STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

March 1, 2010

IN THE MATTER OF:

An Application for a Certificate of Need filed pursuant to Section 19a-638, C.G.S. by	Notice of Agreed Settlement Office of Health Care Access Docket Number: 09-31452-CON
Department of Mental Health and Addiction Services	**Termination of Acute Care Psychiatric and Residential Step-Down Services at Cedar Ridge in Newington**

Patricia A. Rehmer, MSN
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue
Hartford, CT 06134

Dear Commissioner. Rehmer:

This letter will serve as notice of the Agreed Settlement between the Office of Health Care Access and the Department of Mental Health and Addiction Services in the above matter, as provided by Section 19a-638, C.G.S. On March 1, 2010, the Agreed Settlement was adopted as the finding and order of the Office of Health Care Access. A copy of the Agreed Settlement is attached hereto for your information.

By Order of the
Office of Health Care Access

Cristine A. Vogel
Deputy Commissioner

Enclosure
CAV:agf

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

Agreed Settlement

Applicant:	**Department of Mental Health and Addiction Services**
Docket Number:	**09-31452-CON**
Project Title:	**Termination of Acute Care Psychiatric and Residential Step-Down Services at Cedar Ridge in Newington**
Statutory Reference:	**Section 19a-638 of the Connecticut General Statutes**
Filing Date:	**December 14, 2009**
Hearing Date:	**January 14, 2010**
Presiding Officer:	**Cristine A. Vogel, Deputy Commissioner**
Intervenors:	**Connecticut Chapter of the National Alliance on Mental Illness; The Connecticut Hospital Association; Connecticut Legal Rights Project; St. Vincent's Health Services/ Hall-Brooke Behavioral Health; Connecticut Psychiatric Society; Hospital of Central Connecticut; and the Office of Protection and Advocacy for Persons with Disabilities**
Agreed Settlement Date:	**March 1, 2010**
Default Date:	**March 14, 2010**
Staff Assigned:	**Alexis G. Fedorjaczenko** **Steven W. Lazarus**

Project Description: The Department of Mental Health and Addiction Services ("Applicant") is proposing to terminate Acute Care Psychiatric and Residential Step-Down services at Cedar Ridge in Newington by June 30, 2010. The proposal's goal is to ensure access to the pool of psychiatric inpatient capacity and increase community capacity through the development of a variety of community living services and supports that are more responsive to the clinical and behavioral health conditions of individuals and that represent a step-down option for those persons in inpatient care who no longer need those levels of intensity. As part of the proposal DMHAS plans to develop an additional 53 psychiatric inpatient beds and 10 de-certified residential, step-down beds across DMHAS' service system. There is no capital expenditure associated with the proposal.

Nature of Proceedings: On December 14, 2009, the Office of Health Care Access ("OHCA") received the proposal of the Department of Mental Health and Addiction Services ("Applicant") to terminate Acute Care Psychiatric and Residential Step-Down services at Cedar Ridge in Newington, with no associated capital expenditure. The Applicant is a health care facility or institution as defined by Section 19a-630 of the Connecticut General Statutes ("C.G.S.").

A notice to the public concerning OHCA's receipt of the Applicant's Letter of Intent was published in *The Hartford Courant* on September 27, 2009.

On December 3, 2009, and December 31, 2009, OHCA received letters from the New England Health Care Employees Union, District 1199, the Connecticut Legal Rights Project, and State legislators requesting that a public hearing be held in this matter.

On January 8, 2010, OHCA received a request for Intervenor status from the Connecticut Chapter of the National Alliance on Mental Illness, The Connecticut Hospital Association, the Connecticut Legal Rights Project, and St. Vincent's Health Services/ Hall-Brooke Behavioral Health. On January 12, 2010, OHCA granted Intervenor status with full rights of cross-examination to the Connecticut Legal Rights Project and St. Vincent's Health Services/Hall-Brooke Behavioral Health, and granted Intervenor status with limited rights to Connecticut Chapter of the National Alliance on Mental Illness and The Connecticut Hospital Association. On January 12, 2010, OHCA received a request for Intervenor status from the Connecticut Psychiatric Society. On January 14, 2010, OHCA granted Intervenor status with limited rights to the Connecticut Psychiatric Society. On January 14, 2010, OHCA received a request for Intervenor status from the Hospital of Central Connecticut and the Office of Protection and Advocacy for Persons with Disabilities. On January 14, 2010, OHCA granted Intervenor status with limited rights to the Hospital of Central Connecticut and the Office of Protection and Advocacy for Persons with Disabilities.

A public hearing regarding the CON application was held on January 14, 2010. On December 30, 2009, the Applicant was notified of the date, time, and place of the hearing. On January 3, 2010, a notice to the public announcing the hearing was published in *The Hartford Courant.* Deputy Commissioner Cristine A. Vogel served as Presiding Officer. The hearing was conducted as a contested case in accordance with the provisions of the

Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes) and Section 19a-638, C.G.S.

OHCA's authority to review and approve, modify or deny the CON application is established by Section 19a-638, C.G.S. The provisions of this section as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

Findings of Fact

Clear Public Need
Impact of the Proposal on the Applicant's Current Utilization Statistics
Proposal's Contribution to the Quality of Health Care Delivery in the Region
Proposal's Contribution to the Accessibility of Health Care Delivery in the Region

1. It is found that the Department of Mental Health and Addiction Services ("Applicant" or "DMHAS") is a healthcare services agency responsible for health promotion and the prevention and treatment of mental health and substance use disorders in Connecticut. *(November 16, 2009, Initial CON Application, page 3)*

2. It is found that Cedarcrest Hospital is comprised of Cedar Ridge Hospital, its Psychiatric Services Division, and Blue Hills, which is located at the North Hartford campus and provides substance abuse detoxification and rehabilitation services. *(September 14, 2009, Letter of Intent, page 5; November 16, 2009, Initial CON Application, page 4; and January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

3. It is found that Cedar Ridge Hospital ("Cedar Ridge") is a state-operated nonprofit inpatient psychiatric facility located at 525 Russell Road in Newington, Connecticut. *(November 16, 2009, Initial CON Application, pages 3-5 and 24)*

4. It is found that Cedar Ridge serves adults, ages 18 and older, with severe and persistent psychiatric and/or substance abuse disorders, who have a substantial history of recent care in a psychiatric hospital or other psychiatric setting, or have required extensive community treatment and community support services over a sustained period of time. *(November 16, 2009, Initial CON Application, pages 4-5)*

5. It is found that there are a total of 103 beds at Cedar Ridge, including 87 Acute Care Psychiatric Beds and 16 De-certified Residential, Step-Down Beds in the following units:

Table 1a: Acute Care Psychiatric Beds at Cedar Ridge

Unit Type	Unit Location	Total Beds
General Psychiatry	One West	18
	Two West	18
	Two East	18
	Three East	18
Young Adult Program*	Three West	15
Sub-Total	--	**87**

*Designed to provide age-specific psychiatric treatment services to the target population including individuals with a pervasive developmental disorder that may also be "aging-out" of children's services. *(November 16, 2009, Initial CON Application, pages 4-5 and 14-15 and December 14, 2009, Completeness Response, page 203)*

Table 1b: De-certified Residential Step-Down Beds at Cedar Ridge

Transitional Supervised Living Program*	16
Sub-Total	**16**

* An unlocked, Center for Medicaid/Medicare ("CMS") "de-certified" unit providing community reintegration skills for individuals that may be waiting for community placement and/or may be facing obstacles to community re-entry. *(November 16, 2009, Initial CON Application, pages 4-5 and 14-15 and December 14, 2009, Completeness Response, page 203)*

6. The Applicant provided data demonstrating the following average daily census, average length of stay, occupancy rate, total annual admissions, and total annual discharges for Cedar Ridge's 87 acute care psychiatric beds and 16 residential step-down beds:

Table 2a: Occupancy Data, Cedar Ridge 87 Acute Care Psychiatric Beds

	SFY 06-07	SFY 07-08	SFY 08-09	Actual 3 Months 09-10**
Average Daily Census	86	86	89	84
Average Length of Stay	243	333	326	408
Occupancy Rate	98%	99%	98%	98%
Total Annual Admissions	107	79	89	25
Total Annual Discharges to Community*	74	54	64	20
Total Annual Discharges to Residential Step-Down *	27	37	40	15

** Some patients are discharged directly from the Acute Inpatient Services, while other patient step-down to Residential before discharge from that unit. ** SFY 2010 actual volume is based on the reported utilization for the months of July, August, and September. (November 16, 2009, Initial CON Application, pages 21-22)*

Table 2b: Occupancy Data, Cedar Ridge 16 Residential Step-Down Beds

	SFY 06-07	SFY 07-08	SFY 08-09	Actual 3 Months 09-10**
Average Daily Census	16	16	16	15
Average Length of Stay	347	333	335	575
Occupancy Rate	99%	98%	99%	91%
Total Annual Admissions*	27	37	40	15
Total Annual Discharges	38	24	24	--

** The majority of these admissions were patients are transferred directly from Cedar Ridge's Acute IP Units, with the exception of 2 instances in FY 2008 when a patient was admitted into the residential unit from other inpatient facilities, and one instance in FY 2010 in which a patient who had been discharged in September 2009 was readmitted from the community. ** ** SFY 2010 actual volume is based on the*

reported utilization for the months of July, August, and September. (November 16, 2009, Initial CON Application, pages 21-22 and December 14, 2009, Completeness Response, pages 210-211)

7. The Applicant indicates that a special population at Cedar Ridge is young adults ages 18 to 25 who have previously resided in long-term Department of Children and Families ("DCF") placements, with an average of 7-10 out-of-home placements before their 18th birthday. *(November 16, 2009, Initial CON Application, page 7)*

8. The Applicant states that a special population at Cedar Ridge is monolingual or Spanish speaking preferred patients, and that there are currently 4 such patients in a sub-program on the 1-West unit that has the capacity to provide bi-lingual, bi-cultural services. *(November 16, 2009, Initial CON Application, pages 4 and 16)*

9. The Applicant indicates that excluding Cedar Ridge, DMHAS operates five (5) facilities that offer inpatient and/or sub-acute psychiatric services including a total of 500 inpatient psychiatric beds and 26 sub-acute psychiatric beds.

Table 3: DMHAS Inpatient Psychiatric and Sub-Acute Providers

Provider Name **Address and Town** **Description of Services**	**Current Acute Care Psych Capacity**	**FY 2009 Acute Care Psych Utilization**	**Current Resid. Step-Down Capacity**	**FY 2009 Resid. Step-Down Utilization**
Capitol Region Mental Health Center 500 Vine Street, Hartford IP unit offering a broad range of services including medication management, individual and group therapy, occupational therapy, and recreational interventions	16	98.1%	--	--
Connecticut Mental Health Center 34 Park Street, New Haven 20-bed Acute IP Unit; 13-bed Clinical Neuroscience Research Unit offering innovative interventions for OCD, depression, schizophrenia, post-partum depression and menopausal mood disorder, and cocaine addiction; and 10-bed Sub-Acute Unit that provides a "step-down" level of care to patients upon discharge from an IP psychiatric unit	33	100% / 55% *	10	86%
Connecticut Valley Hospital 1000 Silver Street, Middletown, CT General psychiatry and other IP psychiatric services including: Geriatrics, Traumatic/Acquired Brain Injury, Cognitive Rehabilitation, Dialectical Behavior Training and specialized IP services for individuals involved with the criminal justice system.	409	100% / 94% **	--	--
Greater Bridgeport Mental Health Center 1635 Central Avenue, Bridgeport Two 21-bed IP units provide a broad range of services including medication management, individual and group therapy, occupational therapy, and recreational intervention	42	96%	--	--
Southeastern Mental Health Authority 401 West Thames Street, Building 301, Norwich, CT Structured 24-hour sub-acute Brief Care Program serving	--	--	16	100%

individuals experiencing psychiatric symptoms who do not require IP level of care; the program can "step-down" people from IP care before their return to the community				

Note: IP=Inpatient, OCD=Obsessive Compulsive Disorder; * 100% Acute IP Unit / 55% Research Unit ** 100% General Psychiatric Division / 94% Whiting Forensic Division; (November 16, 2009, Initial CON Application, pages 8-10 and December 14, 2009, Completeness Response, page 203)

10. The Applicant indicates that in addition to the five (5) inpatient facilities listed above, DMHAS also:
    - Funds six (6) Intermediate Inpatient Beds at Natchaug Hospital;
    - Reimburses, through the General Assistance Behavioral Health Program, twenty-four (24) general hospitals for Mental Health IV.2 Acute Inpatient Services; and
    - Funds twenty-six (26) Acute Care Beds at twelve (12) general hospitals.

    (November 16, 2009, Initial CON Application, pages 10-11)

11. The Applicant indicates that Cedar Ridge patients are either admitted from the emergency room or an inpatient facility.

Table 4: Cedar Ridge Patient Referral Sources, SFY 2009

Referral Source at Admission	Frequency	Percent
Inpatient Psych/General Hospital	50	56.2%
General Hospital Emergency Department	21	23.6%
Inpatient Psych DMHAS	7	7.9%
Criminal Justice	2	2.2%
DCF Residential/Inpatient	2	2.2%
Mental Health Residential	2	2.2%
Crisis Respite	1	1.1%
General Hospital Medical	1	1.1%
Inpatient Psych Other	1	1.1%
Other	1	1.1%
Self	1	1.1%

(November 16, 2009, Initial CON Application, pages 19-20)

12. It is found that Connecticut Valley Hospital ("CVH") is a 409-bed state-operated inpatient psychiatric facility located at 1000 Silver street in Middletown, Connecticut. *(November 16, 2009, Initial CON Application, pages 8-10 and December 14, 2009, Completeness Response, page 203)*

13. It is found that there are currently 409 Inpatient Psychiatric beds at CVH, distributed among the General Psychiatry (177 beds) and Whiting Forensic (232 beds) divisions of the hospital.

Table 5a: General Psychiatry Beds at CVH

Unit Specialization	Unit Location	# Beds
General Psychiatry	Battell 3 North	20
General Psychiatry	Battell 4 North	22
General Psychiatry	Merritt 3D	20
General Psychiatry	Merritt 3E	25
Geriatric*	Woodward 1 South	15
Geriatric*	Woodward 1 North	15
Geriatric*	Woodward 2 south	15

Cognitive Rehab**	Battell 2 North	25
Traumatic Brain Injury***	Battell 2 South	20
Sub-Total	--	**177**

** Serves elderly individuals with major psychiatric illnesses who cannot be managed in less restrictive settings; ** Serves individuals with moderate to severe cognitive impairments due to their psychiatric illnesses and concomitant multiple medical needs; and* *** Serves individuals with co-occurring major psychiatric conditions and traumatic brain injuries. *(December 14, 2009, Completeness Response, pages 203-204)*

Table 5b: Whiting Forensic Beds at CVH

Division	Unit Specialization	Unit Location	# Beds
Whiting Maximum Security Services	Maximum Security Services *	Whiting 1	18
		Whiting 2	18
		Whiting 3	21
	Extended Treatment Program **	Whiting 4	22
	Specialized Social Learning Program	Whiting 6	12
Dutcher Enhanced Security Service	Treatment and Assessment	Dutcher 2 North	23
		Dutcher 2 South	24
	Community Re-Entry	Dutcher 1 South	22
		Dutcher 3 North	24
		Dutcher 3 South	24
Additional Unit	Restoration Services ***	Battell 4 South	24
Sub-Total	--	--	**232**

* Acute Treatment/ Competency Evaluation and Pre-Sentence Evaluation Units; ** Extended Treatment Program for Psychiatric Security Review Board (PSRB) patients; and *** For patients on reduced bonds. *(December 14, 2009, Completeness Response, pages 203-204)*

14. The Applicant provided data demonstrating the following average daily census, average length of stay, occupancy rate, total annual admissions, and total annual discharges for CVH's General Psychiatry and Whiting Forensic beds.

Table 6a: Occupancy Data, CVH, 177 General Psychiatry Beds

	SFY 06-07	SFY 07-08	SFY 08-09	Actual 3 Months 09-10*
Average Daily Census	178	176	174	171
Average Length of Stay	1,037	1,145	1,222	1,156
Occupancy Rate	100%	99%	97%	94%
Total Annual Admissions	24	32	22	23
Total Annual Discharges	36	40	34	24

** SFY 2010 actual volume is based on the reported utilization for the months of July, August and September. (December 14, 2009, Completeness Response, pages 205-207)*

Table 6b: Occupancy Data, CVH, 232 Whiting Forensic Beds

	SFY 06-07	SFY 07-08	SFY 08-09	Actual 3 Months 09-10*
Average Daily Census	244	246	239	223
Average Length of Stay	811	800	699	649
Occupancy Rate	99%	99%	97%	88%
Total Annual Admissions	242	238	256	89
Total Annual Discharges	229	240	262	91

** SFY 2010 actual volume is based on the reported utilization for the months of July, August and September. (December 14, 2009, Completeness Response, pages 205-207)*

15. The Applicant claims that CVH has the capacity and staffing complement to provide, and is currently providing, specialty services for monolingual and/or Spanish speaking preferred patients. *(November 16, 2009, Initial CON Application, page 16)*

16. The Applicant contends that of the additional beds at CVH, twenty (20) of them will be a newly renovated unit for young adults. *(November 16, 2009, Initial CON Application, pages 3, 11 and 18)*

17. The Applicant testified that the young adult unit will be ready in approximately three weeks, and that DMHAS plans to move this unit intact with all patients and staff, together, for reasons related to staff competency and training. *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

18. The Applicant contends that because clients hospitalized at DMHAS facilities often present with complex issues and needs, there are instances in which a Cedar Ridge client may have reached a point in their recovery in which she/he no longer meets criteria for further inpatient care but due to the complexity of their clinical condition, a safe and appropriate community treatment or housing option is not available. The Applicant contends that these clients often require levels of residential supervision that are not readily available and/or specialized programming that has to be created, and that additional funding is sometimes needed to create discharge plans for these individuals. *(December 14, 2009, Completeness Response, pages 207-208)*

19. The Applicant asserts that without adequate capacity and client movement from one level of care to another across the entire continuum of services, individuals may remain in settings that provide a higher level of care than is appropriate to their needs. *(December 14, 2009, Completeness Response, page 211)*

20. The Applicant provided a copy of an article by H.R. Lamb & L.L. Bachrach, entitled "Some Perspectives on Deinstitutionalization" published in the Psychiatric Services Journal in 2001. According to this article, deinstitutionalization has three components that must be present for individuals with mental illness to significantly benefit: (1) the release of individuals from hospitals into the community; (2) their diversion from hospital admission; and (3) the development of alternative community services. *(November 16, 2009, Initial CON Application, pages 8 and 125-131)*

21. The Applicant provided a listing of community living services and supports that DMHAS has already developed to enhance mental health, prevent mental illness and promote resilience and recovery for individuals with mental health disorders. *(November 16, 2009, Initial CON Application, pages 11-12)*

22. The Applicant contends that because individuals served in community-based residential supports and supervised residential care programs often have long lengths of stay, demand for these services is affected by individuals currently living in the community who require high intensity services in order to remain in the community, as well as by individuals being discharged from inpatient facilities who have intensive

needs such as 1-1 supervision, homemakers, or enhanced crisis supports in order to be successful in the community. *(December 14, 2009, Completeness Response, page 208)*

23. The Applicant contends that existing community services statewide are at or exceed capacity.

Table 7: Statewide Community-Based Residential Capacity

Program Type	Capacity	Unduplicated Clients in Residence
Group Home	245	244
Supervised Residential	575	580
Residential Supports	1,461	1,746

Note: The Applicant testified that the number of clients can exceed capacity because not all individuals receive the same level of wrap-around services--some are more intensive and others need low levels of intervention--so adjustments can be made to provide flexible services to accommodate the population. (December 14, 2009, Completeness Response, page 208; and January 14, 2010, Testimony of DMHAS Chief of Staff, Sabrina Trocchi)

24. The Applicant indicates that approximately eight (8) months prior to submitting the CON application, DMHAS initiated an "inpatient reconfiguration planning process" designed to improve the quality of inpatient clinical care across the DMHAS service system, and that part of that process includes the blending of best practices and services from Cedar Ridge and CVH. *(November 16, 2009, Initial CON Application, page 3 and 5-6)*

25. The Applicant asserts that reconfiguration of DMHAS' inpatient psychiatric beds will help free up considerable resources because currently some individuals are in units that provide a higher level of care than is appropriate to their needs. *(November 16, 2009, Initial CON Application, page 13)*

26. The Applicant contends that by June 30, 2010, DMHAS plans to develop an additional 53 psychiatric inpatient beds and 10 de-certified residential, step-down beds across DMHAS' service system.

Table 8: Proposed Beds To Be Added to the DMHAS System

Provider Name	Proposed Acute Care Psychiatric Capacity	Proposed Residential Step-Down Capacity
Connecticut Valley Hospital	20-bed Young Adult unit* 23 IP psych beds	10-bed cottage
Greater Bridgeport Mental Health Center	10 IP psych beds	--

**Based on increased demand, DMHAS proposes a 20-bed unit versus the 15-bed unit currently at Cedar Ridge. (November 16, 2009, Initial CON Application, pages 3, 7-9, and 14)*

27. The Applicant testified that in addition to the two units being renovated at CVH, DMHAS is looking into other locations within CVH that could be expanded by a couple of beds, and is looking at bed utilization across divisions to ensure adequate inpatient bed availability. *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

28. The Applicant testified that CVH will begin to accept direct admissions from emergency rooms and general hospitals. *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

29. The Applicant contends that the increased length of stay on the acute care psychiatric units between SFYs 2007 and 2009 was due to a shift in the acuity of patients treated at Cedar Ridge resulting from the purchase of additional acute care inpatient capacity from community general hospitals, and that the increase in length of stay from SFY 2009 to SFY 2010 to-date is attributed to a small number of patients discharged in the first quarter 2010 who had been at Cedar Ridge for several years. *(December 14, 2009, Completeness Response, page 210)*

30. The Applicant claims that Acute Care Psychiatric admissions declined after SFY 2007 as additional acute care inpatient psychiatric capacity was purchased by DMHAS in the community, and those acute care beds served to divert individuals with shorter stays that would normally have been seen at Cedar Ridge. At that time, the Applicant contends, Cedar Ridge was becoming more of an Intermediate Care facility with average length of stay increasing. *(November 16, 2009, Initial CON Application, pages 20-21 and January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

31. The Applicant attributes the increase in admissions between SFY 2008 and 2009 to increased utilization management and increased emphasis on discharge planning and use of specialized discharge funding. The Applicant projected that if the current rate of admissions were to continue, there would be another increase, to 100 admissions, in SFY 2010. *(November 16, 2009, Initial CON Application, pages 20-21)*

32. OHCA finds that the Applicant demonstrated that since a utilization management system was put into place with the focus of discharge planning, and as access to more community hospital beds has occurred through contracting, patients have been able to "move" through the health care system with fewer delays.

33. The Applicant asserts that with the development of additional community-based residential services, individuals can be discharged from acute inpatient beds and thus other individuals can be admitted to those same beds, increasing the number of admissions, overall. *(December 14, 2009, Completeness Response, page 211)*

34. The Applicant provided letters from community providers who are part of DMHAS' plan to establish additional community living services and supports to transition minimally 40 individuals who are ready for community living.

Table 9: Proposed New Community Living Services and Supports

Provider Name	Location of Proposed Services	Proposed # Additional Individuals	Description of Proposed Service
Center for Human Development CT Outreach Program	Hartford, Waterbury, Torrington, and Danbury areas	30	Congregate housing with recovery supports
Central Naugatuck Valley HELP, Inc.	Greater Waterbury	18	Supervised housing; Group home; Residential supports
CommuniCare Inc.	Ansonia, Milford, and Branford	10-12	Supervised congregate living with access to social club, vocational services, case management

Community Health Resources	Central and Eastern Connecticut	10	Supported housing; Supported employment; Intensive residential; assertive community treatment
Community Mental Health Affiliates	New Britain and surrounding communities	9	Full range of community support and clinical services
Gilead Community Services, Inc.	Middlesex County	5	Residential supports
InterCommunity, Inc.	Danbury	10	Supervised housing; Social rehabilitation
Interlude, Inc.	Danbury	6	Intensive residential support program
Keystone	Norwalk	6	Supervised housing
Mental Health Association of Connecticut	Torrington and Stamford, with potential proposals for Bridgeport, Danbury, and West Hartford	11	Supervised housing
Mercy Housing and Shelter Corporation	Hartford	7	Supportive housing; Housing First supportive housing
Pathways, Inc.	Greenwich	3-6	Group home; Supervised housing
Reliance House	Norwich	8+	Residential services; Supported housing; Supported education & employment services; Teamworks Clubhouse
Rushford Center	Meriden & Wallingford	20	Group home or other congregate housing; Supportive housing; Clinical and recovery supports
Sound Community Services	New London County	5	Supervised housing; Residential services; employment services
St. Vincent DePaul Mission of Waterbury, Inc.	Waterbury	Unspecified	Group home; Supervised housing
United Services	Northwestern Connecticut	8	Group home; Recovery supports

(November 16, 2009, Initial CON Application, pages 16-17 and Appendix 3)

35. The Applicant testified that the providers listed in the chart above are the result of an initial query to providers about what services they could offer in the event of additional resources, and was not related to the specific needs of any individual client. *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

36. The Applicant testified that DMHAS is engaging in a process to identify whether more appropriate services exist in the community for individuals at all inpatient DMHAS facilities, not just Cedar Ridge *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

37. The Applicant testified that DMHAS is currently negotiating contracts with a number of providers that will result in the discharge of approximately 25 individuals within the next few months, and is working with other providers to further refine their proposals to ensure they clearly reflect the needs and interests of individuals who are ready for discharge. *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

38. The Applicant testified that community living services and supports will be managed within DMHAS' new utilization management process to ensure that individuals are evaluated regularly, as appropriate, are transitioned to other community services and supports, and are not "stuck" in higher levels of community services and supports than what is needed. *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

39. The Applicant testified that there is a line item in the DMHAS budget for discharge planning that will be populated with $6 million for additional community services related to this plan. $3 million is earmarked for this FY annualizing at $6 million for FY 2011. *(January 14, 2010, Testimony of Paul DiLeo, DMHAS Chief Operating Officer)*

40. The Applicant testified that DMHAS has created a process to manage all community and inpatient beds using an administrative service organization ("ASO") that can ask goal directed questions and monitor the treatment process, in order to help formalize goals and plans for individuals and to promote quality of care delivered within acceptable timeframes. *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

41. The Applicant testified that the ASO has two primary functions: (1) utilization management working off of clinical criteria that the department has developed, prior authorizations, continued stay authorizations, and registration of services, and (2) claims adjudication and claims payment. *(January 14, 2010, Testimony of Paul DiLeo, DMHAS Chief Operating Officer)*

42. The Applicant testified that DMHAS currently uses Advanced Behavioral Health ("ABH") as the ASO for utilization management at most levels of care, and is talking with them about redistribution of dollars to also look at the Intermediate Care and residential care levels so they can help move people through the continuum of care, not just in and out of hospitals. *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

43. Jan VanTassel, Executive Director of Connecticut Legal Rights Project, testified that "we agree with DMHAS that Connecticut does not need to spend limited resources to maintain inpatient beds at Cedar Ridge in order to have an effective, comprehensive mental health system of care. In fact, there are very clear benefits that could be derived from the restructuring that DMHAS has proposed." Ms. VanTassel identified five steps that CLRP believes is necessary. *(January 14, 2010, Testimony of* Jan VanTassel, Executive Director *of Connecticut Legal Rights Project)*

44. Kirk W. Lowry, Legal Director of the Connecticut Legal Rights Project, testified that: "The gridlock results in limited access to inpatient psychiatric services. If community-based services and housing capacity are created, residents can move out of state hospital level of care and others can gain access [to] those inpatient psychiatric beds. Increasing community-based services capacity ensures that more people are served in the most integrated setting and creates capacity for inpatient care by decreasing lengths-of-stay." *(January 14, 2010, Testimony of Kirk W. Lowry, Legal Director of Connecticut Legal Rights Project, page 10)*

45. Kirk W. Lowry, Legal Director of the Connecticut Legal Rights Project, testified that: "DMHAS' move to close an unnecessary state hospital is clearly congruent with the national trend." *(January 14, 2010, Testimony of Kirk W. Lowry, Legal Director of Connecticut Legal Rights Project, page 9)*

46. Kate Mattias, Executive Director for the National Alliance on Mental Illness, CT, testified that: "It is estimated that 30% of Cedar Ridge patients do not require hospital level of care. This is directly related to an overburdened community system that lacks the services and housing necessary to place patients no longer in need of inpatient care from ALL state facilities." *(January 14, 2010, Testimony of Kate Mattias, Executive Director for the National Alliance on Mental Illness, CT, page 1)*

47. Karen Kangas, Executive Director of Advocacy Unlimited, speaking as a member of the public, testified that "People who have serious mental illness feel that they do better if they have short hospital stays followed by supportive and integrated community placements" *(January 14, 2010, Testimony of Karen Kangas, Executive Director of Advocacy Unlimited, page 3)*

48. James McGaughey, Executive Director of the State of Connecticut Office of Protection for Persons with Disabilities, testified that "failing to develop and adequately fund community supports for people with truly significant needs has contributed greatly to the phenomenon of 're-institutionalization' of people with psychiatric disabilities in prisons and nursing homes." *(January 14, 2010, Testimony of James McGaughey, Executive Director of the State of Connecticut Office of Protection for Persons with Disabilities, CT, page 3)*

49. Jan VanTassel, Executive Director of Connecticut Legal Rights Project, testified that "It has been documented that housing is a critical element of the mental health system of care essential to sustaining the recovery of persons with mental illness and their pursuit of individual interests such as education and employment." *(January 14, 2010, Testimony of* Jan VanTassel, Executive Director *of Connecticut Legal Rights Project, page 1)*

50. James McCreath, President/CEO of St. Vincent's/Hall-Brooke Behavioral Health testified that: "St. Vincent's currently refers approximately 50 consumers a year to State facilities. These acutely psychotic patients can not stabilize in the typical 10 day stay on a psychiatric unit. Our experience has been that, on average, each transfer takes approximately one month due to capacity issues in the State system." *(January 14, 2010, Testimony of James McCreath, President/CEO, St. Vincent's/Hall-Brooke Behavioral Health, page 2)*

51. James McCreath, President/CEO of St. Vincent's/Hall-Brooke Behavioral Health testified that: "In summary, we believe that closing a State hospital and transitioning services to the community has and can be successfully accomplished. We believe that if Cedar Ridge is to close it must do so with assurances that a network of adequately reimbursed intermediate care beds are established by general hospitals. Funding must be made available to expand or establish a full range of services and monitoring must be established to ensure that consumers who are discharged from intermediate care units receive timely access to needed services." *(January 14, 2010, Testimony of James McCreath, President/CEO, St. Vincent's/Hall-Brooke Behavioral Health, page 2)*

52. Kirk W. Lowry, Legal Director of Connecticut Legal Rights Project, testified that "CLRP agrees with DMHAS that Cedar Ridge should be closed in order to reallocate some resources to community-based programs." Mr. Lowry identified five conditions that CLRP believes DMHAS should meet. *(January 14, 2010, Testimony of Kirk W. Lowry, Legal Director of Connecticut Legal Rights Project)*

53. The Applicant indicates that DMHAS is working with the Department of Social Services for a State Medicaid Plan amendment to reimburse hospitals for Intermediate Care Services provided to Title XIX (Medicaid) individuals. *(November 16, 2009, Initial CON Application, pages 3 and 11 and January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

54. In a letter dated January 11, 2010, Department of Social Services Commissioner Michel P. Starkowski wrote that: "The Department recognizes, however, that some individuals will continue to require inpatient psychiatric care of intermediate duration and that some intermediate care capacity will need to be available in Connecticut's acute care general hospitals. The Department supports reimbursement for intermediate care services under Medicaid, provided there are mechanisms in place to ensure that such intermediate care capacity is limited to the minimum necessary to meet the needs to Connecticut citizens." *(January 11, 2010, Letter from Department of Social Services Commissioner Michel P. Starkowski)*

55. Jim O'Dea, Assistant Vice President for Business Operations at the William W. Backus Hospital, speaking on behalf of the Connecticut Hospital Association, testified that: "Any proposal to close these services at the Cedar Ridge facility should be approved only upon a finding of an appropriately detailed plan and commitment by DMHAS to develop and deploy replacement services, including intermediate care programs, in locations around the state." *(January 14, 2010, Testimony of Jim O'Dea, Assistant Vice President for Business Operations at the William W. Backus Hospital, page 3)*

56. Kirk W. Lowry, Legal Director of the Connecticut Legal Rights Project, testified that "inpatient psychiatric care be delivered in a more integrated manner than in a state hospital. DMHAS' plan to integrate inpatient psychiatric care by contracting and purchase of beds in general hospitals is supported by CLRP." *(January 14, 2010, Testimony of Kirk W. Lowry, Legal Director of Connecticut Legal Rights Project, page 8)*

57. Alicia Woodsby, Public Policy Director for the National Alliance on Mental Illness, CT testified that: "In order to discharge patients who are admitted to intermediate inpatient beds in a timely way, both housing and community support services are required. DMHAS must receive dedicated housing rental vouchers, which they directly administer and are attached to patients who are ready to discharge from a state hospital or general hospital intermediate care bed." *(January 14, 2010, Testimony of Alicia Woodsby, Public Policy Director, National Alliance on Mental Illness, CT, page 1)*

58. The Applicant testified that DMHAS intends to pilot Intermediate Care Services in approximately three (3) high need/ high demand areas of the state with approximately 4-5 beds per general hospital. The Applicant testified that each of the three pilots is

expected to admit approximately 35 individuals per year. *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

59. The Applicant testified that DMHAS identified the need for a state plan amendment 4-6 months ago and since then drafted programmatic recommendations and admission/discharge criteria. According to the Applicant, the state plan amendment is currently being written and once it is submitted, the Applicant anticipates that CMS will take between 60 and 90 days to review the amendment. The Applicant testified that based on DSS conversations with the CMS regional office, they believe there is a good likelihood of approval of the state plan amendment. *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

60. The Applicant testified that the Intermediate Care Services will include both rehabilitation and continuous stabilization, and that Commissioner's Policy Statement No. 33 regarding individualized recovery planning will apply to this service. *(January 14, 2010, Testimony of DMHAS Policy Analyst, Susan Graham)*

61. The Applicant testified that in addition to CMS approval, implementation of pilot Intermediate Care Services will require a statute change to allow DMHAS to be the delegated certifying authority for hospitals, and that such language has been submitted for this legislative session. *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

62. The Applicant testified that there is $1 million allocated for Intermediate Care in the DMHAS budget, but that because it is a Medicaid program, total costs could exceed that amount. *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

63. Sheila Amdur, first Vice-President of the National Board of the National Alliance on Mental Illness, testified that: "DMHAS currently does not have a centralized, systematic, mechanisms/way of measuring the demand for each level of care, and any methods for evaluating appropriateness of care in residential settings." *(January 14, 2010, Testimony of Sheila Amdur, first Vice-President of the National Board of the National Alliance on Mental Illness, page 2)*

64. Kirk W. Lowry, Legal Director of the Connecticut Legal Rights Project, testified that DMHAS "has not created a system to assure long-term access to community-based services. Without that system of monitoring, measuring need, and systematically planning for increased community-based services, gridlock may become intransigent. *(January 14, 2010, Testimony of Kirk W. Lowry, Legal Director of Connecticut Legal Rights Project, page 11)*

65. OHCA finds that the Intervenors generally supported the concept of de-institutionalizing patients; however, OHCA was also presented with plenty of testimony regarding the importance of expanding community services and safe housing opportunities prior to decreasing the number of inpatient beds.

66. OHCA finds that it is necessary for DMHAS to expand the community-based services and secure housing opportunities in order for the system to function well and to resolve the fundamental issues of gridlock.

67. OHCA finds that the Applicant supported the claims that obtaining a State Medicaid Plan Amendment to reimburse hospitals for Intermediate Care Services would relieve the system pressure that hospital emergency departments experience when an inpatient admission is delayed; however, the Applicant was not able to provide a date certain when the plan amendment would be approved and implemented.

68. The Applicant contends that discharge planning for all individuals at Cedar Ridge begins on the day of admission, or even prior to admission, and that plans are continually reassessed for appropriateness based on the patient's treatment progress and goals. *(November 16, 2009, Initial CON Application, pages 14 and 19)*

69. The Applicant testified that they have moved away from the notion of "placing" people into settings and are working with individuals to see what level of care they are interested in going in to. *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)*

70. The Applicant contends that as of November, 2, 2009 and January, 7, 2010, the following discharge plans were in place for the individuals at Cedar Ridge. However, the Applicant noted that the census, individual's clinical condition, choice, and resources change, so these numbers are fluid and approximate.

Table 10: Discharge Plans for Cedar Ridge Current Patients

Current Level of Care	Number of Individuals, November 2009	Number of Individuals, January 2010	Proposed Level of Care	Proposed Provider
Residential Step-Down	6	6	Residential Step-Down Cottage	CVH
Young Adult Unit	10	10	Inpatient Young Adult	CVH
Acute Care Psychiatric	31	34	Acute IP	CVH
Acute Care Psychiatric	3	4	Acute IP	Great Bridgeport Community Mental Health Center
Acute Care Psychiatric	38	37	Community living with existing and/or new service and support resources	local mental health authorities across the state/providers to be determined

(November 16, 2009, Initial CON Application, page 14; and January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer)

71. The Applicant provided a copy of a letter dated November 4, 2009, that had been sent to staff, clients, family members, and other members of the DMHAS community, to outline the transition process for individuals and their families. *(November 16, 2009, Initial CON Application, pages 17 and 153)*

72. The Applicant contends that the process of notification is being conducted on an individualized basis in conjunction with discharge planning needs. *(November 16, 2009, Initial CON Application, page 17)*

73. The Applicant identified the living arrangements upon discharge for the 88 patients served at Cedar Ridge in SFY 2009.

Table 11: Living Arrangements Upon Discharge, SFY 2009

Living Arrangements Upon Discharge	Number of Patients	Percent of Patients
Private Residence	24	27.3%
DMHAS Group Residence	17	19.3%
DMHAS Supported Apartment	17	19.3%
DMHAS Inpatient	11	12.5%
Supervised – Other	5	5.7%
Residential Care Home (for the Aged)	4	4.5%
Non-DMHAS Medical Inpatient	4	4.5%
DMR Residence/Facility	2	2.3%
Missing	2	2.3%
Correctional Facility	1	1.1%
Hospice	1	1.1%

(November 16, 2009, Initial CON Application, page 20)

74. The Applicant contends that DMHAS will be working with Cedar Ridge individuals and families transferred to CVH to arrange transportation, as needed, so that families may continue to visit their loved ones. *(November 16, 2009, Initial CON Application, page 17)*

Financial Feasibility and Cost Effectiveness of the Proposal and its Impact on the Applicant's Rates and Financial Condition
Impact of the Proposal on the Interests of Consumers of Health Care Services and the Payers for Such Services
Consideration of Other Section 19a-637, C.G.S. Principles and Guidelines

75. The project has no associated capital expenditure.

76. The Applicant contends that Cedar Ridge receives revenue from five sources: Medicare Part A, Medicare Part B Professional, Medicare Part B Ancillary, Medicaid, and Commercial Insurers. *(November 16, 2009, Initial CON Application, page 24)*

77. The Applicant contends that the proposal will not result in changes in payers, which are currently the State of Connecticut and Medicare. *(November 16, 2009, Initial CON Application, page 24)*

78. The Applicant testified that "Closing Cedar Ridge will allow for the purchase of services from a myriad of community providers who have developed person-centered community living and support options." *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer, page 1)*

79. The Applicant testified that "The Department is fully prepared to purchase appropriate "discharge" services and supports that will ensure individuals in these beds are moving to community living." *(January 14, 2010, Testimony of DMHAS Commissioner Patricia A. Rehmer, page 2)*

Rationale

The Office of Health Care Access ("OHCA") approaches community and regional need for Certificate of Need ("CON") proposals on a case-by-case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g., the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

The Department of Mental Health and Addiction Services ("DMHAS" or "Applicant") is proposing to terminate Acute Care Psychiatric and Residential Step-Down services at Cedar Ridge in Newington by June 30, 2010. The proposal's goal is to ensure access to the pool of psychiatric inpatient capacity and increase community capacity through the development of a variety of community living services and supports that are more responsive to the clinical and behavioral health conditions of individuals and that represent a step-down option for those persons in inpatient care who no longer need those levels of intensity. As part of the proposal, DMHAS plans to develop an additional 53 psychiatric inpatient beds and 10 de-certified residential step-down beds across DMHAS' service system, and pilot an Intermediate Care Services program for individuals that require shorter stays of acute inpatient psychiatric services,

The Connecticut mental health and addiction services system is complex and has been fragmented and not well functioning. Although DMHAS has executed many programs in the last few years to become more efficient and patient-focused, this proposal represents an opportunity to improve on system development and secure appropriate community services and housing while maintaining access to quality mental health and addiction services for patients. OHCA heard testimony from the Applicant and Intervenors that supported the national trend of eliminating unnecessary psychiatric inpatient facilities if demand declines and avoid the use of psychiatric inpatient beds as a holding place for patients because the appropriate level of care is not available elsewhere. OHCA finds that the Applicant demonstrated that with the implementation of a utilization management system and their recent funding arrangements with hospitals, patients have been able to experience fewer delays with admissions to inpatient care. (Facts 10 and 31) The "gridlock" throughout the Connecticut mental health and addiction services system is well documented and OHCA finds that it is necessary for DMHAS to expand community-based services and secure housing opportunities in order for the system to function well and to resolve the fundamental issues of gridlock.

Furthermore, OHCA finds that the Applicant has demonstrated the ongoing availability of inpatient psychiatric care services at other DMHAS facilities for those individuals who require that level of care, and that such services will continue to meet the needs of specialized patient populations including young adult populations and monolingual and/or Spanish speaking preferred patients. Additionally, OHCA finds that the Applicant's proposal of introducing a new service level of acute care, Intermediate Care Services, is an appropriate approach to maintaining access nearby the patients' homes when a need arises for short-stay stabilization. OHCA finds that the availability of Intermediate Care Services

is likely to reduce the delays currently experienced by patients in Connecticut hospital emergency departments (Fact 67). Although OHCA concludes that these proposals will begin to seriously address the fundamental system issues and will ultimately improve the quality of care and access for patients, OHCA remains concerned about the feasibility of these new services being implemented and available, prior to the proposed termination date of June 30, 2010.

There is no capital expenditure associated with the proposal. However, related to the proposal's goal of increasing capacity of community living supports and short-stay stabilization services, funding has been designated in the amount of $6 million annually for discharge planning and $1 million annually for Intermediate Care. OHCA concludes that the proposal is financially feasible and that the approach of reallocating funds to address system fragmentation is a cost-effective approach that will improve quality of care and access for the Applicant's client population.

Order

NOW, THEREFORE, the Office of Health Care Access ("OHCA") and Connecticut Department of Mental Health and addiction Services ("DMHAS" or "Applicant') hereby stipulate and agree to the terms of settlement with respect to the Applicant's request to terminate acute care psychiatric and residential step-down services at Cedar Ridge in Newington.

1. The Applicant's proposal to terminate acute care psychiatric and residential step-down services at Cedar Ridge in Newington is hereby approved, conditional upon the Applicant's full compliance with the following agreed upon stipulations **prior** to the termination of services:

    a. Regarding an Intermediate Care Services program:

        i. Copies of the legislative proposal(s) and/or bill(s) designating DMHAS as the certifying authority for intermediate care hospital beds (Fact 61). Following approval of the above-referenced bill(s), DMHAS shall provide OHCA with the approved Public Act documentation and the effective date of the Public Act.

        ii. Copies of the Plan Amendment that was submitted and the date of submission to CMS (as referenced in Fact 59) and documentation regarding CMS approval of the same.

        iii. Copies of the signed Agreements between DMHAS and each of the hospital(s) that will be providing Intermediate Care Services (as referenced in Fact 58).

    b. Regarding the availability of community living services and supports:

        i. Copies of the signed Agreements between DMHAS and providers that will develop appropriate services and housing in the community for all individuals currently at Cedar Ridge who are ready for discharge (see Fact 37).

        ii. Copies of letters from providers to DMHAS expressing their plans to develop additional capacity in necessary community services and housing for the future demand of such services that will prevent gridlock in the Intermediate Care Services and the other acute inpatient psychiatric beds.

    c. Assurances, in the form of a letter from DMHAS that they will continue to advocate for funding directed at community services development, housing

and for the Intermediate Care Services to meet the long-term goals of this proposal.

d. The Applicant agrees to file a comprehensive patient transfer plan with OHCA which will include, at a minimum, the following:

    i. A discussion of the continuity of patient services during patient transfers from Cedar Ridge to other DMHAS inpatient facilities;

    ii. A discussion and completion timeline of any needed renovations to Connecticut Valley Hospital, Greater Bridgeport Mental Health Center, or other DMHAS facilities as a direct result of the transfer of clients from Cedar Ridge.

2. The Applicant further agrees that it must receive written acknowledgment from OHCA regarding the Applicant's full compliance with the above stipulations 1a through 1d **prior** to the termination of acute care psychiatric and residential step-down services at Cedar Ridge.

3. The Applicant agrees to provide OHCA with the following subsequent to the date of termination of services at Cedar Ridge, as specified below:

    a. Assurances that DMHAS will identify and measure the demand and the capacity of each level of care services (acute through community).

        i. Copies of reports generated from DMHAS from the new utilization management process that demonstrate individuals are evaluated regularly and appropriately; and that patients experience less of a delay when they are ready for discharge. The reporting period, length of time that reporting will be required, and the data/information required will be established during a meeting between DMHAS and OHCA within 60 days of the date of termination of services at Cedar Ridge.

        ii. A comprehensive plan that identifies the current demand and capacity to meet that demand by service category including, but not limited to, inpatient, step-down, and community-level services. The plan shall make assumptions and support such assumptions with evidence (i.e., research, literature, practice standards, etc.) as to future demand by service category and how the Connecticut mental health and addiction services system will meet that future demand. This plan shall be submitted within 90 days of the date of termination of services at Cedar Ridge.

4. The Applicant and OHCA agree that if any or all of the stipulated requirements cannot be met, the Applicant is not precluded from seeking modification of the Order as allowed under Section 4-181a(b) of the Connecticut General Statutes.

OHCA and DMHAS agree that this Agreed Settlement represents a final agreement between OHCA and DMHAS with respect to this request. The signing of this Agreed Settlement resolves all objections, claims and disputes, which may have been raised by the Applicant with regard to Docket Number: 09-31452-CON.

This Agreed Settlement is an order of the Office of Health Care Access with all the rights and obligations attendant thereto, and the Office of Health Care Access may enforce this Agreed Settlement pursuant to the provisions of Sections 19a-642 and 19a-653 of the Connecticut General Statutes at the Applicant's expense, if the Applicant fails to comply with its terms.

March 1, 2010
Date

Patricia A. Palmer

Duly Authorized Agent for
Department of Mental Health and Addiction Services

The above Agreed Settlement is hereby accepted and so ordered by the Office of Health Care Access on March 1, 2010.

3-1-10
Date

Cristine A. Vogel
Deputy Commissioner