

# Statewide Health Care Facilities and Services Plan

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Connecticut Department Of Public Health  
Office Of Health Care Access

410 Capitol Avenue • Hartford, CT 06134



# TABLE OF CONTENTS

ACKNOWLEDGEMENTS  
EXECUTIVE SUMMARY

## SECTION ONE

<b>1.0 INTRODUCTION</b> .....	1
1.1 Legal Authority and Mandate.....	1
1.2 Purpose and Value .....	1
1.3 Advisory Body .....	2
1.4 Guiding Principles .....	2
1.5 Overview of Plan Structure.....	3
1.6 Interpretation of the Plan .....	3
1.7 Relationship of Plan to Healthy People 2020 and Connecticut State Health Planning .....	4
1.8 Certificate of Need (CON) Overview.....	4
1.8.1 CON Definition, Purpose and History.....	4
1.8.2 Recent CON Changes .....	5
1.8.3 CON Statutes and Implementation.....	5
1.8.4 Certificate of Need and Health Care Reform .....	7
1.8.5 Mergers, Acquisitions and Affiliations .....	7
<b>2.0 OVERARCHING ISSUES</b> .....	11
2.1 Health Care Reform.....	11
2.1.1 Insurance Coverage Expansion.....	11
2.1.2 Community Benefit .....	12
2.1.3 Financial Assistance Policy.....	13
2.1.4 Provider Reimbursement Based on Performance .....	13
2.1.4.1 Value-based Purchasing.....	13
2.1.4.2 Bundled Payments.....	13
2.1.4.3 Infection Control and Preventable Hospitalizations.....	13
2.1.5 Incentives to Improve Quality, Access, Delivery and Outcomes .....	14
2.1.6 Innovation .....	14
2.2 Health Information Technology .....	14
2.2.1 Health Information Technology and Exchange.....	14
2.2.2 Meaningful Use .....	15
2.2.3 Health Information Technology and Exchange of Connecticut.....	15
2.3 Workforce.....	15
2.3.1 Workforce Age.....	17
2.3.2 Workforce Demand .....	17
2.3.3 Nursing Demand.....	18
2.3.4 Five Most In-Demand Health Occupations .....	18
2.3.5 Health Professional Shortage Area (HPSA) Designations .....	20

## SECTION TWO

<b>3.0 ACUTE CARE</b> .....	23
3.1 Acute Care Hospitals .....	23
3.1.1 Acute Care Hospital Utilization .....	25

3.2	Bed Need .....	26
3.2.1	Relationship to Certificate of Need .....	26
3.2.2	Bed Need Methodology .....	26
3.2.3	Bed Need Planning Area(s) .....	27
3.2.4	Acute Care Bed Need Model Results .....	27
3.2.5	Inpatient Bed Capacity .....	31
3.3	Emergency Departments (ED) .....	31
3.3.1	Relationship to Certificate of Need .....	31
3.3.2	Behavioral Health Care in Emergency Departments .....	33
3.3.3	ED Utilization .....	34
3.3.4	ED Planning .....	35
3.3.5	Trauma .....	36
3.3.6	Emergency Medical Services .....	37
3.3.7	Office of Emergency Medical Services (OEMS) .....	37
3.3.8	Life Star .....	37
3.3.9	Mobile Field Hospital .....	38
3.4	Cardiac Services .....	38
3.4.1	Relationship to Certificate of Need .....	38
3.4.2	Cardiac Catheterization .....	38
3.4.3	Percutaneous Coronary Intervention (PCI) .....	39
3.4.3.1	PCI without Surgical Backup .....	39
3.4.4	Open Heart Surgery .....	40
3.4.5	Current Service Locations .....	40
3.4.6	Standards/Guidelines .....	41
3.4.7	Utilization of Cardiac Care .....	43
3.4.8	Unmet Need, Gaps in Services and Capacity Issues .....	44
3.5	Cancer Treatment .....	46
3.5.1	CoC-Accredited Cancer Programs .....	47
3.5.2	Cancer Services Utilization .....	48
<b>4.0</b>	<b>OUTPATIENT SURGERY .....</b>	<b>51</b>
4.1	Relationship to Certificate of Need .....	51
4.2	Overview .....	51
4.3	Ambulatory Surgical Procedures .....	51
4.4	Outpatient Surgical Facilities (OSFs) .....	52
4.4.1	Licensure and Certification .....	52
4.4.1.1	DPH Licensure .....	52
4.4.1.2	CMS Certification .....	52
4.4.2	OSF Types and Ownership .....	52
4.4.3	Facilities and Operating Rooms .....	53
4.5	Surgeries Performed in the Outpatient Setting .....	54
4.6	Standards/Guidelines .....	54
4.7	Current Issues Pertaining to OSFs .....	56
<b>5.0</b>	<b>IMAGING AND NEW TECHNOLOGY .....</b>	<b>59</b>
5.1	Relationship to Certificate of Need .....	59
5.2	General Background .....	59
5.3	Current Imaging Landscape .....	59
5.4	Standards/Guidelines .....	60
5.5	New Technology .....	66
5.5.1	Relationship to Certificate of Need .....	66
5.5.2	Determination of New Technology .....	66
5.5.3	Standards/Guidelines .....	67
<b>6.0</b>	<b>OTHER HEALTH CARE SERVICES AND FACILITIES .....</b>	<b>71</b>
6.1	Relationship to Certificate of Need .....	71
6.2	Long Term and Rehabilitative Care Services .....	71

6.2.1	Future Growth of the Older Population .....	71
6.2.2	Skilled Care and Custodial Care.....	71
6.2.3	Medical Rehabilitative Care .....	71
6.2.4	Long Term Acute Care.....	73
6.2.5	Nursing Home Care .....	73
	6.2.5.1 Chronic and Convalescent Nursing Home.....	74
	6.2.5.2 Rest Home with Nursing Supervision.....	74
	6.2.5.3 Trends in Connecticut’s Nursing Home Facility and Bed Supply .....	75
6.2.6	Residential Care Home.....	75
6.2.7	Hospice Inpatient Care.....	76
6.2.8	Assisted Living Service Agencies .....	76
6.2.9	Continuing Care Retirement Community.....	77
6.2.10	Congregate Living .....	77
6.2.11	Adult Day Care .....	77
6.2.12	Home Care .....	78
	6.2.12.1 Home Health Care Agency and Hospice Care Agency.....	78
	6.2.12.2 Homemaker-Home Health Aide Agency .....	78

## SECTION THREE

<b>7.0</b>	<b>PERSONS AT RISK AND VULNERABLE POPULATIONS.....</b>	<b>81</b>
7.1	Identifying Persons at Risk and Vulnerable Populations .....	81
7.2	Definition of Unmet Health Care Need .....	83
7.3	Methods for Evaluating Unmet Need and Gaps in Services .....	83
	7.3.1 Federal Designation Approach.....	83
	7.3.2 Population-Based Relative Availability Approach .....	84
	7.3.3 Proxy Approach.....	84
7.4	Programs/Plans to Mitigate Unmet Need and Gaps in Services.....	84
	7.4.1 Federally Medically Underserved Areas and Health Professional Shortage Areas .....	84
	7.4.2 The Safety Net System.....	84
	7.4.2.1 Safety Net Hospitals.....	85
	7.4.2.2 Safety Net Community-Based Providers .....	85
	7.4.2.2.1 Community Health Centers (CHCs).....	85
	7.4.2.2.2 School-Based Health Centers .....	85
	7.4.2.2.3 Local Health Departments .....	85
	7.4.3 Physician Networks and Special Service Providers .....	86
	7.4.4 Newborn Screening Program .....	86
	7.4.5 Children and Youth with Special Health Care Needs.....	86
	7.4.6 HIV/AIDS Services in Connecticut.....	87
	7.4.7 Connecticut Chronic Disease Prevention Plan.....	87
	7.4.8 Vulnerable Population Emergency Response Program .....	87
	7.4.9 Rural Community Health Planning.....	88
7.5	Department of Social Services Programs .....	88
	7.5.1 Connecticut Medicaid Program.....	88
	7.5.2 Connecticut Pre-Existing Condition Insurance Plan.....	89
	7.5.3 Charter Oak Health Plan.....	89
7.6	Health Insurance Exchange.....	89
<b>8.0</b>	<b>BEHAVIORAL HEALTH CARE.....</b>	<b>93</b>
8.1	Relationship to Certificate of Need .....	93
8.2	Service Overview .....	93
8.3	Points of Access or Entry into the System.....	93
8.4	Systems which Enable or Assist with Recovery and Resilience.....	94
8.5	Description of Behavioral Health Environment.....	95
	8.5.1 Adult Mental Health Treatment .....	95

8.5.1.1	Hospital-Operated Facilities: Short-term General Hospitals.....	95
8.5.1.2	Hospital-Operated Facilities: Hospitals for Mentally Ill Persons .....	95
8.5.1.3	State-Operated Inpatient Facilities and Local Mental Health Authorities .....	96
8.5.1.4	Community-Based Residential Adult Services .....	97
8.5.1.4.1	Mental Health Residential Living Centers .....	97
8.5.1.4.2	Private Free-standing Community Residences .....	97
8.5.1.5	Community-Based Adult Services .....	98
8.5.1.5.1	Psychiatric Outpatient Clinic for Adults .....	98
8.5.1.5.2	Mental Health Day Treatment .....	98
8.5.1.6	Other Providers of Mental Health Services.....	98
8.5.1.6.1	Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MRs).....	98
8.5.2	Substance Use or Substance Abuse Treatment .....	98
8.5.2.1	Discussion of Substance Use Treatment and Demand.....	98
8.5.2.2	Substance Use Treatment Facilities or Services for Adults, Children and Adolescents.....	99
8.5.2.2.1	Hospital-Operated Facilities: Short-term General Hospitals .....	99
8.5.2.2.2	Hospital-Operated Facilities: Hospitals for Mentally Ill Persons.....	100
8.5.2.2.3	State-Operated Inpatient Facilities and Local Mental Health Authorities.....	100
8.5.2.2.4	Community-Based Residential Adult Services and Community-Based Outpatient Services.....	100
8.5.2.2.5	Other Information Related to Substance Use Treatment Categorization and Criteria.....	100
8.5.3	Mental Health Treatment Facilities or Services for Children and Adolescents .....	101
8.5.3.1	Hospital-Operated Facilities: Short-term General Hospitals.....	101
8.5.3.2	Hospital-Operated Facilities: Hospitals for Mentally Ill Persons .....	101
8.5.3.3	The Department of Children and Families.....	101
8.5.3.3.1	Outpatient Psychiatric Clinics for Children .....	102
8.5.3.3.2	Extended Day Treatment Facilities .....	102
8.5.3.3.3	Child Caring Facilities .....	102
8.5.3.4	Other Child/Adolescent Behavioral Health Services Categories .....	104
8.5.3.4.1	Psychiatric Residential Treatment Facilities .....	104
8.5.3.4.2	Intensive In-Home Services .....	104
8.6	Other Initiatives or Information Sources in the Behavioral Health Environment.....	104
8.7	Relationship Between Behavioral Health and Primary Care .....	109
<b>9.0</b>	<b>PRIMARY CARE .....</b>	<b>113</b>
9.1	Relationship to Certificate of Need.....	113
9.2	Service Introduction .....	113
9.3	Overview of Primary Care Delivery in Connecticut.....	114
9.4	Primary Care Services Provided in Facility Settings .....	114
9.4.1	Primary Care Practitioner Offices/Practices .....	114
9.4.2	Primary Care Providers Licensed as Outpatient Clinics.....	115
9.4.2.1	Community Health Centers/Federally Qualified Health Centers (CHCs/FQHCs).....	115
9.4.2.2	School-Based Health Centers (SBHCs) .....	116
9.4.2.3	Free Clinics .....	118
9.4.2.4	Limited or Special Population Clinics.....	119
9.4.3	Hospital-Operated Primary Care Centers/Clinics.....	119
9.4.4	Limited Primary Care Services Providers .....	120
9.4.4.1	Urgent Care/Walk-in Clinics.....	120
9.4.4.2	Retail or Store-Based Health Clinics.....	120
9.4.4.3	Licensed Outpatient Clinics Operated by Municipalities.....	120
9.4.4.4	Infirmaries Operated by an Educational Institution.....	120
9.4.4.5	Well Child Clinics .....	121

9.4.4.6	Family Planning Clinics .....	121
9.4.5	Federal Government Primary Care Clinics .....	121
9.5	Evaluation of Unmet Need and Gaps in Services .....	121
9.6	Primary Care Facilities and Avoidable ED Visits.....	124
9.7	Ongoing Public and Private Primary Care Initiatives.....	126
9.7.1	Department of Public Health – Connecticut Primary Care Office .....	126
9.7.2	Department of Public Health – Office of Oral Health.....	126
9.7.3	Connecticut Oral Health Initiative .....	127
9.7.4	The Statewide Primary Care Access Authority.....	127
9.7.5	Community Health Center Association of Connecticut .....	128
9.7.6	Screening, Brief Intervention, Referral and Treatment (SBIRT).....	128
9.7.7	The Connecticut Center for Primary Care .....	128
9.7.8	Connecticut Association of School Based Health Centers .....	129

## SECTION FOUR

<b>10.0</b>	<b>NEXT STEPS/RECOMMENDATIONS .....</b>	<b>133</b>
10.1	Acute Care/Ambulatory Surgery.....	133
10.2	Behavioral Health .....	134
10.3	Primary Care .....	135
<b>11.0</b>	<b>DATA SOURCES AND LIMITATIONS.....</b>	<b>139</b>
11.1	Data Sources .....	139
11.2	Data Limitations.....	139
	Glossary .....	141
	Acronyms .....	152
	Appendices	
	Appendix A: Connecticut General Statute (CGS) 19a-634.....	155
	Appendix B: Advisory Body .....	157
	Appendix C: Subcommittees.....	158
	Appendix D: Health Care Practitioners.....	160
	Appendix E: Connecticut Towns by County and Department of Emergency Services and Public Protection, Division of Emergency Management and Homeland Security (DEMHS) Regions .....	162
	Appendix F: Emergency Department Behavioral Health Focus Group Members .....	164
	Appendix G: Emergency Department Focus Groups: Summary.....	166
	Appendix H: Emergency Department Focus Groups: Solutions.....	170
	Appendix I: Emergency Department Visits by Acute Care Hospital FFYs 2008-2011.....	172
	Appendix J: Map of Hospital-based Outpatient Surgical Facilities .....	173
	Appendix K: Map of Hospital Satellite Outpatient Surgical Facilities .....	174
	Appendix L: Map of Free-standing Outpatient Surgical Facilities .....	175
	Appendix M: Map of Hospital-based Magnetic Resonance Imaging (MRI) Scan Providers.....	176
	Appendix N: Map of Hospital Satellite Magnetic Resonance Imaging (MRI) Scan Providers.....	177
	Appendix O: Map of Imaging Centers with Magnetic Resonance Imaging (MRI) Scanners .....	178
	Appendix P: Map of Computed Tomography (CT) Scan Providers .....	179
	Appendix Q: Map of PET and PET/CT Scan Providers .....	180
	Appendix R: DPH Health Status and Services Priorities .....	181
	Appendix S: DPH Programs that Improve Health of Residents and Communities .....	182
	Appendix T: Acute Care General Hospital Psychiatric Days, Discharges and Beds .....	193
	Appendix U: DMHAS Local Mental Health Authorities.....	195

## SECTION FIVE

### INVENTORY OF HEALTH CARE FACILITIES, SERVICES AND EQUIPMENT

Table 1: Listing of Towns by County and DEMHS Region.....	200
Table 2: Acute Care General and Children’s Hospitals.....	202
Table 3: Acute Care and Children’s Hospital Service Lines .....	204
Table 4: Specialty Hospitals:.....	208
Chronic Disease Hospitals	
Hospitals - Hospice	
Hospital for Mentally Ill Persons	
Maternity Hospitals	
Table 5: Outpatient Surgical Facilities .....	209
Table 6: Outpatient Surgical Facilities – Detail of Services.....	214
Table 7: Number of Operating Rooms by Facility.....	219
Table 8: Magnetic Resonance Imaging (MRI) Scanning Providers.....	223
Table 9: Computer Tomography (CT) Scanning Providers .....	234
Table 10: Positron Emission Tomography-Computer Tomography (PET & PET-CT) Scanning Providers.....	243
Table 11: Chronic and Convalescent Nursing Homes and Rest Homes with Nursing Supervision .....	245
Table 12: Residential Care Homes.....	254
Table 13: Assisted Living Service Agencies.....	258
Table 14: Home Health Care Agencies and Homemaker - Home Health Aide Agencies .....	262
Table 15: Mental Health Residential Living Centers.....	266
Table 16: Mental Health Community Residences.....	267
Table 17: Psychiatric Outpatient Clinics for Adults.....	268
Table 18: Mental Health Day Treatment Facilities .....	275
Table 19: Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR) .....	276
Table 20: Facilities for the Care or Treatment of Substance Abusive or Dependent Persons.....	280
Table 21: Health Care Facilities Licensed by the Department of Children and Families .....	288
Outpatient Psychiatric Clinics for Children	
Extended Day Treatment Facilities	
Child Caring Facilities (including categories Group Home, Residential Education, Residential Treatment, Temporary Shelter and Safe Home)	
Table 22: Community Health Centers/Federally Qualified Health Centers.....	297
Table 23: School Based Health Centers .....	301
Table 24: Free Clinics and Limited or Special Population Clinics .....	306
Table 25: Hospital Operated Primary Care Centers/Clinics.....	308
Table 26: Limited Primary Care Services Centers – Other Outpatient Clinics.....	310
Urgent Care/Walk-in Clinics	
Licensed Outpatient Clinics Operated by Municipalities	
Infirmary Operated by an Educational Institution	
Well Child Clinics	
Family Planning Clinics	
Table 27: Dialysis Centers.....	314
Table 28: Other Outpatient Clinics (not primary care in nature) and Recovery Care Centers .....	316

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## OVERVIEW

The Department of Public Health (DPH) Office of Health Care Access' (OHCA) planning and regulatory activities are intended to increase accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services. Section 19a-634 of the Connecticut General Statutes (CGS) charges OHCA with the responsibility of developing and maintaining a *Statewide Health Care Facilities and Services Plan (the Plan)*, along with establishing and maintaining an inventory of all Connecticut health care facilities and services and conducting a biennial utilization study.

It is through the Plan that OHCA's regulatory and planning functions converge, as the Plan is noted in one of nine enumerated statutory guidelines,<sup>1</sup> specifying that when reviewing a Certificate of Need (CON) application, OHCA must take into consideration the relationship of the proposed project to the Plan.

The Plan, considered an advisory document, is intended to be a blueprint for health care delivery in Connecticut, serving as a resource for policymakers and those involved in the CON process and providing information, policies and projections of need to guide planning for specific health care facilities and services.

It includes standards/guidelines/methodologies for Acute Care Bed Need, Outpatient Surgery, Cardiac Services and Imaging Services/Equipment that, when adopted into regulation, will be utilized in the Certificate of Need review process.<sup>2</sup> In addition, the Plan examines unmet need and identifies possible gaps in services.

The Plan also incorporates available health care facilities and services utilization data that provide important information regarding shifts in the use of health care resources and services, identify what types of care specific populations use and how frequently, assist in examining the impact of new medical technologies or procedures, and may also indicate areas that warrant further study. These data serve as a foundation for projecting future health care needs and are the basis for determining resource needs. Additionally, through the inventorying of and reporting on utilization of services, the Plan will provide a means of monitoring the adequacy of access.

An Advisory Body and three service-specific subcommittees (Acute Care/Ambulatory Surgery, Behavioral Health and Primary Care), and an Imaging Workgroup, consisting of representatives from a cross-section of the health care industry and State government, provided guidance on the development of the Plan. Developed with their input, the Plan's standards and guidelines are intended to guide the CON review and decision-making process, and improve the accessibility and quality of health care services provided.

## KEY ISSUES

The Plan identifies key issues surrounding the delivery of health care in Connecticut:

- Even before health care reform has been fully implemented, the state's health care system has begun a transformation in response to and in anticipation of major changes in the way health care is financed and delivered. Many provisions of the 2010 Patient Protection and Affordable Care Act (PPACA) favor integrated systems to create efficiencies and address quality. Hospital mergers and the acquisitions of imaging centers and physician practices are key issues surrounding Connecticut's CON process today.
- As the health care delivery model continues to evolve, it will be important to monitor and assess whether the size, clinician mix and statewide distribution of the health care workforce is sufficient to meet the additional demand.
- Based on acute care bed need projections for 2015, Connecticut has an adequate supply of acute care inpatient beds statewide, however further study is necessary to determine if gaps in service-specific beds exist in certain regions of the state.
- As part of OHCA's planning effort, focus groups were conducted in an effort to identify concerns about behavioral health (mental health and substance use treatment) patients treated in Emergency Departments (EDs) and their

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<sup>1</sup>Connecticut General Statutes Section 19a-639, as amended by Public Act 12-170

<sup>2</sup>These standards and guidelines are not final until adopted as regulation pursuant to Chapter 54 of the Connecticut General Statutes.

ability to access behavioral health services. Three common themes emerged from focus group meetings: (1) behavioral health patients presenting at EDs, although other treatment settings would be more appropriate, (2) limited access to behavioral health services (especially inpatient adult or residential youth services) and (3) lack of coordination of care between EDs and community based services. Focus group participants expressed concern that these issues will continue as long as EDs are the only “24/7” treatment option available.

- Market trends over the past several years have affected the environment in which hospitals and free-standing imaging centers operate. In the past, there was a steady and ongoing migration of imaging services out of the hospital setting, mostly to physician-owned free-standing imaging centers. Today however, reimbursement issues, access to capital, vendor relationships and physician employment are initiating a wave of acquisitions of imaging equipment at free-standing imaging centers by hospitals.<sup>3</sup> CON approval is required for these acquisitions and purchasers must demonstrate clear public need for the equipment.
- The behavioral health industry has shifted focus over the past several years from mainly a treatment driven system to one of recovery assistance and resilience enabling. The industry will continue to support this shift by building resilience in children and adolescents and providing greater recovery mechanisms and opportunities for adults.
- Many primary care providers offer some level of behavioral health care as a service component. Likewise, many behavioral health providers provide a primary care component to address basic needs of their patients. This relationship is a significant effort and growing trend that will likely continue to be emphasized in the health care industry.
- Connecticut’s overall supply of primary care practitioners is adequate, however health care reform’s insurance coverage expansion will likely lead to a new and increased demand for primary care services.

## NEXT STEPS/RECOMMENDATIONS

Next steps and recommendations had several sources; they were either suggested directly by subcommittee and advisory body members, evolved from subcommittee and advisory body discussions, or were suggested by reviewers of the Plan.

## ACUTE CARE/AMBULATORY SURGERY

The next steps/recommendations on acute care/ambulatory surgery are intended to build upon the first Plan’s efforts.

- Explore whether and how data on observation days should be collected and submitted to OHCA and determine how the inclusion of bed days would affect the bed need methodology.
- Examine service type by region to determine if gaps in service exist on a regional basis.
- Investigate the development of planning regions that best facilitate the ability to assess the availability of and future demand for care, taking into consideration existing hospital service areas.
- Explore the formation of a statewide task force comprising key industry stakeholders to further examine action steps and solutions needed to address the concerns identified by the ED Focus Groups about inappropriate use of the ED.
- Evaluate ED capacity issues on an on-going basis.
- Examine availability of on-call specialty physicians to EDs.
- Further study Behavioral Health/ED Focus Group findings with the Connecticut Hospital Association (CHA)/ Department of Mental Health and Addiction Services (DMHAS) to determine if access to behavioral health services is a significant problem at Connecticut’s EDs and if there are any opportunities to help improve access.
- Examine the effect on hospital EDs of increasing reimbursement for outpatient behavioral health programs.
- Examine the benefits of increasing the number of intermediate care center (ICC) beds.
- Examine cardiac program quality measures, including risk-adjusted outcomes, institutional and operator performance.

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<sup>3</sup> Jeter, E. & Sorensen, T. (2010, May 17). The Reconsolidation of Imaging Centers. *ImagingBiz*. Retrieved from <http://www.imagingbiz.com/articles/view/the-reconsolidation-of-imaging-centers>.

- Continue to review and update Connecticut’s cardiac guidelines to reflect current information and recommendations provided by professional societies and organizations with expert knowledge of cardiac care.
- Encourage the adherence to national cancer clinical practice guidelines and investigate the inclusion of standards and guidelines in future Plans.
- Consider adopting the following surgical facility classes as defined by the American College of Surgeons:
  - Class A: Provides for minor surgical procedures performed under topical and local infiltration blocks with or without oral or intramuscular preoperative sedation. These procedures are also appropriately performed in Class B and C facilities.
  - Class B: Provides for minor or major surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs. These procedures are also appropriately performed in Class C facilities.
  - Class C: Provides for major surgical procedures that require general or regional block anesthesia and support of vital bodily functions.
- Consider amending the definition of “operating room” as follows: “Operating Room” means a room with a fully controlled sterile environment that meets either (i) the standard for a Class B or Class C operating room as set forth in the 2006 edition of the American Institute of Architects (AIA) Guidelines for the Design and Construction of Health Care Facilities or (ii) the standards for an operating room as forth in the R.C.S.A. § 19-13-D56, to the extent consistent with section 19a-493b.
- Include treatment rooms in future Plan discussions related to ambulatory surgery capacity.
- With respect to ambulatory surgery standards and guidelines, discuss and consider including backlogs in the service area; ability of physicians to schedule block times; patient throughput at other facilities; and the quality of care at other facilities as additional factors for consideration in the next Plan.

## BEHAVIORAL HEALTH

The next steps/recommendations on behavioral health are intended to build upon the efforts of and discussions held by the behavioral health subcommittee.

- Explore ways that Connecticut’s behavioral health service system can measure or determine capacity as it relates to need and access to care.
- Inventory and discuss behavioral health care services provided by private practitioners and include how the provision of services in private practice contributes to the overall provision of behavioral health care in the state.
- Further advance the discussion of additional types of providers (e.g., private practitioners, Veterans Administration) and the availability of clinical level services in the state and seek and provide more information on recovery supports available to residents in the state.
- Inventory distinct service levels.
- Enhance OHCA’s Hospital Reporting System (HRS) reporting mechanisms to capture accurate, usable data from short term general and children’s general hospitals on hospital-based or hospital-affiliated behavioral health care services (such as a revamped Report 450<sup>4</sup> or a new schedule).
- Provide more focus on the provision and interrelation or co-location of mental health, primary care and/or oral health services within the various settings and provide further discussion as to the concept of “no wrong door” to accessing these services at any location.
- Further consider how health care reform and a possible blended behavioral health license might change the landscape for both behavioral health finance and delivery of care in the future.

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<sup>4</sup>Hospital Report 450 (Hospital Inpatient and Outpatient Other Services Utilization and FTE Employees) is the form into which hospitals electronically report utilization data to OHCA annually.

## PRIMARY CARE

The Primary Care Subcommittee's next steps/recommendations are intended to assure and enhance the quality of care provided by primary care providers in all settings by eliminating health disparities and barriers to access, and tracking and evaluation of health outcomes and patient satisfaction.

- Utilize the results of the DPH Primary Care Office survey of primary care providers to report on and highlight access issues related to primary care facilities and services to better identify practitioners' places of practice, affiliations or relationships with institutions (such as hospitals, FQHCs, multi-specialty practices) and to illustrate any primary care workforce needs, size, and distribution issues which the Primary Care Office identifies.
- Consider adjusting future Behavioral Risk Factor Surveillance System questionnaires so large enough samples are drawn in each county so that results for the questions related to health care access may be used for county level assessment and solutions.
- Consider mandating responses on all license renewal applications to certain survey questions on whether practitioners are actively practicing in the state; the primary location of practice; if the respondent is currently actively treating patients; and if he/she had ever been convicted of a felony.
- Improve OHCA's Hospital Reporting System's reporting mechanisms to capture accurate, usable data from hospitals on hospital-based primary care services (such as a revamped Report 450 or a new schedule) and to collect primary care data on all providers of primary care services.
- Consider more comprehensively primary care provided by hospital-affiliated entities, which are expanding rapidly throughout the state.
- Provide additional Plan focus on the provision of mental health and oral health services in primary care settings, and assess the interrelation of these services with primary care.

