimo	General Public / Governor's Youth Council United Way
✓	Richard Figlewski	General Public
✓	Stephen Knight	Self
✓	George McGoldrick	Self
✓	Chris Ulbrich	Self
	Dawn Lowell	Hunter's Ambulance
✓	Marcia Prutta	Self / CT Board Member League for Nursing
✓	Hal Kaplan Dr.	Self
✓	Larry McGoldrick	Self / Board Member Director HHC

MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation

	PRINT NAME	Representing
left	GERARD B ROCCAPRIORE	FORMER COMMUNITY PROVIDER CONCORTIUM
✓	Kristie Barber	Region II Regional Mental Health Board
✓	Barbara Simonetta	CHCA
✓	Melissa Pappas	aetna.
✓	Stephen LATRCSW	WATERBURY HOSPITAL
✓	Phil Wright, Jr., Judge	Wallingford Probate Court
✓	ARLINE J DUNLAP	Self

No Sign up information was received for the Applicant.

PUBLIC HEARING
APPLICANT
SIGN UP SHEET

November 7, 2012
3:00 p.m.

Docket Number: 12-31775-CON
MidState Medical Center, The Hospital of Central Connecticut And Hartford HealthCare Corporation
Proposal to Terminate Inpatient Behavioral Health Services

PRINT NAME	Phone	Fax	Representing Organization

Paul C. Horton, M.D. 240 Pomeroy Ave., Suite 205 • Meriden, CT 06450

FAX

Date 11-20-12

Number of pages including cover sheet ~~3~~ 4

To Laurie Greci

Phone

Fax # 860-418-7053

From Paul C. Horton, M.D.

Phone (203) 235-2505

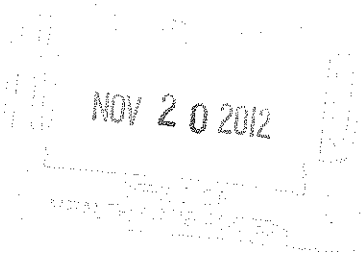
Fax # (203) 235-2506

REMARKS: ☐ Urgent ☐ For your review ☐ Reply ASAP ☐ Please comment

Paul C. Horton, M.D.
240 Pomeroy Avenue, Suite 205
Meriden, Connecticut 06450

Telephone (203) 235-2505
Facsimile (203) 235-2506
phortonmd@aol.com

November 20, 2012



Kevin Hansted, Esq.
Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
Hartford, CT 06134-0308

Dear Mr. Hansted,

Regarding the allocation of only five minutes for my presentation as an Intervenor in the MidState Psychiatric Unit Closure, I request a lengthening of that time frame to 10 minutes. I can give an orienting view in five minutes but cannot also address a number of specific and crucial psychiatric issues that should be part of any discussion of this ill-advised motion. Please consider that it appears that mine will be the only testimony offered by a senior psychiatrist who has long familiarity with a deep understanding of the psychiatric situation in the Meriden-Wallingford area and who can counter MidState's proposal from a medical perspective. And, after all, this is about the delivery of *psychiatric treatment* not simply about how profitable it is for vested interests to close the unit.

Respectfully,

Paul C. Horton, M.D.

N.B. You might want to mull over the attached article as a precautionary note about possible motives for short-shrifting "expensive" psychiatric patients.

New Haven Register

Serving New Haven, CT

Import

FORUM

Anthem gave us our own little Enron

Published: Wednesday, June 12, 2002

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By Dr. Michael A. Nelken

Anthem Blue Cross paid a start-up outfit with no track record to take care of all mental illness among 800,000 Connecticut citizens and left it up to the four-man board of directors of little Psych Management Inc. to determine how and when.

The result of this reckless shell game has been spelled out by the state's attorney general, Richard Blumenthal, at hearings of four committees of the state legislature.

Blumenthal reported that Dr. Peter Benet, the president of PMI, had been asking his board of directors for favors. Besides Benet, the board consisted of only three other psychiatric doctors, Robert Ostroff, Paul Torop and Richard Berkley.

The board gave Benet everything he asked for, free company stock, loans, whatever. Meanwhile, Benet told fish stories about how much money they were making. The four directors owned most of the company. The bottom line: after all the investigations, Anthem Blue decided PMI had to disappear.

Benet stopped paying doctors and stopped treating patients. He heckled his employees to put hospital patients out. He got a new house with the gifts his three friends handed him.

How could this Enron happen in Connecticut?

The state Insurance Commission has no power over PMI because it is not officially an insurance company. Anthem is, but it used PMI as a front, so that gets Anthem off the hook.

Blumenthal wants the legislature to put a stop to this legal hocus pocus. The answer is in the blue pages of your phone book under Connecticut state legislators. Call as many as you want. They get paid to listen.

It is not over. There is no law to keep the next PMI or the next Enron from cheating the public. PMI itself is dead and gone, swept under the rug with a one-page letter that says not to upset patients by telling them what happened.

Don't tell the voters of Connecticut that Anthem Blue Cross sold out their mental health by using a front organization to take the blame for short treatment and low pay. Pay so low that nationally doctors quit in droves, and new patients had to phone all over to find anyone who would see them. Pay so low nationally that hospitals cut staff and became dangerous, with some patients killed. Continued...

1
2
See Full Story

Reader Comments

Comments are held for review before posting, per our Online Comments Policy. If you believe your comment was wrongly removed or not approved, email comments@nhregister.com

Greer, Leslie

From: Carney, Brian
Sent: Wednesday, November 21, 2012 9:16 AM
To: Greer, Leslie
Subject: FW: Docket # 12-31775-CON - Request for Status
Attachments: 31775 Intervenor Request.pdf

fyi

From: Carney, Brian
Sent: Tuesday, November 20, 2012 10:54 AM
To: 'bdurdy@midstatemedical.org'; 'ccapone@thocc.org'; 'karen.goyette@hhchealth.org'; 'klowry@clrp.org'; 'susiern59@aol.com'; 'phortonmd@aol.com'
Cc: 'jfeldman@goodwin.com'; Riggott, Kaila; Hansted, Kevin; Greci, Laurie
Subject: Docket # 12-31775-CON - Request for Status

Applicants/Intervenors,

Please see the attached petition for intervenor status. If you wish to respond to this request, please file by Friday, November 23, 2012, close of business.

Thanks,
Brian Carney

Brian A. Carney, MBA
Department of Public Health
Office of Health Care Access
410 Capitol Ave.
Hartford, CT 06134-0308
Phone: 860-418-7014
Fax: 860-418-7053

Facsimile Transmission

To: KEVIN HANSTED, HEARING OFFICER

Fax # 860-418-7053

Tel # _____

From:
Kristie Barber
Executive Director, Region II Regional Mental Health Board
Tel #860-262-5029 Fax: 860-262-5028

Date: 11/16/12

RE: INTERVENOR STATUS REQUEST

Number of Pages, including cover: 2

REGION II
REGIONAL MENTAL HEALTH BOARD, INC.

Date: November 16, 2012

Kevin Hansted
Hearing Officer
Department of Public Health
Office of Health Care Access
Faxed: 860 418-7053

RE: Certificate of Need Application, Docket Number 12-31775-CON
MidState Medical Center
Proposal to Terminate Inpatient Behavioral Health Services
Intervener Status Request

Dear Mr. Hansted,

I am requesting intervener status as Executive Director, on behalf of the Region II Regional Mental Health Board for the Certificate of Need Application for the proposal to close psychiatric beds at MidState Medical Center. The board's mission is legislatively mandated to review and evaluate the sufficiency, appropriateness, and quality of mental health services in south central Connecticut. Our mandate covers towns in the south central region which includes Meriden and Wallingford. Our board is concerned about the impact of this proposal on the needs of people with behavioral health disorders for whom we advocate and to assure that this proposal will not have a negative impact on these people. I have met with all of stakeholders in this process and the local legislators and I believe I have an informed and unique perspective on the matter to be decided.

I appreciate your consideration of my request for this status.

Sincerely,

Kristie Barber
Executive Director

P.O. Box 351, Middletown, CT 06457
Phone: (860) 262-5027 * Fax (860) 262-5028 * Email: southcentral@rmhb2.org
www.southcentralhealth.org

Greer, Leslie

From: Carney, Brian
Sent: Wednesday, November 21, 2012 9:16 AM
To: Greer, Leslie
Subject: FW: Docket # 12-31775-CON - Request for Status

Leslie……..last, but certainly not least!

From: Carney, Brian
Sent: Wednesday, November 21, 2012 8:37 AM
To: 'Susan Duclos'
Cc: Hansted, Kevin; Riggott, Kaila; Greci, Laurie
Subject: RE: Docket # 12-31775-CON - Request for Status

Susan,

1) No additional response is required – we have noted that you are strongly in favor of Ms. Barber's intervenor status.
2) Yes, we received your materials and they will be included in the table of record.
3) No, you have already provided testimony as an intervenor at the November 7, 2012, hearing. However, you will be allowed to speak as a member of the public at the December 6, 2012, continuation.

Sincerely,
Brian Carney

From: Susan Duclos [mailto:susiern59@aol.com]
Sent: Tuesday, November 20, 2012 8:51 PM
To: Carney, Brian
Subject: Re: Docket # 12-31775-CON - Request for Status

Brian
I am strongly in favor of Ms Barber's intervenor status. How do I file to respond to her request?
I am also hoping you received my faxed documents that I had stated in my pre-trial letter that I had hoped to address at the last hearing. Due to time constraints I was unable to convey some very important information.
It is my understanding that I would not be allowed partial intervenor status at this hearing: is that correct? I just want it to be clearly understood that MMC already has 4 "psych safe" rooms that were made into on-call doctor rooms, and 2 rooms that have been equipment rooms for the past year. MMC could immediately decompress the situation in our ER/ABU by utilizing these available beds. I also wanted to reiterate that OHCA had suggested that MMC maintain an 8 bed unit due to the great meed in the Meriden area, and obviously had no intention of doing so!
Will I be allowed to speak as a private citizen if I am not allowed to be a partial intervenor at the next hearing?
Thanks for answering these questions, as I am obviously a neophyte to this whole process.
Susan Duclos

On Nov 20, 2012, at 10:53 AM, "Carney, Brian" <Brian.Carney@ct.gov> wrote:

Applicants/Intervenors,

Please see the attached petition for intervenor status. If you wish to respond to this request, please file by Friday, November 23, 2012, close of business.

Thanks,
Brian Carney

Brian A. Carney, MBA
Department of Public Health
Office of Health Care Access
410 Capitol Ave.
Hartford, CT 06134-0308
Phone: 860-418-7014
Fax: 860-418-7053

<31775 Intervenor Request.pdf>

Greer, Leslie

From: Greci, Laurie
Sent: Wednesday, November 21, 2012 10:04 AM
To: phortonmd@aol.com
Cc: Greer, Leslie; Carney, Brian; Riggott, Kaila; Hansted, Kevin
Subject: OHCA CON Docket 12-31775-CON concerning the proposal of MidState Medical Center to Terminate Inpatient BH

Importance: High

Dear Dr. Horton:

On November 20, 2012, OHCA received your faxed documents concerning the application of MidState Medical Center to terminate its inpatient behavioral health unit. The fax contained a letter from you to Hearing Office Kevin Hansted and an article from the New Haven Register.

Please provide copies of the letter and article to the following applicants and designated intervenors. Any documents that you provide concerning this application must be copied to each of the listed parties. You may use either fax or email, but you do not need to use both.

Applicant/Intervenor	Name	Email	Fax Number
MidState Medical Center	Barbara Durdy	bdurdy@midstatemedical.org	(203) 694-7601
Hospital of Central Connecticut	Claudio Capone	ccapone@thocc.org	(860) 224-5740
Hartford HealthCare Corp.	Karen Goyette	karen.goyette@hhchealth.org	(860) 545-2127
Self	Susan Duclos, R.N.	susiern59@aol.com	N/A
Connecticut Legal Rights Project	Kirk Lowry	Klowry@clrp.org	(203) 262- 5035

As always, if you have any questions, please do not hesitate to contact me.

Sincerely,

Laurie K. Greci

Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
860 418-7053

IN THE MATTER OF:

A Certificate of Need Application by
MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation
Notice to Petitioner; re: Request for Status

Docket Number: 12-31775-CON
November 21, 2012

RULING ON A PETITION FILED BY REGIONAL MENTAL HEALTH BOARD, INC. TO BE DESIGNATED AS AN INTERVENOR

By petition dated November 16, 2012, the Regional Mental Health Board, Inc. ("Petitioner") requested Intervenor status in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") application of MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation ("Applicants") filed under Docket Number: 12-31775-CON. The CON application is for the termination of inpatient behavioral health services at MidState Medical Center.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with limited rights for the hearing scheduled on December 6, 2012, 3:00 p.m., at the Four Points by Sheraton Meriden, 275 Research Parkway, Meriden, Connecticut. As an Intervenor with limited rights, the Petitioner is allowed to participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 12-31775-CON and will be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicants until the issuance of a final decision by OHCA. As an Intervenor with limited rights, the Petitioner may make a short presentation. The Applicants may cross-examine the Petitioner. The Petitioner is not permitted to cross-examine the Applicants. The Petitioner must pre-file testimony with OHCA on or before November 29, 2012.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

11/21/12
Date

Kevin T. Hansted
Hearing Officer

****
*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	3166
RECIPIENT ADDRESS	912036947601
DESTINATION ID	
ST. TIME	11/21 15:24
TIME USE	00'23
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: BARBARA DURDY

FAX: (203) 694-7601

AGENCY: MIDSTATE MEDICAL CENTER

FROM: BRIAN CARNEY

DATE: 11/21/12 **TIME:**

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: DN: 12-31775-CON Intervenor Ruling

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
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TRANSMISSION OK

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PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: CLAUDIO CAPONE

FAX: (860) 224-5740

AGENCY: HOSPITAL OF CENTRAL CONNECTICUT

FROM: BRIAN CARNEY

DATE: 11/21/12 **TIME:**

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: DN: 12-31775-CON Intervenor Ruling

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

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*** TX REPORT ***
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TRANSMISSION OK

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TIME USE	00'27
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: KAREN GOYETTE

FAX: (860) 545-2127

AGENCY: HARTFORD HEALTHCARE CORP.

FROM: BRIAN CARNEY

DATE: 11/21/12 **TIME:**

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: DN: 12-31775-CON Intervenor Ruling

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

11/21/2012 16:26 FAX 001

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*** TX REPORT ***
****

TRANSMISSION OK

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TIME USE	00'23
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RESULT	OK

11/21/2012 15:32 FAX 001

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*** ERROR TX REPORT ***
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TX FUNCTION WAS NOT COMPLETED

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RESULT	NG #0018 BUSY/NO SIGNAL

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: KIRK LOWRY

FAX: (203) 262-5035

AGENCY: CONNECTICUT LEGAL RIGHTS PROJECT

FROM: BRIAN CARNEY

DATE: 11/21/12 **TIME:**

NUMBER OF PAGES: 2
(including transmittal sheet

Greer, Leslie

From: Carney, Brian
Sent: Wednesday, November 21, 2012 3:46 PM
To: 'Susan Duclos'
Cc: Riggott, Kaila; Hansted, Kevin; Greci, Laurie; Greer, Leslie
Subject: Intervenor Ruling
Attachments: 31775.pdf

Ms. Duclos,

Please see attached ruling on intervenor petition.

Thanks,
Brian

Brian A. Carney, MBA
Department of Public Health
Office of Health Care Access
410 Capitol Ave.
Hartford, CT 06134-0308
Phone: 860-418-7014
Fax: 860-418-7053

IN THE MATTER OF:

A Certificate of Need Application by
MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation
Notice to Petitioner; re: Request for Status

Docket Number: 12-31775-CON
November 21, 2012

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11/21/12
Date

Kevin T. Hansted
Hearing Officer

SHIPMAN & GOODWIN LLP®

COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

November 30, 2012

VIA HAND DELIVERY
Kevin Hansted, Esq.
Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308

Re: Late-Filed Testimony; Docket No. 12-31775-CON

Dear Attorney Hansted:

On behalf of the Applicants and in support of the above-referenced Application, enclosed please find the Applicants' late-filed testimony requested by the Office of Health Care Access regarding the transportation information and assistance to be provided to patients and/or their visitors.

Respectfully Submitted,

Joan Feldman, Esq.

Certificate of Service

I hereby certify that a true and correct copy of the foregoing objection to petitioner's request for Intervenor Status was mailed via first class United States mail this 30th day of November 2012 to:

Connecticut Legal Rights Project
1000 Silver Street
P.O. Box 351
Beers Hall, 2nd Floor
Middletown, CT 06457
Attn: Jan VanTassel

And to

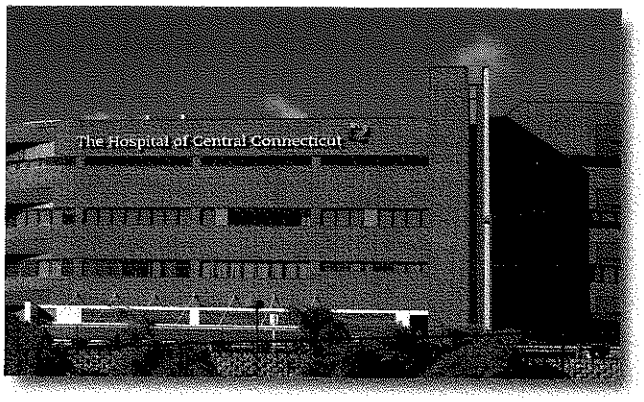
Paul C. Horton, M.D.
240 Pomeroy Avenue, Suite 205
Meriden, CT 06450

And to

Region II, Regional Mental Health Board, Inc.
P.O. Box 351
Middletown, CT 06457
Attn: Kristie Barber

Joan Feldman, Esq.

Transportation Services



The behavioral health treatment team at MidState Medical Center has determined that you would benefit from inpatient hospital care at The Hospital of Central Connecticut (HOCC). HOCC is a leading provider of quality health care services in central Connecticut, and along with MidState Medical Center, belongs to the Hartford HealthCare system.

Visiting Hours at HOCC

Visiting hours at the HOCC behavioral health unit are held daily from 12:30 p.m. to 1:30 p.m. and from 6:00 p.m. to 7:00 p.m. Visitors under the age of 13 are not permitted.

Getting to HOCC

Family and loved ones who wish to visit have several options available to them.

Driving Directions

HOCC is located at 100 Grand Street in New Britain, which is approximately 9 miles from MidState Medical Center. Directions from MidState Medical Center to HOCC are as follows:

- Take a right out of MidState Medical Center.
- Turn left onto Kensington Avenue.
- Turn right onto CT-71 N/Chamberlain Hwy and continue for 0.6 miles.
- Continue onto Connecticut 71A/High Rd for 5.9 miles.
- Turn right onto Arch Street in 1.4 miles.
- Turn left onto Grand Street in 0.6 miles.
- HOCC will be on the left.

Public Transportation

Public transportation is also available. A CT Transit bus route operates between MidState Medical Center and HOCC. The bus to HOCC stops at the Westfield Meriden Mall directly across from MidState Medical Center and makes another stop directly in front of HOCC on Grand Street. The bus leaves Meriden every hour on the hour, 7 days a week. The bus returning to MidState Medical Center can also be picked up on Grand Street in front of HOCC at 35 minutes after the hour 7 days a week. The bus schedules will be available at both MidState Medical Center and HOCC.

Special Assistance

For those individuals who do not have a means to travel to HOCC and public transportation is not an option, MidState Medical Center and HOCC will work together to ensure that a taxi/shuttle service can transport family and loved ones to and from HOCC. This service will be at no cost to you or your loved one.

If you or your family has questions about transportation, please call MidState Medical Center's Acute Behavioral Health Unit at 203-694-XXXX.

MidState Medical Center
A Hartford HealthCare Partner

Greer, Leslie

From: Carney, Brian
Sent: Friday, November 30, 2012 12:13 PM
To: Greer, Leslie
Cc: Riggott, Kaila; Hansted, Kevin; Greci, Laurie
Subject: FW: Request for status ruling
Attachments: 31775 Notice_Barber.pdf

Please see below. As far as I can tell, I don't think Ms. Barber (person requesting status) was ever notified of the ruling and was not aware of the deadline to submit pre-file testimony. I forwarded it to her today and advised her to submit by 4pm.

~Brian~

From: Carney, Brian
Sent: Friday, November 30, 2012 12:02 PM
To: 'execdir@rmhb2.org'
Subject: Request for status ruling

Ms. Barber,

Please see attached ruling on your request for status.

Brian Carney

Brian A. Carney, MBA
Department of Public Health
Office of Health Care Access
410 Capitol Ave.
Hartford, CT 06134-0308
Phone: 860-418-7014
Fax: 860-418-7053

IN THE MATTER OF:

A Certificate of Need Application by
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OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

11/21/12
Date

Kevin T. Hansted
Hearing Officer

Greer, Leslie

From: Hansted, Kevin
Sent: Friday, November 30, 2012 12:49 PM
To: Carney, Brian; Greer, Leslie
Cc: Riggott, Kaila; Greci, Laurie
Subject: RE: Request for status ruling

Brian,

Please prepare a new ruling for me to sign allowing Ms. Barber until the close of business on Monday to submit her prefile testimony.

Kevin T. Hansted
Staff Attorney / Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044

From: Carney, Brian
Sent: Friday, November 30, 2012 12:13 PM
To: Greer, Leslie
Cc: Riggott, Kaila; Hansted, Kevin; Greci, Laurie
Subject: FW: Request for status ruling

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~Brian~

From: Carney, Brian
Sent: Friday, November 30, 2012 12:02 PM
To: 'execdir@rmhb2.org'
Subject: Request for status ruling

Ms. Barber,

Please see attached ruling on your request for status.

Brian Carney

Greer, Leslie

From: Carney, Brian
Sent: Friday, November 30, 2012 1:47 PM
To: execdir@rmhb2.org; 'bdurdy@midstatemedical.org'; 'ccapone@thocc.org'; 'karen.goyette@hhchealth.org'; 'susiern59@aol.com'; 'Klowry@clrp.org'
Cc: Riggott, Kaila; Hansted, Kevin; Greci, Laurie; Greer, Leslie
Subject: 12-31775-CON MidState Proposal to Terminate Inpatient Behavioral Health Services
Attachments: midstate Intervenor revised ruling.pdf

Please see the attached file. It contains a revised ruling on the petition for intervenor status for the Regional Mental Health Board, Inc. The petitioner did not receive notice of the original ruling due to a clerical oversight. The date to submit the pre-file testimony was extended to December 3, 2012 due to this error.

Thanks,
Brian Carney

Brian A. Carney, MBA
Department of Public Health
Office of Health Care Access
410 Capitol Ave.
Hartford, CT 06134-0308
Phone: 860-418-7014
Fax: 860-418-7053

IN THE MATTER OF:

A Certificate of Need Application by
MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation
Notice to Petitioner; re: Request for Status

Docket Number: 12-31775-CON
November 30, 2012

REVISED RULING ON A PETITION FILED BY REGIONAL MENTAL HEALTH BOARD, INC. TO BE DESIGNATED AS AN INTERVENOR

By petition dated November 16, 2012, the Regional Mental Health Board, Inc. ("Petitioner") requested Intervenor status in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") application of MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation ("Applicants") filed under Docket Number: 12-31775-CON. The CON application is for the termination of inpatient behavioral health services at MidState Medical Center.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with limited rights for the hearing scheduled on December 6, 2012, 3:00 p.m., at the Four Points by Sheraton Meriden, 275 Research Parkway, Meriden, Connecticut. As an Intervenor with limited rights, the Petitioner is allowed to participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CON filed under Docket Number 12-31775-CON and will be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicants until the issuance of a final decision by OHCA. As an Intervenor with limited rights, the Petitioner may make a short presentation. The Applicants may cross-examine the Petitioner. The Petitioner is not permitted to cross-examine the Applicants. **The Petitioner must pre-file testimony with OHCA by the close of business on December 3, 2012.**

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

11/30/12
Date

Kevin T. Hansted
Hearing Officer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

November 30, 2012 VIA FAX ONLY

Kristie Barber
Executive Director
Region II Regional Mental Health Board
P.O. Box 351
Middletown, CT 06457

RE: Certificate of Need Application Docket Number 12-31775-CON
MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation
Proposal to Terminate Inpatient Behavioral Health Services at MidState Medical Center

Dear Ms. Barber:

Enclosed is the revised ruling by the Department of Public Health's Office of Health Care Access on your Petition to Intervene on behalf of the Regional Mental Health Board, Inc. that was filed with OHCA on November 16, 2012.

If you have any questions concerning this matter, please contact me at (860) 418-7001.

Sincerely,

Brian A. Carney

Brian A. Carney
Associate Research Analyst

Copy: Barbara Durdy, MidState Medical Center
Claudio Capone, The Hospital of Central Connecticut
Karen Goyette, Hartford HealthCare Corporation
Joan W. Feldman, Esq., Shipman and Goodwin, LLP
Paul C. Horton, M.D.
Susan Duclos, R.N.

IN THE MATTER OF:

A Certificate of Need Application by
MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation
Notice to Petitioner; re: Request for Status

Docket Number: 12-31775-CON
November 30, 2012

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11/30/12
Date

Kevin T. Hansted
Hearing Officer

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3180
RECIPIENT ADDRESS	98602625028
DESTINATION ID	
ST. TIME	11/30 14:31
TIME USE	00'31
PAGES SENT	3
RESULT	OK

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: KRISTIE BARBER

FAX: (860) 262-5028

AGENCY: REGION 11 MENTAL HEALTH BOARD

FROM: BRIAN CARNEY

DATE: 11/30/12 TIME: 1:25

NUMBER OF PAGES: 3
(including transmittal sheet

Comments: PLEASE SEE REVISED RULING FOR STATUS. DATE TO SUBMIT PRE-FILE TESTIMONY REVISED TO MONDAY, DEC 3, 2012 CLOSE OF BUSINESS

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: Carney, Brian
Sent: Monday, December 03, 2012 10:48 AM
To: phortonmd@aol.com
Cc: Greer, Leslie
Subject: FW: 12-31775-CON MidState Proposal to Terminate Inpatient Behavioral Health Services
Attachments: midstate Intervenor revised ruling.pdf

Please see attached and explanation below.

From: Carney, Brian
Sent: Friday, November 30, 2012 1:47 PM
To: execdir@rmhb2.org; 'bdurdy@midstatemedical.org'; 'ccapone@thocc.org'; 'karen.goyette@hhchealth.org'; 'susiern59@aol.com'; 'Klowry@clrp.org'
Cc: Riggott, Kaila; Hansted, Kevin; Greci, Laurie; Greer, Leslie
Subject: 12-31775-CON MidState Proposal to Terminate Inpatient Behavioral Health Services

Please see the attached file. It contains a revised ruling on the petition for intervenor status for the Regional Mental Health Board, Inc. The petitioner did not receive notice of the original ruling due to a clerical oversight. The date to submit the pre-file testimony was extended to December 3, 2012 due to this error.

Thanks,
Brian Carney

Brian A. Carney, MBA
Department of Public Health
Office of Health Care Access
410 Capitol Ave.
Hartford, CT 06134-0308
Phone: 860-418-7014
Fax: 860-418-7053

IN THE MATTER OF:

A Certificate of Need Application by
MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation
Notice to Petitioner; re: Request for Status

Docket Number: 12-31775-CON
November 30, 2012

REVISED RULING ON A PETITION FILED BY REGIONAL MENTAL HEALTH BOARD, INC. TO BE DESIGNATED AS AN INTERVENOR

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11/30/12
Date

Kevin T. Hansted
Hearing Officer

REGION II
REGIONAL MENTAL HEALTH BOARD, INC.

Facsimile Transmission

TO: Kevin Hunsted, Hearing Officer / Brian Carney

Fax#: 860 - 418-7053

Tel#: _____

From:
Kristie Barber
Executive Director, Region II Regional Mental Health Board
Tel: 860-262-5029 Fax: 860-262-5028

Date: 12/3/12

RE: Testimony for Public Hearing

Number of Pages, Including cover: 4

Kevin & Brian.
I emailed you a copy earlier Brian. I did not have Kevin's email.

Thank you,
K Barber

P.O. Box 351, Middletown, CT 06457 \
Phone (860) 262-5027 * Fax (860) 262-5028
Email: rmhb2@aol.com

December 3, 2012

Good day, Deputy Commissioner Davis, Attorney Hansted and staff members of the Office of Health Care Access ("OHCA"). My name is Kristie Barber and I am the Executive Director of the Region II (South Central) Regional Mental Health Board. Our board has been in existence for 38 years and our legislatively mandated mission is to ensure that citizens from the 37 towns in our region in Connecticut are actively involved in evaluating and monitoring mental health services that are provided in south central Connecticut. The quality and accessibility of services in the south central region, which includes Meriden and Wallingford, is fundamental to our mission.

Since the spring of 2012 we have been in the process of evaluating the proposed closure of psychiatric inpatient beds at MidState Medical Center (MidState). I have met with many of the interested parties in this CON application. At the State Capital, Speaker of the House, Chris Donovan and Representative Cathy Abercrombie and I met with the management teams of the hospitals and agency applying for the CON. Senator Len Suzio, a representative from Congresswoman's Rosa DeLauro's office, and I met with the nursing staff from MidState Medical Center. We have had presentations about this proposal by Rushford's management team to our board and committee for Meriden and Wallingford (CAC 9). I have also discussed the proposed closure with members from Keep the Promise (a mental health advocacy coalition) and our local Catchment Area Councils (CACs) Regional Mental Health Board members and consumers on whom the bed closure will have direct impact.

We have completed our due diligence and our board's consensus is to oppose this proposal. This is a position based on the experience of people served by MidState's inpatient unit currently and is not simply an opposition to change. Our decision is based on discussing this with people receiving services, some for decades, and their families or natural supports as well as community members. We believe this proposal to dismantle the well established and strong system of care on the existing inpatient unit at MidState will negatively impact people with mental health disorders by:

1) significantly decreasing the likelihood of a guaranteed number of available inpatient psychiatric beds for Meriden and Wallingford residents.

2) causing increased anxiety to patients in distress by transferring them by ambulance to an out of area inpatient bed, possibly deterring patients from seeking treatment in the future.

3) creating barriers to access for family members and other natural supports as well as continuity of care for essential for stabilization and long term recovery.

The first referenced point is **1) significantly decreasing the likelihood of a guaranteed number of inpatient psychiatric beds available to Meriden and Wallingford residents.** The need for inpatient psychiatric service demands remains high in the Meriden and Wallingford communities, so much so, that in 2008 when OCHA denied the request to terminate the inpatient psychiatric services at MidState and transfer them to the Institute of Living in Harford, OHCA directed MidState to provide psychiatric

inpatient services consisting of no less than eight licensed beds. MidState has instead operated six inpatient psychiatric beds. If the hospital had increased their capacity to eight beds the 100+ transfers per year to other facilities throughout the state over the past four years could have been avoided. The proposed increase of four additional beds at the Hospital of Central Connecticut is not a true increase of capacity, because MidState is licensed for ten inpatient psychiatric beds. Community residents we have spoken with are particularly troubled by the fact that the beds at HOCC will not be dedicated to MidState admissions and that "preferential access" does not assure accessibility to those 10 beds. In addition, the Regional Board maintains this is not an increase of capacity as set forth in the CON by the hospitals; it is a decrease of overall access to inpatient care.

The chart below displays the licensed beds versus active beds for both hospitals and the proposed capacity increase is added to the Hospital of Central Connecticut. Instead of transferring the 10 beds to HOCC, why not increase the active beds at MidState which is already licensed for 10 beds. This will better serve the 100,000 residents in the Meriden and Wallingford areas.

	Licensed beds	Active Beds	Proposed Capacity
MidState Medical Center	10	6	0
Hospital of Central Connecticut	22	22	32

The second referenced point is **2) causing increased anxiety to patients in distress by transferring them by ambulance to an inpatient bed possibly deterring patients from seeking treatment in the future.** A key element in a patient's hospital stay is the proximity to care and the ability to get care as quickly as possible, regardless of the medical emergency. This is especially true for people who are in a psychiatric crisis, because many times the decision to seek treatment is often delayed for a variety of reasons. Once a person goes to the emergency room, they are in considerable distress and even in the best of circumstances an ambulance ride can cause further excessive anxiety. This could be a roadblock to seeking future help.

The third referenced point is **3) creating barriers to access for family members and other natural supports as well as continuity of care for essential for stabilization and long term recovery.**

While we recognize and commend MidState and HOCC for including transportation as a component of their proposal, we assert that this would be a barrier to positive outcomes for patients. With limited visiting hours it is critical that the hospital be accessible for family members and natural supports to visit their loved one. Also, incorporating family and natural supports into the recovery and treatment plan is essential for a better recovery. If services are moved to New Britain this will be a challenge. The trip to New Britain can take over and hour roundtrip and a bus ride would be considerably longer, up to three hours. MidState and HOCC assures the community they will provide transportation by taxi vouchers or a shuttle for people who do not have the means to travel by public transportation. This still remains a critical issue, distance is the barrier.

An overarching theme to this proposal is dismantling an established, strong system of care on the existing inpatient unit at MidState. We have found that people who have been inpatients at MidState refer to their group therapy, individualized attention, and positive outcomes. This was especially true for patients who received care from MidState and also experienced care from other facilities. They stated there is no comparison to the caring, attentive, professional and effective treatment received at MidState. Overwhelming so, their clinical experience at MidState exceeds their expectations, coupled with the proximity to their home and family it is second to none. In addition, the proposed group therapies discussed for the HOCC unit is not considerably different than what is currently offered at MidState.

We hope OHCA evaluates all the components of this CON application and the public's testimony as well as the hospital's testimony. We believe that closing the psychiatric unit at MidState and moving the bed capacity to HOCC would be detrimental to the communities of Wallingford and Meriden. Our board acknowledges the work the hospitals have put into their proposal, however we believe the best outcome is not in this proposal as it stands. We hope to continue to foster a strong working relationship with the hospitals as we go forward to ensure access to quality care provided for people with psychiatric disorders. I thank you for giving me the opportunity to state my position on behalf the Region II Regional Mental Health Board.

I adopt the foregoing pre-filed testimony as my own.

Kristie Barber, Executive Director
Region II Regional Mental Health Board

Greer, Leslie

From: Carney, Brian
Sent: Tuesday, December 04, 2012 11:01 AM
To: 'jfeldman@goodwin.com'; phortonmd@aol.com; 'execdir@rmhb2.org'; 'bdurdy@midstatemedical.org'; 'ccapone@thocc.org'; 'karen.goyette@hhchealth.org'; 'susiern59@aol.com'; 'Klowry@clrp.org'
Cc: Greer, Leslie; Riggott, Kaila; Hansted, Kevin
Subject: FW: MidState Medical Center
Attachments: 31775-4.pdf

Please see the attached Prefiled Testimony from Ms. Kristie Barber; Executive Director, Regional Mental Health Board, Inc.

Thanks,
Brian Carney

From: Greer, Leslie
Sent: Tuesday, December 04, 2012 9:58 AM
To: Greci, Laurie; Carney, Brian; Riggott, Kaila; Hansted, Kevin; Martone, Kim
Subject: MidState Medical Center

Prefile testimony from Kristie Barber.

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca

REGION II
REGIONAL MENTAL HEALTH BOARD, INC.

Facsimile Transmission

TO: Kevin Hunsted, Hearing Officer / Brian Carney

Fax#: 860 - 418-7053

Tel#: _____

From:
Kristie Barber
Executive Director, Region II Regional Mental Health Board
Tel: 860-262-5029 Fax: 860-262-5028

Date: 12/3/12

RE: Testimony for Public Hearing

Number of Pages, Including cover: 4

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Thank you,
K Barber

P.O. Box 351, Middletown, CT 06457 \
Phone (860) 262-5027 * Fax (860) 262-5028
Email: rmhb2@aol.com

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I adopt the foregoing pre-filed testimony as my own.

Kristie Barber, Executive Director
Region II Regional Mental Health Board

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 18, 2012 Via Facsimile Transmission Only

Ms. Lucille Janatka
President and CEO
MidState Medical Center
435 Lewis Avenue
Meriden, CT 06451

RE: MidState Medical Center's Discontinuance of its Inpatient Psychiatric Service

Dear Ms. Janatka:

Please be informed that the Department of Public Health ("DPH") is in receipt of the attached letter, dated May 8, 2012, from The Honorable Rosa L. DeLauro, Third Congressional District of Connecticut, which includes a letter from Barbara Simonetta, Connecticut Health Care Associates' President to Representative DeLauro regarding MidState Medical Center's announcement to close its inpatient psychiatric service. I'd like to inform you that the DPH Division of Office of Health Care Access ("OHCA") is aware that MidState Medical Center has published a notice in The Record-Journal on Sunday, April 22, 2012, that it intends to file a Certificate of Need ('CON") application to terminate inpatient psychiatric services at the hospital pursuant to Section 19a-638a (4) of the Connecticut General Statutes.

If you have any questions regarding the above, please feel free to contact me at (860) 418-7001.

Sincerely,

Kimberly Martone
Director of Operations

Cc: Maryanne Volkringer, Vice President of Business Develpoment, MidState Medical Center
The Honorable Rosa L. DeLauro, Third Congressional District of Connecticut

2413 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-0703
(202) 225-3661

59 ELM STREET
SECOND FLOOR
NEW HAVEN, CT 06510
(203) 562-3718

DURHAM/MIDDLEFIELD/MIDDLETOWN
(860) 344-1159

WEBSITE: HTTP://DELAURO.HOUSE.GOV

UNITED STATES
HOUSE OF REPRESENTATIVES

ROSA L. DeLAURO
3RD DISTRICT, CONNECTICUT

CO-CHAIR, DEMOCRATIC STEERING AND POLICY COMMITTEE

COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEES
RANKING MEMBER
LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES
AGRICULTURE, RURAL DEVELOPMENT, FOOD AND DRUG ADMINISTRATION, AND RELATED AGENCIES

May 8, 2012

The Honorable Jewel Mullen, M.D. M.P.H., M.P.A.
Commissioner
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06106-1367

Dear Dr. Mullen:

Enclosed is a letter I recently received from my constituent, Ms. Barbara Simonetta of 261 Center Street, Wallingford, CT 06492.

I would appreciate it if you could review this correspondence to determine whether you can be of assistance to my constituent in resolving this matter. You can notify me of the outcome through my District Office located at 59 Elm Street, New Haven, Connecticut 06510. If you need any additional information, please contact my staff assistant, Louis Mangini, at 203-562-3718 or louis.mangini@mail.house.gov. My fax number is 203-772-2260.

Sincerely,

ROSA L. DeLAURO
Member of Congress

RLD/lm/ng

Enclosure

CHCA
CONNECTICUT HEALTH CARE ASSOCIATES
261 Center Street, Wallingford, CT 06492 • (203) 265-2297 • (203) 284-0624

April 11, 2012

APR 13 2012

The Honorable Rosa L. DeLauro
59 Elm Street
New Haven, CT 06510

Dear Representative DeLauro:

I am writing on behalf of Connecticut Health Care Associates (CHCA). We are the labor organization that represents the Registered Nurses who are employed at MidState Medical Center (MSMC).

We and the staff nurses who work in the In-Patient Psychiatric Unit at MSMC are concerned with the recent announcement by the MSMC Administration that they are planning to close the unit (as previously attempted in 2007) when they can obtain a Certificate of Need to do so. Such certificate would be granted by the Office of Health Care Access (OHCA) which is now part of the Connecticut Department of Public Health.

MSMC has a mission statement that stresses the care and treatment of patients and their families and the communities that they serve. Their core values are integrity, caring, excellence and safety.

We do not believe that the actions of closing the in-patient unit and transferring all patients that need to be admitted to New Britain or elsewhere would be in the best interests of the patients and their families. How long will the patients wait for a bed? How will those patients' families be able to travel to New Britain or elsewhere to visit their relatives? If they can't reach the patients how will they be able to participate in their treatment? Where will continuity of outpatient care be centered once the patient is discharged – New Britain?

There are few in-patient psychiatric beds available in Connecticut. Patients have waited up to seven days in the Emergency Department at MSMC for a bed anywhere in the state. Sometimes the waiting continues even when there are empty beds upstairs in their own facility. Why is the hospital proposing to close the small unit they have which will only exacerbate the issue?

We wish to express our opposition to the closing of the unit and abandonment of the patients and their families. We seek your support in our endeavor over the next several months as we advocate in the best interest of our patients and the missions to which we are bound as employees at MSMC. We also seek your support when this issue is taken up by OHCA and the Attorney General.

Thank you for your attention to this matter.

Sincerely,

Barbara Simonetta
President

Roberts, Karen

From: Roberts, Karen
Sent: Tuesday, May 15, 2012 3:33 PM
To: Huber, Jack
Subject: FW: Emailing: Public Notices

I think I said I would forward this you – then forgot to. Karen

From: Roberts, Karen
Sent: Tuesday, May 15, 2012 10:50 AM
To: Lazarus, Steven; Greer, Leslie
Cc: Martone, Kim
Subject: Emailing: Public Notices

FYI – if you didn't know about this one. Karen

Home

Tuesday, May 15,

LEGAL NOTICE
CONNECTICUT

LEGAL NOTICE

MidState Medical Center ("MidState") is filing an application for a Certificate of Need under section 19a-638(a)(4) of the Connectic

General Statutes requesting

approval to terminate the provision of inpatient psychiatric services provided at 435 Lewis Avenue, Meriden, Connecticut 06451. MidState's proposal to terminate inpatient psychiatric services will include plans for quality alternative access to inpatient psyc services. MidState's total capital expenditure for this project is $0.

Appeared in: ***The Record-Journal*** on Sunday, 04/22/2012

Printer-friendly version E-mail to a friend

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*** TX REPORT ***
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TRANSMISSION OK

TX/RX NO	2925
RECIPIENT ADDRESS	912036947601
DESTINATION ID	
ST. TIME	05/18 15:08
TIME USE	00'42
PAGES SENT	6
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: LUCILLE JANATKA

FAX: 203 694 7601

AGENCY: MIDSTATE MEDICAL CENTER

FROM: PAOLO FIDUCIA

DATE: 5/18/12 TIME: 3:00 PM

NUMBER OF PAGES: 6
(including transmittal sheet

Comments: LETTER REGARDING MIDSTATE MEDICAL CENTERS DISCONTINUANCE OF ITS INPATIENT PSYCHIATRIC SERVICE

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

May 22, 2012

Via Facsimile Transmission Only

Ms. Barbara Simonetta
President
Connecticut Health Care Associates
261 Center Street
Wallingford, CT 06492

RE: MidState Medical Center's Discontinuance of its Inpatient Psychiatric Service

Dear Ms. Simonetta:

Please be informed that the Department of Public Health ("DPH") is in receipt of the attached letter, dated May 8, 2012, from The Honorable Rosa L. DeLauro, Third Congressional District of Connecticut, which includes a copy of your letter to Representative DeLauro sent on behalf of Connecticut Health Care Associates' regarding MidState Medical Center ("Center") announcement to close its inpatient psychiatric service. I would like to inform you that the DPH Division of Office of Health Care Access ("OHCA") is aware that the Center has published a notice in The Record-Journal on Sunday, April 22, 2012, that they intend to file a Certificate of Need ('CON") application to terminate inpatient psychiatric services at the hospital pursuant to Section 19a-638a (4) of the Connecticut General Statutes. Any information related to the CON when it's filed with OHCA can be found on the OHCA webpage at http://www.ct.gov/dph

If you have any questions regarding the Certificate of Need process in this regard, please contact Kimberly Martone, Director of Operations, Office of Health Care Access at (860) 418-7001.

Sincerely,

Jewel Mullen, M.D. M.P.H., M.P.A
Commissioner

Cc: The Honorable Rosa L. DeLauro, Third Congressional District of Connecticut

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

SUPPLEMENTARY TESTIMONY OF JAN VANTASSEL TO OHCA
RE: MID STATE REQUEST TO CLOSE INPATIENT BEDS

I am the founder and co-chair of the Keep the Promise Coalition, a statewide organization established in 1999 to advocate for a comprehensive, community based system of mental health supports and services in Connecticut.

My testimony at the public hearing on December 6th emphasized the disconnect that appears to exist in the interactions and communications between the Hartford Health Network and the consumers and advocates in the Meriden/Wallingford region. In fact, one of the primary reasons that I chose to testify was because of the eloquent statements of Keep the Promise members about their reaction to the proposed closure of the inpatient beds at Mid State. They believe that they are the target of discrimination and that their concerns are secondary to corporate needs. In short, they have not been heard or respected at a time when person-centered care is supposed to be the standard.

However, I do not believe that I adequately conveyed my firm belief that Mid State simply has not made a strong case for closing these beds. There is no question that there is a demand in the Meriden/Wallingford area for inpatient beds. That was OHCA's finding in 2008, and that remains true today. While the applicant's attorney seems to have a different answer at each hearing for the reason that Mid State did not operate eight beds when ordered by OHCA to do so, the fact remains that they did not do so. Therefore, the fact that Mid State chose to send patients to other facilities should not be used against consumers to justify bed closure.

In addition, there appears to be no question that Mid State is financially solvent and has the capacity to operate ten beds to meet the community demand in the Meriden/Wallingford area. In fact, it was suggested that they have the space to operate more if necessary to meet local needs, such as young adults.

Despite the assertions that bigger units provide better treatment, there was no clear and convincing evidence that outcomes would be better at HOCC or that the therapies provided would be better. In fact, it appeared that Mid State outcomes were positive and provided more opportunity for continuity of care and access to friends and family members. I was particularly touched by one family member who indicated that they visited the hospital on their lunch hour. As one who had to fit visiting my institutionalized mother into my schedule, I could relate to this statement. It reminded me that we are not simply talking about the miles between the facilities. We are talking about assuring that a person in crisis has a real opportunity to see friends and family who are essential to their recovery.

Given these facts, it seems illogical to me that so much time, and some money, is being invested in setting up a transportation assistance system, establishing protocols to assure bed preferences, medicating patients for what they consistently report is an anxiety-provoking ambulance ride, and sending liaisons between HOCC and Mid State, to replace what they already have in Meriden.

If HOCC wants to proceed with its expansion, I have no doubt that those beds will be filled, and they don't need to close the ones in Meriden to do that. If they do so, it would provide an opportunity to actually compare outcomes and treatments, based on reality, not promises. Then perhaps, people from Meriden will demand access to those improved treatments. However, right now all they have are promises from a corporation that has not kept its promises in the past.

For these reasons, I urge you to deny the Mid State request to close its inpatient psychiatric beds.

CHCA
CONNECTICUT HEALTH CARE ASSOCIATES
261 Center Street, Wallingford, CT 06492 • (203) 265-2297 • (203) 284-0624

April 11, 2012

APR 13 2012

The Honorable Rosa L. DeLauro
59 Elm Street
New Haven, CT 06510

Dear Representative DeLauro:

I am writing on behalf of Connecticut Health Care Associates (CHCA). We are the labor organization that represents the Registered Nurses who are employed at MidState Medical Center (MSMC).

We and the staff nurses who work in the In-Patient Psychiatric Unit at MSMC are concerned with the recent announcement by the MSMC Administration that they are planning to close the unit (as previously attempted in 2007) when they can obtain a Certificate of Need to do so. Such certificate would be granted by the Office of Health Care Access (OHCA) which is now part of the Connecticut Department of Public Health.

MSMC has a mission statement that stresses the care and treatment of patients and their families and the communities that they serve. Their core values are integrity, caring, excellence and safety.

We do not believe that the actions of closing the in-patient unit and transferring all patients that need to be admitted to New Britain or elsewhere would be in the best interests of the patients and their families. How long will the patients wait for a bed? How will those patients' families be able to travel to New Britain or elsewhere to visit their relatives? If they can't reach the patients how will they be able to participate in their treatment? Where will continuity of outpatient care be centered once the patient is discharged – New Britain?

There are few in-patient psychiatric beds available in Connecticut. Patients have waited up to seven days in the Emergency Department at MSMC for a bed anywhere in the state. Sometimes the waiting continues even when there are empty beds upstairs in their own facility. Why is the hospital proposing to close the small unit they have which will only exacerbate the issue?

We wish to express our opposition to the closing of the unit and abandonment of the patients and their families. We seek your support in our endeavor over the next several months as we advocate in the best interest of our patients and the missions to which we are bound as employees at MSMC. We also seek your support when this issue is taken up by OHCA and the Attorney General.

Thank you for your attention to this matter.

Sincerely,

Barbara Simonetta
President

2413 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-0703
(202) 225-3661

59 ELM STREET
SECOND FLOOR
NEW HAVEN, CT 06510
(203) 562-3718

DURHAM/MIDDLEFIELD/MIDDLETOWN
(860) 344-1159

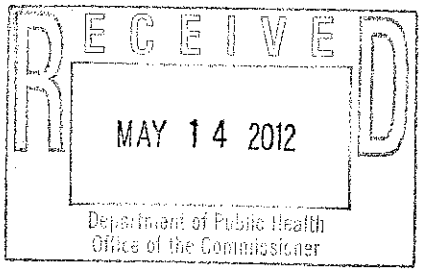
WEBSITE: HTTP://DELAURO.HOUSE.GOV

UNITED STATES
HOUSE OF REPRESENTATIVES
ROSA L. DELAURO
3RD DISTRICT, CONNECTICUT

CO-CHAIR, DEMOCRATIC STEERING AND POLICY COMMITTEE

COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEES
RANKING MEMBER
LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES
AGRICULTURE, RURAL DEVELOPMENT, FOOD AND DRUG ADMINISTRATION, AND RELATED AGENCIES

May 8, 2012



The Honorable Jewel Mullen, M.D. M.P.H., M.P.A.
Commissioner
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06106-1367

Dear Dr. Mullen:

Enclosed is a letter I recently received from my constituent, Ms. Barbara Simonetta of 261 Center Street, Wallingford, CT 06492.

I would appreciate it if you could review this correspondence to determine whether you can be of assistance to my constituent in resolving this matter. You can notify me of the outcome through my District Office located at 59 Elm Street, New Haven, Connecticut 06510. If you need any additional information, please contact my staff assistant, Louis Mangini, at 203-562-3718 or louis.mangini@mail.house.gov. My fax number is 203-772-2260.

Sincerely,

ROSA L. DeLAURO
Member of Congress

RLD/lm/ng

Enclosure

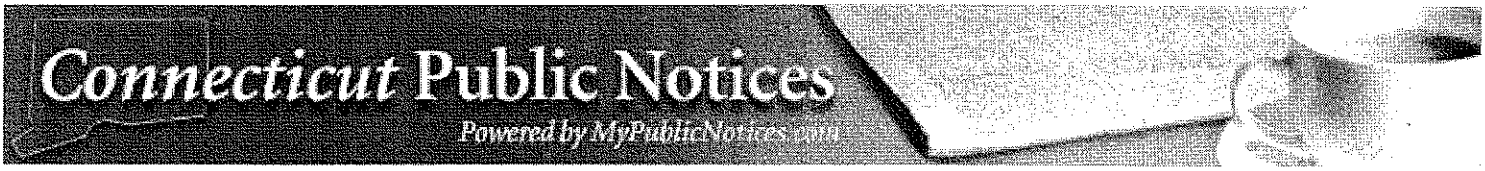
Roberts, Karen

From: Roberts, Karen
Sent: Tuesday, May 15, 2012 3:33 PM
To: Huber, Jack
Subject: FW: Emailing: Public Notices

I think I said I would forward this you – then forgot to. Karen

From: Roberts, Karen
Sent: Tuesday, May 15, 2012 10:50 AM
To: Lazarus, Steven; Greer, Leslie
Cc: Martone, Kim
Subject: Emailing: Public Notices

FYI – if you didn't know about this one. Karen



Home **Tuesday, May 15,**

LEGAL NOTICE
CONNECTICUT

LEGAL NOTICE

MidState Medical Center ("MidState") is filing an application for a Certificate of Need under section 19a-638(a)(4) of the Connectic

General Statutes requesting

approval to terminate the provision of inpatient psychiatric services provided at 435 Lewis Avenue, Meriden, Connecticut 06451. MidState's proposal to terminate inpatient psychiatric services will include plans for quality alternative access to inpatient psyc services. MidState's total capital expenditure for this project is $0.

Appeared in: ***The Record-Journal*** on Sunday, 04/22/2012

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*** TX REPORT ***
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: BARBARA SIMONETTA

FAX: 203 284 0624

AGENCY: CONNECTICUT HEALTH CARE ASSOCIATES

FROM: PAOLO FIDUCIA

DATE: 5/23/12 TIME: 3:45 PM

NUMBER OF PAGES: 6
(including transmittal sheet

Comments:

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

MIDSTATE MEDICAL CENTER
THE HOSPITAL OF CENTRAL CONNECTICUT
AND
HARTFORD HEALTHCARE CORPORATION

PROPOSAL TO TERMINATE INPATIENT BEHAVIORAL HEALTH SERVICES

DOCKET NO. 12-31775-CON

DECEMBER 6, 2012

3:00 P.M.

FOUR POINTS SHERATON
275 RESEARCH PARKWAY
MERIDEN, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

HEARING RE: OFFICE OF HEALTH CARE ACCESS
DECEMBER 6, 2012

. . .Continued verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation, Proposal to Terminate Inpatient Behavioral Health Services, held at the Four Points Sheraton, 275 Research Parkway, Meriden, Connecticut, on December 6, 2012 at 3:14 p.m. . . .

HEARING OFFICER KEVIN HANSTED: Before we begin, I would just ask everyone to please turn off their cell phones, with the exception of any doctors in the room that may need them for emergency purposes. Thank you.

This public hearing before the Office of Health Care Access, identified by Docket No. 12-31775-CON, is a continuation --

A FEMALE VOICE: We can't hear you.

HEARING OFFICER HANSTED: Is that better? No? Better? Why don't you move up? Is that better?

CROWD: Yes.

HEARING OFFICER HANSTED: Okay, good. We're ready to go. Again, in case anyone didn't hear me, please turn off all cell phones, with the exception of doctors. Thank you.

I'll start over. This public hearing before the Office of Health Care Access, identified by Docket No. 12-31775-CON, is a continuation of the public hearing held on November 7, 2012 to consider the application of MidState Medical Center, The Hospital of Central Connecticut, and Hartford HealthCare Corporation to terminate inpatient behavioral health services.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes, the Uniform Administrative Procedures Act.

My name is Kevin Hansted, and I've been designated by Commissioner Jewel Mullen of the Department of Public Health to serve as a Hearing Officer for this matter.

Assisting me here today with the public hearing is Kimberly Martone. The hearing is being recorded by Post Reporting Services.

The way that we will proceed with the

hearing today is to first hear from the Applicant's counsel for a brief overview of the project for the benefit of the public here tonight, followed by each Intervenor.

The Intervenors will have five minutes to provide testimony, and then the Applicants may Cross-Examine the Intervenors.

I would remind anyone here that was at the hearing on November 7th, including the Intervenors, that they are not permitted to speak here tonight.

Then we will go to the public section of the hearing. Each person, who wishes to speak, should write their name on the sign-up sheets, which have been provided outside of the door.

Following the hearing, I will issue a proposed final decision, in accordance with Connecticut General Statutes, Section 4-179.

In making its decision, OHCA will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

At this time, would staff read into the record the added documents? All documents have been identified in the Table of Record for reference purposes.

Ms. Martone?

MS. KIMBERLY MARTONE: Yes, Attorney Hansted. We're adding additional exhibits, are Exhibit CC --

A MALE VOICE: Mike, please. Please use the microphone.

MS. MARTONE: Sorry. The additional exhibits to be added into the record include Exhibit CC to Exhibit ZZ.

HEARING OFFICER HANSTED: Thank you. The Applicants, MidState Medical Center, the Hospital of Central Connecticut and Hartford HealthCare Corporation, have been designated as parties in this proceeding.

At this time, I would like Dr. Horton and Ms. Barber to stand, raise your right hand and be sworn in. Court Reporter, do you want to swear them in? Thank you.

(Whereupon, Dr. Paul C. Horton and Kristie Barber were sworn.)

HEARING OFFICER HANSTED: Thank you. I now ask counsel for the Applicants to make a brief statement for the benefit of the public, which summarizes the CON proposal. Thank you.

MS. JOAN FELDMAN: Thank you, Attorney

Hansted. My name is Joan Feldman. I'm counsel for the Applicants. To start, I would like to clarify, in part, in response to one of the Intervenor's filing, MidState does not have licensed beds that are designated for a particular service.

It was incorrectly stated, that MidState has 10 psychiatric licensed beds. That is not correct. They have six psychiatric beds, and that is pursuant to the CON that they received.

To start, this proposal is a request to terminate its inpatient psychiatric unit that has six beds and have the Hospital of Central Connecticut assume access with respect to those six beds and four beds, in addition to that, on a preferential basis.

HOCC is planning to expand its 22-bed Psychiatric Behavioral Health Unit to have 32 beds. Ten of those beds will be designated for MidState area residents, and I will explain how that preference will work.

I just want to be very clear, that the Applicants strongly believe that this is in the best interest of the patients from our community, in that they will have increased access to a state-of-the-art Behavioral Health Unit that has the capacity to be able

to tailor treatment to the specific needs of the patients, to develop a milieu that is environmentally more conducive to behavioral health patients, and to be able to segregate patients, based on their particular behavioral health treatment needs.

With respect to how the preference will work, six beds will always be reserved for MidState area patients, so there will always be one bed open on the HOCC unit, until there are six MidState area patients on that unit at any given time. There will always be one bed open, up to six beds.

As we stated in our earlier testimony, on average, there were four to five discharges on the HOCC unit per day, so beds turnover on a fairly frequent basis. It is a rapid kind of turnover case.

Once we have six MidState area patients on the unit, there will be preference given for MidState patients for another four beds, so if there are -- if there is a patient in the HOCC Emergency Department bed, is needing admission to an inpatient unit, and there is a MidState patient in the MidState Emergency Department ABU unit requiring inpatient stay, the seventh bed will be given to the patient who is sicker most immediately.

If that happens to be an HOCC patient, the

next open bed will go to a MidState patient, and with the turnover of four to five beds a day, that will likely be within the next 12 or 24 hours.

So, essentially, MidState, not essentially, factually, MidState patients will have greater access to beds than they current have, so there is absolutely no loss, in terms of the number of beds. In fact, there is an increased number of beds being made available to MidState area patients.

Now, currently, MidState is transferring approximately 200 patients per year from its facility to other inpatient Behavioral Health Units.

Many of these facilities that patients are being transferred to are at much greater distances than the HOCC unit, and the hospital does not provide any means of support of transportation for those patients and their families once they're transferred, because that's simply not what hospitals do.

They're not in the business of transporting family members to visit patients. However, with respect to this particular proposal, in response to the concerns of the community and to make visiting, which we understand to be very important, we do not take this lightly, we recognize it as a valuable part of the

treatment, when appropriate, to have family members involved and to have visits from family and loved ones, MidState is proposing, pursuant to its late file, to assist with transportation for those who need that assistance.

We will make public transportation information available, both at the MidState campus and on the HOCC inpatient Behavioral Health Unit.

There will be individuals informed at the first opportunity of the services that are available, so for those that don't happen to see the information, or don't happen to ask, we will make that information known to them.

We will take active steps to make sure that everybody is made aware of the transportation assistance that is available, which does include, for those individuals, who can't afford the transportation, transportation assistance, and for those, who are either unable to take public transportation or don't have their own cars, we will provide either a shuttle service, or a taxi voucher.

We have not made our transportation plans any more definitive than that at this point, other than we are publicly committing to not have that be an

obstacle to visitation.

The reason why we have left it somewhat open-ended at this point in time is we want the input from family and loved ones, so, as mentioned at the last hearing, we plan to convene a working committee, made up of constituents, who include representatives from the treatment team at HOCC, representatives from MidState's treatment team and administrative services, representatives from the community, patients, family members, community providers, essentially, anybody who is interested in assisting with this transition and providing valuable input into how we could better meet the needs of the community.

So that is something that we are committed to doing. We've already begun to plan for that, and we are ready to move forward.

So that I don't go over my time, I just want to say that we believe that the environment of the Behavioral Health Unit is critically important. We think that the HOCC unit will be state-of-the art, once the four-million-dollar renovation is complete.

We believe that the size of the unit will allow for more tailored and specialized care for patients, rather than a five-bed unit, and we believe,

for all the reasons stated in our application, that we will be able to provide a more enhanced level of quality services more efficiently. Thank you.

HEARING OFFICER HANSTED: Thank you, counsel. At this time, I would ask Dr. Horton to present his 10-minute testimony. Dr. Horton, you're welcome to stay there or come up to the podium.

DR. PAUL HORTON: This is fine. Thank you.

HEARING OFFICER HANSTED: Okay.

DR. HORTON: Can you hear me all right? Is this clear? Good. I'll just say, generally, to me, this is a woods and a trees issue, and I feel that there are some overarching issues here that need to be addressed, and I'm going to do that in this brief presentation.

HEARING OFFICER HANSTED: Just bring it closer to yourself. Why don't you try this microphone and see if that's better?

DR. HORTON: How's that? Okay. I began by saying that, to me, this is an issue that has both woods and trees aspects, and, for example, we just heard a lot about the trees. I want to cover, though, some of the overarching aspects. I wish I had more time, but

I'll do the best I can.

When so-called managed care arrived on the scene in Connecticut in the '90s, it did so as a harbinger of a lot of bad things to come, in terms of quality medical care.

With respect to psychiatry, specifically, Anthem got it rolling with its sells. That's right, sells. Sounds like socialism or communism, but, in reality, it was good old American unmanaged greed.

The sell consisted of a pill pusher, in this case a psychiatrist, plus a gaggle of eager beaver social workers and psychologists, who wanted to, quote, "treat" the mentally ill. That is, assume the role of a psychiatrist, without actually having to go to medical school and become a bona fide medical specialist.

I don't blame the social workers and psychologists. They do very well at what they're doing, but it's wrong to give them the responsibility that really should be taken by the psychiatrist.

The psychiatrist in these sells lurked in the background, writing prescriptions for patients they barely knew and not properly evaluated, while the social workers and psychologists provided so-called therapy.

An article in the New Haven Register in

2002 described a modus operandi as a reckless shell game, which defrauded 800,000 Connecticut citizens and led to hearings before Attorney General Richard Blumenthal.

You can read about this scam under the title Anthem Gave Us Our Own Little Enron. New Haven Register, Wednesday, June 12, 2002.

Now you would think things would have gotten better after that, but they didn't. In fact, they're worse now than ever before.

When I came to Meriden in 1974, after serving as a Lieutenant Commander in the Navy Medical Corps, taking care of hundreds of sailors and marines returning from Vietnam with the severest imaginable mental and emotional disorders, I was ready for a challenge, and we had a 20-bed inpatient psychiatric unit, with four flex beds out on Paddock Avenue. Indeed, it was the presence of this hospital unit, which drew me to the Meriden community.

After World War II Veteran's Hospital, I was able to admit and treat as many as 68 patients from my private practice and from the Emergency Room, where I took call.

Because of that availability, I was able to take on and treat the toughest cases, the enraged, the

dangerous, the suicidal.

Under my service, we didn't have anybody leaving the hospital and murdering nine-year-old girls on the streets of Middletown.

It was a great system, and a number of prominent Yale faculty joined me up here to offer this service in one of the state's neediest psychiatric communities.

Over the years, I learned and grew as a psychiatrist, thanks to my patients and the highly specialized services they required. I'm still learning and growing.

Not a day goes by, when I'm not amazed by something that I did not know. And, and this is crucial, I admitted children and adolescents to that service. Now what do we have, and what are we being offered?

What we have in Meriden is a charade of what we were supposed to get when MidState's proposal to close the Psych Unit in 2008 was rejected by this committee.

I will leave aside how far we have plummeted from our care of patients out on Paddock Avenue. MidState promised a measly six beds, with four flex beds. Hospital administration has made sure, I'm

told by a number of sources, that these beds were never filled, and never were these flex beds used, justifying, in the hospital's opinion, the ultimate closure of this unit.

Moreover, they gave us a hospitalist system, which prevents the doctor from admitting, following and treating his own patients on discharge, and even worse is the fact that there are no beds for children and adolescents, who are, and I can tell you with absolute certainty, because I do a lot consulting in Central Connecticut to the public school systems, these kids are the neediest of our burgeoning psychiatric population here in Meriden and places like Bristol.

When Dr. B., I'll just refer to him by his initial, of HOCC met with us this summer over at MidState, I asked him why are there no provisions for children and adolescents in the HOCC?

He replied, tersely, there's no money in it, and that, in a word, sums it all up. It's all about money. By the way, I see MidState made a 24.3-million-dollar profit this year.

Now, indeed, what HOCC proposes, an exclusive for profit model, is tantamount to Anthem/Enron. We will, once again, have the scheme of a

psychiatrist running his finger lightly over his patients, prescribing powerful medications for them, because, remember, these days, to get into the hospital, you've got to be really sick, and, then, turning them over to non-MDs for so-called therapy, the therapy that is being touted as cognitive behavioral therapy, a therapy for which there is no evidence of effectiveness with the major mentally ill, and, by major mentally ill, I'm talking about the kind of people that we admit these days, schizophrenics, bipolars, delusional people, etcetera, etcetera.

I have many reasons of my own for stating that CBT does not work. Suffice it to say, at a recent Harvard psychiatric symposium, the chosen expert on CBT admitted that this was a treatment technique that did not work with the major mentally ill.

CBT is a treatment technique that is best applied to the worried well by therapists, whatever their stripe, who have not gone to medical school, not completed a residency in psychiatry, who are not Boarded in psychiatry. It is a fraud, and we are supposed to send our sickest to New Britain to be poked at by amateurs?

Just this month, in the Psychiatric News,

the official publication of the American Psychiatric Association, with whom I am a fellow, the following was reported by the APA's Committee on Psychotherapy by a psychiatrist.

Quote, "There is a lost generation of psychiatrists that was trained at the point of the deepest commitment to biological reductionism."

The article went on to observe, and Dr. Plaken(phonetic) was being quoted, noted that the diminishing role of psychiatrists and providing psychotherapy occurs against a background of burgeoning evidence, that psychotherapy is an effective biological treatment, so it is quite important that we preserve psychotherapy as part of the skill set and identity of psychotherapists and included in residency training, so that future patients will have the opportunity to receive psychotherapy from psychiatrists, who can maintain the maximum integration of medical and psychological issues in treatment that no other discipline can provide.

Now here's my wish list on this proposal. I think it should be denied. I would wish that this Board -- I don't know what your powers are, but you guys have your ear to the rail of how the State works, and here's what I think should be done.

They should require that the MidState Psychiatric Unit be increased to 10 beds for adults and to add 10 beds for children and adolescents, returning at bed-wise to the number we had at Veteran's Memorial Hospital before its closure.

Two, or three, rather, open the admission process to privately practicing psychiatrists. For one thing, you want older folks involved in this process. You just don't want a bunch of 30 year olds, who were trained at the time that there was this obsession with MRIs, and there was a deregulation of medications, and they were dumping medicines on the market that really were poorly studied, and doctors were prescribing them left and right, and there were a lot of casualties.

We discovered, for example, just take the SSRIs. After more than a decade, they finally concluded that the only SSRI that works with children and adolescents is Prozac. All the rest of them, on balance, are harmful.

I can tell you, MidState, 10 years ago, they were prescribing these SSRIs thoughtlessly.

I would hope that there would be a requirement that a biopsychosocial framework be used as a holistic approach to our patients. Now I taught at Yale.

I was assistant professor back there the '70s, and we had a course, called Mind, Brain and Society.

We recognized that people were complicated, and there were many things you had to consider when you were going to treat them.

I quote from a young MD in psychiatric training, not an old fart like myself, writing in the Residents Forum of Psychiatric News.

It makes sense that the solution to psychiatry's identity crisis must focus not only on the biological side of the field, that's the prescribing part, but, also, on the psychological side, the treatment side, and on the social side. That is, access, relationship with primary care and the general public.

This approach will help make the field more user-friendly, transparent, and scientific in ways that will appeal to a larger number of future physicians, require the patients, who are a danger to themselves and/or others, and especially those, who are sent to the Emergency Room on a physician's emergency certificate, be evaluated directly by a psychiatrist, not just a nurse or social worker.

Now there have been casualties, and I know of one very serious case. It has led to a lawsuit

against MidState, where someone was sent in on a PEC, a dangerous person, was released without benefit of psychiatric evaluation, and that person created a lot of problems for himself and for his boss and his wife and others in the community.

A MALE VOICE: Mr. Chairman, could Dr. Horton summarize at this point?

HEARING OFFICER HANSTED: No. I'm going to let him continue. Thank you.

DR. HORTON: I've just got a couple more things to say. I also ask that patients, that there be a requirement that patients, who are suicidal, not be left unattended in out-of-the-way places in the MidState Emergency Room.

MidState knows or should know from its sentinel event list what I'm referring to. MidState should be required to provide psychiatric consultation on the medical floors of the hospital, and that these consultations be provided by a psychiatrist and not fogged off on a nurse or a social worker, who is put in the position of one who is competent to make bona fide psychiatric diagnoses and offer psychiatric treatment. A hospital ward should not be a triage venue.

Lastly, but perhaps most importantly,

require that MidState provide direct psychiatric assessment by a psychiatrist, who is experienced in evaluating and treating children and adolescents, of all children and adolescents, who are sent to the Emergency Room by physicians or school administrators.

Many of these children are a danger to themselves and to others, as well as victims of abuse and neglect, and we need somebody, who is experienced and trained to be able to recognize what the problems are and what to do about them. I thank you.

HEARING OFFICER HANSTED: Thank you, Dr. Horton. (Applause) Attorney Feldman, do you have any Cross-Exam of Dr. Horton?

MS. FELDMAN: I just have a few questions. Dr. Horton, have you conducted any sort of empirical studies with respect to the efficacy of cognitive behavioral treatment?

DR. HORTON: By empirical studies, you mean controlled, double-blind studies published in reputable journals?

MS. FELDMAN: Yes.

DR. HORTON: No, I have not done that.

MS. FELDMAN: Okay. Have you, Dr. Horton, visited the Hospital of Central Connecticut's Behavioral

Health Unit?

DR. HORTON: No, I have not.

MS. FELDMAN: Okay and, Dr. Horton, do you have medical staff privileges at MidState Medical Center?

DR. HORTON: Well I'm on the senior faculty there. I'm not sure really what those privileges entail.

MS. FELDMAN: Do you have active medical staff privileges?

DR. HORTON: If I did, it wouldn't matter, because they have a hospitalist system, so I can't admit or take care of my patients in any case.

MS. FELDMAN: Are you a member of the active medical staff?

DR. HORTON: I'm a member of the senior staff.

MS. FELDMAN: Okay. No further questions.

HEARING OFFICER HANSTED: Thank you. Okay, at this time, I'd ask Ms. Barber to present her testimony. Thank you.

MS. BARBER: So I would first just invite anyone, who would like to sit down, please, there are some seats there. It could be long, if you'd like to. You do have to cross in front of the room to get there,

but that's okay, so please be comfortable.

HEARING OFFICER HANSTED: You know what? Ms. Barber, before you start, just let me take a 30-second break.

MS. BARBER: Sure.

HEARING OFFICER HANSTED: I want to move these chairs into the audience. We have these chairs sitting up here. Let's use them.

MS. BARBER: Oh, okay. Sure.

(Off the record)

HEARING OFFICER HANSTED: All set? Okay, we'll go back on the record. Thank you, Ms. Barber.

MS. BARBER: Sure. So it's a much different day than the last public hearing. There's no snowstorm outside, and it's very beautiful out, and there are many community members that are here today, which I think is really important to this process, and I appreciate so many people coming here to testify today.

One other note I just want to say is I appreciate and thank you for the opportunity to testify, and appreciate Attorney Hansted and Ms. Martone for listening to us from the Office of Health Care Access.

So my name is Kristie Barber, and I'm the Executive Director of the Region Two or South Central

Region Mental Health Board.

Our Board has been in existence for 38 years, and our legislatively-mandated mission is to insure that citizens from the 36 towns in the regions in Connecticut that we serve are actively involved in evaluating and monitoring mental health services that are provided in South Central Connecticut.

Quality and accessibility of services in the South Central Region, which includes Meriden and Wallingford, is fundamental to our mission.

Since the spring of 2012, we've been in the process of evaluating this proposed closure of psychiatric inpatient beds at MidState.

I met with many of the interested parties involved in the CON application. At the State Capitol, Speaker of the House, Christopher Donovan, and Representative Kathy Abercrombie and I met with the management teams of the hospitals and the agencies applying for this CON.

Senator Len Suzio and a representative from Rosa DeLauro's office met with the nursing staff from MidState Medical Center.

We've had presentations about this proposal from Rushford's management team and to our Board

and Committees and our CAC 9, which serves Meriden and Wallingford.

I've also discussed this proposed closure with members of Keep the Promise Mental Health Advocacy Coalition and our local Catchment Area Councils, and, specifically, with consumers, on whom the bed closure will have a direct impact. I think that's important to note.

I've also spoken with a financial expert, you might say, from Yale-New Haven Hospital or health system, who said, you know, Hartford Hospital is about a 2.2-billion-dollar operation. Yale is about a 3.3-billion-dollar operation. Just before, they were about 2.2, same as Hartford HealthCare.

And, in terms of the financial aspect, that if there is a portion of this that's driven by financial aspect, you know, it could be related to Hartford HealthCare overall is about a five percent profit margin, and so is HOCC, Hospital of Central Connecticut, and MidState is at about a two percent from the numbers that we reviewed, so I can see how part of this has definitely a financial component to it, in terms of reasoning.

So now I'm going to have a quote. The

quote is, "As for me, you must know I shouldn't have precisely chosen madness if there had been any choice. What consoles me is that I'm beginning to consider madness as an illness, like any other, and I accept it as such." And that's from Vincent van Gogh. As you know, a famous artist, who had either bipolar, or there's, you know, difference of opinions of what he had, but nobody would choose to have a psychiatric disability.

And, in saying that, there are many reasons for it, but true bias, or stigma, or discrimination is a part of it, you know? And you can't see it, you know?

It's not like you have a wheelchair. It's not like you have something that's visible, in terms of an illness, and that can be a real challenge.

So, as the Regional Mental Health Board, we've completed our due diligence, and our Board's consensus is to oppose this proposal.

It's a position that's based on experience of people served by MidState's inpatient unit currently, and it's not simply an opposition to change.

Our decision is based on discussing this with people receiving services, some for decades, and their families or natural supports, as well as community

members.

We believe this proposal will dismantle the well-established and strong system of care that exists today on the inpatient unit and will negatively affect people with mental health disorders by significantly decreasing the likelihood of a guaranteed number of available inpatient psychiatric beds in Meriden and Wallingford, for Meriden and Wallingford residents, causing increased anxiety for patients in distress, by transferring them by ambulance to an out-of-area inpatient bed, possibly deterring people from receiving or wanting to seek treatment in the future, and, third, for creating various access for family members and other natural supports, as well as continuity of care essential for stabilization for long-term recovery.

So, in terms of the beds, you know, I think we've gone over this a lot, right? But not everybody has heard it, because you did not sit through the five hours of the last testimony.

The need for inpatient psychiatric services demand runs high in Meriden and Wallingford communities, so much so that, in 2008, when OHCA denied the request to terminate the inpatient psychiatric beds at MidState and transfer them to IOL in Hartford, OHCA

directed MidState to provide psychiatric inpatient services consisting of no less than eight licensed beds.

That's a key point. MidState, instead, operated six inpatient psychiatric beds. If the hospital had increased to the capacity of eight beds, those hundred-plus transfers per year that had been done could have been absorbed.

The other hundred, which are the children and the elderly, that is known that they don't provide that care, so, in saying that, in the proposed increase of these four beds, is not necessarily a true increase in beds, so I have the statistics wrong, in terms of licensed beds, on my chart.

So I would say the proposed capacity is now, as we heard today, is six beds, plus preferential access for four.

A second reference point is causing increased anxiety for patients. A key element to any patient's hospital stay is the proximity to care and the ability to get the care as quickly as possible, regardless of the medical emergency.

So it's especially true of people, who are in psychiatric crisis, because, many times, the decision to seek treatment is often delayed for a variety of

reasons, especially when it comes to mental health disorder.

Once a person goes to the Emergency Room, they are considered in considerable distress, so, even in the best of circumstances, an ambulance ride could cause excessive anxiety.

And they talked before about medicating patients, just to get them in the ambulance and to get them to the next step, so that would be to get to your inpatient bed.

And, then, the third point about is about creating barriers to access for family members or other natural supports, as well as continuity of care essential for stabilization and long-term recovery.

While we recognize and commend MidState and HOCC for including transportation as a component of the proposal, it is an important piece.

We assert that this would still be a barrier to the positive outcomes for patients. With limited visiting hours, it's critical that the hospital is accessible for family members and supports and the loved ones.

Also, incorporating family supports into the treatment plan is also essential for better recovery.

If services are moved to New Britain, this will be a challenge. The trip to New Britain could take over an hour round trip by car and, by bus ride, up to three hours.

And, then, if they're provided taxi vouchers and shuttles, you know, I think that the transportation plan still would need, you know, it would need to be on the forefront to say that this is truly something we want to do for you, and that this is something that is going to be, you know, how do you say it?

To me, it's challenging, as to how would you say that to people? Would say to every person that walks in the door we're going to provide transportation for you if you need it?

I think that gets a little challenging, as to how do you actually administer something like that?

So an overarching theme to this proposal is dismantling the established strong system of care in the existing inpatient unit at MidState.

Last time, I did reference, you know -- I think I wasn't sure before I met with the nurses. Well, what would these nurses at MidState be like? How will they respond?

Well, similar to when I worked at Yale, they had 10, 20, 30, 40 years of tenure at MidState, and they have held this unit together, and I think that that's a critical piece, that people might have multiple missions.

One person that wrote a letter said they had 12 admissions. Over their 12 admissions, they have had, and it's a chronic illness, so chronic illness in your lifetime, you will be there multiple times perhaps, so it's really important that you have that continuity of care.

And I think the nursing staff I truly commend them for what they have done for their patients. Especially true, if we talk about people, who had been to MidState and then experienced care in other hospitals.

That was pretty, you know -- people, who talked about really having negative experience in other hospitals and having a great experience at MidState, and, truly, we haven't heard that much about HOCC and their care. I don't know that much about it, but we would like to.

So, anyway, as I sum up, you know, some of my thoughts here, I want to say I know there's a lot of pressure on both sides for this. Believe me.

In my role as the Board, the Region Mental Health Board, and advocate, this has not been easy, because it's a very emotional situation, and we're also, you know, involved with agencies that are, you know, are on our Board. It's a very political debate, and that causes lots of challenges, so it has not been easy for the Board to say, you know what, this is not something that we agree with, but I think that we needed to do that, because a part of what we need to do is advocacy, and that's a key mission of ours.

So we hope that OHCA evaluates all the components of the CON application and the public's testimony, as well as the hospital's testimony.

We believe that closing the Psychiatric Unit at MidState and moving the bed capacity to HOCC would be detrimental to the communities of Wallingford and Meriden. Preferential would be to keep the 10 beds at MidState. I know that's not in their proposal.

Our Board acknowledges the work of the hospitals that you've put into this proposal, however, we believe the best outcome is not in this proposal as it stands.

We hope to continue to foster a strong working relationship with the hospitals as we go forward

to insure access to quality care provided for people with psychiatric disorders.

Another critical piece of this is, as the proposal moves forward, is that, you know, if this transfer does go through, it's critical that there's a collaboration between the Region Mental Health Boards, because it would also include North Central and North Central Executive Directors here, as well, in terms of are those beds being truly accessed and at what capacity, and are people being able to be served in the best possible way.

The other piece is, you know, to have an independent. I think that that's one of the key features that allows us to have a voice in this process, is we have an independent Board, and, you know, if you work for the hospital, you don't have that independence to come up here and speak. If you work for other agencies, you don't, but that's a key part of our role.

You will hear lots of great testimony today. I'm going to stop talking, so that you can hear many other people that have lots of great things to say. I appreciate the opportunity to do this.

HEARING OFFICER HANSTED: Thank you, Ms. Barber.

MS. BARBER: You're welcome. (Applause)

HEARING OFFICER HANSTED: Attorney Feldman, do you have any Cross-Exam?

MS. FELDMAN: I do. Can everybody hear? Okay. Ms. Barber, in the beginning of your testimony and I think throughout your testimony, you made certain representations with respect to the Board, and, in fact, I believe you said that there was Board consensus in opposition to the application.

Can you tell me was there a Board vote, there was a Board vote to take a position that is opposing the application?

MS. BARBER: I anticipated this question, because it's been asked to me by somebody, other than you, and wondering if the Board had taken a vote for this opposition, and, so, I've done my research on this, in a sense, if you will, because I knew that this would be a question posed to us.

And, as our Board, we've reviewed it, we've discussed it, we've taken a consensus decision to do this. An official vote of our Board was not taken, an official vote of our Board, and, as we've discussed with all my Executive Committee team and the Board, itself, members, that, by consensus, we are opposing this.

MS. FELDMAN: So you are authorized by the Board to speak on behalf of the Board in opposition, so the Board voted to authorize you to speak in opposition to this application?

MS. BARBER: The Executive Committee of our Board and our Board President asked that I do this.

MS. FELDMAN: And that was at an Executive Committee meeting?

MS. BARBER: Um-hum.

MS. FELDMAN: And there was a vote to --

MS. BARBER: There's not a vote. I said we did not vote on this.

MS. FELDMAN: Okay, that's fine. That's just want I wanted to know, whether or not there was a vote.

MS. BARBER: I know that.

MS. FELDMAN: Okay. You also made certain definitive statements with respect to increased anxiety for patients as a result of being transferred from one hospital facility to another.

Can you tell me what the scientific basis for that statement is? Scientific.

MS. BARBER: Scientific?

MS. FELDMAN: Yeah.

MS. BARBER: How would I have scientific basis?

MS. FELDMAN: Well, I guess, then, my question is how do you know that?

MS. BARBER: That's a good question. By tons of testimony from people that have -- people with psychiatric illnesses, who have had very negative experiences in ambulance rides.

MS. FELDMAN: Okay, so, it's not based on any kind of research? It's based on your speaking to individuals, who have told you that it's been a negative experience, is that correct?

MS. BARBER: That is correct.

MS. FELDMAN: Okay. You also stated in your testimony that you heard testimony from the Applicants that we medicate patients, in order -- we would have to medicate patients, in order to transport them?

MS. BARBER: Yup.

MS. FELDMAN: Specifically, for that purpose, to transport them?

MS. BARBER: Dr. Balkunas said that. That's your name, right? Yes, he said that.

MS. FELDMAN: Okay, so, you're stating

that you heard Dr. Balkunas state that patients would be specifically medicated, simply so that they could be transported, and, had they not had to be transported, they would not have received the medication? That's your statement?

MS. BARBER: That's what he said last time.

MS. FELDMAN: Okay. Thank you. I have no further questions.

HEARING OFFICER HANSTED: Okay, thank you. (Applause) Attorney Feldman, I know the doctor wanted to clarify his statement, so I'm going to allow that.

MS. FELDMAN: Thank you.

HEARING OFFICER HANSTED: Thank you.

DR. MICHAEL BALKUNAS: More specifically, what I said was that if patients needed to be medicated, or wanted to be medicated, we certainly would be willing to do that, fully realizing that patients are often scared in ambulances.

We can certainly medicate them, so that they're not fearful, or if they're agitated, but that's really the standard of care around the State and something that's actually good for a patient.

HEARING OFFICER HANSTED: Thank you.

Attorney Feldman, I just want to clarify one thing. I received your late file with regard to the transportation, and, at the previous hearing, I requested a written protocol with regard to the transportation.

Am I correct in understanding that what you've submitted as a late file is what you are relying upon in response to my request?

MS. FELDMAN: What we submitted is very much the meat of what a protocol would look like, but we, as I explained, we thought that it would be premature to develop a protocol without the input of our constituents, meaning the patients and the providers in the community.

We could, of course, do that, but what we thought would be more responsive to your request was to demonstrate what the level of commitment was that we are willing to provide, rather than how it would actually operate.

In the brochure that we provided, we tried to address the protocol pieces with respect to the access points at which patients would be able to interface with staff and receive information about the services available to them.

If you would like a more definitive protocol, you know, please forgive me for presenting it

in that format, we can do a written protocol, if that would be preferable.

HEARING OFFICER HANSTED: Yes. I would like that. I my concern is that -- I'm not questioning the commitment to provide the transportation. My concern is that I don't know how this is going to work.

MS. FELDMAN: Okay.

HEARING OFFICER HANSTED: I can't picture it in my mind.

MS. FELDMAN: Okay.

HEARING OFFICER HANSTED: I just imagine so many difficulties with that that I'd like to be at ease with that.

MS. FELDMAN: Sure. If I may, it was definitely fleshed out extensively. There have been countless discussions and meetings with a cross-section of individuals, who would be part of the process, and, basically, it would originate in the Emergency Department, where the patient would arrive and be treated in the Behavioral Health Unit in the E.D.

Family members would be contacted to the extent that we were able to contact those family members under the law at that point of access to the MidState E.D.

If we did not get consent to contact family members at that point of time, there would be, at the point of HOCC, an initiation process, where the patient, when they were ready to have that discussion, sometimes patients arrive and they're extremely psychotic, we would discuss with them who they would want us to contact, and we would initiate a call to that family member and make them aware of the services that we're providing and how we could assist them in transporting them to HOCC.

That process would also be on the back end of the visit, in terms of assisting family members with getting back to the MidState area.

So we discussed all that, and we can put that in the form of a protocol. We discussed all the logistics of that, and we could provide that to you by early next week.

HEARING OFFICER HANSTED: That would be fine. By the end of next week would be fine.

MS. FELDMAN: Okay.

HEARING OFFICER HANSTED: And what I'm looking for is, you know, from A to Z, how do you determine who gets this transportation? Who is going to pay for it? What taxi or bus service are you going to

use? Are there going to be specific pickup and drop off times, etcetera, right through to the end?

MS. FELDMAN: Okay.

HEARING OFFICER HANSTED: Okay. Thank you.

MS. FELDMAN: Just to be clear, that will be paid for by MidState Medical Center.

HEARING OFFICER HANSTED: Thank you. All right. At this time, I'm just going to take a brief five-minute break, just before we get to the public portion of tonight's hearing, so I'll break for five minutes. Thank you.

(Whereupon, the public comment portion of the hearing commenced.)

HEARING RE: OFFICE OF HEALTH CARE ACCESS
DECEMBER 6, 2012

AGENDA

CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness whereof I have hereunto set my hand and do so attest to the above, this 10th day of December, 2012.

Paul Landman
President

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

IN RE: MIDSTATE MEDICAL CENTER, THE HOSPITAL OF CENTRAL CONNECTICUT AND HARTFORD HEALTHCARE CORPORATION- TERMINATION OF INPATIENT BEHAVIORAL HEALTH SERVICES AT MIDSTATE MEDICAL CENTER	:	**DOCKET NO. 12-31775-CON**
	:	**December 14, 2012**

LATE-FILE TESTIMONY OF MIDSTATE MEDICAL CENTER ON BEHALF OF THE APPLICANTS IN CONNNECTION WITH AND IN SUPPORT OF THE ABOVE-REFERENCED PROCEEDING

Accompanying this cover sheet is the late-filed testimony of MidState Medical Center on behalf of the Applicants in the above-referenced proceeding.

Respectfully Submitted,

MIDSTATE MEDICAL CENTER
THE HOSPITAL OF CENTRAL CONNECTICUT
HARTFORD HEALTHCARE CORPORATION

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

IN RE: MIDSTATE MEDICAL CENTER, THE HOSPITAL OF CENTRAL CONNECTICUT AND HARTFORD HEALTHCARE CORPORATION- TERMINATION OF INPATIENT BEHAVIORAL HEALTH SERVICES AT MIDSTATE MEDICAL CENTER	:	**DOCKET NO. 12-31775-CON**
	:	**December 14, 2012**

MIDSTATE MEDICAL CENTER'S LATE FILE TESTIMONY IN CONNNECTION WITH THE ABOVE-REFERENCED PROCEEDING

1. Clarification With Respect to The Hospital of Central Connecticut's ("HOCC") Bed Preference for MidState Medical Center ("MidState") Patients Requiring Inpatient Psychiatric Admission.

Patients presenting to MidState's Emergency Department who require inpatient psychiatric admission (the "MidState Patients") will be given admission preference for up to ten (10) inpatient beds on HOCC's inpatient psychiatric unit. Specifically, HOCC will keep one (1) bed open or unoccupied on its inpatient psychiatric unit so long as there are less than six (6) MidState Patients admitted to the HOCC unit. Once all six (6) beds are occupied by MidState Patients, MidState Patients will be given preference to beds seven (7) through ten (10). "Preference" means that if there is a MidState Patient and a HOCC patient who are both in need of the inpatient bed, the bed will go to the more medically needy patient, as determined by a HOCC psychiatrist. In the event that the HOCC patient needs inpatient admission, the MidState patient will remain in the MidState Emergency Department's Acute Behavioral Health Unit until the next HOCC bed becomes available, which will automatically be given to the MidState Patient. As stated previously, HOCC experiences, on average, four (4) to five (5) discharges per day, which will likely result in a MidState Patient not waiting more than twenty four (24) hours before admission onto HOCC's inpatient psychiatric unit. Accordingly, and if this Application is approved, MidState Patients will have expanded and preferential access to ten (10) inpatient psychiatric beds on a state-of-the-art unit.

2. Clarification With Respect to MidState's Plan to Offer Transportation Assistance to Family and Loved Ones of Patients Requiring Transportation Assistance to and from HOCC.

If the Application is approved, MidState will offer transportation assistance to family and loved ones of MidState Patients. MidState is committed to making the transportation service as accessible and as uncomplicated for the users as possible. MidState proposes that it contract, at its sole expense, with a transportation company to provide transportation assistance by van from MidState to HOCC during visiting hours. Please see the written Transportation Assistance Protocol and the transportation assistance patient brochure attached hereto as

Exhibits A and B, respectively. In addition, the Advisory Committee comprised of representatives from HOCC, MidState, consumers, and providers shall evaluate patient access for MidState patients to the HOCC inpatient psychiatric unit along with the effectiveness of the transportation assistance services and make adjustments as needed.

3. HOCC's Inpatient Psychiatric Unit Follows Best Practices With Respect to Staffing and Treatment.

Hartford HealthCare is committed to establishing and implementing a single standard of high-quality care across its behavioral health network. Currently, HOCC's inpatient psychiatric unit adheres to the American Psychiatric Association's Best Practice Guidelines in providing treatment to all of its patients. The HOCC inpatient psychiatric unit is accredited by the Joint Commission and in its last survey received high praise with respect to its training of its psychiatric registered nurses. HOCC's patient satisfaction scores have consistently been at the ninetieth percentile (90%). HOCC's inpatient psychiatric unit is a teaching unit with medical residents regularly present on the unit. There are cross disciplinary meetings with all treating clinicians held three (3) times weekly wherein ongoing education is provided at least once per week on topics of mutual interest to the staff. The proposed staffing for the proposed expanded unit is set forth in Exhibit C attached hereto. This staffing level is commensurate with the staffing levels of the Hartford Hospital Institute of Living and Natchaug Hospital. HOCC's inpatient psychiatric unit's Nurse Manager will periodically evaluate the staffing plan taking into consideration the number of admissions, discharges, and transfers, and the education and skills of the nursing staff.

Certificate of Service

I hereby certify that a true and correct copy of the foregoing late file testimony was mailed via first class United States mail or emailed this 14th day of December 2012 to:

Connecticut Legal Rights Project
1000 Silver Street
P.O. Box 351
Beers Hall, 2nd Floor
Middletown, CT 06457
Attn: Jan VanTassel

And to

Paul C. Horton, M.D.
240 Pomeroy Avenue, Suite 205
Meriden, CT 06450

And to

Region II, Regional Mental Health Board, Inc.
P.O. Box 351
Middletown, CT 06457
Attn: Kristie Barber
Executive Director

And to

Susan Duclos, R.N.
susiern59@aol.com

Joan Feldman

Joan Feldman, Esq.

Exhibit A
Transportation Assistance Protocol

MidState Medical Center & The Hospital of Central Connecticut
Transportation Assistance Protocol

MidState Medical Center ("MidState") is committed to providing transportation assistance to families and loved ones (collectively, "Significant Others") of all behavioral health patients requiring inpatient admission to the Hospital of Central Connecticut's inpatient behavioral health unit ("HOCC") from MidState's Acute Behavioral Health Unit ("ABU").

MidState and HOCC have developed a protocol to specifically meet the transportation needs of this patient population. Administration of this policy will be as follows:

A. Transportation Assessment at MidState:

1. Once a decision has been made to transfer a patient to HOCC, the MidState ABU's Crisis Clinician will discuss transportation needs and options with all patients and their Significant Others, subject to the patient's consent.

2. With the patient's consent, Significant Other(s) identified by the patient will be contacted by the Crisis Clinician (or their designee) to determine if they desire transportation assistance from MidState to HOCC and back to MidState from HOCC. If transportation assistance is requested, the Crisis Clinician will describe the transportation assistance services offered by MidState. Written information regarding the transportation assistance services will be given to the interested Significant Others. If the discussion cannot occur at the time of transfer, the Crisis Clinician will make timely contact with the appropriate Significant Other(s) to both notify them of the patient's whereabouts and the transportation assistance services that are available.

3. Those who request transportation assistance will be provided with the toll free telephone number of the Metropolitan Healthcare Service dispatch and be informed that they may call and schedule daily transportation directly with Metropolitan Healthcare Service to and from MidState and HOCC between the hours of 8:00 a.m. and 8:00 p.m., 7 days a week.

4. MidState will pay the full cost of the transportation assistance services between MidState and HOCC for all who request the service regardless of their financial status.

B. Transportation Assessment at HOCC:

1. Prior to the transfer of the patient from MidState to HOCC, a transfer report will be given to HOCC staff. The transfer report will include the status of transportation requests of Significant Other(s). In addition, HOCC clinical staff will confirm transportation assistance requests once the patient has been admitted to ensure that transportation is not an obstacle to visitation. In addition, all patients will be provided

with the transportation assistance brochure.

2. Those who request transportation assistance will be provided with the toll free telephone number of the Metropolitan Healthcare Service and be informed that they may call and schedule daily transportation directly with Metropolitan Healthcare Services to and from MidState and HOCC between the hours of 8:00 a.m. and 8:00 p.m., 7 days a week.

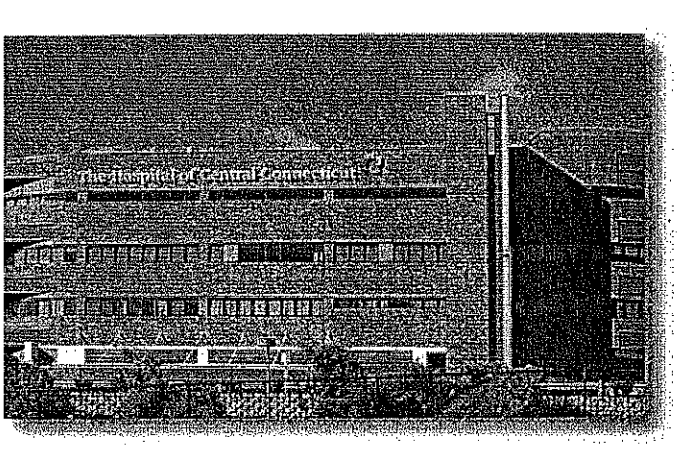
3. MidState will pay for the cost of transportation between MidState and HOCC for all who request the service regardless of their financial status.

C. Quality Assurance:

The Advisory Committee comprised of representatives from HOCC, MidState, consumers and providers shall evaluate the effectiveness of the transportation assistance services based on utilization information collected by MidState and HOCC. MidState will periodically review the effectiveness of and compliance with this protocol.

Exhibit B
Transportation Assistance Patient Brochure

Transportation Assistance for Family and Loved Ones Visiting The Hospital of Central Connecticut



MidState Medical Center offers transportation assistance to families and loved ones of patients being transferred from MidState's emergency department to The Hospital of Central Connecticut's inpatient behavioral health unit. Transportation assistance is provided by Metropolitan Healthcare Services.

The transportation service will be available seven days a week, from 8:00 a.m. until 8:00 p.m., covering visiting hours as well as any family meetings that may be scheduled outside of normal visiting hours.

Family members and loved ones will be picked up at MidState Medical Center and taken directly to The Hospital of Central Connecticut. The van will bring passengers back to MidState Medical Center at the end of the visit.

Family members or loved ones interested in making a reservation should call the Metropolitan Healthcare dispatcher at XXX-XXXX.

Visiting Hours at The Hospital of Central Connecticut

Visiting hours at The Hospital of Central Connecticut are held daily from 12:30 p.m. to 1:30 p.m. and from 6:00 p.m. to 7:00 p.m. Visitors under the age of 13 are not permitted.

MidState Medical Center
A Hartford HealthCare Partner

Exhibit C
HOCC's Proposed Staffing Levels

UNIT W1
ADC 32.00
Pat. Days: 11680

MONDAY - SUNDAY STAFFING GRIDS - AVERAGED
FY 2013

		CENSUS:	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
		SKILL																			
SHIFTS	D	RN	3.00	3.00	3.00	3.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	5.00	5.00	5.00	5.00	5.00	6.00	6.00	6.00
	A	NT	1.00	2.00	2.00	2.00	2.00	2.00	3.00	3.00	3.00	3.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00
	Y	SEC	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	E																				
	V	RN	3.00	3.00	3.00	3.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	5.00	5.00	5.00	5.00	5.00	6.00	6.00	6.00
	E	NT	1.00	2.00	2.00	2.00	2.00	2.00	3.00	3.00	3.00	3.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00
	S	SEC	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	N	RN	2.00	2.00	2.00	2.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00
	I	NT	1.00	1.00	1.00	2.00	2.00	2.00	2.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
	G																				
	H																				
	T																				
Total # of 8 hour shifts			13.0	15.0	15.0	16.0	19.0	19.0	21.0	22.0	22.0	22.0	24.0	27.0	27.0	27.0	27.0	27.0	29.0	29.0	29.0
Total Hours			104.0	120.0	120.0	128.0	152.0	152.0	168.0	176.0	176.0	176.0	192.0	216.0	216.0	216.0	216.0	216.0	232.0	232.0	232.0
Pattern Worked HPPD			7.43	8.00	7.50	7.53	8.44	8.00	8.40	8.38	8.00	7.65	8.00	8.64	8.31	8.00	7.71	7.45	7.73	7.48	7.25
Direct Care Hours PPD exclude sec.			6.29	6.93	6.50	6.59	7.56	7.16	7.60	7.62	7.27	6.96	7.33	8.00	7.69	7.41	7.14	6.90	7.20	6.97	6.75
Administrative / Other FTE Coverage:																					
Director FTE (Mon - Fri)																					
Social Worker			2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80	2.80
Occupational Ther (Mon - Fri)			2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
Sitter			2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
Orientation / MTG FTE			1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10
Clinical Manager			1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Total fte			8.90	8.90	8.90	8.90	8.90	8.90	8.90	8.90	8.90	8.90	8.90	8.90	8.90	8.90	8.90	8.90	8.90	8.90	8.90
Total Prod. Worked HPPD			10.78	11.13	10.43	10.29	11.05	10.47	10.75	10.61	10.13	9.69	9.95	10.52	10.11	9.74	9.39	9.07	9.30	9.00	8.72
Pattern-Actual Paid HPPD			11.82	12.21	11.45	11.29	12.14	11.50	11.81	11.67	11.13	10.65	10.94	11.56	11.12	10.71	10.33	9.97	10.23	9.90	9.59
Projected FY'2013 budg. Paid HPPD			9.97	9.97	9.97	9.97	9.97	9.97	9.97	9.97	9.97	9.97	9.97	9.97	9.97	9.97	9.97	9.97	9.97	9.97	9.97
Pattern-Budget PHPPD (Shifts)			3.24	4.20	2.96	2.81	4.88	3.63	4.59	4.45	3.20	1.96	2.92	4.98	3.74	2.49	1.24	0.00	0.96	-0.29	-1.53
Pattern Calculated FTEs			29.04	32.14	32.14	33.69	38.34	38.34	41.44	42.99	42.99	42.99	46.09	50.73	50.73	50.73	50.73	50.73	53.83	53.83	53.83
Total Hours over/under for all shifts			25.92	33.61	23.64	22.50	39.02	29.05	36.74	35.60	25.63	15.66	23.35	39.87	29.90	19.93	9.96	-0.01	7.68	-2.29	-12.26

RN WHPPD	4.57	4.27	4.00	3.76	4.89	4.63	4.40	4.19	4.00	3.83	3.67	4.48	4.31	4.15	4.00	3.86	4.27	4.13	4.00
NT/S WHPPD	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
TTL Dir WHPPD	6.29	6.93	6.50	6.59	7.56	7.16	7.60	7.62	7.27	6.96	7.33	8.00	7.69	7.41	7.14	6.90	7.20	6.97	6.75
Other.WHPPD	4.49	4.19	3.93	3.70	3.49	3.31	3.15	3.00	2.86	2.73	2.62	2.52	2.42	2.33	2.25	2.17	2.10	2.03	1.97

SUPPLEMENTARY TESTIMONY OF JAN VANTASSEL TO OHCA
RE: MID STATE REQUEST TO CLOSE INPATIENT BEDS

I am the founder and co-chair of the Keep the Promise Coalition, a statewide organization established in 1999 to advocate for a comprehensive, community based system of mental health supports and services in Connecticut.

My testimony at the public hearing on December 6th emphasized the disconnect that appears to exist in the interactions and communications between the Hartford Health Network and the consumers and advocates in the Meriden/Wallingford region. In fact, one of the primary reasons that I chose to testify was because of the eloquent statements of Keep the Promise members about their reaction to the proposed closure of the inpatient beds at Mid State. They believe that they are the target of discrimination and that their concerns are secondary to corporate needs. In short, they have not been heard or respected at a time when person-centered care is supposed to be the standard.

However, I do not believe that I adequately conveyed my firm belief that Mid State simply has not made a strong case for closing these beds. There is no question that there is a demand in the Meriden/Wallingford area for inpatient beds. That was OHCA's finding in 2008, and that remains true today. While the applicant's attorney seems to have a different answer at each hearing for the reason that Mid State did not operate eight beds when ordered by OHCA to do so, the fact remains that they did not do so. Therefore, the fact that Mid State chose to send patients to other facilities should not be used against consumers to justify bed closure.

In addition, there appears to be no question that Mid State is financially solvent and has the capacity to operate ten beds to meet the community demand in the Meriden/Wallingford area. In fact, it was suggested that they have the space to operate more if necessary to meet local needs, such as young adults.

Despite the assertions that bigger units provide better treatment, there was no clear and convincing evidence that outcomes would be better at HOCC or that the therapies provided would be better. In fact, it appeared that Mid State outcomes were positive and provided more opportunity for continuity of care and access to friends and family members. I was particularly touched by one family member who indicated that they visited the hospital on their lunch hour. As one who had to fit visiting my institutionalized mother into my schedule, I could relate to this statement. It reminded me that we are not simply talking about the miles between the facilities. We are talking about assuring that a person in crisis has a real opportunity to see friends and family who are essential to their recovery.

Given these facts, it seems illogical to me that so much time, and some money, is being invested in setting up a transportation assistance system, establishing protocols to assure bed preferences, medicating patients for what they consistently report is an anxiety-provoking ambulance ride, and sending liaisons between HOCC and Mid State, to replace what they already have in Meriden.

If HOCC wants to proceed with its expansion, I have no doubt that those beds will be filled, and they don't need to close the ones in Meriden to do that. If they do so, it would provide an opportunity to actually compare outcomes and treatments, based on reality, not promises. Then perhaps, people from Meriden will demand access to those improved treatments. However, right now all they have are promises from a corporation that has not kept its promises in the past.

For these reasons, I urge you to deny the Mid State request to close its inpatient psychiatric beds.

REGION II
REGIONAL MENTAL HEALTH BOARD, INC.

Facsimile Transmission

TO: Atty Kevin Hennick, Hearing Officer

Fax#: 860-418-7053

Tel#: _____

From:
Kristie Barber
Executive Director, Region II Regional Mental Health Board
Tel: 860-262-5029 Fax: 860-262-5028

Date: 12/14/12

RE: MidState.

Number of Pages, Including cover:

Kevin,
I am attaching the testimony of people who were not able to participate in the hearing. The testimony is handwritten & typed for you.

Thank you,
Kristie

P.O. Box 351, Middletown, CT 06457
Phone (860) 262-5027 * Fax (860) 262-5028
Email: rmhb2@aol.com

11-5-2012

Dear whom it may concern:

I am writing in regard to the closing of the psychiatric unit at Midstate Medical Center. I am a consumer of this psychiatric unit and believe it should not be shut down. First it is conveniently located close to where I live here in Meriden. Second, it is close to my family to visit me while I'm in the hospital. Third, it is easier for the staff at Midstate Medical Center in the psychiatric unit to contact the staff at Rushford with my follow-up plans after I am discharged from the hospital. Fourth, I receive excellent services from the staff there. There is a lot of one-on-one care. They help you identify the problems that led you there, how to get inside/outside support, and with discharge plans. They have groups during the day as nurse assigned to you, psychiatrist & social worker check with you to see how you are doing.

Since I have been to the psychiatric unit at Midstate more than ~~a dozen times~~ several times, I find that the unit has been more than helpful and that it should not be closed. We need it to continuously be open to help me and those who need it.

Sincerely,

Jill C. Overbye

The Friendship Club

11/5/2102

I am writing in regard to the closing of the psychiatric unit at Midstate Medical Center. I am a consumer of this psychiatric unit and believe it should not be shut down. First, it is conveniently located close to where I live here in Meriden. Second, it is close to my family to visit me while I'm in the hospital. Third, it is easier for the staff at Midstate Medical Center in the psychiatric unit to contact the staff at Rushford with my follow-up plans before I am discharged from the hospital. Fourth, I receive excellent services from the staff there. There is a lot of one-on-one care. They help you identify the problems that led you there, how to get inside/outside support, and with discharge plans. They have groups during the day, a nurse assigned to you and psychiatrist and social worker to check with you to see how you are doing.

Since I have been to the psychiatric unit at Midstate more than several times, I find that the unit has been more than helpful and that it should not be closed. We need it to continuously be open to help me and those who need it.

Sincerely,

Jill C. Overbye

To whom it may concern

It has come to my attention that the psych ward at midstate may be changing somewhere else. I think this is not a Good Idea because many people are used knowing and Understanding this Great local cores in the near community. I have been there three times and it has been very benefitial and my Family was more reasured I was there close by. Please keep this very valuable System of mental Health where it is to enable people like me a propper place to heal ~~my~~ the emotional difficulties and mental problems for a great recovery and a good commuting back to the

The Friendship Club

To Whom It May Concern:

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Please keep this very valuable system of mental health where it is to enable people like me a proper place to heal the emotional difficulties and mental problems for a great recovery and a good commute back to the community.

Jonathan Stracher

The Friendship Club

11/6/12

To Whom It May Concern!

1. The families of the in-patients would feel an inconvenience to see their loved ones & have to use more gas & find transportation.

2. The local staff is out standing & we know them and we don't want to start all over with new staff.

3. Patients have a history with their local doctors & don't want to go to new doctors in New Britain.

4. It is hard for some people to rehash their stories again to strangers.

5. People get better faster in familiar surroundings.

These are the reasons that I feel the In-Patient unit should stay in Meriden.

Nancy Schiavone LR

Meriden

TAKen over the phone

To Whom It May Concern: 11/6/2012

1. The families of the in-patients would feel an inconvenience to see their loved ones and have to use more gas and find transportation.

2. The local staff is outstanding and we know them and we don't want to start all over with new staff.

3. Patients have a history with their local doctors and don't want to go to new doctors in New Britain.

4. It is hard for some people to rehash their stories again to strangers.

5. People get better faster in familiar surroundings.

These are the reasons that I feel the In-Patient Unit should stay in Meriden.

Nancy Schiavone

The Friendship Club 11/6/12

To Whom It May Concern:

Though I have not been to the in-patient unit in many years, I am speaking my thoughts + those of my fellow friends.

1. It would be too difficult for families to see their loved ones if unit was moved to New Britian.

2. Question abilities of reliable transportation that would be provided.

3. Too far for for local poor people to travel + understand the way to access services.

4. People want to be in their familiar Community because it is more Comfortable

5. People will get better quicker in familiar surroundings.

Please keep the In-Patient Psych-Unit in Meriden.

Signed - Joyce Heck
Wallingford

TAken over the phone - NR

The Friendship Club

To Whom It May Concern:

Though I have not been to the in-patient unit in many years, I am speaking my thoughts and those of my fellow friends.

1. It would be too difficult for families to see their loved ones if the unit was moved to New Britain.

2. Question the abilities of reliable transportation that would be provided.

3. Too far for local poor people to travel and understand the way to access services.

4. People want to be in their familiar community because it is more comfortable.

5. People will get better quicker in familiar surroundings.

Joyce Heck

11/5/12

To Whom it concerns.

Please Keep the psychiatric unit at Midstate Medical Center in operation. Here are my reasons for this request. These are only some of my reasons.

1. This facility would cause unnecessary job losses if it were to be shut down. Psychiatrists would have to find employment at other locations and possibly out of state.
2. With gas prices rising and the economy falling, clients would be forced to spend money on gas to travel to other cities just to receive treatment causing an extra expense they and their families cannot afford.
3. For those clients and their families who have no transportation it would isolate the patients from their support systems causing longer stays and longer recovery time. The doctors in Meriden know their clients and sending people to strangers who make guesses on the best treatment because a psychiatrist doesn't know their history or diagnosis is dangerous. Possibly even deadly if a client is confused and can't tell the doctor of their allergies.

Truly,

Valerie

The Friendship Club

11/5/2012

To Whom It Concerns:

Please keep the psychiatric unit at Midstate Medical Center in operation. Here are my reasons for this request. These are only some of my reasons.

1. This facility would cause unnecessary job losses if it were to be shut down. Psychiatrists would have to find employment at other locations and possibly out of state.

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Truly,

Valerie

11/5/12

To whom it concerns,

The reasons I would like to keep the Psych beds at Midstate are:

1. It is closer to my home.
2. It is closer to my relatives home and they would visit me at Midstate but they would not visit me if I were in New Britian and by visiting me, it would help greatly with my recovery.

I have been there 3 times and they have been a good support and a wonderful location.

Beverly Comfort-Gillotti

The Friendship Club

11/5/2012

The reasons I would like to keep the psych beds at Midstate are:

1. It is closer to my home.

2. It is closer to my relative's home and they would visit me at Midstate, but they would not visit me if I were in New Britain and by visiting me, it would help greatly with my recovery.

I have been there 3 times and they have been a good support and a wonderful location.

Beverly Comfort-Gillottie

To whom It May It Concern, 11/5/12

I am speaking from my heart. The psych ward is needed at MidState hospital! I am speaking from experience! It is a very needed place to have there. I will speak for myself! For the last ten years, I have been there on and off as an impatient. The rooms are neet and clean and the staff are great and helpful. If this place is closed down, we will have to go to a place further away. That would be a big inconvience to a lot of people! The other assets there are, the beds, the way we are treated and the doctors are great and have a very good bed side manner. So I will come to my point! Please don't move the beds out or the psych ward out either from the MidState hospital!!

Thank You,

Janice L. Wedwell

The Friendship Club

11/5/2012

To Whom It Concerns:

I am speaking from my heart. The psych ward is needed at Midstate Hospital. I am speaking from experience. It is a much needed place to have there. I will speak for myself. For the last ten years, I have been there on and off as an inpatient. The rooms are neat and clean and the staff is great and helpful. If this place is closed down, we will have to go to a place further away. That would be a big inconvenience to a lot of people. The other assets there are the beds, the way we are treated and the doctors are great and have a very good bedside manner. So I will come to my point! Please don't move the beds out or the psych ward out either from the Midstate Hospital!!

Thank you,

Janice L. WidiWilt

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 20, 2012

Via Facsimile

Ms. Barbara A. Durdy
Director, Business Development
MidState Medical Center
435 Lewis Ave.
Meriden, CT 06451

RE: Certificate of Need Application, Docket Number 12-31775-CON
MidState Medical Center, The Hospital of Central Connecticut and
Hartford HealthCare Corporation
Proposal to Terminate Inpatient Behavioral Health Services at MidState Medical Center
Closure of the Public Hearing

Dear Ms. Durdy:

On December 14, 2012, the Office of Health Care Access ("OHCA") received the information requested by OHCA as a late file submission from the public hearing held in this matter on December 6, 2012. With the receipt of the late file submission the hearing on the above application is hereby closed.

If you have any questions regarding this matter, please feel free to contact Brian Carney or Laurie K. Greci at (860) 418-7001.

Sincerely,

Kevin Hansted
Hearing Officer

Copy: Claudio Capone, The Hospital of Central Connecticut
Karen Goyette, Hartford HealthCare Corporation
Joan W. Feldman, Esq., Shipman and Goodwin, LLP
Kristie Barber, Regional Mental Health Board, Inc., Region II
Susan Duclos, R.N. (via email)
Paul C. Horton, M.D.
Kirk W. Lowry, Connecticut Legal Rights Project, Inc.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3217
RECIPIENT ADDRESS	98602625028
DESTINATION ID	
ST. TIME	12/20 12:45
TIME USE	00'21
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Kristie Barber

FAX: 860 262 5028

AGENCY: Reg II Regional Mental Health Board

FROM: Laurie Greci

DATE: 12/20/2012 TIME: _____

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Re: 12-31775-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
****

TRANSMISSION OK

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DESTINATION ID	
ST. TIME	12/20 12:47
TIME USE	00'22
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Karen Goyette

FAX: 860 545 2127

AGENCY: Hartford Healthcare Corp

FROM: Laura Greci

DATE: 12/20/2017 TIME: _____

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Re: 12-31775-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3220
RECIPIENT ADDRESS	98602245740
DESTINATION ID	
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TIME USE	00'29
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Claudio Capone

FAX: 860 224 5740

AGENCY: Hosp of Central CT

FROM: Laura Greci

DATE: 12/20/2012 TIME: _____

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Re: 12-31775-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
****

TRANSMISSION OK

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ST. TIME	12/20 12:49
TIME USE	00'21
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Barbara Durdy

FAX: 203 694 7601

AGENCY: MidState MC

FROM: Laurie Greci

DATE: 12/20/2012 TIME: _____

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Re: 12-31775 -CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3224
RECIPIENT ADDRESS	98602625035
DESTINATION ID	
ST. TIME	12/20 14:11
TIME USE	00'24
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Kirk Lowry

FAX: ~~860~~ 262 5035

AGENCY: CT Legal Rights Project

FROM: Laurie Greci

DATE: 12/20/2012 TIME: _____

NUMBER OF PAGES: 2
(including transmittal sheet

Comments: Re: 12-31775-CON

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: Greer, Leslie
Sent: Thursday, December 20, 2012 1:17 PM
To: 'susiern59@aol.com'
Cc: Greci, Laurie; 'Carney, Brian'
Subject: MidState Medical Center DN: 12-31775-CON
Attachments: 31775.pdf

Tracking:

Recipient	Delivery
'susiern59@aol.com'	
Greci, Laurie	Delivered: 12/20/2012 1:17 PM
'Carney, Brian'	Delivered: 12/20/2012 1:17 PM

Ms. Duclos,
Attached is a letter from OHCA stating the closing of public hearing for MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation.

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca

Paul C. Horton, M.D. 240 Pomeroy Ave., Suite 205 • Meriden, CT 06450

FAX

Date 12/21/12

Number of pages including cover sheet 3

To
Mr. Kevin Hansted

Phone

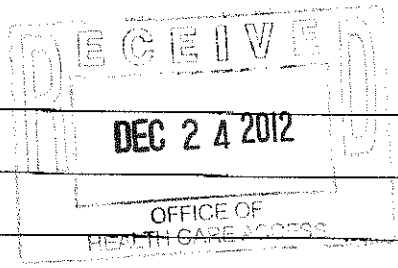
Fax # 860-418-7053

From
Paul C. Horton, M.D.

Phone (203) 235-2505

Fax # (203) 235-2506

REMARKS: ☐ Urgent ☐ For your review ☐ Reply ASAP ☐ Please comment



Paul C. Horton, M.D.
240 Pomeroy Avenue, Suite 205
Meriden, Connecticut 06450

Telephone (203) 235-2505
Facsimile (203) 235-2506
phortonmd@aol.com

December 21, 2012

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

And to
Connecticut Legal Rights Project
1000 Silver Street
P.O. Box 351
Beers Hall, 2nd floor
Middletown, CT 06457
Attn: Jan VanTassel

And to
Region II, Regional Mental Health Board, Inc.
P.O. Box 351
Middletown, CT 06457
Attn: Kristie Barber
Executive Director

And to
Susan Duclos, R.N.
susiern59@aol.com

And to
Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103
Joan Feldman, Esq.

Re: MidState Proposal to close Inpatient Psychiatric Services

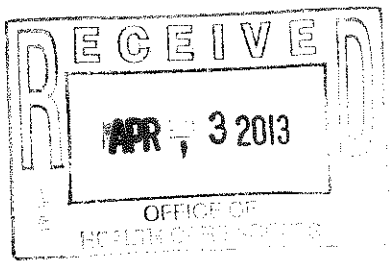
The Newtown 'incident' is the tip of a looming iceberg of mental issues that requires urgent address by all parties concerned. In short, this is not the time to be closing the MidState Psychiatric Inpatient Unit or, for that matter, any psychiatric units anywhere in Connecticut.

Respectfully,

Paul C. Horton, M.D.

Hartford HealthCare

April 2, 2013



Deputy Commissioner Lisa A. Davis
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, Connecticut 06134-0308

RE: Docket Number: 12-31775-CON
Project Title: Termination of Inpatient Behavioral Health Services at MidState Medical Center

Dear Deputy Commissioner Davis:

On behalf of Hartford HealthCare, enclosed please find the signed Agreed Settlement for CON Docket 12-31775-CON - Termination of Inpatient Behavioral Health Services at MidState Medical Center ("MidState"). We would like to thank you and your staff for the thoughtful time and consideration you afforded MidState and The Hospital of Central Connecticut ("HOCC") during the review and deliberation of this important application.

This proposal represents Hartford HealthCare's interest in finding opportunities to best meet the health care needs of the communities it serves in the most cost-effective manner, while enhancing quality and access. With health care reform and the downward pressures on funding, we appreciate the Office of Health Care Access' recognition that as health care providers we need to transform how care is delivered in the state. Your approval of this project allows MidState and HOCC to provide more comprehensive behavioral health care within Central Connecticut with a coordinated and consolidated approach to service delivery.

As you are aware, the state's hospital funding cuts at the end of last year and the proposed additional reductions in Medicaid payments significantly impact HOCC. We would like to inform you that we plan to have continued discussions with the Department of Mental Health and Addiction Services and the Department of Social Services as we evaluate the funding required to support this project.

It is our privilege to provide care to the communities we serve, and we look forward to working with the state on this important initiative.

Sincerely,

Lucille Janatka, Senior Vice President
Hartford HealthCare
President and Chief Executive Officer
MidState Medical Center

Clarence Silvia, Senior Vice President
Hartford HealthCare
President and Chief Executive Officer
The Hospital of Central Connecticut

cc: Elliot Joseph
Kimberly Martone

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Agreed Settlement

Applicants:

MidState Medical Center
435 Lewis Avenue, Meriden, CT 06451

The Hospital of Central Connecticut
100 Grand Street, New Britain, CT 06050

Hartford HealthCare Corporation
80 Seymour Street, Hartford, CT 06102

Docket Number: **12-31775-CON**

Project Title: **Termination of Inpatient Behavioral Health Services at MidState Medical Center**

Project Description: MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation (hereinafter collectively referred to as the "Applicants") seek authorization to terminate inpatient behavioral health services at MidState Medical Center.

Procedural History: The Applicants published notice of their intent to file a CON application in the *RecordJournal* (Meriden) on April 22, 23 and 24, 2012. OnJuly 18, 2012, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application from the Applicants for the above-referenced project. On September 28, 2012, OHCA deemed the CON application complete.

On October 12, 2012, the Applicants were notified of the date, time and place of the public hearing. On October 15, 2012, a notice to the public announcing the hearing was published in the*Record Journal.* Thereafter, pursuant to Conn. Gen. Stat. § 19a-639a, a public hearing regarding the CON application was held on November 7, 2012.The hearing was continued on December 6, 2012.

Commissioner Jewel Mullen designated Attorney Kevin T. Hansted as the hearing officer in this matter. The hearing was conducted as a contested case in accordance with the provisions of the

Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes.) and Conn. Gen. Stat. § 19a-639a.

By petition dated November 1, 2012, the Connecticut Legal Rights Project, Inc. requested Intervenor status with full rights of cross-examination regarding the Applicants' CON application. The Hearing Officer designated Connecticut Legal Rights Project, Inc. as an Intervenor with full rights of cross-examination.

By petition dated November 1, 2012, Paul C. Horton, M.D. requested Intervenor status with full rights of cross-examination regarding the Applicants' CON application. The Hearing Officer designated Dr. Horton as an Intervenor with full rights of cross-examination.

By petition dated November 5, 2012, Susan Duclos, R.N. requested Intervenor status regarding the Applicants' CON application. The Hearing Officer designated Ms. Duclos as an Intervenor with limited rights.

By petition dated November 16, 2012, the Regional Mental Health Board, Inc. requested Intervenor status regarding the Applicants' CON application. The Hearing Officer designated the Regional Mental Health Board as an Intervenor with limited rights.

The Hearing Officer heard testimony from the Applicants' and Intervenors'witnesses, and in rendering this proposed final decision,Deputy Commissioner Davis considered the entire record of the proceeding. The public hearing record was closed on December 20, 2012.

Findings of Fact

1. MidState Medical Center ("MidState") is a not-for-profit hospital located at 435 Lewis Avenue, Meriden, Connecticut. Ex. B, p. 7.

2. The Hospital of Central Connecticut ("The Hospital of Central CT") is a not-for-profit hospital located at 100 Grand Street, New Britain, Connecticut. The hospital also has a second campus in Southington.Ex. B, p. 7.

3. Hartford HealthCare Corporation is an integrated health care delivery system. The system's behavioral health network known as "Hartford HealthCare Behavioral Health Network" includes Hartford Hospital, the Institute of Living, The Hospital of Central CT, MidState, Natchaug Hospital and Rushford. Ex. B, p. 8, 13.

4. Rushford is a comprehensive not-for-profit behavioral health prevention and treatment provider located at 883 Paddock Avenue, Meriden, Connecticut. Ex. B, p. 117.

5. The Applicants state that Hartford HealthCare Behavioral Health Network conducted a thorough review of all behavioral health resources within the Hartford HealthCare

Corporation system to determine how and where the behavioral health service would be provided in the most effective and efficient manner. Ex. B, p. 178

6. The Applicantsareproposingtheterminationof MidState's inpatient behavioral health services and the arrangementof preferred inpatient status at The Hospital of Central CT, New Britain campus for MidState patients in need of behavioral health inpatient treatment. Ex., B, p. 8.

7. MidState currently operates six beds in itsinpatient behavioral health unit ("inpatient unit") for adults. Ex. B, p. 9.

8. The Hospital of Central CT currently operates a 22-bed unit dedicated to inpatient behavioral health services at its New Britain campus. As part of the proposal, The Hospital of Central CT will increase the number of beds in the unit by 10 to create a 32-bed unit. Ex. B, p. 8.

9. MidState,The Hospital of Central CT and Rushford have entered into a Memorandum of Understanding ("MOU") to address the coordination of behavioral health needs in the community. The MOU includes the following provisions:
    a. MidState patients requiring inpatient admission will have preferential access to no fewer than ten beds at The Hospital of Central CT;
    b. MidState staff will help patients gain access to inpatient beds within the Hartford HealthCare Behavioral Health Network, i.e., Hartford Hospital/Institute of Living and Natchaug Hospital, in the event that a bed is not immediately available at The Hospital of Central CT;
    c. MidState will provide transportation assistance to family members and loved ones to visit and participate in treatment of patients admitted to the Hospital of Central CT,from MidState;
    d. Rushford will work cooperatively with MidState and The Hospital of Central CT to arrange follow-up community-based care with priority access to Rushford's Meriden outpatient center after discharge, including next-day appointments;
    e. Rushford will regularly follow-up with MidState patients to ensure compliance with discharge instructions and medications; and
    f. The Hospital of Central CT will form an advisory committee with representation from MidState and Rushford that will meet monthly and monitor compliance with the principles of the MOU and review access and quality data reports for MidState patients.
    Ex. B, pp. 39-40

10. MidState will work concurrently with Rushford to enhance community-based servicesso that behavioral health patients have more services available to them, remain stable in the community and help avoid inpatient admissions. Ex. B, p. 9.

11. Although this proposal would terminate inpatient behavioral health care at MidState, MidState will continue to operate a 9-bed, secure acute care behavioral health unit

("ABU")[1] within its emergency department. The ABU is newly designed with private patient rooms and is staffed by psychiatric nurses. Ex. B, p. 10.

12. John McIntyre, M.D., board-certified psychiatrist[2] and clinical professor of psychiatry at the University of Rochester, attests that the 9-bed ABU unit is a tremendous resource for patients in the community given the size of the unit – in most cases an ABU has a smaller capacity than an inpatient ward. Transcript of November 7, 2012 Public Hearing ("Tr."), Testimony of Dr. John McIntyre, psychiatrist and clinical professor at the University of Rochester.

13. The majority of MidState's behavioral health inpatients are admitted to the hospital directly from the ABU, primarily for episodic mood, schizophrenic, alcohol induced, and depressive disorders. Ex. B, p. 10. CT DPH Office of Health Care Access Acute Care Discharge Database; FY 2011, primary diagnosis, 'svc" field = Psychiatric ("3")

14. If a bed is unavailable, or if MidState cannot provide the appropriate care (e.g., age, acuity level), the patient is transferred from MidState's ABU to another more appropriate setting. Ex. B, p. 11.

15. The following table provides information on the existing providers of inpatient behavioral health services in the greater Meriden area:

Table 1: Existing Providers in Greater Meriden

Provider Name	Town	Number of Behavioral Health Beds	Distance, in miles, from MidState
The Hospital of Central CT	New Britain	22	9
Masonicare	Wallingford	30	9
Middlesex Hospital	Middletown	20	10
Saint Mary's Hospital	Waterbury	12	15
Bristol Hospital	Bristol	16	16
Waterbury Hospital	Waterbury	24	17
Institute of Living	Hartford	70	17
Hospital of St. Raphael	New Haven	25	19
Yale-New Haven Hospital	New Haven	20	21

Ex. B, p. 17.

[1] The Acute Behavioral Health Unit (ABU) is a nine bed monitored unit that treats patients presenting with a mental health emergency. Mental health emergencies may be life threatening and can include suicidal or homicidal behavior, self-injury needing immediate medical attention, severe drug/alcohol impairment, highly erratic or unusual behavior and/or the inability to care for oneself.

[2] Dr. McIntyre has practiced as a psychiatrist for 30 years and has been a former President of the American Psychiatric Association ("APA"). He has served as Chair of the Department of Psychiatry for several hospitals and he is Chair of the APA's Practice Research Network Steering Committee that is responsible for developing and disseminating guidelines for treatment of psychiatric and substance abuse disorders.

16. Approximately 50% of MidState's ABU patients are transferred to other inpatient facilities. Geriatric patients are transferred to Masonicare in Wallingford and pediatric patients are transferred to a provider with an available bed. Ex. B, p. 10.

17. Of the 223 behavioral health patients transferred from MidState to other facilities in FY 2011, 79% had to travel more than nine miles (distance from MidState to The Hospital of Central CT) to receive their care:

Table 2: FY 2011 MidState Behavioral Health Patient Transfers

Provider Name	Total Transfers	Distance (miles), to MidState
Masonicare	45	9
The Hospital of Central CT	1	9
Connecticut Valley Hospital	3	10
Riverview Hospital	1	12
Waterbury Hospital	2	17
Hartford Hospital/Institute of Living	33	22
Hospital of Saint Raphael	10	23
Saint Francis Hospital	42	24
Yale-New Haven Hospital	11	24
Hebrew Home	12	25
Manchester Memorial Hospital	1	27
St. Vincent's Hospital	42	38
Johnson Memorial Hospital	1	45
Natchaug Hospital	8	46
Silver Hills	3	55
Sharon Hospital	6	60
Stamford Hospital	1	61
St. Jude Children's Hospital	1	99
Total	**223**	

Ex. B, p. 10.

18. MidState's ABU will continue to be available to all patients, including pediatric and geriatric behavioral health patients, and the current transfer process for inpatient care will remain in effect. Ex., B, p. 18.

19. From FY 2009 to FY 2011, 83% of the adults discharged from MidState's inpatient behavioral health unit were residents of Meriden or Wallingford:

Table 3: MidState Psychiatric Discharges by Town

Town	Fiscal Year			FYs 2009 to 2011	
	2009	2010	2011	Total	Percentage
Meriden	232	194	200	626	67.1%
Wallingford	55	55	38	148	15.9%
Cheshire	11	9	11	31	3.3%
Middletown	2	7	7	16	1.7%

Other Towns in CT	22	31	45	98	10.5%
Out of State	3	3	8	14	1.5%
Total	**325**	**299**	**309**	**933**	**100.0%**

Source: CT DPH Office of Health Care Access Acute Care Discharge Database; 'svc" field = Psychiatric ("3")

20. From FY 2009 to FY 2011, the occupancy rates of MidState's behavioral health unit were 91%, 88%, and 88% respectively:

Table 4: Inpatient Behavioral Health Utilization by Hospital

Hospital	Measurement	FY 2009	FY 2010	FY 2011
MidState	Days	2,003	1,922	1,930
	Discharges	325	299	309
	Average Length of Stay ("ALOS")	6.2	6.4	6.2
	Available Beds	6	6	6
	Occupancy Rate	91%	88%	88%
The Hospital of Central CT	Days	6,368	6,109	6,486
	Discharges	723	808	808
	ALOS	8.8	7.6	8.0
	Available Beds	22	22	22
	Occupancy Rate	79%	76%	81%

Source: CT DPH Office of Health Care Access Acute Care Discharge Database; 'svc" field = Psychiatric ("3")

21. In the first six months of FY 2012, MidState's inpatient unit operated at 88% capacity for an average daily census ("ADC") of 5.3 patients. Ex. B, p. 20.

22. In an effort to ensure continued patient access, The Hospital of Central CT will expand itsbehavioral health unit by ten beds and provide preferred inpatient status to MidState ABU patients. One bed will remain open or unoccupied on its inpatient psychiatric unit provided that there are less than six MidState patients currently admitted to the inpatient psychiatric unit. Once all six beds are occupied by MidState patients, the MidState patients will be given preference to four additional beds. Bed preference means that if there is a MidState patient and a patient at The Hospital of Central CT in need of an inpatient bed, the bed will go to the more medically needy patient, as determined by a psychiatrist at The Hospital of Central CT. If the bed goes to The Hospital of Central CT patient, then the next available bed will automatically go to the MidState patient. The waiting time for the next available bed is estimated to be no more than 24 hours. Ex. BBB, p. 2.

23. Michael Balkunas, M.D., Chief of Psychiatry and Behavioral Health at The Hospital of Central CT[3], cited the following:
    a. The average daily census at The Hospital of Central CT is 18-19 patients;

[3] Dr. Michael Balkunas is the Chief of Psychiatry and Behavioral Health (since 2004) and the Medical Director of Psychiatry and Behavioral Health Research(since 2006) at The Hospital of Central CT. He is responsible for all administrative and clinical aspects of psychiatry and behavioral health services and supervises all clinical research.

b. Since a 32-bed unit usually has four or five discharges per day, a patient from MidState waiting for a bed at The Hospital of Central CT will get the first bed available on the next day;
c. The Hospital of Central CT's inpatient unit has double rooms and single rooms;
d. Some patients prefer a double room to a single. A depressed patient without family and having no support will make friends with some of the other patients and likes the comfort of having someone else in their room; and
e. On a 32-bed unit, there will be clusters of patients with similar diagnoses, allowing specialized group therapy using therapeutic modalities.Transcript of November 7, 2012 Public Hearing ("Tr"), Testimony of Michael Balkunas, M.D., Chief of Psychiatry and Behavioral Health at The Hospital of Central CT.

24. For family members that wish to visit and participate in the treatment of patients, transportation from MidStateto The Hospital of Central CT may be needed. Ex. B, p. 14.

25. The Applicants have developed a protocol to meet the transportation needs of family members and loved ones to travel to and from The Hospital of Central CT to visit patients admitted from MidState's ABU. MidState will pay the full cost of transportation between MidState and The Hospital of Central CT for all who request the service, regardless of their financial status. An advisory committee comprised of representatives from The Hospital of Central CT, MidState, consumers and providers will be responsible for reviewing the effectiveness of and compliance with the protocol. Ex. BBB, pp. 5 and 6.

26. The Hospital of Central CT offers its behavioral health inpatients specialized therapies that cannot be effectively or efficiently provided at MidState due to the limited number of patients and the diverse diagnoses of patients. These specialized therapies include dialectical behavioral therapy and cognitive behavior techniques. Ex. B, p. 9.

27. According to the Applicants, it is difficult to provide the appropriate care on a six bed behavioral health unit. On a 32 bed unit there will be clusters of patients with similar diagnoses that facilitate specialized group therapy, etcetera, which are clearly the therapeutic modalities in inpatient psychiatric units throughout the United States.Transcript of November 7, 2012 Public Hearing ("Tr"), Testimony of Michael Balkunas, M.D., Chief of Psychiatry and Behavioral Health at The Hospital of Central CT.

28. Of Connecticut's twenty-four adult inpatientbehavioral health programs, MidState staffs the fewest number of beds (6). Besides MidState, only four other programs staff fewer than 14 beds.

Table 5: Inpatient Psychiatric Beds (FY 2011)

Hospital	Psychiatric Staffed Beds
Hartford	78
St. Vincent	75
Yale-New Haven	73
St. Francis	55
Manchester	26

Waterbury	25
St. Raphael	22
The Hospital of Central CT	22
Danbury	18
Lawrence & Memorial	18
William W. Backus	18
Bridgeport Hospital	17
Johnson Memorial	17
Middlesex	17
Stamford	17
John Dempsey	16
Bristol	14
Charlotte Hungerford	14
Day Kimball	14
Essent Sharon	12
St. Mary's	12
Griffin	11
Norwalk	9
MidState	6

Source: Department of Public Health, Office of Health Care Access, Hospital Reporting System, Report 400 (FY 2011)

29. MidState cannot deliver the same level of services or quality of care that a larger and more specialized unit can. Due to its size, The Hospital of Central CT can deliver more comprehensive services at a much lower cost. Transcript of November 7, 2012 Public Hearing ("Tr"), Testimony of Lucille Janatka, President and Chief Executive Officer of MidState.

30. Dr. McIntyreindicates that:
    a. The proposal will improve the quality of care to be received by the patients;
    b. The major reason for the improvement in the quality of care is simply due to the size of the psychiatric unit;
    c. A six-bed psychiatric unit, regardless of the expertise or dedication of the staff cannot offer the full range of treatment available to patients on units of 15 to 40 beds;
    d. The ideal number of beds for a psychiatric unit is somewhere between 14-15 and 40, perhaps up to 50 beds;
    e. Patients with a mental illness, who require hospitalization, have a wide range of psychiatric diagnoses;
    f. On a six-bed unit there is less chance that several patients will have a similar diagnoses making certain therapies, like group therapy, less effective;
    g. An important component of inpatient treatment is called milieu therapy. It is the total experience of the unit, as patients learn from each other and from staff, allowing them to develop coping skills for dealing with daily challenges; and
    h. Another factor that affects the milieu is the treatment facility's physical layout. With the upgrade of the unit at The Hospital of Central CT, care will improve for both MidState and TheHospital of Central CT patients.

Transcript of November 7, 2012 Public Hearing ("Tr."), Testimony of Dr. John McIntyre, psychiatrist and clinical professor at the University of Rochester.

31. Health care is going through a transformation that requires the coordination of care for patients with chronic disease and complex clinical problems and the consolidation of services for more consistent outcomes and higher quality care at a lower cost. Transcript of November 7, 2012 Public Hearing ("Tr"), Testimony ofEliot Joseph, President and Chief Executive Officer of Hartford HealthCare.

32. Rushford's Crisis Stabilization Program is a coordinated crisis response service for residents of Meriden and Wallingford. The overall program includes a telephone hotline that operates 24/7 and is answered by trained mental health counselors and licensed clinicians, a Respite Program, Mobile Crisis coverage, Community Outreach/Education and emergency evaluation and placement of behavioral patients at the MidState Emergency Department. Ex. G, p. 197.

33. The capacity of Rushford's partial hospitalization program[4] will be evaluated for the feasibility of expanding the program due to increased demand. Patients that qualify for this level of service will benefit from the expanded program, helping to reduce the number of admissions and readmissions to inpatient care and shorten the length of stay for certain patients admitted to The Hospital of Central CT inpatient unit. Ex. B, pp. 14, 15.

34. The projected utilization listed below is based on the occupancy rates at MidState and The Hospital of Central CT that have been between 80% and 90% for the past three fiscal years. Ex. B, p. 21.

Table 6: Projected Inpatient Utilization by Fiscal Year at The Hospital of Central CT

Measurement	FY 2013	FY 2014	FY 2015
Days	9,928	9,928	9,928
Patient Discharges	1,241	1,241	1,241
ALOS	8	8	8
Available Beds	32	32	32
Occupancy Rate	85%	85%	85%

Ex. B, p. 21

[4]Partial Hospitalization Programs (PHP) provide treatment after inpatient discharge, offering daily, intensive and comprehensive treatment that is designed to help patients transition from inpatient to outpatient care.Ex. G, p. 195.

35. MidState and The Hospital of Central CT had a similar patient/payer mix for inpatient behavioral health in FY 2011.

Table 7: MidState and The Hospital of Central CT Psychiatric Patient/Payer Mix

Payer	MidState FY 2011	THOCC FY 2011
Medicare	31.7%	31.8%
Medicaid	39.5%	41.3%
Other Federal Programs	1.3%	0.7%
Total Government	**72.5%**	**73.9%**
Commercial Insurers	22.3%	23.3%
Uninsured*	5.2%	2.8%
Workers Compensation	0.0%	0.0%
Total Non-Government	**27.5%**	**26.1%**
Total Payer Mix	**100.0%**	**100.0%**

Source: CT DPH Office of Health Care Access Acute Care Discharge Database; 'svc" field = Psychiatric ("3").
*Includes self-pay, other and no charge categories

36. The Hospital of Central CT'sincremental patient/payer mix as a result of this proposal is as follows:

Table 8: The Hospital of Central CT's Projected Incremental Patient/Payer Mix

Payer	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare	38.4%	38.4%	38.4%
Medicaid	38.8%	38.8%	38.8%
CHAMPUS & TriCare	0.0%	0.0%	0.0%
Total Government	**77.2%**	**77.2%**	**77.2%**
Commercial Insurers	18.7%	18.7%	18.7%
Uninsured	4.1%	4.1%	4.1%
Workers Compensation	0.0%	0.0%	0.0%
Total Non-Government	**22.8%**	**22.8%**	**22.8%**
Total Payer Mix	**100%**	**100%**	**100%**

Ex. G, p. 184-186.

37. With improved coordination of patient care throughout the full continuum of services, cost savings will be realized from reduced rates of admission and readmission for behavioral health patients.Ex. B, p. 23

38. In FY 2011 the direct cost per day of providing inpatient psychiatric care at MidState was $1,421 per day. For the same period the direct cost per day at The Hospital of Central CT was $578 per day. Ex., p. 13

39. The higher direct cost at MidState is due to the inefficiencies associated with operating a small unit. Ex. B, p. 25

40. The direct cost per patient day for the newly consolidated inpatient psychiatric unit at The Hospital of Central CT is projected to be approximately $650 per day. Ex. B, p. 25

41. The estimated total capital expenditure for the renovations at The Hospital of Central CT is $4,744,340. By renovating existing space, the unit will be expanded by ten beds and will be designed to enhance the therapeutic environment. Ex. B, p. 7, 8.

42. MidState projects that revenues and expenses will both decline due to the termination of their inpatient behavioral health program. As the costs to administer the program exceed the revenue generated by keeping the program, incremental gains are projected:

Table 9: MidState's Projected Incremental Revenues and Expenditures by Fiscal Year

	FY 2013	FY 2014	FY 2015
Revenue from Operations	$ (855,000)	$ (1,747,000)	$ (1,788,000)
Total Operating Expenses	(1,185,000)	(2,456,000)	(2,566,000)
Incremental Gain from Operations	**$ 330,000**	**$ 718,000**	**$ 778,000**

Ex. B, p. 176.

43. The Hospital of Central CT projectsincremental gains of $385,939 in FY 2013, $755,252 in FY 2014 and $736,946 in FY 2015 as a result of this proposal:

Table 10:The Hospital of Central CT's Projected Incremental Revenues and Expenditures by Fiscal Year

	FY 2013	FY 2014	FY 2015
Revenue from Operations	$ 1,519,459	$ 3,105,688	$ 3,174,246
Total Operating Expenses	1,133,520	2,350,436	2,437,301
Incremental Gain from Operations	**$ 385,939**	**$ 755,252**	**$ 736,946**

Ex. B, p. 177

44. The Hospital of Central CT's total operating expenses include the depreciation expense for the capital expenditure required to renovate its psychiatric unit and add 4 beds. Ex. B, p. 177.

45. 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 policies and standards not yet adopted as regulations by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1)).

46. OHCA recently published a statewide facilities and services plan. Since the plan was not in circulation at the time the Applicants filed the CON application, OHCA has not made any findings as to this proposal's relationship to the plan. (Conn.Gen.Stat. § 19a-639(a)(2))

47. The Applicants established that there is a clear public need for their proposal. (Conn.Gen.Stat. § 19a-639(a)(3))

48. The Applicants have satisfactorily demonstrated the project's financial feasibility and its impact on the financial strength of the health care system in this state. (Conn.Gen.Stat. § 19a-639(a)(4))

49. The Applicants have satisfactorily demonstratedhow this proposal would affect the accessibility of health care delivery in the region and have satisfactorily demonstrated a potential improvement in quality and cost effectiveness. (Conn.Gen.Stat. § 19a-639(a)(5))

50. The Applicants have satisfactorily evidenced that there would be no adverse change to the provision of health care services to the relevant populations and payer mix. (Conn. Gen. Stat. § 19a-639(a)(6))

51. The Applicants have satisfactorily identified the population to be served by their proposal and have satisfactorily demonstrated that access will be maintained for this population. (Conn.Gen. Stat. § 19a-639(a)(7))

52. The historical utilization of behavioral health inpatient services supports approval of this proposal due to the resulting increase of behavioral health beds to help serve area demand. (Conn.Gen.Stat. § 19a-639(a)(8))

53. The Applicants have satisfactorily demonstrated that their proposal will not result in any unnecessary duplication of behavioral health inpatient services in the area. (Conn.Gen.Stat. § 19a-639(a)(9))

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in General Statutes § 19a-639(a). The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Goldstar Medical Services, Inc., et al. v. Department of Social Services,* 288 Conn. 790 (2008).

Hartford HealthCare Corporation is an integrated health care delivery system.The system's behavioral health network, known as "Hartford HealthCare Behavioral Health Network," includes Hartford Hospital, the Institute of Living, The Hospital of Central Connecticut ("The Hospital of Central CT"), MidState Medical Center ("MidState"), Natchaug Hospital and Rushford. FF3.MidState is located in Meriden and The Hospital of Central CT is located in New Britain.FF1-2.Rushford is a comprehensive behavioral health provider located in Meriden. FF4.

MidState currently operates a six-bed inpatient behavioral health unit ("inpatient unit") for adultsand a 9-bed, secure, acute behavioral health unit (ABU) for all age groups within its emergency department. FF7&11. The majority of MidState's inpatients are admitted directly from the ABU, however 50% of the patients treated in the ABU are transferred to other facilities to receive inpatient care. FF13&16. These transfers primarily occur due to a more appropriate placement (e.g., age, acuity) or due to the lack of an available bed at MidState. FF14. In an effort to improve the effectiveness and efficiency of care by utilizing the resources of the Hartford HealthCare system, MidState proposes to terminate its inpatient behavioral health services and to arrange preferred inpatient status at The Hospital of Central CT. FF6. Critical to the area's ongoing need for behavioral health services, MidState will continue to operate its 9-bed ABU, serving all individuals presenting with mental health emergencies. FF11&18.

With this proposal, MidState behavioral health patients requiring inpatient admission will be transferred to The Hospital of Central CT, which will expand its dedicated inpatient behavioral health unit by ten beds to create a 32-bed unit.FF8.Access to behavioral health services will be enhanced due to four additional beds made available to serve the same patient population. These beds will help reduce the number of patients transferred to other, more distant inpatient facilities. FF17.Rushford will work with MidState and The Hospital of Central CT to arrange follow-up community-based care with priority access to Rushford's Meriden outpatient center. FF9.

The proposal will enhance the quality of behavioral health inpatient care.FF30. A six-bed psychiatric unit, regardless of the expertise or dedication of the staff, cannot offer the full range of treatment made available to patients on a 32-bed unit. FF27-30.Quality will improve as The Hospital of Central CT offers its inpatients specialized therapies that cannot be effectively or efficiently provided at MidState, due to the limited number and diverse diagnoses of patients. FF26.

MidState will provide transportation assistance,at no cost, to family members and otherswho wishto visit and/or participate in the treatment of MidState patients admitted to The Hospital of Central CT inpatient psychiatric unit.FF24-25.Patients and their families will be advised about the

availability of transportation assistance while receiving care at MidState's ABU. In addition, an advisory committee will be formed and meet monthly to review the effectiveness and compliance of thesetransportation protocols; monitor compliance with the principles of the MOU between MidState, The Hospital of Central CT and Rushford; and review access and quality data reports for MidState patients. FF9&25.

Both MidState and The Hospital of Central CT project incremental gains from operations for the first three fiscal years following approval of the proposal. FF42-43.These gains result, in part, from The Hospital of Central CT'sability to deliver psychiatric inpatient care at a much lower cost than MidState.The direct cost per day following the expansion of the psychiatric unit at The Hospital of Central CT is projected to be $650and represents a significant reduction in cost compared to the existing program at MidState.FF38-40.

The transformation of health care towards consistent outcomes, higher quality and lower cost care will require a coordinated and consolidated approach to service delivery. FF31.The Applicantshave the potential to realize additional savings if patient admissions/readmissions can be reduced as a result of improved patient care coordination and enhanced community servicesbeing developed in conjunction with this proposal.FF10.

OHCA finds that the Applicants have demonstrated that the proposal willimprove the quality and cost effectiveness of health care,while access to care for behavioral health patients in the greater Meriden area will be maintained.

Order

NOW, THEREFORE, the Department of Public Health, Office of Health Care Access ("OHCA") and MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation ("Applicants") hereby stipulate and agree to the terms of settlement with respect to the Applicants' request to terminate inpatient behavioral health services at MidState Medical Center in Meriden as follows:

1. The request of the Applicants to terminate inpatient behavioral health services at MidState Medical Center in Meriden is hereby approved.

2. Only upon completion of the renovations to The Hospital of Central CT's inpatient unit and the establishment of the 10 (ten) additional beds may MidState Medical Center discontinue admitting patients to itsinpatient behavioral health unit. Patients currently admitted to MidState Medical Center's inpatient behavioral health unit at the time of termination may remain at MidState Medical Center to complete their treatment if that is their preference.

3. MidState Medical Center shall report to OHCAthe date of the termination of MidState Medical Center's inpatient behavioral health unit. Such written notification must be filed with OHCA no later than three calendar days following said termination.

4. MidState Medical Center shall continue to provide emergency behavioral health services at its acute behavioral health unit (ABU).

5. The Hospital of Central CT shall expand its behavioral health unit by ten beds and provide preferred inpatient status to MidState ABU patients. One bed will remain open or unoccupied on its inpatient psychiatric unit provided that there are less than eight MidState patients currently admitted to the inpatient psychiatric unit. Once all eight beds are occupied by MidState patients, the MidState patients will be given preference to two additional beds. Bed preference means that if there is a MidState patient and a patient at The Hospital of Central CT in need of an inpatient bed, the bed will go to the more medically needy patient, as determined by a psychiatrist at The Hospital of Central CT. If the bed goes to The Hospital of Central CT patient, then the next available bed will automatically go to the MidState patient. The waiting time for the next available bed is estimated to be no more than 24 hours.

6. MidState Medical Center shall provide assistance to patients ingaining access to inpatient behavioral health beds within the Hartford HealthCare Behavioral Health Network, i.e., Hartford Hospital/Institute of Living and Natchaug Hospital, in the event that a bed is not immediately available at The Hospital of Central CT.

7. MidState Medical Center shall provide transportation assistance to family members and loved ones to visit and/or participate in the treatment of patients admitted to The Hospital of Central CT's inpatient behavioral health unit from MidState Medical Center's ABUin

accordance with the transportation protocol submitted by the Applicants and identified in the Table of Record as Exhibit BBB.

8. MidState Medical Center and The Hospital of Central CTshall arrange follow-up community-based care for the patients transferred from MidState Medical Center with priority access to Rushford Center, Inc.'s Meriden outpatient center after discharge from The Hospital of Central CT.

9. Hartford HealthCare Corporation shall ensure that its affiliate, Rushford Center, Inc., will follow up with every MidState Medical Center patient discharged from the inpatient behavioral health unit at The Hospital of Central CT to ensure that there are no barriers to compliance with discharge plans or accessibility to services in the community.

10. Within 60 days of opening the new behavioral health unit at The Hospital of Central CT, the Applicants shall form an Advisory Committee with representation from MidState Medical Center, The Hospital of Central CT and Rushford Center, Inc. for the purpose of meeting monthly to monitor compliance with the principles of the Applicants' Memorandum of Understanding. At least two (2) representatives of consumers, one (1) representative from the Department of Mental Health and Addiction Services, and one (1) representative of mental health providers other than the Applicants or their affiliates shall be appointed to the Advisory Committee to provide input concerning the patient transfer process, the transportation protocol and any other applicable matters.

11. The Applicants shall submit to OHCA, the written minutes of the Advisory Committee'smonthly meetings on an on-going basis for three full years. The submission shall be received by OHCA within two weeks of the completion of the minutes each month.

12. MidState Medical Center shall submit to OHCA written or electronic quarterly reports that include the following information:

    a. Number of patients presenting to MidState Medical Center's acute behavioral health unit and the town where they reside;
    b. Number of patients transferred from the acute behavioral health unit and the name of the facility to which they were transferred;
    c. Average length of stay within MidState Medical Center'sacute behavioral health unit;
    d. Number of MidState Medical Center acute behavioral health unit patients awaiting transfer beyond 24 hours to be admitted to The Hospital of Central CT's inpatient behavioral health unit, and;
    e. Number of persons requested and provided transportation to The Hospital of Central CT pursuant to the terms of this Agreed Settlement.

13. The Hospital of Central CTshall submit to OHCA written or electronicquarterly reports that include the following information:

a. Number of patients admitted to its inpatient behavioral health unit from MidState Medical Center's acute behavioral health unit;
b. Number of patients from MidState Medical Center's acute behavioral health unit that were put on a wait list and the length of time each patient waited before admission;
c. Average length of stay for patients that were transferred from MidState Medical Center's acute behavioral health unit to The Hospital of Central CT's inpatient behavioral health unit;
d. Patient disposition at discharge, including provider for outpatient care and level of care recommended for patients that were transferred from MidState Medical Center's acute behavioral health unit.

14. The quarterly reporting requirements set forth in Stipulations 12 and 13 above are to be filed for a period of three (3) years. The filings shall be based on calendar year quarters (January - March, April - June, July - September, October - December). The first filing may include a partial quarter, as needed, based on the date of termination of the inpatient behavioral health unit at MidState Medical Center; filings will be due within thirty (30) calendar days of the end of each calendar quarter.

15. Within five (5) calendar days of the execution of this Agreed Settlement, the Applicants shall submit to OHCA a copy of the final executed Memorandum of Understanding between MidState Medical Center, The Hospital of Central CT and Rushford Center, Inc.

16. In filings to OHCA related to any of the above Stipulations, the Applicants shall not provide any patient identifiable or patient confidential information.

17. OHCA and the Applicants agree that this Agreed Settlement represents a final agreement between OHCA and the Applicants with respect to this request. The signing of this Agreed Settlement resolves all objections, claims, and disputes that may have been raised by the Applicants with regard to Docket Number: 12-31775-CON.

18. This Agreed Settlement is an order of the Office of Health Care Access with all the rights and obligations attendant thereto, and the Office of Health Care Access may enforce this Agreed Settlement pursuant to the provisions of Conn. Gen. Stat. §§ 19a-642 and 19a-653 at the Applicants' expense if the Applicants fail to comply with its terms.

19. This Agreed Settlement shallensure to the benefit of and be binding upon the Office of Health Care Access and the Applicants, and their successors and assigns.

Signed by Lucille Janatka, President / CEO
(Print name) (Title)

3/25/13
Date

Duly Authorized for
MidState Medical Center

Signed by Clarence Silvia, President & CEO
(Print name) (Title)

3/28/13
Date

Duly Authorized for
The Hospital of Central Connecticut

Signed by Elliot Joseph, President + CEO
(Print name) (Title)

3/28/13
Date

Duly Authorized for
Hartford HealthCare Corporation

The above Agreed Settlement is hereby accepted and so ordered by the Office of Health Care Access on _____.

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

April 8, 2013

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:	Notice of Agreed Settlement Office of Health Care Access Docket Number: 12-31775-CON
MidState Medical Center **The Hospital of Central Connecticut** **Hartford HealthCare Corporation**	**Termination of Inpatient Behavioral Health Services at MidState Medical Center**

To:

Barbara A. Durdy Director, Business Development MidState Medical Center 435 Lewis Avenue Meriden, CT 06451	Claudio Capone Director, Strategic Business Planning and Physician Relations The Hospital of Central Connecticut 100 Grand St. New Britain, CT 06050	Karen Goyette Vice President, Strategic Planning and Business Development Hartford HealthCare Corp. 80 Seymour St. Hartford, CT 06102

Dear Ms. Durdy, Mr. Capone and Ms. Goyette:

This letter will serve as notice of the approved Certificate of Need Application in the above matter, as provided by Section 19a-638, C.G.S. On April 8, 2013, the Agreed Settlement, attached hereto, was adopted and issued as an Order of the Department of Public Health, Office of Health Care Access.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:lkg

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Agreed Settlement

Applicants:

MidState Medical Center
435 Lewis Avenue, Meriden, CT 06451

The Hospital of Central Connecticut
100 Grand Street, New Britain, CT 06050

Hartford HealthCare Corporation
80 Seymour Street, Hartford, CT 06102

Docket Number: **12-31775-CON**

Project Title: **Termination of Inpatient Behavioral Health Services at MidState Medical Center**

Project Description: MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation (hereinafter collectively referred to as the "Applicants") seek authorization to terminate inpatient behavioral health services at MidState Medical Center.

Procedural History: The Applicants published notice of their intent to file a CON application in the *RecordJournal* (Meriden) on April 22, 23 and 24, 2012. OnJuly 18, 2012, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application from the Applicants for the above-referenced project. On September 28, 2012, OHCA deemed the CON application complete.

On October 12, 2012, the Applicants were notified of the date, time and place of the public hearing. On October 15, 2012, a notice to the public announcing the hearing was published in the*Record Journal.* Thereafter, pursuant to Conn. Gen. Stat. § 19a-639a, a public hearing regarding the CON application was held on November 7, 2012.The hearing was continued on December 6, 2012.

Commissioner Jewel Mullen designated Attorney Kevin T. Hansted as the hearing officer in this matter. The hearing was conducted as a contested case in accordance with the provisions of the

Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes.) and Conn. Gen. Stat. § 19a-639a.

By petition dated November 1, 2012, the Connecticut Legal Rights Project, Inc. requested Intervenor status with full rights of cross-examination regarding the Applicants' CON application. The Hearing Officer designated Connecticut Legal Rights Project, Inc. as an Intervenor with full rights of cross-examination.

By petition dated November 1, 2012, Paul C. Horton, M.D. requested Intervenor status with full rights of cross-examination regarding the Applicants' CON application. The Hearing Officer designated Dr. Horton as an Intervenor with full rights of cross-examination.

By petition dated November 5, 2012, Susan Duclos, R.N. requested Intervenor status regarding the Applicants' CON application. The Hearing Officer designated Ms. Duclos as an Intervenor with limited rights.

By petition dated November 16, 2012, the Regional Mental Health Board, Inc. requested Intervenor status regarding the Applicants' CON application. The Hearing Officer designated the Regional Mental Health Board as an Intervenor with limited rights.

The Hearing Officer heard testimony from the Applicants' and Intervenors' witnesses, and in rendering this proposed final decision,Deputy Commissioner Davis considered the entire record of the proceeding. The public hearing record was closed on December 20, 2012.

Findings of Fact

1. MidState Medical Center ("MidState") is a not-for-profit hospital located at 435 Lewis Avenue, Meriden, Connecticut. Ex. B, p. 7.

2. The Hospital of Central Connecticut ("The Hospital of Central CT") is a not-for-profit hospital located at 100 Grand Street, New Britain, Connecticut. The hospital also has a second campus in Southington.Ex. B, p. 7.

3. Hartford HealthCare Corporation is an integrated health care delivery system. The system's behavioral health network known as "Hartford HealthCare Behavioral Health Network" includes Hartford Hospital, the Institute of Living, The Hospital of Central CT, MidState, Natchaug Hospital and Rushford. Ex. B, p. 8, 13.

4. Rushford is a comprehensive not-for-profit behavioral health prevention and treatment provider located at 883 Paddock Avenue, Meriden, Connecticut. Ex. B, p. 117.

5. The Applicants state that Hartford HealthCare Behavioral Health Network conducted a thorough review of all behavioral health resources within the Hartford HealthCare

Corporation system to determine how and where the behavioral health service would be provided in the most effective and efficient manner. Ex. B, p. 178

6. The Applicantsareproposingtheterminationof MidState's inpatient behavioral health services and the arrangementof preferred inpatient status at The Hospital of Central CT, New Britain campus for MidState patients in need of behavioral health inpatient treatment. Ex., B, p. 8.

7. MidState currently operates six beds in itsinpatient behavioral health unit ("inpatient unit") for adults. Ex. B, p. 9.

8. The Hospital of Central CT currently operates a 22-bed unit dedicated to inpatient behavioral health services at its New Britain campus. As part of the proposal, The Hospital of Central CT will increase the number of beds in the unit by 10 to create a 32-bed unit. Ex. B, p. 8.

9. MidState,The Hospital of Central CT and Rushford have entered into a Memorandum of Understanding ("MOU") to address the coordination of behavioral health needs in the community. The MOU includes the following provisions:
    a. MidState patients requiring inpatient admission will have preferential access to no fewer than ten beds at The Hospital of Central CT;
    b. MidState staff will help patients gain access to inpatient beds within the Hartford HealthCare Behavioral Health Network, i.e., Hartford Hospital/Institute of Living and Natchaug Hospital, in the event that a bed is not immediately available at The Hospital of Central CT;
    c. MidState will provide transportation assistance to family members and loved ones to visit and participate in treatment of patients admitted to the Hospital of Central CT,from MidState;
    d. Rushford will work cooperatively with MidState and The Hospital of Central CT to arrange follow-up community-based care with priority access to Rushford's Meriden outpatient center after discharge, including next-day appointments;
    e. Rushford will regularly follow-up with MidState patients to ensure compliance with discharge instructions and medications; and
    f. The Hospital of Central CT will form an advisory committee with representation from MidState and Rushford that will meet monthly and monitor compliance with the principles of the MOU and review access and quality data reports for MidState patients.
    Ex. B, pp. 39-40

10. MidState will work concurrently with Rushford to enhance community-based servicesso that behavioral health patients have more services available to them, remain stable in the community and help avoid inpatient admissions. Ex. B, p. 9.

11. Although this proposal would terminate inpatient behavioral health care at MidState, MidState will continue to operate a 9-bed, secure acute care behavioral health unit

("ABU")[1] within its emergency department. The ABU is newly designed with private patient rooms and is staffed by psychiatric nurses. Ex. B, p. 10.

12. John McIntyre, M.D., board-certified psychiatrist[2] and clinical professor of psychiatry at the University of Rochester, attests that the 9-bed ABU unit is a tremendous resource for patients in the community given the size of the unit – in most cases an ABU has a smaller capacity than an inpatient ward. Transcript of November 7, 2012 Public Hearing ("Tr."), Testimony of Dr. John McIntyre, psychiatrist and clinical professor at the University of Rochester.

13. The majority of MidState's behavioral health inpatients are admitted to the hospital directly from the ABU, primarily for episodic mood, schizophrenic, alcohol induced, and depressive disorders. Ex. B, p. 10. CT DPH Office of Health Care Access Acute Care Discharge Database; FY 2011, primary diagnosis, 'svc" field = Psychiatric ("3")

14. If a bed is unavailable, or if MidState cannot provide the appropriate care (e.g., age, acuity level), the patient is transferred from MidState's ABU to another more appropriate setting. Ex. B, p. 11.

15. The following table provides information on the existing providers of inpatient behavioral health services in the greater Meriden area:

Table 1: Existing Providers in Greater Meriden

Provider Name	Town	Number of Behavioral Health Beds	Distance, in miles, from MidState
The Hospital of Central CT	New Britain	22	9
Masonicare	Wallingford	30	9
Middlesex Hospital	Middletown	20	10
Saint Mary's Hospital	Waterbury	12	15
Bristol Hospital	Bristol	16	16
Waterbury Hospital	Waterbury	24	17
Institute of Living	Hartford	70	17
Hospital of St. Raphael	New Haven	25	19
Yale-New Haven Hospital	New Haven	20	21

Ex. B, p. 17.

[1] The Acute Behavioral Health Unit (ABU) is a nine bed monitored unit that treats patients presenting with a mental health emergency. Mental health emergencies may be life threatening and can include suicidal or homicidal behavior, self-injury needing immediate medical attention, severe drug/alcohol impairment, highly erratic or unusual behavior and/or the inability to care for oneself.

[2] Dr. McIntyre has practiced as a psychiatrist for 30 years and has been a former President of the American Psychiatric Association ("APA"). He has served as Chair of the Department of Psychiatry for several hospitals and he is Chair of the APA's Practice Research Network Steering Committee that is responsible for developing and disseminating guidelines for treatment of psychiatric and substance abuse disorders.

16. Approximately 50% of MidState's ABU patients are transferred to other inpatient facilities. Geriatric patients are transferred to Masonicare in Wallingford and pediatric patients are transferred to a provider with an available bed. Ex. B, p. 10.

17. Of the 223 behavioral health patients transferred from MidState to other facilities in FY 2011, 79% had to travel more than nine miles (distance from MidState to The Hospital of Central CT) to receive their care:

Table 2: FY 2011 MidState Behavioral Health Patient Transfers

Provider Name	Total Transfers	Distance (miles), to MidState
Masonicare	45	9
The Hospital of Central CT	1	9
Connecticut Valley Hospital	3	10
Riverview Hospital	1	12
Waterbury Hospital	2	17
Hartford Hospital/Institute of Living	33	22
Hospital of Saint Raphael	10	23
Saint Francis Hospital	42	24
Yale-New Haven Hospital	11	24
Hebrew Home	12	25
Manchester Memorial Hospital	1	27
St. Vincent's Hospital	42	38
Johnson Memorial Hospital	1	45
Natchaug Hospital	8	46
Silver Hills	3	55
Sharon Hospital	6	60
Stamford Hospital	1	61
St. Jude Children's Hospital	1	99
Total	**223**	

Ex. B, p. 10.

18. MidState's ABU will continue to be available to all patients, including pediatric and geriatric behavioral health patients, and the current transfer process for inpatient care will remain in effect. Ex., B, p. 18.

19. From FY 2009 to FY 2011, 83% of the adults discharged from MidState's inpatient behavioral health unit were residents of Meriden or Wallingford:

Table 3: MidState Psychiatric Discharges by Town

Town	Fiscal Year			FYs 2009 to 2011	
	2009	2010	2011	Total	Percentage
Meriden	232	194	200	626	67.1%
Wallingford	55	55	38	148	15.9%
Cheshire	11	9	11	31	3.3%
Middletown	2	7	7	16	1.7%

Other Towns in CT	22	31	45	98	10.5%
Out of State	3	3	8	14	1.5%
Total	**325**	**299**	**309**	**933**	**100.0%**

Source: CT DPH Office of Health Care Access Acute Care Discharge Database; 'svc" field = Psychiatric ("3")

20. From FY 2009 to FY 2011, the occupancy rates of MidState's behavioral health unit were 91%, 88%, and 88% respectively:

Table 4: Inpatient Behavioral Health Utilization by Hospital

Hospital	Measurement	FY 2009	FY 2010	FY 2011
MidState	Days	2,003	1,922	1,930
	Discharges	325	299	309
	Average Length of Stay ("ALOS")	6.2	6.4	6.2
	Available Beds	6	6	6
	Occupancy Rate	91%	88%	88%
The Hospital of Central CT	Days	6,368	6,109	6,486
	Discharges	723	808	808
	ALOS	8.8	7.6	8.0
	Available Beds	22	22	22
	Occupancy Rate	79%	76%	81%

Source: CT DPH Office of Health Care Access Acute Care Discharge Database; 'svc" field = Psychiatric ("3")

21. In the first six months of FY 2012, MidState's inpatient unit operated at 88% capacity for an average daily census ("ADC") of 5.3 patients. Ex. B, p. 20.

22. In an effort to ensure continued patient access, The Hospital of Central CT will expand itsbehavioral health unit by ten beds and provide preferred inpatient status to MidState ABU patients. One bed will remain open or unoccupied on its inpatient psychiatric unit provided that there are less than six MidState patients currently admitted to the inpatient psychiatric unit. Once all six beds are occupied by MidState patients, the MidState patients will be given preference to four additional beds. Bed preference means that if there is a MidState patient and a patient at The Hospital of Central CT in need of an inpatient bed, the bed will go to the more medically needy patient, as determined by a psychiatrist at The Hospital of Central CT. If the bed goes to The Hospital of Central CT patient, then the next available bed will automatically go to the MidState patient. The waiting time for the next available bed is estimated to be no more than 24 hours. Ex. BBB, p. 2.

23. Michael Balkunas, M.D., Chief of Psychiatry and Behavioral Health at The Hospital of Central CT[3], cited the following:
    a. The average daily census at The Hospital of Central CT is 18-19 patients;

[3] Dr. Michael Balkunas is the Chief of Psychiatry and Behavioral Health (since 2004) and the Medical Director of Psychiatry and Behavioral Health Research(since 2006) at The Hospital of Central CT. He is responsible for all administrative and clinical aspects of psychiatry and behavioral health services and supervises all clinical research.

b. Since a 32-bed unit usually has four or five discharges per day, a patient from MidState waiting for a bed at The Hospital of Central CT will get the first bed available on the next day;
c. The Hospital of Central CT's inpatient unit has double rooms and single rooms;
d. Some patients prefer a double room to a single. A depressed patient without family and having no support will make friends with some of the other patients and likes the comfort of having someone else in their room; and
e. On a 32-bed unit, there will be clusters of patients with similar diagnoses, allowing specialized group therapy using therapeutic modalities.Transcript of November 7, 2012 Public Hearing ("Tr"), Testimony of Michael Balkunas, M.D., Chief of Psychiatry and Behavioral Health at The Hospital of Central CT.

24. For family members that wish to visit and participate in the treatment of patients, transportation from MidStateto The Hospital of Central CT may be needed. Ex. B, p. 14.

25. The Applicants have developed a protocol to meet the transportation needs of family members and loved ones to travel to and from The Hospital of Central CT to visit patients admitted from MidState's ABU. MidState will pay the full cost of transportation between MidState and The Hospital of Central CT for all who request the service, regardless of their financial status. An advisory committee comprised of representatives from The Hospital of Central CT, MidState, consumers and providers will be responsible for reviewing the effectiveness of and compliance with the protocol. Ex. BBB, pp. 5 and 6.

26. The Hospital of Central CT offers its behavioral health inpatients specialized therapies that cannot be effectively or efficiently provided at MidState due to the limited number of patients and the diverse diagnoses of patients. These specialized therapies include dialectical behavioral therapy and cognitive behavior techniques. Ex. B, p. 9.

27. According to the Applicants, it is difficult to provide the appropriate care on a six bed behavioral health unit. On a 32 bed unit there will be clusters of patients with similar diagnoses that facilitate specialized group therapy, etcetera, which are clearly the therapeutic modalities in inpatient psychiatric units throughout the United States.Transcript of November 7, 2012 Public Hearing ("Tr"), Testimony of Michael Balkunas, M.D., Chief of Psychiatry and Behavioral Health at The Hospital of Central CT.

28. Of Connecticut's twenty-four adult inpatientbehavioral health programs, MidState staffs the fewest number of beds (6). Besides MidState, only four other programs staff fewer than 14 beds.

Table 5: Inpatient Psychiatric Beds (FY 2011)

Hospital	Psychiatric Staffed Beds
Hartford	78
St. Vincent	75
Yale-New Haven	73
St. Francis	55
Manchester	26

Waterbury	25
St. Raphael	22
The Hospital of Central CT	22
Danbury	18
Lawrence & Memorial	18
William W. Backus	18
Bridgeport Hospital	17
Johnson Memorial	17
Middlesex	17
Stamford	17
John Dempsey	16
Bristol	14
Charlotte Hungerford	14
Day Kimball	14
Essent Sharon	12
St. Mary's	12
Griffin	11
Norwalk	9
MidState	6

Source: Department of Public Health, Office of Health Care Access, Hospital Reporting System, Report 400 (FY 2011)

29. MidState cannot deliver the same level of services or quality of care that a larger and more specialized unit can. Due to its size, The Hospital of Central CT can deliver more comprehensive services at a much lower cost. Transcript of November 7, 2012 Public Hearing ("Tr"), Testimony of Lucille Janatka, President and Chief Executive Officer of MidState.

30. Dr. McIntyreindicates that:
    a. The proposal will improve the quality of care to be received by the patients;
    b. The major reason for the improvement in the quality of care is simply due to the size of the psychiatric unit;
    c. A six-bed psychiatric unit, regardless of the expertise or dedication of the staff cannot offer the full range of treatment available to patients on units of 15 to 40 beds;
    d. The ideal number of beds for a psychiatric unit is somewhere between 14-15 and 40, perhaps up to 50 beds;
    e. Patients with a mental illness, who require hospitalization, have a wide range of psychiatric diagnoses;
    f. On a six-bed unit there is less chance that several patients will have a similar diagnoses making certain therapies, like group therapy, less effective;
    g. An important component of inpatient treatment is called milieu therapy. It is the total experience of the unit, as patients learn from each other and from staff, allowing them to develop coping skills for dealing with daily challenges; and
    h. Another factor that affects the milieu is the treatment facility's physical layout. With the upgrade of the unit at The Hospital of Central CT, care will improve for both MidState and TheHospital of Central CT patients.

Transcript of November 7, 2012 Public Hearing ("Tr."), Testimony of Dr. John McIntyre, psychiatrist and clinical professor at the University of Rochester.

31. Health care is going through a transformation that requires the coordination of care for patients with chronic disease and complex clinical problems and the consolidation of services for more consistent outcomes and higher quality care at a lower cost. Transcript of November 7, 2012 Public Hearing ("Tr"), Testimony ofEliot Joseph, President and Chief Executive Officer of Hartford HealthCare.

32. Rushford's Crisis Stabilization Program is a coordinated crisis response service for residents of Meriden and Wallingford. The overall program includes a telephone hotline that operates 24/7 and is answered by trained mental health counselors and licensed clinicians, a Respite Program, Mobile Crisis coverage, Community Outreach/Education and emergency evaluation and placement of behavioral patients at the MidState Emergency Department. Ex. G, p. 197.

33. The capacity of Rushford's partial hospitalization program[4] will be evaluated for the feasibility of expanding the program due to increased demand. Patients that qualify for this level of service will benefit from the expanded program, helping to reduce the number of admissions and readmissions to inpatient care and shorten the length of stay for certain patients admitted to The Hospital of Central CT inpatient unit. Ex. B, pp. 14, 15.

34. The projected utilization listed below is based on the occupancy rates at MidState and The Hospital of Central CT that have been between 80% and 90% for the past three fiscal years. Ex. B, p. 21.

Table 6: Projected Inpatient Utilization by Fiscal Year at The Hospital of Central CT

Measurement	FY 2013	FY 2014	FY 2015
Days	9,928	9,928	9,928
Patient Discharges	1,241	1,241	1,241
ALOS	8	8	8
Available Beds	32	32	32
Occupancy Rate	85%	85%	85%

Ex. B, p. 21

[4]Partial Hospitalization Programs (PHP) provide treatment after inpatient discharge, offering daily, intensive and comprehensive treatment that is designed to help patients transition from inpatient to outpatient care.Ex. G, p. 195.

35. MidState and The Hospital of Central CT had a similar patient/payer mix for inpatient behavioral health in FY 2011.

Table 7: MidState and The Hospital of Central CT Psychiatric Patient/Payer Mix

Payer	MidState FY 2011	THOCC FY 2011
Medicare	31.7%	31.8%
Medicaid	39.5%	41.3%
Other Federal Programs	1.3%	0.7%
Total Government	**72.5%**	**73.9%**
Commercial Insurers	22.3%	23.3%
Uninsured*	5.2%	2.8%
Workers Compensation	0.0%	0.0%
Total Non-Government	**27.5%**	**26.1%**
Total Payer Mix	**100.0%**	**100.0%**

Source: CT DPH Office of Health Care Access Acute Care Discharge Database; 'svc" field = Psychiatric ("3").
*Includes self-pay, other and no charge categories

36. The Hospital of Central CT'sincremental patient/payer mix as a result of this proposal is as follows:

Table 8: The Hospital of Central CT's Projected Incremental Patient/Payer Mix

Payer	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare	38.4%	38.4%	38.4%
Medicaid	38.8%	38.8%	38.8%
CHAMPUS & TriCare	0.0%	0.0%	0.0%
Total Government	**77.2%**	**77.2%**	**77.2%**
Commercial Insurers	18.7%	18.7%	18.7%
Uninsured	4.1%	4.1%	4.1%
Workers Compensation	0.0%	0.0%	0.0%
Total Non-Government	**22.8%**	**22.8%**	**22.8%**
Total Payer Mix	**100%**	**100%**	**100%**

Ex. G, p. 184-186.

37. With improved coordination of patient care throughout the full continuum of services, cost savings will be realized from reduced rates of admission and readmission for behavioral health patients.Ex. B, p. 23

38. In FY 2011 the direct cost per day of providing inpatient psychiatric care at MidState was $1,421 per day. For the same period the direct cost per day at The Hospital of Central CT was $578 per day. Ex., p. 13

39. The higher direct cost at MidState is due to the inefficiencies associated with operating a small unit. Ex. B, p. 25

40. The direct cost per patient day for the newly consolidated inpatient psychiatric unit at The Hospital of Central CT is projected to be approximately $650 per day. Ex. B, p. 25

41. The estimated total capital expenditure for the renovations at The Hospital of Central CT is $4,744,340. By renovating existing space, the unit will be expanded by ten beds and will be designed to enhance the therapeutic environment. Ex. B, p. 7, 8.

42. MidState projects that revenues and expenses will both decline due to the termination of their inpatient behavioral health program. As the costs to administer the program exceed the revenue generated by keeping the program, incremental gains are projected:

Table 9: MidState's Projected Incremental Revenues and Expenditures by Fiscal Year

	FY 2013	FY 2014	FY 2015
Revenue from Operations	$ (855,000)	$ (1,747,000)	$ (1,788,000)
Total Operating Expenses	(1,185,000)	(2,456,000)	(2,566,000)
Incremental Gain from Operations	**$ 330,000**	**$ 718,000**	**$ 778,000**

Ex. B, p. 176.

43. The Hospital of Central CT projectsincremental gains of $385,939 in FY 2013, $755,252 in FY 2014 and $736,946 in FY 2015 as a result of this proposal:

Table 10:The Hospital of Central CT's Projected Incremental Revenues and Expenditures by Fiscal Year

	FY 2013	FY 2014	FY 2015
Revenue from Operations	$ 1,519,459	$ 3,105,688	$ 3,174,246
Total Operating Expenses	1,133,520	2,350,436	2,437,301
Incremental Gain from Operations	**$ 385,939**	**$ 755,252**	**$ 736,946**

Ex. B, p. 177

44. The Hospital of Central CT's total operating expenses include the depreciation expense for the capital expenditure required to renovate its psychiatric unit and add 4 beds. Ex. B, p. 177.

45. 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 policies and standards not yet adopted as regulations by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1)).

46. OHCA recently published a statewide facilities and services plan. Since the plan was not in circulation at the time the Applicants filed the CON application, OHCA has not made any findings as to this proposal's relationship to the plan. (Conn.Gen.Stat. § 19a-639(a)(2))

47. The Applicants established that there is a clear public need for their proposal. (Conn.Gen.Stat. § 19a-639(a)(3))

48. The Applicants have satisfactorily demonstrated the project's financial feasibility and its impact on the financial strength of the health care system in this state. (Conn.Gen.Stat. § 19a-639(a)(4))

49. The Applicants have satisfactorily demonstratedhow this proposal would affect the accessibility of health care delivery in the region and have satisfactorily demonstrated a potential improvement in quality and cost effectiveness. (Conn.Gen.Stat. § 19a-639(a)(5))

50. The Applicants have satisfactorily evidenced that there would be no adverse change to the provision of health care services to the relevant populations and payer mix. (Conn. Gen. Stat. § 19a-639(a)(6))

51. The Applicants have satisfactorily identified the population to be served by their proposal and have satisfactorily demonstrated that access will be maintained for this population. (Conn.Gen. Stat. § 19a-639(a)(7))

52. The historical utilization of behavioral health inpatient services supports approval of this proposal due to the resulting increase of behavioral health beds to help serve area demand. (Conn.Gen.Stat. § 19a-639(a)(8))

53. The Applicants have satisfactorily demonstrated that their proposal will not result in any unnecessary duplication of behavioral health inpatient services in the area. (Conn.Gen.Stat. § 19a-639(a)(9))

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in General Statutes § 19a-639(a). The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Goldstar Medical Services, Inc., et al. v. Department of Social Services,* 288 Conn. 790 (2008).

Hartford HealthCare Corporation is an integrated health care delivery system.The system's behavioral health network, known as "Hartford HealthCare Behavioral Health Network," includes Hartford Hospital, the Institute of Living, The Hospital of Central Connecticut ("The Hospital of Central CT"), MidState Medical Center ("MidState"), Natchaug Hospital and Rushford. FF3.MidState is located in Meriden and The Hospital of Central CT is located in New Britain.FF1-2.Rushford is a comprehensive behavioral health provider located in Meriden. FF4.

MidState currently operates a six-bed inpatient behavioral health unit ("inpatient unit") for adultsand a 9-bed, secure, acute behavioral health unit (ABU) for all age groups within its emergency department. FF7&11. The majority of MidState's inpatients are admitted directly from the ABU, however 50% of the patients treated in the ABU are transferred to other facilities to receive inpatient care. FF13&16. These transfers primarily occur due to a more appropriate placement (e.g., age, acuity) or due to the lack of an available bed at MidState. FF14. In an effort to improve the effectiveness and efficiency of care by utilizing the resources of the Hartford HealthCare system, MidState proposes to terminate its inpatient behavioral health services and to arrange preferred inpatient status at The Hospital of Central CT. FF6. Critical to the area's ongoing need for behavioral health services, MidState will continue to operate its 9-bed ABU, serving all individuals presenting with mental health emergencies. FF11&18.

With this proposal, MidState behavioral health patients requiring inpatient admission will be transferred to The Hospital of Central CT, which will expand its dedicated inpatient behavioral health unit by ten beds to create a 32-bed unit.FF8.Access to behavioral health services will be enhanced due to four additional beds made available to serve the same patient population. These beds will help reduce the number of patients transferred to other, more distant inpatient facilities. FF17.Rushford will work with MidState and The Hospital of Central CT to arrange follow-up community-based care with priority access to Rushford's Meriden outpatient center. FF9.

The proposal will enhance the quality of behavioral health inpatient care.FF30. A six-bed psychiatric unit, regardless of the expertise or dedication of the staff, cannot offer the full range of treatment made available to patients on a 32-bed unit. FF27-30.Quality will improve as The Hospital of Central CT offers its inpatients specialized therapies that cannot be effectively or efficiently provided at MidState, due to the limited number and diverse diagnoses of patients. FF26.

MidState will provide transportation assistance,at no cost, to family members and otherswho wishto visit and/or participate in the treatment of MidState patients admitted to The Hospital of Central CT inpatient psychiatric unit.FF24-25.Patients and their families will be advised about the

availability of transportation assistance while receiving care at MidState's ABU. In addition, an advisory committee will be formed and meet monthly to review the effectiveness and compliance of thesetransportation protocols; monitor compliance with the principles of the MOU between MidState, The Hospital of Central CT and Rushford; and review access and quality data reports for MidState patients. FF9&25.

Both MidState and The Hospital of Central CT project incremental gains from operations for the first three fiscal years following approval of the proposal. FF42-43.These gains result, in part, from The Hospital of Central CT'sability to deliver psychiatric inpatient care at a much lower cost than MidState.The direct cost per day following the expansion of the psychiatric unit at The Hospital of Central CT is projected to be $650and represents a significant reduction in cost compared to the existing program at MidState.FF38-40.

The transformation of health care towards consistent outcomes, higher quality and lower cost care will require a coordinated and consolidated approach to service delivery. FF31.The Applicantshave the potential to realize additional savings if patient admissions/readmissions can be reduced as a result of improved patient care coordination and enhanced community servicesbeing developed in conjunction with this proposal.FF10.

OHCA finds that the Applicants have demonstrated that the proposal willimprove the quality and cost effectiveness of health care,while access to care for behavioral health patients in the greater Meriden area will be maintained.

Order

NOW, THEREFORE, the Department of Public Health, Office of Health Care Access ("OHCA") and MidState Medical Center, The Hospital of Central Connecticut and Hartford HealthCare Corporation ("Applicants") hereby stipulate and agree to the terms of settlement with respect to the Applicants' request to terminate inpatient behavioral health services at MidState Medical Center in Meriden as follows:

1. The request of the Applicants to terminate inpatient behavioral health services at MidState Medical Center in Meriden is hereby approved.

2. Only upon completion of the renovations to The Hospital of Central CT's inpatient unit and the establishment of the 10 (ten) additional beds may MidState Medical Center discontinue admitting patients to itsinpatient behavioral health unit. Patients currently admitted to MidState Medical Center's inpatient behavioral health unit at the time of termination may remain at MidState Medical Center to complete their treatment if that is their preference.

3. MidState Medical Center shall report to OHCAthe date of the termination of MidState Medical Center's inpatient behavioral health unit. Such written notification must be filed with OHCA no later than three calendar days following said termination.

4. MidState Medical Center shall continue to provide emergency behavioral health services at its acute behavioral health unit (ABU).

5. The Hospital of Central CT shall expand its behavioral health unit by ten beds and provide preferred inpatient status to MidState ABU patients. One bed will remain open or unoccupied on its inpatient psychiatric unit provided that there are less than eight MidState patients currently admitted to the inpatient psychiatric unit. Once all eight beds are occupied by MidState patients, the MidState patients will be given preference to two additional beds. Bed preference means that if there is a MidState patient and a patient at The Hospital of Central CT in need of an inpatient bed, the bed will go to the more medically needy patient, as determined by a psychiatrist at The Hospital of Central CT. If the bed goes to The Hospital of Central CT patient, then the next available bed will automatically go to the MidState patient. The waiting time for the next available bed is estimated to be no more than 24 hours.

6. MidState Medical Center shall provide assistance to patients ingaining access to inpatient behavioral health beds within the Hartford HealthCare Behavioral Health Network, i.e., Hartford Hospital/Institute of Living and Natchaug Hospital, in the event that a bed is not immediately available at The Hospital of Central CT.

7. MidState Medical Center shall provide transportation assistance to family members and loved ones to visit and/or participate in the treatment of patients admitted to The Hospital of Central CT's inpatient behavioral health unit from MidState Medical Center's ABUin

accordance with the transportation protocol submitted by the Applicants and identified in the Table of Record as Exhibit BBB.

8. MidState Medical Center and The Hospital of Central CTshall arrange follow-up community-based care for the patients transferred from MidState Medical Center with priority access to Rushford Center, Inc.'s Meriden outpatient center after discharge from The Hospital of Central CT.

9. Hartford HealthCare Corporation shall ensure that its affiliate, Rushford Center, Inc., will follow up with every MidState Medical Center patient discharged from the inpatient behavioral health unit at The Hospital of Central CT to ensure that there are no barriers to compliance with discharge plans or accessibility to services in the community.

10. Within 60 days of opening the new behavioral health unit at The Hospital of Central CT, the Applicants shall form an Advisory Committee with representation from MidState Medical Center, The Hospital of Central CT and Rushford Center, Inc. for the purpose of meeting monthly to monitor compliance with the principles of the Applicants' Memorandum of Understanding. At least two (2) representatives of consumers, one (1) representative from the Department of Mental Health and Addiction Services, and one (1) representative of mental health providers other than the Applicants or their affiliates shall be appointed to the Advisory Committee to provide input concerning the patient transfer process, the transportation protocol and any other applicable matters.

11. The Applicants shall submit to OHCA, the written minutes of the Advisory Committee'smonthly meetings on an on-going basis for three full years. The submission shall be received by OHCA within two weeks of the completion of the minutes each month.

12. MidState Medical Center shall submit to OHCA written or electronic quarterly reports that include the following information:

    a. Number of patients presenting to MidState Medical Center's acute behavioral health unit and the town where they reside;
    b. Number of patients transferred from the acute behavioral health unit and the name of the facility to which they were transferred;
    c. Average length of stay within MidState Medical Center'sacute behavioral health unit;
    d. Number of MidState Medical Center acute behavioral health unit patients awaiting transfer beyond 24 hours to be admitted to The Hospital of Central CT's inpatient behavioral health unit, and;
    e. Number of persons requested and provided transportation to The Hospital of Central CT pursuant to the terms of this Agreed Settlement.

13. The Hospital of Central CTshall submit to OHCA written or electronicquarterly reports that include the following information:

a. Number of patients admitted to its inpatient behavioral health unit from MidState Medical Center's acute behavioral health unit;
b. Number of patients from MidState Medical Center's acute behavioral health unit that were put on a wait list and the length of time each patient waited before admission;
c. Average length of stay for patients that were transferred from MidState Medical Center's acute behavioral health unit to The Hospital of Central CT's inpatient behavioral health unit;
d. Patient disposition at discharge, including provider for outpatient care and level of care recommended for patients that were transferred from MidState Medical Center's acute behavioral health unit.

14. The quarterly reporting requirements set forth in Stipulations 12 and 13 above are to be filed for a period of three (3) years. The filings shall be based on calendar year quarters (January - March, April - June, July - September, October - December). The first filing may include a partial quarter, as needed, based on the date of termination of the inpatient behavioral health unit at MidState Medical Center; filings will be due within thirty (30) calendar days of the end of each calendar quarter.

15. Within five (5) calendar days of the execution of this Agreed Settlement, the Applicants shall submit to OHCA a copy of the final executed Memorandum of Understanding between MidState Medical Center, The Hospital of Central CT and Rushford Center, Inc.

16. In filings to OHCA related to any of the above Stipulations, the Applicants shall not provide any patient identifiable or patient confidential information.

17. OHCA and the Applicants agree that this Agreed Settlement represents a final agreement between OHCA and the Applicants with respect to this request. The signing of this Agreed Settlement resolves all objections, claims, and disputes that may have been raised by the Applicants with regard to Docket Number: 12-31775-CON.

18. This Agreed Settlement is an order of the Office of Health Care Access with all the rights and obligations attendant thereto, and the Office of Health Care Access may enforce this Agreed Settlement pursuant to the provisions of Conn. Gen. Stat. §§ 19a-642 and 19a-653 at the Applicants' expense if the Applicants fail to comply with its terms.

19. This Agreed Settlement shallensure to the benefit of and be binding upon the Office of Health Care Access and the Applicants, and their successors and assigns.

Signed by Lucille Janatka, President / CEO
(Print name) (Title)

3/25/13
Date

Duly Authorized for
MidState Medical Center

Signed by Clarence Silvia, President & CEO
(Print name) (Title)

3/28/13
Date

Duly Authorized for
The Hospital of Central Connecticut

Signed by Elliot Joseph, President + CEO
(Print name) (Title)

3/28/13
Date

Duly Authorized for
Hartford HealthCare Corporation

The above Agreed Settlement is hereby accepted and so ordered by the Office of Health Care Access on 4/8/2013.

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

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*** TX REPORT ***
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TRANSMISSION OK

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: BARBARA DURDY

FAX: (203) 694-7601

AGENCY: MIDSTATE MEDICAL CENTER

FROM: LAURIE GRECI

DATE: 4/8/13 **TIME:**

NUMBER OF PAGES: 19
(including transmittal sheet

Comments: DN: 12-31775-CON Agreed Settlement

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

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DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: CLAUDIO CAPONE

FAX: (860) 224-5740

AGENCY: HOSPITAL OF CENTRAL CONNECTICUT

FROM: LAURIE GRECI

DATE: 4/8/13 **TIME:**

NUMBER OF PAGES: 19
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Comments: DN: 12-31775-CON Agreed Settlement

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DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JOAN W. FELDMAN

FAX: (860) 251-5211

AGENCY: SHIPMAN & GOODWIN LLP

FROM: LAURIE GRECI

DATE: 4/8/13 **TIME:**

NUMBER OF PAGES: 19
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Comments: DN: 12-31775-CON Agreed Settlement

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OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: KAREN GOYETTE

FAX: (860) 545-2127

AGENCY: HARTFORD HEALTHCARE CORPORATION

FROM: LAURIE GRECI

DATE: 4/8/13 **TIME:**

NUMBER OF PAGES: 19
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Comments: DN: 12-31775-CON Agreed Settlement

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FAX SHEET

TO: KIRK LOWRY

FAX: (860) 262-5035

AGENCY: CONNECTICUT LEGAL RIGHTS PROJECT

FROM: LAURIE GRECI

DATE: 4/9/13 **TIME:**

NUMBER OF PAGES: 19
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DEPARTMENT OF PUBLIC HEALTH
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FAX SHEET

TO: PAUL C. HORTON

FAX: (203) 235-2506

AGENCY: PAUL C. HORTON, M.D.

FROM: LAURIE GRECI

DATE: 4/8/13 **TIME:**

NUMBER OF PAGES: 19
(including transmittal sheet

Comments: DN: 12-31775-CON Agreed Settlement

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 ***Fax: (860) 418-7053***

Greer, Leslie

From: Greci, Laurie
Sent: Monday, April 08, 2013 3:29 PM
To: susiern59@aol.com
Cc: Greer, Leslie; Riggott, Kaila
Subject: Agreed Settlement for 12-31775-CON (MidState Medical Center's proposal to terminate inpatient behavioral health services)
Attachments: 31775 Agreed Settlement.pdf

Dear Ms. Duclos,

Attached you will find the Agreed Settlement between the Department of Public Health, Office of Health Care Access and the Certificate of Need Applicants (MidState Medical Center, Hospital of Central Connecticut and Hartford HealthCare Corp.)

If you have any questions, please feel free to contact Brian Carney or me.

Regards,
Laurie Greci

Laurie K. Greci
Associate Research Analyst
Department of Public Health
Health Care Access
laurie.greci@ct.gov
860 418-7032
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