Sec. 19a-634. (Formerly Sec. 19a-150).Statewide health care facility utilization study. Statewide health care facilities and services plan. Inventory of health care facilities, equipment and services.

(a) The Office of Health Care Access shall conduct, on an annual basis, a statewide health care facility utilization study. Such study shall include, but not be limited to, an assessment of: (1) Current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) geographic areas and subpopulations that may be underserved or have reduced access to specific types of health care services; and (3) other factors that the office deems pertinent to health care facility utilization. Not later than June thirtieth of each year, the Commissioner of Public Health shall report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services on the findings of the study. Such report may also include the office's recommendations for addressing identified gaps in the provision of health care services and recommendations concerning a lack of access to health care services.

(b) The office, in consultation with such other state agencies as the Commissioner of Public Health deems appropriate, shall establish and maintain a statewide health care facilities and services plan. Such plan may include, but not be limited to: (1) An assessment of the availability of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) an evaluation of the unmet needs of persons at risk and vulnerable populations as determined by the commissioner; (3) a projection of future demand for health care services and the impact that technology may have on the demand, capacity or need for such services; and (4) recommendations for the expansion, reduction or modification of health care facilities or services. In the development of the plan, the office shall consider the recommendations of any advisory bodies which may be established by the commissioner. The commissioner may also incorporate the recommendations of authoritative organizations whose mission is to promote policies based on best practices or evidence-based research. The commissioner, in consultation with hospital representatives, shall develop a process that encourages hospitals to incorporate the statewide health care facilities and services plan into hospital long-range planning and shall facilitate communication between appropriate state agencies concerning innovations or changes that may affect future health planning. The office shall update the statewide health care facilities and services plan on or before July 1, 2012, and every five years thereafter.

(c) For purposes of conducting the statewide health care facility utilization study and preparing the statewide health care facilities and services plan, the office shall establish and maintain an inventory of all health care facilities, the equipment identified in subdivisions (8) and (9) of subsection (a) of section 19a-638, and services in the state, including health care facilities that are exempt from certificate of need requirements under subsection (b) of section 19a-638. The office shall develop an inventory questionnaire to obtain the following information: (1) The name and location of the facility; (2) the type of facility; (3) the hours of operation; (4) the type of services provided at that location; and (5) the total number of clients, treatments, patient visits, procedures performed or scans performed in a calendar year. The inventory shall be completed biennially by health care facilities and providers and such health care facilities and providers shall not be required to provide patient specific or financial data.

Sec. 19a-634.(Formerly Sec. 19a-150).Statewide health care facility utilization study. Statewide health care facilities and services plan. Inventory of health care facilities, equipment and services.

(a) The Office of Health Care Access shall conduct, on a biannual basis, a statewide health care facility utilization study. Such study may include an assessment of: (1) Current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) geographic areas and subpopulations that may be underserved or have reduced access to specific types of health care services; and (3) other factors that the office deems pertinent to health care facility utilization. Not later than June thirtieth of the year in which the biannual study is conducted, the Commissioner of Public Health shall report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services on the findings of the study. Such report may also include the office's recommendations for addressing identified gaps in the provision of health care services and recommendations concerning a lack of access to health care services.

(b) The office, in consultation with such other state agencies as the Commissioner of Public Health deems appropriate, shall establish and maintain a statewide health care facilities and services plan. Such plan may include, but not be limited to: (1) An assessment of the availability of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) an evaluation of the unmet needs of persons at risk and vulnerable populations as determined by the commissioner; (3) a projection of future demand for health care services and the impact that technology may have on the demand, capacity or need for such services; and (4) recommendations for the expansion, reduction or modification of health care facilities or services. In the development of the plan, the office shall consider the recommendations of any advisory bodies which may be established by the commissioner. The commissioner may also incorporate the recommendations of authoritative organizations whose mission is to promote policies based on best practices or evidence-based research. The commissioner, in consultation with hospital representatives, shall develop a process that encourages hospitals to incorporate the statewide health care facilities and services plan into hospital long-range planning and shall facilitate communication between appropriate state agencies concerning innovations or changes that may affect future health planning. The office shall update the statewide health care facilities and services plan not less than once every two years.

(c) For purposes of conducting the statewide health care facility utilization study and preparing the statewide health care facilities and services plan, the office shall establish and maintain an inventory of all health care facilities, the equipment identified in subdivisions (8) and (9) of subsection (a) of section 19a-638, and services in the state, including health care facilities that are exempt from certificate of need requirements under subsection (b) of section 19a-638. The office shall develop an inventory questionnaire to obtain the following information: (1) The name and location of the facility; (2) the type of facility; (3) the hours of operation; (4) the type of services provided at that location; and (5) the total number of clients, treatments, patient visits, procedures performed or scans performed in a calendar year. The inventory shall be completed biennially by health care facilities and providers and such health care facilities and providers shall not be required to provide patient specific or financial data.

Appendix B

Advisory Body

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Appendix D
Health Care Practitioners

Practitioner Type	CT Licensed Practitioners[a]	Mean Age[b]	Age 60 and Older[b]	Rate per 100,000 CT Population[c]
Acupuncturist	340	49.5	19%	9.5
Advanced Emergency Medical Technician	864	39.3	7%	24.2
Advanced Practice Registered Nurse	3,664	48.7	19%	102.5
Athletic Trainer	606	34.0	1%	17.0
Audiologist	268	48.2	19%	7.5
Certified Alcohol and Drug Counselor	286	53.9	29%	8.0
Chiropractor	997	47.6	12%	27.9
Dental Anesthesia/Conscious Sedation Permit	125	54.2	36%	3.5
Dental Conscious Sedation Permit	19	47.9	26%	0.5
Dental Hygienist	3,654	45.4	11%	102.2
Dentist	3,385	50.7	29%	94.7
Dietitian/Nutritionist	783	46.3	14%	21.9
Electrologist	165	53.5	27%	4.6
Emergency Medical Responder	6,575	38.1	5%	184.0
Emergency Medical Responder - CSP	1,367	43.6	3%	38.2
Emergency Medical Service-Instructor	540	46.2	12%	15.1
Emergency Medical Technician	11,914	37.7	5%	333.3
Hearing Instrument Specialist	122	56.1	33%	3.4
Homeopathic Physician	9	57.4	33%	0.3
Licensed Alcohol and Drug Counselor	773	54.3	33%	21.6
Licensed Clinical Social Worker	5,709	51.5	31%	159.7
Licensed Nurse Midwife	217	49.3	18%	6.1
Licensed Practical Nurse	13,249	47.8	24%	370.7
Marital and Family Therapist	1,112	52.1	31%	31.1
Massage Therapist	4,775	44.6	11%	133.6
Naturopathic Physician	279	45.2	11%	7.8
Nursing Home Administrator	781	53.5	32%	21.9
Occupational Therapist	2,065	41.1	4%	57.8
Occupational Therapist Assistant	683	43.7	7%	19.1
Optician	707	50.2	22%	19.8
Optician Apprentice	288	36.9	5%	8.1
Optometrist	654	49.8	20%	18.3
Paramedic	2,145	40.8	3%	60.0
Perfusionist	70	47.7	10%	2.0
Physical Therapist	4,609	43.8	10%	129.0
Physical Therapist Assistant	676	42.9	6%	18.9
Physician Assistant	1,867	40.5	7%	52.2
Physician/Surgeon	17,154	51.7	27%	480.0
Podiatrist	307	50.8	23%	8.6
Professional Counselor	1,881	51.6	33%	52.6

Practitioner Type	CT Licensed Practitioners[a]	Mean Age[b]	Age 60 and Older[c]	Rate per 100,000 CT Population[d]
Psychologist	1,879	53.4	35%	52.6
Radiographer	4,123	45.4	13%	115.4
Registered Nurse	57,429	48.8	22%	1606.8
Respiratory Care Practitioner	1,714	47.0	12%	48.0
Speech and Language Pathologist	2,485	46.8	19%	69.5

[a]Includes all practitioners holding an active CT license.

[b]Erroneous age values and age values of less than 14 and greater than 90 have been omitted from the calculation.

[c]Based on Census 2010 data.

Appendix E

Connecticut Towns by County and Department of Emergency Services and Public Protection, Division of Emergency Management and Homeland Security (DEMHS) Regions

Town Name	County Name	DEMHS Region No.
Andover	Tolland County	3
Ansonia	New Haven County	2
Ashford	Windham County	4
Avon	Hartford County	3
Barkhamsted	Litchfield County	5
Beacon Falls	New Haven County	5
Berlin	Hartford County	3
Bethany	New Haven County	2
Bethel	Fairfield County	5
Bethlehem	Litchfield County	5
Bloomfield	Hartford County	3
Bolton	Tolland County	3
Bozrah	New London County	4
Branford	New Haven County	2
Bridgeport	Fairfield County	1
Bridgewater	Litchfield County	5
Bristol	Hartford County	3
Brookfield	Fairfield County	5
Brooklyn	Windham County	4
Burlington	Hartford County	3
Canaan	Litchfield County	5
Canterbury	Windham County	4
Canton	Hartford County	3
Chaplin	Windham County	4
Cheshire	New Haven County	2
Chester	Middlesex County	2
Clinton	Middlesex County	2
Colchester	New London County	4
Colebrook	Litchfield County	5
Columbia	Tolland County	4
Cornwall	Litchfield County	5
Coventry	Tolland County	4
Cromwell	Middlesex County	3
Danbury	Fairfield County	5
Darien	Fairfield County	1
Deep River	Middlesex County	2
Derby	New Haven County	2
Durham	Middlesex County	2
East Granby	Hartford County	3
East Haddam	Middlesex County	3
East Hampton	Middlesex County	3

Town Name	County Name	DEMHS Region No.
East Hartford	Hartford County	3
East Haven	New Haven County	2
East Lyme	New London County	4
East Windsor	Hartford County	3
Eastford	Windham County	4
Easton	Fairfield County	1
Ellington	Tolland County	3
Enfield	Hartford County	3
Essex	Middlesex County	2
Fairfield	Fairfield County	1
Farmington	Hartford County	3
Franklin	New London County	4
Glastonbury	Hartford County	3
Goshen	Litchfield County	5
Granby	Hartford County	3
Greenwich	Fairfield County	1
Griswold	New London County	4
Groton	New London County	4
Guilford	New Haven County	2
Haddam	Middlesex County	2
Hamden	New Haven County	2
Hampton	Windham County	4
Hartford	Hartford County	3
Hartland	Hartford County	5
Harwinton	Litchfield County	5
Hebron	Tolland County	3
Kent	Litchfield County	5
Killingly	Windham County	4
Killingworth	Middlesex County	2
Lebanon	New London County	4
Ledyard	New London County	4
Lisbon	New London County	4
Litchfield	Litchfield County	5
Lyme	New London County	4
Madison	New Haven County	2
Manchester	Hartford County	3
Mansfield	Tolland County	4
Marlborough	Hartford County	3
Meriden	New Haven County	2
Middlebury	New Haven County	5
Middlefield	Middlesex County	2

Town Name	County Name	DEMHS Region No.
Middletown	Middlesex County	3
Milford	New Haven County	2
Monroe	Fairfield County	1
Montville	New London County	4
Morris	Litchfield County	5
Naugatuck	New Haven County	5
New Britain	Hartford County	3
New Canaan	Fairfield County	1
New Fairfield	Fairfield County	5
New Hartford	Litchfield County	5
New Haven	New Haven County	2
New London	New London County	4
New Milford	Litchfield County	5
Newington	Hartford County	3
Newtown	Fairfield County	5
Norfolk	Litchfield County	5
North Branford	New Haven County	2
North Canaan	Litchfield County	5
North Haven	New Haven County	2
North Stonington	New London County	4
Norwalk	Fairfield County	1
Norwich	New London County	4
Old Lyme	New London County	4
Old Saybrook	Middlesex County	2
Orange	New Haven County	2
Oxford	New Haven County	5
Plainfield	Windham County	4
Plainville	Hartford County	3
Plymouth	Litchfield County	5
Pomfret	Windham County	4
Portland	Middlesex County	3
Preston	New London County	4
Prospect	New Haven County	5
Putnam	Windham County	4
Redding	Fairfield County	5
Ridgefield	Fairfield County	5
Rocky Hill	Hartford County	3
Roxbury	Litchfield County	5
Salem	New London County	4
Salisbury	Litchfield County	5
Scotland	Windham County	4
Seymour	New Haven County	2
Sharon	Litchfield County	5

Town Name	County Name	DEMHS Region No.
Shelton	Fairfield County	2
Sherman	Fairfield County	5
Simsbury	Hartford County	3
Somers	Tolland County	3
South Windsor	Hartford County	3
Southbury	New Haven County	5
Southington	Hartford County	3
Sprague	New London County	4
Stafford	Tolland County	3
Stamford	Fairfield County	1
Sterling	Windham County	4
Stonington	New London County	4
Stratford	Fairfield County	1
Suffield	Hartford County	3
Thomaston	Litchfield County	5
Thompson	Windham County	4
Tolland	Tolland County	3
Torrington	Litchfield County	5
Trumbull	Fairfield County	1
Union	Tolland County	4
Vernon	Tolland County	3
Voluntown	New London County	4
Wallingford	New Haven County	2
Warren	Litchfield County	5
Washington	Litchfield County	5
Waterbury	New Haven County	5
Waterford	New London County	4
Watertown	Litchfield County	5
West Hartford	Hartford County	3
West Haven	New Haven County	2
Westbrook	Middlesex County	2
Weston	Fairfield County	1
Westport	Fairfield County	1
Wethersfield	Hartford County	3
Willington	Tolland County	4
Wilton	Fairfield County	1
Winchester	Litchfield County	5
Windham	Windham County	4
Windsor	Hartford County	3
Windsor Locks	Hartford County	3
Wolcott	New Haven County	5
Woodbridge	New Haven County	2
Woodbury	Litchfield County	5
Woodstock	Windham County	4

Appendix E: Connecticut Towns by County and Department of Emergency Services and Public Protection, Division of Emergency Management and Homeland Security (DEMHS) Regions

Appendix F
Emergency Department Behavioral Health Focus Group Members

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Appendix G
Emergency Department Focus Groups: Summary

Sec. 19a-634. (Formerly Sec. 19a-150).Statewide health care facility utilization study. Statewide health care facilities and services plan. Inventory of health care facilities, equipment and services.
As part of the OHCA Facility Plan process, the Subcommittees for Acute Care and Behavioral Health agreed to co-sponsor focus groups with hospital emergency department (ED) staff including ED, behavioral health and nurse directors. The aim of the focus groups was to gain better insight on how well persons presenting with behavioral health needs were receiving care either in the general hospital or through community programs. The Connecticut Hospital Association (CHA) provided the logistical support securing three meeting locations throughout the state and registering ED staff. A University of Connecticut Health Center research associate, on contract to the Department of Mental Health and Addiction Services, facilitated the groups.

Focus groups were held on May 23, 24 and 30, 2012 at CHA's headquarters in Wallingford, the Mount Sinai Campus of St. Francis Hospital and Medical Center in Hartford, and Bridgeport Hospital. A total of twenty-nine ED staff from seventeen hospitals representing large urban centers, medium-sized cities and smaller communities participated in the focus groups.

Each group was asked to discuss the following areas:

- Patient management: patient characteristics such as presenting behavioral health disorders, complicating factors such as co-morbid medical conditions; whether those admitted were first time or recurring patients; type of insurance coverage (i.e., public entitlement, no insurance, private); and any issues concerning payer requirements (preauthorization criteria, length of stay, etc.);
- Behavioral health resources/system capacity: the availability of appropriate services within the hospital and/or in the hospital's catchment area; discharge planning to assure placement in the appropriate level of care; referral networks between ED staff and community behavioral health providers and/or administrative services organizations; and care coordination; and
- Other challenges: noting any constraints/barriers in placing patients in behavioral health services outside the hospital such as transportation, appropriate housing, timely access to outpatient appointments and other recovery support services.

Several common themes emerged (not in ranked order) from the three focus groups, including:

1. Inappropriate use of the ED by behavioral health patients (e.g., patients from geriatric/nursing homes, group homes, school referrals, police drop-offs) competing with ED resources and affecting overall quality of care delivered in the ED.
2. Limited access to behavioral health services especially for those patients requiring inpatient (adults) or residential (youth) services as well as difficulty initiating services for new patients (e.g., securing an outpatient appointment for assessment/intake, medication, or other social/recovery services).
3. Lack of coordination of care between ED and community based services.

Inappropriate Use of ED by Behavioral Health Patients

There was a range of concerns raised by focus group participants as to the inappropriate use of EDs. These included:

- the police conducting "sweeps" and dropping off patients who are intoxicated - giving the patient a choice of jail or the ED;
- schools sending students who may be acting out or have conduct problems;
- nursing homes transferring patients who are disruptive/combative or who have dementia;
- concerned parents bringing their child who is intoxicated from alcohol and other drugs or exhibiting difficult behaviors; and
- family care givers who can no longer cope and need a respite.

In addition to seeing the severely chronically ill behavioral health patient, many ED participants stated that they are seeing new patients, referred to by participant as "the moderately" mentally ill. Several factors were suggested as to the rise in the number of this type of patient. Participants cited the poor economy and resulting adverse life events, such as unemployment or difficulty meeting financial obligations (possibly having lost insurance coverage), home foreclosures, caring for a sick family member, being socially isolated (aging population) and other environmental factors. Most of these patients do not present with an immediate medical concern, but can tie up ED beds for many hours or even days waiting for a behavioral health assessment and an appropriate discharge from the ED. For instance, most focus group participants noted the rise in patients from skilled nursing facilities (SNFs) who cannot be discharged back to the SNF until they receive a "psychiatric clearance" from the ED.

Participants reported that there has been an increase in combative patients placing ED staff at risk of physical harm. Consistently across the groups, it was reported that the number of serious assaults by patients have become commonplace, resulting in hospitals taking additional steps to enhance security, such as increased security presence in the ED, increased use of hand-held metal detectors, and, in some cases, employing specially trained dogs, to assure patient and staff safety. Participants spoke about patients hiding weapons or other implements on their body that could pose a danger to themselves or ED staff. There was also discussion of the increased incidence of staff turnover resulting from patient assaults, and the resulting costs to hospitals to train new personnel.

Children and adolescents comprise one population increasingly presenting at EDs. Concerned parents are looking more often to the ED when they are unsure where to find help for a child who is abusing alcohol and other drugs, or is so disruptive that parents cannot manage their behavior. One hospital located in a large urban community reported a 50% increase in the volume of pediatric patients presenting to the ED in the past year. Participants noted a lack of substance use treatment programs for children, and waiting lists of child/adolescent partial hospital programs and residential beds, as contributing factors.

Another group comprises family members who can no longer cope with the care of an elderly parent. The parent may be socially isolated, depressed or experiencing dementia but not a medical or psychiatric emergency.

These patients and others can be costly in the diversion of ED resources. The ability for hospital EDs to manage the behavioral health population varied, with larger hospitals providing dedicated space to accommodate those with behavioral health needs. Nevertheless, even the larger, inner city hospitals may be overwhelmed. Some hospitals try to separate this population from the general ED medical patient population. Participants noted the importance of separating children from adults being treated in behavioral health ED; however, many do not have the capacity. One participant noted that, with the rise in patients inappropriately accessing ED services, care has become more "custodial" rather than clinical, as resources are diverted away from serving patients who truly need emergency medical care.

All focus groups reported a significant rise in behavioral visits over the past several years, with one hospital reporting a 20% increase. As mentioned, some attribute this to the economic downturn with the corresponding loss of insurance coverage. Certainly the increase in patient populations such as those experiencing life stressors as mentioned above is another. The chronically ill behavioral health patients, who cycle through treatment and relapse (or decompensation), may also be accessing the ED more often, due to the fewer community resources (e.g., counseling, medication

management or housing). The ED participants felt that the severity of those presenting with a behavioral health problem is increasing (i.e., more acute and more often).

Adding to this problem is the ubiquitous message placed on medical practices or behavioral health clinics' after-hours automated phone responses, stating, "If this is an emergency to go to the nearest emergency room." ED staff note that the majority of these patients do not need emergency room treatment, and could be more effectively and less expensively managed in an outpatient setting. As long as EDs are the only available care facilities operating 24 hours / 7 days a week, many will look to them whether the visit is appropriate or not. Participants stated that EDs have become a "dumping ground" for patients with nowhere else to go, and "when there's nowhere else to go, the ED's door is always open."

Limitations on length of stay (five days) for general hospital inpatient psychiatric beds by private insurance companies was cited as being problematic, resulting in patients receiving inadequate care, frequently relapsing and then returning to the ED.

EDs must provide one-to-one staffing for patients presenting with serious psychiatric concerns (including suicidal thoughts), or who exhibit aggressive behaviors, in order to avoid harm to themselves or others. This means that EDs must have specialized personnel, such as crisis workers, on staff. In smaller hospitals, getting a psychiatric evaluation may take some time, as the psychiatrist may not be physically present in the hospital, and available only by telephone, or available in person during limited hours. All of these issues place a burden on hospitals to appropriately staff EDs, at additional cost, and result in increased length of stays for patients.

While all focus group participants strongly confirmed the recent increase in chronic alcoholic patients (many who detox in the ED), some hospitals noted a rise in patients presenting with PCP (Phencyclidine) or "angel dust" use, and noted that such patients are more likely to exhibit violent behaviors. Also more ED patients are presenting with nonmedical use of narcotic pain relievers, other prescription drugs (stimulants), and cough medicine (dextromethorphan), particularly in the eastern part of the state.

While most patients who are admitted to an ED have some form of insurance (private or public entitlement-Medicaid) or are indigent and qualify for State-operated behavioral health services, there remains a cohort who is not insured, ineligible for public insurance, or does not qualify for State-operated services. EDs find it very difficult to find a community referral for these patients, which is one of the primary barriers to discharging a patient needing behavioral health care.

Limited access/capacity for inpatient (adults) or residential (adolescents) services

Most hospitals represented in the focus groups noted the shortage of inpatient beds for both adults and children needing psychiatric or substance use treatment services. For children with serious emotional disturbance, the wait for placement in a residential bed can take days if not weeks or may never happen. The burden of having a section of the ED separated for children waiting for a residential placement is especially difficult for smaller hospitals. The lack of available inpatient beds for adults was discussed at all focus groups, particularly regarding access to intermediate care beds that were recently placed on line as part of the Connecticut Behavioral Health Partnership (Medicaid) initiative. Participants noted that overall the decline in State-operated beds for adults, and community residential beds for children, for the most seriously ill behavioral health patients, places an extreme burden on EDs. These patients utilize a disproportionate amount of resources that were formerly available to the less severely ill patients, creating a "logjam" in the ED, and longer lengths of stays for all patients.

The limited availability of adult respite beds, which could be used to stabilize patients outside of the ED setting, continues to add to the inability to discharge patients needing mental health services. Across hospitals represented in the focus groups, the average length of stay in an ED for those awaiting admission to a behavioral health service ranged from twelve to thirty-two hours, with longer waits for those needing an inpatient psychiatric bed. The lack of observation beds (less than twenty-four hours or extended stay for up to seventy-two hours) was mentioned, in the context of being able to "hold" the patient until an appropriate discharge could be completed, thus freeing up ED beds. For the most part, observation beds are in short supply due to reimbursement constraints by payers, and respite or observation beds are not available for homeless patients.

Difficulty initiating services for new patients

For those "new" patients with behavioral health needs, it is difficult to schedule an appointment in the community for an initial assessment in order to obtain outpatient treatment or medication management. While most focus group participants stated an average wait time of three to six weeks, one hospital indicated it could take as long as six months for an outpatient appointment. Participants reported that some outpatient clinics require three appointments before a patient can see a psychiatrist for medication management, with the process taking several months. This also results in frequent re-admissions to the ED, while someone is waiting to receive outpatient services. In the past, patients such as these would not even present at the ED, as they would be receiving outpatient treatment or case management services.

It can be difficult to connect ED patients who need referral to community alcohol and drug or mental health services outside of normal program operational hours. The EDs' busiest hours are usually evenings (after 4:00 p.m.), when it is impossible to arrange a referral to a community behavioral health provider. This necessitates keeping the patient until the next day, when a referral may be arranged. Weekends are even more difficult, since it is impossible to arrange a referral until Monday.

Lack of coordination of care between ED and community based services

Even for those with private or public insurance, obtaining preauthorization for behavioral health services is very time consuming. At one focus group, hospital ED participants reported difficulties in obtaining timely referrals and preauthorizations for behavioral health services for Medicaid Low Income Adults from the CT-Behavioral Health Partnership administrative services organization.

Some ED participants noted that communication between the ED and community programs is often poor. Some areas reported problems with Sober Houses, which provide housing for persons in recovery, discharging them when a person relapses, rather than assisting them in arranging alternative services. All groups noted a "low tolerance" on the part of some treatment agencies for certain behaviors, such as missing appointments, or testing positive for substance use. Such circumstances should be acknowledged, anticipated and accommodated as human elements of the recovery process. Once discharged or released from a community based service program, these individuals then present at EDs, requiring psychiatric medications. It was also noted that there is a lack of community-based case management services, which would achieve some measure of coordination of care between the ED and community providers, although in some EDs, there exists a strong tie with State-operated services for adults. A few participants mentioned the need for a comprehensive resource directory and an up-to-date census report, indicating where alcohol and drug residential beds are available.

As mentioned above, the readmitting practices of some SNFs, group homes and other institutions, that frequently send patients to the ED, is also causing gridlock. Many of the referred patients aren't appropriate for the ED, and once diagnosed, must be discharged as soon as possible back to the referring facility. Often the referring agency/facility states that the patient is no longer appropriate for their program.

Overall, all regions reported use of the ED as a clearinghouse, or entry point, for access to all services (group home, inpatient, outpatient, substance abuse, etc.), leading to a back-up in the ED and inability to adequately care for those truly needing emergency services. For example, access to many detoxification facilities is only available upon referral from an ED. For opiate treatment, patients spend five to six hours in an ED for this referral. Others wait days for placement and are eventually stabilized and discharged from the ED before obtaining placement.

In the end, these system issues add days of untreated behavioral health needs, huge costs to hospitals and insurers, and disruption in patients' and family members' lives. Some participants noted the ED length of stay for behavioral health patients is routinely five to seven days, and that the ED is essentially functioning as a short-term inpatient unit and detoxification facility for behavioral health clients who cannot access beds in appropriate facilities. All participants agreed that behavioral health patients are not getting an adequate quality of care in the emergency department and would be better served in other settings if resources were available. Participants noted, "The ED is not conducive to providing quality care" and that these patients do not have positive outcomes in the ED setting.

Appendix H

Emergency Department Focus Groups: Solutions

No Connecticut hospital is alike in terms of available resources, patient volume, and community demographics, but the majority of issues described by focus group participants appeared to be common to both large urban hospitals and smaller community hospitals. While federal law requires all Emergency Departments (EDs) to provide or arrange treatment necessary to attempt to stabilize patients who are found to have an emergency medical condition, they also provide treatment for individuals whose health needs are not of an emergency nature, but for whom EDs may be the only accessible or timely entry point into the broader health care system. Whereas participants shared many similar frustrations about the behavioral health system, perhaps the overarching concern was the function of the ED in the continuum of care as a "custodial care" institution, where behavioral health patients are "boarded" in the ED. From a planning perspective, the focus groups acknowledged that capacity issues for EDs must be monitored to ensure that overcrowding and wait times for patients do not threaten to compromise patient care.

Common themes identified by focus group participants included (i) inappropriate use of EDs by behavioral health patients, (ii) limited access to behavioral health services/difficulty initiating services for new patients, and (iii) lack of coordination between EDs and community based services. These themes are addressed in further detail in an accompanying document, entitled "Emergency Department Focus Groups Summary."

While these problems are not unique to Connecticut, participants agreed that a frank, open, and ongoing discussion of potential solutions, including consideration of specific measures implemented among prehospital providers, ED providers, and providers of follow-up care, and the role government can play to incentivize the implementation of such solutions, are essential and beneficial elements of the planning process.

Current Measures

Participants cited the success of certain programs that may potentially be expanded to other regions or populations. For example, the child psychiatric emergency mobile teams (EMPS) are reportedly working well in most areas. One participant stated that four out of five child/adolescent crisis clients are diverted from the ED through this system. It was recommended that this approach might be utilized successfully with the adult population as well. Another program participants believe is "very helpful" is the "ED diversion program" through DMHAS for behavioral health patients. In addition, the "wraparound" diversion alternative to hospitalization for child and adolescent patients was noted as a successful program in one region of the state.

Participants shared ideas about policies and practices that their hospitals' EDs have initiated to try to cope with behavioral health system issues. For instance, one large urban hospital experienced an increase in patients presenting with non-emergent complaints, afterhours and on weekends, from the local mental health care providers. The hospital engaged these providers, educating them on the appropriate use of the ED, and persuading them to change the messaging on their voicemail systems regarding possible emergency client calls. These modest changes resulted in a reduction in patient volume. Another hospital adopted the practice of admitting nonviolent children and adolescents presenting with behavioral health concerns into its inpatient pediatric unit for observation, in order to avoid "boarding" them in the ED.

Most participants stated that the increasing number of ED visitors were resulting in new challenges to guarantee patient and worker safety. Many reported that their hospitals have taken decisive measures to address this challenge, increasing security staff, and investing in technology and equipment, such as hand-held metal detectors, to assure patient safety. Participants also cited the challenge of managing medications for those behavioral health patients presenting with medical co-morbidities, and those with multiple prescriptions. One hospital reported that it resorted to employing pharmacy technicians in the ED, to manage multiple prescriptions for patients who may remain in the ED for several days at a time.

One large urban hospital dealt with an increase in geriatric patients presenting with behavioral health concerns by staffing more medical case managers in the ED, both to manage these patients and coordinate with SNFs. This same hospital reported that its crisis clinicians were essentially functioning as case managers for a significant portion of their time, although they also stated that this solution is "unbillable and unreimbursable but helps with flow" in the ED. Across the board, participants stated that case management was lacking for behavioral health patients, in pre- and post-hospital settings.

Another participant reported that group homes for persons with developmental disabilities in the region served by their ED were developing and sharing with the ED their elaborate treatment plans for dealing with very violent patients. These detailed plans ensured that the group homes would take the patient back after an ED visit. Participants suggested that such a practice might be replicated with geriatric/nursing home patients and behavioral health group home patients.

Participants shared a number of measures currently used to address the growing need to care for behavioral health patients in the ED, including:

- segregating patients such as children and adolescents and geriatric patients, placing them in a separate, more appropriate environment ;
- hiring nurses with psychiatric training and the skills necessary to manage ED patients presenting with mental health problems;
- establishing dedicated units within the ED to handle patients requiring a detoxification from alcohol or opiates; and
- instituting protocols for recurring ED patients seeking narcotic pain relievers, to stop the inappropriate prescribing of potentially addictive medication.

Recommendations

Some participants recommended the formation of a statewide task force to collect and share best practices, and to ensure a degree of consistency in ED behavioral health services throughout the state. Other states have published “white papers” that may be used as guidance. Furthermore, it was suggested that the taskforce look at innovative practices in other states, for example:

- Development of State-funded, self-contained psychiatric emergency facilities (as was done in California and New York);
- Integrated care that is coordinated across systems as recommended in New York’s Medicaid Redesign Team-Behavioral Health Reform Work Group (October 2011 http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf

Participants suggested repeatedly that there should be ongoing public evaluation of the effectiveness and availability of current behavioral health services. Areas recommended include:

- Availability and access to intermediate care beds recently placed on-line to accommodate reduction in State-operated inpatient beds;
- Overall effectiveness of behavioral health services in the state as relates to quality of care and long term outcomes;
- Geographic distribution of resources, treatment demand, and adequate capacity, especially for:
  - Respite Beds
  - Continuing care beds
  - Adult acute inpatient beds (State and general hospital)
  - Adolescent residential beds
  - Observation beds (23 hour either in ED or outside)
- Management of behavioral health resources locally and cross-system coordination.

Participants voiced several suggestions that could lead to true cost savings, both by hospitals and other providers, and at the same time improve patient access to appropriate behavioral health services. Those mentioned include:

- Bridge care: this could be in the form of observation or respite beds or a patient/peer navigator depending on the severity of the behavioral health condition, allowing the ED to discharge the patient with an interim treatment plan for further evaluation or referral to services. This model would provide for continuity of care and patient support during a vulnerable time when the patient most needs it.
- Urgent Walk-In Behavioral Health Centers: similar to urgent care clinics for medical conditions, this type of outpatient facility could accommodate the needs of those without a severe mental illness or substance use disorder. Given the movement to integrate primary and behavioral health care, these centers could be co-located with existing primary care centers.
- On-line Capacity Management System: automated information on behavioral health service capacity would greatly reduce time spent searching for a placement outside the ED. While in part, this exists, it is fragmented with no overarching systematic approach.

Appendix I

Emergency Department Visits by Acute Care Hospital FFYs 2008-2011

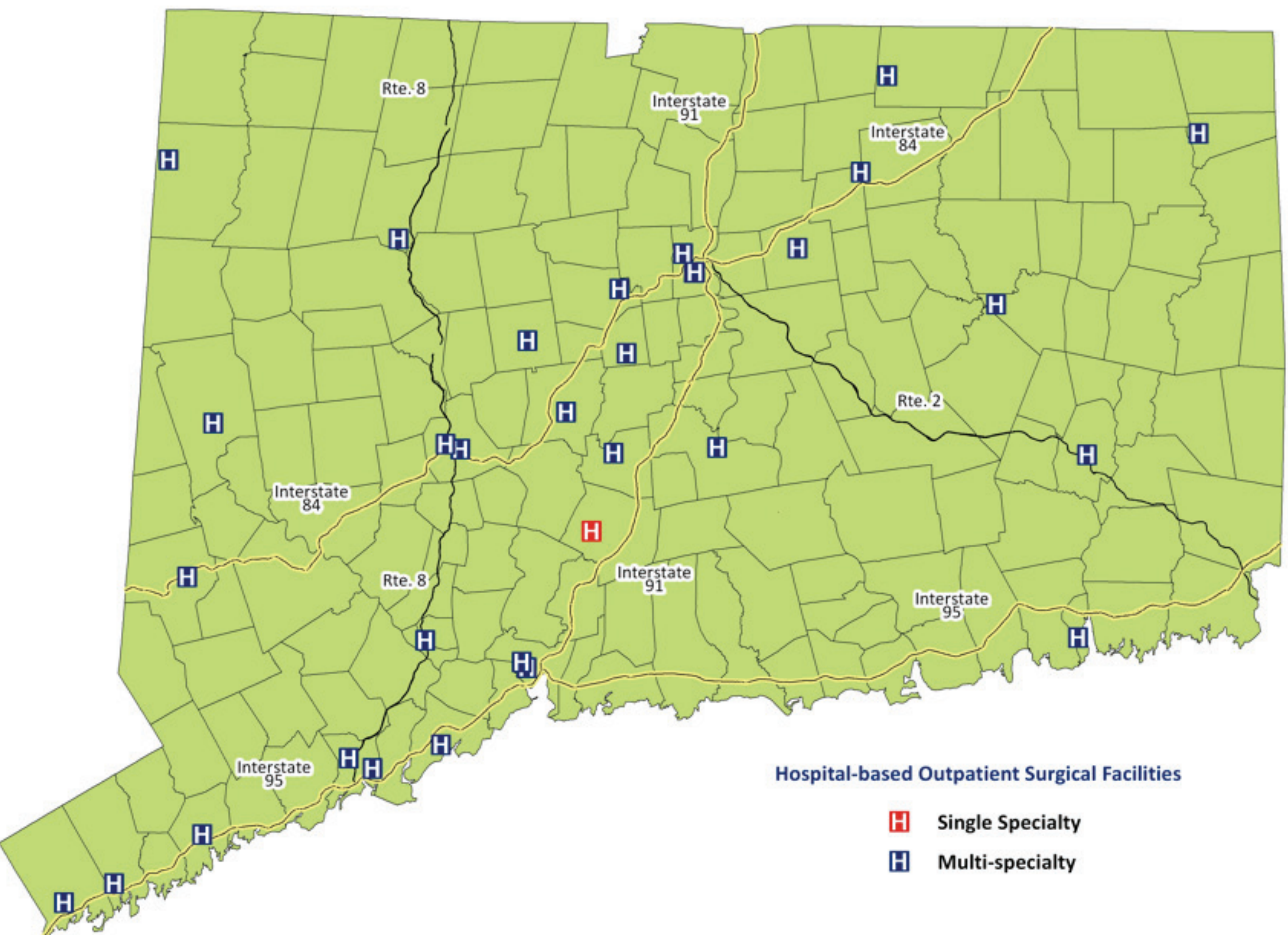
Hospital	FY 2008	FY 2009	FY 2010	FY 2011	% Chg '08-11	% Chg 10-11
Backus	57,035	61,756	63,765	61,510	8%	-4%
Bridgeport	72,054	82,456	82,084	83,652	16%	2%
Bristol	41,165	40,121	39,686	39,683	-4%	0%
Danbury	64,478	66,153	67,232	67,440	5%	0%
Day Kimball	28,458	28,832	28,824	27,738	-3%	-4%
Greenwich	38,838	41,934	41,697	41,728	7%	0%
Griffin	38,391	38,259	38,025	39,316	2%	3%
Hartford	80,573	87,829	91,953	92,620	15%	1%
Hungerford	38,765	39,592	39,022	40,014	3%	3%
Johnson	20,977	19,866	19,951	20,087	-4%	1%
L&M	80,369	79,855	81,255	80,636	0%	-1%
Manchester	44,868	45,558	46,091	47,020	5%	2%
MidState	47,482	48,403	50,882	55,829	18%	10%
Middlesex	87,534	87,781	90,052	90,739	4%	1%
Milford	38,895	39,854	36,958	36,890	-5%	0%
HCC	92,818	100,174	102,602	107,559	16%	5%
CCMC	45,940	50,779	53,762	51,250	12%	-5%
New Milford	18,667	18,147	17,399	17,750	-5%	2%
Norwalk	47,812	48,554	47,163	47,676	0%	1%
Rockville	25,011	25,835	26,010	26,087	4%	0%
Sharon[a]	14,270	14,124	13,306	13,899	-3%	4%
St. Francis	68,613	70,135	69,329	71,893	5%	4%
St. Mary's	68,306	68,905	67,212	68,435	0%	2%
St. Raphael	52,183	53,698	54,934	56,459	8%	3%
St. Vincent's	59,517	63,360	68,679	74,924	26%	9%
Stamford	61,997	62,502	65,223	66,862	8%	3%
John Dempsey	30,174	28,565	29,439	30,088	0%	2%
Waterbury	54,313	57,139	56,562	56,212	3%	-1%
Windham	27,802	29,665	31,623	32,887	18%	4%
Yale	126,724	130,313	131,338	133,620	5%	2%
Statewide	1,574,029	1,630,144	1,652,058	1,680,503	7%	2%

Source: Connecticut Hospital Association Chime, Inc. Emergency Department Data

[a]OHCA Sharon Hospital Emergency Department Data

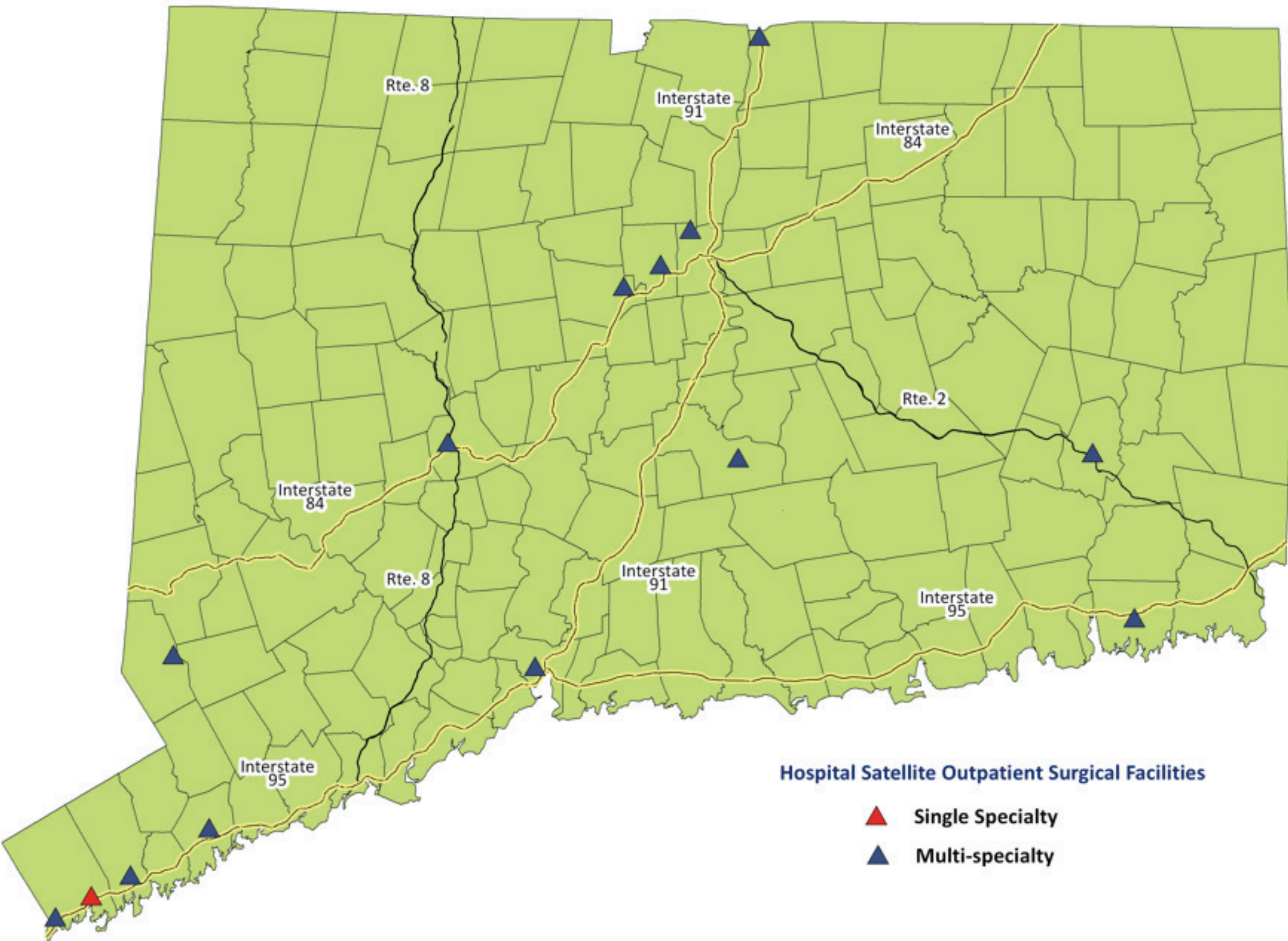
Appendix J

Map of Hospital-based Outpatient Surgical Facilities



Appendix J: Map of Hospital-based Outpatient Surgical Facilities

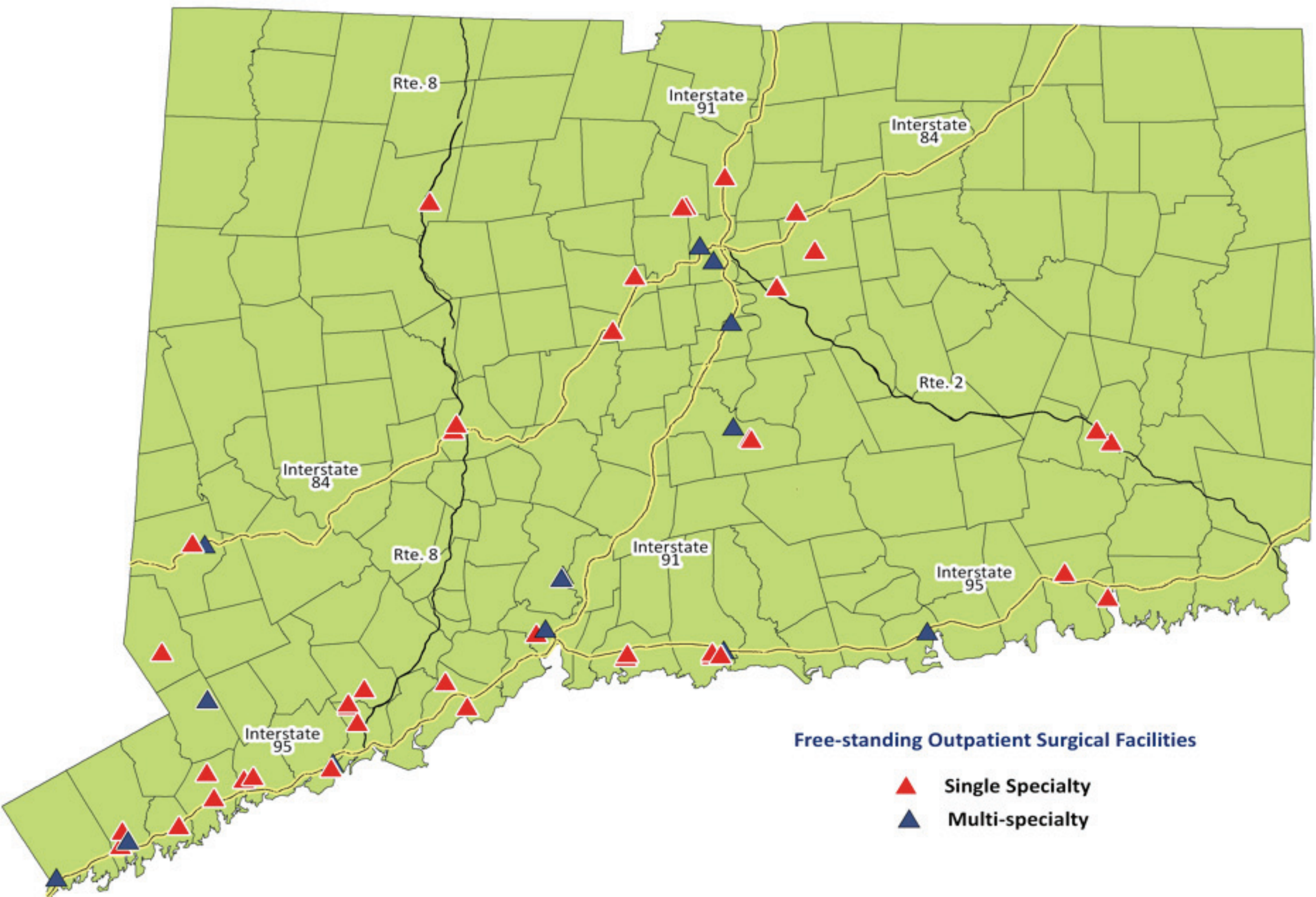
Appendix K
Map of Hospital Satellite Outpatient Surgical Facilities



Appendix K: Map of Hospital Satellite Outpatient Surgical Facilities

Appendix L

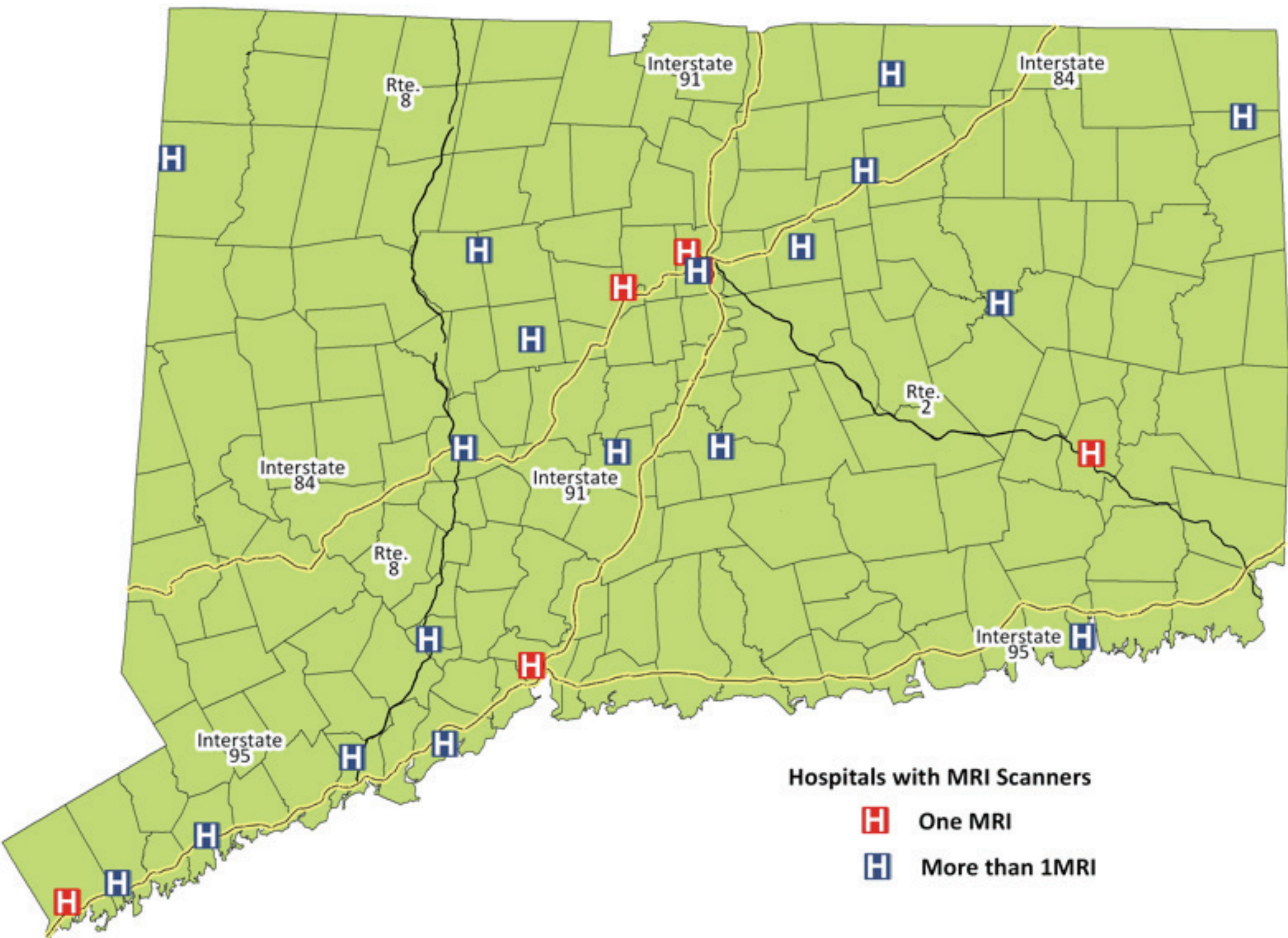
Map of Free-standing Outpatient Surgical Facilities



Appendix L: Map of Free-standing Outpatient Surgical Facilities

Appendix M

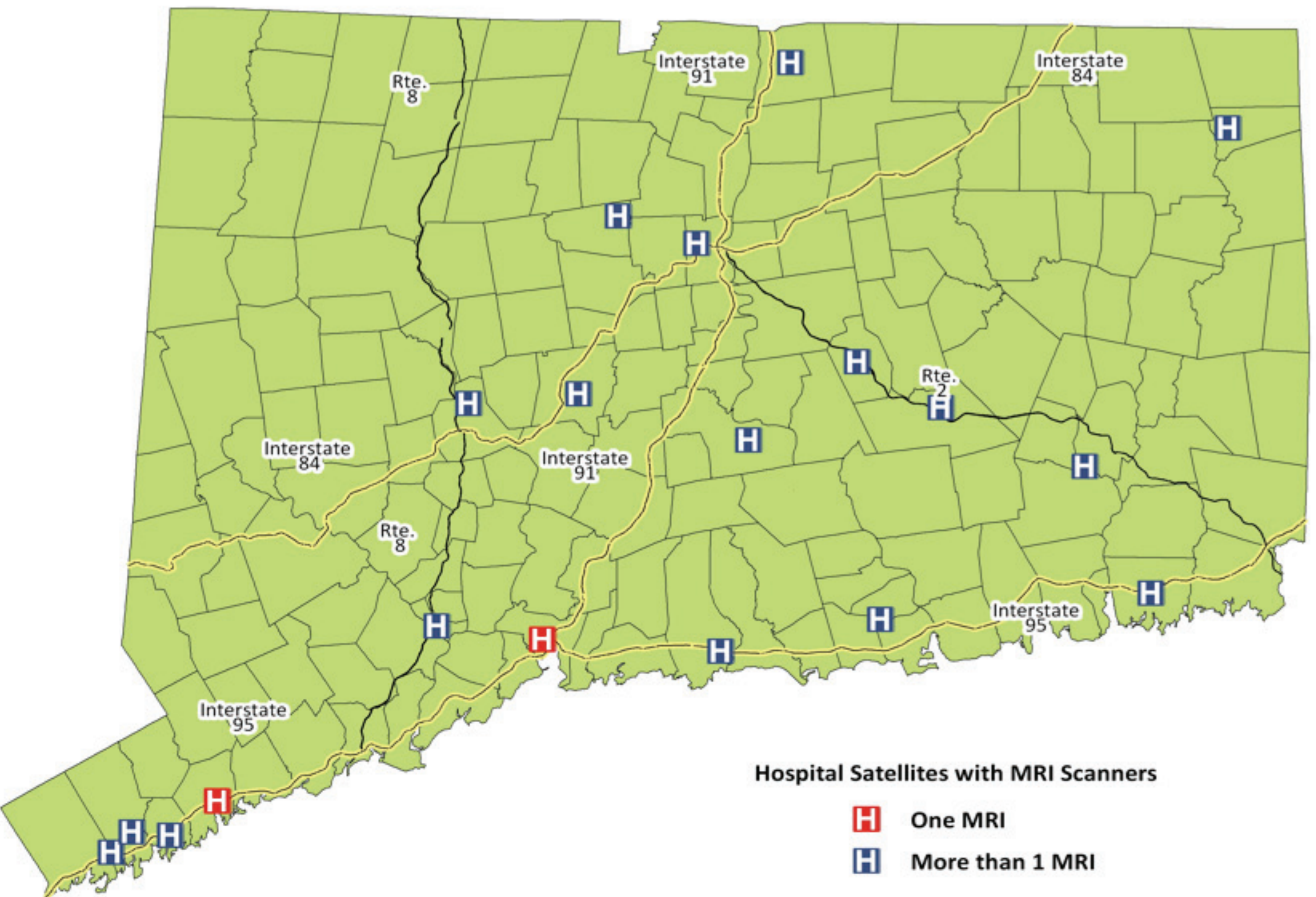
Map of Hospital-based Magnetic Resonance Imaging (MRI) Scan Providers



Prepared May 2012 DHP OHCA
Source: DPH OHCA Survey 2011 and Certificate of Need Database

Appendix N

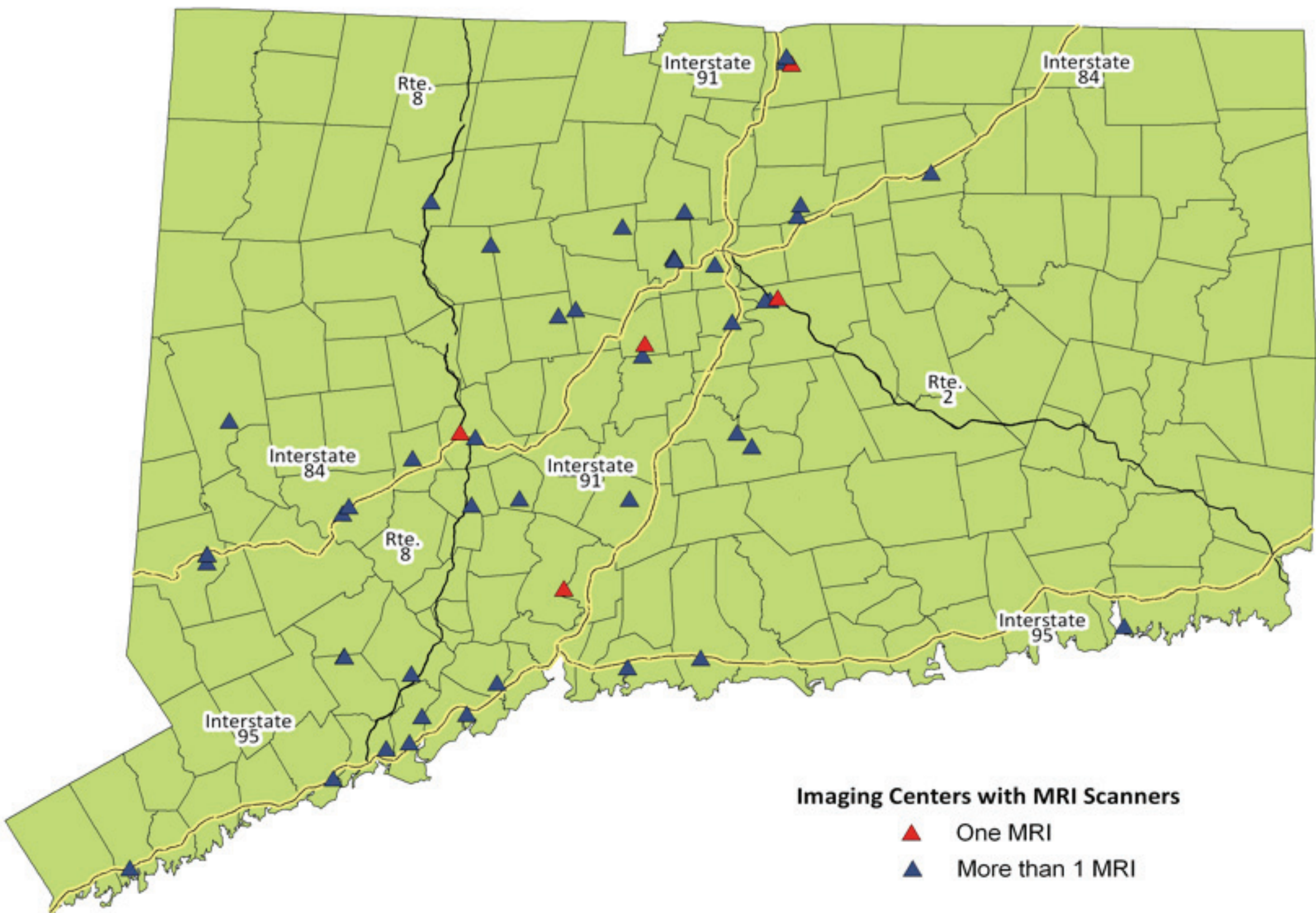
Map of Hospital Satellite Magnetic Resonance Imaging (MRI) Scan Providers



Prepared May 2012 DHP OHCA
Source: DPH OHCA Survey 2011 and Certificate of Need Database

Appendix O

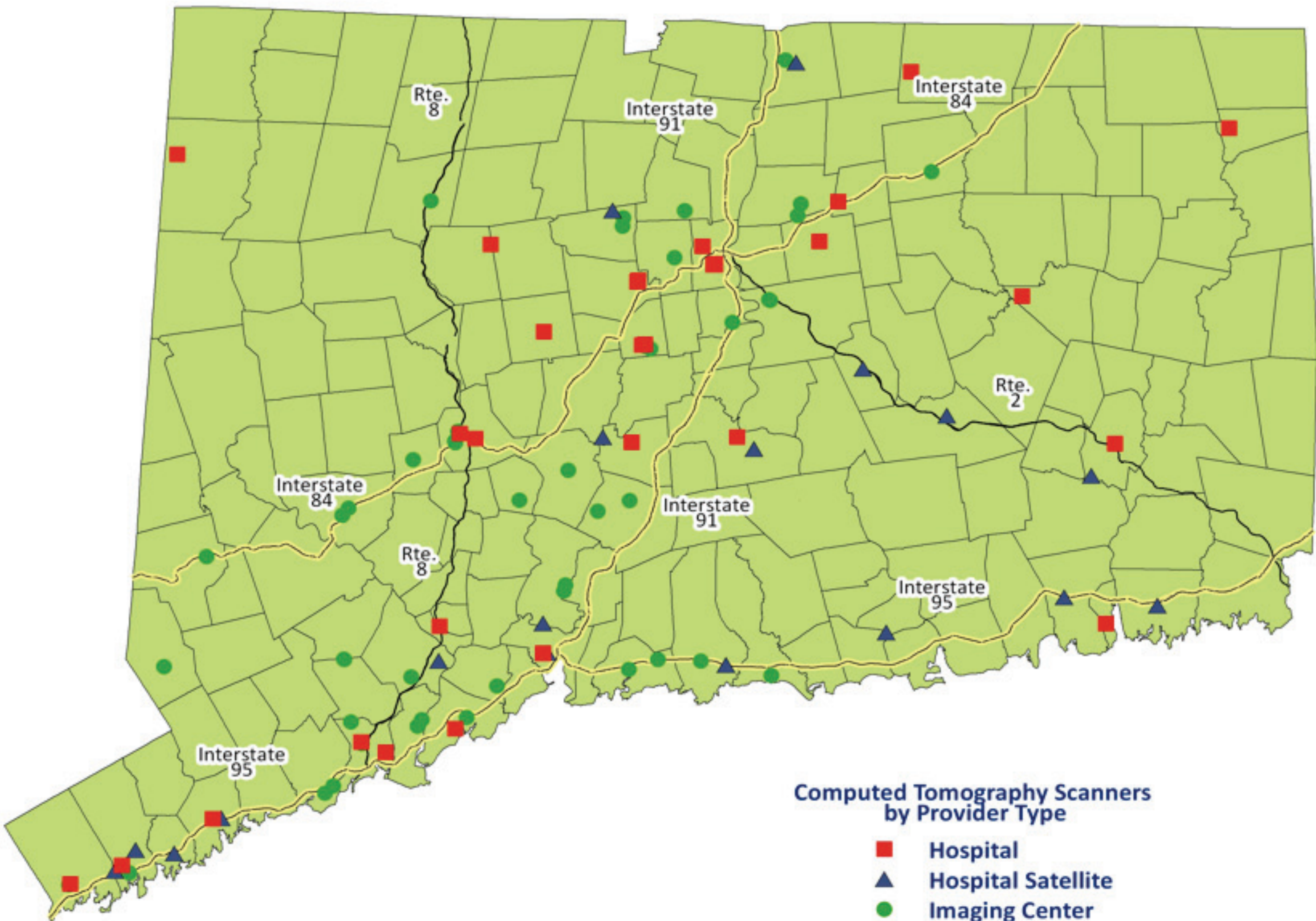
Map of Imaging Centers with Magnetic Resonance Imaging (MRI) Scanners



Prepared May 2012 DHP OHCA
Source: DPH OHCA Survey 2011 and Certificate of Need Database

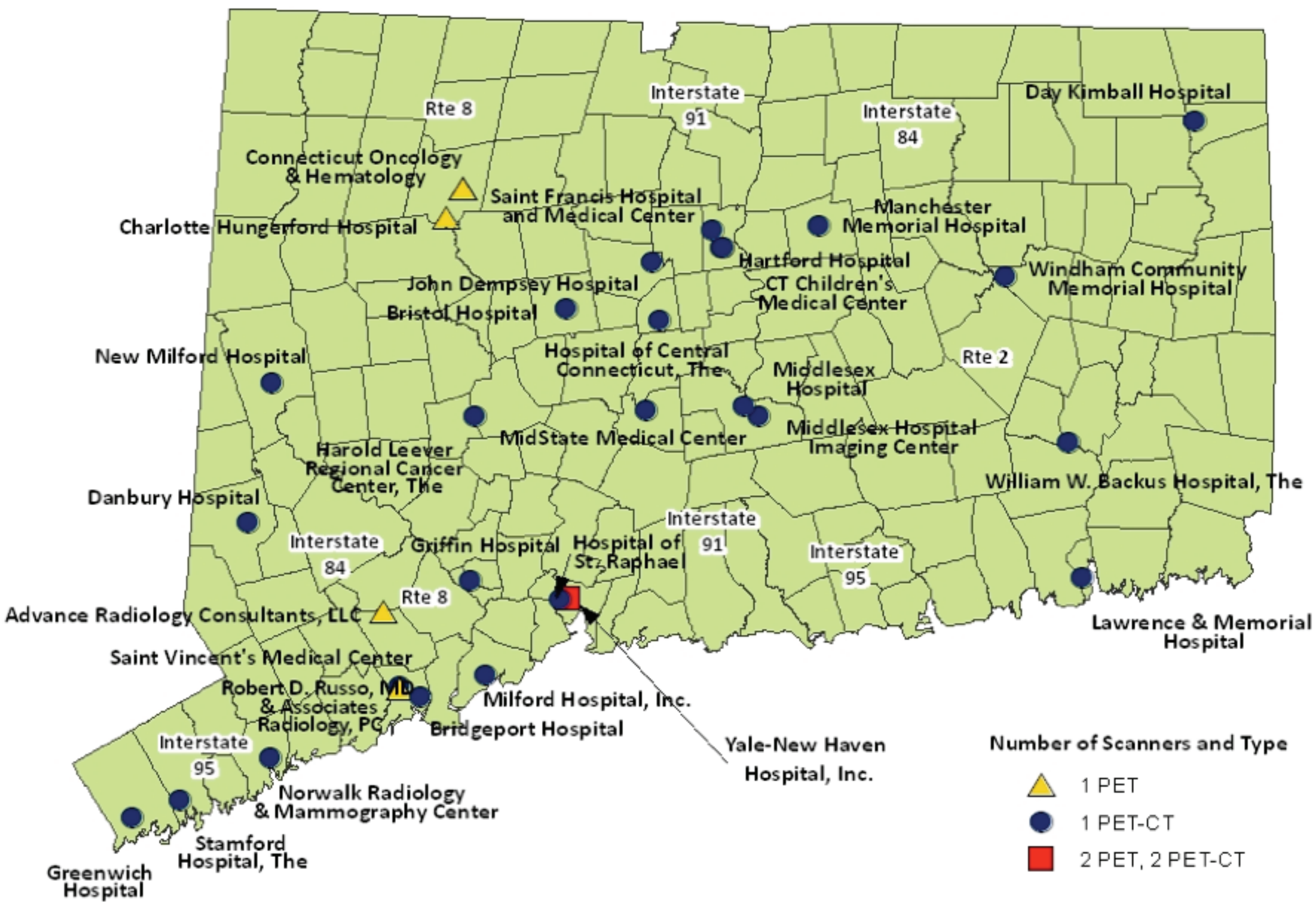
Appendix O: Map of Imaging Centers with Magnetic Resonance Imaging (MRI) Scanners

Appendix P
Map of Computed Tomography (CT) Scan Providers



Appendix P: Map of Computed Tomography (CT) Scan Providers

Appendix Q
Map of Positron Emission Tomography (PET) and Positron Emission Tomography/Computed Tomography (PET/CT) Scan Providers



Appendix Q: Map of Positron Emission Tomography (PET) and Positron Emission Tomography/Computed Tomography (PET/CT) Scan Providers

Appendix R
DPH Health Status and Services Priorities

HEALTH STATUS PRIORITIES[220]

1. Prevention and cessation of tobacco use
2. Reduction of the factors associated with intentional, unintentional, and occupational injury
3. Improvement in rates of breast, cervical, and colorectal cancer screening and follow-up
4. Improvement in rates of hypertension detection and control
5. Improvement in rates of diabetes monitoring and control
6. Improvement in diet and rates of blood cholesterol monitoring and control
7. Further determination and reduction of the factors associated with adverse pregnancy outcomes
8. Reduction of risky sexual behavior that leads to acquisition of HIV/AIDS, STDs, and unwanted pregnancy
9. Reduction of physical inactivity
10. Reduction of alcohol abuse
11. Reduction of illicit substance use and practices associated with transmission of infectious diseases

HEALTH SERVICES PRIORITIES

1. Reinforce and strengthen the public health infrastructure
2. Focus resources on the collection, analysis, interpretation, and dissemination of health data and information for better monitoring of the health care delivery system
3. Promote the development of adequate programs and services for persons 65 years of age and older
4. Monitor the growth and development of managed care and its impact on the delivery and utilization of personal health care services
5. Expand access to affordable health insurance and primary and preventive health care services to the uninsured and underinsured

ESSENTIAL PUBLIC HEALTH PROGRAMS

1. Infectious disease control
   - 1.1. Monitoring and control of all infectious diseases
   - 1.2. Investigation of outbreaks of infectious diseases and food poisoning
   - 1.3. Immunization programs

2. Health provider quality assurance
   - 2.1. Setting and enforcing standards for professional provider qualifications and provider and facility quality assurance

3. Environmental assurance
   - 3.1. Protection of food and water through the setting and enforcing of quality standards
   - 3.2. Lead abatement in housing and testing of children for blood lead levels

4. Health services assurance
   - 4.1. Setting and enforcing standards for preventive health care
   - 4.2. Assuring the provision of health care services to underserved populations
   - 4.3. Family nutrition programs

[220] Connecticut Department of Public Health, Office of Policy, Planning, and Evaluation. 1999. *Looking Toward 2000: An Assessment of Health Status and Health Services*. Hartford, CT

Appendix S

Department of Public Health Programs that Improve Health of Residents and Communities

<table>
<tr><th>Program name</th><th>Description</th></tr>
<tr><td>Condition</td><td>Link: http://www.ct.gov/dph/cwp/view.asp?a=3115&q=387268&dphNav_GID=</td></tr>
<tr><td>Asthma</td><td>“Mission Statement - Reduce asthma associated morbidity and mortality and improve the quality of life for Connecticut residents living with asthma.”
Asthma Action Plan (AAP) is to help families become proactive and anticipatory with respect to asthma exacerbation and their control. Interventions are outlined in three categories: 1) Environmental interventions;2) Clinical management and professional education interventions;3) Patient education and public awareness interventions.” Note: The Asthma Webpage contains several links to publications and educational resources related to the Asthma program.</td></tr>
<tr><td>Cancer</td><td>“The Connecticut Breast and Cervical Cancer Early Detection Program (CBCCEDP) is a comprehensive screening program available throughout Connecticut for medically underserved women. The primary objective of the program is to significantly increase the number of women who receive breast and cervical cancer screening, diagnostic and treatment referral services. All services are offered free of charge through the Connecticut Department of Public Health's contracted health care providers located statewide.”

Stay In The Game CT-“The Centers for Disease Control and Prevention (CDC) has funded the Connecticut Colorectal Cancer Control Program to increase and optimize the appropriate use of high-quality colorectal cancer screening among persons 50 years of age and older and to reduce disparities in colorectal cancer burden, screening and access to care. The Department of Public Health (DPH) directs the program in collaboration with seven select health care facilities. At each of these health care facilities you may be eligible to receive a no-cost colonoscopy and be referred to a primary care physician for follow-up services.”

Comprehensive Cancer Control Program (CCCP) - “The CCCP is housed in the Health Education, Management and Surveillance Section of the Public Health Initiatives Branch. The CCCP includes the Breast and Cervical Cancer Early Detection Program and the WISEWOMAN Program and is funded through the Centers for Disease Control and Prevention (CDC) Cooperative Agreements and State funds.”
“The CCCP provides leadership for and coordination of statewide cancer control efforts. The CCCP collaborates with community partners to share resources to:
• promote cancer prevention;
• improve early detection;
• increase access to health and social services and
• reduce the burden of cancer.”
Note: the Cancer webpage includes links to the Plan’s latest publication and other related reports and resources.</td></tr>
</table>

Program name	Description
Condition	Link: http://www.ct.gov/dph/cwp/view.asp?a=3115&q=387268&dphNav_GID=
Cardiovascular Health - Wisewomen	“In 2001, the State of Connecticut Department of Public Health’s Breast and Cervical Cancer Program expanded to include cardiovascular disease screening for uninsured and underinsured women age 40 to 64. Eight out of 14 contracted health care provider sites include WISEWOMAN programs. In addition to a clinical breast exam, Pap test, and mammogram, women who participate in the Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) Program receive screening for cardiovascular disease. This program provides women, who are found at risk for cardiovascular disease, an opportunity to participate in nutrition and physical activity interventions which will help decrease their risk of cardiovascular disease. Services included in this program are: • CVD Risk Assessment • Blood Pressure Screening • Lipid Screening • Blood Glucose Screening • Risk Reduction Counseling • Nutrition Counseling • Physical Activity Counseling • Referral for treatment if screening results are elevated.”
Diabetes	“The mission of the Connecticut Diabetes Prevention and Control Program (DPCP) is to create a comprehensive system of care for the prevention and treatment of diabetes. Our goal is to reduce the incidence or delay the onset of diabetes and its complications and enhance the quality of life for people affected by diabetes. History: Since 1994, with the funding and support of the Centers for Disease Control and Prevention, (CDC), the CT DPCP has worked with partners to increase diabetes awareness to the residents of Connecticut and to provide diabetes information to health care professionals. These efforts are aligned and coordinated with the Ten Essential Public Health Services and the Chronic Care Model. Program Goals: The Connecticut DPCP serves as a convener of the diabetes public health system. The CT DPCP strives to provide networking opportunities to members of the diabetes system of care in order to examine diabetes issues statewide and to share program successes. Specific goals are based on priorities established by the CDC and include: • Prevention of diabetes as per the Diabetes Prevention Program. • Prevention of the complications, disabilities and burden associated with diabetes by increasing the rates of eye exams, foot exams, A1C testing and influenza and pneumococcal vaccines. • Elimination of diabetes-related health disparities by working with Community Health Centers and other community based organizations working with disparate populations. • Maintaining a diabetes surveillance system. • Decreasing the rates of smoking in people with diabetes.

Program name	Description
Condition	Link: http://www.ct.gov/dph/cwp/view.asp?a=3115&q=387268&dphNav_GID=
Diabetes (Continued)	Administrative goals for the DPCP include: • Strategic planning to promote the diabetes state plan. • Collaboration and coordination with other chronic disease programs. • Provision of training and technical assistance to health care workers, community based organizations and others working on diabetes projects. • Promotion of social, environmental and systems approaches to diabetes prevention and control. • Implementation of health interventions. The CT DPCP goals and work plan are aligned with priorities of the CDC Division of Diabetes Translation. These include: • Improve access to effective lifestyle interventions. • Increase diabetes preventive behaviors. • Enhance community and environmental strategies to prevent diabetes. • Improve the health behavior and self-management practices of people with diabetes. • Enhance the access and delivery of effective preventive healthcare services. • Improve community and environmental strategies to support people with diabetes. • Improve the science of health and healthcare disparities related to diabetes. • Prioritize and disseminate public health strategies to eliminate disparities. • Build capacity for communication, evaluation, marketing, policy, and partnerships.”
Food Protection	“The Food Protection Program’s overall mission is to reduce the risk of foodborne disease by ensuring reasonable protection from contaminated food and improving the sanitary condition of food establishments. This is accomplished by enforcement of regulations, training and education, technical consultation, special investigations, and food safety promotion.”
Genomics	Genomic discoveries will continue to play an increasing role in disease prevention, detection, and treatment. For this reason, the Connecticut Department of Public Health developed a *Connecticut Genomics Action Plan* in 2005, and in 2008 created a *Public Health Genomics Office*. The Genomics Office will strive to integrate developing genomic technologies into public health policy, programs, and practice. The Office will also serve as a resource for health professionals and the public about the role of genomics in disease prevention and health improvement.

Program name	Description
Condition	Link: http://www.ct.gov/dph/cwp/view.asp?a=3115&q=387268&dphNav_GID=
Heart Disease and Stroke Prevention Program	"The Heart Disease and Stroke Prevention Program (HDSP) works to reduce the burden of heart disease and stroke among Connecticut residents. Heart disease and stroke are, respectively, the number one and three causes of death in Connecticut and the nation. In 2006, it is estimated that heart disease and stroke will cost the residents of Connecticut $4.7 billion dollars in medical expenses and lost productivity. The HDSP focuses on priorities and strategies established by the Centers for Disease Control and Prevention (CDC) to reduce the incidence of, and death and disability from, heart disease and stroke. The CDC priorities for heart disease and stroke prevention are: • Controlling high blood pressure • Controlling high blood cholesterol • Knowing the signs and symptoms, importance of calling 9-1-1 • Improving emergency response • Improving quality of care • Eliminating disparities The CDC's strategies to address these priorities include: • Facilitating collaboration among public and private sector partners. • Defining the cardiovascular disease (CVD) burden and assess existing population-based strategies for primary and secondary heart disease and stroke prevention. • Developing and updating a comprehensive heart disease and stroke prevention state plan addressing heart-healthy policies, changing physical and social environments, and eliminating disparities based on geography, gender, race or ethnicity, or income • Identifying culturally appropriate approaches to promote cardiovascular health (CVH) with racial, ethnic and other priority populations. • Increasing awareness of the signs and symptoms of heart attack and stroke PRIMARY STROKE CENTER (PSC) DESIGNATION PROGRAM The Primary Stroke Center (PSC) Designation Program is a quality initiative that addresses the public health need for acute care hospitals to ensure rapid diagnostic evaluation and treatment of stroke patients. To be designated a Primary Stroke Center a hospital must demonstrate the capacity to meet criteria adapted from the American Stroke Association practice standards and recommendations from the Brain Attack Coalition. The goal of the program is to decrease premature deaths and disabilities associated with stroke."
HEARTSafe Community Program	"The HEARTSafe Community program is intended to encourage all communities to strengthen every link in the cardiac "Chain of Survival" in their community." "Heartbeats are earned for CPR training, AED availability, and pre-hospital advanced life support."(excerpt from the brochure)

Program name	Description
Condition	Link: http://www.ct.gov/dph/cwp/view.asp?a=3115&q=387268&dphNav_GID=
HIV/AIDS	"HIV/AIDS Services in Connecticut: Connecticut receives funding from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) to provide prevention services and core medical/support services throughout the state. CDC funded Connecticut-based prevention services include evidence-based HIV prevention interventions targeting PLWHA, Men-Who-Have-Sex–With Men (MSM) African Americans, Latino/as, Youth, Inmates and those recently released to the community, and Injection Drug Users (IDUs); Counsel-ing Testing and Referral (CTR);Routine HIV Testing; Comprehensive Risk Counseling Services (CRCS), and Drug Treatment Advocacy, as well as statewide funded Syringe Exchange Programs and the Children's HIV Perinatal Health Initiative. Core medical services and support services are funded throughout Connecticut through grants from the Health Resources and Services Administration (HRSA). These services include core medical services such as outpatient/ambulatory, oral health care, local AIDS pharmaceutical assistance, early intervention services, health insurance cost sharing assistance, home health care, home and community-based health services, mental health, hospice, medical nutrition therapy, substance abuse-outpatient and medical case management. Support services include non-medical case management, child care services, emergency financial assistance, food bank/home-delivered meals, health education/risk reduction, housing services, legal services, linguistic/translation, medical transportation, outreach, and psychosocial support. "The DPH now convenes a Connecticut HIV Planning Consortium (CHPC) with a primary mission to conduct statewide planning and to facilitate information sharing across local, regional and statewide programs involved in HIV/AIDS care and prevention service delivery. CHPC is the statewide integrated care and prevention planning body that was officially introduced in October 2007. The DPH has charged the CHPC to develop this 2009-2012 statewide Comprehensive Plan for the delivery of HIV Care and Prevention services that informs the policy as well as Ryan White Part B and Prevention funding decisions implemented by DPH. The defining feature of this Plan is the full integration of care and prevention planning into one comprehensive statewide health planning document and a proactive action plan to address care and prevention service needs and gaps based on the recommendations proposed in the 2008 Statewide Coordinated Statement of Need (SCSN)." http://www.ct.gov/dph/lib/dph/aids_and_chronic/care/pdf/2009_2012_comprehensive_hiv_care_and_prevention_plan.pdf http://www.ct.gov/dph/cwp/view.asp?a=3135&Q=387012&PM=1 Note: The Webpage includes Links for Health Care and Support Services; HIV Prevention and Education; and HIV/AIDS Surveillance and Viral Hepatitis Prevention

Program name	Description
Condition	Link: http://www.ct.gov/dph/cwp/view.asp?a=3115&q=387268&dphNav_GID=
Injury Prevention	"The State of Connecticut Department of Public Health's Injury Prevention Program focuses on the Departmental Health Status Priority addressing the "reduction of the factors associated with intentional, unintentional and occupational injury". The Injury Prevention Program, following National recommendations for intentional and unintentional injury prevention, conducts community-based programs with contractors to address risk and resiliency factors associated with and implement strategies to decrease injury." "The Injury Prevention Program promotes, through collaborative relationships, environmental and policy change initiatives to prevent injury morbidity and mortality. Most Injury Prevention Programs, while population-based, are focused on defined geographical areas or populations served by community-based agencies and local health departments." "The Injury Prevention Program, in keeping with the national trend toward integrating the public health approach into prevention strategies, promoting interagency collaboration and utilizing successful model programs, will continue to work with interagency and interdisciplinary partners toward a broader population-based, wraparound approach for improving health and reducing death and disabilities due to injury."
Lyme Disease	"Lyme disease, first identified in Connecticut in 1975, continues to be an important public health concern. Surveillance maintained by the Department of Public Health has shown that we have the highest number of cases relative to the population of any state. The Department of Public Health (DPH) has had an active role in contributing to the understanding of Lyme disease and other diseases spread to people by ticks including ehrlichiosis and babesiosis." "In Connecticut, providing the public with information about vector borne diseases, including Lyme disease and its complex transmission cycle, involves three State agencies: the Department of Public Health, The Connecticut Agricultural Experiment Station, and the Department of Environmental Protection."
Obesity Prevention Program	DPH Receives Community Transformation Grant Funding (2011)-"The Centers for Disease Control and Prevention (CDC) awarded funding to 61 states and communities throughout the US to conduct community transformation activities to reduce chronic disease rates, prevent the development of secondary health conditions, and address health disparities. The Connecticut Department of Public Health was one of the 26 states and communities funded to build capacity in Connecticut's communities. All 61 grantees will address the following priority areas: 1) tobacco-free living; 2) active living and healthy eating; and 3) evidence-based quality clinical and other preventive services, specifically prevention and control of high blood pressure and high cholesterol Public Prevention Health Fund: Community Transformation Grant- "The purpose of this initiative is to create healthier communities by; 1) building capacity to implement broad evidence and practice-based policy, environmental, programmatic and infrastructure changes, as appropriate, in large counties, and in states, tribes and territories, including in rural and frontier areas and 2) supporting implementation of such interventions in five strategic areas (Strategic Directions) aligning with Healthy People 2020 focus areas and achieving demonstrated progress in the following five performance measures outlined in the Affordable Care Act:

Program name	Description
Condition	Link: http://www.ct.gov/dph/cwp/view.asp?a=3115&q=387268&dphNav_GID=
Obesity Prevention Program (Continued)	• changes in weight, • changes in proper nutrition, • changes in physical activity, • changes in tobacco use prevalence, and • changes in emotional well-being and overall mental health, as well as other program specific measures."
Oral Health	The Office of Oral Health promotes the oral health of Connecticut residents and the reduction of disease and health disparities to ensure the public's overall health and well-being. The vision of the office is to provide leadership and expertise in dental public health and maintain a strong and sustainable infrastructure to support essential public health activities related to oral health.
Sexually Transmitted Diseases	"The mission of the Sexually Transmitted Diseases (STD) Control Program is to reduce the occurrence of STDs through disease surveillance, case and outbreak investigation, screening, preventive therapy, outreach, diagnosis, case management, and education. The Department of Public Health mandates reporting of 5 STDs; syphilis, gonorrhea, chlamydia, neonatal herpes, and chancroid. Surveillance activities are conducted on the 3 most common STDs; syphilis, gonorrhea, and chlamydia, all of which can be cured with proper treatment."
Sickle Cell Disease	"The Connecticut Department of Public Health coordinates a statewide program, the Adult Sickle Cell Disease Program, to provide comprehensive coordination of adults with Sickle Cell Disease (SCD). This program focus is to improve adult SCD healthcare services and also provide advocacy for optimal use of State and federal resources into the future."
Tobacco use	DPH's Smoking/Tobacco use program "coordinates and assists state and local efforts to prevent people from starting to use tobacco, help current tobacco users quit, and reduce nonsmokers' exposure to second-hand and third-hand smoke."
Tuberculosis	The mission of the Connecticut Tuberculosis (TB) Control Program is to interrupt and prevent transmission of TB, prevent emergence of drug-resistant TB, and reduce and prevent death, disability, illness, emotional trauma, family disruption, and social stigma caused by TB. The TB Control Program works closely with local health authorities, home care agencies, providers of medical care, the Department of Corrections, and drug treatment facilities to assure that the program mission is accomplished. Through State funding, the Program provides anti-tuberculosis medications to hundreds of medical clinicians; reimburses clinicians for TB diagnostic treatment and prevention services for the uninsured; provides consultation on TB case management and screening to local health departments, prisons, convalescent/nursing homes, schools, universities, hospitals and other health care providers; and has a special TB Elimination Advisory Committee to help develop state-specific guidelines for TB treatment and prevention.

For Children	Link: http://www.ct.gov/dph/taxonomy/v4_taxonomy.asp?DLN=46942&dphNav=|46942|
Captain 5-a--Day	"Captain 5-a-Day is a super hero who is featured in audiotapes for children to encourage them to eat fruits and vegetables and to be physically active. His name reminds everyone to eat a total of five servings of fruit and vegetables and to exercise every day. Classroom activities packaged in an adventure box demonstrate that learning about new foods can be lots of fun. A parent workbook and video (in both English and Spanish) are included in the program. These materials were developed by the Connecticut Department of Public Health, in partnership with the Connecticut Department of Social Services and the U.S. Department of Agriculture."
Childhood Lead Poisoning	"The mission of the Connecticut Department of Public Health Lead Poisoning Prevention and Control Program continues to be to protect the health and safety of the people of Connecticut and to prevent lead poisoning and promote wellness through education and a wide range of program activities that relate to lead poisoning prevention and in particular, childhood lead poisoning prevention."
Children's Environmental Health	"Children face an array of potential exposures to toxic environmental hazards. Children are more at risk from exposure to environmental hazards. The CT DPH has a number of programs related to children's' environmental health" such as Asthma, Indoor quality, Lead, Radon, tobacco, child day care and drinking water. See Webpage link "DPH Resources for Children's Environmental Health" for details on the programs. http://www.ct.gov/dph/lib/dph/environmental_health/eoha/pdf/dph_resources_final_(2).pdf
Immunizations	"The mission of the Immunization Program is to prevent disease, disability and death from vaccine-preventable diseases in infants, children, adolescents and adults through surveillance, case investigation and control, monitoring of immunization levels, provision of vaccine, and professional and public education."
Nutrition	See Captain 5-a-day program above
WIC Program	"The Special Supplemental Nutrition Program for Women, Infants, and Children – better known as the WIC Program – serves to safeguard the health of low-income women, infants, and children up to age 5 who are at nutritional risk by providing nutritional assessment and education, referrals to health care and nutritious foods to supplement diets."

For Children	Link: http://www.ct.gov/dph/cwp/view.asp?a=3115&q=387268&dphNav_GID=
Early Childhood Partners	"The Connecticut Early Childhood Partners (ECP) initiative brought together eight State agencies and statewide institutions, under the leadership of the Department of Public Health and with extensive input from numerous community interests over the course of 18 months, to create a Strategic Plan to meet the needs of all families so their children arrive at school healthy and ready to succeed." "The plan was developed with funding and technical assistance from the State Early Childhood Comprehensive Systems Initiative (SECCS), launched by the Maternal and Child Health Bureau (MCHB) of the U.S. Department of Human Services in 2002. The Federal Maternal and Child Health Bureau awarded grants to all states to develop plans to provide leadership for the development of cross-service systems integration partnerships for early childhood support states and communities to build family-centered early childhood service systems that address the critical components of access to health, socio-emotional health, early care and education, parenting education, and family support services."
Early Hearing Detection and Intervention	"The Connecticut Early Hearing Detection and Intervention (EHDI) program strives to assure all babies are screened at birth, and that those with a hearing loss are diagnosed early and enrolled in an Early Intervention program, if eligible." "The goal of universal newborn hearing screening is to provide early hearing detection and intervention in an effort to prevent speech, language and other delays and support children in reaching their maximum potential."
Family Health History	"The Department of Public Health is joining the U.S. Surgeon General's Family History initiative to promote health and prevent disease for Connecticut's citizens. DPH is promoting this Family History initiative to encourage family discussion of their health history. Together with the U.S. Surgeon General, the Department of Public Health urges all Connecticut families to increase their awareness of the importance of family health history and to join together to protect their health."
Maternal and Child Health Block Grant	"The MCHB is the principal focus within HRSA for all Maternal and Child Health (MCH) activities within the Department of Health and Human Services. MCHB's mission is to provide national leadership through working in partnership with states, communities, public/private partners, and families, to strengthen the MCH infrastructure, and to build knowledge and human resources. Its mission also includes ensuring continued improvement in the health, safety, and well-being of the MCH population. To achieve its mission, MCHB directs resources towards a combination of direct health care services, enabling services, population-based services, and infrastructure or resource-building activities." "Each year, all States are required to submit an Application and Annual Report for federal funds for their MCH programs to the MCHB in the Health Resources and Services Administration (HRSA).
Newborn Genetic Screening	"The Newborn Screening Program consists of three components: Testing, Tracking, and Treatment. Specimens are tested at the Department of Public Health (DPH) State Laboratory and all abnormal results are reported to the DPH Tracking Unit who reports the results to the primary care providers and assures referrals are made to the State-funded Regional Treatment Centers." "The aim of this program is to screen all babies born in CT prior to hospital discharge or within the first 4 days of life and the goal is early identification of infants at increased risk for selected metabolic or genetic diseases so that medical treatment can be promptly initiated to avert complications and prevent irreversible problems and death."

Environmental Health	Link: http://www.ct.gov/dph/taxonomy/v4_taxonomy.asp?DLN=46944&dphNav=|46944|
Asbestos	The goal of the Asbestos Program is to reduce the chance of exposure to asbestos, which is known to cause cancer. Asbestos has been found in over 3,000 building materials and products. Asbestos-containing materials (ACM) are still brought into the United States and can commonly be found in existing buildings." "The Asbestos Program makes sure that asbestos is removed properly as required by law. The Asbestos Program works together with the Environmental Practitioner Licensing Unit to license and regulate asbestos abatement contractors and asbestos consultants. The Asbestos Program is also responsible for ensuring that asbestos-containing materials in schools are correctly managed. These regulations apply to all public and private, not-for-profit schools for grades kindergarten to grade 12 (K-12)."
Day Care SAFER Program	"The Child Day Care SAFER Program is an initiative to identify licensed child day cares that are operating on land or in buildings that could be impacted by hazardous chemicals. The SAFER Program also works to ensure that new day cares are located in places that are safe from hazardous chemicals left by past (or current) operations. We are also using the SAFER Program to help child day cares be more environmentally safe and green."
Environmental Hazards	"There are many man-made and naturally occurring chemicals in our environment that can harm our health. These hazards can be in the air we breathe, the water we drink, the food we eat or the products we use in our homes and yards or the schools our children attend. DPH has programs to evaluate these chemicals in the environment, assess whether exposures are significant enough to cause harm, and provide health education information so the public can be better informed about these hazards and how to avoid them."
Environmental Laboratories	"The Environmental Laboratory Certification Program mission is to promote the benchmark by which accurate, precise, and legally defensible analytical data is reported by the environmental laboratory industry for use in compliance and in accordance with federal and State law. This is accomplished by ensuring that environmental laboratories located in or doing business in CT meets all applicable EPA and CT standards."
Fish Program	"The Connecticut Department of Public Health issues a yearly advisory for decreasing fish consumption when chemical levels are unsafe. Fish from Connecticut waters are a good low cost source of protein. Unfortunately, fish can take up (bio-accumulate) chemicals such as mercury and polychlorinated biphenyls (PCBs) that may affect your family's health. The following fact sheets provide information on the advisory, including how to eat fish safely."
Food Protection	"The Food Protection Program's overall mission is to reduce the risk of foodborne disease by ensuring reasonable protection from contaminated food and improving the sanitary condition of food establishments. This is accomplished by enforcement of regulations, training and education, technical consultation, special investigations, and food safety promotion."
Healthy Homes	"The Connecticut Department of Public Health Healthy Homes Initiative is a holistic and comprehensive approach designed to address the connection between housing and health. The goal of the Healthy Homes Initiative is to promote health and well-being through safe and healthy home environments. This is accomplished by addressing physical, chemical, and toxic hazards in the home through a variety of programs."

Environmental Health (Continued)	Link: http://www.ct.gov/dph/taxonomy/v4_taxonomy.asp?DLN=46944&dphNav=|46944|
Lead	See Childhood Lead Poisoning above
Mosquito Management	See West Niles virus above.
Occupational Health	"Workplace Hazard Assessment Program The Connecticut Department of Public Health offers health and safety evaluations for all Connecticut employers free of charge. These non-regulatory on-site evaluations are designed both to assist Connecticut employers with identifying potential workplace hazards and to provide recommendations for implementing or improving appropriate controls to enhance their existing health and safety efforts. If you are an employer, collective bargaining representative/union officer, or physician treating a current employee, and are interested in learning more about the Workplace Hazard Assessment Program, please read the information below."
Radon	"The CT DPH Radon Program's mission is to promote radon awareness, testing, mitigation, and radon-resistant new construction throughout the state in order to reduce the number of radon-induced lung cancer deaths in Connecticut."
Other	http://www.ct.gov/dph/cwp/view.asp?a=3115&q=387268&dphNav_GID=
Behavioral Risk Factor Surveillance System (BRFSS)	BRFSS Turning Information into Health "The BRFSS is an ongoing telephone survey of adults conducted in all 50 states and coordinated by the Centers for Disease Control and Prevention (CDC) in Atlanta, GA." "The BRFSS originally collected data on health behaviors related to the leading causes of death, but has since been expanded to include issues related to health care access, utilization of preventive health services, and to address emerging issues such as cigar smoking or diet pill use."
Preventive Health and Health Services (PHHS) Block Grant	"The Preventive Health and Health Services (PHHS) Block Grant provides funding for health problems in Connecticut that range from childhood lead poisoning prevention to youth violence and suicide protection. PHHS Block Grant dollars fund a total of 9 different Connecticut health programs."
Refugee and Immigrant Health	"The Department of Public Health's (DPH) Refugee and Immigrant Health Program, under the supervision of the Tuberculosis Control Program, is the public health component of Connecticut's Refugee Assistance Program. The Refugee and Immigrant Health Program provides annual reports on identified refugee health issues to the Department of Social Services, which is the lead State agency for refugee issues. The program cooperates with and complements the State Refugee Resettlement Plan by ensuring that refugee health problems are addressed promptly. This decreases the likelihood of any adverse effects on the public's health and addresses the personal health of refugees so that each refugee may begin to pursue a productive life in the United States under optimal health circumstances."

Appendix T

Acute Care General Hospital Psychiatric Days, Discharges and Beds, FFY 2011

General Hospital	Patient Days Ages 0-17	Patient Days Ages 18+	Patient Days Total	Discharges Ages 0-17	Discharges Ages 18+	Discharges Total	Staffed[a] Beds Ages 0-17	Staffed Beds Ages 18+	Staffed Beds Total	Available[a] Beds Ages 0-17	Available Beds Ages 18+	Available Beds Total
Backus	0	4,597	4,597	0	634	634	0	18	18	0	20	20
Bridgeport	0	5,985	5,985	0	705	705	0	17	17	0	19	19
Bristol	0	4,640	4,640	0	1,038	1,038	0	14	14	0	16	16
Charlotte Hungerford	16	4,205	4,221	3	696	699	0	14	14	0	17	17
Conn. Children's	0	0	0	0	0	0	0	0	0	0	0	0
Danbury	53	6,217	6,270	14	732	746	1	18	19	1	22	23
Day Kimball	0	4,097	4,097	0	685	685	0	14	14	0	15	15
Greenwich	0	0	0	0	0	0	0	0	0	0	0	0
Griffin	0	3,989	3,989	0	500	500	0	11	11	0	16	16
Hartford	**8,493**	**28,341**	**36,834**	**1,102**	**3,140**	**4,242**	**24**	**78**	**102**	**29**	**94**	**123**
Hospital of Central CT	0	6,838	6,838	0	790	790	0	22	22	0	24	24
John Dempsey	0	5,683	5,683	0	809	809	0	16	16	0	25	25
Johnson	0	3,492	3,492	0	562	562	0	17	17	0	20	20
Lawrence & Memorial	0	4,800	4,800	0	374	374	0	18	18	0	18	18
Manchester	1,348	**8,284**	9,632	198	**1,218**	**1,416**	5	**26**	31	10	**26**	36
MidState	0	1,835	1,835	0	283	283	0	6	6	0	6	6
Middlesex	0	6,026	6,026	0	733	733	0	17	17	0	20	20
Milford	0	0	0	0	0	0	0	0	0	0	0	0
New Milford	0	0	0	0	0	0	0	0	0	0	0	0
Norwalk	6	3,245	3,251	1	506	507	0	9	9	0	22	22
Rockville	0	0	0	0	0	0	0	0	0	0	0	0
Saint Francis	**4,755**	**10,686**	**15,441**	**461**	**1,457**	**1,918**	**20**	**55**	**75**	**20**	**55**	**75**
Saint Mary	0	3,999	3,999	0	597	597	0	12	12	0	12	12

General Hospital	Patient Days Ages 0-17	Patient Days Ages 18+	Patient Days Total	Discharges Ages 0-17	Discharges Ages 18+	Discharges Total	Staffed[a] Beds Ages 0-17	Staffed Beds Ages 18+	Staffed Beds Total	Available[a] Beds Ages 0-17	Available Beds Ages 18+	Available Beds Total
Saint Raphael	**5,435**	7,904	**13,339**	**467**	672	1,139	**15**	22	**37**	**23**	25	**48**
Saint Vincent	**4,809**	**24,234**	**29,043**	**386**	**2,551**	**2,937**	**17**	**75**	**92**	**17**	**75**	**92**
Sharon	0	3,399	3,399	0	274	274	0	12	12	0	12	12
Stamford	0	5,033	5,033	0	579	579	0	17	17	0	20	20
Waterbury	1,133	5,690	6,823	142	717	859	5	25	30	5	25	30
Windham	0	0	0	0	0	0	0	0	0	0	0	0
Yale-New Haven	**4,284**	**26,515**	**30,799**	**306**	**2,668**	**2,974**	**12**	**73**	**85**	**15**	**73**	**88**
Totals	30,332	189,734	220,066	3,080	22,920	26,000	99	606	705	120	677	797

Source: OHCA Hospital Reporting System (HRS), Report 400 for Fiscal Year 2011

The numbers bolded in each column represent the five highest numbers for each category (e.g., the five highest Psychiatric Patient Days Ages 0 - 17 for FY 2011)

[a]Hospitals are licensed for a specific number of beds, but have fewer beds physically set up and "available" for use and may operate or staff fewer beds than available.

Appendix U
DMHAS Local Mental Health Authorities

The following information is based upon the DMHAS webpage at www.ct.gov/dmhas.

The Department of Mental Health and Addiction Services operates and/or funds Local Mental Health Authorities (LMHAs) offering a wide range of therapeutic programs and crisis intervention services throughout the state. There are also many private non-profit agencies that can be accessed through each of the LMHAs. In addition, DMHAS operates inpatient treatment facilities for persons with severe addiction and/or psychiatric problems: State-Operated Inpatient Treatment Facilities.

REGION ONE

ADMINISTRATIVE OFFICE:
The administrative office equals the LMHA in Region One.

SOUTHWEST CT MENTAL HEALTH SYSTEM
97 Middle Street
Bridgeport, CT 06604
PH: 203-579-7300 Fax: 203-579-6305

F.S. DUBOIS CENTER (State operated)
780 Summer Street
Stamford, CT 06905

For general information: **203-388-1600**
Fax: 203-388-1681
To inquire re: crisis services: **203-358-8500**

Catchment Area 1 and 2: Serving the towns of Byram, Cos Cob, Darien, East Norwalk, East Portchester, Georgetown, Glenbrook, Glenville, Green Farms, Greenwich, New Canaan, Noroton, Noroton Heights, Norwalk, Old Greenwich, Riverside, Rowayton, Saugatuck, South Norwalk, Springdale, Stamford, Weston, Westport, and Wilton.

GREATER BRIDGEPORT COMMUNITY MENTAL HEALTH CENTER (State operated)
1635 Central Avenue
Bridgeport, CT 06610
For general information: **203-551-7400**
To inquire re: services **203-551-7507 (8am to 6pm)**

COMMUNITY-BASED SERVICES (State operated)
97 Middle Street
Bridgeport, CT 06604
PH: 203-579-7300

Catchment Area 3 and 4: Serving the towns of Bridgeport, Easton, Fairfield, Monroe, Nichols, Southport, Stepney, Stevenson, Stratford, and Trumbull.

REGION TWO

BHCARE (VALLEY OFFICES)(formerly Birmingham Health Servicers) (private non-profit)
435 East Main Street
Ansonia, CT 06401
PH: 203-736-2601 FAX: 203-736-2641
Catchment Area 5: Serving the towns of Ansonia, Derby, Oxford, Seymour and Shelton.

BHCARE (SHORELINE OFFICES) (private non-profit)
14 Sycamore Way
Branford, CT 06405
PH: 203-483-2630 FAX: 203-483-2659
Catchment Area 8: Serving the towns of Branford, East Haven, Guilford, Madison, North Branford, and North Haven

BRIDGES...A COMMUNITY SUPPORT SYSTEM, INC.
(private non-profit)
949 Bridgeport Ave.
Milford, CT 06460
PH: 203-878-6365 FAX: 203-877-3088
Catchment Area 6: Serving the towns of Milford, Orange and West Haven.

CONNECTICUT MENTAL HEALTH CENTER
34 Park Street
New Haven, CT 06790
PH: 203-974-7300
24 Hour Crisis Service: 203-974-7735 or -7713
(9am-10pm)
PH: 203-974-7300 (10pm-8am)
Catchment Area 7: Serving the towns of Bethany, Hamden, New Haven and Woodbridge.

RUSHFORD CENTER (private non-profit)
883 Paddock Ave.
Meriden, CT 06450
PH: 203-630-5280 FAX: 203-634-7040
Catchment Area 9: Serving the towns of Meriden and Wallingford

RIVER VALLEY SERVICES (State operated)
Leak Hall, P.O. Box 351
Middletown, CT 06457
PH: 860-262-5200 FAX: 860-262-5203

RIVER VALLEY SERVICES-OLD SAYBROOK OFFICE
2 Center Road West
Old Saybrook, CT 06475
PH: 860 395-5040

REGION THREE

SOUTHEASTERN MENTAL HEALTH AUTHORITY
(State operated)
401 West Thames Street, Building 301
Norwich, CT 06360
PH: 860-859-4500 FAX: 860-859-4797
Catchment Area 11 & 12: Serving the towns of Bozrah, Colchester, East Lyme, Franklin, Griswold, Groton, Ledyard, Lisbon, Montville, New London, North Stonington, Norwich, Preston, Salem, Sprague, Stonington, Voluntown, and Waterford

UNITED SERVICES (private non-profit)
1007 North Main Street
P.O. Box 839
Dayville, CT 06241
PH: 860-774-2020 FAX: 860-774-0826
Catchment Area 13 & 14: Serving the towns of Ashford, Brooklyn, Canterbury, Chaplin, Columbia, Coventry, Eastford, Hampton, Killingly, Lebanon, Mansfield, Plainfield, Pomfret, Putnam, Scotland, Sterling, Thompson, Union, Willington, Windham, and Woodstock.

REGION FOUR

COMMUNITY HEALTH RESOURCES
(private non-profit)
995 Day Hill Road
Windsor, CT 06095
PH: 877-884-3571 Fax: 860-731-5536

Programs under Community Health Resources:

GENESIS CENTER, INC.
587 East Middle Turnpike
Manchester, CT 06040
PH: 860-646-3888 FAX: 860-645-4132
Catchment Area 15: Serving the towns of Amston, Andover, Bolton, Buckland, Ellington, Hebron, Manchester, Rockville, South Windsor, Talcottville, Tolland, Vernon, and Wapping.

NORTH CENTRAL COUNSELING SERVICES
47 Palomba Drive
Enfield, CT 06082
PH: 860-253-5020 FAX: 860-253-5030
Catchment Area 17: Serving the towns of Bloomfield, Broad Brook, East Granby, East Hartland, East Windsor, Enfield, Granby, Hazardville, Melrose, North Granby, Poquonock, Scitico, Somers, Somersville, Stafford, Stafford Springs, Staffordville, Suffield, Thompsonville, Warehouse Point, West Granby, West Suffield, Wilson, Windsor, Windsor Locks, and Windsorville.

INTERCOMMUNITY MENTAL HEALTH GROUP
(private non-profit)
281 Main Street
East Hartford, CT 06118
PH: 860-569-5900 FAX: 860-569-5614
Catchment Area 16: Serving the towns of East Glastonbury, East Hartford, Glastonbury, Maple Hill, Marlborough, Newington, Rocky Hill, South Glastonbury, and Wethersfield.

CAPITOL REGION MENTAL HEALTH CENTER
(State operated)
500 Vine Street
Hartford, CT 06112
PH: 860-297-0800 FAX: 860-297-0914
24 Hour Crisis Service: 860-297-0999
Catchment Area 18 and 23: Serving the towns of Avon, Canton, Canton Center, Collinsville, Elmwood, Farmington, Hartford, Simsbury, Tariffville, Unionville, Weatogue, West Hartford, and West Simsbury.

COMMUNITY MENTAL HEALTH AFFILIATES, INC. (private non-profit)
Administration Offices
29 Russell Street
New Britain, CT 06052
PH: 860-826-1358 FAX: 860-229-6575
OUTPATIENT SERVICES
55 Winthrop Street
New Britain, CT 06052
PH: 860-224-8192
Catchment Area 19: Serving the towns of Berlin, Bristol, Burlington, East Berlin, Kensington, Marion, Milldale, New Britain, Pequabuck, Plainville, Plantsville, Plymouth, Southington and Terryville

REGION FIVE

ADMINISTRATIVE OFFICE: The administrative office oversees the LMHAs in Region Five.

WESTERN CT MENTAL HEALTH NETWORK
Rowland State Government Center Rowland State Government Center
55 West Main Street, Suite 410
Waterbury, CT 06702-2004
PH: 203-805-6400 FAX: 203-805-6432

WESTERN CT MENTAL HEALTH NETWORK - WATERBURY AREA (State operated)
95 Thomaston Ave.
Waterbury, CT 06702
PH: 203-805-5300 FAX: 203-805-5310
Catchment Area 20: Serving the towns of Beacon Falls, Bethlehem, Cheshire, Lakeside, Middlebury, Naugatuck, Oakville, Oxford, Prospect, South Britain, Southbury, Thomaston, Union City, Waterbury, Watertown, Waterville, Wolcott and Woodbury.

WESTERN CT MENTAL HEALTH NETWORK - DANBURY AREA (State operated)
78 Triangle Street, Bldg. I-4
Danbury, CT 06810
PH: 203-448-3200 FAX: 203-448-3199
Catchment Area 21: Serving the towns of Bethel, Botsford, Bridgewater, Brookfield, Brookfield Center, Danbury, Gaylordsville, Hawleyville, New Fairfield, New Milford, Newtown, Redding, Redding Center, Redding Ridge, Ridgefield, Roxbury, Sandy Hook, Sherman, West Redding.

WESTERN CT MENTAL HEALTH NETWORK - TORRINGTON AREA(State operated)
240 Winsted Road, Third Floor
Torrington, CT 06790
PH: 860-496-3700 FAX: 860-496-3800
Catchment Area 22: Serving the towns of Bantam, Barkhamsted, Canaan, Colebrook, Cornwall, Cornwall Bridge, Falls Village, Goshen, Hartland, Harwinton, Kent, Lakeville, Limerock, Litchfield, Marble Dale, Morris, New Hartford, New Preston, Norfolk, North Canaan, North Kent, Northfield, Pine Meadow, Pleasant Valley, Riverton, Salisbury, Sharon, South Kent, Taconic, Torrington, Warren, Washington, Washington Depot, West Cornwall, West Goshen, Winchester, Winchester Center, Winsted