

Application
For
Certificate of Need (CON)

Received by OHCA
on 4/29/16

Submitted to the

State of Connecticut
Department of Public Health
Office of Healthcare Access

April 28, 2016

by

Health Core Group, LLC

32 John Henry Lane
Milford, CT 06461

ORIGINAL COPY

Application Checklist

Instructions:

1. Complete the following checklist and submit as the first page of the CON application:
 - Attached is a paginated hard copy of the CON application (all social security numbers must be redacted), including a completed affidavit, signed and notarized by the appropriate individuals.
 - Included is a completed supplemental application form for Establishment of a New Health Care Facility (Mental Health and/or Substance Abuse Treatment)
 - Attached is the CON application filing fee in the form of a check made out to the "Treasurer State of Connecticut" in the amount of \$500.
 - Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. **[See ATTACHMENT I]**
 - Attached is a completed Financial Worksheet B **[See ATTACHMENT II]**
 - Submission includes one (1) original hard copy placed in a 3-ring binder [per Steven Lazarus, OHCA].
 - The following have been submitted on a USB drive:
 1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format; and
 2. An electronic copy of the completed application forms in **MS Word** (the applications) and **MS Excel** (Financial Worksheet)

For OHCA Use Only:

Docket No.: _____
OHCA Verified by: _____

Check No.: _____
Date: _____

General Information

Name of Applicant:

Name of Co-Applicant:

Health Core Group, LLC

None

Connecticut Statute Reference:

Main Site	MAIN SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
	Westport	None	Sober House	Westport House
	STREET & NUMBER			
	9 Fragrant Pines Court			
	TOWN			ZIP CODE
	Westport			06880

Project Site	PROJECT SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME
	Westport	None	Outpatient Office	Westport Behavioral Health
	STREET & NUMBER			
	162 Kings Highway North			
	TOWN			ZIP CODE
	Westport			06880

Operator	OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)	
	None	Sober House	Health Core Group, LLC	
	STREET & NUMBER			
	32 John Henry Lane			
	TOWN			ZIP CODE
	Milford			06461

Chief Executive	NAME		TITLE	
	Albert Samaras		Executive Director	
	STREET & NUMBER			
	32 John Henry Lane			
	TOWN		STATE	ZIP CODE
	Milford		CT	06461
	TELEPHONE	FAX	E-MAIL ADDRESS	
888.302.6790	203.557.8631	asamaras@westportsoberhouse.com		

Is the applicant an existing facility? If yes, attach a copy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	See ATTACHMENT III
Does the Applicant have non-profit status? If yes, attach documentation.	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Identify the Applicant's ownership type.	PC <input type="checkbox"/> LLC <input checked="" type="checkbox"/> Corporation <input type="checkbox"/>	Other: _____
Applicant's Fiscal Year (mm/dd)	Start: 01/01	End: 12/31

Contact:

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

Contact Information	NAME		TITLE	
	Peter B Rockholz		Consultant	
	STREET & NUMBER			
	81 Bowman Drive			
	TOWN		STATE	ZIP CODE
	Greenwich		CT	06831
	TELEPHONE		FAX	E-MAIL ADDRESS
	203.313.1418		203.532.5576	pbrmssw@aol.com
RELATIONSHIP TO APPLICANT		Contractor		

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

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

Affidavit

Applicant: Health Core Group, LLC

Project Title: Westport House Outpatient

I, Albert Samaras, Executive Director (CEO) of Health Core Group, LLC being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.



Signature

1/18/16

Date

Subscribed and sworn to before me on January 22, 2016



Notary Public/Commissioner of Superior Court

My commission expires: **ROBERT C. HAUCK**
NOTARY PUBLIC OF CONNECTICUT
~~My Commission Expires 1/31/2018~~

Executive Summary

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

The Applicant, Health Core Group, LLC (d/b/a Westport Behavioral Health) -- a Connecticut corporation -- proposes to establish a new outpatient treatment facility for adults with behavioral health disorders in Westport, Connecticut beginning on or after July 1, 2016.

Health Core Group, LLC has operated sober living residences in Westport since 2014, with a total of 33 beds. It does not currently provide clinical services, and is not currently required to hold a license. The residents of these homes (i.e., Westport House) are the primary target population of the proposed service. All are self-pay and/or insured clients, most of whom are admitted following inpatient treatment episodes at facilities across the country. They move in with the anticipated stay of 9-12 months and are therefore considered to be residents of Westport.

Westport Behavioral Health has signed a lease for space in a medical office building within walking distance of Westport House, has contracted with a medical director, clinical director and a licensed clinical social worker, and is prepared to obtain DPH licenses to begin providing outpatient services.

Services will include an organized intensive outpatient treatment (IOT) program designed to meet the unique needs of young adult males in need of continuing treatment and care for substance use disorders (SUD) and co-occurring mental health disorders (COD). The project anticipates serving a minimum of 66 individuals per year.

Current Westport House residents have been receiving a lower level-of-care (i.e., outpatient counseling) than has been determined to be medically necessary. IOT services specifically for self-paying, young adult male clients are not readily available in the service area. The proposed services will not duplicate, nor have a negative impact on, existing services or referral patterns in the area.

The Applicant is fiscally sound and will realize incremental gains from the point of start-up; and will establish a charity care fund to assist those who are unable to meet the full cost of care. The executive director has a strong business background, including in this industry -- with experience implementing a similar project in New Haven.

The proposed service will improve: access to and coordination of patient care; quality, accessibility and cost-effectiveness of health care in the region; and patient choice and outcomes. It is consistent with DPH regulations, and aligned with both the DPH Facilities Plan and the State Health Improvement Plan (SHIP). It will meet a well-documented and increasing need for addiction treatment at a time when we are experiencing an unprecedented national public health crisis -- an epidemic of opiate dependence and related mortality.

Project Description

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

Health Core Group, LLC (d/b/a Westport Behavioral Health) -- which currently operates three sober recovery and transitional houses for young adults in Westport, Connecticut (hereinafter referred to collectively as "Westport House") -- proposes to establish an outpatient behavioral health treatment facility primarily to provide medically-necessary services to residents of Westport House. These include individuals with primary substance use disorders (SUD) and co-occurring mental health disorders (COD). Most of these individuals move into our sober house(s) following inpatient treatment episodes at hospitals or addiction rehabilitation centers across the country, and become residents of Westport by virtue of the fact that they enter with anticipated minimum durations of nine-to-twelve months. The primary geographic area to be served by this proposal, therefore, includes Westport Connecticut¹.

Necessity

The determination of the necessity for this proposal emerged as Westport House leadership learned of the need and demand for a service that its residents were not currently receiving. A convergence of the following four factors suggested a compelling need for the service we propose:

1. Medical/clinical necessity -- The first 30 residents of Westport House received individual counseling by local therapists -- some of whom provided services at the sober living facility. As the medical (including clinical) needs of these residents became more evident, the therapists indicated there was a collective need for a higher level-of-care (e.g., intensive outpatient treatment (IOT)) and for a more structured and integrated program of services. The proposed services will be supervised directly by an addiction psychiatrist (M.D.) who will validate the medical necessity of the services to be provided. An initial review indicates the nearly universal need for ASAM level II.1² treatment among newly admitted residents.
2. Consumer preference -- Westport House residents include primarily individuals and their families who are able to meet the cost of residential care and outpatient treatment out-of-pocket -- with or without insurance benefit support. They demand an exceptional quality of care and expect the best possible results. They prefer a high level of customer service including being able to receive timely, succinct and complete updates on residents' progress and prognosis.
3. Continuity and coordination of care -- current industry best practices include providing

1 Additional individuals from the surrounding area who are in need of professional intensive outpatient services, and desire to receive services at Westport Behavioral Health, may be served but are not the population target of this application.

2 American Society of Addiction Medicine Patient Placement Criteria, Revised (ASAM PPC-2R); level II.1 -- Intensive Outpatient Treatment

seamless step-down care following a primary treatment episode at a higher level-of-care. It also includes the assurance of quality and efficiency through offering a service that is dedicated to the unique needs of a target population. In our case, this includes addressing the developmental needs of young adults, and the gender-specific needs of men. Furthermore, individuals in continuing care following a primary course of treatment share common issues and concerns. In addition, they are in an excellent position to benefit by sharing the experiences of readjusting to life in the community while living in a sober residence dedicated to facilitating sustained recovery.

4. Industry trending – Health Core Group leadership maintains relationships and association memberships with similar organizations, nationwide. It has learned that the proposed service is emerging as a best practice and is increasingly becoming a preferred model of care in other states (e.g., Florida, Texas, California, Connecticut).

Benefits for the Applicant

There are two major anticipated benefits, to be realized by the Applicant, that will have a positive impact on client care, including:

1. Customer satisfaction – the more satisfied our clients are, the more likely they will be to maintain contact and to feel hopeful for sustained recovery. This will result in improved client outcomes.
2. Reputation – by providing a clinically appropriate and high quality continuing care service, our reputation within the referent and professional communities will strengthen nationally – resulting in a robust and sustained referral base.

Key Elements of the Proposal

The Westport Behavioral Health facility will provide developmentally-appropriate (i.e., young adult) and gender-specific (i.e., male) outpatient substance abuse treatment services including individual, group and family therapy, and recovery-supportive rehabilitation services such as: recreational, psycho-educational, educational, vocational and creative arts – individually coordinated through case management services.

Treatment services will be offered along a continuum from once-per-week individual counseling to intensive outpatient treatment (IOT). The latter will include a minimum of three (3), 3-hour sessions per week (minimum: 9 hours per week) with additional services based upon needs identified in individual treatment plans. IOT will be delivered within a structured program including case management, urine drug screening, medication monitoring and cognitive-behavioral therapy.

Westport Behavioral Health has begun to prepare to operate within leased medical offices that are within walking distance of the Westport House sober living homes. It is anticipated that a certificate of occupancy (CO) will be issued by the end of May 2016. Westport Behavioral Health has begun to hire or contract with key staff members. If we are able to obtain both a certificate of need (CON) and licensing from the Connecticut Department of Public Health (DPH), we hope to be able to begin providing services July 1, 2016.

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

On or about July 1, 2015, when Westport House completed its first 12 months of operations, and the facility (Health Core Group, LLC) realized stable financial viability, consideration was given to establishing a dedicated outpatient treatment facility to provide the continuing clinical services desired and needed by Westport House residents. Following the similar experience of owner Albert Samaras at Turning Point in New Haven, he began developing a business plan and executing a search for appropriate medical offices within close proximity to the sober living facilities.

In October, 2015, Mr. Samaras identified a potential site and since that time has accomplished the following key steps toward establishing the new facility:

- Ensured adequate, self-funded financial means to provide start-up and transitional operating funding
- Entered into contracts with both a medical director and a clinical director
- Signed a lease for the proposed facility site
- Hired a Director of Clinical Operations
- Developed an initial scholarship policy for outpatient participants in need of financial assistance

3. Provide the following information:

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

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
Outpatient Treatment	162 Kings Highway North, Westport, CT 06880	Adults with substance use disorders and related co-occurring mental disorders	Mon-Fri 9am-9pm Sat 9am-1pm	New service

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

TABLE 2
SERVICE AREA TOWNS

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

Town	Reason for Inclusion
Westport	Location of residence for clients of Westport House facilities in need of continuing treatment and care for substance use disorders.

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

The following licenses will need to be obtained from the Department of Public Health (DPH) in order to implement this proposal:

- Private, freestanding outpatient facility for the treatment of substance abusive or dependent persons
- Private, freestanding psychiatric outpatient clinic for adults

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

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

Health Core Group, LLC does not currently hold a license issued by the Department of Public Health.

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

The following key individuals are engaged to implement the proposed services. Copies of their Curriculum Vitae appear in *ATTACHMENT IV*

- Albert Samaras, Executive Director
- Ava Diamond, LCSW, Clinical Director
- Joseph A. Russo, M.D., Medical Director
- Liz Modugno, LCSW, Clinical Therapist

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

The following key articles, supporting the need for the proposed service, appear in *ATTACHMENT VII*:

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

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

The 2013 *National Survey on Drug Use and Health (NSDUH)* – this federally funded study clearly documents the need for substance use disorder (SUD) treatment, nationally. The most relevant pages (92-98) of *Section 7.3 Need for and Receipt of Specialty Treatment* are provided in *ATTACHMENT VII*. This section addresses the need for treatment for

illicit drug and alcohol use both separately and combined. The benchmark findings relevant to this application include:

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

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

- About 243,000 or 8.1% of all Connecticut individuals were dependent on or abused alcohol
- About 83,000 or 2.8% of all Connecticut individuals were dependent on or abused illicit drugs
- Of all Connecticut individuals with alcohol dependence or abuse, 94.0% did not receive treatment
- Of all Connecticut individuals with illicit drug dependence or abuse, 79.5% did not receive treatment

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

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

d. *letters of support for the proposal;*

Letters of support for this proposal have been obtained from the following, and copies appear in *ATTACHMENT X*:

- Susan Gallant, MSW, Primary Recovery Services, Monroe, CT
- Mike Nowakowski, former client, Westport, CT
- Lisa Arnold, MFT, LADC, Fairfield University, Fairfield, CT

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

The most relevant and current standards of practice applicable to the proposed project are outlined in *Treatment Improvement Protocol (TIP) 47*, published by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2006)³. This publication, titled *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment*, clearly identifies fourteen Principles of Intensive Outpatient Treatment. An excerpt from this publication, codifying the principles, appears in *ATTACHMENT V*. Below is a brief description of how Westport Behavioral Health proposes to meet these guidelines.

Principles of Intensive Outpatient Treatment (IOT):

(1) Make treatment readily available.

Westport Behavioral Health IOT service availability will be guaranteed for the target population, with initial sessions scheduled in advance, for all clients referred directly from Westport House sober living services. Intake sessions will occur within 24 hours.

(2) Ease entry.

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

(3) Build on existing motivation.

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

(4) Enhance therapeutic alliance.

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

(5) Make retention a priority.

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

(6) Assess and address individual treatment needs.

An important component of the IOT program will be case management. Along with a

³ Center for Substance Abuse Treatment. Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Treatment Improvement Protocol (TIP) Series 47. DHHS Publication No. (SMA) 06-4182. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

comprehensive, ongoing clinical assessment, and individual treatment plans, the primary clinician will be responsible for coordinating needed rehabilitative and recovery support services in the community.

(7) Provide ongoing care.

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

(8) Monitor abstinence.

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

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

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

(10) Use medications if indicated.

The Westport Behavioral Health Medical Director is an addiction psychiatrist (MD) with considerable experience working with individuals experiencing addiction and co-occurring mental disorders. He is a qualified prescriber of naltrexone and buprenorphine/naloxone. While he recognizes the professional literature supports the combination of evidence-based psycho-social therapy and medication-assisted treatment, he takes a conservative approach to the use of medications including avoiding those with abuse potential, and provides client education.

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

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

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

Family interventions, family therapy and family education will be offered to Westport Behavioral Health clients through licensed clinical social workers and family therapists according to individual treatment plans. As appropriate, families will be invited to visit the facility to address the individual goals and continuing care needs of the client. For those who are distant from their family members and/or significant others, Westport

Behavioral Health may employ telemedicine and/or telephonic/SKYPE voice/video interface to enhance the quality of distance therapy. As appropriate, those area employers who are 'recovery friendly' and supportive of the program, will be engaged to provide support through properly authorized communication with staff.

(13) Incorporate evidence-based approaches.

Westport Behavioral Health utilizes an approach that incorporates research-supported practices, clinical experience, client preferences and feedback as evidence upon which to base the selection of approaches for each individual. This is known as 'evidence based practice' as a process. Through this process, individual 'evidence-based' interventions may be selected on an individual client basis. The only 'wholesale' evidence-based component will be Twelve-Step Facilitation. In addition, Westport Behavioral Health will typically utilize additional, select practices such as Motivational Interviewing (MI), Cognitive-Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT), among others.

(14) Improve program administration.

Westport Behavioral Health benefits from the existing administrative infrastructure of Health Core Group, LLC (d/b/a Westport Behavioral Health) which has operated since 2014. Its executive director has considerable business and hands-on experience in developing and managing services to individuals with addictions in Connecticut. Westport Behavioral Health will draw upon the talents of individuals with extensive executive, managerial and supervisory experience. The executive director and clinical director (see attached curriculum vitae) will provide expert guidance to facility staff.

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

Referrals for the proposed outpatient service will come primarily from Westport House – an internal source.

Health Core Group, LLC has developed key referral and transfer arrangements with local providers. Copies of written agreements with those currently implemented appear in *ATTACHMENT VI* including the following:

- Norwalk Hospital (emergency medical and psychiatric services)
- Progressive Diagnostics, LLC (urine drug testing)

Public Need and Access to Care

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

While no standards of the Department of Public Health (DPH) exist that are directly applicable to the proposed project, it is required to be consistent with the following sections of the DPH Regulations (Public Health Code):

19a-495-570 - Licensure of private freestanding facilities for the care or the treatment of substance abusive or dependent persons

Westport Behavioral Health will be applying for licensure and will, therefore, implement the proposed project in a manner consistent with the requirements set forth in 19a-495-570.

Title 20 – Professional licenses

All medical and clinical professional staff members and consultants who will be providing services at Westport Behavioral Health will be required to be appropriately licensed to practice in the state of Connecticut, and to maintain licenses in accordance with Title XX of the Public Health Code.

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

The proposed project is aligned with two plans established by the Department of Public Health, as follows:

DPH Facilities Plan – 2014 Supplement

Table 25 of the Plan identifies the Top Health Needs in Connecticut. Item #4 of this list provides a general reference to the Substance Abuse and Mental Health needs of "all communities." The Plan does not provide more detailed objectives.

Healthy Connecticut 2020: State Health Improvement Plan (SHIP)

One of the focus areas identified in the SHIP is *Focus Area 6* regarding mental health, and alcohol and substance abuse. Specifically, *Objective MHSA-6* mentions "Reduce by 5% the use of illicit drugs across the lifespan (ages 12 and older)". Given the significant incidence of illicit drug use histories among our target population, this objective will be directly addressed through the proposed project. By providing clinical and recovery supportive services, the project will reduce relapse among otherwise high risk individuals and therefore contribute to the 5% reduction objective.

In addition, among the *Strategies* of the SHIP (page 126) is the approach to "Identify and implement techniques for increasing engagement and retention in recovery." This is a primary objective of the proposed project that will be addressed by using age- and gender-specific continuing care services that will promote sustained recovery.

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

a. identify the target patient population to be served;

The target population for Westport Behavioral Health outpatient treatment services includes young adult males (ages approximately 17-25) who are residents of three (3) sober living residences in Westport, Connecticut – operated by Health Core Group, LLC. These residents of Westport are mostly from upper-middle- to upper-class families, and most are being transferred directly -- or have recently received primary treatment (e.g., within the past six months) for SUD/COD -- from inpatient substance abuse treatment

facilities; and who meet industry standard criteria (i.e., American Society of Addiction Medicine (ASAM))⁴ for the need for continuing treatment at an intensive outpatient level-of-care (i.e., ASAM PPC-2 level II.1).

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

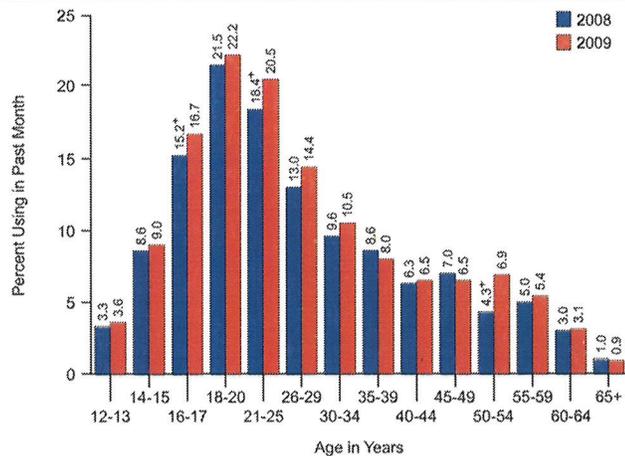
The proposed primary Westport Behavioral Health target population of Westport House recovery housing residents is currently receiving a lower level of care (i.e., outpatient counseling) by local independent, licensed/credentialed behavioral health professionals in the community. None of our clients are currently receiving intensive outpatient treatment (IOT) services at another facility in the community. These community professionals have indicated, through clinical assessments, the need for our clients to receive IOT level-of-care (i.e., ASAM PPC-2, level II.1). While we maintain authorizations to communicate with these professionals about our shared clients, the coordination of care does not meet our or our clients' families' expectations. One of these licensed therapists (LCSW) has been hired by Westport Behavioral Health to serve the target population in a more comprehensive and intensive manner.

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

National data (e.g., National Household Survey on Drug Abuse (now the National Survey on Drug Use and Health)) produced since 1971 have clearly and consistently documented the young adult population (ages 18-25) as having the highest incidence and prevalence of use and abuse of alcohol and other drugs in the United States. The unaddressed need for treatment services, especially for this age group is also well documented and compelling.

Most recent data shown below in *Figure 1* below from the (2009) National Survey of Drug Use and Health (NSDUH), released in September 2010, clearly support this continuing trend:

Figure 1: Past Month Illicit Drug Use among Persons Aged 12 or Older, by Age: 2008 and 2009



* Difference between this estimate and the 2009 estimate is statistically significant at the .05 level.

A 2007 report by the federal Substance Abuse and Mental Health Services Administration (SAMHSA, June 2009) entitled *Young Adults' Need for and Receipt of Alcohol and Illicit*

4 American Society of Addiction Medicine Patient Placement Criteria, Revised (ASAM PPC-2R)

Drug Use Treatment: 2007 concluded the following:

- About one-fifth of young adults aged 18 to 25 (21.1 percent) were classified as needing treatment for alcohol or illicit drug use; 17.2 percent were in need of alcohol use treatment, 8.4 percent were in need of illicit drug use treatment, and 4.4 percent were in need of both alcohol and illicit drug use treatment
- Less than one-tenth (7.0 percent) of the young adults who were in need of alcohol or illicit drug use treatment in the past year received it at a specialty facility in the past year

A summary of the NSDUH 2009 report that addressed the young adult age cohort provided the following key points:

Young Adults Aged 18 to 25

- Rates of current use of illicit drugs in 2009 were higher for young adults aged 18 to 25 (21.2 percent) than for youths aged 12 to 17 (10.0 percent) and adults aged 26 or older (6.3 percent).
- From 2008 to 2009, the rate of current illicit use among young adults aged 18 to 25 increased from 19.6 to 21.2 percent, driven largely by an increase in marijuana use (from 16.5 to 18.1 percent).
- From 2002 to 2009, there were net increases in young adults' past month nonmedical use of psychotherapeutic drugs (from 5.5 to 6.3 percent) and nonmedical use of pain relievers (from 4.1 to 4.8 percent).

Target Population

Data from the specific target population provide the most exacting measure of actual demand – versus approximations based upon estimates of population need. *Table A* reflects actual primary drugs of choice and psychiatric co-morbidity diagnoses of residents at Westport House (expressed in percentages).

TABLE A -- Westport House residents' primary drug of choice and co-occurring mental health disorders: 2015

Drug	Percentage	Mental Disorder	Percentage
Opiates	50%	Anxiety Disorders	31%
Alcohol	22%	ADHD	28%
Marijuana	19%	Depression	13%
Benzodiazepines	6%	Bipolar Disorder	12%
Amphetamines	3%	Other	16%
TOTAL	100%	TOTAL	100%

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

The primary purpose for locating an outpatient treatment facility in Westport is to enable Westport Behavioral Health to better meet existing sober living clients' treatment and continuing care needs in a dedicated program; and to improve client health outcomes -- including reduced rates of relapse -- by offering proximal access to a medically-necessary level of service through a culturally-appropriate, coordinated and integrated approach.

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

We chose the specific location at 162 Kings Highway North in Westport because it is an existing medical office location that is within walking distance (9-minute walk) to allow Westport House residents to have the option to walk. Otherwise, it is only a three-minute drive to the facility.

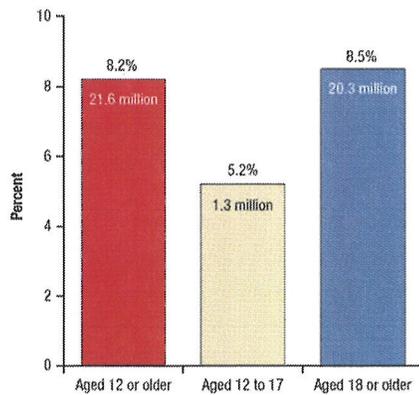
e. provide incidence, prevalence or other demographic data that demonstrates community need;

General Population – Incidence and prevalence

The general population segment within which the target population rests includes adults (18 years of age and above) with diagnosable substance use disorders (SUD)⁵ who reside in Fairfield County, Connecticut.

The most current national data are available for 2013 from the Substance Abuse and Mental Health Services Administration (SAMHSA) based upon results from the National Survey on Drug Use and Health (NSDUH).⁶ The 2013 (most recent) NSDUH estimates the prevalence of SUD (including alcohol and illicit drugs) among adults in the United States at 8.5% (see Figure 2 below).

Figure 2 - Substance use disorder (SUD) in the past year among individuals aged 12 or older in the United States: 2013



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

According to the United States Census Bureau⁷, the population of Fairfield County in 2014 was 945,438, (about 26% of the total population of Connecticut). It reports that 76.1% of those are aged 18 and over – placing their estimate of the adult population in Fairfield County at 719,478.

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

the estimate of 8.5% for the general United States population will be used for projections.

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

⁶ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (September 4, 2014). *The NSDUH Report: Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings*. Rockville, MD.

⁷ www.census.gov

Need for treatment in Fairfield County, Connecticut

Perhaps the most compelling, recent evidence available to demonstrate treatment need in Connecticut comes from the *Behavioral Health Barometer - Connecticut 2014*, issued by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in 2015.⁸ The following excerpt validates the extrapolated estimate of treatment need suggested above [note that the figures below include 12-17 year olds], and also identifies the percentage of those in need who are not served in any given year:

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

Using this benchmark, it can be estimated that of the 718,478 adults in Fairfield County, 8.4%, or 60,436 need treatment but did not receive it. This provides strong evidence of the need for treatment services in Fairfield County, far in excess of what could possibly be provided through the proposed service.

Specific to Westport, extrapolating from census data (ct.gov website), it is estimated that **2,315 residents of Westport (8.4% of 27,561) need treatment for SUD.** The target population is unique in that all residents of Westport House are diagnosed with SUD and are clinically assessed as needing outpatient levels of continuing treatment.

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

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

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

⁸ Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Connecticut, 2014*. HHS Publication No. SMA-15-4895CT. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

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

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

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

“For the first time ever, heroin has surpassed alcohol as the primary drug for those seeking rehabilitation treatment in the state,” said Peter Rockholz, deputy commissioner of the state Department of Mental Health and Addiction Services.

Also, in the past couple of years, the number of heroin deaths in Connecticut has doubled from one a week to two a week, Rockholz said. The U.S. Drug Enforcement Administration now considers heroin the main drug of concern in Connecticut and the Northeast.” (www.mapinc.org/drugnews/v08/n1154/a04.html)

Heroin Epidemic

The current epidemic of heroin abuse in the United States and Connecticut continues to escalate. Every day there is a new article in the mainstream media about the heroin epidemic and heroin-related fatalities. A Google search for “heroin epidemic” returns over 4,000,000 results, and for “heroin epidemic Fairfield County” returns over 25,000 results. Each includes articles in all major mainstream media outlets, within the past month, including front-page articles in the Wall Street Journal, the New York Times, the Washington Post, the Hartford Courant, CNN, Time, and numerous others.

The rising concern about overdose deaths in Connecticut is a motivating factor that appears to result in increasing treatment admissions in Fairfield County. The inescapable public awareness facilitated by the media appears to have reduced stigma in favor of families mobilizing to save lives of loved ones. In the case of Fairfield County – where the population is 80% Caucasian, and has among the highest income-per-capita in the nation, this public health crisis affects families of all socio-economic levels and racial/ethnic groups.

But, as evidenced by data from the Connecticut Chief Medical Examiner (see figure below), overdose deaths in Connecticut (similar to other states) continue to rise more than a decade after the current epidemic began, and disproportionately affect

Caucasians. According to a summary of the data appearing in the Hartford Courant, July 12, 2015 (*Heroin Deaths Spike in Connecticut; Push Past 300 in 2014* (copy provided in ATTACHMENT VII) while comprising 70% of the population of Connecticut, whites represented 84% of heroin deaths in the last three years.

Connecticut Accidental Drug Intoxication Deaths
Office of the Chief Medical Examiner

	2012	2013	2014	2015
Accidental Intoxication Deaths*	357	495	568	723
-Heroin, Morphine, and/or Codeine detected	195	286	349	444
-Heroin in any death	174	258	327	415
-Heroin alone	86	109	115	110
-Heroin + Fentanyl	1	9	37	107
-Heroin + Cocaine	50	69	73	106
-Morphine/Opioid/Codeine NOS	21	28	22	29
-Cocaine in any death	105	147	126	176
-Cocaine alone	46	53	22	29
-Oxycodone in any death	71	75	107	95
-Methadone in any death	33	48	51	70
-Hydrocodone in any death	15	19	15	20
-Fentanyl in any death**	14	37	75	186
-Fentanyl + Cocaine	2	16	14	43
-Fentanyl + Prescription Opioid	4	7	14	23
-Fentanyl + Heroin	1	9	37	107
-Hydromorphone	1	0	12	17
-Amphetamine/Methamphetamine	7	5	11	20
-MDMA	0	0	2	1

*Some deaths had combinations of drugs; pure ethanol intoxications are not included.

** Including 14 acetyl-fentanyl intoxications

NOS, not otherwise specified

Updated 2/14/16

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

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

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

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

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

The target population includes a relatively small number of clients, virtually all of whom are from upper socioeconomic groups – and who are able to pay for treatment out-of-pocket, with or without insurance benefits. This population is currently required to pay for their sober living residence costs estimated at an average of \$4,000 per month in addition to the projected cost of outpatient treatment. It is not anticipated that low income individuals will have the resources to participate and so this proposal will not likely have a benefit to them. However, within the target population, it is anticipated that there will be individuals with various disabilities and those within racial and ethnic minority groups that will access services at frequencies reflecting the general population.

The proposed services are not targeted specifically to reach out to any such subpopulation, nor does Health Core Group, LLC refuse services to individuals based upon disability, race or ethnicity.

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

Health Core Group, LLC (the Applicant) does not currently offer clinical services.

h. explain how access to care will be affected;

Access to appropriate care by the target population will be minimally improved – attributable to the proximity and dedicated nature of the proposed service. Access to care for the broader community will also be slightly improved, as this proposal will initiate a new service and will accept appropriate referrals who wish to receive our services. However, we are not projecting any such volume at this time.

i. discuss any alternative proposals that were considered.

No alternative proposals needed to be considered.

9. Describe how the proposal will:

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

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

It is widely understood in the addictions field that time-in-treatment is linearly associated with improved outcomes. In other words, the longer one remains engaged in treatment, the better their odds are for achieving sustained recovery (e.g., long-term abstinence). According to the national Drug Abuse Treatment Outcome Study (DATOS), "The length of time clients stayed in treatment was directly related to improvements in follow-up outcomes, replicating findings from previous national treatment evaluations".⁹ Providing continuing, uninterrupted treatment, extending it into the community, enables clients to increase their health outcomes. This results in a reduction in the over-use of repeated acute care episodes, reduced costs to society and improved functioning.

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

The Westport Behavioral Health outpatient treatment program will improve accessibility to needed behavioral health services for the relatively small target population of Westport residents. The existence of this new service in the community presents the potential for individuals from the surrounding area (i.e., lower Fairfield County) to access outpatient services specifically designed for young adult males in need of continuing treatment for substance use disorders (SUD) and co-occurring mental disorders (COD).

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

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

By providing a dedicated regimen of clinical services that are closely coordinated with sober housing and related recovery supports, pro-social community involvement and wellness activities, the proposed service will contribute to decreasing long-term behavioral healthcare costs – especially the need for chronic, acute care episodes, and particularly the costs associated with heroin overdose incidents. National studies estimate that the benefit-cost ratio achieved by providing addiction treatment is 7:1 (i.e., \$7.00 saved in societal costs for every \$1.00 spent)¹⁰.

Finally, by sharing administrative and support service infrastructure with Health Core

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

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

Group, LLC, Westport Behavioral Health will minimize indirect costs, allowing for an investment in high quality professional staff and services that will produce exceptional results.

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

This proposal is an excellent example of how patient care coordination can be improved. By providing dedicated clinical services (i.e., outpatient treatment) essentially “in-house” -- by the same provider that provides sober housing (residential) -- communication, treatment planning and care coordination will be fully integrated. Furthermore, since residents will engage in intensive outpatient groups together, nine hours per week, and then return to communal living at the Westport House, they will benefit from highly valuable peer-to-peer interaction and support that will meaningfully enhance their recovery.

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

Residents of Westport House (target population) include individuals from upper socioeconomic groups. It is not anticipated that indigent persons will have the resources necessary to pay for sober residence and intensive outpatient treatment. In addition, Medicaid does not cover the cost of sober housing. Therefore, it is not anticipated that the proposal will have a measureable impact on access to care for Medicaid recipients and indigent persons.

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

The Health Core Group, LLC policy on scholarship (charity) care has been established to provide support for the occasional resident of Westport House who is unable to meet the full cost of outpatient treatment in addition to the cost of sober living care. Given the expectation that all Westport House residents will otherwise meet the cost of care out-of-pocket, no sliding scale has been established at this time.

The policy on scholarship care appears in *APPENDIX VIII*.

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

The proposal will not reduce access to services by Medicaid recipients or indigent persons.

Similar services are available within the contiguous service area at facilities that are approved Medicaid providers and/or receive public funding to support medically-indigent persons (see *Table 9*). Specifically, Connecticut Renaissance, Family and Children’s Agency, Inc., and Norwalk Hospital – all located in Norwalk – accept Medicaid payments and/or have government resources to subsidize care for indigent patients.

It is conceivable that the proposed service may on occasion engage an individual who is Medicaid-eligible or recently indigent, and who requests services at Westport Behavioral Health. Addiction and co-occurring mental illness do not discriminate. There are individuals in Westport who “lost it all” to addiction, may be newly homeless and who turn from the comforts of self-sufficiency to requiring public assistance. Westport Behavioral Health is committed to assisting such individuals, and will set aside five-percent of self-pay revenues

for 'scholarship' assistance (i.e., charity care) in anticipation of this need.

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

Westport Behavioral Health will not impose facility fees for services it provides.

The estimated rates for intensive outpatient treatment (IOT) provided in *Financial Worksheet B (ATTACHMENT II)*, are within the mid-range of rates for existing providers in Connecticut. Therefore, we do not anticipate that the proposal will affect patient health care costs in any way.

Financial Information

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

Financial and service utilization data provided in *Financial Worksheet B (ATTACHMENT II)* clearly demonstrate that the proposed service will produce incremental net gains from the beginning of operations, and increasing through the first three years of projections.

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

TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

Purchase/Lease	Cost
Equipment (Medical, Non-medical Imaging)	
Land/Building Purchase	
Construction/Renovation	
Other (specify) Office equipment; computers	\$10,000
Total Capital Expenditure (TCE)	\$10,000
Lease (Medical, Non-medical Imaging)	0
Total Capital Cost (TCO)	\$10,000
Total Project Cost (TCE+TCO)	\$10,000

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

Health Core Group, LLC will not receive any outside funding or financing for the proposed project. The estimated capital outlay of \$10,000 (see *Table 3*) will be available using cash on hand. Since the outpatient client base will consist of existing Westport House residents who will begin receiving clinical services immediately upon opening of the new service, there will be no delay in revenue generation – and no need for developmental operations outlay.

- 18. Include as an attachment:**

a. audited financial statements for the most recently completed fiscal year. If audited

financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books.). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;

See Combined Financial Statements for Health Core Group, LLC representing operations for fiscal year 2015 (January 1 – December 31, 2015) in ATTACHMENT IX.

- b. a complete Financial Worksheet B (for-profit entity) providing a summary of revenue, expense, and volume statistics, “without the CON project,” “incremental to the CON project,” and “with the CON project.” Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.**

A completed *Financial Worksheet B* for Health Core Group, LLC appears in ATTACHMENT II.

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

**TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES**

	FY 2016	FY 2017	FY 2018
Revenue from Operations	\$172,377	\$705,914	\$723,241
Total Operating Expenses	\$140,804	\$637,786	\$654,507
Gain/Loss from Operations	\$31,573	\$68,128	\$68,734

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

The figures provided in *Financial Worksheet B* (ATTACHMENT II) were reported based upon the following assumptions:

- Fiscal year is January 1- December 31
- FY 2016 incremental reflects three (3) months operations
- Revenues are projected to increase by approximately 7.5% annually
- Expenses are projected to increase by approximately 5.0% annually
- Fringe benefits are estimated at 16% of salaries – reflective of some part-time staff
- Clients are required to pay in advance for services. Bad debt has not been necessary to project, nor is it expected to be
- Allowances reflect estimates of negotiated rates with insurance companies

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

No incremental losses are projected for the proposal.

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

Based upon the projected incremental operating expenses in *Financial Worksheet B* and *Table 4*, and the average of projected unit costs indicated in *Financial Worksheet B*, the following units of service (i.e., 3-hour intensive outpatient treatment session/day) will be required to begin to show an incremental gain:

- FY2016 – 383 units
- FY2017 – 1,692 units
- FY2018 – 1,657 units

Utilization

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

**TABLE 5
HISTORICAL UTILIZATION BY SERVICE**

Service**	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY 2013	FY 2014	FY 2015	FY 2016
Sober Housing (existing)	0	12	44	27
Outpatient Treatment (proposed)	0	0	0	0
Total	0	12	44	27

* Current FY2016 reflects services for the period Jan 1- Feb 29.

** Volume numbers represent numbers of individuals served per year.

**TABLE 6
PROJECTED UTILIZATION BY SERVICE**

Service	Projected Volume*			
	FY 2016**	FY 2017	FY 2018	FY 2019
Sober Housing (existing)	84	84	84	84
Outpatient Treatment (proposed)***	21	66	66	66
Total	105	150	150	150

* Projected volume figures reflect numbers of individuals served per year.

** Reflects three months of initial operations (i.e., Oct-Dec).

*** Individuals receiving outpatient treatment also receive sober housing services (i.e., duplicated count)

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

The following assumptions were used in completing *Tables 5 and 6*:

- The first sober house at Westport House was opened in July 2014 (13 beds)
- Two additional sober residences opened in 2015 (total of 20 beds)
- All residents will enter IOT on their first day in residence and remain in IOT for an average of six (6) weeks
- Average total length-of-stay in residence will be ten and one-half (10.5) months
- New admissions will average 4.5 per month
- Total residential capacity will remain at 33
- An average 90% utilization is projected
- Outpatient treatment is projected to begin no later than October 1, 2016
- Utilization projections include the census on January 1

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

**TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX**

Payer	Current FY 2015		Projected					
	Discharges	%	FY 2016*		FY 2017		FY 2018	
			Discharges	%	Discharges	%	Discharges	%
Medicare			0		0		0	
Medicaid			0		0		0	
CHAMPUS & TriCare			0		0		0	
Total Government			0		0		0	
Commercial Insurers			14	66.7%	44	66.7%	44	66.7%
Uninsured Workers Compensation			7	33.3%	22	33.3%	22	33.3%
Total Non- Government			21	100.0%	66	100.0%	66	100.0%
Total Payer Mix			21	100.0%	66	100.0%	66	100.0%

* Represents projected 3 months (Oct-Dec).

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

The target population for the proposed service includes young adult males (ages approximately 17-25) who are residents of three (3) sober living residences in Westport, Connecticut – operated by Health Core Group, LLC. These residents of Westport are mostly being transferred directly, or have recently received primary treatment (e.g., within the past six months) for SUD/COD, from inpatient substance abuse treatment facilities; and who meet

industry standard criteria (i.e., American Society of Addition Medicine (ASAM))¹¹ for the need for continuing treatment at an intensive outpatient level-of-care.

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

**TABLE 8
UTILIZATION BY TOWN**

Town	Utilization FY 2015*
Sober Living (residential) Westport	44
Outpatient (proposed) Westport	0

* Utilization numbers reflected number of individuals served.

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

Information provided in *Table 9* includes DPH-licensed facilities that provide similar services (i.e., intensive outpatient treatment (IOT) programs) in the proposed service area (i.e., Westport) and the contiguous towns of: Norwalk, Wilton, Easton and Fairfield.

**TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS**

Service or Program Name	Population Served	Facility ID	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization
Connecticut Renaissance, Inc.	Adults (Matrix Model) and adolescents DMHAS-funded; DCF-funded; Medicaid	unavailable	4 Byington Place, Norwalk	Mon-Fri 9am-5pm	unavailable
Family and Children's Agency, Inc.	Women DMHAS-funded; Medicare	unavailable	165 Flax Hill Rd., Norwalk		unavailable
Norwalk Hospital – Outpatient	Adults Mental health and co-occurring SUD Medicaid; Medicare; other insurance	unavailable	24 Stevens Street, Norwalk	MWF 9am-noon Evenings	unavailable
The Recovery Center of Westport	Adults	unavailable	328 Post Road East, Westport	No IOT services provided	0*

* Although listed as being licensed, The Recovery Center of Westport does not offer an Intensive Outpatient Treatment (IOT) program

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

Of the four (4) existing facilities licensed to provide intensive outpatient treatment (IOT) in Westport and the contiguous municipalities, two (2) (Connecticut Renaissance and Family and Children's Agency) almost exclusively serve public-sector clients with State/Federal funding

11 American Society of Addiction Medicine Patient Placement Criteria, Revised (ASAM PPC-2R)

or Medicaid reimbursement and are located in the urban setting of Norwalk. Family and Children's Agency offers IOT services only to women at its Norwalk facility. Though reportedly licensed, The Recovery Center of Westport does not offer IOT programming.

Since opening in July 2014, Westport House has not had any of its residents receive IOT services through any of these licensed facilities.

Based upon this review, we conclude that the implementation of this proposal will have no measurable impact on existing area providers.

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

The known referral patterns include two population segments: public sector and private sector. The majority of existing providers of intensive outpatient treatment (IOT) services in the area primarily serve clients supported by public funding (e.g., DMHAS, Judicial Branch) and Medicaid payment for services. Most of their referrals are involved with courts and community supervision (i.e., probation).

Individuals with private insurance and who are otherwise "self-pay" clients also include those with court involvement or pending charges who are encouraged by attorneys and family members to seek treatment. Others are motivated to self-refer for treatment. Many of these individuals obtain IOT services elsewhere in Fairfield County, within reasonable driving distance, at facilities that primarily serve other private sector clients.

The residents of Westport House currently do not receive IOT services in the area. They are a new segment of the population in need of this level of care, and do not contribute to exiting referral pathways.

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

Based upon the facts that no past-year nor current residents of Westport House receive(d) intensive outpatient treatment services at any of the existing providers identified in *Table 9*, and that the projected new clients will all be served by the proposed Westport Behavioral Health facility, current referral patterns will not be affected.

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

Currently, residents of Westport House are not receiving intensive outpatient treatment (IOT) services. The proposed service will offer new gender (male)- and age (young adult)-specific treatment that does not duplicate services in the area.

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

The proposal will have a positive impact on patient choice in the region by offering a dedicated, gender- and developmentally-specific outpatient substance abuse treatment service for young adult males.



Supplemental CON Application Form
**Establishment of a New Health Care Facility (Mental
Health and/or Substance Abuse Treatment)***
Conn. Gen. Stat. § 19a-638(1)

Applicant: Health Core Group, LLC

Project Name: Westport Behavioral Health

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

Affidavit

Applicant: Health Core Group, LLC

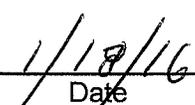
Project Title: Westport House Outpatient

I, Albert Samaras, Executive Director (CEO)
(Name) (Position – CEO or CFO)

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

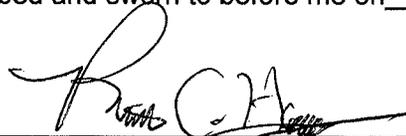


Signature



Date

Subscribed and sworn to before me on January 22, 2015



Notary Public/Commissioner of Superior Court

ROBERT C. HAUCK
NOTARY PUBLIC OF CONNECTICUT
My Commission Expires 1/31/2016

My commission expires: _____

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

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

While similar services are provided in the service area (i.e., outpatient behavioral health treatment for adults), one aspect of the proposed service that is somewhat unique is the gender- and developmentally-specific programming to be provided at Westport Behavioral Health – specifically, intensive outpatient treatment (IOT) for young adult males.

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

Initiating the proposal will minimally require the following DPH-licensed health care professionals:

- One (1) – Medical doctor/psychiatrist (M.D.)
- Two (2) – Licensed clinical social workers (LCSW)

2. Projected Volume

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

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

Population group – residents of Westport
Westport:

Substance abuse Treatment need: 2,315 per year

This estimate is based on the projected target population of Westport and applying an extrapolated percentage based upon national data (see page 20). The estimate of residents in need includes an unknown segment who initially require a higher level-of-care (e.g., inpatient).

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

Westport:

Outpatient Treatment: 66 per year

This projection anticipates that all residents entering Westport House will be served by the proposed outpatient treatment program.

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

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

The target population for Westport Behavioral Health outpatient treatment services includes

young adult males (ages approximately 17-25) who are residents of three (3) sober living residences (Westport House) in Westport, Connecticut – operated by the Applicant. These residents of Westport are mostly from upper-middle- to upper-class families, and most are being transferred directly, or have recently received primary treatment (e.g., within the past six months) for SUD/COD, from inpatient substance abuse treatment facilities; and who meet industry standard criteria (i.e., American Society of Addiction Medicine (ASAM))¹² for the need for continuing treatment at an outpatient level-of-care.

National data (e.g., National Household Survey on Drug Abuse (now the National Survey on Drug Use and Health)) produced since 1971 have clearly and consistently documented the young adult population (ages 18-25) as having the highest incidence and prevalence of use and abuse of alcohol and other drugs in the United States. The unaddressed need for treatment services, especially for this age group is also well documented and compelling.

A summary of the NSDUH 2009 report that addressed the young adult age cohort provided the following key points:

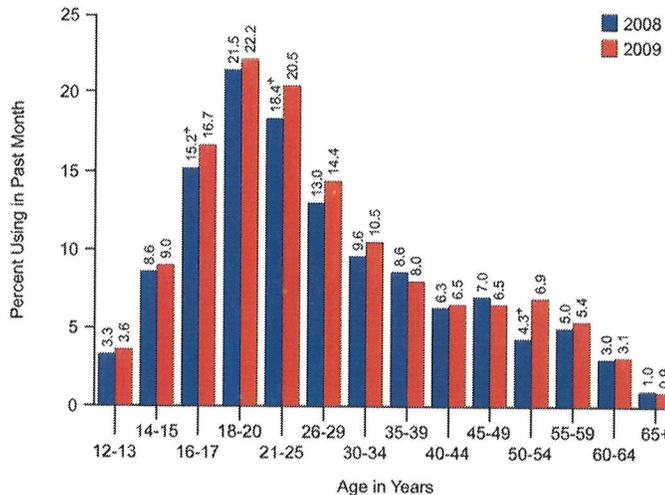
Young Adults Aged 18 to 25

- Rates of current use of illicit drugs in 2009 were higher for young adults aged 18 to 25 (21.2 percent) than for youths aged 12 to 17 (10.0 percent) and adults aged 26 or older (6.3 percent).
- From 2008 to 2009, the rate of current illicit use among young adults aged 18 to 25 increased from 19.6 to 21.2 percent, driven largely by an increase in marijuana use (from 16.5 to 18.1 percent).

Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (September 4, 2010). The NSDUH Report: Substance Use and Mental Health Estimates from the 2009 National Survey on Drug Use and Health: Overview of Findings. Rockville, MD.

Most recent data shown below in *Figure 4* below from the (2009) National Survey of Drug Use and Health (NSDUH), released in September 2010, clearly support this continuing trend:

Figure 4: Past Month Illicit Drug Use among Persons Aged 12 or Older, by Age: 2008 and 2009



12 American Society of Addiction Medicine Patient Placement Criteria, Revised (ASAM PPC-2R)

+ Difference between this estimate and the 2009 estimate is statistically significant at the .05 level.

A 2007 report by the federal Substance Abuse and Mental Health Services Administration (SAMHSA, June 2009) entitled *Young Adults' Need for and Receipt of Alcohol and Illicit Drug Use Treatment: 2007* concluded the following:

- About one-fifth of young adults aged 18 to 25 (21.1 percent) were classified as needing treatment for alcohol or illicit drug use; 17.2 percent were in need of alcohol use treatment, 8.4 percent were in need of illicit drug use treatment, and 4.4 percent were in need of both alcohol and illicit drug use treatment
- Less than one-tenth (7.0 percent) of the young adults who were in need of alcohol or illicit drug use treatment in the past year received it at a specialty facility in the past year
- From 2002 to 2009, there were net increases in young adults' past month nonmedical use of psychotherapeutic drugs (from 5.5 to 6.3 percent) and nonmedical use of pain relievers (from 4.1 to 4.8 percent).

Source: Substance Abuse and Mental Health Services Administration. *Young Adults' Need for and Receipt of Alcohol and Illicit Drug Use Treatment: 2007* HHS Publication No. SMA-08-0325. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2008.

Health Core Group, LLC
Certificate of Need (CON) Application

LIST OF ATTACHMENTS

	<u>Page</u>
<u>ATTACHMENT I</u> - Evidence of Public Notice Listing – The Hour	37
<u>ATTACHMENT II</u> - Financial Worksheet B	39
<u>ATTACHMENT III</u> - Resolution of Health Core Group, LLC	41
<u>ATTACHMENT IV</u> - Proposed Staff Curriculum Vitae	43
<u>ATTACHMENT V</u> - Standards of Practice Guidelines -- Substance Abuse: Clinical Issues in Intensive Outpatient Treatment: SAMHSA Treatment Improvement Protocol (TIP) 47 [excerpts]	56
<u>ATTACHMENT VI</u> - Memoranda of Understanding (MOUs)	66
<u>ATTACHMENT VII</u> – Articles in Support of the Need for the Proposed Service	69
<ul style="list-style-type: none">• The NSDUH Report, June 25, 2009 (excerpts)• Behavior Health Barometer: Connecticut, 2014 (excerpts)• <i>Heroin Deaths Spike in Connecticut; Push Past 300 in 2014</i> – Hartford Courant• “Town responds to growing prevalence of heroin” – New Canaan Advertiser• “Substance Abuse Intensive Outpatient Programs: Assessing the Evidence” (summary)	
<u>ATTACHMENT VIII</u> – Scholarship Policy (“Charity Care”)	94
<u>ATTACHMENT IX</u> - Health Core Group LLC Compiled Financial Statements 2015	96
<u>ATTACHMENT X</u> - Letters of Support for the Project	102

Attachment I

Evidence of Public Notice Listing The Hour

PUBLISHER'S AFFIDAVIT

STATE OF CONNECTICUT)

ss. Norwalk

COUNTY OF FAIRFIELD)

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

1. I am over the age of eighteen (18) and believe in the Obligation of an oath;
2. I am the Classified Advertising Supervisor of The Hour Publishing Company, publisher of the following newspapers:
 - 1) The Hour, a daily newspaper, published in Norwalk, Connecticut;
 - 2) The Wilton Villager, a weekly newspaper, published in Norwalk, Connecticut; and
 - 3) The Stamford Times, a weekly newspaper, published in Norwalk, Connecticut.

LEGAL NOTICE
Notice is hereby given that, pursuant to Connecticut General Statutes Section 19a-638, Health Core Group, LLC - a Connecticut corporation - intends to establish Behavioral Health Outpatient Treatment services for adults in Westport Connecticut, with an associated capital expenditure of \$10,000. Interested persons may contact the State of Connecticut, Department of Public Health, Office of Health Care Access, Attention: Steven Lazarus, 410 Capitol Ave. MS #13HCA, Hartford, CT 06134 or by phone at 860.418.7001 for additional information.

On April 1st, 2016, April 2nd, 2016 and April 3rd, 2016 an advertisement placed by Health Core Access was published in The Hour newspaper.

J. Battista

Jocelyn A. Battista, Classified Advertising Supervisor

Subscribed and sworn to before me this 6th day of April, 2016.

Brett L. Whitton

Brett L. Whitton
Commissioner of the Superior Court

Attachment II

Financial Attachment B

FOR-PROFIT

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

LINE	Total Entity Description	(1) FY 2015 Actual Results		(2) FY 2016 Projected		(3) FY 2016* Projected		(4) FY 2017 Projected		(5) FY 2017 Projected		(6) FY 2018 Projected		(7) FY 2018 Projected		(8) FY 2019 Projected		(9) FY 2019 Projected	
		Without CON	With CON	Without CON	With CON	Without CON	Incremental	Without CON	Incremental	Without CON	Incremental	Without CON	Incremental	Without CON	Incremental	Without CON	Incremental	Without CON	Incremental
A. OPERATING REVENUE																			
1	Total Gross Patient Revenue	\$1,322,039	\$1,630,939	\$299,447	\$1,630,939	\$299,447	\$1,101,777	\$2,629,559	\$1,101,777	\$2,629,559	\$1,127,050	\$2,786,415	\$1,149,591	\$2,915,133	\$1,149,591	\$2,915,133	\$402,357	\$402,357	\$402,357
2	Less: Allowances		\$95,540	\$95,540	\$95,540	\$95,540	\$95,540	\$95,540	\$95,540	\$95,540	\$95,540	\$95,540	\$95,540	\$95,540	\$95,540	\$95,540	\$95,540	\$95,540	\$95,540
3	Less: Charity Care		\$1,339	\$1,339	\$1,339	\$1,339	\$1,339	\$1,339	\$1,339	\$1,339	\$1,339	\$1,339	\$1,339	\$1,339	\$1,339	\$1,339	\$1,339	\$1,339	\$1,339
4	Less: Other Deductions		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
5	Medicare		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
6	Medicaid		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
7	CHAMPUS & Tricare		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
8	Other		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
9	Commercial Insurers		\$143,310	\$143,310	\$143,310	\$143,310	\$143,310	\$143,310	\$143,310	\$143,310	\$143,310	\$143,310	\$143,310	\$143,310	\$143,310	\$143,310	\$143,310	\$143,310	\$143,310
10	Uninsured		\$1,421,192	\$1,421,192	\$1,421,192	\$1,421,192	\$1,421,192	\$1,421,192	\$1,421,192	\$1,421,192	\$1,421,192	\$1,421,192	\$1,421,192	\$1,421,192	\$1,421,192	\$1,421,192	\$1,421,192	\$1,421,192	\$1,421,192
11	Self Pay		\$29,087	\$29,087	\$29,087	\$29,087	\$29,087	\$29,087	\$29,087	\$29,087	\$29,087	\$29,087	\$29,087	\$29,087	\$29,087	\$29,087	\$29,087	\$29,087	\$29,087
12	Workers Compensation		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
13	Other		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
14	TOTAL NON-GOVERNMENT		\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039
15	Net Patient Service Revenue* (Government/Non-Government)		\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039
16	Less: Provision for Bad Debts		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
17	Net Patient Service Revenue (Net Provision for Bad Debts)		\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039
18	Net Assets Released from Restrictions		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
19	TOTAL OPERATING REVENUE		\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039	\$1,322,039
B. OPERATING EXPENSES																			
1	Salaries and Wages	\$265,897	\$232,237	\$52,216	\$232,237	\$52,216	\$208,861	\$485,559	\$208,861	\$485,559	\$215,217	\$601,242	\$215,217	\$601,242	\$215,217	\$601,242	\$215,217	\$601,242	\$215,217
2	Fringe Benefits	\$42,543	\$51,717	\$8,364	\$51,717	\$8,364	\$33,418	\$75,072	\$33,418	\$75,072	\$34,635	\$90,199	\$34,635	\$90,199	\$34,635	\$90,199	\$34,635	\$90,199	\$34,635
3	Physicians Fees		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
4	Supplies and Drugs	\$3,747	\$4,147	\$400	\$4,147	\$400	\$1,600	\$5,347	\$1,600	\$5,347	\$1,600	\$5,347	\$1,600	\$5,347	\$1,600	\$5,347	\$1,600	\$5,347	\$1,600
5	Depreciation and Amortization		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
6	Provision for Bad Debts-Other*		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
7	Interest Expense		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
8	Malpractice Insurance Cost	\$161,500	\$251,760	\$228,000	\$251,760	\$228,000	\$95,040	\$323,040	\$95,040	\$323,040	\$97,891	\$325,891	\$97,891	\$325,891	\$97,891	\$325,891	\$97,891	\$325,891	\$97,891
9	Lease Expense	\$526,785	\$505,873	\$505,873	\$505,873	\$505,873	\$505,873	\$505,873	\$505,873	\$505,873	\$505,873	\$505,873	\$505,873	\$505,873	\$505,873	\$505,873	\$505,873	\$505,873	\$505,873
10	Other Operating Expenses	\$1,000,472	\$1,192,808	\$1,192,808	\$1,192,808	\$1,192,808	\$1,101,281	\$3,726,947	\$1,101,281	\$3,726,947	\$1,185,378	\$3,854,507	\$1,185,378	\$3,854,507	\$1,185,378	\$3,854,507	\$1,185,378	\$3,854,507	\$1,185,378
11	TOTAL OPERATING EXPENSES		\$2,000,472	\$2,000,472	\$2,000,472	\$2,000,472	\$1,912,808	\$11,912,808	\$1,912,808	\$11,912,808	\$1,912,808	\$11,912,808	\$1,912,808	\$11,912,808	\$1,912,808	\$11,912,808	\$1,912,808	\$11,912,808	\$1,912,808
12	INCOME/(LOSS) FROM OPERATIONS		\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567
NON-OPERATING INCOME																			
1	Income before provision for income taxes		\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567	\$321,567
2	Provision for income taxes*		\$97,594	\$97,594	\$97,594	\$97,594	\$97,594	\$97,594	\$97,594	\$97,594	\$97,594	\$97,594	\$97,594	\$97,594	\$97,594	\$97,594	\$97,594	\$97,594	\$97,594
3	NET INCOME		\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973
4	Retained Earnings, beginning of year		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
5	Retained Earnings, end of year		\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973	\$223,973
6	Principal Payments		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
D. PROFITABILITY SUMMARY																			
1	Hospital Operating Margin		24.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%
2	Hospital Non-Operating Margin		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin		18.1%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%	18.3%
4	FTEs		12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
F. VOLUME STATISTICS*																			
1	Inpatient Discharges		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	Outpatient Visits		0	468	468	468	468	468	468	468	468	468	468	468	468	468	468	468	468
3	TOTAL VOLUME		0	468	468	468	468	468	468	468	468	468	468	468	468	468	468	468	468

* FY 2016 incremental (proposed project) reflects 3 months projections (Oct 1-Dec 31)
 Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
 *Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
 *Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
 *Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Attachment III

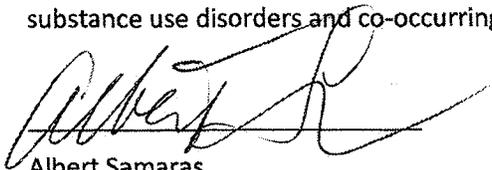
Resolution of Health Core Group, LLC

Health Core Group, LLC
32 John Henry Lane
Milford, CT 06461

At a meeting of Health Core Group, LLC on December 6, 2015, it was

RESOLVED

That Health Core Group, LLC is authorized to make application to the State of Connecticut, Office of Health Care Access for a Certificate of Need (CON) to establish a facility for outpatient treatment of substance use disorders and co-occurring mental disorders in Westport, Connecticut.



Albert Samaras

December 6, 2015

Managing Member

Attachment IV

Proposed Staff Curriculum Vitae

ALBERT SAMARAS

SUMMARY

Business Leader with over 20 years of experience in executive management and business development. Founded two nationally recognized addiction treatment programs for college-age men: **Turning Point and Westport House**. Served others in early recovery by co-founding the Turning Point Extended Care and Sober Living program in New Haven, CT in 2009. Was critical to it being recognized as a leading recovery program for young men in the United States. In 2014, founded Westport House in Westport, CT to serve young men in early recovery from substance abuse in the Fairfield County area. Westport House receives referrals from across the country and is recognized as a premier addiction recovery program by leading industry experts.

PROFESSIONAL BACKGROUND

Westport House, Westport, CT

2014 – present

The Westport House "*phased-integration model*" has quickly become recognized nationally as a highly effective substance treatment model for young men. Combining structured residential, life skills, physical fitness, and recreation with evidence-based treatment services, Westport House integrates young men back into life with the tools and foundation for success.

Executive Director/Founder

- Building upon the success of the Turning Point "*preparative care model*", founded Westport House in 2014 to serve the needs of young men in early recovery from substance abuse and co-occurring disorders.
- By the end of 2015, developed three residential locations in Westport serving over 30 residential clients.

Turning Point (CT Clinical Services, Inc.), New Haven, CT

2009 – 2014

Joined this former non-profit in early 2009 to build and execute a new model of structured sober living and outpatient clinical treatment services for young men.

Vice President

- Essential to its transition from a small non-profit sober living organization to a nationally recognized transitional living and outpatient treatment program for young men.
- During his five year tenure at Turning Point as Vice President, annual revenue increased from \$300k to over \$13mm, capacity increased from 30 to 130 beds, facilities increased from two to nine (including an outpatient clinic), and the number of employees rose from three to over one hundred.

Source Medical, Wallingford, CT**2001 – 2007**

Promoted through field-level sales to national account manager for this leading provider of enterprise management software solutions for hospitals, physician practices and radiology clinics. In January of 2004, was recruited by Prescient Healthcare Systems...later acquired by Source Medical in 2006.

National Account Manager

- Successfully penetrated and managed strategic national accounts including United Surgical Partners International and Symbion Healthcare.
- Ensured implementation and consulting projects meet client's expectations and business outcomes.

Account Executive

- Marketed Enterprise Scheduling, Revenue Cycle Management, Electronic Health Records, Materials Management, Quality Assurance and Business Intelligence solutions to hospitals and surgical facilities in a 12-state Midwest territory.
- Delivered 10-20% Annual Revenue Growth in Competitive Markets.
- Consistently led sales team in revenue and new sales generation by leveraging product knowledge, relationships with industry influencers and strong consultative sales techniques.

Health Information Systems, Wallingford, CT**1994 – 2001**

Joined HIS in 1994 to implement and support the company's physician practice and surgery management systems. In 1997, after demonstrating exceptional product and industry knowledge, excellent client relationship skills and a aptitude for sales, was offered the position of Senior Account Executive marketing the company's software systems and services to hospitals, ambulatory surgical centers, primary care practices, multi-physician outpatient clinics, and regional health organizations throughout the western United States.

Senior Account Executive

- Set company marks for total sales in 1998, 1999 and 2000.
- Set company mark for largest individual sale in 2001 - \$1,350,000 contract with Panorama Orthopedics and Spine Center in Golden, CO.
- Worked closely with customers and internal R&D department on new product development and enhancements to existing functionality.

EDUCATION, TRAINING AND SOFTWARE

Central Connecticut State University, New Britain, CT**1991 – 1994**

BS - Management Information Systems (completed majority of coursework)

Certificates/Training

Trained and proficient in the following sales methodologies: Sandler Selling System, SPIN Selling, Solution Selling, Strategic Selling,

Software

- Seibel, ACT!, WebEx, Live Meeting, Excel, PowerPoint, Word, Access, Outlook

AVA DIAMOND, LCSW

PROFILE

I am a seasoned Licensed Clinical Social Worker who has merged education, training, practice, and personality to advance in my career as a Clinician and Leader. I am entrepreneurial and pioneering in my approach to developing programs to meet the needs of my clients and audiences. My therapeutic services and coaching programs are utilized Nationally and with a wide range of client issues. I have created and implemented therapeutic and educational programs for community forums, higher education institutions, and healthcare facilities. I have been invited to speak on radio shows and have written numerous articles for websites and ezines. Areas of expertise include:

- *Addiction treatment for adolescents and adults
- *Family therapy
- *Couples therapy
- *Dual Diagnosis treatment
- *Character Development with Adolescents and Young Adults
- *Life Transitions
- *Health Care Provider Burnout/Resiliency Training
- *Mental Fitness Coaching
- *Grief and Loss
- *Motivation Enhancement
- *Parenting
- *Narrative Therapy
- *Emerging Adulthood
- *Mood Management
- *Communication Skills

Proficiency in the following evidence-based clinical practices:

- *DBT
- *CBT
- *EMDR (level II)
- *Motivational Interviewing
- *Trauma-informed CBT

EXPERIENCE

PSYCHOTHERAPIST, EDUCATOR, MENTAL FITNESS COACH

2009-PRESENT

My private practice is housed in New Canaan, CT, but is utilized Nationally via SKYPE. Additionally, my Mental Fitness Coaching work is done in-home and via SKYPE with clients worldwide. My Mental Fitness Coaching program is a motivation-enhancing program that blends evidence-based psychology theory/practices with my first hand understanding of athletic pursuits. My clients gain what I call the Two C's of Success: Clarity and Conviction. My practice is with individuals and families engaging in psychotherapy for issues related to developmental stages and changes, addiction, body image issues, eating disorders, and/or family dysfunction. I am also contracted to teach, speak, write, and develop therapeutic

21 Mill Rd. Danbury, CT, 06810 ava@avadiamondlcsww.com 203-671-4152

programs for a variety of clinical and educational organizations. Examples of contracts have included teaching my own resiliency program (www.healthcareREST.com) at Yale University School of Medicine and at UMass Memorial Hospital; writing for fitness and sober living magazines; and developing the family education and support program for Westport Sober House. www.avadiamondlcsw.com

**FAMILY THERAPIST, NEWPORT ACADEMY, BETHLEHEM, CT-
1/2014-PRESENT**

Provided family therapy for residence in this adolescent residential treatment program for addiction, eating disorders, and the range mental health issues. Effectively moved families into healthier dynamics as they engaged in a directed therapeutic process of increased transparency and improved communication skills. Facilitated multifamily group education and support. Managed interagency relations and developed continuing care plans.

**PROGRAM SPECIALIST/CLINICAL CONSULTANT, CMHA, NEW BRITAIN, CT-
10/2013-1/2014**

Charged with the task of shoring up the clinical care for the Children and Families Department of this large mental health organization. Evaluated clinical leadership, clinicians skills, and program structure for IOP and EDT programs. Developed interventions to improve clinical effectiveness and revitalize staff investment in their roles.

**CLINICAL COORDINATOR, YALE NEW HAVEN HOSPITAL/HSR, HAMDEN, CT-
2009-2013**

Supervised clinical and case management staff who providing addiction treatment and parenting therapy through the Family Based Recovery Program (FBR), an intensive, in-home treatment model that utilizes attachment theory and motivational interviewing approach, primarily. Served as the interagency liaison and was responsible for data management and program development on site. Provided state-wide organization case presentations for learning purposes.

ADDITIONAL WORK EXPERIENCE INCLUDES:

*PER DIEM CLINICAL SOCIAL WORK, CEDARHURST SCHOOL, YNHH
*CONTRIBUTING COLUMNIST AND RADIO SHOW GUEST SPEAKER ON
MENTAL HEALTH RELATED TO PHYSICAL HEALTH; PARENTING; AND
PERSONAL EMPOWERMENT *SPEAKING ENGAGEMENTS FOR NEW
CANAAN CARES, NEW CANAAN, CT *COMMUNITY ENGAGEMENT AND
EDUCATION PROGRAM DEVELOPMENT, JEWISH FEDERATION,
WOODBIDGE, CT

EDUCATION

CT STATE LICENSED CLINICAL SOCIAL WORKER (LCSW) #003461
COLUMBIA UNIVERSITY, SCHOOL OF SOCIAL WORK – MASTERS IN
SOCIAL WORK, 1992

UNIVERSITY OF SOUTHERN CALIFORNIA- BACHELORS IN
COMMUNICATION,

1987

*INTENSIVE TRAININGS IN NARRATIVE MEDICINE, COLUMBIA UNIVERSITY
*CONTINUING EDUCATION TRAINING IN MINDFULNESS, DBT, TRAUMA-
INFORMED CBT, MOTIVATIONAL INTERVIEWING
*CERTIFIED IN EMDR (LEVEL 2)

SKILLS

*PIONEERING AND EMPOWERING LEADERSHIP SKILLS
*ABILITY TO DEVELOP INTERVENTIONS AND PROGRAMS USING A BROAD
RANGE OF CLINICALLY EFFECTIVE AND CREATIVELY ENGAGING
APPROACHES
*NOTABLY CAPABLE OF EARNING THE TRUST AND RESPECT OF
COLLEAGUES, CLIENTS, AND COMMUNITIES.
*ENTREPRENEURIAL AND INNOVATIVE IN PRACTICE
*PROFESSIONAL ATHLETE

REFERENCES

AVAILABLE UPON REQUEST

JOSEPH A. RUSSO, M.D.
728 Post Road East, Suite 205
Westport, CT 06880
203-227-9902(office)
845-661-9545 (cell)
dr.josephrusso@gmail.com

CAREER SUMMARY

- * **Seasoned Psychiatrist with 16 years of experience and a recognized expert within the field of Addiction Psychiatry for 12 years**
- * **Proven track record in utilizing cutting edge research, assessment tools and methodology in areas of substance abuse, dual diagnosis, and mental illness**
- * **Dynamic and effective in his ability to serve as Owner and Medical Director of a thriving Outpatient Treatment Center and Private Practice specialized in treating addictions and mental illness in Westport, CT**
- * **Medical Director of an Outpatient Addictions Treatment Center specializing in the Naltrexone Implant in Norwalk, CT**
- * **Key opinion leader in the Tri-State Area for successfully treating Alcohol and Opioid addictions**
- * **Strong believer in a Patient Centered Approach and treating all illnesses as biologically driven**

WORK EXPERIENCE:

Start Fresh Recovery - Norwalk, West Hartford, CT
Medical Director August 2015

Connecticut Recovery, P.C.
President and Medical Director
August 2015

Russo Aesthetic and Wellness
President and Medical Director
April 2015

The Recovery Center of Westport
Medical Director September 2008-Present

Private Practices:
Westport, CT May 2006-Present
Jefferson Valley, NY November 2014-present

**Hall-Brooke Behavioral Health Services
Unit Chief of Addiction Services
June 2004-April 2006**

**Hall-Brooke Behavioral Health Services
Staff Psychiatrist, Adult Inpatient Unit
July 2003-June 2004**

EDUCATION:

**M.D. St. George's University School of Medicine
Summa Cum Laude August 1995-May 1999**

**Chief Resident, PGY-1 to PGY-4
Maimonides Medical Center Department of Psychiatry
July 1999-June 2003**

**B.A., Psychology New York University
Cum Laude September 1990-May 1994**

**Certification in Aesthetic and Wellness Medicine
Empire Medical Training, NYC
December 2014-March 2015**

ACADEMIC APPOINTMENTS:

**Staff Professor The Westchester Institute of Psychotherapy and
Psychoanalysis
December 2009-Present**

**Chief Resident Maimonides Medical Center
Department of Psychiatry
April 2002-April 2003**

**Geriatric Fellow First Annual Dementia Congress
Chicago, Ill Sept. 2002**

HONORS AND AWARDS:

**SUMMA CUM LAUDE St. George's University School
Graduate of Medicine**

New York M.D. License

February 2010-Present

MEDIA:

A Discussion on Dual Diagnosis: Mental Illness and Substance Abuse and Dependence

WICC RADIO: Frank Scifo, M.D. Presents Dec. 2004

FORENSIC/LEGAL:

Multiple Assessments – capacity, substance abuse, dual diagnoses, psychiatric disorders, organic syndromes, dementia, DUI, criminal

Expert Witness Testimony – court appearances in Connecticut - Bridgeport, Fairfield

EXTRACURRICULAR:

Privileging and Credentialing Committee	
Hall-Brooke Behavioral Health Services	2004-2006
Clinical Integration Council	
Hall-Brooke Behavioral Health Services	2004-2006
Resident's Advisory Council	
Maimonides Medical Center	2001-2002
PSI UPSILON International Fraternity	
VICE PRESIDENT, New York University	1992-1994

PERSONAL:

US Citizen

Interests:

sculpture, watercolors, oil painting, acting, film, architecture, carpentry, boating, scuba diving

ELIZABETH V. MODUGNO

35 HIGH PARK AVENUE
STRATFORD CT, 06615

(203) 383-0501
LIZMODUGNO@GMAIL.COM

PROFILE/SUMMARY

Well-rounded Licensed Clinical Social Worker who utilizes a client-centered approach intertwined with psychotherapy, case management, psycho-education, CBT, Mindfulness, EMDR, and other therapies. Educated on evidenced-based therapeutic interventions for working with individuals, couples and families struggling with addiction, mental illness and other life stressors, while remaining knowledge-seeking and teachable. Works well on a team and independently to adhere to client needs.

EDUCATION

UNIVERSITY OF CONNECTICUT

- **Masters of Social Work**, Substantive Area in Mental Health and Substance Abuse: GPA: 3.9/4.0
 - **Bachelor of Arts in Psychology, Minor in Criminal Justice:** Magna Cum Laude Honors GPA: 3.7/4.0
-

LICENSE/TRAINING

- **LICENSED CLINICAL SOCIAL WORKER:** Effective June 2012
 - **EMDR LEVEL I & II TRAINED:** March 2010 Level I /May 2010 Level II
-

RELATED EXPERIENCE

PRIVATE PRACTICE

AUGUST 2012-CURRENT
CT

WESTPORT,

- Work with individuals and families struggling with addiction, depression, anxiety and other life stressors while utilizing CBT, EMDR, Psycho-education, and other forms of therapy
- Collaborate with local therapists, psychiatrists, APRNs, case managers and surrounding agencies with higher levels of care to provide clients an all-inclusive treatment experience

TURNING POINT/CENTER FOR CHANGE

SEPTEMBER 2012-SEPTEMBER 2015
Per Diem Substance Abuse Counselor

NEW HAVEN, CT

- Facilitate substance abuse/mental health groups, including *Life Skills, Mindful Awareness, Vipassana Meditation, and Challenging Substance Use* to help clients navigate through the Stages of Change
- Provide individual therapy to clients when their primary therapist was unavailable

APT FOUNDATION

SEPTEMBER 2010-FEBRUARY 2013
HAVEN, CT

BRIDGEPORT/NEW

- **Substance Abuse Counselor (April 2012-February 2014)**
 - Provided individual counseling and facilitated group therapy including Anger Management, Seeking Safety, Social Skills, Healing Trauma, etc to adult female clients referred by CSSD, DOC, and DMHAS
 - Worked collaboratively with medical, psychiatric, vocational, case management, and administrative staff to coordinate appropriate services
- **Methadone Rehabilitation Counselor (September 2010-March 2011)**
 - Provided individual counseling, case management and groups to 50-75 clients in methadone clinic
 - Worked with diverse clinical team of psychiatrist, counselors, researchers, and medical staff to evaluate methadone maintenance and provide clinical care

DIXWELL NEWHALLVILLE MENTAL HEALTH

MAY 2010-APRIL 2011
CT

NEW HAVEN,

- **Mental Health Clinician**
 - Provided trauma therapy for clients referred by Office of Victim Services, DMHAS, and Refugee Services
 - Developed clinical skills in urban trauma facility with individuals, couples, and groups diagnosed with mental health, substance abuse and medical issues
- **MSW Intern**
 - Attended and completed EMDR Level I & II trainings and used EMDR in individual therapy sessions under supervision of EMDR Consultant Donald deGraffenreid, LCSW.
 - Practiced client-centered, EMDR, narrative, cognitive, behavioral and solution-focused therapy with individuals and received supervision to develop better therapeutic skills

NEW HAVEN HOME RECOVERY

JULY 2008-APRIL 2010

NEW HAVEN, CT

- **Vocational Case Manager in New Haven Family Partnership Supportive Housing Program**
 - Conducted case-management with clients diagnosed with mental health, substance abuse and HIV/AIDS living in supportive housing
 - Worked with clients to develop job seeking skills, acquire gainful employment, and maintain jobs
- **MSW Internship at Martha's Place Shelter**
 - Performed clinical case management, group therapy and counseling with single women to secure housing, obtain employment, maintain health and medical care, and work on personal goals
 - Completed bio-psycho-social assessments, intakes, and diagnosed newly admitted clients

COMMUNITY OUTREACH: NYC ALTERNATIVE BREAK

SPRING 2008

NEW YORK, NY

- Volunteered with HIV/AIDS organizations in New York City to advocate for and assist individuals with HIV/AIDS (Project Achieve, Lower Eastside Harm Reduction, Rivington House, and God's Love We Deliver)
- Made safe sex packets, packaged food for homebound AIDS patients, spent time with AIDS patients residing at long term care facility, and attended seminars about new HIV/AIDS treatments

COMMUNITY OUTREACH: BIG BROTHER BIG SISTERS

2007-2008

WINDHAM, CT

Windham Middle School After-school Program, Windham CT- Site Manager (2008)

- Supervised student-child matches, reported suspected abuse at home, and organized programs

Sweeney Elementary, Willimantic CT- Big Sister (2007-2008)

- Mentored and tutored second grade "little brother" weekly and built bonds through play.

HEART HOUSE INTERN

2007-2008

STORRS, CT

- Worked with the substance abuse center on the UConn campus to educate the student body and organized harm-reduction programs on campus for students
- Scheduled, contacted, and assisted students dealing with legal charges on campus

DEPT. OF MENTAL HEALTH AND ADDICTION SERVICES INTERN

SUMMER 2007

BRIDGEPORT,

CT

- Interned with the P.U.S.H. Program to assist and integrate inpatient clients to outpatient status
- Scheduled and attended volunteer and work opportunities for and with clients with MH/SA issues

Attachment V

Standards of Practice Guidelines

Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

Robert F. Forman, Ph.D.
Consensus Panel Chair

Paul D. Nagy, M.S., LCAS, LPC, CCS
Consensus Panel Co-Chair

A Treatment Improvement Protocol

TIP 47

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

1 Choke Cherry Road
Rockville, MD 20857

Acknowledgments

Numerous people contributed to the development of this Treatment Improvement Protocol (TIP) (see pp. xi-xiv as well as appendixes C, D, and E). This publication was produced by JBS International, Inc. (JBS), under the Knowledge Application Program (KAP) contract numbers 270-99-7072 and 270-04-7049 with the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Christina Currier served as the Center for Substance Abuse Treatment (CSAT) Government Project Officer, and Andrea Kopstein, Ph.D., M.P.H., served as Deputy Government Project Officer. Lynne MacArthur, M.A., A.M.L.S., served as the JBS KAP Executive Project Co-Director. Barbara Fink, RN, M.P.H., served as the JBS KAP Managing Project Co-Director. Other KAP personnel included Dennis Burke, M.S., M.A., and Emily Schiffrin, M.S., Deputy Directors for Product Development; Patricia A. Kassebaum, M.A., Senior Writer; Elliott Vanskike, Ph.D., Senior Writer/Publication Manager; Candace Baker, M.S.W., Senior Writer; Wendy Caron, Editorial Quality Assurance Manager; Frances Nebesky, M.A., Quality Assurance Editor; Leah Bogdan, Junior Editor; and Pamela Frazier, Document Production Specialist. In addition, Sandra Clunies, M.S., ICADC, served as Content Advisor. Dixie M. Butler, M.S.W., and Paddy Shannon Cook were writers.

Disclaimer

The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of CSAT, SAMHSA, or DHHS. No official support of or endorsement by CSAT, SAMHSA, or DHHS for these opinions or for particular instruments, software, or resources described in this document is intended or should be inferred. The guidelines in this document should not be

considered substitutes for individualized client care and treatment decisions.

Public Domain Notice

All materials appearing in this volume except those taken directly from copyrighted sources are in the public domain and may be reproduced or copied without permission from SAMHSA/CSAT or the authors. Do not reproduce or distribute this publication for a fee without specific, written authorization from SAMHSA's Office of Communications.

Electronic Access and Copies of Publication

Copies may be obtained free of charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889; or electronically through www.ncadi.samhsa.gov.

Recommended Citation

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

Originating Office

Practice Improvement Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

DHHS Publication No. (SMA) 06-4182
NCADI Publication No. BKD551
Printed 2006

2 Principles of Intensive Outpatient Treatment

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

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

The 14 principles described in this chapter are

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

Executive Summary

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

The Changing IOT Landscape

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

Defining Substance Abuse Treatment and IOT

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

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

One result of the convergence of research and practice is the development of evidence-based principles that shape and guide substance abuse treatment. The consensus panel recommends 14 principles for IOT programs. These principles lay a theoretical foundation for discussions of IOT services,

clinical challenges, and treatment approaches and adaptations. In their focus on client engagement and retention, individualizing treatment, using the entire continuum of care, and reaching out to families, employers, and the community, the 14 principles help define the IOT program's contemporary role.

Continuum of Care and IOT Services

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

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

Entry, Engagement, and Treatment Issues

Many clients who enter substance abuse treatment drop out in the early stages (Claus and Kindleberger 2002). Entry and engagement are crucial processes; how an IOT program addresses them can influence strongly whether clients remain in treatment. Client intake and engagement can involve contradictory processes such as collecting intake information from clients while initiating a caring, empathic relationship. Balancing administrative tasks and therapeutic intervention is a challenge clinicians face during a client's first hours in an IOT program. To help clinicians achieve that balance, the consensus panel recommends assessing potential clients' readiness for change and using strategies that moti-

vate them to enter and continue treatment. Clinicians should begin to establish a therapeutic relationship as soon as clients present themselves for treatment. Any barriers to treatment must be addressed. Based on screening and assessments, clients should be matched with the best treatment modality and setting to support their recovery. An individualized treatment plan should be developed with the cooperation of the client to address the client's needs.

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

Treatment Approaches Used in IOT

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

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

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

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

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

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

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

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

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

Treating Different Populations

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

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

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

Many people with co-occurring mental and substance use disorders are not receiving appropriate care (Watkins et al. 2001) and find themselves shuttling between psychiatric and substance abuse treatment, caught between two systems (Drake et al. 2001). Integrated treatment attends to both disorders together, adapts standard interventions to allow for clients' cognitive limitations, and

provides comprehensive services to care for both disorders. Programs that do not adopt an integrated approach are advised to coordinate services with mental health providers.

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

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

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

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

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

Other general guidelines for programs that treat clients from other cultures include

assessing policies and practices to spot potential barriers for diverse clients, training staff members in cultural competence, providing materials at an appropriate reading level or translating materials into clients' languages, and using outreach to promote awareness of the program.

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

Attachment VI

Memoranda of Understanding (MOU)

MEMORANDUM OF UNDERSTANDING

between

Health Core Group, LLC, dba Westport Behavioral Health

and

Norwalk Hospital

This Memorandum of Understanding ("MOU") is dated for reference purposes as of March 8, 2016, and is entered into voluntarily by and among the undersigned Norwalk Hospital ("Hospital" or "party(ies)") and Health Core Group, LLC, dba Westport Behavioral Health ("WBH" or "party(ies)").

The purpose of this MOU is to establish the terms and understanding between the undersigned parties, specially as it relates to the Hospital agreeing to accept the clients of WBH in the event of an urgent medical and/or psychiatric need.

Nothing in this MOU is intended to create any relationship among the Hospital and WBH other than that of independent entities agreeing with each other solely for the purposes set forth in this MOU.

This MOU is not legally binding on the parties, but rather is a voluntary agreement based on the belief and commitment of the undersigned Hospital to accept and treat the clients of WBH in the event of an urgent medical and/or psychiatric need. This MOU is in no way meant to affect any of the participating Hospital's rights, privileges, titles, claims, or defenses provided under federal or state law or common law.

This MOU is at-will and may be modified by mutual consent of authorized officials from either parties. This MOU shall become effective upon signature by the authorized officials from the parties and will remain in effect until modified or terminated by any one of the partners by mutual consent.

The participating Hospital shall maintain the confidentiality of patient and other records as required by law.

By signing below, the Hospital is evidencing its intent to comply with this MOU and agreeing to make reasonable efforts to comply with the above terms.

NORWALK HOSPITAL

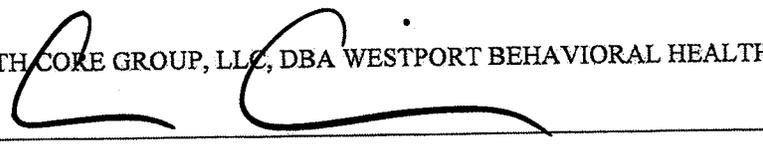


(Name, Organization, Position)

Psychiatry

3/8/16
(Date)

HEALTH CORE GROUP, LLC, DBA WESTPORT BEHAVIORAL HEALTH



Gregory Gillam, Westport House, Director of Clinical Operations

3/21/2016
(Date)



Progressive Diagnostics, LLC Qualification and Identification Information:

CLIA #07D2090970

CT License No CL-0715

EIN No 47-2786390

Laboratory Director Dr. Yujing Wen, Ph. D.

To Whom It May Concern:

This letter confirms that Progressive Diagnostics, LLC will supply the Health Core Group, LLC with high complexity qualitative screen and quantitative liquid chromatography–mass spectrometry confirmation testing services.

Best Regards,

A handwritten signature in black ink, appearing to read 'C. Kuliga', is written over a horizontal line.

Curt Kuliga
CEO & Co-Founder
Progressive Diagnostics, LLC

Attachment VII

Articles in Support of the Need for the Proposed Service

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

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

Acknowledgments

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

Public Domain Notice

All material appearing in this report is in the public domain and may be reproduced or copied without permission from SAMHSA. However, this publication may *not* be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, U.S. Department of Health and Human Services. When using estimates and quotations from this report, citation of the source is appreciated.

Recommended Citation

Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Electronic Access and Copies of Publication

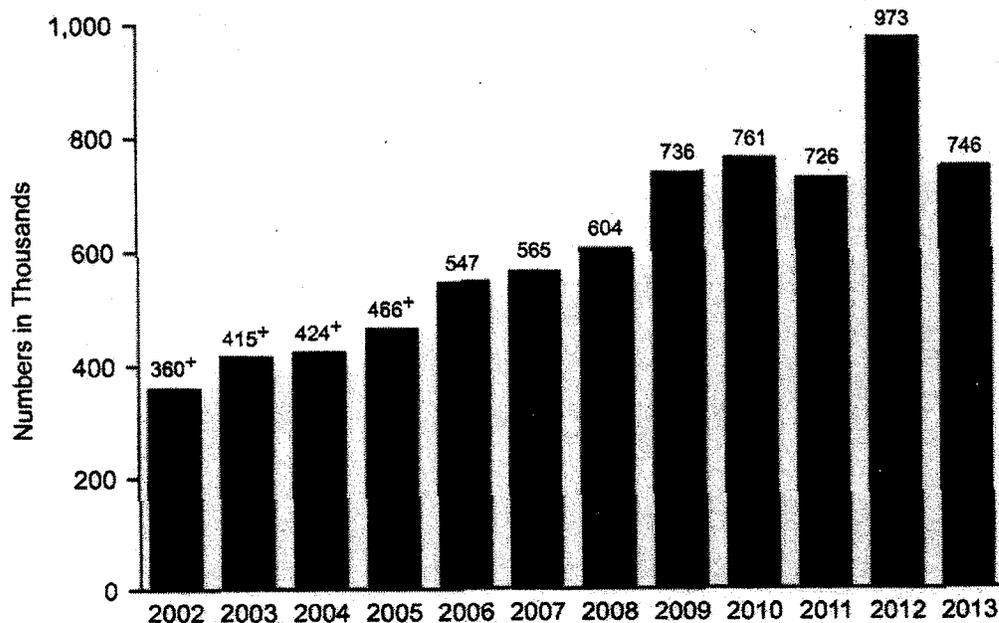
This publication may be downloaded from <http://store.samhsa.gov/home>. Hard copies may be obtained from SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Originating Office

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

September 2014

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



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

7.3 Need for and Receipt of Specialty Treatment

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

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

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

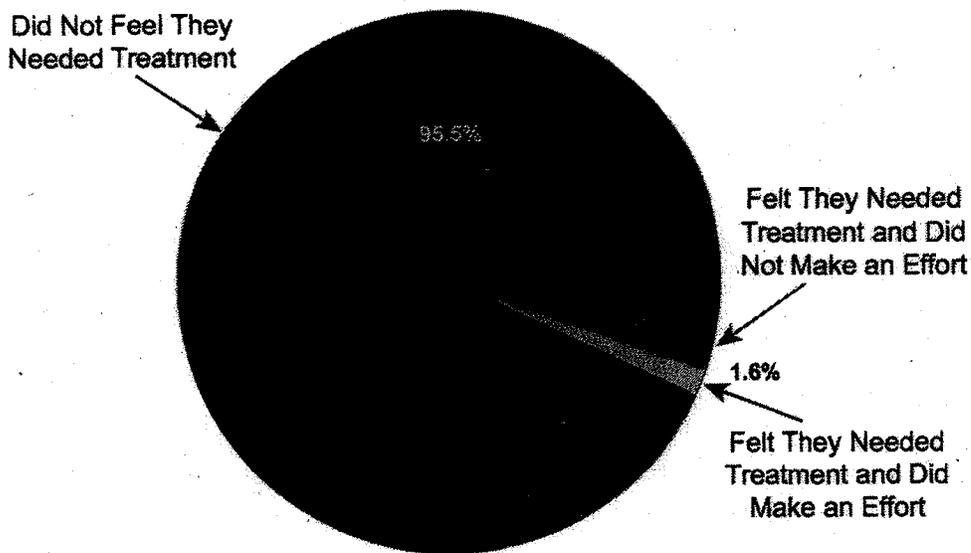
In addition to questions about symptoms of substance use problems that are used to classify respondents' need for treatment based on DSM-IV criteria, NSDUH includes questions asking respondents about their perceived need for treatment (i.e., whether they felt they needed treatment or counseling for illicit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

Illicit Drug or Alcohol Use Treatment and Treatment Need

- In 2013, 22.7 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem (8.6 percent of persons aged 12 or older). The number in 2013 was similar to the numbers in 2002 to 2012 (ranging from 21.6 million to 23.6 million). The rate in 2013 was similar to the rates in 2011 (8.4 percent) and 2012 (8.9 percent), but it was lower than the rates in 2002 to 2010 (ranging from 9.2 to 9.8 percent).
- In 2013, 2.5 million persons (0.9 percent of persons aged 12 or older and 10.9 percent of those who needed treatment) received treatment at a specialty facility for an illicit drug or alcohol problem. The number in 2013 was similar to the numbers in 2002 (2.3 million) and in 2004 through 2012 (ranging from 2.3 million to 2.6 million), and it was higher than the number in 2003 (1.9 million). The rate in 2013 was not different from the rates in 2002 to 2012 (ranging from 0.8 to 1.0 percent).
- In 2013, 20.2 million persons (7.7 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty facility in the past year. The number in 2013 was similar to the numbers in 2002 to 2012 (ranging from 19.3 million to 21.1 million). The rate in 2013 was similar to the rates in 2010 to 2012 (ranging from 7.5 to 8.1 percent), but it was lower than the rates in 2002 to 2009 (ranging from 8.3 to 8.8 percent).
- Of the 2.5 million persons aged 12 or older who received specialty substance use treatment in 2013, 875,000 received treatment for alcohol use only, 936,000 received treatment for illicit drug use only, and 547,000 received treatment for both alcohol and illicit drug use. These estimates in 2013 were similar to the estimates in 2012 and 2002.
- Among persons in 2013 who received their most recent substance use treatment at a specialty facility in the past year, 41.7 percent reported using private health insurance as a source of payment for their most recent specialty treatment, 40.6 percent reported using their "own savings or earnings," 29.0 percent reported using Medicaid, 29.0 percent reported using public assistance other than Medicaid, 26.8 percent reported using Medicare, and 23.0 percent reported using funds from family members. None of these estimates changed significantly between 2012 and 2013.

- In 2013, among the 20.2 million persons aged 12 or older who were classified as needing substance use treatment but not receiving treatment at a specialty facility in the past year, 908,000 persons (4.5 percent) reported that they perceived a need for treatment for their illicit drug or alcohol use problem (Figure 7.10). Of these 908,000 persons who felt they needed treatment but did not receive treatment in 2013, 316,000 (34.8 percent) reported that they made an effort to get treatment, and 592,000 (65.2 percent) reported making no effort to get treatment. These estimates were stable between 2012 and 2013.
- The rate and the number of youths aged 12 to 17 who needed treatment for an illicit drug or alcohol use problem in 2013 (5.4 percent and 1.3 million) were lower than those in 2012 (6.3 percent and 1.6 million), 2011 (7.0 percent and 1.7 million), 2010 (7.5 percent and 1.8 million), and 2002 (9.1 percent and 2.3 million). Of the 1.3 million youths who needed treatment in 2013, 122,000 received treatment at a specialty facility (about 9.1 percent of the youths who needed treatment), leaving about 1.2 million who needed treatment for a substance use problem but did not receive it at a specialty facility.

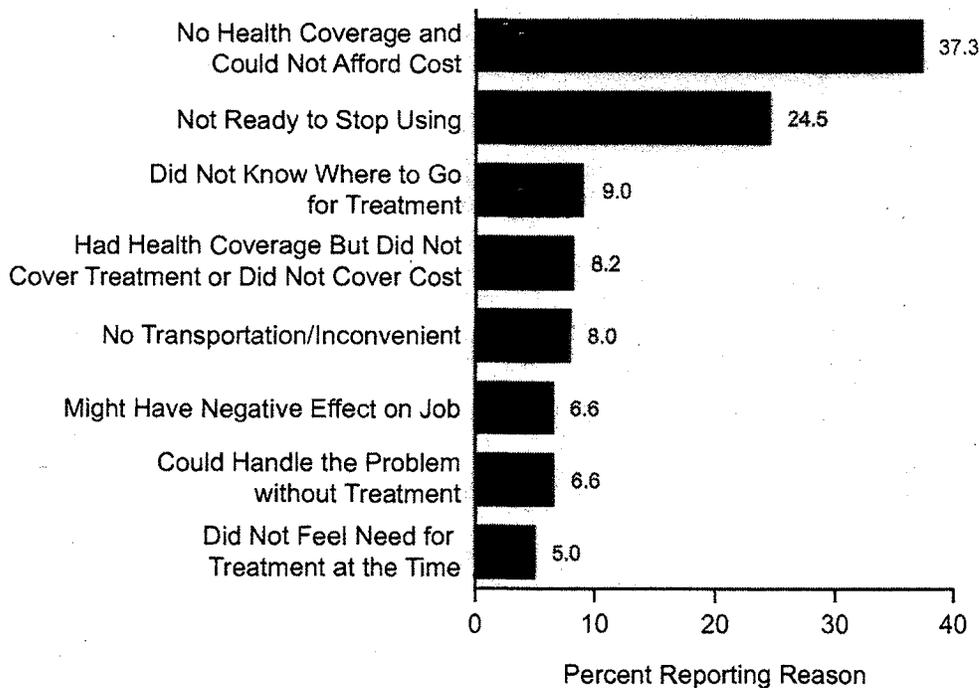
Figure 7.10 Past Year Perceived Need for and Effort Made to Receive Specialty Treatment among Persons Aged 12 or Older Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use: 2013



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

- Based on 2010-2013 combined data, commonly reported reasons for not receiving illicit drug or alcohol use treatment among persons aged 12 or older who needed and perceived a need for treatment but did not receive treatment at a specialty facility were (a) not ready to stop using (40.3 percent), (b) no health coverage and could not afford cost (31.4 percent), (c) possible negative effect on job (10.7 percent), (d) concern that receiving treatment might cause neighbors/community to have a negative opinion (10.1 percent), (e) not knowing where to go for treatment (9.2 percent), and (f) no program having type of treatment (8.0 percent).
- Based on 2010-2013 combined data, among persons aged 12 or older who needed but did not receive illicit drug or alcohol use treatment, felt a need for treatment, and made an effort to receive treatment, commonly reported reasons for not receiving treatment were (a) no health coverage and could not afford cost (37.3 percent), (b) not ready to stop using (24.5 percent), (c) did not know where to go for treatment (9.0 percent), (d) had health coverage but did not cover treatment or did not cover cost (8.2 percent), and (e) no transportation or inconvenient (8.0 percent) (Figure 7.11).

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



Illicit Drug Use Treatment and Treatment Need

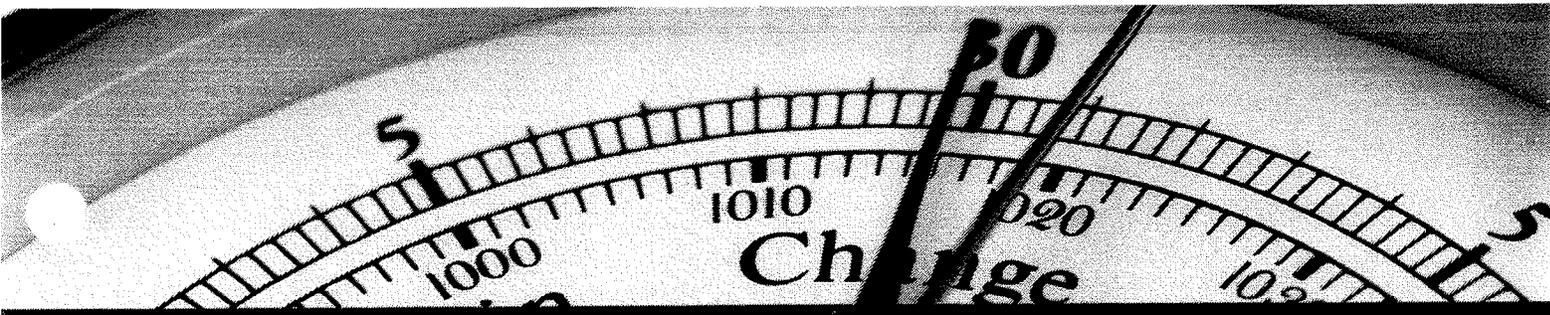
- In 2013, the number of persons aged 12 or older needing treatment for an illicit drug use problem was 7.6 million (2.9 percent of the total population). The number in 2013 was similar to the number in each year from 2002 through 2012 (ranging from 7.2 million to 8.1 million). The rate of persons needing treatment for an illicit drug use problem in 2013 was lower than the rates in 2002 (3.3 percent) and 2004 (3.3 percent), but it was similar to the rates in 2012 and 2003 (3.1 percent in each year) and in 2005 to 2011 (ranging from 2.8 to 3.2 percent).
- Of the 7.6 million persons aged 12 or older who needed treatment for an illicit drug use problem in 2013, 1.5 million (0.6 percent of the total population and 19.5 percent of persons who needed treatment) received treatment at a specialty facility for an illicit drug use problem in the past year. The number in 2013 was similar to the numbers in 2012 (1.5 million), 2002 (1.4 million), and in 2004 to 2011 (ranging from 1.2 million to 1.6 million), but it was higher than the number in 2003 (1.1 million). The rate in 2013 was similar to the rates in 2002 to 2012 (ranging from 0.5 to 0.6 percent).
- There were 6.1 million persons (2.3 percent of the total population) who needed but did not receive treatment at a specialty facility for an illicit drug use problem in 2013. The number in 2013 was similar to the numbers in 2002 to 2012 (ranging from 5.8 million to 6.6 million). The rate in 2013 was similar to the rates in 2006 to 2012 (ranging from 2.3 to 2.5 percent), but it was lower than the rates in 2002 to 2005 (ranging from 2.6 to 2.8 percent).
- Of the 6.1 million persons aged 12 or older who needed but did not receive specialty treatment for illicit drug use in 2013, 395,000 (6.4 percent) reported that they perceived a need for treatment for their illicit drug use problem, and 5.7 million did not perceive a need for treatment. The number of persons in 2013 who needed treatment for an illicit drug use problem but did not perceive a need for treatment was similar to the number in 2012 (5.9 million). However, the number of persons who needed treatment and perceived a need for treatment for an illicit drug problem in 2013 was lower than the number in 2012 (588,000 persons).
- Of the 395,000 persons aged 12 or older in 2013 who felt a need for treatment for use of illicit drugs, 148,000 reported that they made an effort to get treatment, and 247,000 reported making no effort to get treatment. These estimates in 2013 for making or not making an effort to get treatment were similar to those in 2012.
- In 2013, among youths aged 12 to 17, 908,000 persons (3.6 percent) needed treatment for an illicit drug use problem, but only 90,000 received treatment at a specialty facility (10.0 percent of youths aged 12 to 17 who needed treatment), leaving 817,000 youths who needed treatment but did not receive it at a specialty facility. These estimates in 2013 were similar to those in 2012, except that the number and the rate of youths who needed treatment for an illicit drug use problem in 2013 were lower than those in 2012 (1.0 million and 4.2 percent).

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

Alcohol Use Treatment and Treatment Need

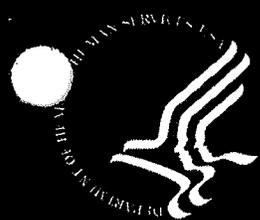
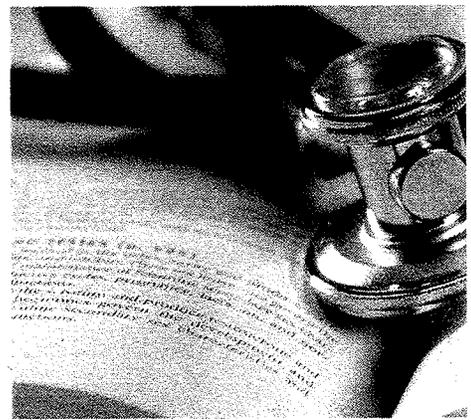
- In 2013, the number of persons aged 12 or older needing treatment for an alcohol use problem was 18.0 million (6.9 percent of the population aged 12 or older). The number in 2013 was similar to the numbers in 2010 to 2012 (ranging from 17.4 million to 18.6 million) and in 2002, 2003, and 2008 (ranging from 18.2 million to 19.1 million). However, the number in 2013 was lower than the numbers in 2004 to 2007 and in 2009 (ranging from 19.4 million to 19.6 million). The rate in 2013 (6.9 percent) was similar to the rates in 2011 (6.8 percent) and 2012 (7.0 percent), but it was lower than the rates in 2002 to 2010 (ranging from 7.3 to 8.0 percent).
- Among the 18.0 million persons aged 12 or older who needed treatment for an alcohol use problem in 2013, 1.4 million (0.5 percent of the total population and 7.9 percent of the persons who needed treatment for an alcohol use problem) received alcohol use treatment at a specialty facility. The number and the rate of the need and receipt of treatment at a specialty facility for an alcohol use problem in 2013 did not change significantly since 2002 (ranging from 1.3 million to 1.7 million and from 0.5 to 0.7 percent).
- The number of persons aged 12 or older who needed but did not receive treatment at a specialty facility for an alcohol use problem in 2013 (16.6 million) was similar to the numbers in 2002 (17.1 million), 2003 (16.9 million), and from 2008 to 2012 (ranging from 15.9 million to 17.7 million), but it was lower than the numbers from 2004 to 2007 (ranging from 17.8 million to 18.0 million). The rate in 2013 (6.3 percent of the population aged 12 or older) was similar to the rates in 2010 to 2012 (ranging from 6.2 to 6.7 percent), but it was lower than the rates in 2002 to 2009 (ranging from 7.0 to 7.4 percent).
- Among the 16.6 million persons aged 12 or older who needed but did not receive specialty treatment for an alcohol use problem in 2013, 554,000 persons (3.3 percent) felt they needed treatment for their alcohol use problem. The number and rate in 2013 were similar to those in 2012 (665,000 persons and 4.0 percent) and 2002 (761,000 persons and 4.5 percent). Of the 554,000 persons in 2013 who perceived a need for treatment for an alcohol use problem but did not receive specialty treatment, 353,000 did not make an effort to get treatment, and 201,000 made an effort but were unable to get treatment.

- The number and the rate of youths aged 12 to 17 who needed treatment for an alcohol use problem in 2013 (735,000 and 3.0 percent) were lower than those in 2012 (889,000 and 3.6 percent). Of the youths in 2013 who needed treatment for an alcohol use problem, only 73,000 received treatment at a specialty facility (0.3 percent of all youths and 10.0 percent of youths who needed treatment). These estimates were similar to those in 2012. The number and the rate of youths who needed but did not receive treatment for an alcohol use problem in 2013 (662,000 and 2.7 percent) were lower than those in 2012 (814,000 and 3.3 percent).
- Among persons aged 12 or older who needed but did not receive alcohol use treatment and felt they needed treatment (based on 2010-2013 combined data), commonly reported reasons for not receiving treatment were (a) not ready to stop using (50.5 percent), (b) no health coverage and could not afford cost (26.4 percent), (c) not finding a program that offered the type of treatment (7.6 percent), (d) not knowing where to go for treatment (7.3 percent), (e) possible negative effect on job (7.1 percent), (f) no transportation or inconvenient (7.0 percent), (g) could handle the problem without treatment (6.8 percent), and (h) having health coverage that did not cover treatment or did not cover cost (6.7 percent).



Behavioral Health Barometer

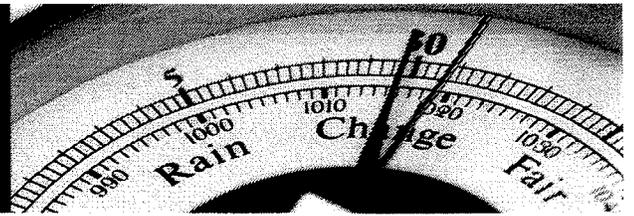
Connecticut, 2014



Substance Abuse and Mental Health Services Administration

SAMHSA

www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)



Acknowledgments

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by RTI International under contract No. 283-07-0208 with SAMHSA, U.S. Department of Health and Human Services (HHS).

Public Domain Notice

All material appearing in this report is in the public domain and may be reproduced or copied without permission from SAMHSA. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, HHS.

Electronic Access and Printed Copies

This publication may be downloaded or ordered at <http://store.samhsa.gov>. Or call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Recommended Citation

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

Originating Office

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

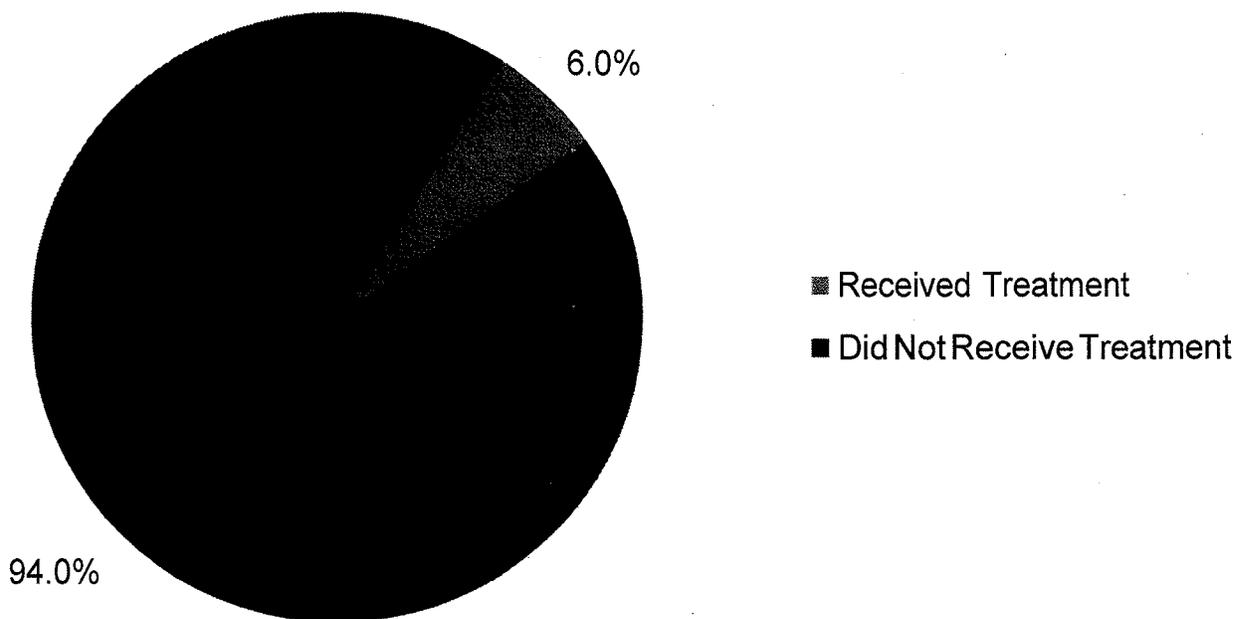
SUBSTANCE USE TREATMENT

ALCOHOL



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

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



6.0%

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

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

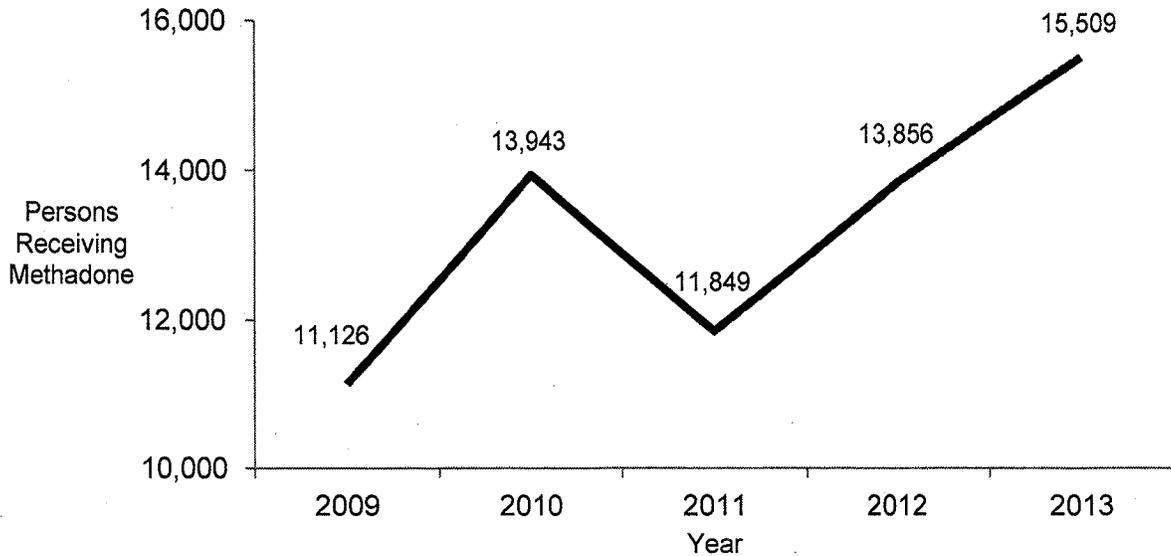
SUBSTANCE USE TREATMENT

OPIOIDS (MEDICATION-ASSISTED THERAPY)



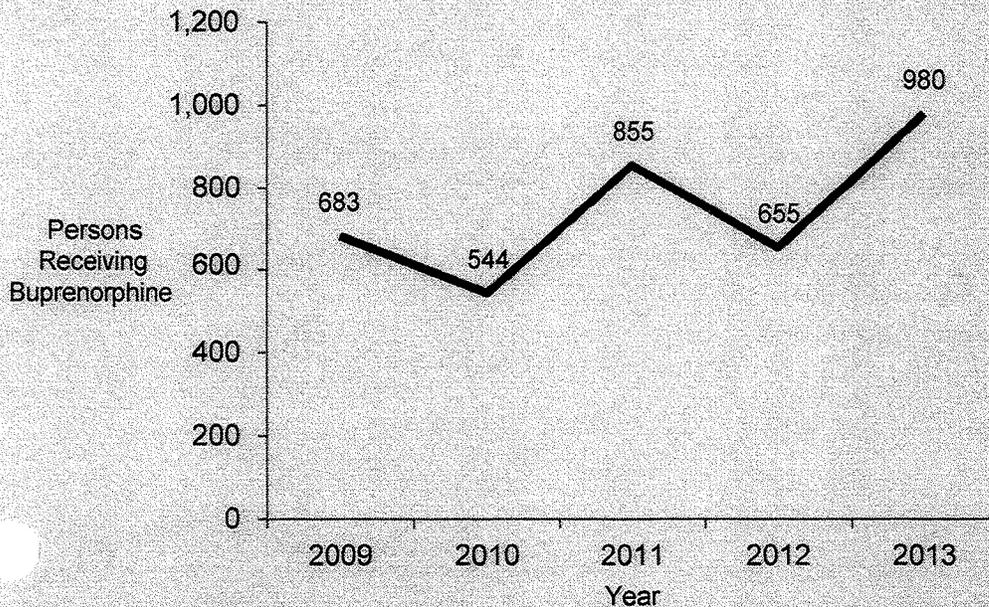
Individuals Enrolled in Opioid Treatment Programs (OTPs) in Connecticut Receiving Methadone: Single-Day Counts (2009–2013)⁷

The number of individuals in Connecticut who received methadone in OTPs as part of their substance use treatment increased from 2009 to 2013.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2009 to 2013.

Individuals Enrolled in Substance Use Treatment in Connecticut Receiving Buprenorphine: Single-Day Counts (2009–2013)^{7,8}

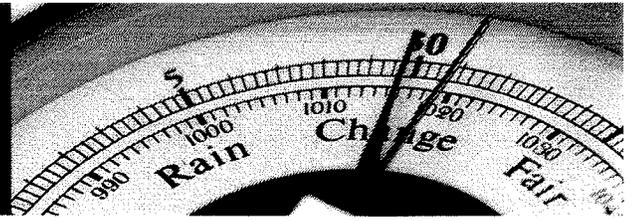


The number of individuals in Connecticut who received buprenorphine as part of their substance use treatment increased from 2009 to 2013.

In a single-day count in 2013, 15,509 individuals in Connecticut were receiving methadone as part of their substance use treatment, and 980 were receiving buprenorphine.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2009 to 2013.

DEFINITIONS



Any mental illness (AMI) among adults aged 18 or older is defined as currently or at any time in the past year having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). Adults who had a diagnosable mental, behavioral, or emotional disorder in the past year, regardless of their level of functional impairment, were defined as having any mental illness.

Binge alcohol use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

Dependence on or abuse of alcohol or illicit drugs is defined using DSM-IV criteria.

Heavy alcohol use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days.

Illicit drugs include marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, or prescription-type drugs used nonmedically, based on data from original NSDUH questions, not including methamphetamine use items added in 2005 and 2006.

Illicit drug use treatment and **alcohol use treatment** refer to treatment received in order to reduce or stop illicit drug or alcohol use, or for medical problems associated with illicit drug or alcohol use. They include treatment received at any location, such as a hospital (inpatient), rehabilitation facility (inpatient or outpatient), mental health center, emergency room, private doctor's office, self-help group, or prison/jail.

Major depressive episode (MDE) is defined as in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), which specifies a period of at least 2 weeks in the past year when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms.

Mental health treatment/counseling is defined as having received inpatient or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health.

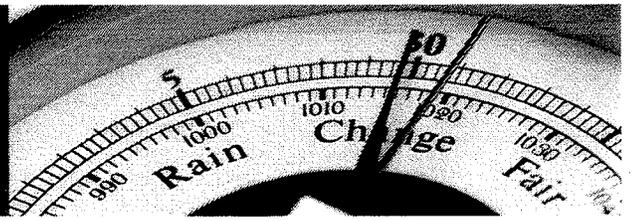
Nonmedical use of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.

Number of persons enrolled in substance use treatment refers to the number of clients in treatment at alcohol and drug abuse facilities (both public and private) throughout the 50 States, the District of Columbia, and other U.S. jurisdictions.

Serious mental illness (SMI) is defined by SAMHSA as adults aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.

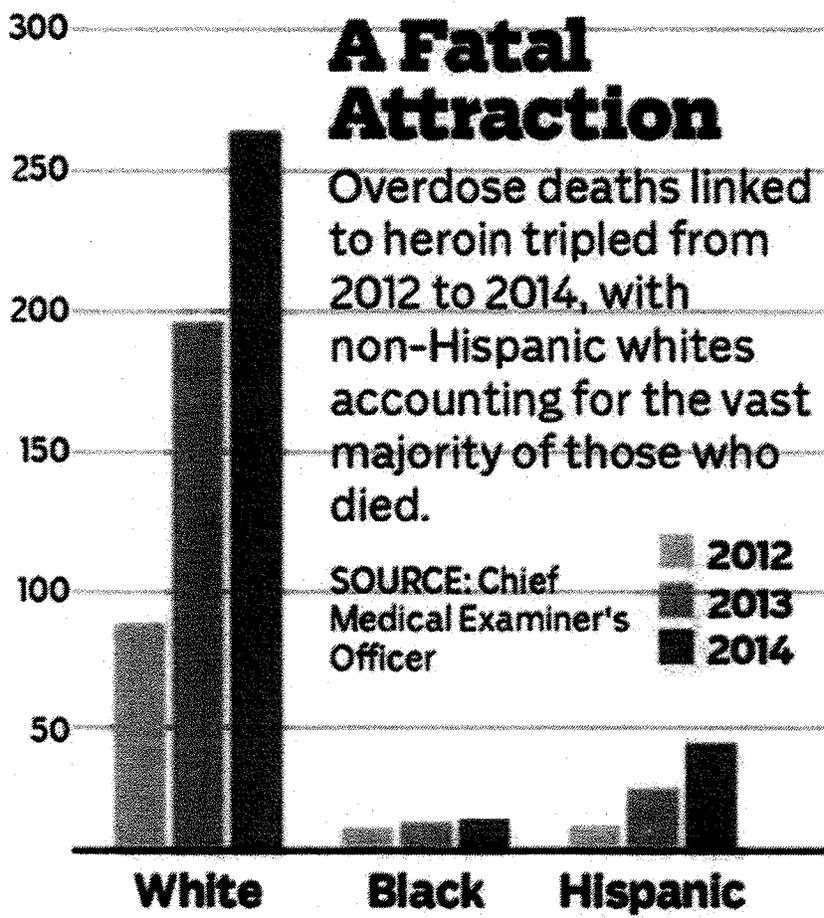
Treatment for depression is defined as seeing or talking to a medical doctor or other professional or using prescription medication for depression in the past year.

SOURCES



- Center for Behavioral Health Statistics and Quality. (2011). *Results from the 2010 National Survey on Drug Use and Health: Summary of national findings*. (HHS Publication No. SMA 11-4658, NSDUH Series H-41). Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- Center for Behavioral Health Statistics and Quality. (2012). *Results from the 2011 National Survey on Drug Use and Health: Summary of national findings* (HHS Publication No. SMA 13-4713, NSDUH Series H-44). Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- Center for Behavioral Health Statistics and Quality. (2013). *Results from the 2012 National Survey on Drug Use and Health: Summary of national findings* (HHS Publication No. SMA 13-4795, NSDUH Series H-46). Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- Center for Behavioral Health Statistics and Quality. (2014). *Results from the 2013 National Survey on Drug Use and Health: Summary of national findings* (HHS Publication No. SMA 14-4863, NSDUH Series H-48). Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- Center for Mental Health Services. (2011). *2011 CMHS Uniform Reporting System Output Tables*. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Retrieved from <http://www.samhsa.gov/dataoutcomes/urs/urs2011.aspx>
- Center for Mental Health Services. (2014). *2013 CMHS Uniform Reporting System Output Tables*. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Retrieved from <http://www.samhsa.gov/dataoutcomes/urs/urs2013.aspx>
- Office of Applied Studies. (2010). *Results from the 2009 National Survey on Drug Use and Health: Mental health findings*. (HHS Publication No. SMA 10-4609; NSDUH Series H-39). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Office of Applied Studies. (2010). *Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of national findings*. (HHS Publication No. SMA 104586Findings, NSDUH Series H-38A). Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Heroin Deaths Spike In Connecticut; Push Past 300 In 2014



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

By Nicholas Rondinone and Matthew Kauffman

July 12, 2015

In Connecticut, heroin deaths jump to 306 in 2014

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

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

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

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



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

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

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

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

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

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

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

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

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



Two From Hartford Arrested In Large Vermont Heroin Bust

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

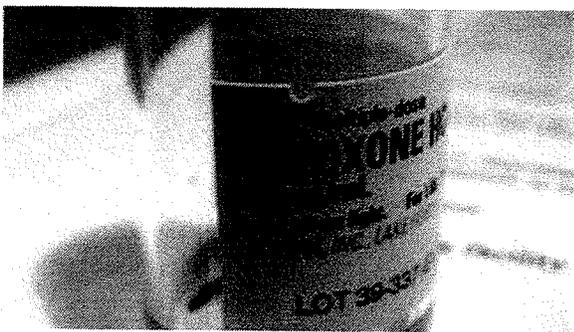
The city of Hartford has been exploring equipping police with the drug, although ambulance crews already carry it, Deputy Chief Brian Foley said. Those crews typically arrive quickly at the scene of an overdose, which is not always the case in more rural areas, Foley said.

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

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

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

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



Thumbs High For Narcan, Trans Laws

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

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

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

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

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

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

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

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

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

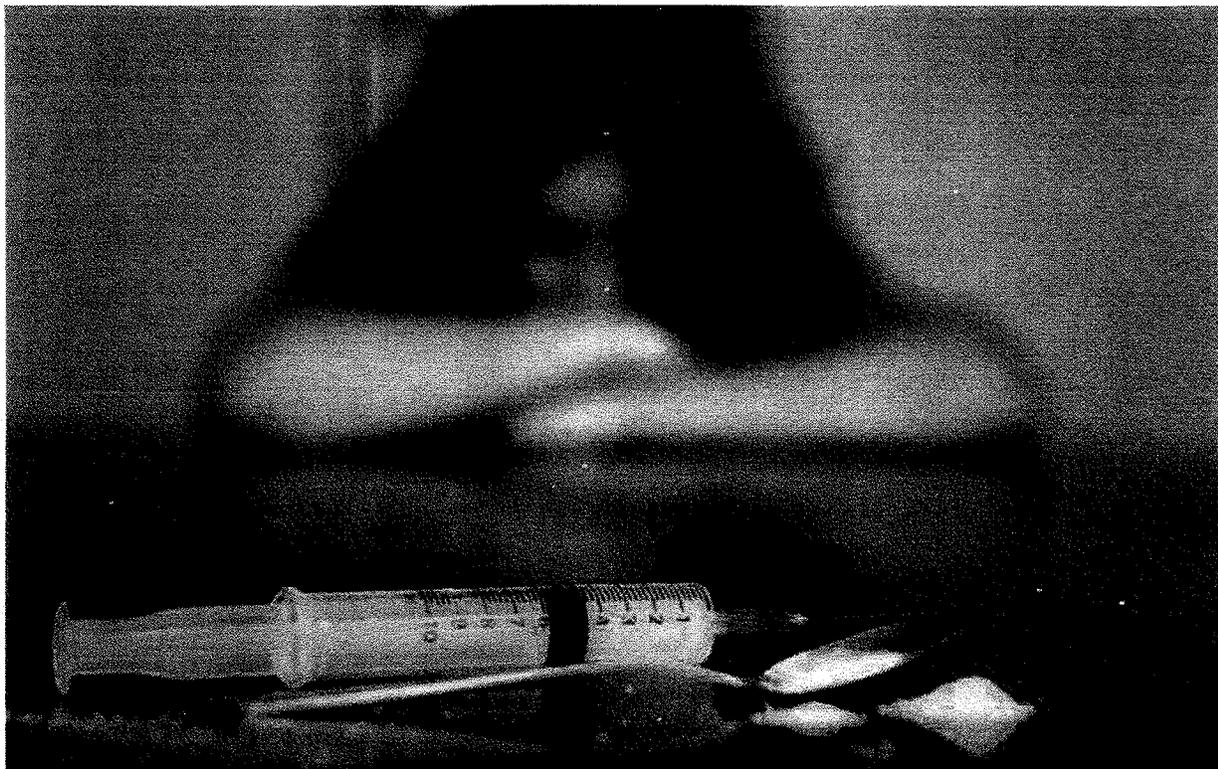
"What we saw; what we heard; what we hear is mom had back surgery, she got 30 Vicodin or Percocet and she used five. She leaves them in the medicine chest and the kid goes in there to take one and seems to enjoy the feeling he gets," Rehmer said. "He continues to take them and he goes to buy one on the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

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

Copyright © 2015, Hartford Courant

Town responds to growing prevalence of heroin

By Kristan Sveda on March 26, 2015



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

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

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

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

Opioids in home medicine cabinets

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

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

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

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

More overdoses than traffic deaths

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

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

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

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

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

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

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

Finding Help

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

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

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

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

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

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

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



Published in final edited form as:

Psychiatr Serv. 2014 June 1; 65(6): 718–726. doi:10.1176/appi.ps.201300249.

Substance Abuse Intensive Outpatient Programs: Assessing the Evidence

Dennis McCarty, Ph.D.,

Department of Public Health & Preventive Medicine, Oregon Health and Science University, Portland, OR

Lisa Braude, Ph.D.,

DMA Health Strategies, Lexington, MA

D. Russell Lyman, Ph.D.,

DMA Health Strategies, 9 Meriam Street, Suite 4, Lexington, MA 02420-5312, Phone: 781-863-8003, Fax: 781-863-1519, russl@dmahealth.com

Richard H. Dougherty, Ph.D., A.M.,

DMA Health Strategies, Lexington, MA

Allen S. Daniels, Ed.D.,

Westat, Cincinnati, OH

Sushmita Shoma Ghose, Ph.D., and

Westat, Appleton, WI

Miriam E. Delphin-Rittmon, Ph.D.

Office of Policy, Planning, and Innovation, Substance Abuse and Mental Health Services Administration, Rockville, MD

Abstract

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

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

Correspondence to: D. Russell Lyman.

Disclosures of Conflicts of Interest: Dennis McCarty is the Principal Investigator on Research Service Agreements with Alkermes and Purdue Pharma. He is the Principal Investigator on three awards from the National Institute on Drug Abuse (R21 DA035640, R01 DA029716, U10 DA015815) and an investigator on four awards from the National Institutes of Health (R01 MH100001, P50 DA018165, R01 DA030431, R21 DA031361).

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

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

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

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

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

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

Description of the service

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

Attachment VIII

Scholarship Policy

WESTPORT BEHAVIORAL HEALTH

Policy and Procedures

Topic

Scholarship Care

Policy

Westport Behavioral Health shall endeavor to provide scholarship assistance to individuals in need.

Purpose

To enable individuals who are unable to meet the full cost of care for outpatient treatment services to receive such services that they need.

Procedures

1. Westport Behavioral Health reserves a minimum of 5% of self-pay profits from outpatient treatment services for scholarship care.
2. Clients who request financial assistance will apply directly to the CEO of Health Core Group, LLC.
3. The CEO will consider applications on an individual basis.
4. Applicants must demonstrate extreme financial hardship and the lack of personal financial resources in order to qualify for scholarship assistance.
5. Client applicants who are denied scholarship assistance, due to the availability of personal financial resources, may be referred to similar service providers in the area that have public or private resources to meet the client's financial requirements.

Attachment IX

Health Core Group, LLC Financial Statement 2015

Health Core Group, LLC dba Westport House
PROFIT AND LOSS
 January - December 2015

	TOTAL
Income	
Admission Fee	4,000.00
Refunds-Allowances	1,982.10
Residential Fee	541,463.14
Phase I	708,151.10
Phase II	54,055.00
Total Residential Fee	1,303,669.24
Transitional Support Services	9,500.00
Uncategorized Income	4,637.50
Total Income	\$1,323,788.84
Gross Profit	\$1,323,788.84
Expenses	
Automobile	1,000.00
Auto Lease Expense	5,324.30
Cleaning	69.67
Gas	6,146.14
Parking	352.50
Service	1,027.98
Tolls	100.50
Total Automobile	14,021.09
Bad Debts	5,000.00
Bank Charges	205.46
Commissions & fees	100.00
Dues & Subscriptions	825.00
Facility Expenses	
Artwork, Bath Supplies, Kitchen Utensiles, Misc.	29,628.18
Cleaning	793.04
Electronics	7,679.59
Furnishings	59,802.92
Health & Wellness Equipment	240.61
Interior Design Fees	22,529.00
Landscaping	340.32
Maintenance	671.76
Small Tools & Equipment	398.84
Total Facility Expenses	122,084.26
Food	47,691.75
Take Out	10,217.61
Total Food	57,909.36
General Operating Expenses	
Accounting Fees	3,080.00
Bank Fees	944.00
Credit Card Machine Rental	445.92

	TOTAL
Credit Card Processing	6,212.76
Donation	1,880.00
Information Technology	
Ancillary Equipment	485.69
Cell Phones (deleted)	235.01
Cloud & Misc. E-Services	740.36
EMR System (FYldb)	3,717.21
Office Phones	935.91
Total Information Technology	6,114.18
Office Expenses	2,497.30
Postage	220.68
Resident Refunds	26,248.21
Program Fees	5,035.18
Total Resident Refunds	31,283.39
Total General Operating Expenses	52,678.23
Guarantee Payment Al Samaras	79,500.00
Housing	
Phase I	
Cable, Internet, & House Phone	4,670.10
Disposal Fees	1,030.00
House Lease	113,500.00
Maid Service	13,293.10
Utilities	
Electricity	7,671.57
Fuel Oil	5,994.84
Propane	99.31
Water	2,159.99
Total Utilities	15,925.71
Total Phase I	148,418.91
Phase II	
1Fragrant Pines	
Disposal Fees	320.00
House Lease	35,500.00
Total 1Fragrant Pines	35,820.00
22F Cross Highway	763.66
Cable & Internet	555.16
House Lease	48,000.00
Maid Service	1,293.50
Utilities	
Electricity	1,155.93
Fuel Oil	332.08
Water	186.43
Total Utilities	1,674.44
Total 22F Cross Highway	52,286.76
Total Phase II	88,106.76
Total Housing	236,525.67

	TOTAL
Human Resources	
Background Check	120.00
Total Human Resources	120.00
Insurance	1,321.97
Broker Fee	500.00
Liability/Property/Auto	2,886.52
Total Insurance	4,708.49
Insurance - Liability	1,535.36
Marketing	1,544.19
Account-based Marketing	
Collateral	257.70
Fundraiser	2,800.00
Miscellaneous	1,515.27
Travel & Meals	128.85
Air Travel	3,272.68
Car Rental	550.16
Fuel	1,263.74
Hotel	3,123.82
Meals	1,284.22
Parking	540.97
Taxi	375.50
Tolls	41.25
Total Travel & Meals	10,581.19
Total Account-based Marketing	15,154.16
Advertising	98.19
Apparel	556.56
Artwork & Production	1,515.30
E-Marketing	6,599.94
Merchandise	336.23
Print Media	2,119.11
Search Engine Optimization	6,300.00
Total Advertising	17,525.33
Conferences & Trade Shows	
Conference/Trade Show - Other	350.00
Fees	3,155.00
Travel & Meals	
Air Travel	253.00
Hotel	1,499.73
Meals	6.21
Taxi	9.36
Total Travel & Meals	1,768.30
Total Conferences & Trade Shows	5,273.30
Information Technology	
Hardware/Software	24.12
Salesforce CRM	363.00
Website	10,022.61
Website Domains	294.24

	TOTAL
Total Information Technology	10,703.97
Literature	
Artwork	5,950.00
Total Literature	5,950.00
Meals/Entertainment	2,794.31
Photography	980.00
Public Relations	109.98
Rental Car	254.41
Total Marketing	60,289.65
Other General and Admin Expenses	111.66
Payroll Expenses	
Payroll Processing	1,731.23
Salary Wages Expense	140,379.68
Bonuses	4,500.00
Medication Contribution	100.00
Private Insurance Contribution	1,625.00
Total Salary Wages Expense	146,604.68
Subcontract Expense	35,965.00
Wages	108,098.79
Total Payroll Expenses	292,399.70
Phones & Telecommunications	
Cell Phone/lpads	3,148.24
Xpander Communications	430.23
Total Phones & Telecommunications	3,578.47
Program Expenses	412.50
Career Counseling	9,000.00
Clinical Services	3,557.05
Family Program	3,275.00
Group Therapy	4,475.00
Individual Therapy	6,920.00
Total Clinical Services	18,227.05
Drug Screening - Laboratory Analysis	6,925.00
Drug Screening Supplies	5,675.98
Health & Wellness Activities	616.71
Fitness Trainer	1,500.00
Gym Membership	2,804.43
Meditation	1,200.00
MMA	3,140.00
Yoga	7,816.51
Total Health & Wellness Activities	17,077.65
Household Consumables	1,646.24
Miscellaneous Supplies	463.68
Petty Cash	500.00
Recreation	8,967.22
Outside Activities	2,896.60
Beach	20.00

	TOTAL
Bowling	735.60
Comedy Show	1,611.24
Concert	4,260.82
Driving Range	45.26
Fishing	2,150.00
Flag Football	1,000.00
Go Karting	1,670.25
High Ropes	503.43
Kayaking	1,357.41
Mini Golf	233.20
Movies	1,864.01
Museum	798.52
Paintball	1,821.78
Rock Climbing	510.00
Sailing	513.15
Skiing	418.77
Sky Zone	545.50
Sports Event	1,630.39
Team Sports	1,775.97
Total Outside Activities	26,361.90
Total Recreation	35,329.12
Resident Medication	397.71
Resident Miscellaneous	1,692.53
Resident Transportation Services	8,045.07
Resident Welcome Kits	2,249.64
Total Program Expenses	107,642.17
Repair & Maintenance	3,923.97
Supplies	
Miscellaneous	52.47
Total Supplies	52.47
Taxes & Licenses	18,936.21
Travel (deleted)	756.20
Travel Meals (deleted)	436.97
Uncategorized Expense	1,200.00
Total Expenses	\$1,064,540.39
Net Operating Income	\$259,248.45
Other Income	
Clinical Services	950.00
Total Other Income	\$950.00
Other Expenses	
Miscellaneous	180.00
Total Other Expenses	\$180.00
Net Other Income	\$770.00
Net Income	\$260,018.45

Attachment X

Letters of Support for the Project



February 1, 2016

To Whom It May Concern,

I am writing to support the addition of Intensive Outpatient Program services to the Westport House. I am currently serving as the Clinical Outreach Director at Primary Recovery Services. At Primary Recovery, we offer an array of services ranging from Treatment Consultations, Interventions, Intensive Case Management, Sober Companions, Sober Escorts, and Diagnostic Assessments, which are catered to helping our clients not only break the cycle of destructive patterns, but navigate through all stages of the recovery process. We are an independent company with no affiliations, financial ties or agreements with external entities or treatment centers. Prior to the opening of Westport House, we had a difficult time placing our clients returning from primary care in a structured, sober living environment due to the lack of availability of resources in this area. Westport House has provided our community with high quality transitional living that is rich in resource and sophisticated clinical care.

What is lacking in the community, however, is the availability of intensive outpatient services. Our clients that are discharged from in-patient settings directly benefit from receiving structured clinical care to reinforce skills that they have acquired. With the addition of Intensive Outpatient Services, the clients at Westport House would receive increased duration of clinical treatment hours, have the flexibility to maintain outside responsibilities, increase their community support network, gain valuable tools for relapse prevention, as well as a variety of other benefits.

At Primary Recovery Services, we are in full support of the addition of these services to be provided by Westport House. Should you have any questions, please contact me at 203-521-2830.

Best,

Susan Gallant MSW
Director of Clinical Outreach
Primary Recovery Services
203-521-2830
sue@primaryrecoveryservices.com

Mike Nowakowski
1/27/2016

m.nowakowski09@gmail.com

860-309-1287

Dear Sir or Madam,

I am writing today to give my support to conduct intensive therapy within the Westport House. After having attended a three month in-patient substance abuse treatment facility, I was a resident of the Westport House for 6 weeks (from May of 2015 to July of 2015). I am currently a resident of Westport, and I found that this transition was vital to my reintegration back into the community in which I reside.

During my three month stay at an in-patient treatment facility, I was shielded from the dangers/triggers of day-to-day stressors and any exposure to alcohol which could have put my early sobriety in jeopardy. Transitioning from an in-patient facility to a sober living environment gave me the stability and reintroduction to day-to-day life with the support and direction that would allow me to nurture my very fragile state of early recovery. Without this support, I can honestly say that being thrown back into the daily stressors and triggers that present themselves on a daily basis would have been detrimental to my recovery.

For the therapy that I needed, I had to seek support outside of Westport House and piece together the levels of care that would allow me greatest success with my reintegration into daily society and back into the Westport community, where I live. Therapy gave me a chance to discuss any potential problems or barriers that could be hindering or jeopardizing the state of my delicate early sobriety. It gave me a safe outlet to discuss with experienced professionals what I was going through mentally, physically, and spiritually, as well as ways to address these issues. Talking about these topics gave me the hope, strength, and confidence I needed to assimilate back to my full time job, my marriage, and my home life. Having all of these services in-house would make it incredibly easy for me to discuss these issues as they came up. From my own personal experience, I found that ease of access and a quick response time from those staff members would be best complemented by intensive therapy services that continued past my residence at the House.

As a resident of the Town of Westport, as well as a former resident of the Westport House, I can attest that therapy is an essential part of the program, and exist in order to give residents the support and timely, expedient care that they need to be successful in early recovery.

Sincerely,

Mike Nowakowski

January 27, 2016

To Whom It May Concern:

My name is Lisa Arnold and I am the Clinical Coordinator of the Collegiate Recovery Program at Fairfield University. I am writing this letter because I recently learned that Westport House extended care facility in Westport, CT has recently applied to begin an IOP and OP for their clients. Having worked in the field of addiction and recovery for twenty one years, I am well aware that continuum of care is of utmost importance in the life of a recovering addict.

Transitioning back into the real world is a huge undertaking for a young person in recovery. The stressors of life press hard against their character defects, and in times of stress, it is easy to forget or stop using coping mechanisms if they are not continuously being learned and reinforced after discharge from a treatment or extended care facility. The idea that Westport House may provide this service from the time of residence and beyond will ultimately provide recovering young adults with valuable insight to navigate their path into their new lives, and reinforce the valuable skills they learned during their stay at the house.

It is common knowledge in the field of addiction and recovery that ongoing work on a recovering addict's treatment plan, particularly their relapse prevention skills, is imperative to the successful prognosis and the outcome of their treatment experience.

I applaud Westport House for taking on this endeavor, and I endorse the addition of these important modalities into their menu of treatment options. . I have worked directly with Westport House residents, and they are a wonderful group of young men eager to learn and grow in their newly sober lives. It would be so beneficial to them to be offered this wonderful opportunity.

Respectfully,

Lisa Arnold, MFT, LADC

Greer, Leslie

From: Armah, Olga
Sent: Friday, May 27, 2016 12:46 PM
To: pbrmssw@aol.com
Cc: User, OHCA; Riggott, Kaila; Armah, Olga
Subject: Completeness Questions on CON Application # 16-32084
Attachments: 16-32084 Completeness.docx

Dear Mr. Rockholz,

Please see attached request for additional information regarding CON application 16-32084 – Establishment of a psychiatric outpatient day treatment and substance abuse or dependence treatment clinic for young male adults in Westport. There are additional items that need to be addressed.

Please contact me if you have any questions. Responses are due by **Tuesday July 26, 2016**.

Regards.

Olga

Olga Armah, M. Phil

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

Phone: 860 418 7070

Fax: 860 418 7053

mailto: olga.armah@ct.gov

Web: www.ct.gov/ohca



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Acting Commissioner



Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

May 31, 2016

VIA EMAIL

pbrmssw@aol.com

Peter B. Rockholz
Consultant
Health Core Group, LLC
81 Bowman Drive
Greenwich, CT 06831

RE: Certificate of Need Application, Docket Number 16-32084-CON
Establishment of a Psychiatric Outpatient Substance Abuse Disorder Treatment Clinic for Adults

Dear Mr. Rockholz:

On April 29th, 2016, the Department of Public Health ("DPH"), Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application on behalf of Health Core Group, LLC, d/b/a Westport Behavioral Health ("Applicant") proposing to establish a psychiatric outpatient day treatment clinic and a freestanding facility for the care or treatment of substance abuse or dependence for young adults in Westport.

OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email. *Please email your responses to all of the following email addresses:* OHCA@ct.gov; olga.armah@ct.gov; and kaila.riggott@ct.gov.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than **July 26, 2016**, otherwise your application will be automatically considered withdrawn.



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

Affirmative Action/Equal Opportunity Employer

Repeat each question before providing your response and paginate and date your response, i.e., each page, in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant’s document preceding it. Please begin your submission using **Page 106** and reference “**Docket Number: 16-32084-CON.**”

1. Explain if and how individuals in Westport and surrounding towns (not residents of Westport House) would access the proposed intensive outpatient treatment clinic and services.
2. Provide utilization by town/city and state origin of Westport House residents using the table below:

UTILIZATION BY TOWN

Town and state	Utilization FY 2015

3. The following table contains information provided on page 19. Update the table to reflect only young male adults (17- 25 years old):

ESTIMATE OF DIAGNOSABLE SUBSTANCE USE DISORDERS INCIDENCE IN FAIRFIELD COUNTY

SUBSTANCE USE DISORDER	POPULATION (18 years and above) ¹	PREVALENCE ^{2, 3}	INCIDENCE
Fairfield County	718,478	8.4%	60,436
Westport	27,561	8.4%	2,315
Service Area as Percent of Connecticut	4%	n/a	4%

4. Provide a discussion on why revenues and expenses are projected to increase annually by 7.5% and 5.0%, respectively, as indicated on page 26.
5. Page 28 states that all residents will enter IOT, however Table 6 shows that 66 of the 84 of the residents would be in IOT from FY 2017 through FY 2019. Explain the inconsistency and update and resubmit the table, if needed.
6. Would the proposed IOT program accept referrals from DMHAS, the Judicial Branch and/or Medicaid, as described on page 30? If yes, describe the process? If no, explain why not.
7. Can individuals referred for IOT by the entities noted in #6 apply for the scholarship assistance as described on pages 24 and 94?

8. Update and resubmit the Financial Worksheet B on page 40 with projections for FY 2019.
9. Update the following table with visits breakout and three full fiscal years of projections. Ensure visit totals are consistent with “Outpatient Visits” row on page 40. Also, update the table to account for the Medicaid-eligible patients or recently indigents noted on page 24.

**CURRENT AND PROJECTED PAYER MIX FOR
WESTPORT BEHAVIORAL HEALTH BY NUMBER OF CLIENTS AND VISITS**

Payer	Current			Projected								
	FY 2016			FY 2017			FY 2018			FY 2019		
	Patient Vol.	%	Visits Vol.	Patient Vol.	%	Visits Vol.	Patient Vol.	%	Visits Vol.	Patient Vol.	%	Visits Vol.
Medicare*	0			0			0					
Medicaid*	0			0			0					
CHAMPUS & TriCare	0			0			0					
Total Government	0			0			0					
Commercial Insurers	14	67%		44	67%		44	67%				
Self-pay												
Uninsured	7	33%		22	33%		22	33%				
Workers Compensation												
Total Non-Government	21	100%		66	100%		66	100%				
Total Payer Mix	21	100%	468	66	100%	1,872	66	100%	1,872			

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7001 or (860) 418-7070.

Sincerely,

Olga Armah
Associate Research Analyst

Greer, Leslie

From: Armah, Olga
Sent: Wednesday, June 01, 2016 11:05 AM
To: Peter Rockholz
Cc: User, OHCA; Riggott, Kaila
Subject: RE: Completeness Questions on CON Application # 16-32084

Thanks.

Olga Armah

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



From: Peter Rockholz [<mailto:pbrmssw@aol.com>]
Sent: Friday, May 27, 2016 12:55 PM
To: Armah, Olga
Subject: RE: Completeness Questions on CON Application # 16-32084

Olga
I have received your email regarding questions.
Peter Rockholz

From: [Armah, Olga](#)
Sent: 5/27/2016 12:46 PM
To: pbrmssw@aol.com
Cc: [User, OHCA](#); [Riggott, Kaila](#); [Armah, Olga](#)
Subject: Completeness Questions on CON Application # 16-32084

Dear Mr. Rockholz,

Please see attached request for additional information regarding CON application 16-32084 – Establishment of a psychiatric outpatient day treatment and substance abuse or dependence treatment clinic for young male adults in Westport. There are additional items that need to be addressed.

Please contact me if you have any questions. Responses are due by **Tuesday July 26, 2016**.

Regards.

Olga
Olga Armah, M. Phil
Associate Research Analyst
Office of Health Care Access
CT Department of Public Health

Greer, Leslie

From: pbrmssw@aol.com
Sent: Friday, June 03, 2016 11:40 AM
To: Armah, Olga
Cc: User, OHCA; Riggott, Kaila
Subject: Re: Completeness Questions on CON Application # 16-32084
Attachments: Responses to OHCA questions.pdf; Health Core Group LLC Financial Worksheet B Rev 6-2-16.xlsx; Responses to questions [1100865].docx

Olga

Please see, attached, reponses to completeness questions for CON Application # 16-32084 by Health Core Group, LLC.

You will find a .pdf version of the entire response, along with both a Word version of the narrative and an Excel version of a revised Financial Worksheet B.

My client is currently paying rent and Westport House residents are anxious to begin treatment. Please advise if it is a possibility for these responses to enable the CON Application to be deemed complete within a timeframe less than 30 days.

Thank you,

Peter

Peter B Rockholz, M.S.S.W., LCSW
Behavioral Health Consultant
81 Bowman Drive
Greenwich, CT 06831
203.313.1418
pbrmssw@aol.com

-----Original Message-----

From: Armah, Olga <Olga.Armah@ct.gov>
To: Peter Rockholz <pbrmssw@aol.com>
Cc: User, OHCA <OHCA@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>
Sent: Wed, Jun 1, 2016 11:05 am
Subject: RE: Completeness Questions on CON Application # 16-32084

Thanks.

Olga Armah

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



From: Peter Rockholz [<mailto:pbrmssw@aol.com>]
Sent: Friday, May 27, 2016 12:55 PM

To: Armah, Olga
Subject: RE: Completeness Questions on CON Application # 16-32084

Olga
I have received your email regarding questions.
Peter Rockholz

From: [Armah, Olga](#)
Sent: 5/27/2016 12:46 PM
To: pbrmssw@aol.com
Cc: [User, OHCA](#); [Riggott, Kaila](#); [Armah, Olga](#)
Subject: Completeness Questions on CON Application # 16-32084

Dear Mr. Rockholz,

Please see attached request for additional information regarding CON application 16-32084 – Establishment of a psychiatric outpatient day treatment and substance abuse or dependence treatment clinic for young male adults in Westport. There are additional items that need to be addressed.

Please contact me if you have any questions. Responses are due by **Tuesday July 26, 2016**.

Regards.

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

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



Responses to questions presented by the Office of Health Care Access via email from Olga Armah on Friday, May 27, 2016

1. Explain if and how individuals in Westport and surrounding towns (not residents of Westport House) would access the proposed intensive outpatient treatment clinic and services.

The clinic is designed for and intended to serve Westport House residents. However, it will have the physical space and staffing capacity to serve additional individuals who need and request IOT program services, and will consider doing so if the actual demand presents itself. Such individuals (i.e., young adult males) from surrounding towns who wish to be admitted directly to our outpatient services may either self-refer or be referred through a behavioral health professional. This referral would take place via a phone call or email to an admissions representative. Self-referrals would require an intake evaluation to be conducted by a psychiatrist prior to admission. Pending this evaluation demonstrating a need for the services (i.e., ASAM PPC-2R level II.1), the self-referral may be admitted to outpatient treatment immediately (pending availability). Referrals made through a licensed professional would be screened and admitted immediately (pending availability). All such individuals must otherwise meet clinic criteria for admission, including the demonstrated ability to pay the full cost of care.

2. Provide utilization by town/city and state origin of Westport House residents using the table below:

Town of origin – Westport House residents FY2015

UTILIZATION BY TOWN		
Town and state	Utilization FY 2015	
CT	Bridgewater	1
	Cos Cob	1
	Darien	2
	Fairfield	1
	Greenwich	4
	Hamden	1
	Meriden	1
	Milford	1
	New Canaan	2
	Redding	1
	Ridgefield	2
	Rowayton	1
	South Windsor	1
	Southport	1
	Stamford	2
	Trumbull	2
	Weston	1
Westport	3	

	Wilton	2
NY	Manlius	1
	Scarsdale	1
	Purchase	1
	Bronx	1
	Duanesburg	1
	Staten Island	1
SD	Mitchell	1
FL	Clearwater	1
LA	Marrero	1
MA	Westborough	1
	Walpole	1
NH	Laconia	1
NJ	Howell	1
	Mahwah	1
	Short Hills	1
TX	Arlington	1
	Houston	1
	San Antonio	1
WV	Wheeling	1
Sweden	Stockholm	1

3. The following table contains information provided on page 19. Update the table to reflect only young male adults (17- 25 years old):

ESTIMATE OF DIAGNOSABLE SUBSTANCE USE DISORDERS INCIDENCE IN FAIRFIELD COUNTY

SUBSTANCE USE DISORDER	POPULATION (ages 17-25)	PREVALENCE**	INCIDENCE
Fairfield County	98,281*	21.1%	20,737
Westport	3,770	21.1%	795
Service Area as Percent of Connecticut	4%	n/a	4%

* Reference: 2010 U.S. Census

** SAMHSA, June 2009, Loc. cit. (see page 35)

It should be noted that the information contained in the table above reflects the 2010 census population of Westport without consideration of the fact that virtually the entire target population (Westport House residents) is not included in the census figures since about one-half originally come from places outside the area as indicated in item #2 above and were not counted in the 2010 census. This group of individuals has a diagnosable SUD prevalence of 100%.

- 4. Provide a discussion on why revenues and expenses are projected to increase annually by 7.5% and 5.0%, respectively, as indicated on page 26.**

The projections that are mentioned on page 26 are in error. The figures of 7.5% and 5.0% for revenues and expenses, respectively are incorrect. As is indicated on *Financial Worksheet B* on page 40, the correct figures - based upon the dollar amounts provided -- reflect approximately 2.5% increases in both revenues and expenses year-to-year. The same percentages are reflected in the figures provided in Table 4 on page 26. These increases are modest and reasonable and are reflective of increases in the costs of materials, consulting services, salaries and fringe benefits and the like. Revenues will also increase modestly through improved billing and collections, and improved negotiated rates expected to occur upon accreditation of the facility by a national accrediting body.

- 5. Page 28 states that all residents will enter IOT, however Table 6 shows that 66 of the 84 of the residents would be in IOT from FY 2017 through FY 2019. Explain the inconsistency and update and resubmit the table, if needed.**

The figures provided in Table 6 are accurate. What is not explained on page 28 is that while all entering Westport House residents will also enter the IOT program upon admission, after completion of the IOT program they will remain as residents of Westport House – in a second phase of sober living. The apparent inconsistency is explained by the fact that, for each full year, the number of persons served in Sober Housing in Table 6 includes those Westport House residents remaining in the sober living facilities on January 1 and who have already completed the IOT program. These are estimated to be 18 annually, reflecting the difference between 84 and 66.

- 6. Would the proposed IOT program accept referrals from DMHAS, the Judicial Branch and/or Medicaid, as described on page 30? If yes, describe the process? If no, explain why not.**

The IOT program would accept referrals from DMHAS and the Judicial Branch (e.g., Court Support Services Division) who meet diagnostic and intake criteria for admission to the program. These criteria include demonstrating the ability to pay the full cost of care. Since Westport Behavioral Health will not receive any public support (i.e., Federal, State or Local government) such as grants or contracts or public donations, it is not in a position to accept Medicaid assignment and does not anticipate applying for a rate as an approved provider. The referral process would be the same as for other self- and professional referrals as described in item #1 above.

- 7. Can individuals referred for IOT by the entities noted in #6 apply for the scholarship assistance as described on pages 24 and 94?**

Yes, individuals referred for IOT by DMHAS and the Judicial Branch can apply for scholarship assistance.

- 8. Update and resubmit the Financial Worksheet B on page 40 with projections for FY 2019.**

The original submission of *Financial Worksheet B* on page 40 does include projections for FY 2019. However, items C (retained earnings) and E (FTEs) were not included for FY 2019. A revised *Financial Worksheet B* is provided on page 110 and is intended as a replacement for page 40.

9. Update the following table with visits breakout and three full fiscal years of projections. Ensure visit totals are consistent with "Outpatient Visits" row on page 40. Also, update the table to account for the Medicaid-eligible patients or recently indigents noted on page 24.

CURRENT AND PROJECTED PAYER MIX FOR
WESTPORT BEHAVIORAL HEALTH BY NUMBER OF CLIENTS AND VISITS

Payer	Current			Projected								
	FY 2016			FY 2017			FY 2018			FY 2019		
	Patient Vol.	%	Visits Vol.	Patient Vol.	%	Visits Vol.	Patient Vol.	%	Visits Vol.	Patient Vol.	%	Visits Vol.
Medicare*	0		0	0		0	0	0	0	0		0
Medicaid*	0		0	0		0	0	0	0	0		0
CHAMPUS & TriCare	0		0	0		0	0	0	0	0		0
Total Government	0		0	0		0	0	0	0	0		0
Commercial Insurers	14	67%	312	44	67%	1,254	44	67%	1,254	44	67%	1,254
Self-pay												
Uninsured	7	33%	156	22	33%	618	22	33%	618	22	33%	618
Workers Compensation	0	0	0	0		0	0		0	0		0
Total Non-Government	21	100%	468	66	100%	1,872	66	100%	1,872	66	100%	1,872
Total Payer Mix	21	100%	468	66	100%	1,872	66	100%	1,872	66	100%	1,872

FOR-PROFIT
 Applicant Name: Health Core Group, LLC
 Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:
 Financial Worksheet (B)

LINE	Total Entity Description	FY 2015 Actual Results		FY 2016*		FY 2017		FY 2018		FY 2019		FY 2020		FY 2021		
		Projected	Without CON	Projected	Incremental	Projected	Incremental	Projected	Incremental	Projected	Incremental	Projected	Incremental	Projected	Incremental	Projected
A. OPERATING REVENUE																
1	Total Gross Patient Revenue	\$1,322,039	\$1,421,192	\$289,447	\$1,690,639	\$1,527,781	\$1,101,777	\$2,629,558	\$1,642,365	\$1,127,050	\$2,769,415	\$1,765,542	\$1,149,591	\$2,915,133	\$1,765,542	\$4,023,571
2	Less: Allowances			\$95,540	\$95,540	\$389,456	\$389,456	\$397,093	\$397,093	\$6,716	\$6,716	\$7,220	\$7,220	\$7,220	\$7,220	\$7,220
3	Less: Charity Care			\$1,530	\$1,530	\$6,407	\$6,407	\$6,407	\$6,407	\$6,716	\$6,716	\$7,220	\$7,220	\$7,220	\$7,220	\$7,220
4	Less: Other Deductions															
5	Net Patient Service Revenue	\$1,322,039	\$1,421,192	\$172,377	\$1,593,569	\$1,527,781	\$705,914	\$2,233,695	\$1,642,365	\$1,642,365	\$2,365,606	\$1,765,542	\$740,014	\$2,505,556	\$1,765,542	\$2,505,556
6	Medicaid															
7	CHAMPUS & TriCare															
8	Other															
9	Total Government	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
10	Commercial Insurers			\$143,310	\$143,310	\$584,185	\$584,185	\$595,639	\$595,639	\$595,639	\$595,639	\$595,639	\$595,639	\$595,639	\$595,639	\$595,639
11	Uninsured															
12	Workers Compensation	\$1,322,039	\$1,421,192	\$29,067	\$1,450,259	\$1,527,781	\$1,211,729	\$1,769,967	\$1,642,365	\$1,642,365	\$1,769,967	\$1,765,542	\$133,982	\$1,899,524	\$1,765,542	\$1,899,524
13	Other															
	Total Non-Government	\$1,322,039	\$1,421,192	\$172,377	\$1,593,569	\$1,527,781	\$705,914	\$2,233,695	\$1,642,365	\$1,642,365	\$2,365,606	\$1,765,542	\$741,534	\$2,507,076	\$1,765,542	\$2,507,076
Net Patient Service Revenue* (Governments/Non-Government)		\$1,322,039	\$1,421,192	\$172,377	\$1,593,569	\$1,527,781	\$705,914	\$2,233,695	\$1,642,365	\$1,642,365	\$2,365,606	\$1,765,542	\$741,534	\$2,507,076	\$1,765,542	\$2,507,076
14	Less: Provision for Bad Debts															
Net Patient Service Revenue less provision for bad debts		\$1,322,039	\$1,421,192	\$172,377	\$1,593,569	\$1,527,781	\$705,914	\$2,233,695	\$1,642,365	\$1,642,365	\$2,365,606	\$1,765,542	\$740,014	\$2,505,556	\$1,765,542	\$2,505,556
15	Other Operating Revenue															
17	Net Assets Released from Restrictions															
	TOTAL OPERATING REVENUE	\$1,322,039	\$1,421,192	\$172,377	\$1,593,569	\$1,527,781	\$705,914	\$2,233,695	\$1,642,365	\$1,642,365	\$2,365,606	\$1,765,542	\$740,014	\$2,505,556	\$1,765,542	\$2,505,556
B. OPERATING EXPENSES																
1	Salaries and Wages	\$265,897	\$271,021	\$52,216	\$323,237	\$277,694	\$208,861	\$486,555	\$286,025	\$215,217	\$501,242	\$294,606	\$221,674	\$516,280	\$294,606	\$221,674
2	Fringe Benefits	\$42,543	\$43,363	\$8,354	\$51,717	\$41,654	\$33,418	\$75,072	\$45,764	\$34,435	\$80,199	\$47,137	\$35,468	\$82,605	\$47,137	\$35,468
3	Physicians Fees															
4	Supplies and Drugs															
5	Depreciation and Amortization	\$3,747	\$3,747	\$400	\$4,147	\$3,747	\$1,600	\$5,347	\$3,747	\$1,600	\$5,347	\$3,747	\$1,600	\$5,347	\$3,747	\$1,600
6	Provision for Bad Debts-Other ^b															
7	Interest Expense															
8	Malpractice Insurance Cost															
9	Lease Expense	\$161,500	\$228,000	\$23,760	\$251,760	\$228,000	\$95,040	\$323,040	\$228,000	\$97,891	\$325,891	\$228,000	\$100,828	\$328,828	\$228,000	\$100,828
10	Other Operating Expenses	\$526,755	\$505,873	\$36,074	\$469,800	\$550,186	\$298,867	\$849,033	\$601,842	\$305,364	\$907,206	\$662,026	\$311,777	\$972,803	\$662,026	\$311,777
	TOTAL OPERATING EXPENSES	\$1,000,472	\$1,052,004	\$140,804	\$1,192,808	\$1,101,261	\$637,786	\$1,739,047	\$1,165,378	\$654,507	\$1,819,885	\$1,235,516	\$671,347	\$1,906,863	\$1,235,516	\$671,347
INCOME/(LOSS) FROM OPERATIONS		\$321,567	\$369,188	\$31,573	\$400,761	\$426,520	\$68,128	\$494,648	\$476,987	\$68,734	\$545,721	\$530,026	\$68,667	\$598,693	\$530,026	\$68,667
NON-OPERATING INCOME																
Income before provision for income taxes		\$321,567	\$369,188	\$31,573	\$400,761	\$426,520	\$68,128	\$494,648	\$476,987	\$68,734	\$545,721	\$530,026	\$68,667	\$598,693	\$530,026	\$68,667
Provision for income taxes ^c		\$97,594	\$111,880	\$0	\$111,880	\$129,080	\$20,643	\$149,723	\$147,906	\$20,826	\$168,732	\$149,237	\$21,013	\$170,250	\$149,237	\$21,013
NET INCOME		\$223,973	\$257,308	\$31,573	\$288,881	\$297,440	\$47,485	\$344,925	\$329,081	\$47,908	\$376,989	\$380,789	\$68,667	\$449,456	\$380,789	\$68,667
Retained Earnings, beginning of year		\$223,973	\$223,973	\$0	\$223,973	\$481,281	\$31,573	\$512,854	\$778,721	\$79,058	\$857,779	\$1,107,802	\$126,966	\$1,234,768	\$1,107,802	\$126,966
Retained Earnings, end of year		\$447,946	\$481,281	\$31,573	\$512,854	\$778,721	\$79,058	\$857,779	\$1,107,802	\$126,966	\$1,234,768	\$1,484,768	\$195,933	\$1,684,224	\$1,484,768	\$195,933
Principal Payments																
D. PROFITABILITY SUMMARY																
1	Hospital Operating Margin	24.3%	26.0%	18.3%	25.1%	27.9%	9.7%	22.1%	29.0%	9.5%	23.1%	30.0%	9.3%	23.9%	30.0%	9.3%
2	Hospital Non-Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	16.9%	18.1%	18.3%	18.1%	18.5%	6.7%	15.4%	20.0%	6.6%	15.9%	21.5%	9.3%	17.9%	21.5%	9.3%
E. FTEs		12	12	4	16	13	5	18	13	5	18	13	5	18	13	5
F. VOLUME STATISTICS^d																
1	Inpatient Discharges	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	Outpatient Visits	0	0	468	468	1,872	1,872	1,872	1,872	1,872	1,872	1,872	1,872	1,872	1,872	1,872
	TOTAL VOLUME	0	0	468	468	1,872	1,872	1,872	1,872	1,872	1,872	1,872	1,872	1,872	1,872	1,872
	* FY 2016 incremental (proposed project) reflects 3 months' projections (Oct 1- Dec 31)															

^aTotal amount should equal the total amount on cell line "Net Patient Revenue" Row 14
^bProvide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No. 2011-07, July 2011.
^cProvide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
^dProvide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Greer, Leslie

From: Armah, Olga
Sent: Thursday, June 30, 2016 3:02 PM
To: pbrmssw@aol.com
Cc: User, OHCA; Riggott, Kaila
Subject: RE: Completeness Questions on CON Application # 16-32084
Attachments: 16-32084 Completeness #2.docx

Dear Peter,

We have one additional question regarding the above application. The response is due by **Monday August 29, 2016**.

Please contact me if you have any questions.

Sincerely,

Olga

Olga Armah

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



From: pbrmssw@aol.com [<mailto:pbrmssw@aol.com>]
Sent: Friday, June 03, 2016 11:40 AM
To: Armah, Olga
Cc: User, OHCA; Riggott, Kaila
Subject: Re: Completeness Questions on CON Application # 16-32084

Olga

Please see, attached, responses to completeness questions for CON Application # 16-32084 by Health Core Group, LLC.

You will find a .pdf version of the entire response, along with both a Word version of the narrative and an Excel version of a revised Financial Worksheet B.

My client is currently paying rent and Westport House residents are anxious to begin treatment. Please advise if it is a possibility for these responses to enable the CON Application to be deemed complete within a timeframe less than 30 days.

Thank you,

Peter

Peter B Rockholz, M.S.S.W., LCSW
Behavioral Health Consultant
81 Bowman Drive

Greenwich, CT 06831
203.313.1418
pbrmssw@aol.com

-----Original Message-----

From: Armah, Olga <Olga.Armah@ct.gov>
To: Peter Rockholz <pbrmssw@aol.com>
Cc: User, OHCA <OHCA@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>
Sent: Wed, Jun 1, 2016 11:05 am
Subject: RE: Completeness Questions on CON Application # 16-32084

Thanks.

Olga Armah

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



From: Peter Rockholz [<mailto:pbrmssw@aol.com>]
Sent: Friday, May 27, 2016 12:55 PM
To: Armah, Olga
Subject: RE: Completeness Questions on CON Application # 16-32084

Olga
I have received your email regarding questions.
Peter Rockholz

From: [Armah, Olga](mailto:Olga.Armah@ct.gov)
Sent: 5/27/2016 12:46 PM
To: pbrmssw@aol.com
Cc: User, OHCA; Riggott, Kaila; Armah, Olga
Subject: Completeness Questions on CON Application # 16-32084

Dear Mr. Rockholz,

Please see attached request for additional information regarding CON application 16-32084 – Establishment of a psychiatric outpatient day treatment and substance abuse or dependence treatment clinic for young male adults in Westport. There are additional items that need to be addressed.

Please contact me if you have any questions. Responses are due by **Tuesday July 26, 2016**.

Regards.

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

Hartford, CT 06134

Phone: 860 418 7070

Fax: 860 418 7053

mailto: olga.armah@ct.gov

Web: www.ct.gov/ohca



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Acting Commissioner



Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

July 5, 2016

VIA EMAIL

pbrmssw@aol.com

Peter B. Rockholz
Consultant
Health Core Group, LLC
81 Bowman Drive
Greenwich, CT 06831

RE: Certificate of Need Application, Docket Number 16-32084-CON
Establishment of a Psychiatric Outpatient Substance Abuse Disorder Treatment Clinic for
Adults

Dear Mr. Rockholz:

On April 29th, 2016, the Department of Public Health ("DPH"), Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application on behalf of Health Core Group, LLC, d/b/a Westport Behavioral Health ("Applicant") proposing to establish a psychiatric outpatient day treatment clinic and a freestanding facility for the care or treatment of substance abuse or dependence for young adults in Westport.

OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email. *Please email your responses to all of the following email addresses:* OHCA@ct.gov; olga.armah@ct.gov; and kaila.riggott@ct.gov.

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than **August 29, 2016**, otherwise your application will be automatically considered withdrawn.



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

Affirmative Action/Equal Opportunity Employer

Repeat each question before providing your response and paginate and date your response, i.e., each page, in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using **Page 111** and reference "**Docket Number: 16-32084-CON.**"

- The application specifies that Health Core Group, LLC. is not a Medicaid provider. Page 24 indicates the proposal will not reduce access to services to Medicaid recipients or indigent persons. Pursuant to Conn. Gen. Stat. Section 19a-639(10) italicized below, please provide in detail, good cause for not providing services to Medicaid recipients.

Conn. Gen. Stat. § 19a-639(a)(10))§ Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7001 or (860) 418-7070.

Sincerely,

Olga Armah
Associate Research Analyst

Greer, Leslie

From: pbrmssw@aol.com
Sent: Wednesday, July 06, 2016 9:49 PM
To: Armah, Olga; User, OHCA; Riggott, Kaila
Cc: ggillam@westportsoberhouse.com
Subject: Re: Completeness Questions on CON Application # 16-32084
Attachments: Additional question response.docx; Additional question response.pdf

Olga

Attached, please find the response to the additional question you sent regarding the application for a CON byHealth Core Group, LLC. I believe we have provided the necessary information to have the application deemed complete. Please advise on the status of this application as our clients are anxiously anticipating being able to receive services.

Thanks again,

Peter

Peter B Rockholz
Behavioral Health Consultant
81 Bowman Drive
Greenwich, CT 06831
203.313.1418
pbrmssw@aol.com

Response to an additional question presented by the Office of Health Care Access (OHCA) via email from Olga Armah on June 30, 2016

Response date: July 6, 2016

Question:

The application specifies that Health Core Group, LLC. is not a Medicaid provider. Page 24 indicates the proposal will not reduce access to services to Medicaid recipients or indigent persons. Pursuant to Conn. Gen. Stat. Section 19a-639(10) italicized below, please provide in detail, good cause for not providing services to Medicaid recipients.

Conn. Gen. Stat. § 19a-639(a)(10))§ Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers

Response:

The proposed target population of this application includes young adult men who are residents of Westport House sober living houses in Westport, Connecticut. We have indicated that -- since recovery housing costs are not a covered expense -- only those able to afford recovery housing at Westport House out-of-pocket would be included, and Health Core Group, LLC did not anticipate the target population would include residents who were either eligible for Medicaid or otherwise financially or medically indigent.

Health Core Group, LLC will fully comply with *CGS Section 19a-639* and herein clarifies that it will provide outpatient treatment services to individuals who are among the proposed, and any future, target population regardless of the third-party rates established for outpatient services. We must correct, therefore, the response to question #6 on page 108 of this application that suggested we would not accept Medicaid rates for outpatient treatment services.

Health Core Group, LLC will, in fact, provide services to Medicaid recipients or indigent persons, and will not exclude applicants who otherwise meet admission criteria based solely on different reimbursement rates between Medicaid and other health care payers. The applicant will register with the Connecticut Department of Social Services as a Medicaid provider.

Greer, Leslie

From: Armah, Olga
Sent: Thursday, July 07, 2016 9:06 AM
To: pbrmssw@aol.com
Cc: ggillam@westportsoberhouse.com; User, OHCA; Riggott, Kaila
Subject: RE: Completeness Questions on CON Application # 16-32084

Hi Peter,

This is to acknowledge receipt of the response. I will let you know if we have additional questions.

Thanks.

Olga

Olga Armah

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



From: pbrmssw@aol.com [<mailto:pbrmssw@aol.com>]
Sent: Wednesday, July 06, 2016 9:49 PM
To: Armah, Olga; User, OHCA; Riggott, Kaila
Cc: ggillam@westportsoberhouse.com
Subject: Re: Completeness Questions on CON Application # 16-32084

Olga

Attached, please find the response to the additional question you sent regarding the application for a CON byHealth Core Group, LLC. I believe we have provided the necessary information to have the application deemed complete. Please advise on the status of this application as our clients are anxiously anticipating being able to receive services.

Thanks again,

Peter

Peter B Rockholz
Behavioral Health Consultant
81 Bowman Drive
Greenwich, CT 06831
203.313.1418
pbrmssw@aol.com

Greer, Leslie

From: Armah, Olga
Sent: Monday, July 18, 2016 12:03 PM
To: pbrmssw@aol.com
Cc: User, OHCA; Riggott, Kaila
Subject: Docket # 16-32084-CON Deemed Complete
Attachments: 16-32084-CON Notification of Application Deemed Complete.pdf

Dear Mr. Rockholz:

Please note that OHCA has deemed complete the above noted CON application. See the attached.

Olga Armah, M. Phil

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

Phone: 860 418 7070

Fax: 860 418 7053

mailto: olga.armah@ct.gov

Web: www.ct.gov/ohca



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

July 18, 2016

Via Email Only

pbrmssw@aol.com

Peter B. Rockholz
Consultant
Health Core Group, LLC
81 Bowman Drive
Greenwich, CT 06831

RE: Certificate of Need Application, Docket Number 16-32084-CON
Establishment of an Outpatient Substance Abuse Disorder Treatment Clinic for Adults
Certificate of Need Completeness Letter

Dear Mr. Rockholz:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of July 15, 2016.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7012.

Sincerely,

A handwritten signature in blue ink that reads "Olga Armah".

Olga Armah
Associate Research Analyst



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

Affirmative Action/Equal Opportunity Employer

Greer, Leslie

From: Walker, Shauna
Sent: Tuesday, September 13, 2016 7:55 AM
To: pbrmssw@aol.com
Cc: Riggott, Kaila; Armah, Olga; Greer, Leslie
Subject: CON 16-32084 - Additional Information Needed

Dear Mr. Rockholz:

The Department of Public Health ("DPH"), Office of Health Care Access ("OHCA") is in the process of finalizing a decision for CON 16-32084, however, additional information is needed. We would like the following table updated with full fiscal years of projections for Medicaid-eligible patients:

Payer	Projected								
	FY 2017			FY 2018			FY 2019		
	Patient Volume	%	Visit Volume	Patient Volume	%	Visit Volume	Patient Volume	%	Visit Volume
Medicare*	0			0			0		
Medicaid*	0			0			0		
CHAMPUS & TriCare	0			0			0		
Total Government	0			0			0		
Commercial Insurers	14	67%	312	44	67%	1,254	44	67%	1,254
Self-pay									
Uninsured	7	33%	156	22	33%	618	22	33%	618
Workers Compensation									
Total Non-Government	21	100%	468	66	100%	1,872	66	100%	1,872
Total Payer Mix	21	100%	468	66	100%	1,872	66	100%	1,872

If you have any questions, please do not hesitate to contact me.

Much Regards,

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

Greer, Leslie

From: Walker, Shauna
Sent: Tuesday, September 13, 2016 12:07 PM
To: pbrmssw@aol.com
Cc: Riggott, Kaila; Armah, Olga; Greer, Leslie
Subject: RE: CON 16-32084 - Additional Information Needed
Attachments: Health Core Group LLC Financial Worksheet B Rev 6-2-16.xlsx

Mr. Rockholz:

My apologies, but it appears as if we will need updated financial information as well. Please update the attached spreadsheet to account for any projected net patient revenue for Medicaid clients, as well as any changes in income.

Again, feel free to contact me with any questions.

Much Regards,

Shauna L. Walker

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



From: Walker, Shauna
Sent: Tuesday, September 13, 2016 7:55 AM
To: 'pbrmssw@aol.com' <pbrmssw@aol.com>
Cc: Riggott, Kaila <Kaila.Riggott@ct.gov>; Armah, Olga <Olga.Armah@ct.gov>; Greer, Leslie <Leslie.Greer@ct.gov>
Subject: CON 16-32084 - Additional Information Needed

Dear Mr. Rockholz:

The Department of Public Health ("DPH"), Office of Health Care Access ("OHCA") is in the process of finalizing a decision for CON 16-32084, however, additional information is needed. We would like the following table updated with full fiscal years of projections for Medicaid-eligible patients:

Payer	Projected		
	FY 2017	FY 2018	FY 2019

	Patient Volume	%	Visit Volume	Patient Volume	%	Visit Volume	Patient Volume	%	Visit Volume
Medicare*	0			0			0		
Medicaid*	0			0			0		
CHAMPUS & TriCare	0			0			0		
Total Government	0			0			0		
Commercial Insurers	14	67%	312	44	67%	1,254	44	67%	1,254
Self-pay									
Uninsured	7	33%	156	22	33%	618	22	33%	618
Workers Compensation									
Total Non-Government	21	100%	468	66	100%	1,872	66	100%	1,872
Total Payer Mix	21	100%	468	66	100%	1,872	66	100%	1,872

If you have any questions, please do not hesitate to contact me.

Much Regards,

Shauna L. Walker

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue

Hartford, CT 06134

Phone: (860) 418-7069

Email: Shauna.Walker@ct.gov



FOR-PROFIT

Applicant Name: Health Core Group, LLC
Financial Worksheet (B)

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

LINE	Total Entity: Description	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
		FY 2015 Actual Results	FY 2016 Projected W/out CON	FY 2016* Projected Incremental	FY 2016 Projected With CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected With CON
A. OPERATING REVENUE														
1	Total Gross Patient Revenue	\$1,322,039	\$1,421,192	\$269,447	\$1,690,639	\$1,527,781	\$1,101,777	\$2,629,558	\$1,642,365	\$1,127,050	\$2,769,415	\$1,765,542	\$1,149,591	\$2,915,133
2	Less: Allowances			\$95,540	\$95,540		\$389,456	\$389,456		\$397,093	\$397,093		\$402,357	\$402,357
3	Less: Charity Care			\$1,530	\$1,530		\$6,407	\$6,407		\$6,716	\$6,716		\$7,220	\$7,220
4	Less: Other Deductions				\$0			\$0			\$0			\$0
	Net Patient Service Revenue	\$1,322,039	\$1,421,192	\$172,377	\$1,593,569	\$1,527,781	\$705,914	\$2,233,695	\$1,642,365	\$723,241	\$2,365,606	\$1,765,542	\$740,014	\$2,505,556
5	Medicare				\$0			\$0			\$0			\$0
6	Medicaid				\$0			\$0			\$0			\$0
7	CHAMPUS & TriCare				\$0			\$0			\$0			\$0
8	Other				\$0			\$0			\$0			\$0
	Total Government	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
9	Commercial Insurers			\$143,310	\$143,310		\$584,185	\$584,185		\$595,639	\$595,639		\$607,552	\$607,552
10	Uninsured				\$0			\$0			\$0			\$0
11	Self Pay	\$1,322,039	\$1,421,192	\$29,067	\$1,450,259	\$1,527,781	\$121,729	\$1,649,510	\$1,642,365	\$127,602	\$1,769,967	\$1,765,542	\$133,982	\$1,899,524
12	Workers Compensation				\$0			\$0			\$0			\$0
13	Other				\$0			\$0			\$0			\$0
	Total Non-Government	\$1,322,039	\$1,421,192	\$172,377	\$1,593,569	\$1,527,781	\$705,914	\$2,233,695	\$1,642,365	\$723,241	\$2,365,606	\$1,765,542	\$741,534	\$2,507,076
	Net Patient Service Revenue* (Government+Non-Government)	\$1,322,039	\$1,421,192	\$172,377	\$1,593,569	\$1,527,781	\$705,914	\$2,233,695	\$1,642,365	\$723,241	\$2,365,606	\$1,765,542	\$741,534	\$2,507,076
14	Less: Provision for Bad Debts				\$0			\$0			\$0			\$0
	Net Patient Service Revenue less provision for bad debts	\$1,322,039	\$1,421,192	\$172,377	\$1,593,569	\$1,527,781	\$705,914	\$2,233,695	\$1,642,365	\$723,241	\$2,365,606	\$1,765,542	\$740,014	\$2,505,556
15	Other Operating Revenue				\$0			\$0			\$0			\$0
17	Net Assets Released from Restrictions				\$0			\$0			\$0			\$0
	TOTAL OPERATING REVENUE	\$1,322,039	\$1,421,192	\$172,377	\$1,593,569	\$1,527,781	\$705,914	\$2,233,695	\$1,642,365	\$723,241	\$2,365,606	\$1,765,542	\$740,014	\$2,505,556
B. OPERATING EXPENSES														
1	Salaries and Wages	\$265,897	\$271,021	\$52,216	\$323,237	\$277,694	\$208,861	\$486,555	\$286,025	\$215,217	\$501,242	\$294,606	\$221,674	\$516,280
2	Fringe Benefits	\$42,543	\$43,363	\$8,354	\$51,717	\$41,654	\$33,418	\$75,072	\$45,764	\$34,435	\$80,199	\$47,137	\$35,468	\$82,605
3	Physicians Fees				\$0			\$0			\$0			\$0
4	Supplies and Drugs				\$0			\$0			\$0			\$0
5	Depreciation and Amortization	\$3,747	\$3,747	\$400	\$4,147	\$3,747	\$1,600	\$5,347	\$3,747	\$1,600	\$5,347	\$3,747	\$1,600	\$5,347
6	Provision for Bad Debts-Other ^b				\$0			\$0			\$0			\$0
7	Interest Expense				\$0			\$0			\$0			\$0
8	Malpractice Insurance Cost				\$0			\$0			\$0			\$0
9	Lease Expense	\$161,500	\$228,000	\$23,760	\$251,760	\$228,000	\$95,040	\$323,040	\$228,000	\$97,891	\$325,891	\$228,000	\$100,828	\$328,828
10	Other Operating Expenses	\$526,785	\$505,873	\$56,074	\$561,947	\$550,166	\$298,867	\$849,033	\$601,842	\$305,364	\$907,206	\$662,026	\$311,777	\$973,803
	TOTAL OPERATING EXPENSES	\$1,000,472	\$1,052,004	\$140,804	\$1,192,808	\$1,101,261	\$637,786	\$1,739,047	\$1,165,378	\$654,507	\$1,819,885	\$1,235,516	\$671,347	\$1,906,863
	INCOME/(LOSS) FROM OPERATIONS	\$321,567	\$369,188	\$31,573	\$400,761	\$426,520	\$68,128	\$494,648	\$476,987	\$68,734	\$545,721	\$530,026	\$68,667	\$598,693
	NON-OPERATING INCOME				\$0			\$0			\$0			\$0
	Income before provision for income taxes	\$321,567	\$369,188	\$31,573	\$400,761	\$426,520	\$68,128	\$494,648	\$476,987	\$68,734	\$545,721	\$530,026	\$68,667	\$598,693
	Provision for income taxes ^c	\$97,594	\$111,880	\$0	\$111,880	\$129,080	\$20,643	\$149,723	\$147,906	\$20,826	\$168,732	\$149,237	\$21,013	\$170,250
	NET INCOME	\$223,973	\$257,308	\$31,573	\$288,881	\$297,440	\$47,485	\$344,925	\$329,081	\$47,908	\$376,989	\$380,789	\$68,667	\$449,456
C. Retained Earnings, beginning of year														
	Retained Earnings, beginning of year		\$223,973	\$0	\$223,973	\$481,281	\$31,573	\$512,854	\$778,721	\$79,058	\$857,779	\$1,107,802	\$126,966	\$1,234,768
	Retained Earnings, end of year	\$223,973	\$481,281	\$31,573	\$512,854	\$778,721	\$79,058	\$857,779	\$1,107,802	\$126,966	\$1,234,768	\$1,488,591	\$195,633	\$1,684,224
	Principal Payments				\$0			\$0			\$0			\$0
D. PROFITABILITY SUMMARY														
1	Hospital Operating Margin	24.3%	26.0%	18.3%	25.1%	27.9%	9.7%	22.1%	29.0%	9.5%	23.1%	30.0%	9.3%	23.9%
2	Hospital Non Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	16.9%	18.1%	18.3%	18.1%	19.5%	6.7%	15.4%	20.0%	6.6%	15.9%	21.6%	9.3%	17.9%
E. FTEs														
	FTEs	12	12	4	16	13	5	18	13	5	18	13	5	18
F. VOLUME STATISTICS^d														
1	Inpatient Discharges	0	0	0	0	0	0	0	0	0	0	0	0	0
2	Outpatient Visits	0	0	468	468	0	1,872	1,872	0	1,872	1,872	0	1,872	1,872
	TOTAL VOLUME	0	0	468	468	0	1,872	1,872	0	1,872	1,872	0	1,872	1,872

* FY 2016 incremental (proposed project) reflects 3 months' projections (Oct 1- Dec 31)

^aTotal amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

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

^cProvide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

^dProvide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Greer, Leslie

From: Walker, Shauna
Sent: Wednesday, September 14, 2016 8:08 AM
To: Riggott, Kaila; Armah, Olga; Greer, Leslie
Subject: FW: CON 16-32084 - Additional Information Needed
Attachments: Volume table amended 9-13-16.docx; Health Core Group LLC Financial Worksheet B Rev 9-13-16.xlsx

From: pbrmssw@aol.com [<mailto:pbrmssw@aol.com>]
Sent: Tuesday, September 13, 2016 8:06 PM
To: Walker, Shauna <Shauna.Walker@ct.gov>
Subject: RE: CON 16-32084 - Additional Information Needed

Shauna

Thanks for working with us. I believe you will find the table and financial worksheet reflective of Health Core Group's commitment to providing charity care and care to those in need from the Westport area with Medicaid coverage.

Please let me know if you need further information.

Peter

Sent from [Mail](#) for Windows 10

From: [Walker, Shauna](#)
Sent: Tuesday, September 13, 2016 3:15 PM
To: [Peter Rockholz](#)
Subject: RE: CON 16-32084 - Additional Information Needed

Hello,

Attached is a copy of the table in a word document.

From: Peter Rockholz [<mailto:pbrmssw@aol.com>]
Sent: Tuesday, September 13, 2016 9:02 AM
To: Walker, Shauna <Shauna.Walker@ct.gov>
Subject: RE: CON 16-32084 - Additional Information Needed

Shauna

I will have a completed table to you by the end of the day.

I do hope this doesn't cause a delay in the process.

Thanks for your help!

Peter

From: [Walker, Shauna](#)
Sent: 9/13/2016 7:54 AM

To: pbrmssw@aol.com

Cc: [Riggott, Kaila](#); [Armah, Olga](#); [Greer, Leslie](#)

Subject: CON 16-32084 - Additional Information Needed

Dear Mr. Rockholz:

The Department of Public Health (“DPH”), Office of Health Care Access (“OHCA”) is in the process of finalizing a decision for CON 16-32084, however, additional information is needed. We would like the following table updated with full fiscal years of projections for Medicaid-eligible patients:

Payer	Projected								
	FY 2017			FY 2018			FY 2019		
	Patient Volume	%	Visit Volume	Patient Volume	%	Visit Volume	Patient Volume	%	Visit Volume
Medicare*	0			0			0		
Medicaid*	0			0			0		
CHAMPUS & TriCare	0			0			0		
Total Government	0			0			0		
Commercial Insurers	14	67%	312	44	67%	1,254	44	67%	1,254
Self-pay									
Uninsured	7	33%	156	22	33%	618	22	33%	618
Workers Compensation									
Total Non-Government	21	100%	468	66	100%	1,872	66	100%	1,872
Total Payer Mix	21	100%	468	66	100%	1,872	66	100%	1,872

If you have any questions, please do not hesitate to contact me.

Much Regards,

Shauna L. Walker

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue

Hartford, CT 06134

Phone: (860) 418-7069

Email: Shauna.Walker@ct.gov



Payer	Projected								
	FY 2017			FY 2018			FY 2019		
	Patient Volume	%	Visit Volume	Patient Volume	%	Visit Volume	Patient Volume	%	Visit Volume
Medicare*	0			0			0		
Medicaid*	7	10.6%	200	7	10.6%	200	7	10.6%	200
CHAMPUS & TriCare	0			0			0		
Total Government	7	10.6%	200	7	10.6%	200	7	10.6%	200
Commercial Insurers	40	60.6%	1140	40	60.6%	1140	40	60.6%	1140
Self-pay									
Uninsured	19	28.8%	542	19	28.8%	542	19	28.8%	542
Workers Compensation									
Total Non-Government	59	89.4%	1682	59	89.4%	1682	59	89.4%	1682
Total Payer Mix	66	100.0%	1882	66	100.0%	1882	66	100.0%	1882

FOR-PROFIT

Applicant Name: Health Core Group, LLC
Financial Worksheet (B)

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

LINE	Total Entity: Description	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
		FY 2015 Actual Results	FY 2016 Projected W/out CON	FY 2016* Projected Incremental	FY 2016 Projected With CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected With CON
A. OPERATING REVENUE														
1	Total Gross Patient Revenue	\$1,322,039	\$1,421,192	\$269,447	\$1,690,639	\$1,527,781	\$1,101,777	\$2,629,558	\$1,642,365	\$1,127,050	\$2,769,415	\$1,765,542	\$1,149,591	\$2,915,133
2	Less: Allowances			\$95,540	\$95,540		\$369,420	\$369,420		\$375,468	\$375,468		\$377,782	\$377,782
3	Less: Charity Care			\$1,530	\$1,530		\$12,814	\$12,814		\$13,432	\$13,432		\$14,440	\$14,440
4	Less: Other Deductions				\$0			\$0			\$0			\$0
	Net Patient Service Revenue	\$1,322,039	\$1,421,192	\$172,377	\$1,593,569	\$1,527,781	\$719,543	\$2,247,324	\$1,642,365	\$738,150	\$2,380,515	\$1,765,542	\$757,369	\$2,522,911
5	Medicare				\$0			\$0			\$0			\$0
6	Medicaid				\$0		\$28,800	\$28,800		\$28,800	\$28,800		\$28,800	\$28,800
7	CHAMPUS & TriCare				\$0			\$0			\$0			\$0
8	Other				\$0			\$0			\$0			\$0
	Total Government	\$0	\$0	\$0	\$0	\$0	\$28,800	\$28,800	\$0	\$28,800	\$28,800	\$0	\$28,800	\$28,800
9	Commercial Insurers			\$143,310	\$143,310		\$531,000	\$531,000		\$541,620	\$541,620		\$552,452	\$552,452
10	Uninsured				\$0			\$0			\$0			\$0
11	Self Pay	\$1,322,039	\$1,421,192	\$29,067	\$1,450,259	\$1,527,781	\$159,743	\$1,687,524	\$1,642,365	\$167,730	\$1,810,095	\$1,765,542	\$176,117	\$1,941,659
12	Workers Compensation				\$0			\$0			\$0			\$0
13	Other				\$0			\$0			\$0			\$0
	Total Non-Government	\$1,322,039	\$1,421,192	\$172,377	\$1,593,569	\$1,527,781	\$690,743	\$2,218,524	\$1,642,365	\$709,350	\$2,351,715	\$1,765,542	\$728,569	\$2,494,111
	Net Patient Service Revenue* (Government+Non-Government)	\$1,322,039	\$1,421,192	\$172,377	\$1,593,569	\$1,527,781	\$719,543	\$2,247,324	\$1,642,365	\$738,150	\$2,380,515	\$1,765,542	\$757,369	\$2,522,911
14	Less: Provision for Bad Debts				\$0			\$0			\$0			\$0
	Net Patient Service Revenue less provision for bad debts	\$1,322,039	\$1,421,192	\$172,377	\$1,593,569	\$1,527,781	\$719,543	\$2,247,324	\$1,642,365	\$738,150	\$2,380,515	\$1,765,542	\$757,369	\$2,522,911
15	Other Operating Revenue				\$0			\$0			\$0			\$0
17	Net Assets Released from Restrictions				\$0			\$0			\$0			\$0
	TOTAL OPERATING REVENUE	\$1,322,039	\$1,421,192	\$172,377	\$1,593,569	\$1,527,781	\$719,543	\$2,247,324	\$1,642,365	\$738,150	\$2,380,515	\$1,765,542	\$757,369	\$2,522,911
B. OPERATING EXPENSES														
1	Salaries and Wages	\$265,897	\$271,021	\$52,216	\$323,237	\$277,694	\$208,861	\$486,555	\$286,025	\$215,217	\$501,242	\$294,606	\$221,674	\$516,280
2	Fringe Benefits	\$42,543	\$43,363	\$8,354	\$51,717	\$41,654	\$33,418	\$75,072	\$45,764	\$34,435	\$80,199	\$47,137	\$35,468	\$82,605
3	Physicians Fees				\$0			\$0			\$0			\$0
4	Supplies and Drugs				\$0			\$0			\$0			\$0
5	Depreciation and Amortization	\$3,747	\$3,747	\$400	\$4,147	\$3,747	\$1,600	\$5,347	\$3,747	\$1,600	\$5,347	\$3,747	\$1,600	\$5,347
6	Provision for Bad Debts-Other ^b				\$0			\$0			\$0			\$0
7	Interest Expense				\$0			\$0			\$0			\$0
8	Malpractice Insurance Cost				\$0			\$0			\$0			\$0
9	Lease Expense	\$161,500	\$228,000	\$23,760	\$251,760	\$228,000	\$95,040	\$323,040	\$228,000	\$97,891	\$325,891	\$228,000	\$100,828	\$328,828
10	Other Operating Expenses	\$526,785	\$505,873	\$56,074	\$561,947	\$550,166	\$298,867	\$849,033	\$601,842	\$305,364	\$907,206	\$662,026	\$311,777	\$973,803
	TOTAL OPERATING EXPENSES	\$1,000,472	\$1,052,004	\$140,804	\$1,192,808	\$1,101,261	\$637,786	\$1,739,047	\$1,165,378	\$654,507	\$1,819,885	\$1,235,516	\$671,347	\$1,906,863
	INCOME/(LOSS) FROM OPERATIONS	\$321,567	\$369,188	\$31,573	\$400,761	\$426,520	\$81,757	\$508,277	\$476,987	\$83,643	\$560,630	\$530,026	\$86,022	\$616,048
	NON-OPERATING INCOME				\$0			\$0			\$0			\$0
	Income before provision for income taxes	\$321,567	\$369,188	\$31,573	\$400,761	\$426,520	\$81,757	\$508,277	\$476,987	\$83,643	\$560,630	\$530,026	\$86,022	\$616,048
	Provision for income taxes ^c	\$97,594	\$111,880	\$0	\$111,880	\$129,080	\$20,643	\$149,723	\$147,906	\$20,826	\$168,732	\$149,237	\$21,013	\$170,250
	NET INCOME	\$223,973	\$257,308	\$31,573	\$288,881	\$297,440	\$61,114	\$358,554	\$329,081	\$62,817	\$391,898	\$380,789	\$65,009	\$445,798
C. Retained Earnings, beginning of year														
	Retained Earnings, beginning of year		\$223,973	\$0	\$223,973	\$481,281	\$31,573	\$512,854	\$778,721	\$92,687	\$871,408	\$1,107,802	\$155,504	\$1,263,306
	Retained Earnings, end of year	\$223,973	\$481,281	\$31,573	\$512,854	\$778,721	\$92,687	\$871,408	\$1,107,802	\$155,504	\$1,263,306	\$1,488,591	\$220,513	\$1,709,104
	Principal Payments				\$0			\$0			\$0			\$0
D. PROFITABILITY SUMMARY														
1	Hospital Operating Margin	24.3%	26.0%	18.3%	25.1%	27.9%	11.4%	22.6%	29.0%	11.3%	23.6%	30.0%	11.4%	24.4%
2	Hospital Non Operating Margin	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	16.9%	18.1%	18.3%	18.1%	19.5%	8.5%	16.0%	20.0%	8.5%	16.5%	21.6%	8.6%	17.7%
E. FTEs														
	FTEs	12	12	4	16	13	5	18	13	5	18	13	5	18
F. VOLUME STATISTICS^d														
1	Inpatient Discharges	0	0	0	0	0	0	0	0	0	0	0	0	0
2	Outpatient Visits	0	0	468	468	0	1,882	1,882	0	1,882	1,882	0	1,882	1,882
	TOTAL VOLUME	0	0	468	468	0	1,882	1,882	0	1,882	1,882	0	1,882	1,882

* FY 2016 incremental (proposed project) reflects 3 months' projections (Oct 1- Dec 31)

^aTotal amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

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

^cProvide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

^dProvide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Greer, Leslie

Subject: FW: CON 16-32084 - Additional Information Needed

Hi Peter,

I have a few follow up questions for you.

Looking at the updated volume projections, the totals remain the same as before, yet include a proportion of Medicaid clients. To account for the proportion of Medicaid clients it appears as if the number of self-pay and commercially insured individuals were slightly decreased. Although the updated financial worksheet reflects net patient revenue for Medicaid clients and a smaller amount of net patient revenue for commercial insurers, there now appears to be an increase in net patient revenue for those that are self-insured. Would you be able to explain?

Can you provide a brief explanation in regards to how you calculated the projected number of Medicaid clients?

In your application you mentioned that all residents of sober housing will enter the IOT program upon admission. Does this mean that sober housing will accept Medicaid clients as well, as the projected volume of clients (66) remains the same? As noted in your application, individuals receiving outpatient treatment also receive sober housing services.

SERVICE/PROGRAM	CURRENT	PROJECTED		
	FY 2016	FY 2017	FY 2018	FY 2019
Sober Housing Residents	84	84	84	84
Number to be Admitted to Intensive Outpatient Treatment Program*	21	66	66	66

If you have any questions, please do not hesitate to contact me.

Regards,

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



Greer, Leslie

Subject: FW: CON 16-32084 - Additional Information Needed

From: pbrmssw@aol.com [<mailto:pbrmssw@aol.com>]

Sent: Wednesday, September 14, 2016 9:49 PM

To: Walker, Shauna <Shauna.Walker@ct.gov>

Subject: RE: CON 16-32084 - Additional Information Needed

Shauna

It is correct that the volume projections for Medicaid clients were offset by reduced volume projections for both insurance and self-pay clients in the outpatient program. This was necessary since the Westport House sober living homes have a fixed capacity. In order to accommodate Medicaid client projections (which were not included in original projections), the other categories needed to be adjusted accordingly.

Regarding the changes in revenue projections, it is accurate that self-pay revenues are projected higher. This is the result of an upward adjustment in the self-pay rate for outpatient services - moving them closer to the anticipated insurance rates. This was necessary in order to ensure financial viability. Medicaid rates meet about 40% of the actual cost of care. With a fixed capacity, it became necessary to revisit the self-pay rate schedule which was lagging behind insurance rates. In addition, an adjustment was not only appropriate -- since it reflects the national market -- but is also consistent with what Westport House is currently experiencing as an increasingly high net worth clientele with higher ability to pay.

The projected number of Medicaid clients is an estimate using both the Medicaid utilization rate for Westport (approximately 5% of population) and the recent experience at Westport House where there have been more Medicaid enrolled residents than was anticipated. Since the actual number of potential clients is relatively low, we chose to make a liberal projection of about 10%.

Yes, Westport House sober housing will accept Medicaid clients who otherwise meet admission criteria.

I hope this provides sufficient information to complete the review of our application. Please let me know if you need additional information.

Peter

Sent from [Mail](#) for Windows 10

Greer, Leslie

From: Olejarz, Barbara
Sent: Friday, October 07, 2016 1:29 PM
To: pbrmssw@aol.com
Cc: Martone, Kim; Riggott, Kaila; Armah, Olga; Walker, Shauna; Greer, Leslie
Subject: Agreed Settlement
Attachments: 32084.pdf

10/6/16

Peter,

Attached is the signed Agreed Settlement for Health Core Group, LLC d/b/a Westport Behavioral Health (Docket Number: 16-32084-CO

Barbara K. Olejarz
Administrative Assistant to Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (860) 418-7005
Email: Barbara.Olejarz@ct.gov



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner



Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

Agreed Settlement

Applicant: Health Core Group, LLC
d/b/a Westport Behavioral Health
9 Fragrant Pines Court
Westport, CT 06880

Docket Number: 16-32084-CON

Project Title: Establishment of a Psychiatric Outpatient Clinic for Adults and Facility for the Care or Treatment of Substance Abusive or Dependent Persons in Westport, Connecticut

Project Description: Health Core Group, LLC d/b/a Westport Behavioral Health ("HCG" or "Applicant") is proposing to establish a psychiatric outpatient clinic and facility for the care or treatment of substance abusive or dependent adults at 162 Kings Highway North, Westport, Connecticut, at an associated capital cost of \$10,000.

Procedural History: The Applicant published notice of its intent to file a Certificate of Need ("CON") application in *The Hour* (Norwalk) on April 1, 2 and 3, 2016. On April 29, 2016, the Office of Health Care Access ("OHCA") received the CON application from the Applicant for the above-referenced project and deemed the application complete on July 15, 2016. OHCA received no responses from the public concerning the proposal and no hearing requests from the public per Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a(e). Deputy Commissioner Addo considered the entire record in this matter.



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

Affirmative Action/Equal Opportunity Employer

Findings of Fact and Conclusions of Law

1. HCG is a for-profit organization that operates three sober recovery and transitional houses (“Westport House”) for young adult males in Westport, Connecticut. Ex. A, pp. 4, 7, 9.
2. Westport House residents are referred from anywhere in the country following hospital inpatient or addiction rehabilitation center treatment for substance use disorders. Ex. A, p. 7.
3. The Applicant began providing sober housing July 1, 2014, and currently has a residential capacity of 33 beds and an average occupancy rate of 90%. Ex. A, p. 28.
4. HCG is proposing to establish a psychiatric outpatient clinic and facility for the care or treatment of substance abusive or dependent adults to provide intensive outpatient treatment (“IOP”) for substance use disorders and co-occurring mental health disorders to young adult males (17 to 25 years of age) in Westport. Ex. A, pp. 6, 15.
5. The address of the proposed IOP program, 162 Kings Highway North, Westport, CT, is less than one mile away from Westport House. Ex. A, p. 18.
6. The Applicant is proposing to locate the IOP program in an existing building in Westport close to Westport House to make the program easily accessible to clients in sober living and facilitate a sustained recovery, reduce rates of relapse and improve health outcomes. Ex. A, p. 17.
7. The proposed program will primarily treat Westport House clients transferred directly from inpatient substance abuse treatment facilities that are in early recovery from addiction and in need of continuing treatment at an IOP level of care. Ex. A, pp. 14, 15, 16.
8. Westport House residents identified as needing IOP are currently receiving outpatient counseling, a lower level of care, from local independent licensed/credentialed behavioral health professionals in the community. Ex. A, p. 16.
9. The proposed program will also serve young adult male residents from the surrounding area in need of IOP services that may opt to receive treatment at the facility. Ex. A, pp. 8, 29.
10. The Applicant intends to meet the current standards of practice outlined in the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol, critical to effective IOP, by providing a continuum of care that will: make treatment readily available; make program entry easy; build on existing motivation; emphasize therapeutic alliance; make program retention a priority; assess and address individual treatment needs; provide ongoing care; monitor abstinence; use mutual help and other community-based supports; use medication if needed; educate clients about substance abuse, recovery and relapse; engage families, employer and significant others; and incorporate evidenced-based approaches. Ex. A, pp. 11-14, 59.

11. The Applicant’s proposed program will provide developmentally appropriate and gender-specific outpatient substance treatment services including individual, group and family therapy, case management services and recovery-supportive rehabilitation such as recreational, psycho-educational, vocational and creative arts. Ex. A, p. 8.
12. In addition to once-per-week individual counseling, the proposed IOP will be delivered within structured and individualized treatments that include:
 - a. A minimum of three 3-hour sessions per week;
 - b. Case management;
 - c. Urine drug screening;
 - d. Medication monitoring; and
 - e. Cognitive-behavioral therapy.
 Ex. A, p. 8.
13. The program will operate from 9:00 a.m. to 9:00 p.m., Monday through Friday and from 9:00 a.m. to 1:00 p.m. on Saturdays. Ex. A, p. 9.
14. In FY 2015, 83% of Westport House clients from Connecticut were Fairfield County residents.

TABLE 1
FY 2015 CLIENT ORIGIN FOR WESTPORT HOUSE

SERVICE AREA	NO. OF CLIENTS	PERCENT OF CT TOTAL
Greenwich	5	17%
Westport	3	10%
Trumbull	2	7%
Darien	2	7%
New Canaan	2	7%
Ridgefield	2	7%
Stamford	2	7%
Wilton	2	7%
Fairfield	2	7%
Norwalk	1	3%
Redding	1	3%
Weston	1	3%
Fairfield County Total	25	83%**
Other Connecticut	5	17%
Connecticut Total	30	100%

*An additional 20 clients originated from out-of-state

**Actual total varies due to rounding

Ex. A, pp. 106-107.

15. Young adult males within the Applicant’s proposed service area represent 4% of Fairfield County’s population 17 to 25 years old. Based on prevalence rates predicated upon national data, approximately 795 of these young adult males may have a diagnosable substance use disorder.

TABLE 2
ESTIMATE OF DIAGNOSABLE SUBSTANCE USE DISORDERS INCIDENCE IN FAIRFIELD COUNTY

SUBSTANCE USE DISORDER	POPULATION (17 to 25 years old) ¹	PREVALENCE ²	INCIDENCE
Fairfield County	98,281	21.1%	20,737
Westport	3,770	21.1%	795
Service area as percent of Fairfield County	4%	n/a	4%

Sources:

¹2010 U.S. Census.

²Substance Abuse and Mental Health Services Administration. 2008. *Young Adults’ Need for and Receipt of Alcohol and Illicit Drug Use Treatment: 2007*. HHS Publication No. SMA-08-0325. Rockville, MD.

Ex. A, p. 107.

16. The Applicant projects that a minimum of 66 residents of Westport House will enter the IOP program following admission, each year from FY17 through FY19.

TABLE 3
HEALTH CORE GROUP, LLC PROJECTED UTILIZATION

SERVICE/PROGRAM	CURRENT	PROJECTED		
	FY 2016	FY 2017	FY 2018	FY 2019
Intensive Outpatient Treatment Program*	21	66	66	66

Fiscal Year is January 1 – December 31

* Individuals receiving IOP also receive sober housing services.

Assumptions:

IOP estimated to begin October 1, 2016.

All sober house residents will be in IOP from their first day in residence and remain in treatment for an average of six weeks.

Ex. A, pp. 6, 27-28, 108.

17. Referrals for the proposed program will come primarily from Westport House, however the program will have the physical space and staffing capacity to accept additional individuals through self-referrals, referrals through behavioral health professionals or Connecticut state agencies such as the Department of Mental Health and Addiction Services (DMHAS) and the Judicial Branch. Ex. A, pp. 12, 22, 106, 108.
18. The Applicant has developed key referral and transfer arrangements with Norwalk Hospital and Progressive Diagnostics, LLC, both local providers. Norwalk Hospital will accept and treat the Applicant’s clients in the event of an urgent medical and/or psychiatric need and the latter will carry out urine drug testing. Ex. A, pp. 14, 67.

19. While there are six existing providers of IOP in towns contiguous to the proposed service area (Norwalk, Wilton, Weston and Fairfield), none of these providers have programs specific to young adult males.

TABLE 4
PROVIDERS OF THE PROPOSED SERVICES IN SERVICE AREA

TOWN	PROVIDER	STREET ADDRESS
Norwalk	Connecticut Renaissance, Inc.	4 Byington Place
Norwalk	Family and Children's Agency, Inc.	165 Flax Hill Rd 9 Mott Ave
Norwalk	Norwalk Hospital – Outpatient	24 Stevens Street
Norwalk	Connecticut Counseling Centers, Inc. Norwalk Methadone Program ¹	20 North Main St
Norwalk	Saint Vincent's Behavioral Health Services Norwalk Clinic ¹	1 Lois Lane
Westport	The Recovery Center of Westport	328 Post Road East

Sources:

¹ Substance Abuse and Mental Health Services Administration, Behavioral Health Treatment Services Locator, <https://findtreatment.samhsa.gov>, accessed Sep. 21, 2016.

Ex. A, p. 29.

20. All six existing providers in the proposed service area accept Medicaid and/or government-funded insurance. Ex. A, p. 29; Substance Abuse and Mental Health Services Administration, Behavioral Health Treatment Services Locator, <https://findtreatment.samhsa.gov>, accessed Sep. 21, 2016.
21. Currently the Applicant accepts self-pay and/or insured clients only. HCG has set aside five percent of self-pay profits for scholarship assistance to provide charity care to Medicaid-eligible or indigent individuals. Ex. A, pp. 6, 24, 95.
22. Although HCG currently only accepts self-pay and/or insured clients, the Applicant plans to register with the Connecticut Department of Social Services as a Medicaid provider and to accept Medicaid clients for outpatient treatment services. Ex. A, pp. 111.

23. Based on Westport House’s FY2016 payer mix, the Applicant projects approximately 10% Medicaid, 60% commercial insurers and 30% self-pay for the proposed IOP program.

**TABLE 5
PROJECTED PAYER MIX FOR APPLICANT BY NUMBER OF CLIENTS AND VISITS**

Payer	Projected								
	FY 2017			FY 2018			FY 2019		
	Patient Volume	%**	Visit Volume	Patient Volume	%**	Visit Volume	Patient Volume	%**	Visit Volume
Medicare*	0			0			0		
Medicaid*	7	10%	200	7	10%	200	7	10%	200
CHAMPUS & TriCare	0			0			0		
Total Government	7	10%	200	7	10%	200	7	10%	200
Commercial Insurers	40	61%	1140	40	61%	1140	40	61%	1140
Self-pay	19	29%	542	19	29%	542	19	29%	542
Uninsured									
Workers Compensation									
Total Non-Government	59	90%	1,682	59	90%	1,682	59	90%	1,682
Total Payer Mix	66	100%	1,882	66	100%	1,882	66	100%	1,882

*Includes managed care activity.
Medicaid projections based on the Medicaid utilization rate for Westport and enrollment of residents at Westport House.
**May not add up due to rounding.

Ex. A, pp. 112, 114.

24. The Applicant estimates a total capital expenditure of \$10,000 for the purchase of office equipment and computers. The Applicant will fund the proposal with cash. Ex. A, p. 25

25. Based on an average treatment duration of six weeks, average projected utilization and 2.5% increases in revenue and expenses, the Applicant projects incremental gains from the onset of operations.

**TABLE 6
APPLICANT’S PROJECTED INCREMENTAL GAIN FROM OPERATIONS**

	FY 2017	FY 2018	FY 2019
Revenue from Operations	\$719,543	\$738,150	\$757,369
Total Operating Expenses	\$637,786	\$654,507	\$671,347
Income (Loss) from Operations	\$81,757	\$83,643	\$86,022

*Increase in expenses is reflective of increases in the costs of materials, consulting services, salaries and fringe benefits. Increase in revenue is based on improved billing, collections and negotiated rates.
Ex. A, pp. 25, 28, 108, 113.

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

27. This CON application is consistent with the Statewide Health Care Facilities and Services Plan. (Conn. Gen. Stat. § 19a-639(a)(2)).
28. The Applicant has established that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3)).
29. The Applicant has demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4)).
30. The Applicant has satisfactorily demonstrated that the proposal will improve the accessibility and maintain the quality and cost effectiveness of health care delivery in the region. (Conn. Gen. Stat. § 19a-639(a)(5)).
31. The Applicant has shown that there would be no adverse change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6)).
32. The Applicant has satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7)).
33. The Applicant's historical provision of services in the area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8)).
34. The Applicant has satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9)).
35. The Applicant has demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10)).
36. The Applicant has demonstrated that the proposal will not negatively impact the diversity of health care providers and client choice in the region. (Conn. Gen. Stat. § 19a-639(a)(11)).
37. The Applicant has satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or accessibility to care. (Conn. Gen. Stat. § 19a-639(a)(12)).

DISCUSSION

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

HCG is a for-profit organization that operates Westport House, comprising three sober recovery and transitional houses for young adult males in Westport, Connecticut. *FF1* The Applicant proposes to establish a psychiatric outpatient clinic and facility for the care or treatment of substance abusive or dependent adults to provide IOP to young adult males, ages 17 to 25 years, with substance use disorders and co-occurring mental health disorders. *FF4*

The proposed program will primarily treat new Westport House clients transferred directly from inpatient substance abuse treatment facilities and young adult male residents from the surrounding towns in need of IOP. *FF7, FF9* New Westport House clients are in early recovery from addiction and in need of continuing treatment at an IOP level of care. *FF7* Currently, Westport House residents receive outpatient counseling from local behavioral health providers who have determined the majority of the residents need IOP level of care for a sustained recovery. *FF8*

The Applicant intends to meet the current standards of practice outlined in the SAMHSA Treatment Improvement Protocol. These standards of practice are critical to effective IOP as they provide a continuum of care that will make treatment readily available, assess and address individual treatment needs, make program retention a priority and incorporate evidenced-based approaches. *FF10*

It is estimated that about 20,737 young adult males between the ages of 17 and 25 years in Fairfield County and 795 in Westport have diagnosable substance use disorder and may need IOP. *FF15* Although there are six existing providers of IOP in towns contiguous to the proposed service area, none of these providers have programs specific to young adult males. *FF19*

The Applicant is proposing to locate the IOP program in an existing building in Westport close to Westport House to provide dedicated, coordinated and uninterrupted services that are not available elsewhere in the community. The location will be easily accessible to clients in sober living to facilitate a sustained recovery, reduce rates of relapse and improve health outcomes. *FF6*

The proposed program will have minimal effect on existing providers, as the majority of the Applicant's referrals will come primarily from Westport House. *FF17* The Applicant projects that from FY17 to FY19, a minimum of 66 residents of Westport House will enter the IOP program, annually, following admission. *FF16* The program will also accept clients through self-referrals, referrals through behavioral health professionals or Connecticut state agencies such as DMHAS and the Judicial Branch. *FF17*

Although HCG currently only accepts self-pay and/or insured clients, the Applicant plans to register with the Connecticut Department of Social Services as a Medicaid provider and to accept Medicaid clients for outpatient treatment services to improve access to services for Medicaid recipients or indigent persons. *FF22* HCG projects a payer mix of approximately 10% Medicaid, 60% commercially insured and 30% self-pay patients, based on the existing payer mix of outpatient visits for Westport House residents. *FF23*

HCG will fund the total project cost of \$10,000 with cash. *FF24* The Applicant projects that based on average projected treatment and utilization and 2.5% increases in revenue and expenses, there will be incremental gains from operations of \$81,757, \$83,643 and \$86,022 in the first three years of operations. *FF25* Based on these two factors, the Applicant has shown that the proposal is financially feasible.

The Applicant has satisfactorily demonstrated clear public need for the IOP program in Westport without unnecessary duplication of services in the area. In order to ensure that access to care will improve for the population currently being served, including that of the Medicaid population, and to ensure the proposal is consistent with the Statewide Health Care Facilities and Services Plan, OHCA requires that the Applicant agree to take certain actions as stated in the order attached hereto.

Order

NOW, THEREFORE, the Department of Public Health, Office of Health Care Access (“OHCA”) and Health Core Group, LLC d/b/a Westport Behavioral Health (“HCG” or “Applicant”), through their authorized representatives, hereby stipulate and agree to the following terms of settlement with respect to the Applicant’s request to establish a psychiatric outpatient clinic for adults and facility for the care or treatment of substance abusive or dependent persons in Westport, Connecticut:

1. HCG shall provide notification to OHCA of the date of commencement of operations and shall provide a copy of the facility license(s) it has obtained. Such notification shall be provided within thirty (30) days of start of operations.
2. HCG shall ensure that there is equal access to the proposed services for young adult males in the service area, including Medicaid recipients.
3. The Applicant shall apply to the Connecticut Department of Social Services and be approved as a Medicaid provider and make all efforts to comply with the requirements of participation. The Applicant shall provide documentation to OHCA evidencing approval of its enrollment application. Such documentation shall be filed within thirty (30) days of approval as a Connecticut Medicaid provider.
4. The Applicant shall communicate availability of the aforementioned services to Medicaid clients to area health care providers, including, but not limited to, hospitals and addiction rehabilitation providers. HCG shall provide documentation to OHCA evidencing that HCG has notified area health care providers of its participation in the Connecticut Medicaid Program. Such documentation shall be filed within thirty (30) days of approval as a Connecticut Medicaid provider.
5. HCG shall take all practical steps to achieve a payer mix, based on patient volume, which includes 10% Connecticut Medicaid patients for its outpatient treatment program within the first year of operation, including but not limited to outreach efforts described in 4 above. HCG shall report such payer mix to OHCA at the end of its first year of operation and if the payer mix target is not met, HCG submit such documentation as OHCA determines appropriate, to demonstrate HCG’s efforts to re-evaluate its outreach initiatives and develop strategies to increase utilization by Connecticut Medicaid patients.
6. HCG shall file annual reports to OHCA for the following information outlined below. The annual periods shall be January 1 through December 31 for two (2) full years following commencement of outpatient treatment at the Westport facility. The required report is due no later than two (2) months after the end of each annual period. The first report may be based on a partial reporting period depending on the date clients begin receiving services and should identify the partial reporting timeframe:

- a. The number of visits and patients receiving IOP services at the Westport program by payor category. **Utilize the table format below:**

	Total	Medicare	Medicaid	CHAMPUS/ Tricare	Commercial	Uninsured	Worker's Comp.	Self-Pay
Number of patients								
Number of visits								
Percent (%)								

- b. The number of patients receiving IOP services by source of admission. **Utilize the table format below:**

	Total	Westport House	Self- Referral	Private Practitioner	State Agency	Other
Number of patients						
Percent (%)						

7. OHCA and HCG agree that this settlement represents a final agreement between OHCA and HCG with respect to OHCA Docket No. 16-32084-CON. The execution of this settlement resolves all objections, claims and disputes, which may or could have been raised by HCG with regard to OHCA Docket Number 16-32084-CON.
8. OHCA may enforce this settlement under the provisions of Conn. Gen. Stat. §§ 19a-642; 19a-653 and all other remedies available at law, with all fees and costs of such enforcement to be governed by State Law.
9. This settlement shall be binding upon HCG and its successors and assigns.

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

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

10/7/16
Date


Yvonne T. Addo, MBA
Deputy Commissioner

10/6/16
Date


Duly Authorized Agent for
Health Core Group, LLC

Signed by Albert Samaras (Print name), President (Title)