# Application
# For
# Certificate of Need (CON)

Submitted to the

**State of Connecticut**

Department of Public Health

Office of Healthcare Access

**August 31, 2015**

by


**MC1 Healthcare, LLC**

187 South Canaan Road

Canaan, CT 06018

# 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.**

☒ **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.:** 15-32024-CON **Check No.:** 16623
**OHCA Verified by:** SL **Date:** 9/1/15

☒ **Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)***

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

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

☒ **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.**

☒ **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.**

# AFFIDAVIT

Applicant: MC1 Healthcare, Llc

Project Title: Mountainside - Wilton, CT

I, Martin Fedor, Managing Partner
(Individual's Name) (Position Title – CEO or CFO)

of MC1 Healthcare being duly sworn, depose and state that
(Hospital or Facility Name)

MC1 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]
Signature

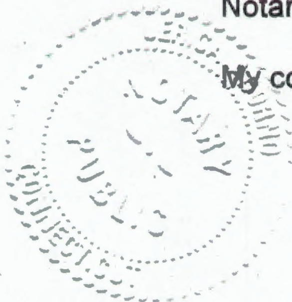
8/24/15
Date

Subscribed and sworn to before me on 8/24/15

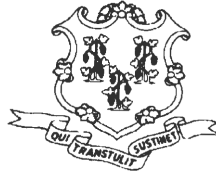
[signature]

Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2018



JERICA ADORNO
NOTARY PUBLIC
State of Connecticut
My Commission Expires
May 31, 2018




# 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:** **MC1 Healthcare, LLC**

**Contact Person:** **Peter B. Rockholz**

**Contact Person's Title:** **Consultant**

**Contact Person's Address:** **81 Bowman Drive, Greenwich, CT 06831**

**Contact Person's Phone Number:** **203.313.1418**

**Contact Person's Fax Number:** **203.532.5576**

**Contact Person's Email Address:** **pbrmssw@aol.com**

**Project Town:** **Wilton, CT**

**Project Name:** **Mountainside – Wilton, CT**

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

**Estimated Total Capital Expenditure:** **$10,000**

## MC1 Healthcare, LLC

## Application for Certificate of Need (CON)

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

*a.* ***Please provide a narrative detailing the proposal.***

MC1 Healthcare, LLC, d/b/a Mountainside Treatment Center ("Mountainside"), a for-profit organization registered to conduct business in Connecticut, proposes to open a new outpatient treatment service for adults (male and female) with substance use disorders (SUD) in Wilton, Connecticut. Mountainside currently operates detoxification, residential and outpatient SUD services, licensed by the Connecticut Department of Public Health (DPH) and accredited by the Council on Accreditation of Rehabilitation Facilities (CARF), at its main campus in Canaan, Connecticut. The new service will primarily serve existing clients in early recovery from addiction who receive detoxification and/or residential treatment at Mountainside Treatment Center and then return to the Fairfield County area where they will receive continuing care.

Mountainside has been operating addiction treatment programs since 1998, providing services to approximately 9,000 clients annually, including those in the insurance and self-pay sectors exclusively. The proposed service will address the need to provide stepdown continuing treatment for the largest concentration of Mountainside's national client population – one-fifth of which is from Fairfield County. In order to maximize client outcomes and to reduce relapse to addiction, Mountainside will offer a structured intensive outpatient treatment (IOT) program – a highly effective solution to facilitating long-term recovery. The proposed location, at the center of Fairfield County, will provide a convenient setting for clients, providing accessibility, proximity and privacy, within about 30 minutes driving distance and a 20-mile radius of Wilton.

The need for SUD treatment nationally, and within Connecticut including Fairfield County far exceeds capacity. The current epidemic of opiate (e.g., heroin, prescription opioids) addiction is amplifying this need as well as changing the landscape of the treatment industry. Heroin has exceeded alcohol as the primary drug for which clients seek treatment. Accidental deaths associated with heroin overdose have reached an all-time high, creating a major public health crisis. The uniquely high rate of relapse to opiates, and the extreme risk of overdose among those achieving initial abstinence, compels treatment providers to attend to the continuing needs of discharging clients. Mountainside and other high-quality providers are compelled to respond with the most effective, evidence-based approaches available.

The proposed outpatient service will begin operation immediately upon award of a certificate of need (CON) and issuance of a license by the Department of Public Health (DPH). Existing clients in the target population will be enrolled in advance and will populate the program from its inception. With a minimal capital outlay, and benefitting from administrative efficiencies of its existing infrastructure, Mountainside projects operating with a modest margin from start-up, and will be cost-effective. A gradual increase in both client volume and fees will ensure continued viability. Within the proposed space, Mountainside will be able to expand services to meet actual demand as it is presented.

The proposed outpatient service will improve health care services in the area, improve client outcomes including reduced recidivism and reduced medical costs and costs to society by enabling clients to increase the likelihood of achieving sustained recovery. The introduction of this service will have minimal impact on the existing licensed providers in the area.

## 2. Clear Public Need

### a. *Provide the following regarding the proposal's location:*

#### i. *The rationale for choosing the proposed service location;*

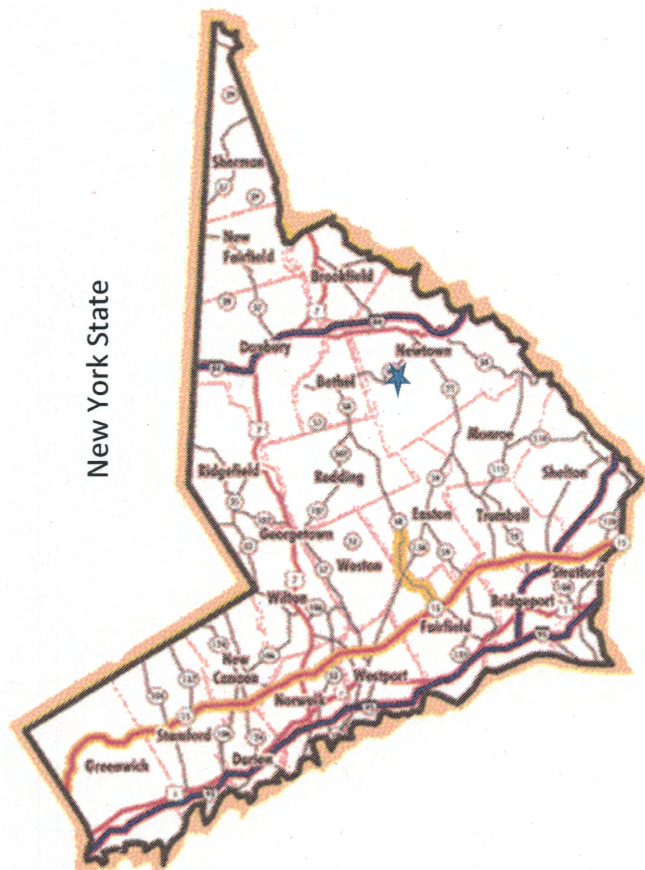
The main rationale for locating an outpatient treatment facility in Fairfield County is to enable us to better meet Mountainside's existing residential clients' continuing care needs; and to improve client health outcomes including reduced rates of relapse.

By offering an industry- and client-preferred level of continuing care services (i.e., intensive outpatient treatment (IOT)) near their home communities within reasonable driving distance, we will be better able to ensure that our clients' treatment and discharge plans can be implemented with greater certainty through a lower level-of-care, delivered by the same provider.

We chose Wilton because it is geographically, logistically and population-based at the center of Fairfield County -- where the highest concentration (20% of total) of our discharged residential clients return (see map in Figure 1 below).

More specifically, the following factors were central to the choice of location:

**Figure 1 - Map of Fairfield County**




<u>Accessibility</u> – Mountainside's Wilton facility will be located on Route 7 (Danbury Road) -- the primary north-south State highway through Fairfield County. It is situated five (5) miles north both the Norwalk and Westport exits of the Merritt Parkway (Route 15) -- the primary east-west State highway through the center of lower Fairfield County.

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

<u>Privacy</u> – We have selected an attractive yet relatively non-descript commercial office building to house our new services, rather than a dedicated building, in order to maximize client anonymity and privacy.

Clients will share the main building entrance that serves several other businesses, ensuring that clients will not be seen walking directly into Mountainside's counseling offices. The parking area behind the building is large, as it is shared by occupants and visitors of a cluster of office buildings – removing the possible assumption by others that an individual is one of our clients. Being in the rear of the building, the parking area is also shielded from Route 7 to further help protect client privacy.

Finally, while convenience is generally highly valued by clients, the necessity to drive up to 30 minutes each way will be offset by the benefit that they are less likely to be seen by friends and neighbors when accessing services that are located away from their home towns.

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

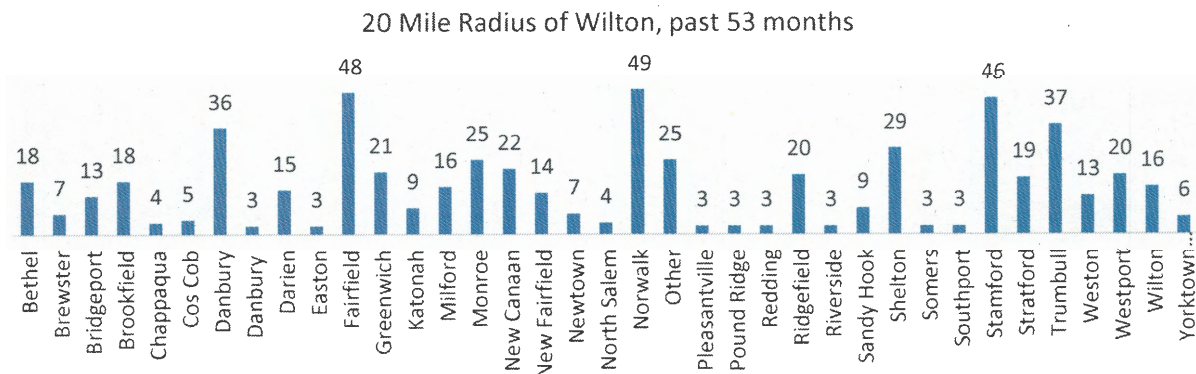
The primary service area will include all 22 cities and towns in Fairfield County, specifically:

Bethel, Bridgeport, Brookfield, Danbury, Darien, Easton, Fairfield, Greenwich, Milford, Monroe, New Canaan, New Fairfield, Newtown, Norwalk, Redding, Ridgefield, Shelton, Stamford, Stratford, Trumbull, Weston, Westport, and Wilton.

With Wilton situated in the center of Fairfield County, these towns are within a twenty-mile radius, and within about 30 minutes' driving time, of the proposed facility. This will allow reasonable access to services by the primary target population of clients returning home following a residential treatment stay.

We selected the towns listed above based largely on the fact that one-fifth (20%) of Mountainside's admissions to its residential programs are from these towns. They represent the largest geographical concentration of our clients in need of continuing care in the community of anywhere in the country. The actual distribution of clients from these cities and towns over the past 53 months is shown in Figure 2 below. In addition to the target Connecticut cities and towns, eight (8) towns listed below and within the 20-mile radius are in New York State. Our demonstration of need will only be presented for the towns in Connecticut, while the actual demand for services will be higher.

**Figure 2 - Frequency distribution of Mountainside admissions, by town**




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

General Population – Incidence and prevalence

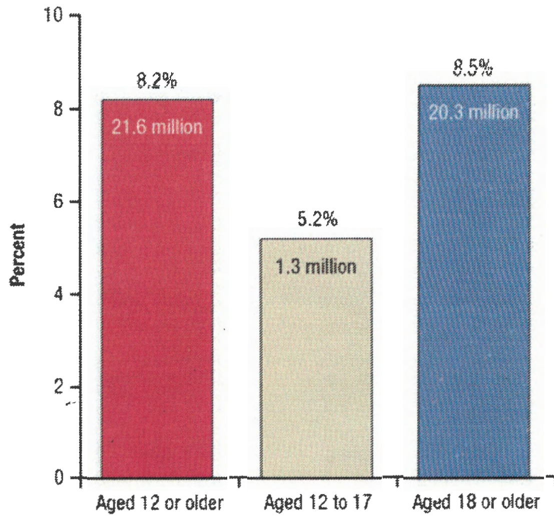
The general population segment within which the target population rests includes adults (18 years of age and above) with diagnosable substance use disorders (SUD)[1] who reside in Fairfield County, Connecticut.

The most current national data are available for 2013 from the Substance Abuse and Mental Health Services Administration (SAMHSA) based upon results from the National Survey on Drug Use and

[1] Meaning those with moderate-to-severe SUD according to criteria defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

Health (NSDUH).[2] The 2013 (most recent) NSDUH estimates the prevalence of SUD (including alcohol and illicit drugs) among adults in the United States at 8.5% (see Figure 3 below).

**Figure 3 - Substance use disorder (SUD) in the past year among individuals aged 12 or older in the United States: 2013**




Source: SAMHSA. Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2013.

According to the United States Census Bureau[3], the population of Fairfield County in 2014 was 945,438, (about 26% of the total population of Connecticut). It reports that 76.1% of those are aged 18 and over – placing their estimate of the adult population in Fairfield County at 719,478.

Extrapolating by applying the NSDUH prevalence estimate of 8.5%, the census data would suggest there are about 61,000 adults with SUD in Fairfield County. Actual data from Connecticut are not available. For example, DMHAS needs data reflect services only within the public-funded treatment system and do not include data from private, for-profit providers who primarily serve self-pay clients. In addition, high net-worth clients often receive treatment in programs located elsewhere across the country. Therefore, the estimate of 8.5% for the general United States population will be used for projections.

Need for treatment in Fairfield County, Connecticut

Perhaps the most compelling, recent evidence available to demonstrate treatment need in Connecticut comes from the *Behavioral Health Barometer - Connecticut 2014*, issued by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in 2015.[4] The following excerpt validates the extrapolated estimate of treatment need suggested above [note that the figures below include 12-17 year olds], and also identifies the percentage of those in need who are not served in any given year:

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

Using this benchmark, it can be estimated that of the 718,478 adults in Fairfield County, 8.4%, or 60,436 need treatment but did not receive it. This provides strong evidence of the need for treatment

[2] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (September 4, 2014). *The NSDUH Report: Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings*. Rockville, MD.

[3] www.census.gov

[4] Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Connecticut, 2014*. HHS Publication No. SMA–15–4895CT. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

services in Fairfield County, far is excess of what could possibly be provided through the proposed service.

Illicit drug and alcohol abuse: unmet treatment need and demand -- discussion

The *Behavioral Health Barometer* differentiates rates for alcohol (94.0%) and illicit drugs (79.5%) for those needing but not receiving treatment in Connecticut. This raises two qualitative issues around different substances of choice related to the consideration of treatment need. First, an important distinction should be made between "need" and "demand" and, secondly, we are experiencing an historic national epidemic of heroin addiction that is receiving an unprecedented national response.

Based upon this evidence, a conclusion that there is a very high "unmet need" for alcohol treatment would be reasonable, but an adjustment should be made considering the challenge of motivating alcohol-dependent persons to seek treatment especially in the face of stigma and denial – hallmarks of the disease of alcoholism. While many individuals and their family members suffer the daily consequences of untreated alcoholism, they continue to do so for long periods, often in response to the individual's denial and the family's perceptions of societal stigma. In most cases, treatment is voluntary and therefore, what would be considered as actual demand is likely much lower than the documented unmet need.

The comparable data provided for illicit drug abuse and dependence suggests that the unmet treatment need is considerable lower than for alcohol. It would certainly be reasonable to conclude that treatment capacity for drugs is much greater than for alcohol and that the need for increased capacity for alcohol is greater than for drugs. Again, qualitative factors should be considered before these conclusions are reached. First, heroin addiction is qualitatively different from alcohol addiction in terms of the rapidity of addiction, and the higher incidence of emergency medical response and overdose deaths. Individuals are much more likely to seek treatment when they perceive the need to do so. Urgent medical necessity is an effective motivator. This is especially the case with heroin as the potential for overdose mortality is relatively high.

These observations are intended to say that, while a greater percentage of individuals with treatment need for opiate use disorder receive treatment compared to the same for alcohol use disorder, the greatest actual proportional demand for services is for heroin. This is reflected in the dramatic shift in actual treatment admissions at national, state and local levels.

For example, a December 21, 2008 article in the Hartford Courant, titled *Heroin Moves into Connecticut Suburbia* cites observations by the (then) State of Connecticut addictions authority:

> "For the first time ever, heroin has surpassed alcohol as the primary drug for those seeking rehabilitation treatment in the state, said Peter Rockholz, deputy commissioner of the state Department of Mental Health and Addiction Services.
>
> Also, in the past couple of years, the number of heroin deaths in Connecticut has doubled from one a week to two a week, Rockholz said. The U.S. Drug Enforcement Administration now considers heroin the main drug of concern in Connecticut and the Northeast." (www.mapinc.org/drugnews/v08/n1154/a04.html)

Heroin Epidemic

The current epidemic of heroin abuse in the United States and Connecticut continues to escalate. Every day there is a new article in the mainstream media about the heroin epidemic and heroin-related fatalities. A Google search for "heroin epidemic" returns over 9 million results, and for "heroin epidemic Fairfield County" returns 25,800 results. Each includes articles in all major mainstream media outlets, within the past month, including front-page articles in the Wall Street Journal, the New York Times, the Washington Post, the Hartford Courant, CNN, Time, and numerous others.

The rising concern about overdose deaths in Connecticut is a motivating factor that appears to result in increasing treatment admissions in Fairfield County. The inescapable public awareness facilitated by the media appears to have reduced stigma in favor of families mobilizing to save lives of loves ones. In the case of Fairfield County – where the population is 80% Caucasian, and has among the highest income-per-capita in the nation, this public health crisis affects families of all socio-economic levels and racial/ethnic groups. But, as evidenced by data from the Connecticut Chief Medical Examiner (figure below), overdose deaths in Connecticut (similar to other states) continue to rise more than a decade after the current epidemic began, and disproportionately affect Caucasians. According to a summary of the data appearing in the Hartford Courant, July 12, 2015 (*Heroin Deaths Spike in Connecticut; Push Past 300 in 2014* (copy provided in Attachment IV) which comprising 70% of the population of Connecticut, whites represented 84% of heroin deaths in the last three years.

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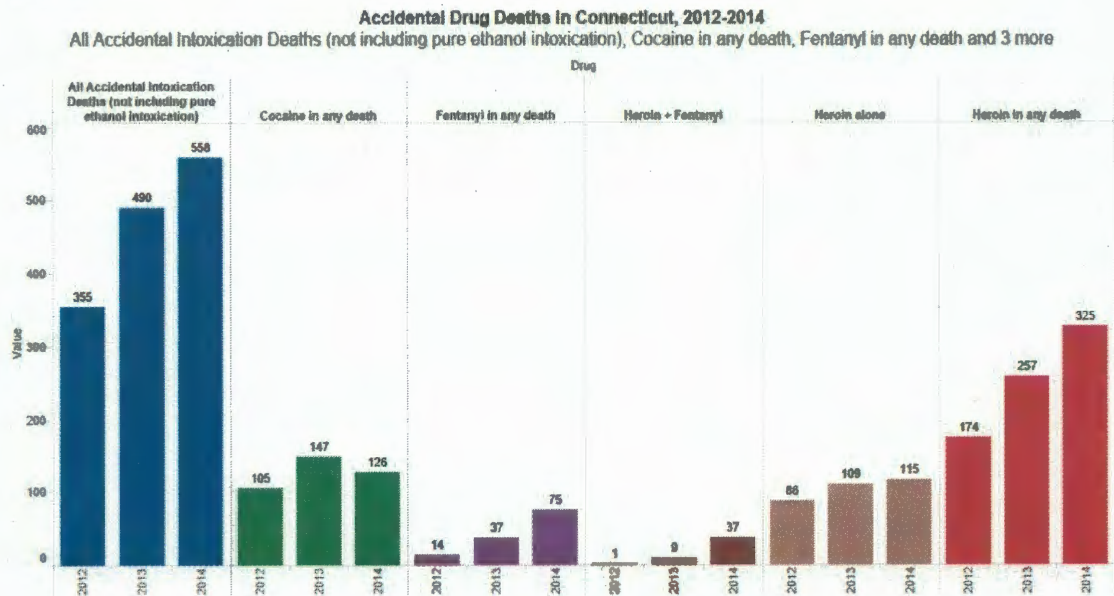
Multiple Values




The epidemic reaches across all socio-economic groups. This is illustrated in recent articles from virtually every town in Fairfield County. For example, the New Canaan Advertiser published an article on March 26, 2015 entitled "Town responds to growing prevalence of heroin" (see Attachment IV). New Canaan has the highest income per capita in Connecticut and is among the highest in the United States.

In fact, according to (then) DMHAS Deputy Commissioner Rockholz, what is now a major national heroin epidemic began more than 20 years ago in Fairfield County, with young adults becoming rapidly addicted to prescription opiates and then switching to heroin, as cited in an article in *The Justice Journal* (www.thejusticejournal.com/article35.shtml). Excerpts include:

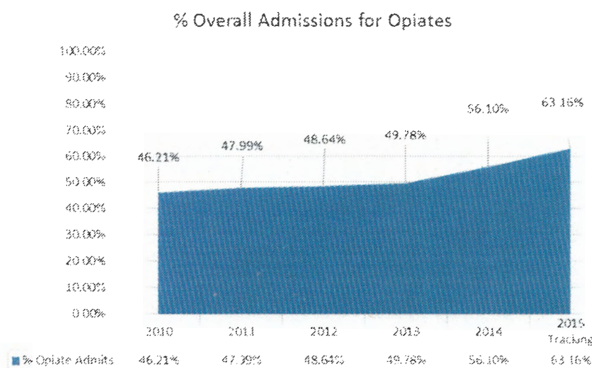
> "Dorrie Carolan, co-founder of the Newtown Parent Connection, a substance abuse awareness and support group, has heard similar reports from parents and teens she works with in northern Fairfield County.
>
> 'It's happening in Newtown, it's happening in Ridgefield,' said Carolan, whose son died of a prescription drug overdose in 1993."
>
> The epidemic began with the misuse of readily available prescription opiates ("painkillers") and a switch to the much less costly and increasingly available, high purity heroin, as described by "Ryan":

"Ryan said his heroin addiction began when he realized he could "just drive to Bridgeport and buy heroin for $10," as opposed to the $40 he would spend on OxyContin. He estimated between 75 and 80 percent of the kids he knew who were abusing OxyContin eventually tried heroin."

Primary Target Population

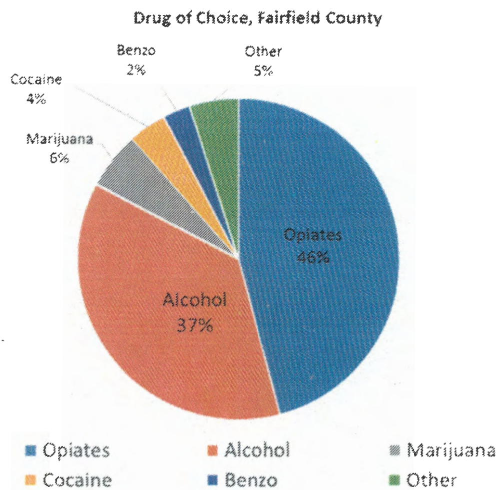
Mountainside's clientele includes those with relatively high net worth, with many from the high income communities in Fairfield County. The target population of residential clients returning to Fairfield County increasingly includes an increasing percentage whose primary substance of abuse is heroin. The increase in national and state treatment admissions for heroin over the past few years has been experienced at Mountainside (see Figure 4 below).

***Figure 4 – Mountainside opiate admissions as percentages of all admissions: 2010-2015***




Similar to other programs across the state, Mountainside has seen a dramatic shift in the primary drug of choice for admissions. Historically, alcohol was the number one drug by a wide margin. As is evident in Figure 5, however, heroin has become the drug of choice for an increasing majority of all clients.

***Figure 5 – Mountainside admissions by primary drug of abuse***



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

The proposed Wilton CT outpatient target population is currently being served in several lower levels of care by a variety of community providers. Based upon a review of actual aftercare referrals from the residential program for the past 3.5 years, Table A provides a summary of what type of service clients from Fairfield County are being referred to.

***Table A – Current aftercare referrals and projected Wilton referrals***

| TYPE OF CARE | % of Total | Estimated annual Mountainside referrals from Fairfield County | Projected Referrals to Wilton IOT |
|---|---|---|---|
| Sober Living | 29% | 70 | |
| Intensive Outpatient (IOT) | 17% | 40 | 24 |
| Extended Care (residential) | 16% | 38 | |
| Outpatient Treatment | 10% | 24 | 6 |
| Private Practice Clinicians | 9% | 22 | 11 |
| Refused Recommendation | 8% | 19 | 10 |
| 12-Step Meetings | 7% | 17 | 8 |
| Psychiatrist | 1% | 2 | |
| Other | 1% | 2 | |
| **TOTAL** | **100%** | **234** | **59** |

A total of forty-five percent (45%) of clients are referred to continuing residential services including sober living and extended care at locations either in Canaan or other parts of Connecticut. An uncertain number of these clients are later referred to IOT following their residential stay. Of the estimated 40 clients referred to IOT (17% of total), 20 are currently being served by five existing facilities in Fairfield County, and 20 are being served by IOT programs in other parts of Connecticut including at Mountainside's IOT program in Canaan. Another total of 21% receive outpatient/counseling services through area providers in the community.

About 7% of clients only attend 12 Step meetings versus participating in treatment, and 8% refuse to participate in any recommended continuing treatment or support groups. Of these two groups, several have been referred to IOT programming. Anecdotally, we understand that about one-half of these would prefer to attend a Mountainside IOT if it were available in lower Fairfield County.

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

In order to ensure a thorough accounting of existing intensive outpatient SUD treatment providers in the proposed service area, we began with those listed on SAMHSA's website with the following search criteria: Outpatient substance abuse treatment; Cash (self-payment) or private health insurance; young adults and adults. The resulting list identified five (5) facilities located in three Fairfield County cities (Stamford, Bridgeport and Norwalk).

The second search, which we expected to result in more complete information, was the State of Connecticut Department of Public Health (DPH) list of licensed outpatient substance abuse treatment facilities providing IOT within 20 miles of Wilton, Connecticut (source: www.ct.gov/dph). This list includes three (3) of those listed by SAMHSA, and ten (10) additional facilities in Fairfield County.

We continued with a search for existing outpatient substance abuse-specific treatment programs offering IOT in Fairfield County working with adults in the "private pay" category at the DMHAS-funded Connecticut Clearinghouse website (www.ctclearinghouse.org), locating one (1) additional facility not found on the other two lists.

Finally, we compared the compiled lists to our database of referral services that our residential clinicians use to make discharge referrals. This search identified one (1) additional IOT provider in the target area that was not on any of the lists. With this, we considered our search to be exhaustive.

The non-duplicated list of sixteen (16) existing providers of the proposed service in Fairfield County includes:

| | Provider | Street | Town |
|---|---|---|---|
| 1 | Silver Hill Hospital, Inc. | 208 Valley Road | New Canaan |
| 2 | Connecticut Renaissance, Inc. | 4 Byington Place | Norwalk |
| 3 | Family and Children's Agency, Inc. | 9 Mott Avenue | Norwalk |
| 4 | Norwalk Hospital – Outpatient | 20 North Main Street | Norwalk |
| 5 | Connecticut Renaissance, Inc. | 141 Franklin Street | Stamford |
| 6 | Liberation Programs, Inc. | 115 Main Street | Stamford |
| 7 | Liberation Programs, Inc. | 117 Main Street | Stamford |
| 8 | Liberation Programs, Inc. | 399 Mill Hill Avenue | Bridgeport |
| 9 | Family Resource Associates, LLC | 3300 Main Street | Stratford |
| 10 | New Era Rehabilitation Center, Inc. | 3851 Main Street | Bridgeport |
| 11 | Chemical Abuse Services Agency, Inc. | 592 Kossuth Street | Bridgeport |
| 12 | MCCA, Inc. | 38 Old Ridgebury Road | Danbury |
| 13 | Recovery Network of Programs, Inc. | 480 Bond Street | Bridgeport |
| 14 | Connecticut Counseling Centers, Inc. | 60 Beaverbrook Road | Danbury |
| 15 | Greenwich Hospital | 5 Perryridge Road | Greenwich |
| 16 | The Recovery Center of Westport | 328 Post Road East | Westport |

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

Of the 16 existing intensive outpatient treatment providers in Fairfield County, eight (8) almost exclusively serve public-sector clients with State/Federal funding or Medicaid reimbursement and are located the urban settings of Norwalk, Bridgeport and Stamford. Also, seven (7) of the facilities serve only their clients on methadone maintenance/MAT at those locations.

Of the listed programs, only five (5) primarily serve populations within a socio-economic category similar to Mountainside's (i.e., exclusively insurance or 'self-pay' clients). First, Silver Hill Hospital's IOT program is intended as "The final phase in our continuum of care..." for existing patients, and specializes in treating co-occurring mental disorders (source: www.silverhillhospital.org). Similarly, Greenwich Hospital's IOT program is described as "A step-down program for patients leaving inpatient care or a stand-alone treatment program for patients with active addictions" (source: www.greenwichhospital.org). Both Family Resource Associates and The Recovery Center of Westport are small practices with limited capacity. And, finally, MCCA provides IOT at its Danbury location, offering co-occurring mental health treatment, and includes Medicaid and General Assistance (GA) clients.

We anticipate that the addition of Mountainside's Wilton facility to the area will have a minimal effect on existing area providers. As mentioned above (section 2.a.iv.), discharged Mountainside residential clients currently receive continuing care services through a variety of community providers including sober living, licensed clinics and independent, licensed professionals.

As is illustrated in Table A above, we project that a total of 59 of the 234 Fairfield County client pool will likely enroll in the proposed IOT program in Wilton. Since 18 of these either refused to participate

or are solely attending 12 Step meetings, and an estimated five (5) clients are anticipated to transfer from Mountainside's IOT program in Canaan, only the remaining 36 clients will be redirected from area providers. Of these, 26 are estimated to be receiving a lower level of care (outpatient counseling) due to the absence of an IOT program consistent with Mountainside's philosophy (based upon anecdotal information). For the remaining 10 clients, all of whom are receiving IOT services at one of five (5) existing providers, we anticipate continuing to refer one-half of these (e.g., 5) based upon client preference (e.g., proximity) or clinical need (e.g., co-occurring mental health needs).

Based upon this review, we conclude that the implementation of this proposal will have minimal impact on existing area providers.

3. **Projected Volume**

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

***Table 1: Projected Volume – Number of Individuals to be Served***

| | **Projected Volume by Fiscal Year*** | | | |
|---|---|---|---|---|
| **Service Type** | **FY 2015**** | **FY 2016** | **FY 2017** | **FY 2018** |
| Intensive Outpatient Treatment (IOT) Program | 9 | 55 | 58 | 62 |
| **Total** | **9** | **55** | **58** | **62** |

* MC1 Healthcare's Fiscal Year is January 1 – December 30
** FY 2015 includes November 1 – December 30 only (2 mos.)

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

The projected volume of individuals to be served in intensive outpatient treatment (IOT) as presented in Table 1 above is based on actual admissions of clients from the target service area (Fairfield County CT) who receive treatment at one or more of Mountainside's residential programs in Canaan, CT (see Table B below).

The projection uses actual counts of existing residential clients from the target area (i.e., within 20 mile radius of Wilton, CT) and applies the current rate of increase (6.9%) to extend into the following three (3) full years. This is viewed as a conservative estimate.

The resultant volume figures are then adjusted by applying a conversion rate of 25%, which is the approximate conversion rate currently experienced at our IOT program in Canaan, CT. Conversion rate means the percentage of total discharges that eventually enroll in IOT. This, too, is viewed as a conservative estimate.

c. ***Provide historical volumes for three full years and the current year to date for any of the Applicant's existing services that support the need to implement the proposed service.***

The primary target population includes clients being discharged from a residential treatment episode at Mountainside in Canaan, Connecticut and returning to Fairfield County for continuing care services. Therefore, the historical volume of Mountainside's residential rehabilitation program, and the portion from Fairfield County, may be the most valid and reliable indicator of actual need for the proposed service.

The following table shows total annual residential admissions for the current year-to-date and the three previous years along with the actual admissions of clients from Fairfield County, with the percentage of the total. The shaded areas show projections for the first three full years of the new facility, using the current growth rate of 6.9%.

***Table B– Actual and projected Mountainside admissions – Residential totals and Fairfield County***

| | 2012 | 2013 | 2014 | 2015* | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|---|
| **Mountainside Residential** | 697 | 667 | 829 | 981 | 1048 | 1119 | 1195 |
| **Fairfield County** | 125 | 127 | 191 | 204 | 218 | 233 | 249 |
| **Fairfield County %** | 17.9% | 19.0% | 23.0% | 20.8% | 20.8% | 20.8% | 20.8% |

* 2015 figures are projected based upon 7-month actuals

Based upon the historical volume at Mountainside's residential programs and the portion from Fairfield County, it is reaonable to conclude that there is a solid basis for projecting a subpopulation that will generate actual demand for treatment – a more valid and reliable estimate than one based upon speculation or extrapolated need.

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

Previously mentioned articles provide direct strong evidence to support the need for SUD treatment among the target population. In particular, two documents produced by the Substance Abuse and Mental Health Services Administration (SAMHSA) have been excerpted and appear in Attachment VI, including:

The 2013 *National Survey on Drug Use and Health (NSDUH)* – this federally funded study clearly documents the need for substance use disorder (SUD) treatment, nationally. The most relevant pages (92-98) of *Section 7.3 Need for and Receipt of Specialty Treatment* are provided in Attachment IV. This section addresses the need for treatment for illicit drug and alcohol use both separately and combined. The benchmark findings relevant to this application include:

- Of persons aged 12 or older, 8.6 percent needed treatment for an illicit drug or alcohol use problem.
- Of those persons aged 12 or older who needed treatment for SUD, 10.9 percent received such treatment.

The *Behavioral Health Barometer: Connecticut 2014* – this document provides summaries of data analysis from the NSDUH survey, using data specific to the state of Connecticut. The most relevant pages (16-26) of the report are provided in Attachment IV. The salient findings of this summary report covering years 2009-2013, include:

- About 243,000 or 8.1% of all Connecticut individuals were dependent on or abused alcohol
- About 83,000 or 2.8% of all Connecticut individuals were dependent on or abused illicit drugs
- Of all Connecticut individuals with alcohol dependence or abuse, 94.0% did not receive treatment

- Of all Connecticut individuals with illicit drug dependence or abuse, 79.5% did not receive treatment

In addition, we have presented the case for the importance of, and value in, offering intensive outpatient treatment (IOT) as a continuing care option for clients with SUD. The effectiveness of this level of care has been studied through meta-analysis, published as "Substance Abuse Intensive Outpatient Programs: Assessing the Evidence" (co-authored by current DMHAS Commissioner, Miriam Delphin-Rittmon, Ph.D.) and available in the public domain through the National Institutes of Health (NIH) at PMC 2015 June 01. An excerpt of the author manuscript is provided in Attachment VI. Major conclusions of the study include:

- The level of evidence for IOPs was considered high.
- IOPs are an important part of the continuum of care for alcohol and drug use disorders.
- Public and commercial health plans should consider IOP treatment as a covered health benefit.

**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.***

Key staff list for Mountainside – Wilton, CT:

- Stephen Langley, CAC – Executive Director
- Sarah Osborne, LPC, LADC, NCC – Program Director
- Randall Dwenger, M.D. – Medical Director
- Alkesh Navin Patel, M.D. – Addiction Psychiatrist

To be hired: initially, one (1) clinician with either: LADC, LPC, LMFT, LCSW.

Curricula vitae for the four (4) professionals named above, and a job description for the clinician (TBH) position, appear in ATTACHMENT II.

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

In addition to adding a new, high quality outpatient substance abuse treatment facility within the region, Mountainside will serve to improve health care outcomes for individuals beginning recovery from SUD. By providing essential, continuing treatment (i.e., 'step-down') following primary inpatient/residential treatment the proposed service will help minimize relapse and enhance transition to productive, independent and self-supporting healthy lifestyles in the community.

It is widely understood in the addictions field that time-in-treatment is linearly associated with improved outcomes. In other words, the longer one remains engaged in treatment, the better their odds are for achieving sustained recovery (e.g., long-term abstinence). According to the national Drug Abuse Treatment Outcome Study (DATOS), "The length of time clients stayed in treatment was directly related to improvements in follow-up outcomes, replicating findings from previous national treatment evaluations".[5] Providing continuing, uninterrupted treatment, extending it into the community, enables clients to increase their health outcomes. This results in a reduction in the over-use of repeated acute care episodes, reduced costs to society and improved functioning.

Revisiting the data presented above (e.g., Table A), those Mountainside clients who currently choose to not engage in continuing care, or who opt for either individual counseling or 12 Step attendance only including as an alternative to IOT due to its unavailability, will be better served and more likely to achieve

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[5] Hubbard, R. L., Craddock, S. G., Flynn, P. M., Anderson, J., & Etheridge, R. M. (1997). Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11*(4), 261-278.

long-term recovery by participating in the proposed service.

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

The most relevant and current standards of practice applicable to the proposed project are outlined in *Treatment Improvement Protocol (TIP) 47*, published by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2006)[6]. This publication, titled *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment*, clearly identifies fourteen Principles of Intensive Outpatient Treatment (see excerpt in ATTACHMENT IV). These include (with brief responses describing how Mountainside will address each):

(1) *Make treatment readily available.*

Mountainside IOT service availability will be guaranteed for the target population, with initial sessions scheduled in advance, for all clients referred directly from Mountainside's residential services. Intake sessions will occur within 72 hours.

(2) *Ease entry.*

Prior to outpatient treatment admission, client treatment records will be available following the completion of confidentiality regulations-compliant forms by the client. Since the outpatient and residential programs are both operated by the same entity, entry will be as smooth as could be possible.

(3) *Build on existing motivation.*

Mountainside residential staff work with each client to encourage continuing care following discharge. With no lapse in continuity between residential and outpatient treatment, the direct transfer ('handshake') of clients will ensure the maximization of existing client motivation to continue their care.

(4) *Enhance therapeutic alliance.*

Mountainside outpatient staff will receive clinical supervision and training with a major focus on engagement skills and other critical factors associated with positive client outcomes. The therapeutic alliance will be further enhanced by the continuity of philosophical approach to SUD across Mountainside's levels-of-care.

(5) *Make retention a priority.*

Along with engagement, client retention will be a primary performance measure for clinical staff. It will be included as a criteria in annual reviews. Additional efforts to maximize retention will include the use of on-site recovery support meetings and activities to build community among clients.

(6) *Assess and address individual treatment needs.*

An important component of the IOT program will be case management. Along with a comprehensive, ongoing clinical assessment, and individual treatment plans, the primary clinician will be responsible for coordinating needed rehabilitative and recovery support services in the community.

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[6] Center for Substance Abuse Treatment. *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Treatment Improvement Protocol (TIP) Series 47.* DHHS Publication No. (SMA) 06-4182. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

*(7) Provide ongoing care.*

As each client progresses toward their treatment goals, monthly reviews will determine the need for, and intensity of, continuing care services. Mountainside will adjust the frequency of outpatient services accordingly, including moving from three (3) 3-hour IOT session sessions per week to weekly, monthly and eventually quarterly check-in sessions as defined in the individual treatment plans.

*(8) Monitor abstinence.*

In addition to thrice-weekly observations in Mountainside IOT sessions by staff and other clients in recovery – for physical, behavioral and attitudinal signs of possible use - clinical staff conduct routine and random urines drug screens on all clients. These are processed through a certified laboratory.

*(9) Use mutual-help and other community-based supports.*

Mountainside is grounded in the Twelve Steps of Alcoholics Anonymous/Narcotics Anonymous. Virtually all staff are individuals in recovery from addiction. All outpatient clients are expected to attend AA/NA and/or other appropriate recovery support groups and meetings on a regular basis. Such expectations are outlined in writing in each individual's treatment plan.

*(10) Use medications if indicated.*

The Mountainside Medical Director and the addiction psychiatrist (MD) have considerable experience working with individuals experiencing addiction and co-occurring mental disorders. While they recognize the professional literature supports the combination of evidence-based psycho-social therapy and medication-assisted treatment, they take a conservative approach to the use of medications, avoid prescribing those with abuse potential, and provide client education.

*(11) Educate about substance abuse, recovery, and relapse.*

Formal education about substance abuse, recovery, relapse, family dynamics, wellness and other essential components to recovery is a hallmark of the Mountainside approach, and will be delivered through psycho-educational sessions on a weekly basis by professional clinicians during the IOT sessions.

*(12) Engage families, employers, and significant others.*

Family interventions, family therapy and family education will be offered to Mountainside clients through a licensed marital and family therapist and licensed clinical social workers according to individual treatment plans. As appropriate, families will be invited to visit the facility to address the individual goals and continuing care needs of the client. For those who are distant from their family members and/or significant others, Mountainside may employ telemedicine and/or telephonic/SKYPE voice/video interface to enhance the quality of distance therapy. As appropriate, those area employers who are 'recovery friendly' and supportive of the program, will be engaged to provide support through properly authorized communication with staff.

*(13) Incorporate evidence-based approaches.*

Mountainside utilizes an approach that incorporates research-supported practices, clinical experience, client preferences and feedback as evidence upon which to base the selection of approaches for each individual. This is known as 'evidence based practice' as a process. Through this process, individual 'evidence-based' interventions may be selected on an individual client basis. The only 'wholesale' evidence-based component will be Twelve-Step Facilitation. In

addition, Mountainside will typically utilize additional, select practices such as Motivational Interviewing (MI), Cognitive-Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT), among others.

*(14) Improve program administration.*

Mountainside benefits from the existing administrative infrastructure of MC1 Healthcare, LLC (d.b.a. Mountainside Treatment Center) which has eighteen (18) years of experience in developing and managing services to individuals with addictions in Connecticut. Mountainside plans to continue to grow in scale, diversity of services and sophistication, while drawing upon the talents of individuals with extensive executive, managerial and supervisory experience. The proposed executive director and director (see attached curriculum vitae) have and will continue to provide expert guidance to facility staff.

## 5. Organizational and Financial Information

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

MC1 Healthcare is a limited liability corporation (LLC), registered with the Connecticut Secretary of the State (Business ID #0973673).

***b. Does the Applicant have non-profit status?***

☐ Yes (Provide documentation) ☒ No

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

MC1 Healthcare, LLC holds an active license (#0388) issued by the State of Connecticut Department of Public Health (DPH) for the following categories at its Canaan, Connecticut location:

- Residential Detoxification and Evaluation Beds
- Intermediate and Long Term Treatment and Rehabilitation Residential Beds
- Day and or Evening Treatment
- Outpatient Treatment

A copy of this license appears as ATTACHMENT III.

Concurrent with this CON application, the Applicant submitted an application for licensure from DPH on August 8, 2015 for a new facility to provide Outpatient Substance Abuse Treatment services at the Wilton, Connecticut site.

***d. 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.***

Not Applicable

*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.)***

Please see financial statements (accountant's compilation report) for MC1 Healthcare, LLC for the fiscal year ended 12/31/2014 in ATTACHMENT V.

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

***Table 2: Proposed Capital Expenditures/Costs***

| | |
|---|---|
| Medical Equipment Purchase | |
| Imaging Equipment Purchase | |
| Non-Medical Equipment Purchase | $10,000 |
| Land/Building Purchase * | |
| Construction/Renovation ** | |
| Other Non-Construction (Specify) | |
| **Total Capital Expenditure (TCE)** | **$10,000** |
| Medical Equipment Lease (Fair Market Value) *** | |
| Imaging Equipment Lease (Fair Market Value) *** | |
| Non-Medical Equipment Lease (Fair Market Value) *** | |
| Fair Market Value of Space *** | |
| **Total Capital Cost (TCC)** | **$0** |
| **Total Project Cost (TCE + TCC)** | **$10,000** |
| Capitalized Financing Costs (Informational Purpose Only) | $0 |
| Total Capital Expenditure with Cap. Fin. Costs | $10,000 |

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

The anticipated capital expenditure of $10,000 will be paid by MC1 Healthcare, LLC using cash.

**6. Patient Population Mix: Current and Projected**

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

***Table 3: Patient Population Mix***

| | **Current FY 2015**** | **Year 1 FY 2016** | **Year 2 FY 2017** | **Year 3 FY 2018** |
|---|---|---|---|---|
| Medicare* | 0 | 0 | 0 | 0 |
| Medicaid* | 0 | 0 | 0 | 0 |
| CHAMPUS & TriCare | | | | |
| **Total Government** | | | | |
| Commercial Insurers* | 48,392 | 316,317 | 344,603 | 375,419 |
| Self-Pay | 16,920 | 110,600 | 120,491 | 131,265 |
| Workers Compensation | | | | |
| **Total Non-Government** | **65,312** | **426,917** | **465,094** | **506,684** |
| **Total Payer Mix** | **65,312** | **426,917** | **465,904** | **506,684** |

**** Includes managed care activity.***

** Includes November 1 – December 30, 2015 (two months)

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

Mountainside only accepts direct commercial insurance or similar (e.g., managed care) third-party payment assignment or self-pay paid in full, in advance. Clients are expected to cover the full cost of services, including through a combination of insurance and self-pay. Mountainside does not accept Medicaid or other governmental insurance or entitlements, and receives no State or Federal funding.

The projected client population mix assumes that 65% of admissions will be supported by commercial insurance (non-governmental). This is a conservative estimate, as the most recent rate of insurance coverage for IOT clients at Mountainside's Canaan location is approaching 80%. The remainder of clients will be 'self-pay' and expected to assume the full negotiated cost of care.

The numbers of projected clients is based upon actual admissions to Mountainside's residential treatment programs in Canaan who are from Fairfield County. These numbers are adjusted using an estimated 25% conversion rate.

### 7. Financial Attachments I & II

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

See Financial Attachment I (B) in ATTACHMENT V.

***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 <u>full</u> fiscal years of the project.***

See Financial Attachment II in ATTACHMENT V.

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

<u>Financial Attachment I (B) assumptions</u>:

- Mountainside assumes an opening of service date of November 1, 2015.
- Revenue projections assume client fees to be paid by: 65% commercial insurance and 35% self-pay. This is based upon actual experience at the Canaan IOT program.
- Bad debt is projected at 1.25% for insurance and 0.0% for self-pay – also based upon actual experience at the Canaan facility.
- Rates are projected to increase at 3% per year, to recover annual inflation and expense increases.
- Projections assume an average daily client census of 7 in FY2016; 8 in FY2017 and 8 in FY2018. This reflects the current trend of increasing residential admissions at 6.9% per year, and average treatment episode duration of twelve (12) weeks.
- Fringe benefits are estimated at .30 of salaries.
- Lease costs are projected to increase by 3% per year; other operating expenses are estimated to increase at 15% per year – reflective in part of incremental costs associated with the 6.9% projected annual increase in client volume.
- Full-time equivalents (FTEs) for direct clinical staff are estimated based upon a maximum client-to-staff ratio of 8:1. FTEs include two (2) clinicians, one (1) administrative assistant, and one half-time physician (MD) equivalent.

<u>Financial Attachment II assumptions (additional):</u>

- Insurance payments assume an average 30% negotiated discount.
- Units of service are three-hour IOT sessions, provided three (3) times per week per client. Increases in units are driven by increasing client census (volume).

**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).***

The proposed rates for services at Mountainside's Wilton facility will be the same as the current and future rates at Mountainside's Canaan, Connecticut outpatient facility. Mountainside has had 18 years' experience in setting reasonable private rates that it has been able to successfully collect. The actual experience shows that insurance rates are negotiated lower (beginning at about $375/session), and virtually 100% of self-pay clients do pay the full rates in advance.

The rates in Wilton might otherwise be higher -- based upon the higher cost-of-living in lower Fairfield County -- but Mountainside has decided to keep its rates uniform. Rates are anticipated to be raised a modest 3% per year during the first three years of operation.

Mountainside's rate schedule is as follows:

| **Mountainside Intensive Outpatient Treatment (IOT) Fees*** | | | |
|---|---|---|---|
| | **2016** | **2017** | **2018** |
| Insurance | $545 | $560 | $575 |
| Uninsured | $275 | $285 | $290 |
| % change (approx.) | | +3% | +3% |

*Fees are for each 3-hour IOT session (unit of service).

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

Based upon initial, three-year expense and rate projections, the following numbers of units (i.e., 3-hour IOT sessions) will be required to begin to show an incremental gain from operations:

Fiscal Year 1 (2016): 1,125 units

Fiscal Year 2 (2017): 1,196 units

Fiscal Year 3 (2018: 1,281 units

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

No incremental losses are projected.

**g. *Describe how this proposal is cost effective.***

The Mountainside outpatient treatment program is designed to provide seamless, continuing treatment for individuals with substance use disorders (SUD). These services provide extended treatment duration in a less-restrictive, and therefore lower cost, setting that maximizes the potential for achievement of long-term recovery in the community. By addressing emerging and underlying emotional and psychological factors associated with relapse to substance use, the proposed service will reduce future healthcare costs related to relapse, including repeated addiction treatment and associated medical costs.

By providing a dedicated regimen of clinical services that are closely coordinated with sober housing and related recovery supports, pro-social community involvement and wellness activities, the proposed service will contribute to decreasing long-term behavioral healthcare costs – especially the need for chronic, acute care episodes, and particularly the costs associated with heroin overdose incidents. National studies

estimate that the benefit-cost ratio achieved by providing addiction treatment is 7:1 (i.e., $7.00 saved in societal costs for every $1.00 spent)[7].

Finally, by sharing administrative and support service infrastructure with MC1 Healthcare LLC, Mountainside will minimize indirect costs, allowing for an investment in high quality professional staff and services that will produce exceptional results.

## Supplemental CON Application Form
## Establishment of a New Health Care Facility (Mental Health and/or Substance Abuse Treatment)

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

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

Services to be provided at the new facility do not include any that would be considered unique among facilities within the service area serving a similar population in an intensive outpatient treatment (IOT) program.

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

In addition to the two (2) part-time, licensed physicians (MD) already engaged by Mountainside -- who will provide medical and psychiatric supervision -- the following full-time DPH-licensed health care professional positions will be required to initiate the proposed Wilton outpatient facility:

Two (2) clinicians with any of the following DPH licenses:

- Licensed Alcohol and Drug Counselor (LADC)
- Licensed Professional Counselor (LPC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)

**9. Projected Volume**

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

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

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

The specific target population to be served includes adults returning to towns in Fairfield County, Connecticut following a residential treatment episode at Mountainside Treatment Center in Canaan, Connecticut. This population includes individuals with a substance use disorder (SUD) in need of continuing care at the intensive outpatient level-of-care.

[7] White House Office of National Drug Control Policy, *Cost Benefits of Investing Early in Substance Abuse Treatment*, Fact Sheet available at www.whitehouse.gov/ondcp.

***Figure 6 – Population, estimated need, and number and percentages to be served, by town***

| Town | Population | In Need | To be served (2016) | % of Need |
|---|---|---|---|---|
| Bethel | 19264 | 1637 | 4 | 0.24% |
| Bridgeport | 147216 | 12513 | 3 | 0.02% |
| Brookfield | 16860 | 1433 | 4 | 0.28% |
| Danbury | 83684 | 7113 | 9 | 0.13% |
| Darien | 21330 | 1813 | 3 | 0.17% |
| Easton | 7616 | 647 | 1 | 0.15% |
| Fairfield | 60855 | 5173 | 12 | 0.23% |
| Greenwich | 62396 | 5304 | 7 | 0.13% |
| Milford | 53137 | 4517 | 4 | 0.09% |
| Monroe | 19834 | 1686 | 6 | 0.36% |
| New Canaan | 20194 | 1716 | 5 | 0.29% |
| New Fairfield | 14145 | 1202 | 3 | 0.25% |
| Newtown | 28113 | 2390 | 4 | 0.17% |
| Norwalk | 87776 | 7461 | 11 | 0.15% |
| Redding | 9312 | 792 | 1 | 0.13% |
| Ridgefield | 25164 | 2139 | 7 | 0.33% |
| Shelton | 40999 | 3485 | 7 | 0.20% |
| Stamford | 126456 | 10749 | 10 | 0.09% |
| Stratford | 52112 | 4430 | 4 | 0.09% |
| Trumbull | 36571 | 3109 | 8 | 0.26% |
| Weston | 10372 | 882 | 3 | 0.34% |
| Westport | 27308 | 2321 | 5 | 0.22% |
| Wilton | 19657 | 1671 | 4 | 0.24% |
| **TOTAL** | **990371** | **84182** | **125** | **0.15%** |

Data presented in Figure 6 above are based upon the following assumptions:

- Population numbers are 2013 estimates provided by the Connecticut Department of Public Health on its website.
- The estimates of individuals "In need" of SUD treatment are calculated by applying the 8.5% estimated average for the United States population provided by SAMHSA (see Attachment IV).
- The estimated number of individuals to be served (client volume) is based upon annual averages of actual past 53-month figures from Mountainside's residential admission records, by town.
- The percentages reported are the percentage of estimated individuals to be served of the estimated number of persons in need of treatment.

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

The previously cited *National Survey on Drug Use and Health (NSDUH) – 2013*, issued by SAMHSA, indicates that 8.5% of those aged 18 and over are in need of treatment for SUD. The *Behavioral Health Barometer: Connecticut, 2014* (SAMHSA, 2015) (also cited previously) provides an estimated percentage of the unmet need for SUD treatment among the population of adults in Connecticut of 8.4%. Since the target population is one that has received (residential) treatment, we have used the 8.5% figure, and projected need for services in each of the towns serving the target population.

Both sources cited herein are Federal documents available in the public domain (excerpts are provided in Attachment IV).

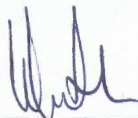
## Affidavit

Applicant: MC1 Healthcare, Llc

Project Title: Mountainside - Wilton, CT

I, Martin Fedor, Managing Partner
(Name) (Position – CEO or CFO)

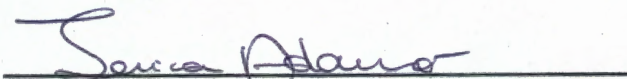
of MC1 Healthcare being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.



Signature

8/24/15
Date

Subscribed and sworn to before me on 8/24/15



Notary Public/Commissioner of Superior Court

My commission expires: May 31, 2018

JERICA ADORNO
NOTARY PUBLIC
State of Connecticut
My Commission Expires
May 31, 2018

**MC1 Healthcare, LLC**

**Certificate of Need (CON) Application**

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- The NSDUH Report, June 25, 2009 (excerpts)
- Behavior Health Barometer: Connecticut, 2014 (excerpts)
- *Heroin Deaths Spike in Connecticut; Push Past 300 in 2014* – Hartford Courant
- "Town responds to growing prevalence of heroin" – New Canaan Advertiser
- "Substance Abuse Intensive Outpatient Programs: Assessing the Evidence"
- Substance Abuse: Clinical Issues in Intensive Outpatient Treatment: SAMHSA Treatment Improvement Protocol (TIP) 47 (excerpts)

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# Attachment I

## Evidence of Public Notice Listing

## The Hour

**PUBLISHER'S AFFIDAVIT**

**LEGAL NOTICE**

Notice is hereby given that, pursuant to Connecticut General Statutes Section 19a-638, MC1 Healthcare, LLC – a Connecticut corporation – intends to apply for a certificate of need to locate outpatient substance abuse counseling services for private adult clients at 372 Danbury Road, Wilton Connecticut, with an associated capital expenditure of $10,000. Interested persons may contact the State of Connecticut, Department of Public Health, Office of Health Care Access, Attention: Steven Lazarus, 410 Capitol Ave. MS #13HCA, Hartford, CT 06134 or by phone at 860.418.7001 for additional information.

STATE OF CONNECTICUT )
ss. Norwalk
COUNTY OF FAIRFIELD )

I, JOCELYN A. BATTISTA, being duly sworn, dispose and say:

1. I am over the age of eighteen (18) and believe in the Obligation of an oath;

2. I am the Classified Advertising Supervisor of The Hour Publishing Company, publisher of the following newspapers:

   1) The Hour, a daily newspaper, published in Norwalk, Connecticut;

   2) The Wilton Villager, a weekly newspaper, published in Norwalk, Connecticut; and

   3) The Stamford Times, a weekly newspaper, published in Norwalk, Connecticut.

On July 17th, 2015, July 18th, 2015 and July 19th, 2015 an advertisement placed by Mountain Side was published in The Hour newspaper.

Jocelyn A. Battista, Classified Advertising Supervisor

Subscribed and sworn to before me this 20th day of July, 2015.

Brett L. Whitton
Commissioner of the Superior Court

# Attachment II

## Proposed Staff Curriculum Vitae

# Stephen Langley

24 ABBY DRIVE

HEBRON, CT, 06248 UNITED STATES (860) 318-5212

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## Professional Experience

MOUNTAINSIDE TREATMENT CENTER, CANAAN, CT UNITED STATES

*Executive Director, Oct 2013 – present*

- Steward of the culture of excellence maintained by this CARF accredited, leading provider of chemical dependency detoxification, residential, extended care and outpatient treatment services.
- Day to day responsibilities include leadership of all treatment and services teams: Detox/Residential/Clinical; Client Services; Family Wellness; Outpatient; and Operations. Additional responsibilities include program development, safety and security, and Federal and State regulatory compliance.

*Senior Vice President, Client Services, Jan 2013 – Oct 2013*
*Vice President, Client Services, Jan 2012 – Jan 2013*
*Director, Client Services, Jan 2011 – Jan 2012*
*Director, Extended Care, Apr 2008 – Jan 2011*

NATIONAL FOOD PROCESSORS ASSOCIATION, WASHINGTON, DC UNITED STATES

*Vice-President, Member Services, Mar 1996 – Jan 1999*

- Establish and maintain effective working relationships with clients, government officials, and media representatives and use these relationships to develop new business opportunities.
- Write interesting and effective press releases, prepare information for media kits and develop and maintain company internet or intranet web pages.
- Identify main client groups and audiences, determine the best way to communicate publicity information to them, and develop and implement a communication plan.
- Assign, supervise and review the activities of public relations staff.
- Develop and maintain the company's corporate image and identity, which includes the use of logos and signage.
- Respond to requests for information about employers' activities or status.

AMERICAN MEAT INSTITUTE, ARLINGTON, VA UNITED STATES

*Director of Member Services, Aug 1989 – Mar 1996*

- Formulate, direct and coordinate marketing activities and policies to promote products and services, working with advertising and promotion managers.
- Identify, develop, or evaluate marketing strategy, based on knowledge of establishment objectives, market characteristics, and cost and markup factors.
- Direct the hiring, training, or performance evaluations of marketing or sales staff and oversee their daily activities.

## Education

TUNXIS COMMUNITY COLLEGE, BRISTOL, CT UNITED STATES

- Associates Degree, Drug and Alcohol Recovery Counselor, May 2010
- CAC Certification, Connecticut Certification Board, March 2011

## Additional Skills

- Strong Communication Skills
- Proven Team Leader
- Able to Multi-Task
- Proven Track Record of Achieving Results
- Proficient in Multiple Computer Programs, Including Microsoft Office

# Sarah Osborne, LPC, LADC, NCC

Mountainside Outpatient Services Program Director
Route 7, Box 717 Canaan, CT 06018
Phone: 860 362 5028 • E-Mail: sarah.osborne@mountainside.com


**Areas of Interest**
• Eye Movement Desensitization and Reprocessing Therapy (EMDR) • Wellness Oriented Recovery
• Neuropsychology • Co-Occurring Supervision/Training • Program Development
• Process Innovation/Improvement • Team Development/Coaching • Quality Assurance Standards
• Extensive Training in Trauma & Co-Occurring Care

**Awards**
• Best in Class 2015 – Developing and Opening Moutainside Outpatient Services
Intensive Outpatient, Outpatient, and Individual Therapy

**Presentations**
• URICA – How to utilize the results effectively to track clinical progress
• Ethical Boundaries in Clinical Settings
• Borderline Personality Disorder
• EMDR overview

**Credentials**
• LPC – Licensed Professional Counselor CT DPH #002454; Exp 11/30/2015
• LADC – Licensed Alcohol and Drug Counselor CT DPH #001045; Exp 11/30/2015
• NCC – Nationally Certified Counselor NBCC #301314; Exp 11/30/2017

## Education

**Master of Science; Clinical Mental Health Counseling 2009 – 2012**
Western Connecticut University, Danbury, CT

## Professional Experience

**Mountainside Canaan, CT** **September 2013 - Present**

**Outpatient Services Program Director** **May 2014 - Present**

- Developing the Wellness in Recovery curriculum for Outpatient Services
- Introducing EMDR to Mountainside and establishing it in the Outpatient Services program
- Provide clinical supervision to Outpatient Services department, student interns and other professionals seeking licensure
- Manage assigned caseload of 10-15 clients; including case notes, treatment plans, & clinical interventions.

- Coordinating with family members and referents regarding client's progress in treatment & continuing care plans.
- Run psychotherapy and psychoeducational groups
- Conduct program chart audits

**Clinician; Residential** **September 2013 – May 2014**

- Provide clinical supervision to student interns and professionals seeking licensure
- Manage assigned caseload of 6-8 clients; including case notes, treatment plans, & clinical interventions.
- Coordinating with family members and referents regarding client's progress in treatment
- & continuing care plans.
- Run daily psychotherapy and psychoeducational groups

**Recovery Network of Programs • Bridgeport, CT February 2011 – October 2013**

**RNP – Clinical Coordinator; Horizons • Bridgeport, CT** **September 2012 – October 2013**

- Repeatedly recognized for top performance through fast-track promotion and selection for high-priority initiatives.
- Creating a family program that centers on co-occurring disorders.
- Supervise the Trauma Initiative within the program. Implementing Healing Trauma, DBT, • M-TREM, and coordinating the creation of a trauma centered clinical environment.
- Creating programmatic flow changes to increase quality and compliance in clinical care
- Teach clinical staff how to implement a client centered co-occurring model.

**RNP - Counselor; New Prospects • Bridgeport, CT** **February 2011- September 2012** 

Established DBT and Healing Trauma groups within the program.  Introduced a Women for Sobriety group.

## Professional Memberships

- Eye Movement Desensitization and Reprocessing International Association (EMDRIA)
- Northern CT EMDRIA Regional Network member
- American Counseling Association (ACA)
- International Association of Addictions and Offender Counselors (IAAOC)

## CURRICULUM VITAE

**Randall R. Dwenger, MD**
**PO Box 718**
**3 Brook Street**
**Lakeville, CT 06018 860.435.8863**

### EDUCATION:

Pre-medical: DePauw University, Greencastle, Indiana 1976-1980, BA degree, cum laude in chemistry and psychology, May 1980

Medical School: Indiana University School of Medicine, Indianapolis, Indiana, 1980-1984, MD degree, May 1984

Residency: Institute of Living, Hartford, Connecticut Psychiatry, July 1984 - June 1988 (includes six months medicine internship at: Mount Sinai Hospital, Hartford, Connecticut January 1985 - June 1985)

### PROFESSIONAL EXPERIENCE:

Mountainside Treatment Center, Canaan, CT, January 2014 – present

- Medical Director

Private Practice, Lakeville, CT, July 2007 – present

- Psychiatric Evaluation, Medication Management and Individual Psychotherapy services for adolescent and general adult population
- Consulting Psychiatrist – Salisbury School, Salisbury, CT (2007-present)
  Millbrook School, Millbrook, NY (2008-present)
  Mountainside Treatment Center, Canaan, CT (2008-present)
  Kent School, Kent, CT (2013-present)
  Berkshire School (2008-2012)

Veterans Administration – Winsted CBOC, Winsted, CT, June 2007-October 2013

- Psychiatric evaluation and medication management for general psychiatry and dualdiagnosis veterans in outpatient mental health setting

CMHA (Community Mental Health Affiliates)
(at the former "Northwest Center for Family Services" sites)
Lakeville, CT and Torrington CT, May 2007 – December 2009

- Psychiatric Evaluation and Medication Management services for general adult and adolescent population in a community-based outpatient mental health clinic

Veterans Administration – New York Harbor Healthcare System, New York, NY
October 1999 – April 2007

Director, Outpatient Psychiatry Clinic – Manhattan Campus
May 2005 – April 2007

- Clinical and administrative oversight/supervision of outpatient psychiatric services for veteran population within large metropolitan medical center.
- Psychiatric evaluation and medication management for general psychiatry and dualdiagnosis veterans in outpatient mental health setting
- Oversight of several administrative initiatives including: Chairman of Mental Health Stakeholders for JCAHO continued readiness for NY-Harbor VA; Coordinating Performance Improvement for Mental Health for NY-Harbor VA; Monitoring department's performance on National Director Performance Measures, January 2003 - present

Medical Director, Veterans Health Care Center – Chapel Street Clinic,
October 1999 – May 2005

- Psychiatric evaluation and medication management for general psychiatry and dualdiagnosis veterans in outpatient Community-Based Mental Health clinic
- Psychiatric/medical oversight and consultation for programs at Chapel Street CBOC, including TORCH (Homeless Veterans Program), Mental Health - Intensive Case Management (MH-ICM), SARP, and Mental Hygiene Clinic programs
- Coordinator/Director of outpatient SARP (Substance Abuse Rehabilitation Program) – July 2004 – April 2005
- Supervision of Psychiatry Residents – SUNY/Downstate

New York Hospital Medical Center of Queens, Fresh Meadows, NY

Medical Director, New Start / New Life Center,
January 1998 – September 1999

- Psychiatric evaluation and medication monitoring for dual-diagnosis and general psychiatry clients in outpatient setting

Bayley Seton Hospital, Staten Island, NY
Director, Center for Chemical Dependency, July 1991 - January 1998

- Administrative, fiscal and clinical/programmatic/medical supervision for inpatient chemical dependency detoxification program – including 27-bed Chemical Dependency Unit and 20-bed Alcohol Detox Unit
- Development of Chemical Dependency Outpatient Center
- Supervision of Psychiatry Residents
- Associate Psychiatry Staff, Bayley Seton Hospital and St. Vincent's Medical Center (Staten Island)

Hospital Committees:

- Ethics Committee
- AIDS Task Force
- Medical Records Committee
- Pharmacy and Therapeutics Committee
- Department of Psychiatry, Training Council
- Department of Psychiatry, Quality Assurance – Monitoring and Evaluation Committee, Chairman

Other:

- Continuous Quality Improvement; Facilitator, Team Leader

The Regent Hospital, New York, NY

Director of Chemical Dependency, September 1990 - June 1991

- Program development and administrative, clinical, supervisory responsibilities for inpatient 15-bed chemical dependency program for treatment-resistant Older Adolescent/Young Adult population
- Outpatient therapy and Medication Monitoring for Adolescent and General Adult populations (through Metropolitan Medical Group)

Fair Oaks Hospital, Summit, NJ

Adolescent Center for Chemical Education, Prevention and Treatment (ACCEPT)
Associate Director, July 1988 - July 1989
Director, July 1989 - September 1990

- Administrative, clinical and supervisory responsibilities in a 20bed inpatient unit for chemically-dependent and duallydiagnosed adolescents
- Outpatient individual and family therapy for Adolescent and General Adult populations

Institute of Living, Hartford, CT

Chief Resident, July 1987 - June 1988
Resident, Adult Psychiatry, July 1984 - June 1988
Clinical Supervision of PGY-1 Residents, September 1987 - June 1988
Team Leader, Adolescent Psychiatry Unit, August 1986 - June 1987

**MEDICAL LICENSURE:**

New York, 1990 - [# 183297]
New Jersey, 1988 - 1990
Connecticut, 1986 – 1996; 2006 – [#027715]
Massachusetts, 2008 – [#238121]
Indiana, 1984 - 1987

**BOARD CERTIFICATION:**

American Board of Psychiatry and Neurology, November, 1992 [#36120]

**REGISTRATIONS/CERTIFICATIONS:**

DEA: BD 1464611
Buprenorphine Prescriber DEA: XD 1464611
Controlled Substance Registration (CT): CSP.00041336

**ACADEMIC APPOINTMENTS:**

Assistant Professor of Psychiatry, SUNY-Downstate, 2001-2007 Assistant Professor of Psychiatry, New York Medical College, 1993 – 1998

**HOSPITAL AFFILIATIONS:**

Sharon Hospital – Sharon, CT

**AWARDS:**

Outstanding Teaching Service, SUNY-Downstate Dept of Psychiatry, 2000-2001
Outstanding Teaching Service, SUNY-Downstate Dept of Psychiatry, 2001-2002
Distinguished Teacher Award, SUNY-Downstate Dept of Psychiatry, 2004-2005

**PUBLICATIONS:**

"The History of Anorexia," A. Slaby and R. Dwenger, in The Eating Disorders, A. James Gianini (ed.), Springer-Verlay (pub), NY, NY 1991

***ALKESH NAVIN PATEL, M.D.***


**Permanent Residence**

*9 Lydia Drive*
*West New York, NJ 07093*
*Cell (347) 886 8732*
*Email: alkesh.patel@mssm.edu*

**Practice/Office Address**

*275 Seventh Avenue*
*12th Floor*
*New York, NY 10001*
*Office (212) 604-1785*


**Formal Education:**

1993-1997 Bachelor of Science
Concentration in Biology. GPA 3.4
Additional Studies completed in Spanish Language & Composition
***Tufts University***
Medford, Massachusetts

1997-2001 Doctor of Medicine
***Ross University School of Medicine***
Academic Campus: Dominica, West Indies
Clinical Campus: Various US Medical Centers

**Residency & Fellowship Training:**

2009-2010 Addiction Psychiatry Fellowship
Icahn School of Medicine at Mount Sinai Hospital New York, New York

2004-2008 Residency Training Program in Psychiatry
The Chicago Medical School
Rosalind Franklin University of Medicine and Science North Chicago, Illinois

2003-2004 Residency Training in Anesthesiology
Albert Einstein College of Medicine
The Montefiore Medical Center
Bronx, NY

2002-2003 Residency Training in Internal Medicine
University of Medicine and Dentistry of New Jersey
The New Jersey Medical School. Newark, NJ

**Board Certifications & Licensure Credentials:**

Board Certification in ***General Psychiatry***, April 3, 2009
American Board of Psychiatry & Neurology, Certificate # 59771

Board Certification in ***Addiction Psychiatry***, October 12, 2010

American Board of Psychiatry & Neurology, Certificate # 2084

Board Certification in ***Addiction Medicine,*** December 11, 2010
American Board of Addiction Medicine, Certificate # 2010354

Certification as ***Medical Review Officer*** (MRO), 2010
Official designation by ASAM as an expert in toxicology

DEA Registration, August 2006.

***DATA Waiver Registration for Buprenorphine for Office Based Treatment of Opioid Dependence. (Received 2008) Obtained Additional Authorization From CSAT to Treat Up to 100 Patients.***

New York Medical License No 246733 (*Active, Unrestricted*). (Obtained 2007)

## Academic & Hospital Appointments

1/2011-Present

**Assistant Professor of Psychiatry**

Icahn School of Medicine at Mount Sinai
The Mount Sinai Hospital
New York, New York

## Memberships and Committees

Mount Sinai Hospital Multidisciplinary Pain Committee
Mount Sinai Department of Psychiatry, Residency Review Committee
American Academy of Addiction Psychiatry (AAAP) Educational Committee
American Psychiatric Association (APA)
American Academy of Addiction Psychiatry (AAAP)
American Academy of Pain Medicine (AAPM)
American Society of Addiction Medicine (ASAM)

## Clinical Appointments

**Associate Medical Director**
Supportive Recovery Services (SRS)
Opioid Treatment Program
Evaluate Veterans for Medication-Assisted Treatment for Opioid Addiction
With Utility of Buprenorphine and Methadone
James J. Peters Veteran Affairs Medical Center
Icahn School of Medicine Major Academic Teaching Affiliate
Bronx, NY
2014-Present

**Director of Mental Health & Substance Abuse Services**
Senior HIV Psychiatry Consultant
Founded Integrated HIV/Primary Care Buprenorphine Program

Co-Chair Opiate Subcommittee on Problematic Patient Cases
Oversight of QI Project on Opioid Prescribing/Monitoring in the HIV Clinic
Mount Sinai Comprehensive Health Program
The Mount Sinai Medical Center
New York, NY
2012-2014

**Medical Director and Chief Addiction Psychiatrist**
Bridge Back to Life Treatment Centers, Inc. (Manhattan Campus)
Addiction Treatment Services/Intensive Outpatient Program
Supervise Clinical Care of Clients on Injectable Naltrexone and Buprenorphine
New York, NY
2012-Present

**Consultant Addiction Psychiatrist**
A.C.I. (A.R.E.B.A. Casriel Institute) Treatment Center
Intensive Outpatient Program
Oversight of Buprenorphine induction, maintenance, and detoxification
New York, NY
2013-Present

**Consultant Psychiatrist**
Women's Mental Health & Substance Abuse Program
New York City Department of Corrections
Corizon Health/Prison Health Services
Riker's Island, NYC
2009-Present

## Academic Leadership Experience

**Associate Director Addiction Psychiatry Fellowship Training Program**
Supervisor, Mentor, Clinical Educator for Addiction Psychiatry Trainees
Responsible for Administrative Oversight, Program Development, and
Adhering to ACGME Standards for Continued Accreditation
Icahn School of Medicine at Mount Sinai
The Mount Sinai Medical Center
New York, NY
2011-Present

**Addiction Psychiatry Clerkship Director Pain Medicine Fellowship Training Program**
Responsible for Mentorship, Clinical Education of Pain Medicine Trainees from
Anesthesiology and Physical Medicine & Rehabilitation Specialties
Strengthened Collaboration between Pain Medicine and Addiction Psychiatry
Trainees by Developing Didactic Curriculum Focusing on Chronic Pain,
Buprenorphine/Methadone Pharmacology and Pain/Addiction Clinical Interfaces
Icahn School of Medicine at Mount Sinai
The Mount Sinai Medical Center
New York, NY
2012-Present

## Lecture Presentations in Substance Abuse

**Clinical Diagnosis & Management of Alcohol Withdrawal Syndrome**
Annual CME Consortium Medical Conference
Icahn School of Medicine at Mount Sinai
Faculty Lecturer, 10/2012

**Neurobiology of Addictions and Brain Reward Circuitry**
Mount Sinai Grand Rounds
HIV Grand Rounds, 8/2012

**Pharmacological Management of Opioid Addiction**
Mount Sinai Clinical Fellow Lecture Series. Academic Year 2011, 2012

**Pharmacotherapy Interventions for Substance Abuse** Icahn School of
Medicine at Mount Sinai.
Psychiatry Residency PGY-2 Lecture Series, 2012

**Poster Presentation: A Trial of Chronic Opioid Therapy for a Methadone Maintenance Patient with Non-Cancer Pain**
International Conference on Opioids
Harvard Medical School Campus
Boston, Massachusetts. June 2013

**Vodka as a Tonic for Victrelis: A Tale of Addiction and Advanced Hepatitis C Co-Presenter: Testing and Screening for Alcohol Use Disorders**
Hepatitis C Case Conference Rounds, 8/2013

**Clinical Considerations in the Treatment of Opioid Addiction:**
**Neurobiology, Pharmacotherapies, and Appropriate Monitoring in Chronic Opioid Therapy**
Pharmacology Lecture Series on Opioids
Audience: Second Year Medical Student Class
Icahn School of Medicine at Mount Sinai, 11/2013

## Media Exposure/Expert Speaker Presentations in Substance Abuse

**Diagnosis & Treatment of Sexual Addiction**
Promises Treatment Center/Sexual Recovery Institute
Certified Sex Addiction Therapist, (CSAT) in training
Guest Speaker, on Expert Panel, with Robert Weiss, LCSW, CSAT-S
New York, NY
8/2012

**Reel Recovery Film Festival**
Expert Panel Speaker, Co-Host with Mavis Humes Baird, CSAT
After Movie Discussion on Film *Shame* about Sex Addiction
Written by Ali Morgan and Steve McQueen Staring Michael Fassbender
New York, NY
10/2012

## Select Publications in Substance Abuse

**Abstract Publication Poster Presentation**
International Conference on Opioids
Harvard Medical School Campus
Boston, Massachusetts. June 2013

**Patel A**, Alexeenko L, Epstein J. A Trial of Chronic Opioid Therapy for a Methadone Maintenance Patient with Non-Cancer Pain. Journal of Opioid Management, 2013.

***GUEST EDITOR***

### *Psychiatric Annals: A Journal of Continuing Psychiatric Education*

**CHALLENGES OF ADDICTION: Integrated Treatment Approaches for Varied Substance Use Disorders (September 2013 Edition)**

**Patel A**. Addiction in Chronic Pain Patients: Evidence-Based Approaches for Monitoring Chronic Opioid Therapy. Psychiatric Annals 2013; 43: 403-407.

**Patel A.** Challenges of Addiction: Guest Editorial. Psychiatric Annals 2013; 43: 392393.

Alexeenko L, **Patel A**, Ungar A. A 51-Year-Old Man with Bipolar Disorder, HIV, Fatigue, Hypersomnolence, and Increased Appetite. Psychiatric Annals 2013; 43: 395-398.

Jerome R, Cooper-Serber E, Rodriguez-Caprio G, **Patel A.** A 25-Year-Old Man with HIV, Major Depression, Methamphetamine Use, and Unsafe Sex Practices. Psychiatric Annals 2013; 43: 399-402.

Ng M, **Patel A**, Martel-Laferriere V, Perumalswami P. A 50-Year-Old Male with Cirrhosis, HCV, Alcohol-Use Disorder, and Unexpected Decline While on DAA Therapy. Psychiatric Annals 2013; 43: 412-415.

## Teaching Recognition Award

Resident Teacher of the Year Award
Chicago Medical School. Rosalind Franklin University of Medicine & Science
Nominated by Medical Students and Attending Faculty
Psychiatry Residency Graduation, June 2008

MOUNTAINSIDE

# Job description

**Job Holder:** To be determined

**Job Title:** Outpatient Clinician

**Department:** Outpatient Services

**Reports to:** Outpatient Program Director

**FLSA:** Exempt

**Job Summary:** Collaborate with a multi-disciplinary treatment team to create an individualized recovery experience that incorporates the body, mind and spirit of each client. Provide individual and group therapy sessions and facilitate treatment groups. Coordinate care with external providers and community resources.

Essential Duties and Responsibilities include the following, other duties may be assigned:

- Review discharge records from previous treatment providers
- Collaborate with family members, former providers and referral sources
- Complete comprehensive clinical utilization reviews on a regular basis and communicate all Insurance needs to Utilization Review Department.
- Create a comprehensive and collaborative treatment plan, including referrals to Family Wellness Program, APRN, Psychiatrist, Mind Body Spirit Program, Adventure Based Counseling Program and Continuing Care. Utilize identified screening/assessment tools, stage-wise interventions and treatment models.
- Conduct therapeutic treatment utilizing best practices of counseling, case management and crisis intervention.
- Facilitate groups with a focus on integrated care. Maintain clinical chart in accordance with agency and accreditation standards.
- Role model, explain and encourage pro-social behaviors such as: 12-step meeting etiquette, time management, appropriate language, dress and the importance of building same gender fellowships.
- Continue to collaborate with Mountainside team as a whole
- Participate in individual and group clinical supervision. Attend trainings to improve clinical skills or as assigned by your supervisor.

## General

- Adopt the Mountainside culture of providing a Best in Class Service to all of our clients.
- Comply with Mountainside procedures, policies and regulations relevant to your role. Undertake relevant training on Mountainside's policies and procedures as delivered by your manager, Human Resources or other departments.
- Comply with any specific responsibilities necessary for your role as outlined by your line manager or Human Resources to ensure you keep up to date with developments in these areas.
- Carry out additional responsibilities as individually notified, either through your objectives or as directed by your manager.

## Qualifications:

Perform this job successfully; an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

### Education and Qualifications

- Minimum credential of CAC, preference given to LADC, LPC, LMFT LCSW
- Graduate Degree in related field preferred

### Skills and Abilities

- Computer Skills: EMR (Electronic Medical Records), word processing, spreadsheet, and other software applications to prepare reports, invoices, financial statements and letters
- Able to work independently and as part of a multi-disciplinary team.

### Knowledge and Experience

- Knowledge of principles and techniques of group and individual counseling
- Ability to gather, analyze and evaluate information pertinent to the clinical care of clients
- Knowledge and experience in the provision of evidence based integrated care
- Considerable knowledge of federal and state laws and regulations regarding client confidentiality
- Ability to establish and maintain cooperative professional relationships
- Minimum two years' experience/knowledge in substance abuse and/or co-occurring disorders integrated treatment.

### Aptitude, Disposition & Competencies

- Enthusiastic
- Good boundaries
- Client-centered
- Team Player

# Attachment III

# MC1 Healthcare, LLC License

# STATE OF CONNECTICUT

## Department of Public Health

## LICENSE

## License No. 0388

## Facility for the Care or Treatment of Substance Abusive or Dependent Persons

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

MC1 Healthcare LLC of Canaan, CT, d/b/a Mountainside Treatment Center is hereby licensed to maintain and operate a private freestanding Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

**Mountainside Treatment Center** is located at 187 South Canaan Rd, South Canaan, CT 06018 with:

Stephen B. Langley as Executive Director.

The service classification(s) and if applicable, the residential capacities are as follows:

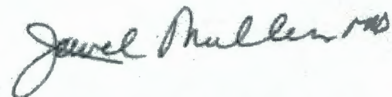
*20* Residential Detoxification and Evaluation Beds
*58* Intermediate and Long Term Treatment and Rehabilitation Beds
Day or Evening Treatment
Outpatient Treatment

This license expires **September 30, 2015** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2013.

License revised to reflect:

*Reconfiguration of beds Eff: 10/2/14*



Jewel Mullen, MD, MPH, MPA
Commissioner

# Attachment IV

# Articles in Support of the Need for the Proposed Service

- The NSDUH Report, June 25, 2009 (excerpts)
- Behavior Health Barometer: Connecticut, 2014 (excerpts)
- *Heroin Deaths Spike in Connecticut; Push Past 300 in 2014* – Hartford Courant
- "Town responds to growing prevalence of heroin" – New Canaan Advertiser
- "Substance Abuse Intensive Outpatient Programs: Assessing the Evidence"
- Substance Abuse: Clinical Issues in Intensive Outpatient Treatment: SAMHSA Treatment Improvement Protocol (TIP) 47 (excerpts)

# Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Behavioral Health Statistics and Quality

**Acknowledgments**

This report was prepared by the Center for Behavioral Health Statistics and Quality (CBHSQ), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS), and by RTI International (a trade name of Research Triangle Institute), Research Triangle Park, North Carolina. Work by RTI was performed under Contract No. HHSS283201000003C.

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**Recommended Citation**

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**Electronic Access and Copies of Publication**

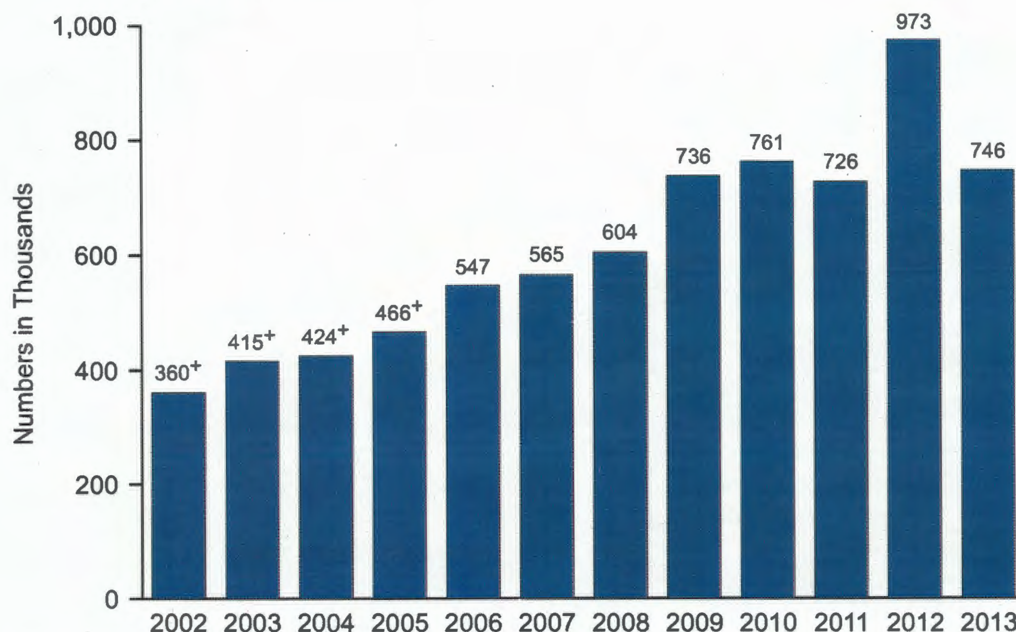
This publication may be downloaded from http://store.samhsa.gov/home. Hard copies may be obtained from SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

**Originating Office**

Substance Abuse and Mental Health Services Administration
Center for Behavioral Health Statistics and Quality
1 Choke Cherry Road, Room 2-1067
Rockville, MD 20857

September 2014

## Figure 7.9 Received Most Recent Treatment in the Past Year for the Use of Pain Relievers among Persons Aged 12 or Older: 2002-2013




+ Difference between this estimate and the 2013 estimate is statistically significant at the .05 level.

### 7.3 Need for and Receipt of Specialty Treatment

This section discusses the need for and receipt of treatment for a substance use problem at a "specialty" treatment facility. Specialty treatment is defined as treatment received at any of the following types of facilities: hospitals (inpatient only), drug or alcohol rehabilitation facilities (inpatient or outpatient), or mental health centers. It does not include treatment at an emergency room, private doctor's office, self-help group, prison or jail, or hospital as an outpatient. An individual is defined as needing treatment for an alcohol or drug use problem if he or she met the DSM-IV (APA, 1994) diagnostic criteria for alcohol or illicit drug dependence or abuse in the past 12 months or if he or she received specialty treatment for alcohol use or illicit drug use in the past 12 months.

In this section, an individual needing treatment for an illicit drug use problem is defined as receiving treatment for his or her drug use problem only if he or she reported receiving specialty treatment for illicit drug use in the past year. Thus, an individual who needed treatment for illicit drug use but received specialty treatment only for alcohol use in the past year or who received treatment for illicit drug use only at a facility not classified as a specialty facility was not counted as receiving treatment for illicit drug use. Similarly, an individual who needed treatment for an alcohol use problem was counted as receiving alcohol use treatment only if the treatment was received for alcohol use at a specialty treatment facility. Individuals who reported

receiving specialty substance use treatment but were missing information on whether the treatment was specifically for alcohol use or drug use were not counted in estimates of specialty drug use treatment or in estimates of specialty alcohol use treatment; however, they were counted in estimates for "drug or alcohol use" treatment.

In addition to questions about symptoms of substance use problems that are used to classify respondents' need for treatment based on DSM-IV criteria, NSDUH includes questions asking respondents about their perceived need for treatment (i.e., whether they felt they needed treatment or counseling for illicit drug use or alcohol use). In this report, estimates for perceived need for treatment are discussed only for persons who were classified as needing treatment (based on DSM-IV criteria) but did not receive treatment at a specialty facility. Similarly, estimates for whether a person made an effort to get treatment are discussed only for persons who felt the need for treatment and did not receive it.

**Illicit Drug or Alcohol Use Treatment and Treatment Need**

- In 2013, 22.7 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem (8.6 percent of persons aged 12 or older). The number in 2013 was similar to the numbers in 2002 to 2012 (ranging from 21.6 million to 23.6 million). The rate in 2013 was similar to the rates in 2011 (8.4 percent) and 2012 (8.9 percent), but it was lower than the rates in 2002 to 2010 (ranging from 9.2 to 9.8 percent).

- In 2013, 2.5 million persons (0.9 percent of persons aged 12 or older and 10.9 percent of those who needed treatment) received treatment at a specialty facility for an illicit drug or alcohol problem. The number in 2013 was similar to the numbers in 2002 (2.3 million) and in 2004 through 2012 (ranging from 2.3 million to 2.6 million), and it was higher than the number in 2003 (1.9 million). The rate in 2013 was not different from the rates in 2002 to 2012 (ranging from 0.8 to 1.0 percent).

- In 2013, 20.2 million persons (7.7 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty facility in the past year. The number in 2013 was similar to the numbers in 2002 to 2012 (ranging from 19.3 million to 21.1 million). The rate in 2013 was similar to the rates in 2010 to 2012 (ranging from 7.5 to 8.1 percent), but it was lower than the rates in 2002 to 2009 (ranging from 8.3 to 8.8 percent).

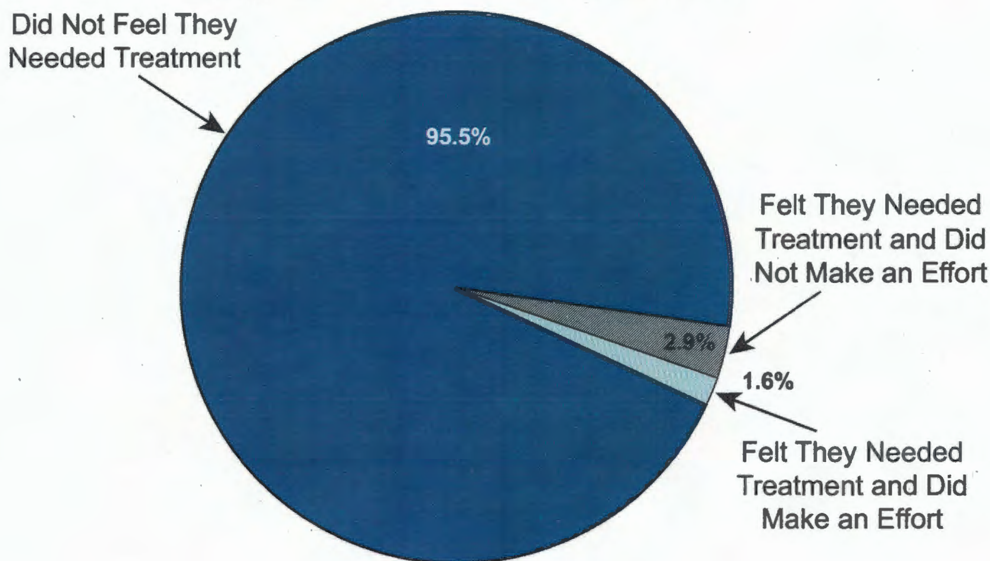
- Of the 2.5 million persons aged 12 or older who received specialty substance use treatment in 2013, 875,000 received treatment for alcohol use only, 936,000 received treatment for illicit drug use only, and 547,000 received treatment for both alcohol and illicit drug use. These estimates in 2013 were similar to the estimates in 2012 and 2002.

- Among persons in 2013 who received their most recent substance use treatment at a specialty facility in the past year, 41.7 percent reported using private health insurance as a source of payment for their most recent specialty treatment, 40.6 percent reported using their "own savings or earnings," 29.0 percent reported using Medicaid, 29.0 percent reported using public assistance other than Medicaid, 26.8 percent reported using Medicare, and 23.0 percent reported using funds from family members. None of these estimates changed significantly between 2012 and 2013.

- In 2013, among the 20.2 million persons aged 12 or older who were classified as needing substance use treatment but not receiving treatment at a specialty facility in the past year, 908,000 persons (4.5 percent) reported that they perceived a need for treatment for their illicit drug or alcohol use problem (Figure 7.10). Of these 908,000 persons who felt they needed treatment but did not receive treatment in 2013, 316,000 (34.8 percent) reported that they made an effort to get treatment, and 592,000 (65.2 percent) reported making no effort to get treatment. These estimates were stable between 2012 and 2013.

- The rate and the number of youths aged 12 to 17 who needed treatment for an illicit drug or alcohol use problem in 2013 (5.4 percent and 1.3 million) were lower than those in 2012 (6.3 percent and 1.6 million), 2011 (7.0 percent and 1.7 million), 2010 (7.5 percent and 1.8 million), and 2002 (9.1 percent and 2.3 million). Of the 1.3 million youths who needed treatment in 2013, 122,000 received treatment at a specialty facility (about 9.1 percent of the youths who needed treatment), leaving about 1.2 million who needed treatment for a substance use problem but did not receive it at a specialty facility.

## Figure 7.10 Past Year Perceived Need for and Effort Made to Receive Specialty Treatment among Persons Aged 12 or Older Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use: 2013

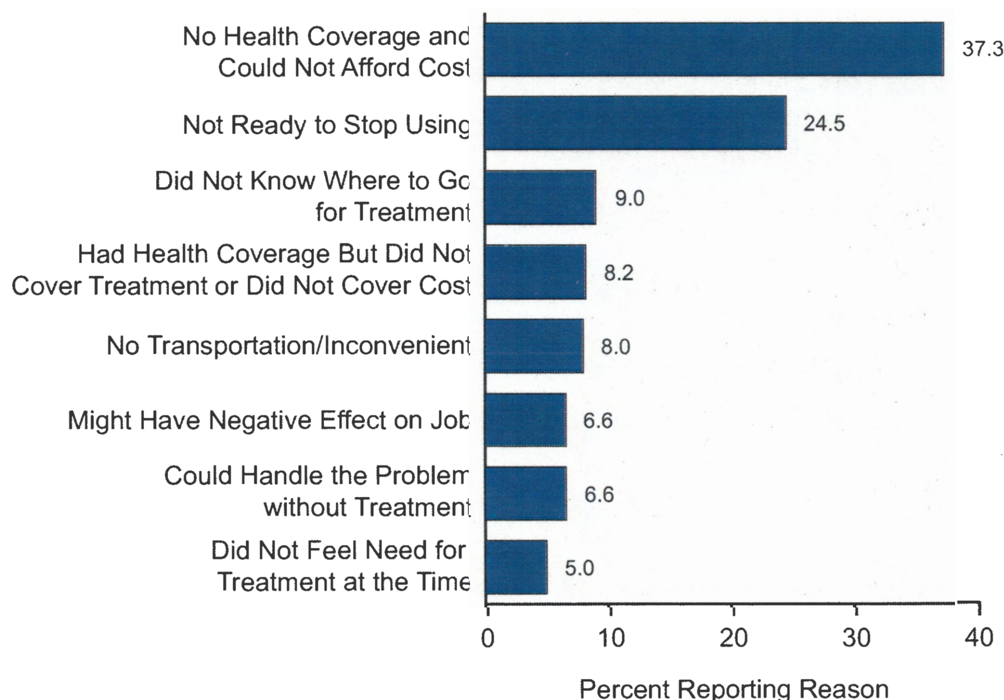



20.2 Million Needing But Not Receiving
Treatment for Illicit Drug or Alcohol Use

- Based on 2010-2013 combined data, commonly reported reasons for not receiving illicit drug or alcohol use treatment among persons aged 12 or older who needed and perceived a need for treatment but did not receive treatment at a specialty facility were (a) not ready to stop using (40.3 percent), (b) no health coverage and could not afford cost (31.4 percent), (c) possible negative effect on job (10.7 percent), (d) concern that receiving treatment might cause neighbors/community to have a negative opinion (10.1 percent), (e) not knowing where to go for treatment (9.2 percent), and (f) no program having type of treatment (8.0 percent).

- Based on 2010-2013 combined data, among persons aged 12 or older who needed but did not receive illicit drug or alcohol use treatment, felt a need for treatment, and made an effort to receive treatment, commonly reported reasons for not receiving treatment were (a) no health coverage and could not afford cost (37.3 percent), (b) not ready to stop using (24.5 percent), (c) did not know where to go for treatment (9.0 percent), (d) had health coverage but did not cover treatment or did not cover cost (8.2 percent), and (e) no transportation or inconvenient (8.0 percent) (Figure 7.11).

## Figure 7.11 Reasons for Not Receiving Substance Use Treatment among Persons Aged 12 or Older Who Needed and Made an Effort to Get Treatment But Did Not Receive Treatment and Felt They Needed Treatment: 2010-2013 Combined



**Illicit Drug Use Treatment and Treatment Need**

- In 2013, the number of persons aged 12 or older needing treatment for an illicit drug use problem was 7.6 million (2.9 percent of the total population). The number in 2013 was similar to the number in each year from 2002 through 2012 (ranging from 7.2 million to 8.1 million). The rate of persons needing treatment for an illicit drug use problem in 2013 was lower than the rates in 2002 (3.3 percent) and 2004 (3.3 percent), but it was similar to the rates in 2012 and 2003 (3.1 percent in each year) and in 2005 to 2011 (ranging from 2.8 to 3.2 percent).

- Of the 7.6 million persons aged 12 or older who needed treatment for an illicit drug use problem in 2013, 1.5 million (0.6 percent of the total population and 19.5 percent of persons who needed treatment) received treatment at a specialty facility for an illicit drug use problem in the past year. The number in 2013 was similar to the numbers in 2012 (1.5 million), 2002 (1.4 million), and in 2004 to 2011 (ranging from 1.2 million to 1.6 million), but it was higher than the number in 2003 (1.1 million). The rate in 2013 was similar to the rates in 2002 to 2012 (ranging from 0.5 to 0.6 percent).

- There were 6.1 million persons (2.3 percent of the total population) who needed but did not receive treatment at a specialty facility for an illicit drug use problem in 2013. The number in 2013 was similar to the numbers in 2002 to 2012 (ranging from 5.8 million to 6.6 million). The rate in 2013 was similar to the rates in 2006 to 2012 (ranging from 2.3 to 2.5 percent), but it was lower than the rates in 2002 to 2005 (ranging from 2.6 to 2.8 percent).

- Of the 6.1 million persons aged 12 or older who needed but did not receive specialty treatment for illicit drug use in 2013, 395,000 (6.4 percent) reported that they perceived a need for treatment for their illicit drug use problem, and 5.7 million did not perceive a need for treatment. The number of persons in 2013 who needed treatment for an illicit drug use problem but did not perceive a need for treatment was similar to the number in 2012 (5.9 million). However, the number of persons who needed treatment and perceived a need for treatment for an illicit drug problem in 2013 was lower than the number in 2012 (588,000 persons).

- Of the 395,000 persons aged 12 or older in 2013 who felt a need for treatment for use of illicit drugs, 148,000 reported that they made an effort to get treatment, and 247,000 reported making no effort to get treatment. These estimates in 2013 for making or not making an effort to get treatment were similar to those in 2012.

- In 2013, among youths aged 12 to 17, 908,000 persons (3.6 percent) needed treatment for an illicit drug use problem, but only 90,000 received treatment at a specialty facility (10.0 percent of youths aged 12 to 17 who needed treatment), leaving 817,000 youths who needed treatment but did not receive it at a specialty facility. These estimates in 2013 were similar to those in 2012, except that the number and the rate of youths who needed treatment for an illicit drug use problem in 2013 were lower than those in 2012 (1.0 million and 4.2 percent).

- Among persons aged 12 or older who needed but did not receive illicit drug use treatment and felt they needed treatment (based on 2010-2013 combined data), the commonly reported reasons for not receiving treatment were (a) no health coverage and could not afford cost (42.1 percent), (b) not ready to stop using (27.5 percent), (c) concern that receiving treatment might cause neighbors/community to have negative opinion (15.9 percent), (d) possible negative effect on job (15.2 percent), (e) not knowing where to go for treatment (12.8 percent), and (f) having health coverage that did not cover treatment or did not cover the cost (9.6 percent).

**Alcohol Use Treatment and Treatment Need**

- In 2013, the number of persons aged 12 or older needing treatment for an alcohol use problem was 18.0 million (6.9 percent of the population aged 12 or older). The number in 2013 was similar to the numbers in 2010 to 2012 (ranging from 17.4 million to 18.6 million) and in 2002, 2003, and 2008 (ranging from 18.2 million to 19.1 million). However, the number in 2013 was lower than the numbers in 2004 to 2007 and in 2009 (ranging from 19.4 million to 19.6 million). The rate in 2013 (6.9 percent) was similar to the rates in 2011 (6.8 percent) and 2012 (7.0 percent), but it was lower than the rates in 2002 to 2010 (ranging from 7.3 to 8.0 percent).

- Among the 18.0 million persons aged 12 or older who needed treatment for an alcohol use problem in 2013, 1.4 million (0.5 percent of the total population and 7.9 percent of the persons who needed treatment for an alcohol use problem) received alcohol use treatment at a specialty facility. The number and the rate of the need and receipt of treatment at a specialty facility for an alcohol use problem in 2013 did not change significantly since 2002 (ranging from 1.3 million to 1.7 million and from 0.5 to 0.7 percent).

- The number of persons aged 12 or older who needed but did not receive treatment at a specialty facility for an alcohol use problem in 2013 (16.6 million) was similar to the numbers in 2002 (17.1 million), 2003 (16.9 million), and from 2008 to 2012 (ranging from 15.9 million to 17.7 million), but it was lower than the numbers from 2004 to 2007 (ranging from 17.8 million to 18.0 million). The rate in 2013 (6.3 percent of the population aged 12 or older) was similar to the rates in 2010 to 2012 (ranging from 6.2 to 6.7 percent), but it was lower than the rates in 2002 to 2009 (ranging from 7.0 to 7.4 percent).

- Among the 16.6 million persons aged 12 or older who needed but did not receive specialty treatment for an alcohol use problem in 2013, 554,000 persons (3.3 percent) felt they needed treatment for their alcohol use problem. The number and rate in 2013 were similar to those in 2012 (665,000 persons and 4.0 percent) and 2002 (761,000 persons and 4.5 percent). Of the 554,000 persons in 2013 who perceived a need for treatment for an alcohol use problem but did not receive specialty treatment, 353,000 did not make an effort to get treatment, and 201,000 made an effort but were unable to get treatment.

- The number and the rate of youths aged 12 to 17 who needed treatment for an alcohol use problem in 2013 (735,000 and 3.0 percent) were lower than those in 2012 (889,000 and 3.6 percent). Of the youths in 2013 who needed treatment for an alcohol use problem, only 73,000 received treatment at a specialty facility (0.3 percent of all youths and 10.0 percent of youths who needed treatment). These estimates were similar to those in 2012. The number and the rate of youths who needed but did not receive treatment for an alcohol use problem in 2013 (662,000 and 2.7 percent) were lower than those in 2012 (814,000 and 3.3 percent).

- Among persons aged 12 or older who needed but did not receive alcohol use treatment and felt they needed treatment (based on 2010-2013 combined data), commonly reported reasons for not receiving treatment were (a) not ready to stop using (50.5 percent), (b) no health coverage and could not afford cost (26.4 percent), (c) not finding a program that offered the type of treatment (7.6 percent), (d) not knowing where to go for treatment (7.3 percent), (e) possible negative effect on job (7.1 percent), (f) no transportation or inconvenient (7.0 percent), (g) could handle the problem without treatment (6.8 percent), and (h) having health coverage that did not cover treatment or did not cover cost (6.7 percent).

# Behavioral Health Barometer

## Connecticut, 2014

Substance Abuse and Mental Health Services Administration

**SAMHSA**

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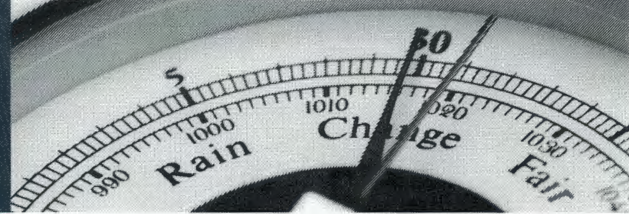


## Acknowledgments

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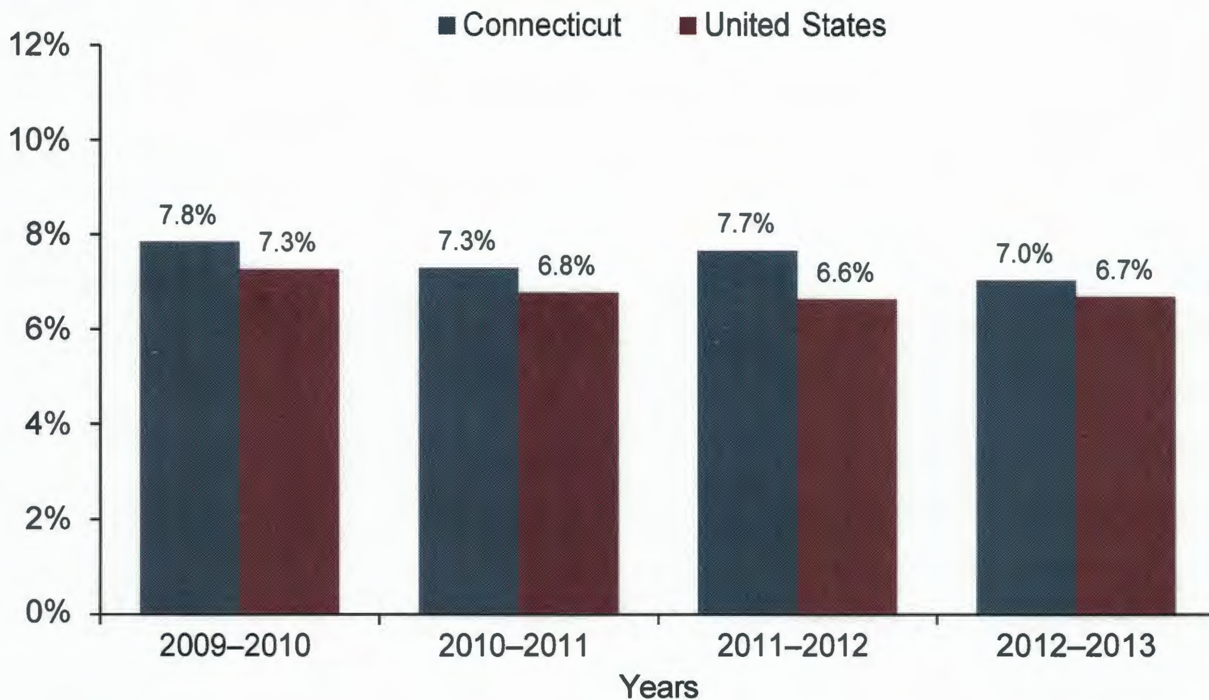
## Originating Office

Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

## Past-Year Alcohol Dependence or Abuse Among Individuals Aged 12 or Older in Connecticut and the United States (2009–2013)[1]

*Connecticut's percentage of alcohol dependence or abuse among individuals aged 12 or older was similar to the national percentage in 2012–2013.*




8.1%

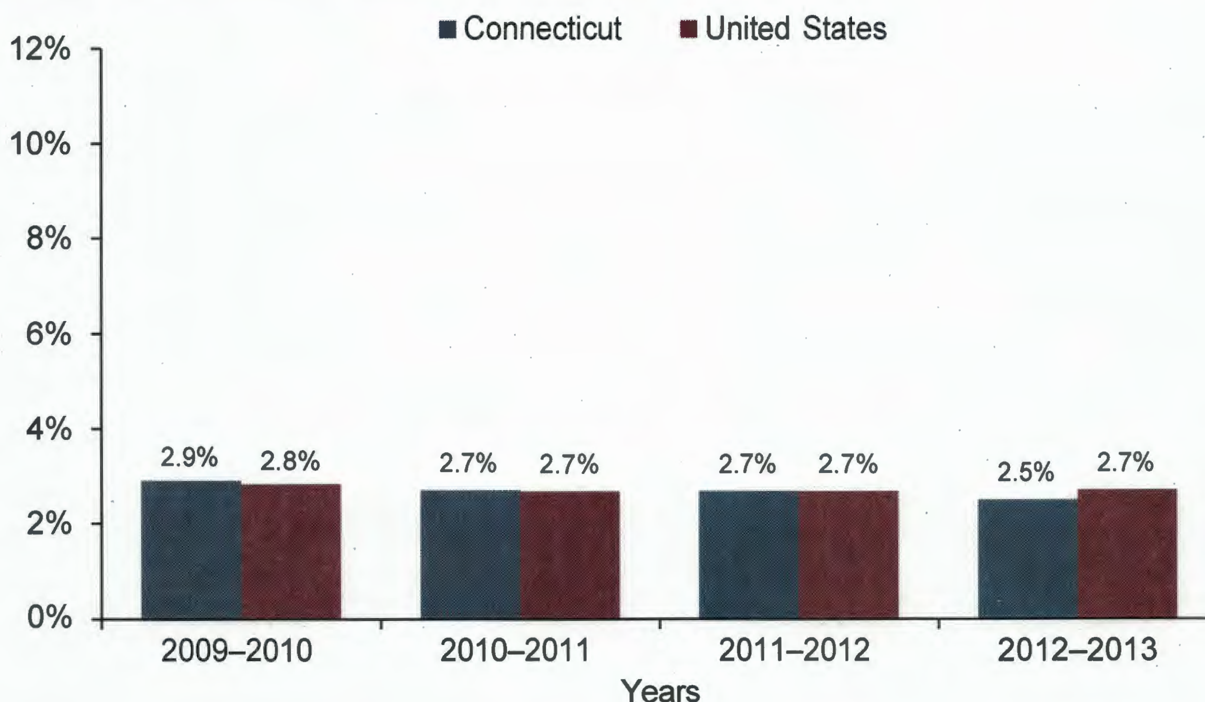
In Connecticut, about 243,000 individuals aged 12 or older (8.1% of all individuals in this age group) per year in 2009–2013* were dependent on or abused alcohol within the year prior to being surveyed. The percentage did not change significantly over this period.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 to 2013.

* These estimates are based on combined data from multiple years of the National Survey of Drug Use and Health (NSDUH), whereas estimates in the accompanying fi are from an estimation procedure that uses 2 consecutive years of NSDUH data plus other information from the state. The estimates from these two methods may differ. For more information, please see Figure Notes 1 and 2 on p. 19.

## Past-Year Illicit Drug Dependence or Abuse Among Individuals Aged 12 or Older in Connecticut and the United States (2009–2013)[1]

*Connecticut's percentage of illicit drug dependence or abuse among individuals aged 12 or older was similar to the national percentage in 2012–2013.*




**2.8%**

In Connecticut, about 83,000 individuals aged 12 or older (2.8% of all individuals in this age group) per year in 2009–2013* were dependent on or abused illicit drugs within the year prior to being surveyed. The percentage did not change significantly over this period.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 to 2013.

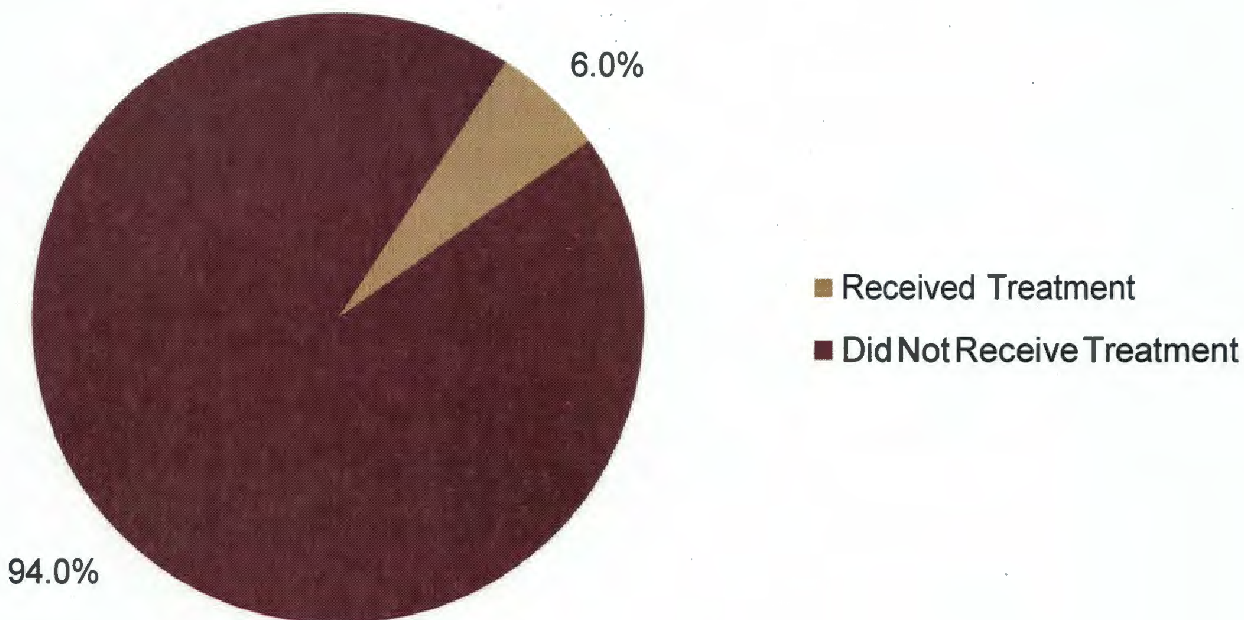
* These estimates are based on combined data from multiple years of the National Survey of Drug Use and Health (NSDUH), whereas estimates in the accompanying fi are from an estimation procedure that uses 2 consecutive years of NSDUH data plus other information from the state. The estimates from these two methods may differ. For more information, please see Figure Notes 1 and 2 on p. 19.



Statistical tests (t-tests) have been conducted for all statements appearing in the text on this page of the report that compare estimates between years or between the state and the nation as a whole. Unless explicitly stated that a difference is not statistically significant, all statements that describe differences are significant at the .05 level.

## Past-Year Alcohol Use Treatment Among Individuals Aged 12 or Older with Alcohol Dependence or Abuse in Connecticut (2009–2013)[2]

*Connecticut's percentage of treatment for alcohol use among individuals aged 12 or older with alcohol dependence or abuse was similar to the national percentage in 2009–2013.*

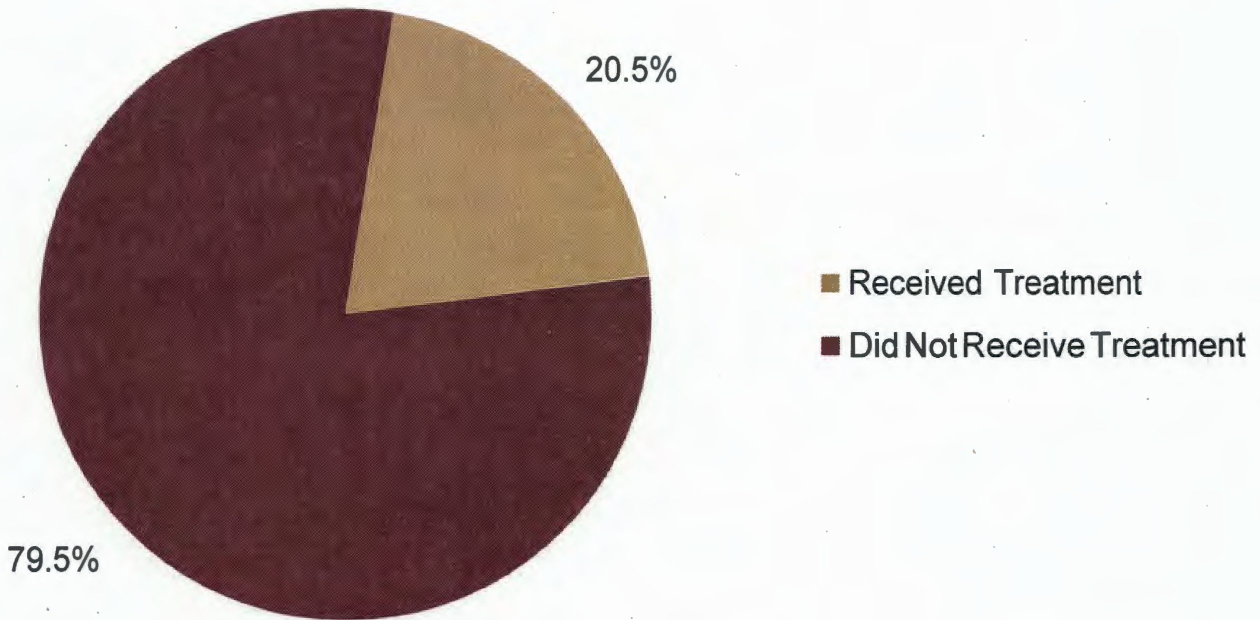


In Connecticut, among individuals aged 12 or older with alcohol dependence or abuse, about 15,000 individuals (6.0%) per year in 2009–2013 received treatment for their alcohol use within the year prior to being surveyed.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 to 2013.

## Past-Year Illicit Drug Use Treatment Among Individuals Aged 12 or Older with Illicit Drug Dependence or Abuse in Connecticut (2005–2013)[2]

*Connecticut's percentage of treatment for illicit drug use among individuals aged 12 or older with drug dependence or abuse was similar to the national percentage in 2005–2013.*



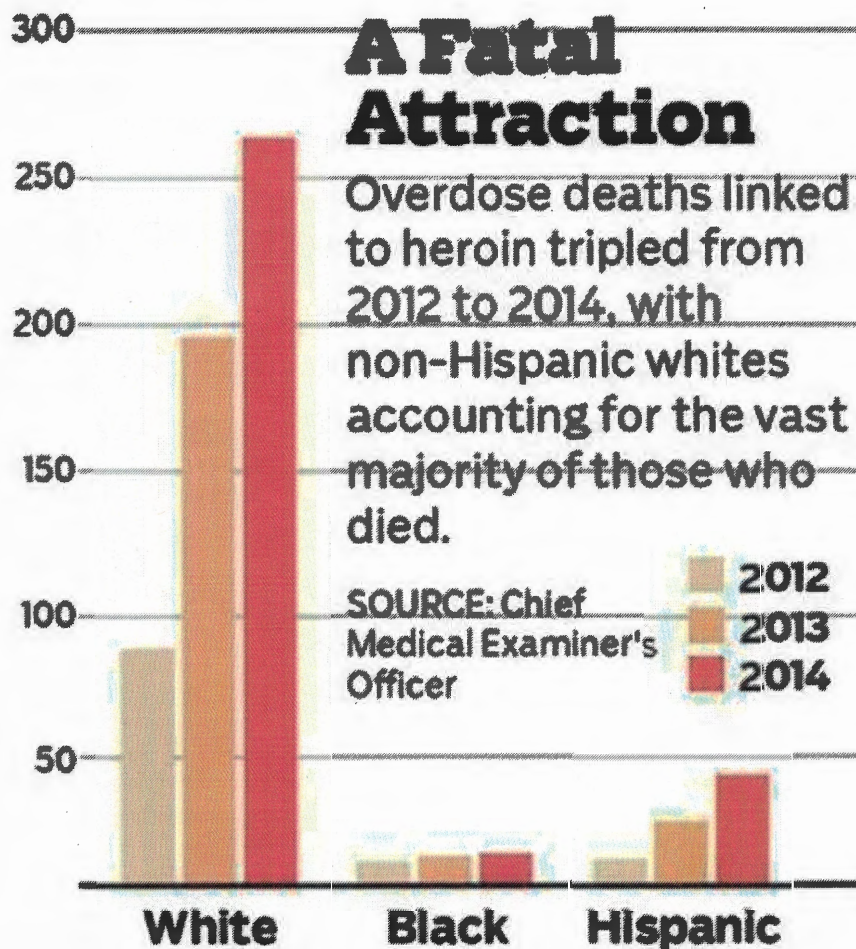

*In Connecticut, among individuals aged 12 or older with illicit drug dependence or abuse, about 18,000 individuals (20.5%) per year in 2005–2013 received treatment for their illicit drug use within the year prior to being surveyed.*

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2005 to 2013.



Statistical tests (t-tests) have been conducted for all statements appearing in the text on this page of the report that compare estimates between years or between the state and the nation as a whole. Unless explicitly stated that a difference is not statistically significant, all statements that describe differences are significant at the .05 level.

# Heroin Deaths Spike In Connecticut; Push Past 300 In 2014




A graphic shows the dramatic spike in overdose deaths linked to heroin in Connecticut for 2014.

By Nicholas Rondinone and Matthew Kauffman

July 12, 2015

In Connecticut, heroin deaths jump to 306 in 2014

Heroin deaths have increased dramatically across Connecticut over the past three years, with the drug playing a direct role in 306 fatalities last year, state medical examiner records reveal.

In combination with other drugs or alone, heroin was a key factor in 222 deaths in 2013 and 100 in 2012. The troubling trend mirrors national numbers recently released by the federal government.

While most heroin-related deaths involved residents of the larger cities, the number of towns with at least one fatality jumped from 45 in 2012 to 79 in 2014.

"It's in Glastonbury; it's in Avon; it's in Farmington; it's down in Fairfield County," said Pat Rehmer, the former commissioner of the state Department of Mental Health and Addiction Services who now serves as senior vice president of Behavioral Health Network at Hartford HealthCare.

State Police Seize 1,055 Bags Of Heroin In Highway Stop

From 2012 to 2014, heroin was blamed for the deaths of 30 people from Waterbury, 30 from Hartford and 27 from New Haven. But there were also large numbers of deaths in mid-sized communities, including 24 in Torrington, 14 in New London, nine in Montville and seven in East Hampton.

It's been more than three years since Sean Madec, a 18-year-old from New London who loved playing music and had recently become an uncle, fatally overdosed on heroin and cocaine in a Mystic hotel.

On Jan. 14, 2012, Madec, was brought by emergency personnel to Lawrence and Memorial Hospital but he was already dead, said his grandmother, 72-year-old Sandra Kenny of Groton. Before that, he had been in a suite at the Residence Inn snorting heroin and cocaine purchased with several friends.

"It's something that touches all families," Kenny said. "If you want it, you can get it. It doesn't discriminate."

The federal Centers for Disease Control and Prevention this week declared the sharp national increase in heroin use a "public health crisis" and called for a comprehensive response, including tighter control of narcotic painkillers that are often associated with heroin abuse, and greater access to naloxone, a drug marketed as Narcan that can counter the effects of an opioid overdose. Earlier this week, EMTs in Stamford credited Narcan with saving the life of an apparent overdose victim who was not breathing.

State police troopers began carrying Narcan kits in late October 2014 and since then have used it 33 times, with nearly one third of those uses taking place in Griswold, according to department.

"[Narcan] has been effective to curb overdoses," said state police Trooper Kelly Grant, a department spokesperson. "The troopers arriving on scene is a life-saving step. They are there fast."

Rehmer said that the move to get Narcan into the hands of more emergency responders and police has made a real difference.

Two From Hartford Arrested In Large Vermont Heroin Bust

"It saves lives, there's no doubt about it," Rehmer said. She said now it needs to get into the hands of parents, along with education about the drug.

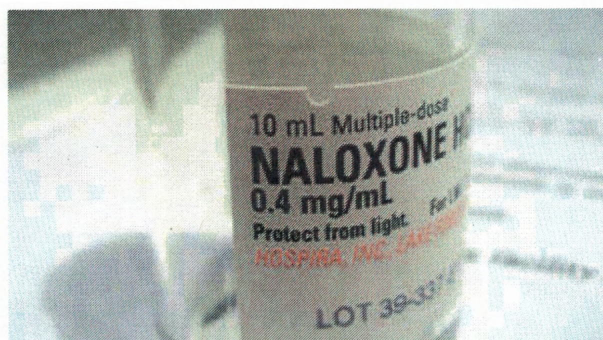
The city of Hartford has been exploring equipping police with the drug, although ambulance crews already carry it, Deputy Chief Brian Foley said. Those crews typically arrive quickly at the scene of an overdose, which is not always the case in more rural areas, Foley said.

The federal report cited a steady increase in heroin use, abuse and deaths dating to 2002, with a particularly sharp increase in addiction and deaths beginning in 2011. Overall, the agency estimated, 517,000 people nationally were abusing or addicted to heroin in 2013 — roughly double the figure a decade earlier.

There was a particularly steep rise in heroin use among non-Hispanic whites, while blacks and Hispanics collectively saw a decline in rates of heroin use over the decade, the CDC reported.

Whites also are over-represented among heroin-related deaths in Connecticut. Non-Hispanic whites in the state accounted for 84 percent of heroin deaths in the last three years, while making up only about 70 percent of the population. The greatest increase in deaths, however, was among Hispanics, with the number of fatalities rising from 9 in 2012 to 38 last year.

Three quarters of those who died in Connecticut were men — a ratio that held steady from 2012 to 2014. While drug abuse is often assumed to be associated with younger users, the number of deaths in Connecticut in the past three years was fairly evenly spread among people 25 to 50 years old. And the biggest increases in deaths were among those over 50, rising from 16 in 2012 to 61 in 2014.



Thumbs High For Narcan, Trans Laws

Tracking heroin deaths can be tricky because medical examiners do not always list the specific drugs implicated in an overdose death. The CDC report, for example, notes that in about one-quarter of fatal overdoses, death certificates do not identify the drug or drugs involved. Moreover, as heroin deaths increased — and awareness increased as well — it became difficult to determine if the rapid increase in apparent deaths was merely the result of more accurate reporting by coroners.

Before 2013, many drug deaths in Connecticut were identified simply as "multidrug intoxication." But when Chief Medical Examiner James Gill took office in May 2013, he instructed medical examiners to list specific drugs on death certificates. He also reviewed toxicology reports from 2012 and 2013 to discern the drugs implicated in past deaths.

Law-enforcement seizures of heroin — considered a proxy for the amount of the drug exported into the country — have quadrupled in recent years, as drug cartels have flooded the U.S. market. That has pushed down the price of heroin, even as the purity has increased, leading to more drug use and more overdoses.

"Increasing availability points to the importance of public health and law enforcement partnering to comprehensively address this public health crises," the CDC reported.

Partnerships among local, state and federal law enforcement have formed to head off the problem. The state police operate a statewide narcotics task force that has offices across Connecticut and works with federal law enforcement to share intelligence aimed at both monitoring how heroin is getting into the state, and targeting the drug dealers.

In Hartford, the police department works closely with the Drug Enforcement Administration, the FBI and Homeland Security and state police to share information and intelligence about heroin that's been collected by each organization, according to Foley.

Experts generally agree on how heroin addiction starts for many addicts. According to the CDC, individuals who are addicted to painkillers were 40 times more likely to being addicted to heroin.

Foley said nine out of 10 heroin addicts he has spoken to say their addiction to the drug started with taking a painkiller. "The biggest driver of heroin use is Oxycontin and the over prescription of painkillers," he said.

For young adults, the road to heroin addiction often begins with prescription painkillers, Rehmer agreed.

"What we saw; what we heard; what we hear is mom had back surgery, she got 30 Vicodin or Percocet and she used five. She leaves them in the medicine chest and the kid goes in there to take one and seems to enjoy the feeling he gets," Rehmer said. "He continues to take them and he goes to buy one on the street for $10 a pill and you can get heroin for about $5 a bag."

In a Twitter chat following the release of the report, Dr. Tom Friedman, director of the CDC, said: "We're awash in prescription opiates. Patients need the best, safest treatment. For chronic pain, that's rarely an opiate."

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THE NEWS OF NEW CANAAN, CONN. • A HAN NETWORK SITE

# Town responds to growing prevalence of heroin

By Kristan Sveda on March 26, 2015

It might seem like there is an epidemic in town, with the recent arrest of a New Canaan woman for possession and sale of heroin, the recent death of a man who had been arrested here last year in a vehicle where heroin was found, and the arrest of two Norwalk men possessing heroin in New Canaan in December.

Police Sgt. Carol Ogrinc, New Canaan's youth and public information officer, said since 2012 there have been five narcotics violations involving heroin in New Canaan. Though that may seem to be a low number, Ogrinc said the department is still increasingly concerned about the nationwide trend of heroin deaths on the rise and use of heroin climbing among young adults ages 18 to 30.

“In the past two or three years in Connecticut, overdoses have spiked from three years ago,” says Ogrinc. “That’s not just heroin. It’s scary and very concerning.”

Connecticut’s Office of the Chief Medical Examiner reports that statewide accidental overdoses involving heroin lead to 897 deaths last year — 46% of all recorded overdose deaths last year. Of those, 52 heroin overdoses were recorded in Fairfield County.

**Opioids in home medicine cabinets**

Dr. John Douglas, clinical director for Silver Hill Hospital’s new outpatient opioid addiction program, told the Advertiser the hospital is seeing an increasing number of calls from those looking for opioid addiction treatment.

Experts agree the increasingly common use among teens of prescription pain medications has lead to a resurgence of heroin use. Heroin is an opioid, much like oxycodone, Percocet and other commonly prescribed pain medications that teens are stealing from medicine cabinets at home to get high.

“Typically, what happens is people start using pain pills from parents or relatives,” said Douglas. “They get addicted to them and try to buy them on the street and find the price is extremely expensive. That’s how they progress from pain pills to intravenous heroin.”

Douglas said overdose typically occurs when a user tries to stop. Their body has built up a tolerance for the drug, he said. After a few days without using, that tolerance decreases, but they remember taking a certain amount. “Overdose is usually accidental,” said Dr. Douglas. “They relapse on the same amount they are used to using, but it’s way too much because they hadn’t been using it for a few days, and they lost that build up of tolerance.”

**More overdoses than traffic deaths**

Heroin and pain killers are some of the most addictive drugs in the world, said Douglas.

“Heroin is much cheaper and it’s so much more pure today, so that’s why it’s really hooking people much more than it did in the ‘80s,” Ogrinc said. While pain pills cost anywhere from $20 to $60 a bag, heroin is $3 to $10 a bag.

Douglas said addiction to any drug can be equally damaging, but those coming to the hospital with addiction to prescription drugs are typically in the first phase of addiction and have just started getting addicted to opioids. Those coming to the hospital with heroin addiction are in the later stages of addiction. They typically have been struggling with addiction longer, have been arrested, have been victims of sexual assault, lost their jobs or have lost touch with their family. He said patients are typically in their 20s and 30s.

“All of those social problems further complicate and increase the severity of the psychiatric problems they are dealing with, in addition to the substance abuse,” said Douglas. “That’s why

it's so important to get the word out early, to keep people from progressing to the later stages of addiction. They go through more and more pain and lose more and more of their life."

That's why Silver Hill, located on Valley Road, has initiated the outpatient opioid addiction program, which launched a little more than a month ago.

"More people are dying from drug overdose than die in traffic accidents, and most of those cases are heroin or pain killers," Douglas said.

**Finding Help**

The Silver Hill program is six weeks and serves predominantly local residents. "We get patients stable from abusing these substances," Douglas said. It starts with medications to help stabilize their addiction. These treatments have shown to significantly reduce the likelihood of a relapse or death, he said. Then patients go through four weeks of daily group therapy and weekly individual therapy as well as individualized medication management and family therapy.

"Family involvement is a big part of our program," Dr. Douglas said. "We really encourage families to help be a support for our patients."

Once patients are stable, they complete a year-long continuing care phase, coming back for monthly group sessions to help encourage communications and help heal families.

Ogrinc told the Advertiser that the police department, about four months ago, started training officers to carry the nasal spray Narcan in patrol cars. "If we are called to a scene where we suspect there is a drug overdose, we have the Narcan to administer, which immediately reverses the effects of the opioid," said Ogrinc. "Paramedics have always had it available, but now EMS and officers have it, too."

The department is also working in conjunction with New Canaan Cares to hold a program called "Staying Ahead of the Curve." The program addresses the teen party scene and drug choice among New Canaan youth, and offers parenting strategies for staying "one step ahead of disaster." The next event is April 22, 9:30 a.m. at New Canaan High School's Wagner Room. Registration is available on the newcanaancares.org website. Click on Calendar.

One of the things Ogrinc wants teens to know is that the Good Samaritan Law protects them from punishment if they report someone who has overdosed. They can call 911 and be immune from charges. "That person's life is more important than anything," says Ogrinc. She said social pressures and school pressures can be difficult on teens. The school resource officer frequently visits health and civics classes when the topics of alcohol and drugs come up to discuss the health risks and legal risks.

"There is a good amount of teens who respond to those lessons, especially with the recent tragedy," said Ogrinc. "We think it's important that people come out and ask questions and we get the message out. It's a serious problem nationwide, but we are not naive."

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# Substance Abuse Intensive Outpatient Programs: Assessing the Evidence

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## Abstract

**Objective**—Substance abuse intensive outpatient programs (IOPs) are direct services for people with substance use disorders or co-occurring mental and substance use disorders who do not require medical detoxification or 24-hour supervision. IOPs are alternatives to inpatient and residential treatment. They are designed to establish psychosocial supports and facilitate relapse management and coping strategies. This article assesses their evidence base.

**Methods**—Authors searched major databases: PubMed, PsycINFO, Applied Social Sciences Index and Abstracts, Sociological Abstracts, Social Services Abstracts, Published International Literature on Traumatic Stress, the Educational Resources Information Center, and the Cumulative Index to Nursing and Allied Health Literature. They identified 12 individual studies and one review published between 1995 and 2012. They chose from three levels of research evidence

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(high, moderate, and low) based on benchmarks for the number of studies and quality of their methodology. They also described the evidence of service effectiveness.

**Results—**Based on the quality of trials, diversity of settings, and consistency of outcomes, the level of evidence for IOP research was considered high. Multiple randomized trials and naturalistic analyses compared IOPs with inpatient or residential care; these types of services had comparable outcomes. All studies reported substantial reductions in alcohol and drug use between baseline and follow-up. However, substantial variability in the operationalization of IOPs and outcome measures was apparent.

**Conclusions—**IOPs are an important part of the continuum of care for alcohol and drug use disorders. They are as effective as inpatient treatment for most individuals seeking care. Public and commercial health plans should consider IOP treatment as a covered health benefit. Standardization of the elements included in IOPs may improve their quality and effectiveness.

Substance abuse intensive outpatient programs (IOPs) are ambulatory services for individuals with substance use disorders who do not meet diagnostic criteria for residential or inpatient substance abuse treatment or for those who are discharged from 24-hour care in an inpatient treatment facility and continue to need more support than the weekly or bi-weekly sessions provided in traditional outpatient care (1). IOP services offer a minimum of 9 hours of service per week in three, 3-hour sessions; however, some programs provide more sessions per week and/or longer sessions per day, and many programs become less intensive over time (1,2). Because services are provided in outpatient settings, the duration may be longer than that required for inpatient services. IOPs allow individuals to remain in their own homes and communities, which may improve their adjustment to community life (1).

Since 2002, the annual census of specialty addiction treatment facilities in the United States has consistently identified intensive outpatient treatment programs as second in prevalence only to regular outpatient treatment for alcohol and drug use disorders. In 2011, there were 6,089 programs in the United States that reported offering IOPs (44% of 13,720 addiction treatment programs), and IOPs served 141,964 patients—12% of the 1.2 million patients in care (3).

This article reports the results of a literature review that was undertaken as part of the Assessing the Evidence Base Series (see text box 1). The purpose of this review was to provide policymakers, treatment providers, and consumers with extant information on IOPs so that they can make informed decisions when comparing these programs with alternative treatments. Public and commercial health plan administrators may use this information to assess the need to include IOPs as a covered benefit. Our assessment of IOPs defines the programs as a level of care, reviews available research, and evaluates the quality of the evidence, most notably compared with the effectiveness of inpatient treatment services.

## Description of the service

IOPs treat individuals with substance use disorders or co-occurring mental and substance use disorders who do not require medical detoxification or 24-hour supervision. They



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provide a specified number of hours per week of structured individual, group, and/or family therapy as well as psychoeducation about substance use and mental disorders.

The American Society of Addiction Medicine (ASAM) defines five levels of care to guide practitioners in selecting the appropriate intensity for treating alcohol and drug use disorders: Level 0.5 (early intervention services), Level I (outpatient services), Level II (intensive outpatient services), Level III (residential and inpatient services), and Level IV (medically managed intensive inpatient services) (2). Thus, IOPs represent a higher level of care than usual outpatient services and a lower level of care than residential and inpatient services.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a set of core services for inclusion in IOPs, such as a specified number of hours of structured programming per week; individual, group, and/or family therapy; and psychoeducation about substance use and mental disorders (1). Table 1 summarizes the service.

IOP goals help the individual learn early-stage relapse management and coping strategies, ensure that the person has psychosocial support, and address individual symptoms and needs. However, broad variation across programs in terms of service delivery (e.g., mechanisms for screening and assessment), treatment planning and provision, crisis management, discharge planning, and the intensity and duration of care limit attempts to assess the quality and effectiveness of care across IOPs. Moreover, IOP services vary by setting: hospitals, community behavioral health centers, or day treatment programs. The ASAM criteria note that the duration of treatment varies with the severity of the person's illness and his or her response to the treatment intervention. Therefore, progress in a particular level of care, rather than a predetermined length of stay, determines an individual's movement through the treatment continuum.

In the clinical and research literature, IOPs may also include partial hospitalization and day treatment (ASAM Level II.5), both of which are used to treat people who have serious mental illness and/or substance use problems. For the purposes of this review, partial hospitalization and day treatment for substance use are included in the definition of an IOP. Day treatment models operate full-day schedules 5 to 7 days per week and may treat patients with co-occurring serious mental illness.

## Methods

### Search strategy

We identified and reviewed research from 1995 through 2012. We conducted a survey of major databases: PubMed (U.S. National Library of Medicine and National Institutes of Health), PsycINFO (American Psychological Association), Applied Social Sciences Index and Abstracts, Sociological Abstracts, Social Services Abstracts, Published International Literature on Traumatic Stress, the Educational Resources Information Center, and the Cumulative Index to Nursing and Allied Health Literature. We also examined bibliographies of major reviews and meta-analyses. We used combinations of the following search terms:

# Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

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Consensus Panel Chair

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## A Treatment Improvement Protocol

# TIP 47

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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## Disclaimer

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# 2 Principles of Intensive Outpatient Treatment

## In This Chapter...

Principle 1: Make Treatment Readily Available

Principle 2: Ease Entry

Principle 3: Build on Existing Motivation

Principle 4: Enhance Therapeutic Alliance

Principle 5: Make Retention a Priority

Principle 6: Assess and Address Individual Treatment Needs

Principle 7: Provide Ongoing Care

Principle 8: Monitor Abstinence

Principle 9: Use Mutual Help and Other Community-Based Supports

Principle 10: Use Medications if Indicated

Principle 11: Educate About Substance Use Disorders, Recovery, and Relapse

Principle 12: Engage Families, Employers, and Significant Others

Principle 13: Incorporate Evidence-Based Approaches

Principle 14: Improve Program Administration

This chapter presents 14 principles that integrate the findings of addictions research with the opinion of the consensus panel. By synthesizing research and practice, the consensus panel will assist clinicians in applying these principles to the clinical decisions they face daily. The 14 principles are expressed throughout this TIP in the form of specific recommendations. They are summarized here to provide a concise overview of effective intensive outpatient treatment (IOT) principles.

The *Principles of Drug Addiction Treatment: A Research-Based Guide* (National Institute on Drug Abuse 1999) offers a valuable starting point for the principles that are described in this chapter. The National Institute on Drug Abuse (NIDA) principles pertain to the full spectrum of addiction treatment modalities, not only to IOT. The consensus panel chose to accentuate the principles that are critical to effective IOT.

The 14 principles described in this chapter are

1. Make treatment readily available.
2. Ease entry.
3. Build on existing motivation.
4. Enhance therapeutic alliance.
5. Make retention a priority.
6. Assess and address individual treatment needs.
7. Provide ongoing care.
8. Monitor abstinence.
9. Use mutual-help and other community-based supports.
10. Use medications if indicated.
11. Educate about substance abuse, recovery, and relapse.
12. Engage families, employers, and significant others.
13. Incorporate evidence-based approaches.
14. Improve program administration.

# Executive Summary

This volume, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment*, and its companion text, *Substance Abuse: Administrative Issues in Outpatient Treatment*, revisit the subject matter of Treatment Improvement Protocol (TIP) 8, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse*, published in 1994 (CSAT 1994c). When TIP 8 was published, one volume of about 100 pages sufficed to address relevant topics in intensive outpatient treatment (IOT). Today, the same task requires two volumes, each devoted to a distinct audience, clinicians and administrators. The primary audience for this volume is clinicians working in IOT programs.

## The Changing IOT Landscape

Arnold M. Washton (1997) points out that the first large expansion of IOT took place during the 1980s, when White, middle-class individuals with cocaine addiction, many of whom were business professionals, sought treatment and did not want to take time away from work or face the stigma of checking into a residential treatment facility. A second expansion of IOT was ushered in by managed care with a focus on cost containment. Throughout the 1990s, IOT grew, becoming the dominant setting for most clients with substance use disorders. This growth was spurred by the expansion of IOT's population from clients with a moderate range of problems to include clients who are homeless, adolescents, and persons with co-occurring mental disorders, all of whom formerly were considered too difficult for IOT programs to treat successfully. This expansion in clients and services means that IOT clinicians must keep abreast of a broadening array of treatment approaches and services provided beyond their programs. The current volume's focus on clinicians reflects both the increased treatment options available and the expanded range of knowledge and skills required.

## Defining Substance Abuse Treatment and IOT

For most of the 20th century, substance abuse was considered an acute disorder. Viewing substance abuse more like pneumonia than like chronic diseases such as hypertension or diabetes had shaped the expectations and treatment choices of clinicians. As McLellan and colleagues (2000) point out, regarding substance abuse as a chronic disorder means realigning treatment and outcome expectations so that they resemble those for other chronic disorders. Today, many IOT programs are involved in treatment beyond the traditional 4 to 12 weeks. Increasingly, IOT programs focus on ongoing care that addresses many areas of clients' lives through case management and the involvement of other service providers and families and communities.

A parallel development has been the frequent application of research findings into practice in the field of substance abuse treatment. Research has yielded new understanding about the complexity of substance use disorders that takes into account biochemical processes, learning, spirituality, and environment. IOT programs are integral to the process of translating scientific findings into clinically effective treatments. The collaboration between research and practice has moved some treatments out of research centers and into IOT programs. Cognitive-behavioral interventions, relapse prevention training, motivational enhancement, and case management are used in community-based treatment settings as a result of the cross-fertilization of research and treatment.

One result of the convergence of research and practice is the development of evidence-based principles that shape and guide substance abuse treatment. The consensus panel recommends 14 principles for IOT programs. These principles lay a theoretical foundation for discussions of IOT services, clinical challenges, and treatment approaches and adaptations. In their focus on client engagement and retention, individualizing treatment, using the entire continuum of care, and reaching out to families, employers, and the community, the 14 principles help define the IOT program's contemporary role.

## Continuum of Care and IOT Services

An IOT program is most effective at helping its clients if it is part of a continuum of care. The American Society of Addiction Medicine has established five levels of care: medically managed intensive inpatient, residential, intensive outpatient, outpatient, and early intervention. In addition, continuing community care (e.g., 12-Step support groups), which a client participates in after the conclusion of formal treatment, is another important level of service. A continuum of care ensures that clients can enter substance abuse treatment at a level appropriate to their needs and step up or down to a different intensity of treatment based on their responses. Clinicians enhance the capabilities of their programs when they are informed about and willing to refer clients to other treatment providers. Close monitoring of clients' progress toward treatment goals is key to determining when they are ready for the next appropriate level of care. Any transition in treatment increases the likelihood that a client will drop out. A step-up or stepdown in treatment intensity in the same program or a referral to a nonaffiliated provider can be disruptive for the client. Mee-Lee and Shulman (2003) recommend that a continuum of care feature seamless transfer between levels, congruence in treatment philosophy, and efficient transfer of records. Clinicians need to be thoroughly familiar with local treatment options, including support groups, so that they can orient clients as the clients transition to new treatment situations.

Services integral to all IOT programs are core services. The consensus panel believes that these core services, such as group and individual counseling, psychoeducational programming, monitoring of drug use, medication management, case management, medical and psychiatric examinations, crisis intervention coverage, and orientation to community-based support groups, are indispensable and should be available through all IOT programs. Additional services that are offered at the program site or through links with partner organizations are enhanced services. This concept is flexible, and what might be considered enhanced services for some programs may be essential services for a program with a different client population. (Clients whose first language is not English might need language classes to find work and participate in mutual-help groups, whereas a program that primarily serves native speakers would have little call for such a service.) Enhanced services include adult education classes, recreational activities, adjunctive therapies (e.g., biofeedback, acupuncture, meditation), child care, nicotine cessation treatment, housing, transportation, and food.

## Entry, Engagement, and Treatment Issues

Many clients who enter substance abuse treatment drop out in the early stages (Claus and Kindleberger 2002). Entry and engagement are crucial processes; how an IOT program addresses them can influence strongly whether clients remain in treatment. Client intake and engagement can involve contradictory processes such as collecting intake information from clients while initiating a caring, empathic relationship. Balancing administrative tasks and therapeutic intervention is a challenge clinicians face during a client's first hours in an IOT program. To help clinicians achieve that balance, the consensus panel recommends assessing potential clients' readiness for change and using strategies that motivate them to enter and continue treatment. Clinicians should begin to establish a therapeutic relationship as soon as clients present themselves for treatment. Any barriers to treatment must be addressed. Based on screening and assessments, clients should be matched with the best treatment modality and setting to support their recovery. An individualized treatment plan should be developed with the cooperation of the client to address the client's needs.

Client retention is a priority throughout treatment. The consensus panel draws on research and the experience of practiced clinicians to address the issues of engagement and retention. Clients can become distracted from recovery if family members continue to use substances, boundaries between clients and staff are not established clearly, work conflicts with treatment, or they receive incompatible recommendations from different service systems. Clinicians need to know how to ensure the privacy of their clients and the safety and security of the program facility while maintaining open and productive therapeutic relationships with their clients. Clinicians also need to be familiar with common issues that can derail clients in group therapy such as intermittent attendance and other clients who are disruptive, ambivalent, or withdrawn. When clinicians understand and prepare for these problems, their clients have a better chance of being retained in and benefiting from treatment. A major factor in client retention is the quality of the relationship between client and counselor. The client is more likely to do well in treatment if a strong therapeutic alliance exists.

## Treatment Approaches Used in IOT

IOT is compatible with different treatment approaches. Involving clients' families in their recovery is an effective strategy. Substance-using behavior may be rooted in part in a client's family history—whether family of origin or family of choice. Families

can play a crucial role in a client's recovery. Providers should prepare for family involvement, education, and other services so that family members can support recovery. Family involvement in treatment has been linked to positive outcomes for clients in substance abuse treatment (Rowe and Liddle 2003). For IOT providers, adopting a family systems approach means including family members in every stage of treatment: the intake interview, counseling sessions, family dinners or weekends, and graduation celebrations. If family members are to support a client's recovery, they must be disabused of unrealistic expectations and learn about relapse prevention. IOT providers should consider offering family education groups, multifamily groups, and family support groups. If family therapy (which in most States requires a licensed, master's-level clinician) is warranted and an IOT clinic cannot offer it, referral relationships can be developed with an organization that provides individual family therapy, couples therapy, and child-focused therapy.

Providers should be familiar with the strengths and challenges of different treatment approaches so they can serve their clients better by modifying and blending approaches as necessary. The 12-Step facilitation approach is common in the treatment environment. Twelve-Step-oriented treatment helps clients achieve abstinence and understand the principles of Alcoholics Anonymous and other 12-Step groups through group counseling, homework assignments, and psychoeducation. The 12-Step approach emphasizes cognitive, behavioral, spiritual, and health aspects of recovery and is effective with many different types of clients.

Cognitive-behavioral therapy focuses on teaching clients skills that will help them understand and reduce their relapse risks and maintain abstinence. Clients must be motivated and counselors must be trained extensively for cognitive-behavioral therapy to succeed.

Motivational approaches, such as motivational interviewing and motivational enhancement therapy, also rely on extensive staff training and high levels of client self-awareness. Through empathic listening, counselors explore clients' attitudes toward substance abuse and treatment, supporting past successes and encouraging problemsolving strategies. These approaches are client centered and goal driven and encourage client self-sufficiency.

Therapeutic community approaches are used most often in residential settings but have been adapted for IOT. In therapeutic community approaches, a structured community of clients and staff members is the main therapeutic agent—peers and counselors are role models, the work at the facility is used as therapy, and group sessions focus on self-awareness and behavioral change. The intensity of the treatment calls for extensive staff training and can result in high client dropout. However, therapeutic communities have proved successful with difficult clients (e.g., those with long histories of substance use and those who have served time in prison).

The Matrix model integrates a number of other treatment approaches, including mutual-help, cognitive-behavioral, and motivational interviewing. A strong therapeutic relationship between client and counselor is the centerpiece of the Matrix approach. Other features are learning about withdrawal and cravings, practicing relapse prevention and coping techniques, and submitting to drug screens.

Contingency management and community reinforcement approaches encourage clients to change behavior; these approaches reinforce abstinence by rewarding some behaviors and punishing others. Programs select a goal that is reasonable, is attainable, and contributes to overall treatment objectives and then reward small steps the client makes toward that goal. Contingency management and community reinforcement

approaches have been successful with clients who have chronic substance use disorders, when the costs for staff training and incentives can be addressed.

## Treating Different Populations

Many of the approaches used in IOT programs were developed to treat substance use disorders in White, middle-class men. Adaptations to these approaches are necessary to treat a variety of clients such as those in the justice system, women, clients with co-occurring disorders, and adolescents.

Increasing numbers of people with substance use disorders are involved with the justice system. Justice agencies and treatment providers need to work closely with each other, communicating clearly and coordinating their efforts. Cooperation of a different kind must exist between clinicians and clients. Therapeutic alliance is especially important when working with clients in the justice system who may have difficulty trusting a clinician and forming meaningful relationships outside the criminal environment.

The number of treatment programs for women is increasing. These programs add enhanced services designed to address substance abuse in the context of pregnancy and parenting, self-esteem issues, and histories of physical, sexual, and emotional abuse. To treat women, clinicians often avoid confrontational techniques and focus on providing a safe and supportive environment with clearly established boundaries between client and counselor.

Many people with co-occurring mental and substance use disorders are not receiving appropriate care (Watkins et al. 2001) and find themselves shuttling between psychiatric and substance abuse treatment, caught between two systems (Drake et al. 2001). Integrated treatment attends to both disorders together, adapts standard interventions to allow for clients' cognitive limitations, and provides comprehensive services to care for both disorders. Programs that do not adopt an integrated approach are advised to coordinate services with mental health providers.

A comprehensive approach to services also is important for adolescents who are using substances. Adolescents experience incredible upheaval in their lives and often need habilitation rather than rehabilitation. Many are in treatment for the first time and need to be oriented to treatment culture. Because adolescents often are living at home, family involvement is crucial. A behavioral contract—stipulating desired behaviors and rewards—and case management—addressing medical, social, and psychological needs—are also beneficial treatment tools.

IOT programs are being called on to serve an increasingly diverse client population. Almost one-third of Americans belong to an ethnic or racial minority group, and more than 10 percent of the U.S. population was born outside the country (Schmidley 2003). Although there is widespread agreement that clinicians should be culturally competent, no consensus exists about what cultural competence means. As a starting point, clinicians should understand how to work with someone from outside their own culture and strive to understand the specific culture of the client being served. Whereas the ability to treat clients from outside one's culture is an extension of the skills of a good clinician, understanding the cultural context of individual clients is more demanding. Clinicians need to strike a balance between a broad cultural background and the specific cultural context of a client's life; an observation that is applicable to a large group may be misleading or harmful if applied to an individual.

For foreign-born clients, level of acculturation often is an issue. Most research shows that the more acculturated clients are, the more their substance use approximates U.S. norms. Programs that serve substantial numbers of foreign-born clients may consider

offering language-specific programs and linking clients to language classes, job training, and employment services. Clients from other cultures may be averse to the emphasis on self-disclosure and self-sufficiency in substance abuse treatment. Counselors must be prepared to work within the client's value system, which may be at odds with values promoted by the treatment program.

Likewise, programs should ensure that program practices and materials do not pose a barrier to clients of non-Christian faiths. Many mutual-help programs have a strong Christian element; clients from other faiths should be informed of this orientation and provided with information about secular or religion-specific mutual-help groups.

Other general guidelines for programs that treat clients from other cultures include assessing policies and practices to spot potential barriers for diverse clients, training staff members in cultural competence, providing materials at an appropriate reading level or translating materials into clients' languages, and using outreach to promote awareness of the program.

The consensus panel offers an extensive list of resources for further research as well as demographic, substance use, and treatment information on members of racial and ethnic groups; persons with physical or cognitive disabilities; persons with HIV/AIDS; persons who are lesbian, gay, or bisexual; rural populations; and homeless populations. These resources are found in appendix 10-A.

# Attachment V

## Financial Attachment I (B) and II

## FINANCIAL WORKSHEET I (B)

**FOR-PROFIT**

**Applicant Name: MC1 Healthcare LLC**
**Financial Worksheet (B)**

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

| LINE | Total Entity: Description | (1) FY2015* Projected Results | (2) FY 2016 Projected W/out CON | (3) FY 2016 Projected Incremental | (4) FY 2016 Projected With CON | (5) FY 2017 Projected W/out CON | (6) FY 2017 Projected Incremental | (7) FY 2017 Projected With CON | (8) FY 2018 Projected W/out CON | (9) FY 2018 Projected Incremental | (10) FY 2018 Projected With CON | (11) Projected W/out CON | (12) Projected Incremental | (13) Projected With CON |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **A.** | **OPERATING REVENUE** | | | | | | | | | | | | | |
| 1 | Total Gross Patient Revenue | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| 2 | Less: Allowances | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| 3 | Less: Charity Care | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| 4 | Less: Other Deductions | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| | **Net Patient Service Revenue** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 5 | Medicare | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| 6 | Medicaid | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| 7 | CHAMPUS & TriCare | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| 8 | Other | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| | **Total Government** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| 9 | Commercial Insurers | $48,392 | $0 | $316,317 | $316,317 | | $344,603 | $344,603 | | $375,419 | $375,419 | | | $0 |
| 10 | Uninsured | $0 | $0 | $0 | $0 | | $0 | $0 | | $0 | $0 | | | $0 |
| 11 | Self Pay | $16,920 | $0 | $110,600 | $110,600 | | $120,491 | $120,491 | | $131,265 | $131,265 | | | $0 |
| 12 | Workers Compensation | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| 13 | Other | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| | **Total Non-Government** | $65,312 | $0 | $426,917 | $426,917 | $0 | $465,094 | $465,094 | $0 | $506,685 | $506,685 | $0 | $0 | $0 |
| | **Net Patient Service Revenue[a] (Government+Non-Government)** | $65,312 | $0 | $426,917 | $426,917 | $0 | $465,094 | $465,094 | $0 | $506,685 | $506,685 | $0 | $0 | $0 |
| 14 | Less: Provision for Bad Debts | $864 | $0 | $5,649 | $5,649 | | $6,154 | $6,154 | | $6,704 | $6,704 | | | $0 |
| | **Net Patient Service Revenue less provision for bad debts** | ($864) | $0 | ($5,649) | ($5,649) | $0 | ($6,154) | ($6,154) | $0 | ($6,704) | ($6,704) | $0 | $0 | $0 |
| 15 | Other Operating Revenue | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| 17 | Net Assets Released from Restrictions | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| | **TOTAL OPERATING REVENUE** | $64,448 | $0 | $421,269 | $421,269 | $0 | $458,941 | $458,941 | $0 | $499,981 | $499,981 | $0 | $0 | $0 |
| **B.** | **OPERATING EXPENSES** | | | | | | | | | | | | | |
| 1 | Salaries and Wages | $22,917 | $0 | $137,500 | $137,500 | | $141,625 | $141,625 | | $145,874 | $145,874 | | | $0 |
| 2 | Fringe Benefits | $6,875 | $0 | $41,250 | $41,250 | | $42,488 | $42,488 | | $43,762 | $43,762 | | | $0 |
| 3 | Physicians Fees | $0 | $0 | $0 | $0 | | $0 | $0 | | $0 | $0 | | | $0 |
| 4 | Supplies and Drugs | $824 | $0 | $6,427 | $6,427 | | $7,391 | $7,391 | | $8,500 | $8,500 | | | $0 |
| 5 | Depreciation and Amortization | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| 6 | Provision for Bad Debts-Other[b] | $0 | $0 | $0 | $0 | | $0 | $0 | | $0 | $0 | | | $0 |
| 7 | Interest Expense | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| 8 | Malpractice Insurance Cost | $1,000 | $0 | $6,000 | $6,000 | | $6,500 | $6,500 | | $7,000 | $7,000 | | | $0 |
| 9 | Lease Expense | $20,000 | $0 | $120,000 | $120,000 | | $123,600 | $123,600 | | $127,308 | $127,308 | | | $0 |
| 10 | Other Operating Expenses | $9,145 | $0 | $71,331 | $71,331 | | $92,730 | $92,730 | | $120,549 | $120,549 | | | $0 |
| | **TOTAL OPERATING EXPENSES** | $60,761 | $0 | $382,508 | $0 | $0 | $414,334 | $414,334 | $0 | $452,993 | $452,993 | $0 | $0 | $0 |
| | **INCOME/(LOSS) FROM OPERATIONS** | $3,688 | $0 | $38,761 | $421,269 | $0 | $44,606 | $44,606 | $0 | $46,988 | $46,988 | $0 | $0 | $0 |
| | **NON-OPERATING INCOME** | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| | Income before provision for income taxes | $3,688 | $0 | $38,761 | $421,269 | $0 | $44,606 | $44,606 | $0 | $46,988 | $46,988 | $0 | $0 | $0 |
| | Provision for income taxes[c] | $1,659 | $0 | $17,442 | $17,442 | | $20,073 | $20,073 | | $21,144 | $21,144 | | | $0 |
| | **NET INCOME** | $2,028 | $0 | $21,318 | $21,318 | $0 | $24,534 | $24,534 | $0 | $25,843 | $25,843 | $0 | $0 | $0 |
| **C.** | **Retained Earnings, beginning of year** | $0 | $0 | $2,028 | $2,028 | | $23,347 | $23,347 | | $47,880 | $47,880 | | | $0 |
| | **Retained Earnings, end of year** | $2,028 | $0 | $23,347 | $23,347 | | $47,880 | $47,880 | | $73,723 | $73,723 | | | $0 |
| | Principal Payments | $0 | $0 | $0 | $0 | | | $0 | | | $0 | | | $0 |
| **D.** | **PROFITABILITY SUMMARY** | | | | | | | | | | | | | |
| 1 | Hospital Operating Margin | 5.7% | 0.0% | 9.2% | 100.0% | 0.0% | 9.7% | 9.7% | 0.0% | 9.4% | 9.4% | 0.0% | 0.0% | 0.0% |
| 2 | Hospital Non Operating Margin | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 3 | Hospital Total Margin | 3.1% | 0.0% | 5.1% | 5.1% | 0.0% | 5.3% | 5.3% | 0.0% | 5.2% | 5.2% | 0.0% | 0.0% | 0.0% |
| **E.** | **FTEs**** | 2 | 0 | 2.5 | 2.5 | | 2.5 | 2.5 | | 2.5 | 2.5 | | | 0 |
| **F.** | **VOLUME STATISTICS[d]** | | | | | | | | | | | | | |
| 1 | Inpatient Discharges | 0 | 0 | 0 | 0 | | | 0 | | | 0 | | | 0 |
| 2 | Outpatient Visits*** | 193 | 0 | 1,239 | 1,239 | | 1,324 | 1,324 | | 1,414 | 1,414 | | | 0 |
| | **TOTAL VOLUME** | 193 | 0 | 1,239 | 1,239 | 0 | 1,324 | 1,324 | 0 | 1,414 | 1,414 | 0 | 0 | 0 |

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

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

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

* Projected entity start-up November 1, 2015: FY2015 amounts reflect 2 months initial operation projections (Nov 1- Dec 30); applicant fiscal year is Jan 1-Dec 30.

** FTEs represent 1 clerical position, 1 clinical position, and a part time MD/Psychiatrist

** Outpatient visits are counted as single encounters/groups. The Outpatient program provides clients with three 3-hours encounters/groups per week for 12 weeks. The total number of units is calculated as follows:

**FINANCIAL ATTACHMENT II**

**12.C(ii).** Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:

Type of Service Description: Outpatient
Type of Unit Description: Encounter/visit
# of Months in Operation: 2

| FY 2015 (Nov-Dec) FY Projected Incremental Total Incremental Expenses | (1) $60,761 | (2) Rate | (3) Units | (4) Gross Revenue Col. 2 * Col. 3 | (5) Allowances/ Deductions | (6) Charity Care | (7) Bad Debt | (8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7 | (9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total | (10) Gain/(Loss) from Operations Col. 8 - Col. 9 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total Facility by Payer Category:** | | | | | | | | | | |
| Medicare | | | | $0 | | | | $0 | $0 | $0 |
| Medicaid | | $0 | | $0 | | | | $0 | $0 | $0 |
| CHAMPUS/TriCare | | $0 | | $0 | | | | $0 | $0 | $0 |
| **Total Governmental** | | | 0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Commericial Insurers | | $550 | 126 | $69,132 | $20,739 | $0 | $864 | $47,528 | $48,813 | ($1,285) |
| Self-Pay | | $250 | 68 | $16,920 | $0 | $0 | | $16,920 | $11,947 | $4,973 |
| **Total NonGovernment** | | $0 | 193 | $86,052 | $20,739 | $0 | $864 | $64,448 | $60,761 | $3,688 |
| **Total All Payers** | | $0 | 193 | $86,052 | $20,739 | $0 | $864 | $64,448 | $60,761 | $3,688 |

Type of Service Description: Outpatient
Type of Unit Description: Encounter/visit
# of Months in Operation: 12

| FY 2016 FY Projected Incremental Total Incremental Expenses | (1) $382,508 | (2) Rate | (3) Units | (4) Gross Revenue Col. 2 * Col. 3 | (5) Allowances/ Deductions | (6) Charity Care | (7) Bad Debt | (8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7 | (9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total | (10) Gain/(Loss) from Operations Col. 8 - Col. 9 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total Facility by Payer Category:** | | | | | | | | | | |
| Medicare | | | | $0 | | | | $0 | $0 | $0 |
| Medicaid | | $0 | | $0 | | | | $0 | $0 | $0 |
| CHAMPUS/TriCare | | $0 | | $0 | | | | $0 | $0 | $0 |
| **Total Governmental** | | | 0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Commericial Insurers | | $561 | 805 | $451,882 | $135,564 | $0 | $5,649 | $310,669 | $307,296 | $3,373 |
| Self-Pay | | $255 | 434 | $110,600 | | | | $110,600 | $75,212 | $35,388 |
| **Total NonGovernment** | | $0 | 1,239 | $562,482 | $135,564 | $0 | $5,649 | $421,269 | $382,508 | $38,761 |
| **Total All Payers** | | $0 | 1,239 | $562,482 | $135,564 | $0 | $5,649 | $421,269 | $382,508 | $38,761 |

Type of Service Description: Outpatient
Type of Unit Description: Encounter/visit
# of Months in Operation: 12

| FY 2017 FY Projected Incremental Total Incremental Expenses | (1) $414,334 | (2) Rate | (3) Units | (4) Gross Revenue Col. 2 * Col. 3 | (5) Allowances/ Deductions | (6) Charity Care | (7) Bad Debt | (8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7 | (9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total | (10) Gain/(Loss) from Operations Col. 8 - Col. 9 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total Facility by Payer Category:** | | | | | | | | | | |
| Medicare | | | | $0 | | | | $0 | $0 | $0 |
| Medicaid | | | | $0 | | | | $0 | $0 | $0 |
| CHAMPUS/TriCare | | | | $0 | | | | $0 | $0 | $0 |
| **Total Governmental** | | | 0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Commericial Insurers | | $572 | 860 | $492,291 | $147,687 | $0 | $6,154 | $338,450 | $332,864 | $5,586 |
| Self-Pay | | $260 | 463 | $120,491 | | | | $120,491 | $81,470 | $39,021 |
| **Total NonGovernment** | | $0 | 1,324 | $612,781 | $147,687 | $0 | $6,154 | $458,941 | $414,334 | $44,606 |
| **Total All Payers** | | $0 | 1,324 | $612,781 | $147,687 | $0 | $6,154 | $458,941 | $414,334 | $44,606 |

Type of Service Description: Outpatient
Type of Unit Description: Encounter/visit
# of Months in Operation: 12

| FY 2018 FY Projected Incremental Total Incremental Expenses | (1) $452,993 | (2) Rate | (3) Units | (4) Gross Revenue Col. 2 * Col. 3 | (5) Allowances/ Deductions | (6) Charity Care | (7) Bad Debt | (8) Net Revenue Col.4 - Col.5 -Col.6 - Col.7 | (9) Operating Expenses Col. 1 Total * Col. 4 / Col. 4 Total | (10) Gain/(Loss) from Operations Col. 8 - Col. 9 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total Facility by Payer Category:** | | | | | | | | | | |
| Medicare | | | | $0 | | | | $0 | $0 | $0 |
| Medicaid | | $0 | | $0 | | | | $0 | $0 | $0 |
| CHAMPUS/TriCare | | $0 | | $0 | | | | $0 | $0 | $0 |
| **Total Governmental** | | | 0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Commericial Insurers | | $584 | 919 | $536,313 | $160,894 | $0 | $6,704 | $368,715 | $363,922 | $4,794 |
| Self-Pay | | $265 | 495 | $131,265 | | | | $131,265 | $89,072 | $42,194 |
| **Total NonGovernment** | | $0 | 1,414 | $667,579 | $160,894 | $0 | $6,704 | $499,981 | $452,993 | $46,988 |
| **Total All Payers** | | $0 | 1,414 | $667,579 | $160,894 | $0 | $6,704 | $499,981 | $452,993 | $46,988 |

# Attachment VI

## MC1 Healthcare, LLC

## Compiled Financial Statements 2014

# MC1 Healthcare, LLC

Compiled Financial Statements
December 31, 2014 and December 31, 2013

SINNAMON & ASSOCIATES, LLC
CERTIFIED PUBLIC ACCOUNTANTS

# MC1 HEALTHCARE, LLC

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December 31, 2014 and December 31, 2013


| | |
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| Accountants Compilation Report | 1 |
| Statement of Financial Position | 2 |
| Statement of Activities | 3 |
| Statement of Cash Flows | 4 |

SINNAMON & ASSOCIATES, LLC
*Certified Public Accountants*

Accountants Compilation Report

MC1 Healthcare, LLC

We have compiled the accompanying balance sheet of MC1 Healthcare, LLC as of December 31, 2014 and December 31, 2013 and the related statements of income, changes in member's equity and cash flows for the years then ended. We have not audited or reviewed the accompanying financial statements and, accordingly, do not express and opinion or provide any assurance about whether the financial statements are in accordance with accounting principles generally accepted in the United States of America.

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America and for designing, implementing, and maintaining internal control relevant to the preparation and fair presentation of the financial statements.

Our responsibility is to conduct the compilation in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants. The objective of a compilation is to assist management in presenting financial information in the form of financial statements without undertaking to obtain or provide any assurance that there are no material modifications that should be made to the financial statements.

Management has elected to omit substantially all of the disclosures required by accounting principles generally accepted in the United States of America. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the Company's financial position, results of operations, and cash flows. Accordingly, the financial statements are not designed for those who are not informed about such matters.

We are not independent with respect to MC1 Healthcare, LLC as of and for the year ended December 31, 2014 and December 31, 2013, because we performed certain accounting services that impaired our independence.

Sinnamon & Associates LLC

Sinnamon & Associates, LLC
Certified Public Accountants

February 27, 2015
Canaan, Connecticut



CPA America Counts on CPAs℠

194 Ashley Falls Road, P.O. Box 665
Canaan, CT 06018
860.824.7734 *phone*
860.584.9927 *fax*



Bristol Office 860.582.0119
george@sinnamoncpa.com
www.sinnamoncpa.com

237 East Center Street
Manchester, CT 06040

# MC1 HEALTHCARE, LLC

## CONSOLIDATED BALANCE SHEET
## DECEMBER 31, 2014 and DECEMBER 31, 2013

### ASSETS

| | 2014 | 2013 |
|---|---|---|
| Current Assets: | | |
| Cash and Cash Equivalents | $ 430,844 | $ 1,888,866 |
| Other Current Assets | 4,547,608 | 2,503,415 |
| Total Current Assets | 4,978,452 | 4,392,281 |
| Property and Equipment, net of Depreciation | 1,770,065 | 1,668,744 |
| Other Assets: | 45,185 | 4,198 |
| TOTAL ASSETS | $ 6,793,702 | $ 6,065,223 |

### LIABILITIES AND MEMBER'S EQUITY

| | 2014 | 2013 |
|---|---|---|
| Current Liabilities | 2,307,535 | 1,269,543 |
| Long-Term Liabilities | 345,623 | 508,078 |
| Member's Equity: | 4,140,544 | 4,287,602 |
| TOTAL LIABILITIES AND MEMBER'S EQUITY | $ 6,793,702 | $ 6,065,223 |



See Accountant's Compilation Report

# MC1 HEALTHCARE, LLC

## CONSOLIDATED STATEMENT OF INCOME AND CHANGES IN MEMBER'S EQUITY
## FOR THE YEARS ENDED DECEMBER 31, 2014 and DECEMBER 31, 2013

| | 2014 | 2013 |
|---|---|---|
| Revenue | $ 24,238,849 | $ 17,120,573 |
| Operating Expenses | 19,169,470 | 12,167,325 |
| Total Operating Income | 5,069,379 | 4,953,248 |
| Other (Income) Expense | 1,893,163 | 372,424 |
| Net Income | 3,176,216 | 4,580,824 |
| Member's Equity - Beginning of Year | 4,287,602 | 4,706,778 |
| Distributions | (3,323,274) | (5,000,000) |
| Member's Equity - End of Year | $ 4,140,544 | $ 4,287,602 |

See Accountant's Compilation Report

# MC1 HEALTHCARE, LLC

## CONSOLIDATED STATEMENT OF CASH FLOWS

## FOR THE YEARS ENDED DECEMBER 31, 2014 and DECEMBER 31, 2013

| | 2014 | 2013 |
|---|---|---|
| Cash Flows From Operating Activities: | | |
| Net Income | $ 3,176,216 | $ 4,580,824 |
| Adjustments To Reconcile Change In Net Assets | | |
| To Net Cash Provided By Operating Activities: | | |
| Depreciation and Amortization | 314,758 | 249,243 |
| Loss on Disposal of Assets | 12,719 | 178,134 |
| (Increase) Decrease in Other Current Assets | (2,044,193) | (697,108) |
| Increase (Decrease) in Current Liabilities | 1,037,992 | 461,795 |
| Net Cash Provided By Operating Activities | 2,497,492 | 4,772,888 |
| Cash Flows From Investing Activities: | | |
| Purchase of Property, Equipment and Improvements | (469,785) | (231,001) |
| Net Cash Used in Investing Activities | (469,785) | (231,001) |
| Cash Flows From Financing Activities: | | |
| Changes in Notes Payable Debt | (162,455) | 477,184 |
| Distributions to Member | (3,323,274) | (5,000,000) |
| Net Cash Used In Financing Activities | (3,485,729) | (4,522,816) |
| Net Increase (Decrease) in Cash and Cash Equivalents | (1,458,022) | 19,071 |
| Cash and Cash Equivalents - Beginning | 1,888,866 | 1,869,795 |
| Cash and Cash Equivalents - Ending | $ 430,844 | $ 1,888,866 |

| | | |
|---|---|---|
| Supplemental Information: | | |
| Cash Paid for Interest | 12,544 | 9,361 |
| Property Acquired with Loan Obligations | - | 103,636 |

## Greer, Leslie

**From:** Armah, Olga
**Sent:** Tuesday, September 29, 2015 3:56 PM
**To:** pbrmssw@aol.com
**Cc:** User, OHCA; Riggott, Kaila
**Subject:** 15-32024 CON

Dear Mr. Rockholz:

On September 1, 2015, OHCA received the Certificate of Need application of MC1 Healthcare, LLC d/b/a/ Mountainside Treatment Center ("Mountainside") proposing to establish a substance use disorders intensive outpatient treatment clinic in Wilton. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email.

Repeat each question before providing your response and paginate and date your response, i.e., each page in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using **Page 91** and reference "**Docket Number: 15-32024-CON**."

1. Please provide a more current copy of the Department of Public Health license on page 45.
2. The application indicates that 20% of residential admissions to the Canaan campus are from Fairfield County. Using the table below, provide the number of patients by patient town (including non-Fairfield County residents) discharged from that facility in FY 2015 and include the period covered by the fiscal year.

**UTILIZATION BY TOWN**

| Town | Utilization FY 2015 |
|---|---|
| | |

3. If the target population is currently served in several lower levels of care by a variety of community providers (page 11) explain why those levels of care are not sufficient.
4. Provide evidence that Family Resource Associates and The Recovery Center of Westport (page 12) have limited capacity.
5. Describe how other Fairfield County residents that are not discharges of the Canaan residential program would access the proposed services.
6. Reconcile the data in Table A (page 11), Table B (page 14), Table 3 (page 19) and Financial Worksheet I (page 82) of the application.
7. Clarify what the data in Table 3 (page 19) represent, that is, are they for the Canaan campus and do they reflect encounters/visits or patients? Provide the data by patients and encounter/visit.
8. Update payer mix Table 3 (page 19) with data on patients and encounter/visits specific to the proposed clinic.

Please note that pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request no later than sixty days from the date of this email transmission. Therefore, please provide your written responses to OHCA no later than Monday, November 30, 2015, otherwise your application will be automatically considered withdrawn. ***Please email your responses to all of the following email addresses:* OHCA@ct.gov, *olga.armah@ct.gov*, *kaila.riggott@ct.gov*** . If you have any questions concerning this letter, please feel free to contact me at (860) 418-7070.

Sincerely,

***Olga Armah, M. Phil***
Associate Research Analyst
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134

Phone: 860 418 7070
Fax: 860 418 7053
mailto: olga.armah@ct.gov
Web: www.ct.gov/ohca

**Greer, Leslie**

---

**From:** Armah, Olga
**Sent:** Wednesday, September 30, 2015 8:20 AM
**To:** Riggott, Kaila
**Cc:** Greer, Leslie
**Subject:** FW: 15-32024 CON

Acknowledgement of receipt FYI.


*Olga Armah*
CT Department of Public Health
Office of Health Care Access (OHCA)
Phone: 860 418 7070
Fax: 860 418 7053
Mailto: olga.armah@ct.gov
Web: www.ct.gov/ohca

**From:** pbrmssw@aol.com [mailto:pbrmssw@aol.com]
**Sent:** Tuesday, September 29, 2015 6:42 PM
**To:** Armah, Olga
**Subject:** Re: 15-32024 CON

Olga

I have received your email. I will call you. We will be submitting a response within a day or two.

Thank you,

Peter Rockholz

-----Original Message-----
From: Armah, Olga <Olga.Armah@ct.gov>
To: pbrmssw <pbrmssw@aol.com>
Cc: User, OHCA <OHCA@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>
Sent: Tue, Sep 29, 2015 3:56 pm
Subject: 15-32024 CON

Dear Mr. Rockholz:

On September 1, 2015, OHCA received the Certificate of Need application of MC1 Healthcare, LLC d/b/a/ Mountainside Treatment Center ("Mountainside") proposing to establish a substance use disorders intensive outpatient treatment clinic in Wilton. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email.

Repeat each question before providing your response and paginate and date your response, i.e., each page in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using **Page 91** and reference "**Docket Number: 15-32024-CON**."

1. Please provide a more current copy of the Department of Public Health license on page 45.
2. The application indicates that 20% of residential admissions to the Canaan campus are from Fairfield County. Using the table below, provide the number of patients by patient town (including non-Fairfield County residents) discharged from that facility in FY 2015 and include the period covered by the fiscal year.

**UTILIZATION BY TOWN**

| Town | Utilization FY 2015 |
|---|---|
| | |

3. If the target population is currently served in several lower levels of care by a variety of community providers (page 11) explain why those levels of care are not sufficient.
4. Provide evidence that Family Resource Associates and The Recovery Center of Westport (page 12) have limited capacity.
5. Describe how other Fairfield County residents that are not discharges of the Canaan residential program would access the proposed services.
6. Reconcile the data in Table A (page 11), Table B (page 14), Table 3 (page 19) and Financial Worksheet I (page 82) of the application.
7. Clarify what the data in Table 3 (page 19) represent, that is, are they for the Canaan campus and do they reflect encounters/visits or patients? Provide the data by patients and encounter/visit.
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Sincerely,

***Olga Armah, M. Phil***
Associate Research Analyst
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134

Phone: 860 418 7070
Fax: 860 418 7053
mailto: olga.armah@ct.gov

## Greer, Leslie

| | |
|---|---|
| **From:** | pbrmssw@aol.com |
| **Sent:** | Monday, October 05, 2015 4:24 PM |
| **To:** | Armah, Olga |
| **Cc:** | User, OHCA; Riggott, Kaila; matthew.eakin@mountainside.com |
| **Subject:** | Re: 15-32024 CON |
| **Attachments:** | CON Questions Response 100315.docx; CON Questions Response 100315.pdf |

Olga

Please see, attached, electronic copies in both MS Word and .pdf of MC1 Healthcare, LLC d/b/a/ Mountainside Treatment Center's response to the questions you raised below. I hope this will complete the CON application. Please advise.

Peter B. Rockholz, M.S.S.W., LCSW
Consultant

-----Original Message-----
From: Armah, Olga <Olga.Armah@ct.gov>
To: pbrmssw <pbrmssw@aol.com>
Cc: User, OHCA <OHCA@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>
Sent: Tue, Sep 29, 2015 3:56 pm
Subject: 15-32024 CON

Dear Mr. Rockholz:

On September 1, 2015, OHCA received the Certificate of Need application of MC1 Healthcare, LLC d/b/a/ Mountainside Treatment Center ("Mountainside") proposing to establish a substance use disorders intensive outpatient treatment clinic in Wilton. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email.

Repeat each question before providing your response and paginate and date your response, i.e., each page in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using **Page 91** and reference "**Docket Number: 15-32024-CON**."

1. Please provide a more current copy of the Department of Public Health license on page 45.
2. The application indicates that 20% of residential admissions to the Canaan campus are from Fairfield County. Using the table below, provide the number of patients by patient town (including non-Fairfield County residents) discharged from that facility in FY 2015 and include the period covered by the fiscal year.

**UTILIZATION BY TOWN**

| Town | Utilization FY 2015 |
|---|---|
| | |

| | |
|---|---|

3. If the target population is currently served in several lower levels of care by a variety of community providers (page 11) explain why those levels of care are not sufficient.
4. Provide evidence that Family Resource Associates and The Recovery Center of Westport (page 12) have limited capacity.
5. Describe how other Fairfield County residents that are not discharges of the Canaan residential program would access the proposed services.
6. Reconcile the data in Table A (page 11), Table B (page 14), Table 3 (page 19) and Financial Worksheet I (page 82) of the application.
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Please note that pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request no later than sixty days from the date of this email transmission. Therefore, please provide your written responses to OHCA no later than Monday, November 30, 2015, otherwise your application will be automatically considered withdrawn. ***Please email your responses to all of the following email addresses:* OHCA@ct.gov, *olga.armah@ct.gov, kaila.riggott@ct.gov*** . If you have any questions concerning this letter, please feel free to contact me at (860) 418-7070.

Sincerely,

***Olga Armah, M. Phil***
Associate Research Analyst
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134

Phone: 860 418 7070
Fax: 860 418 7053
mailto: olga.armah@ct.gov
Web: www.ct.gov/ohca

**Responses to questions raised by OHCA – transmitted via email by Olga Armah, M.Phil., Associate Research Analyst on September 29, 2015.**

1. ***Please provide a more current copy of the Department of Public Health license on page 45.***

   A copy of Department of Public Health license #0388 (Renewal) appears in Appendix 1 (page 98).

2. ***The application indicates that 20% of residential admissions to the Canaan campus are from Fairfield County. Using the table below, provide the number of patients by patient town (including non-Fairfield County residents) discharged from that facility in FY 2015 and include the period covered by the fiscal year.***

**Table C – Mountainside Canaan Residential Discharges by Town and State (Jan 1 – Aug 31, 2015)**

| Town | Utilization FY2015* |
|---|---|
| **Connecticut – Fairfield County** | **115 (19.7%)** |
| Bethel | 4 |
| Bridgeport | 6 |
| Brookfield | 2 |
| Danbury | 17 |
| Darien | 3 |
| Easton | 2 |
| Fairfield | 6 |
| Greenwich | 5 |
| Milford | 3 |
| Monroe | 7 |
| New Canaan | 1 |
| New Fairfield | 1 |
| Newtown | 3 |
| Norwalk | 8 |
| Redding | 1 |
| Ridgefield | 5 |
| Shelton | 7 |
| Stamford | 12 |
| Stratford | 4 |
| Trumbull | 3 |
| Weston | 2 |
| Westport | 6 |
| Wilton | 7 |
| **Connecticut – Other Cities/Towns** | **215 (36.8%)** |
| Bristol | 7 |
| Torrington | 7 |
| New Haven | 6 |

| | |
|---|---|
| Hartford | 5 |
| Wallingford | 5 |
| Madison | 4 |
| Middletown | 4 |
| Lakeville | 4 |
| Simsbury | 4 |
| West Hartford | 4 |
| South Windsor | 4 |
| New Britain | 4 |
| W Hartford | 3 |
| Suffield | 3 |
| Watertown | 3 |
| Litchfield | 3 |
| Waterbury | 3 |
| Glastonbury | 3 |
| East Haven | 3 |
| Terryville | 3 |
| North Branford | 3 |
| Vernon Rockville | 3 |
| North Haven | 3 |
| Guilford | 3 |
| Prospect | 3 |
| Waterford | 3 |
| Enfield | 3 |
| Hamden | 3 |
| Southbury | 3 |
| Rocky Hill | 3 |
| New Milford | 2 |
| Oxford | 2 |
| Norfolk | 2 |
| Killingworth | 2 |
| Putnam | 2 |
| Burlington | 2 |
| Unionville | 2 |
| Harwinton | 2 |
| Meriden | 2 |
| Sharon | 2 |
| West Simsbury | 2 |
| Canton | 2 |
| Groton | 2 |
| Falls Village | 2 |
| Uncasville | 2 |
| Farmington | 2 |
| Niantic | 2 |
| Durham | 2 |
| Marlborough | 2 |

| | |
|---|---|
| Naugatuck | 2 |
| Cromwell | 2 |
| Windsor | 2 |
| Tolland | 2 |
| Kent | 2 |
| New Hartford | 2 |
| Bethlehem | 1 |
| New Fairfield | 1 |
| Norwich | 1 |
| Windsor Locks | 1 |
| Old Lyme | 1 |
| Mystic | 1 |
| Old Saybrook | 1 |
| Avon | 1 |
| Bloomfield | 1 |
| Wethersfield | 1 |
| Plainfield | 1 |
| Storrs Mansfield | 1 |
| Plainville | 1 |
| Thomaston | 1 |
| Pleasant Valley | 1 |
| Goshen | 1 |
| Pomfret | 1 |
| W. Hartford | 1 |
| Pomfret Center | 1 |
| Kensington | 1 |
| Deep River | 1 |
| Prospect | 1 |
| Winchester Center | 1 |
| East Granby | 1 |
| Derby | 1 |
| East Haddam | 1 |
| Middlefield | 1 |
| East Hartford | 1 |
| Clinton | 1 |
| Roxbury | 1 |
| Branford | 1 |
| Salisbury | 1 |
| Berlin | 1 |
| Lebanon | 1 |
| Ledyard | 1 |
| Ansonia | 1 |
| Bolton | 1 |
| Granby | 1 |
| Bozrah | 1 |
| Newington | 1 |

| | |
|---|---|
| South Glastonbury | 1 |
| South Windham | 1 |
| West Suffield | 1 |
| Mansfield Center | 1 |
| North Franklin | 1 |
| Cheshire | 1 |
| North Granby | 1 |
| Southbury | 1 |
| Hamden | 1 |
| Southington | 1 |
| Woodbridge | 1 |
| Stafford Springs | 1 |
| Chester | 1 |
| **Other States** | **255 (43.5%)** |
| CA | 2 |
| FL | 4 |
| MA | 74 |
| MD | 3 |
| ME | 5 |
| NC | 2 |
| NH | 4 |
| NJ | 37 |
| NY | 109 |
| PA | 5 |
| RI | 4 |
| VT | 4 |
| WA | 1 |
| WY | 1 |
| **TOTAL** | **585 (100%)** |

* Includes January 1- August 31, 2015

**3.** ***If the target population is currently served in several lower levels of care by a variety of community providers (page 11) explain why those levels of care are not sufficient.***

To clarify, the reference made to the "target population" on page 11 is to the estimated pool of 234 discharges from residential treatment in Canaan back to Fairfield County, for the first full year of the service (2016). "Lower levels of care" means step-down continuing care from the more intensive, residential treatment services offered at the Mountainside Canaan campus. These levels include: lower intensity residential care including sober housing and long-term care; intensive outpatient; outpatient treatment; individual counseling; and recovery supports – in addition to some who refused clinical discharge recommendations.

Of this pool, it is estimated that 59 (25%) will be referred directly to the new IOT service in Wilton. Therefore, it might be concluded that, for about three-fourths of the target population, lower levels of care do appear to be 'sufficient'. In addition, of the 59 projected referrals, 24 (41%) are currently being served in IOT at either Mountainside's Canaan location or spread across the five (5) other IOT programs in Fairfield County, as discussed in the response to Question 2.a.vi. on pages

12-13. This subpopulation, also, would be considered as being served at a 'sufficient' level of care. They will simply be served at the Wilton location as opposed to where they are being served now.

This leaves the question of the remaining 35 projected referrals to the Wilton IOT. Of these, one-half (18 of 36) of those currently either refusing recommendations or attending 12-Step meetings only, are anticipated to be successfully enrolled in the new Mountainside IOT program. Anecdotally, these clients are reported by case managers as having the highest incidence of relapse. Reducing such relapses is a primary reason for establishing the Wilton IOT – to address a preventable public health problem.

The last segment of the target population pool includes those receiving outpatient treatment or individual counseling. While exact data are not available, a random review of clinical records suggests that about two-thirds of these clients were clinically recommended for IOT level of care. The review also indicates that of these, about 40% reportedly relapsed following discharge. For this reason, we estimate that this is a subpopulation (n=21) that is receiving an insufficient level of service – and that the Wilton IOT will offer a more effective, evidence-based clinical response.

4. ***Provide evidence that Family Resource Associates and The Recovery Center of Westport (page 12) have limited capacity.***

To clarify, the reference to Family Resource Associates and The Recovery Center of Westport as having "limited capacity" (page 12) was intended to be descriptive of the fact that these organizations' licensed programs are relatively small in size and that the new Mountainside program would not, in our view, have any significant impact on these existing services. Our use of terms might have been better selected in order to avoid misinterpretation. The question was about impact on existing services, not on assessing or documenting the need for service capacity in the region.

5. ***Describe how other Fairfield County residents that are not discharges of the Canaan residential program would access the proposed services.***

Fairfield County residents that are not discharges of the Canaan residential program would access the proposed services by calling Mountainside's main toll-free phone number to speak with an intake specialist located at the Canaan campus. A telephonic intake screening will determine the appropriateness of the request for services and whether the resident is able to pay for services, and schedule an in-person appointment for an intake assessment at the Wilton facility.

Mountainside maintains referral relationships with most area hospitals and addictions treatment facilities, with many therapists in Connecticut and Westchester County (NY), as well as with rehabilitation and recovery programs across the country. Since intensive outpatient treatment (IOT) is increasingly a preferred step-down level of continuing care, rehab programs discharging patients to home in Fairfield County may refer their patients directly to the new Wilton facility.

In addition, Mountainside employs three (3) full-time community relations specialists – one of whom is assigned to cover the Fairfield County area. These specialists continuously raise awareness among area healthcare professionals of the services available through Mountainside. This will soon include the IOT program to be offered in Wilton. Both professional referrals and self-referrals will be accepted at Mountainside in Wilton.

***6. Reconcile the data in Table A (page 11), Table B (page 14), Table 3 (page 19) and Financial Worksheet I (page 82) of the application.***

Both *Table A* (page 11) *and Table B* (page 14) were developed independently, in response to separate questions, using slightly different data sources to illustrate different points. Now reconciling these with the required *Table 3* (page 19) and *Financial Worksheet I* (page 82), therefore, will necessitate providing revised data in *Table A (Revised)* below to replace *Table A* on page 11. In addition, instead of using *Table 3*, the reconciliation will need to utilize *Table 3 (Revised)* that is provided in response to Question 8 below.

***Table A (Revised) – Current aftercare referrals and projected Wilton referrals***

| TYPE OF CARE | % of Total | Estimated annual Mountainside referrals from Fairfield County | Projected Referrals to Wilton IOT (FY2016) |
|---|---|---|---|
| (Sober Living | 29% | 59 | |
| Intensive Outpatient (IOT) | 17% | 35 | 20 |
| Extended Care (residential) | 16% | 33 | |
| Outpatient Treatment | 10% | 20 | 6 |
| Private Practice Clinicians | 10% | 20 | 11 |
| Refused Recommendation | 9% | 18 | 10 |
| 12-Step Meetings | 7% | 17 | 8 |
| Psychiatrist | 1% | 3 | |
| Other | 1% | 2 | |
| **TOTAL** | **100%** | **204** | **55** |

*Table A (Revised)* shows the correct percentages totaling 100%, and revises the projected referrals to Wilton IOT to reconcile with *Table 3 (Revised)* for the first full year (FY2016) of the new service. This revision also now reconciles *Table A (Revised)* with *Table B* on page 14.

Finally, the request from OHCA included verbal instruction to provide data on IOT admissions (i.e., number of individuals to be served) to replace 'outpatient visits' on row F.2. of *Financial Worksheet I (B)* in order to reconcile with the tables mentioned above. See the table excerpt below for the revised data.

**Financial Worksheet I (B) (Revised excerpt)**

| F. VOLUME STATISTICS | 2015 | 2016 w/o CON | 2016 Incre-mental | 2016 with CON | 2017 w/o CON | 2017 Incre-mental | 2017 with CON | 2018 w/o CON | 2018 Incre-mental | 2018 with CON |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. Inpatient Discharges | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2. Intensive Outpatient Treatment (IOT) Admits | 9 | 0 | 46 | 55 | 0 | 3 | 58 | 0 | 4 | 62 |
| **TOTAL VOLUME** | **9** | **0** | **46** | **55** | **0** | **3** | **58** | **0** | **4** | **62** |

***7. Clarify what the data in Table 3 (page 19) represent, that is, are they for the Canaan campus and do they reflect encounters/visits or patients? Provide the data by patients and encounter/visit.***

The data presented in *Table 3* on page 19 represent revenues (in dollars) projected for the new Wilton facility – information that was not requested and needs to be corrected. Since Question 8 below is duplicative in part of this question, please see the response to Question 8 for the correct data requested for *Table 3* (i.e., number of patients and encounters/visits).

***8. Update payer mix Table 3 (page 19) with data on patients and encounter/visits specific to the proposed clinic.***

*Table 3 (Revised)*, below, provides both the corrected data as requested in the original CON instructions for *Table 3* (i.e., numbers of projected patients), and the additional data requested in this question (i.e., numbers of projected encounters/visits). Data are presented as: number of patients/number of encounters for the proposed new outpatient clinic in Wilton. Encounters (i.e., units of service) are 3-hour sessions of intensive outpatient treatment (IOT).

***Table 3 (Revised): Patients/Encounters Mix – Mountainside Wilton***

| | **Current FY 2015**** | **Year 1 FY 2016** | **Year 2 FY 2017** | **Year 3 FY 2018** |
|---|---|---|---|---|
| Medicare* | 0 | 0 | 0 | 0 |
| Medicaid* | 0 | 0 | 0 | 0 |
| CHAMPUS & TriCare | | | | |
| **Total Government** | | | | |
| Commercial Insurers* | 7/143 | 41/917 | 43/980 | 46/1046 |
| Self-Pay | 2/50 | 14/322 | 15/355 | 16/368 |
| Workers Compensation | | | | |
| **Total Non-Government** | **9/193** | **55/1239** | **58/1324** | **62/1414** |
| **Total Payer Mix** | **9/193** | **55/1239** | **58/1324** | **62/1414** |

**** Includes managed care activity.***

** Includes November 1 – December 30, 2015 (two months)

## Appendix 1 – Department of Public Health License

# STATE OF CONNECTICUT

## Department of Public Health

## LICENSE

## License No. 0388

## Facility for the Care or Treatment of Substance Abusive or Dependent Persons

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

MC1 Healthcare LLC of Canaan, CT, d/b/a Mountainside Treatment Center is hereby licensed to maintain and operate a private freestanding Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

**Mountainside Treatment Center** is located at 187 South Canaan Rd, Canaan, CT 06018 with:

Stephen B. Langley as Executive Director.

The service classification(s) and if applicable, the residential capacities are as follows:

20 Residential Detoxification and Evaluation Beds
58 Intermediate and Long Term Treatment and Rehabilitation Beds
Day or Evening Treatment
Outpatient Treatment

This license expires **September 30, 2017** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2015. **RENEWAL**

Jewel Mullen, MD, MPH, MPA
Commissioner

# Greer, Leslie

**From:** Armah, Olga
**Sent:** Tuesday, October 06, 2015 8:21 AM
**To:** pbrmssw@aol.com
**Cc:** User, OHCA; Riggott, Kaila; matthew.eakin@mountainside.com
**Subject:** RE: 15-32024 CON

Dear Mr. Rockholz,

Thank you for responding. We will review the responses and contact you if we have additional questions.

Thanks again.

Olga
*Olga Armah*
CT Department of Public Health
Office of Health Care Access (OHCA)
Phone: 860 418 7070
Fax: 860 418 7053
Mailto: olga.armah@ct.gov
Web: www.ct.gov/ohca

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**Sent:** Monday, October 05, 2015 4:24 PM
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Olga

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Peter B. Rockholz, M.S.S.W., LCSW
Consultant

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P.O. Box 340308

Hartford, CT 06134

Phone: 860 418 7070
Fax: 860 418 7053
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## Greer, Leslie

| | |
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| **Sent:** | Monday, November 02, 2015 1:36 PM |
| **To:** | pbrmssw@aol.com |
| **Cc:** | User, OHCA; Riggott, Kaila; matthew.eakin@mountainside.com; Greci, Laurie |
| **Subject:** | RE: 15-32024 CON |
| **Attachments:** | 15-32024-CON Notification of Application Deemed Complete.docx |

Dear Mr. Rockholz,

OHCA has deemed complete the application.

Thanks.

Olga


*Olga Armah*
CT Department of Public Health
Office of Health Care Access (OHCA)
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Hartford, CT 06134

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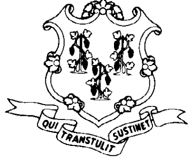
mailto: olga.armah@ct.gov
Web: www.ct.gov/ohca




# STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

*Office of Health Care Access*

November 2, 2015 VIA EMAIL ONLY

Peter B. Rockholz
Consultant
81 Bowman Drive
Greenwich 06831

RE: Certificate of Need Application; Docket Number: 15-32024-CON
MC1 Healthcare, LLC. d/b/a Mountainside Treatment Center
Proposal to Establish a Substance Use Disorder Clinic for Adults in Wilton, Connecticut
Notification Deeming the CON Application Complete

Dear Mr. Rockholz:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of November 2, 2015.

If you have any questions regarding this matter, please feel free to contact me at (860) 418-7070 or Kaila Riggott (860) 418-7037.

Sincerely,

*Olga Armah*

Olga Armah
Associate Research Analyst

*An Equal Opportunity Provider*
*(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)*
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## Greer, Leslie

**From:** Greer, Leslie
**Sent:** Wednesday, December 23, 2015 10:40 AM
**To:** 'pbrmssw@aol.com'
**Cc:** Armah, Olga; Riggott, Kaila; Hansted, Kevin; Martone, Kim
**Subject:** MC1 Healthcare, LLC d/b/a Mountainside Treatment Center Final Decision
**Attachments:** 32024_201512231038.pdf

**Tracking:**

| Recipient | Delivery |
|---|---|
| 'pbrmssw@aol.com' | |
| Armah, Olga | Delivered: 12/23/2015 10:40 AM |
| Riggott, Kaila | Delivered: 12/23/2015 10:40 AM |
| Hansted, Kevin | Delivered: 12/23/2015 10:40 AM |
| Martone, Kim | Delivered: 12/23/2015 10:40 AM |

Mr. Rockholz,
Attached is the Final Decision to establish a substance abuse disorder treatment facility for adults in Wilton, CT.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
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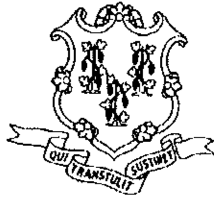


# Department of Public Health
# Office of Health Care Access
# Certificate of Need Application

## Final Decision

**Applicant:** **MC1 Healthcare, LLC**
**187 South Canaan Road**
**Canaan, CT 06018**

**Docket Number:** **15-32024-CON**

**Project Title:** **Proposal to Establish a Substance Abuse Disorder Treatment Facility for Adults in Wilton, Connecticut**

**Project Description:** MC1 Healthcare, LLC, d/b/a Mountainside Treatment Center ("Mountainside" or "Applicant") is proposing to establish a new facility for the care and treatment of substance abusive or dependent adults at 372 Danbury Road, Wilton, Connecticut, at an associated capital cost of $10,000.

**Procedural History:** The Applicant published notice of its intent to file a Certificate of Need ("CON") application in *The Hour* (Norwalk) on July 17, 18 and 19, 2015. On September 1, 2015, the Office of Health Care Access ("OHCA") received the CON application from the Applicant for the above-referenced project and deemed the application complete on November 2, 2015. OHCA received no responses from the public concerning the proposal and no hearing requests from the public per Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a(e). Deputy Commissioner Brancifort considered the entire record in this matter.

# Findings of Fact and Conclusions of Law

1. MC1 Healthcare, LLC, d/b/a Mountainside Treatment Center ("Mountainside" or "Applicant"), is a for-profit organization licensed by the Department of Public Health to maintain and operate a private freestanding facility for the care and treatment of substance abusive or dependent persons. Ex. A, p. 4; Ex. C, p. 98.

2. Mountainside currently provides detoxification, residential and outpatient substance use disorder ("SUD")[1] services at its main campus in Canaan, CT ("Mountainside-Canaan"). Mountainside is certified by the Commission on Accreditation of Rehabilitation Facilities, an independent, nonprofit accreditor of health and human services.[2] Ex. A, p. 4.

3. Since 1998, Mountainside has been providing services to approximately 9,000 clients annually, exclusively for those who self-pay or have commercial insurance. Ex. A, p. 4.

4. Mountainside proposes to establish a SUD facility that provides intensive outpatient treatment ("IOT") in Wilton, CT to treat commercially insured or self-pay adults (18 years of age and above). Ex. A, pp. 4, 19.

5. The proposed facility will primarily treat existing clients of Mountainside-Canaan who are in early recovery from addiction and require continuing care. Ex. A, p. 4.

6. IOT is an effective program to facilitate the long-term recovery from addiction and an important part of the continuum of care for alcohol and drug use disorders. IOT is an alternative to inpatient and residential treatment designed to establish psychosocial supports and facilitate relapse management and coping strategies. Ex. A, pp. 15, 69-70.

7. IOT provides services for clients who do not require medical detoxification or 24-hour supervision and represents a higher level of care than outpatient services but a lower level of care than residential and inpatient services. IOT allows individuals to remain in their own homes and communities, which may improve their adjustment to community life. Ex. A, p. 69-71.

8. The towns from which the highest numbers of patients will be served include 21 in Fairfield County: Bethel, Bridgeport, Brookfield, Danbury, Darien, Easton, Fairfield, Greenwich, Milford, New Canaan, New Fairfield, Newtown, Redding, Ridgefield, Shelton, Stamford, Stratford, Trumbull, Weston, Westport and Wilton as well as Monroe. Ex. A, p. 6.

[1] Includes alcohol and illicit drugs.
[2] Source: www.carf.org/About/WHoWeAre/.

9. The Applicant is choosing to locate the new facility in Wilton as:
   a) one-fifth (20%) of Mountainside's residential program patients admitted to its Canaan campus are from Fairfield County towns and represents the largest geographical concentration of clients in need of continuing care in the community;
   b) the location of the facility on a main route is geographically centralized in proximity to clients who will be traveling there three times per week for treatment; and
   c) estimates suggest there are a significant number of Fairfield County residents with SUD.

   Ex. A, pp. 5-7.

10. From January 1, 2015 to August 31, 2015, 35% of Mountainside's residential program admissions from Connecticut were Fairfield County residents. Ex. C, p. 6.

**TABLE 1**
**FY 2015 CLIENT ORIGIN FOR MOUNTAINSIDE TREATMENT CENTER**

| SERVICE AREA* | NO. OF CLIENTS | PERCENT OF CT TOTAL |
|---|---|---|
| County: Fairfield | 116 | 35% |
| Hartford | 73 | 22% |
| New Haven | 53 | 16% |
| Litchfield | 41 | 12% |
| Middlesex | 16 | 5% |
| New London | 16 | 5% |
| Tolland | 9 | 3% |
| Windham | 6 | 2% |
| Connecticut Total | 330 | 100% |

*An 255 additional clients originated out-of-state
Ex. C, pp. 91-94.

11. Adults within the Applicant's proposed service area represent 26% of the state's adult population. Based on prevalence rates predicated upon national data, approximately 61,155 adults within the service area may have a diagnosable SUD.

**TABLE 2**
**ESTIMATE OF DIAGNOSABLE SUBSTANCE USE DISORDERS INCIDENCE IN CONNECTICUT**

| SUBSTANCE USE DISORDER | POPULATION (18 years and above)[1] | PREVALENCE[2, 3] | INCIDENCE |
|---|---|---|---|
| Connecticut | 2,819,794 | 8.5% | 239,682 |
| Fairfield County | 719,478 | 8.5% | 61,155 |
| **Service Area as Percent of Connecticut** | **26%** | **n/a** | **26%** |

Sources:
[1] *http://www.census.gov/popest/data/state/totals/2014/index.html 2014 Connecticut population estimate is 3,599,341.*
[2] Substance and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. September 4, 2014. The National Survey on Drug Use and Health Behavioral Report: *Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings. Rockville, MD.*
[3] Actual prevalence data for Connecticut are not available.
Ex. A, p. 7.

12. There are 16 existing providers of SUD IOT in the proposed service area.

**TABLE 3**
**PROVIDERS OF THE PROPOSED SERVICES IN SERVICE AREA**

| TOWN | PROVIDER | STREET ADDRESS |
|---|---|---|
| Bridgeport | Chemical Abuse Services Agency, Inc. | 592 Kossuth Street |
| Bridgeport | Liberation Programs, Inc. | 399 Mill Hill Avenue |
| Bridgeport | New Era Rehabilitation Center, Inc. | 3851 Main Street |
| Bridgeport | Recovery Network of Programs, Inc. | 480 Bond Street |
| Danbury | Connecticut Counseling Centers, Inc. | 60 Beaverbrook Road |
| Danbury | MCCA, Inc. | 38 Old Ridgebury Road |
| Greenwich | Greenwich Hospital | 5 Perryridge Road |
| New Canaan | Silver Hill Hospital, Inc. | 208 Valley Road |
| Norwalk | Connecticut Renaissance, Inc. | 4 Byington Place |
| Norwalk | Family and Children's Agency, Inc. | 9 Mott Avenue |
| Norwalk | Norwalk Hospital – Outpatient | 20 North Main Street |
| Stamford | Connecticut Renaissance | 141 Franklin Street |
| Stamford | Liberation Programs, Inc. | 115 Main Street |
| Stamford | Liberation Programs, Inc. | 119 Main Street |
| Stratford | Family Resource Associates, LLC | 3300 Main Street |
| Westport | The Recovery Center of Westport | 728 Post Road East |

Ex. A, p. 12.

13. Of the 16 existing providers in the proposed service area, 15 accept Medicaid and/or government-funded insurance. Ex. A, p. 12; Substance Abuse and Mental Health Services Administration, Behavioral Health Treatment Services Locator, https://findtreatment.samhsa.gov, accessed Dec. 17, 2015.

14. The Applicant estimates that in FY2016, its existing residential facility, Mountainside-Canaan, will refer 59 discharged Fairfield County patients to the proposed facility. Over the past four years, Mountainside-Canaan referred an average of 35 (17%) of its 207 Fairfield County patients to IOT—either to its Canaan facility or one of five other unrelated IOT facilities in Fairfield County. The Applicant estimates that in FY2016, 20 of those patients would instead be referred to the proposed site. Historically 40 patients received outpatient or private practice clinician treatment. An estimated additional 17 patients who would previously have been referred to such lower levels of care would be better suited for its IOT. Lastly, on average 35 patients refused recommended treatment or attended 12-step meetings. The Applicant estimates that 18 such patients would be treated at the proposed facility in FY2016. Ex. A, p. 11; Ex. C, pp. 94-96.

15. The Applicant projects that Fairfield County residents discharged from Mountainside-Canaan needing IOT will seek treatment at the proposed facility, which will be located in the same county. Based on historic observations at Mountainside-Canaan, 25% of discharged patients from residential programs seek IOT. Therefore, the Applicant projects that it will serve 55, 58 and 62 patients from Fairfield County from FY16 through FY18, respectively.

**TABLE 4**
**MOUNTAINSIDE-CANAAN HISTORICAL AND PROJECTED UTILIZATION**

| | HISTORICAL VOLUME | | | | PROJECTED VOLUME | | |
|---|---|---|---|---|---|---|---|
| SERVICE/PROGRAM | FY 2012 | FY 2013 | FY 2014 | FY 2015* | FY 2016 | FY 2017 | FY 2018 |
| Mountainside Residential** | 697 | 667 | 829 | 981 | 1,048 | 1,119 | 1,195 |
| Fairfield County | 125 | 127 | 191 | 204 | 218 | 233 | 249 |

Fiscal Year is January 1 – December 21
* Annualized based on 7 months of actual data
** Based on projections of approximately 6.7% patient volume increase from FY2014 to FY2015
Ex. A, pp. 13-14.

**TABLE 5**
**MOUNTAINSIDE PROJECTED UTILIZATION – WILTON***

| | PROJECTED VOLUME | | | |
|---|---|---|---|---|
| SERVICE/PROGRAM | FY 2015** | FY 2016 | FY 2017 | FY 2018 |
| Intensive Outpatient Treatment Program | 9 | 55 | 58 | 62 |
| **Total** | **9** | **55** | **58** | **62** |

Fiscal Year is January 1 – December 31
* The projection excludes patients originating from areas outside of Fairfield County.
** November 1 – December 30, 2015
Assumptions:
Opening date of November 1, 2015.
Twenty percent of existing residential clients are from the proposed service area (i.e., within 20 miles of Wilton); a current rate of increase in volume of 6.7%; and a 25% conversion rate for total residential discharges that eventually enroll in IOT.
Ex. A, p. 13.

16. Mountainside will continue to refer clients to existing providers based upon client preference (e.g., proximity or clinical need, such as co-occurring mental health needs). Ex. A, p. 13.

17. Mountainside has referral relationships with other facilities, including most area hospitals and addiction treatment facilities, as well as area therapists. These facilities may refer their patients who reside in Fairfield County to the new facility. Mountainside also accepts self-referrals. Ex. C, p. 95.

18. Based on its FY2015 payer mix at Mountainside-Canaan, the Applicant projects the same proportion of 75% commercial insurers and 25% self-pay at the proposed Wilton facility.

**TABLE 7**
**PROJECTED PAYER MIX FOR WILTON FACILITY BY NUMBER OF CLIENTS**

| Payer | Projected | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | FY 2016 | | | FY 2017 | | | FY 2018 | | |
| | Patient Volume | % | Visit Volume | Patient Volume | % | Visit Volume | Patient Volume | % | Visit Volume |
| Medicare* | 0 | | | 0 | | | 0 | | |
| Medicaid* | 0 | | | 0 | | | 0 | | |
| CHAMPUS & TriCare | 0 | | | 0 | | | 0 | | |
| **Total Government** | **0** | | | **0** | | | **0** | | |
| Commercial Insurers | 41 | 75 | 917 | 43 | 75 | 980 | 46 | 75 | 1046 |
| Self-pay | 14 | 25 | 322 | 15 | 25 | 355 | 16 | 25 | 368 |
| Uninsured | 0 | | | 0 | | | 0 | | |
| Workers Compensation | 0 | | | 0 | | | 0 | | |
| **Total Non-Government** | **55** | **100** | **1239** | **58** | **100** | **1324** | **62** | **100** | **1414** |
| **Total Payer Mix** | **55** | **100** | **1239** | **58** | **100** | **1324** | **62** | **100** | **1414** |

*Includes managed care activity.
Ex. C, p. 97.

19. Mountainside only accepts direct commercial insurance or similar (e.g., managed care) third-party payment assignment or advance self-payment. Mountainside does not accept Medicaid or other government insurance and receives no state or federal funding. Ex. A, p. 19.

20. The Applicant estimates a total capital expenditure of $10,000 for the purchase of non-medical equipment. The Applicant will fund the proposal with cash. Ex. A, p. 19.

21. Based on the average treatment duration of 12 weeks and an annual 6.7% increase in the number of clients, the Applicant projects incremental gains from operations starting in the first full year of operation.

**TABLE 9**
**APPLICANT'S PROJECTED INCREMENTAL GAIN FROM OPERATIONS**

| | FY 2016 | FY 2017 | FY 2018 |
|---|---|---|---|
| Revenue from Operations* | $421,269 | $458,941 | $499,981 |
| Total Operating Expenses ** | $382,508 | $414,334 | $452,993 |
| **Income (Loss) from Operations** | **$38,761** | **$44,606** | **$46,988** |
| **Average Daily Census** | **7** | **8** | **8** |

* Assuming a rate increase of 3% per year;
** Lease costs assumed to increase by 3% and other operating expenses by 15% reflective of the increase in the number of clients.
Ex. A, pp. 20, 82.

22. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations not yet adopted by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1)).

23. This CON application is consistent with the Statewide Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2)).

24. The Applicant has established that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3)).

25. The Applicant has demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4)).

26. The Applicant has satisfactorily demonstrated that the proposal will improve the accessibility and maintain the quality and cost effectiveness of health care delivery in the region. (Conn. Gen. Stat.§ 19a-639(a)(5)).

27. The Applicant has shown that there would be no adverse change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6)).

28. The Applicant has satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7)).

29. The Applicant's historical provision of services in the area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8)).

30. The Applicant has satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9)).

31. The Applicant has demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10)).

32. The Applicant has demonstrated that the proposal will not negatively impact the diversity of health care providers and client choice in the region. (Conn. Gen. Stat. § 19a-639(a)(11)).

33. The Applicant has satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or accessibility to care. (Conn. Gen. Stat. § 19a-639(a)(12)).

## DISCUSSION

CON applications are decided on a case-by-case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in § 19a-639(a) of the Statutes. The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

MC1 Healthcare, LLC, d/b/a Mountainside Treatment Center ("Mountainside" or "Applicant"), is a for-profit organization licensed by the Department of Public Health to maintain and operate a private, freestanding facility for the care and treatment of substance abusive or dependent persons. *FF1* Mountainside currently provides detoxification, residential and outpatient substance use disorder ("SUD") services at its main campus in Canaan, CT ("Mountainside-Canaan"). *FF2*

Mountainside proposes to establish a new health care facility in Wilton, CT to provide intensive outpatient treatment ("IOT") to commercially insured or self-pay adult residents. IOT is intended to facilitate long-term recovery from addiction and is an important part of the continuum of care for alcohol and drug use disorders. It is an alternative to inpatient and residential treatment designed to establish psychosocial supports and facilitate relapse management and coping strategies. *FF6* IOT provides services for those not requiring medical detoxification or 24-hour supervision. It offers a higher level of care than outpatient services but a lower level of care than residential and inpatient services, and allows individuals to remain in their own homes and communities, which may improve their adjustment to community life. *FF7* Clients will primarily be Fairfield County residents discharged from the Applicant's residential program in Canaan. These clients are still in early recovery from addiction and require continuing care at a higher level of care than outpatient services *FF5.*

The Applicant is choosing to locate the new facility in Wilton as 20% of Mountainside's residential program clients are from Fairfield County towns (the largest geographical concentration of clients in need of continuing care in the community). Wilton is a geographically centralized location for clients who would be traveling there three times per week for treatment. In addition, it is estimated that a significant number of Fairfield County residents have SUD. *FF9-11.*

The new facility will have a minimal effect on existing providers, as it will primarily serve the Applicant's own clients discharged from its residential facility. *FF14-15.* Historically, an average of 40 patients discharged from Mountainside-Canaan received outpatient or private practice clinician treatment. The Applicant estimates that 17 of those patients were receiving an insufficient level of care and would benefit from a referral to the more treatment-intensive proposed IOT, thereby minimizing the likelihood of patient-relapses. *FF14.* If client preference or clinical need dictates however, Mountainside will continue to make referrals to other existing providers. *FF16.* By referring patients from its Mountainside-Canaan residential facility to the proposed IOT facility-- rather than an unrelated provider--the Applicant will create a continuum of care. Additionally, the Applicant will provide a step-down approach and fill a possible gap in services.

While Mountainside projects a payer mix of 75% commercially insured and 25% self-pay patients at its proposed Wilton location, there are 16 existing SUD IOT providers in the area, 15 of which accept Medicaid patients and/or government-funded insurance. *FF12-13,18-19.* Therefore, there will not be a reduction in access to services for Medicaid recipients or indigent persons.

Mountainside will fund the total project cost of $10,000 with cash. *FF20.* The Applicant projects incremental gains from operations of $38,761, $44,606 and $46,988 in the first three years of operations. *FF21.* Based on these two factors, the Applicant has satisfactorily demonstrated that the proposal is financially feasible.

The Applicant has satisfactorily demonstrated clear public need for the new SUD facility in Wilton and that the proposal will improve access to care for the population currently being served without negatively impacting the diversity of health care providers and patient choice in the service area. The proposal will also strengthen the continuum of care for area patients and therefore, the Applicant has demonstrated that the proposal is consistent with the Statewide Health Care Facilities and Services Plan.

## Order

Based upon the foregoing Findings and Discussion, the Certificate of Need application of MC1 Healthcare, LLC d/b/a Mountainside Treatment Center to establish a facility for the care and treatment of substance abusive or dependent persons, a new health care facility for adults, at 372 Danbury Road, Wilton, Connecticut, is hereby **APPROVED**.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

December 21, 2015
Date

Janet M. Brancifort
Janet M. Brancifort, MPH, RRT
Deputy Commissioner