

Legislative History for Connecticut Act

PA 14-211

SB417

House	6732-6736	5
Senate	3147-3155, 3162-3164	12
<u>Public Health</u>	<u>3742-3759, 4177-4199</u>	<u>41</u>
		58

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**CONNECTICUT
GENERAL ASSEMBLY
HOUSE**

**PROCEEDINGS
2014**

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Calendar. Is there any objection?

Hearing none, so ordered.

Representative Aresimowicz.

REP. ARESIMOWICZ (30th):

Thank you very much, Mr. Speaker.

Mr. Speaker, I move we have Calendar 468 on the
Consent Calendar, sir.

SB493

I further move House Calendar 535 to the Consent
Calendar.

SB114

I'd like to move Calendar Number 537 as amended
by Senate "A" to the Consent Calendar.

SB417

I'd like to move Calendar Number 498 to the
Consent Calendar.

SB269

Item 499, as amended by Senate "A" to the Consent
Calendar.

SB309

Calendar Number 508, House Bill 5312, as amended
by Senate "A" and Senate "B" to the Consent Calendar.

Those would be the bills in their entirety, Mr.
Speaker.

DEPUTY SPEAKER GODFREY:

And -- and Representative Aresimowicz.

REP. ARESIMOWICZ (30th):

Yes, Mr. Speaker. Mr. Speaker, I'd like to --
no. Mr. Speaker, I'd like to remove Calendar Number

SB55

506 from the Consent Calendar, please.

DEPUTY SPEAKER GODFREY:

506 is removed from the Consent Calendar.

Representative Aresimowicz.

REP. ARESIMOWICZ (30th):

Mr. Speaker, I'd like to remove Calendar 508 from the Consent Calendar, please.

DEPUTY SPEAKER GODFREY:

Calendar 508 is removed from the Consent Calendar.

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Mr. Clerk, would you kindly call the Consent Calendar.

THE CLERK:

Mr. Speaker, Consent Calendar Number 1, consisting of Calendar Numbers 548; 512, as amended by Senate "A"; 450, as amended by Senate "C"; 236, as amended by Senate "A"; Calendar 425; Calendar 518, as amended by Senate "A"; Calendar 452; Calendar 511; Calendar 5 -- excuse me -- 458; Calendar 491; Calendar 467; Calendar 468; item under suspension, 535; Senate Bill 00114, as considered under suspension; Senate Bill 417, suspension; Calendar Number 537, as amended by Senate "A"; Calendar 498; Calendar 499, as amended by Senate "A"; Calendar 508; and, House Bill -- what

SB176
SB179
SB70
SB247
SB271
SB426
SB154
SB155
SB262
SB456
SB463
SB493
SB114
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HB5312

is it? Is off -- excuse me -- and House Bill 5312,
which was done under suspension with Senate "A" and
"B."

DEPUTY SPEAKER GODFREY:

Thank you, Mr. Clerk.

Just -- just for my own clarification, was --
that was 326 not 236?

THE CLERK:

Three-two-six.

DEPUTY SPEAKER GODFREY:

Thank you, sir.

Representative Aresimowicz, what's your pleasure
on today's Consent Calendar?

REP. ARESIMOWICZ (30th):

Thank you very much, Mr. Speaker.

Mr. Speaker, I move passage of the bills on
today's Consent.

DEPUTY SPEAKER GODFREY:

Question is on passage of the bills on the
Consent Calendar.

Staff and guests please come to the well of the
House. Members take their seat. The machine will be
open.

THE CLERK:

The House of Representatives is voting by roll.

The House of Representatives is voting by roll, by --
on today's first Consent Calendar. Will members
please report to the Chamber immediately.

DEPUTY SPEAKER GODFREY:

Have all the members voted?

Ladies and gentlemen, before I call for the
machine being locked, I need to note that the board is
not completely in line with the motion. Calendar 520
"A," which unfortunately is up on the board, was --
there was no motion to put that on the Consent
Calendar. Unless there's objection, we'll just fix it
ministerially and proceed on. Is there any objection
to that solution?

Thank you all.

If all the -- if everyone has voted, the machine
will be locked. Clerk will take a tally.

And the Clerk will announce the tally.

THE CLERK:

Consent Calendar Number 1.

Total Number Voting	148
Necessary for Passage	75
Those voting Yea	148
Those voting Nay	0

Those absent and not voting 3

DEPUTY SPEAKER GODFREY:

The Consent Calendar as moved, the bills on it
are passed.

And now, Mr. Clerk, we will do Calendar 528.

THE CLERK:

House Calendar 528, Favorable Report of the joint
standing Committee on Insurance and Real Estate,
Senate Bill 480, AN ACT CONCERNING LIFE INSURANCE
PROCEDURE LICENSES AND REGISTRATIONS OF BROKER-
DEALERS, AGENTS, INVESTMENT ADVISERS AND INVESTMENT
ADVISER AGENTS.

DEPUTY SPEAKER GODFREY:

The distinguished Chairman of the Insurance and
Real Estate Committee, Representative Megna.

REP. MEGNA (97th):

Thank -- thank you, Mr. Speaker.

Mr. Speaker, I move acceptance of the joint
committee's Favorable Report and passage of the bill,
in concurrence with the Senate.

DEPUTY SPEAKER GODFREY:

The question is on passage and concurrence.
Would you explain the bill, please, Representative --

REP. MEGNA (97th):

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machine will be closed. Mr. Clerk will you please
call the tally?

THE CLERK:

Senate Bill Number 429 as amended.

Total voting	36
Those voting Yea	28
Those voting Nay	8
Absent not voting	0

THE CHAIR:

The bill passes. Mr. Clerk, do you have anything else
on your Agenda?

THE CLERK:

On page 4, Calendar 300, Substitute for Senate Bill
Number 417, AN ACT CONCERNING THE PROVISION OF
PSYCHIATRIC AND SUBSTANCE USE TREATMENT SERVICES,
Favorable Report of the Committee on Public Health.
There are amendments.

THE CHAIR:

Senator Gerratana, good evening, madam.

SENATOR GERRATANA:

Good evening, madam. Good evening to you, Madam
President. Madam President, I move acceptance of the
Joint Committee's Favorable Report and passage of the
bill.

THE CHAIR:

The motion is on acceptance and passage. Will you
remark?

SENATOR GERRATANA:

Yes, Madam President. The Clerk has an amendment, LCO
5254, if he would call and I be allowed to summarize.

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Mr. Clerk.

THE CLERK:

LCO Number 5254, Senate "A" offered by Senator
Gerratana and Representative Johnson.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Madam President, this amendment is a strike-all amendment to the underlying bill, and I will explain why we are doing this. The underlying bill allows certain Connecticut licensed health care facilities to provide psychiatric or substance use disorder services and to provide these service at off-site locations.

And in essence, the amendment does the very same thing. However, as we went along in the process we found some weaknesses to the underlying bill. So this amendment will clarify those and certainly strengthen the process in what we are trying to achieve here. The underlying bill was a little bit too loose, and we felt since this was behavioral health and providing the services of behavioral health that there needed to be some reference and protocol set out.

Secondly, there was concern that by allowing patients to receive these services at off-site facilities, that perhaps their confidentiality and other protections would not be in place, and also that there would be a problem for Medicaid reimbursement that -- which was part of the conversation as we were working on the amendment.

Now, I will just talk briefly about the amendment we have in front of us on lines 83 to 91. This describes multicare institutions, and these are institutions which provide outpatient behavioral health services, but more importantly they are licensed. And what we are doing here is we are extending, if you will, the aegis of the licensure to satellite locations and

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other-locations so that patients receive these particular services.

The other part that members might want to read is in lines 185 to 202. And that talks about that these patients receive services that are consistent with the patient's assessment and treatment, and also that the multicare institution that extends these services be -- will have to submit an application and be subject to the licensure, if you will, of the mother institution. So with that I certainly hope that the members will approve this amendment. Thank you.

THE CHAIR:

Thank you. Will -- I'm sorry, will you remark? Will you remark? Good evening, Senator Welch.

SENATOR WELCH:

Good evening, Madam President. I do rise in support of the amendment. I agree with Senator Gerratana that the bill that we have before us unamended, although good in concept, lacks in details, and I think this amendment seeks to really fill in some of those details and make it pretty clear what the Legislature intent is. And the intent would be for these off-site facilities to essentially be operating under the license, the umbrella license, as it were, of the original facility, but also be subject to the regulations of DPH inspection, et cetera, whatever those might be, in fact it asks DPH to come up with those regulations. If I may, through you, Madam President, ask a question to the proponent of the amendment?

THE CHAIR:

Please proceed, sir.

SENATOR WELCH:

Thank you, Madam President. I notice in the underlying bill this is no mention of the term multicare institution. Here beginning in lines 83, which I think, Senator Gerratana you referenced earlier, we are actually creating, I think, a new

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definition, multicare institution. Through you, Madam President, what -- what is the purpose of creating this definition of multicare institution?

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Madam President, as I understand it multicare institution is already mentioned in the regulations regarding the facilities that we are talking about here. Or, I should say, in -- in interpretation of the statutes, as regulations certainly are. And it was necessary to do this so that we understood what we are talking about here, what kind of facilities.

So in essence it congregates, if you will, and puts into one definition, and now we're putting it into statute what multicare institution means. And you can read that in the definition exactly what we are talking about, Madam President.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President. Thank you, Senator Gerratana for that answer. I think with respect to multicare institution, I take away two important points. The first is as we're talking about institutions that offer psychiatric or mental behavioral health services, we're not talking about institutions that don't offer those services.

And I think the other important point that I take away is that these institutions have to already be licensed by DPH, which I think is a very important distinction.

If I may, Madam President, through you, there was a number -- a number of people testified with respect to this bill at the public hearing. And I'm wondering if Senator Gerratana remembers maybe one or two of the

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institutions that are -- have testified in favor of this, and might actually take advantage of this. Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Through you, Madam President. You know, offhand I don't recall exactly who testified in favor, but I did have conversations, Senator Welch, with a number of people who are part of our Behavioral Health Task Force and also the Behavioral Health Partnership.

One person comes to mind from the Rushford facility and who would fit the description here who are trying to extend these services in locations, and under this bill, safe locations, but also, if you will, have the facility go to the patient rather than the patient have to travel, perhaps, an extensive distance to get to the actual facility.

So the satellites and the other locations subject to the licensure are a good alternative. There are many individuals in behavioral health that spoke with me about, you know, having patients meet the times and the places and other parameters that are set upon them that sometimes are a deterrent to receiving these services. So that's my recollection of conversations.

I would have to look on my computer to see who did testify exactly. But just so you know, I did have some conversations with some of these providers. Through you, Madam President.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President. Yes, Rushford, Wheeler Clinic, I think is another one, Catholic Charities, as well.

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Essentially we have a crisis, not only in this state but in many states, dealing with mental health, Madam President, and unfortunately a lot of patients with mental and behavioral health issues don't have access to transportation.

They might be in communities where there is not already one of these institutions. And so I think it's a great benefit to the State of Connecticut if we can allow these institutions to operate in communities without necessarily having the -- the full hospital, as it were, Madam President. So this is a very good amendment.

I thank Senator Gerratana for bringing it forward, because I think it makes abundantly clear at least how we want to execute on the concept that was put forth in the underlying bill, and I would urge its adoption. Thank you, Madam President.

THE CHAIR:

Thank you. Will you remark? Will you remark?
Senator Kane.

SENATOR KANE:

Thank you, Madam President. I rise for a question to the proponent of the bill.

THE CHAIR:

Please proceed, sir.

SENATOR KANE:

Thank you, Madam President. I'm a bit confused by the fiscal note attached to LCO 5254. The -- it says that the amendment strikes the language in the underlying bill and the associated fiscal impact. However, it does say potential. Through you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

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Thank you, Madam President: You are correct, I read the fiscal note just before I brought out the amendment. It does say there may be potential, and that fiscal note reflects upon the fact that maybe there would be more utilization particularly under Medicaid by enacting this approach.

Now, I would say to you, Senator Kane, that I was thinking about that, and I said, the good news is that there would be more access perhaps by having these off site, if you will, locations of these particular facilities.

But also that regardless, when these services are ordered, medically ordered and appropriate, that patients still have to receive them, if not now, maybe later. But we do know that we can save a lot of money also by patients receiving these services in behavioral health care up front and a lot quicker, and that's the intent of this bill. Through you, Madam President.

THE CHAIR:

Senator Welch. I'm sorry, Senator Kane. On this one I'd rather give it to Senator Kane.

SENATOR KANE:

Thank you, Madam President. I -- it's an honor for me to be called Senator Welch, let me tell you.

My follow-up question would be -- I lost my train of thought. My follow-up question would be is there any way for to us continue to view -- because your point was that there may be a fiscal impact because more people may take advantage of these -- access to services. So is there any way that the agency or anyone going to track the -- this as it goes along?

I'm prepared to support the bill here today, but when we talk about the potential, meaning the future impact that this is going to take place, are we prepared to monitor that or view that or come back and say, yeah, it did. A happened or B happened or C happened. Is this a way to react to it, I guess in time? Through

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you, Madam President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Well in general, I guess, many of these institutions have to, by law, track and report on what we call claims that are made so that we know that services are being received. But there's another way also, Senator Kane.

You know, as Co-Chair of the Medical Assistance Program Oversight Council, we meet monthly with the departments and agencies, such as DMHAS and DSS, and in this case, the fiscal note is really talking about Medicaid recipients. And so we meet with DSS, and they report to us, and we ask questions. In fact, this has been of concern both in the Behavioral Health Partnership Oversight Council as well as MAPOC and asking DSS to give us this kind of information.

Ever since we had our Bipartisan Task Force last year in 2013 after, of course, what happened in our state, and the reason for that. We -- many of us in public health and mental health and behavioral health who are concerned in that arena, who are concerned very much about the access to health care had been formulating, and I know through the Behavioral Health Task Force, they are coming up with recommendations, and we have been concerned about that and asking for more data.

We know MAPOC tracks through DSS this kind of data, and I know the Behavioral Health Partnership, this was a topic of discussion, and I know that they also track and are concerned with the day data. Thank you, Madam President.

THE CHAIR:

Senator Kane.

SENATOR KANE:

Thank you, Madam President. I thank Senator Gerratana

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for answering my questions. Especially clarifying the fiscal note and the ability to track potential costs in the future. Appreciate it. Thank you.

THE CHAIR:

Will you remark? Will you remark? If not I will try your minds. All of you in favor of Senate "A" please say aye.

SENATORS:

Aye.

THE CHAIR:

God, was that sick.

SENATORS:

Aye.

THE CHAIR:

All those opposed say Nay. Senate "A" is passed. Oh, my god. Will you remark further? Will you remark further? Senator Gerratana.

SENATOR GERRATANA:

Thank you, Madam President. Madam President, if there is no objection I would like to have this item placed on our Consent Calendar.

THE CHAIR:

Seeing no objections, so ordered, madam.

SENATOR GERRATANA:

Thank you.

THE CHAIR:

Mr. Clerk, do you have anything on your Calendar? At this time we'll stand at ease.

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Opposed. Reconsideration is passed.

SENATOR LOONEY:

Right now since the matter is before us again, Madam President, I would move to mark it passed temporarily.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Thank you, Madam President. Now if the Clerk would call those Consent Calendar items so that we might move to a vote on the Consent Calendar, and then we might proceed to the items that were marked go.

THE CHAIR:

Mr. Clerk.

THE CLERK:

On page 2 Calendar 166, Senate Bill 427.

Page 4 Calendar 300 Senate Bill 417.

Page 6, Calendar 331, House Bill 5248.

Page 7, Calendar 340, House bill 5273.

On page 10, Calendar 416, House Bill 5407. Calendar 415, House Bill 5518. Calendar 396, Senate Bill 114.

On page 11, Calendar 419, House Bill 5477.

Page 12, Calendar 426, House Bill 5023.

On page 18, Calendar 489, House Bill 5227. Calendar 470, House Bill 5506. Calendar 490, House Bill 5113.

On page 19, Calendar 494, House Bill 5573.

Page 20, Calendar 498, House Bill 5467. Calendar 499, House Bill 5419.

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And on page 22 Calendar 513, House Bill 5353.
Calendar 515, House Bill 5361.

And on page 24, Calendar 526, House Bill 5556.
Calendar 524, House Bill 5219.

Page 25, Calendar 4 -- sorry, Calendar 530, House Bill 5368,
page 27, Calendar 546, House Bill 5061.
Calendar 543, House Bill 5037.

On page 28, Calendar 550, House Bill 5514.

Page 29, Calendar 554, House Bill 5148.

Page 30, Calendar 563, House Bill 5554.

Page 31, Calendar 567, House Bill 5229. Calendar 565,
House Bill 5028.

And on page 42, Calendar 384, Senate Bill 442.

THE CHAIR:

Senator Looney, do you have any more good news for us?

SENATOR LOONEY:

Yes, thank you, Madam President. One additional item to add before we call for the actual vote on the Consent Calendar, and that is item an Calendar page 33, Calendar 575, House Bill 5359. With that one addition it would call for a vote on the Consent Calendar.

THE CHAIR:

Mr. Clerk, please call for a vote on the Consent Calendar, and the machine will be open.

THE CLERK:

Immediate roll call has been ordered in the Senate.
Immediate roll call on the second Consent Calendar
today has been ordered in the Senate.

THE CHAIR:

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If all members have voted? All membered voted, the machine will be closed. Mr. Clerk, will you please call the tally.

THE CLERK:

On the second Consent Calendar for today.

Total number voting	35
Those voting Yea	35
Those voting Nay	0
Absent not voting	1

THE CHAIR:

Consent Calendar passes. Senator Looney.

SENATOR LOONEY:

Thank you, Madam President. If the Clerk would call the first item marked go to follow the Consent Calendar.

THE CHAIR:

Mr. Clerk.

THE CLERK:

On page 33, Calendar 579, Substitute for House Bill Number 5348, AN ACT CONCERNING THE PAYMENT OF DELINQUENT PROPERTY TAXES. Favorable Report of the Committee on Planning and Development.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you. Thank you, Madam President. Pursuant to Rule 15 of the Joint Rules, I am recusing myself from consideration of this bill.

THE CHAIR:

Thank you, sir. Please leave the Chamber.

**JOINT
STANDING
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**PUBLIC
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These families, if the proposed bill is passed, can have an improved quality of life, not only for their family but for the individual and the families, mom and dad, sisters and brothers, will be able to do what they're supposed to do, give loving care to their child.

In addition, by putting through this bill there will be other additional opportunities for these families to be involved in the community. Lots of these families currently cannot go out in the community. They cannot go out to dinner. They cannot go to the niece's birthday party because the support is not there for their child affected with autism to participate in these activities.

So again, by putting through this bill it will bring back the quality of life for all these individuals and families affected by the autism disorder.

SENATOR GERRATANA: Thank you. Thank you for coming here today. Were you delayed by traffic?

AIMEE HARAY: Yes, traffic and parking.

SENATOR GERRATANA: Okay, that's quite all right. But we're glad that you gave your testimony. Does anyone have any questions? If not, thank you very much.

AIMEE HARAY: Thank you.

SENATOR GERRATANA: We do appreciate your coming before our Committee.

AIMEE HARAY: Thanks.

SENATOR GERRATANA: Next we go on to Senate Bill 417 and Jeff Walter. Good morning. Welcome. I'm sorry, afternoon.

JEFFREY WALTER: Afternoon now. Good afternoon, Senator Gerratana, Representative Johnson and

members of the Committee. My name is Jeffrey Walter and I'm here to urge adoption of Bill 417.

I recently retired from Rushwood Center after 34 years running one of Connecticut's largest and most comprehensive behavioral health organizations.

And now I have the great pleasure and privilege of working on integrated care with our health system's accountable care organization, Hartford HealthCare Accountable Care Organization.

Bill 417 is critical to the effort to integrate behavioral health in the primary care setting. Currently, the situation is that behavioral health outpatient clinics, substance use clinics as well as psychiatric clinics for adults are licensed for the site specific to their address.

So if they want to provide a behavioral service in a primary care office or any other setting, they have to get fully licensed in that setting, even if it's going to be consultation one afternoon a week, which is not realistic, not efficient. It's not realistic for clinics to go and get licensed for these spots.

So in this new world of healthcare reform and everybody's universal desire to bring these silos that we've had in healthcare, behavioral health and physical medicine together to work on team-based care, we need to remove barriers to doing that, both regulatory and financial barriers that exist to make this happen.

This bill works on a regulatory side by allowing licensed clinics to basically extend their license so that their practitioners, their licensed psychologists and social workers and alcoholic and drug counselors can work in the

primary care setting as part of the primary care team.

This, I would also ask that the Committee consider an amendment, which would add hospital clinics to this bill. This bill as it's written right now, will only affect community-based, non-hospital clinics. We need to add the hospital clinics as well so that they could all participate in this siting initiative.

SENATOR GERRATANA: Good. We do appreciate you coming to testify. There are a number of members who have questions for you. Did you want to summarize your testimony at all?

JEFFREY WALTER: I think that I, that that basically summarizes the bill. There's other folks that will be testifying this bill that will have things to add, I'm sure.

SENATOR GERRATANA: Okay. Representative Miller, followed by Representative Sayers.

REP. MILLER: Thank you, Madam Chair, and thank you for your testimony and I also want to thank you for your long-time chairing the behavioral health partnership where I think we've made some really good progress for the people of Connecticut.

The question I have for you is, if you could give us one or two examples of how this works on a practical basis. I know from my own experiences that when we try to encourage people to get help, it can be intimidating for them and sometimes they look at that building down the street there where people go to get mental health services as a place that they don't want to go and that this would maybe then allow a specialist to see them in a place that they're comfortable with, like their physician's office or something.

Can you give us one or two concrete examples, please.

JEFFREY WALTER: You really hit the nail on the head, and I have a colleague that's speaking this morning, this afternoon as well, Steve Lee, who's a physician's assistant and he has a lot of experience with this kind of model of providing care.

I think that probably members of the Committee know, but if you don't, I'll tell you that the majority of behavioral health care is provided in a primary care setting. What do I mean by that?

More than half of all of the psychiatric medications prescribed in the United States are prescribed by primary care doctors. Most people with behavioral health issues are going to be, they're going to be seen by a primary care doctor.

More than half of the people who get referred out to specialists in the community, and I represent organizations that have been specialists in the community. They don't make it there, for various reasons.

So this model of embedding behavioral health specialists in the primary care setting is tremendously effective and has been proven to be effective across the country where it's been done.

Where has it been done? Kaiser is a good example of where it's been done very well. There's other examples as well.

But you're absolutely right. When you have somebody that's working shoulder to shoulder with physicians, with other, with medical assistants and other mid-level providers, they can, it can be more comfortable for people to be

able to deal with the behavioral issues that are undercutting their effectiveness of their treatment for other diseases.

REP. MILLER: Thank you, and that's exactly what I was looking for and I also wanted to thank you for the many years you've worked with Rushwood. You've helped thousands upon thousands of our people in Connecticut and thank you again.

JEFFREY WALTER: Thank you.

SENATOR GERRATANA: Representative Sayers.

REP. SAYERS: Thank you. Welcome, Jeff. And as a person who spent a good deal of time licensing many of these psych outpatient clinics, what, how would this be different from what we now call satellite programs, for instance?

If a psych outpatient clinic might have a satellite program, I've gone into church basements where there's just one room that is leased to the psych outpatient clinic and they may only provide services there, say one afternoon a week, but it's called the satellite program.

How would this differ?

JEFFREY WALTER: Thank you, Representative Sayers. That's a very good question. The model that we're working off of is, there's already precedent in statute for this model, and that is through the licensing of outpatient clinics for children by the Department of Children and Families. They have what's, they have a category within their licensure called off-site services. They also have a category for satellite.

The difference between a satellite and off-site, is that actually satellites, and I should also say on the adult side as you know, the

Department of Public Health does not really have a provision for licensing satellites.

If you have what a clinic might consider that they have a satellite, but it's really fully licensed as a full clinic, so that's the problem. It's very onerous to license a site where you're going to be a couple of afternoons a week, whether it's a church or a school-based health clinic or a primary care center.

Off site is a different concept and what it really does is, it becomes an extension of their license. So for instance, I've been talking with a private practice group, a multi-specialty private practice group in a suburb of Hartford that has many patients overlapping with a primary care site in our health system and it's right down the road.

They're interested in sending their clinicians right to the primary care site. Well, we don't want to, right now they have to get a full license to do that. Easier if they consider it a satellite. This would allow them to just basically have their clinicians that are working in their licensed site work in this off site, so it's an off-site kind of a concept.

REP. SAYERS: And in listening to what you're saying, I think that the current regulations might be able to be tweaked, and you're correct, because I can remember going to visit an off-site satellite program where one person was the only person that ever occupied that office, but the requirement was that they do quarterly fire drills. So that person had to ring a bell and do a fire drill all by themselves, which when you think of that context was rather foolish, and had that documentation there.

And a lot of times they would have a mechanism for keeping their clinical records and

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frequently because the satellite program would be somewhere like a church basement, where there wasn't always a good place to store within the confidentiality concerns, the medical records. They frequently carried them back and forth to that site and I know as someone who had a license, I had to go somewhere else to review records.

But I think that what you present, there should be a way that you at least tweak the regulations or at least add additional regulations that would address that situation that you're talking about, so thank you.

JEFFREY WALTER: If I could, I know there wasn't a question there, but if I could have a moment to address license in part because we have had discussions with the Department of Public Health, which is my understanding through those meetings that they are in the process of tweaking, as you say, of really, of overhauling these licensing requirements regulations that are 20 years old to adopt to the common world.

This law, this bill if it's enacted, will allow this collaboration that we're looking to form and happen more quickly, because the regulation review process is a little bit longer.

But ultimately, I believe that DPH will have regulations that will support this concept of collaborative care. It makes a whole lot of sense. Thank you.

REP. SAYERS: Right. And currently, many facilities that are primarily licensed as substance abuse facilities such as Rushford, also offer psychiatric services.

JEFFREY WALTER: Uh-huh.

REP. SAYERS: But in the context of this actual psychiatric services most of those facilities

offer, it's only to treat someone who has a substance abuse problem that also might have a psychiatric problem as well, rather than someone who is primarily and only has psychiatric needs, so I think there's really a need to really look at a lot of those regulations and probably update them to today's practices.

JEFFREY WALTER: Right.

REP. SAYERS: So thank you.

JEFFREY WALTER: Exactly.

SENATOR GERRATANA: Thank you. Actually, Jeff, I wanted to just ask you very quickly. What is the license? Is the license for like an outpatient clinic or?

JEFFREY WALTER: There are, Bill 417 relates to two licensures, two licenses. One is a license for adult psychiatric, adult outpatient clinics, adult psychiatric outpatient clinics.

SENATOR GERRATANA: Okay.

JEFFREY WALTER: And the second is a license for facilities for the treatment of substance abusing individuals.

SENATOR GERRATANA: Yes, I read the bill so I'm familiar with what we're talking about. I was just asking you off the top of my head how the department licenses these kinds of facilities, try to think of poor old licenses, these kinds of facilities. And so this would mean that within a health system, I mean, what I'm trying to understand is, who holds the license in these cases and also, I'll get it in now, I was going to ask you if you have any recommendations please submit them in writing --

JEFFREY WALTER: Okay.

SENATOR GERRATANA: -- and hopefully within the next 24 hours. That would be helpful. But go ahead.

JEFFREY WALTER: Sure. Well, I think you're asking a complicated question about when a behavioral health specialist is operating say in the primary care office, whose license are they operating under. Is that?

SENATOR GERRATANA: No. No.

JEFFREY WALTER: No?

SENATOR GERRATANA: We're trying to allow. I'm saying who would be the primary license holder, I guess in a ==

JEFFREY WALTER: This bill --

SENATOR GERRATANA: -- of course a physician's office it's the physician who owns the license.

JEFFREY WALTER: Uh-huh.

SENATOR GERRATANA: If you will. In a different clinical setting there's an entity for instance, you know, school-based health centers are licensed as clinics.

So I'm trying to understand, I guess, who would own the license and how then would the services be offered off site. Under whose license or what license would that be?

JEFFREY WALTER: Right. The service delivery landscape is getting more and more complicated.

SENATOR GERRATANA: Yes, it is.

JEFFREY WALTER: So to stick with this bill, this bill covers the scenario in which a licensed outpatient clinic, substance abuse or psychiatric or both, are operating within their license of sending a specialist into a primary care setting.

So while they're providing services to the patients of the primary care office, they're doing it under their clinic license. That's this bill.

There are other ways that these services could be provided under different licenses, but we're talking about, you know, this scenario.

SENATOR GERRATANA: Okay, so it's under the clinic's license.

JEFFREY WALTER: Right.

SENATOR GERRATANA: Okay. That's really all I wanted to know. Thank you.

JEFFREY WALTER: And there are clinics that are ready today, that are talking with primary care offices right now that would love to go in and provide these services today --

SENATOR GERRATANA: Right.

JEFFREY WALTER: -- if their license allowed it.

SENATOR GERRATANA: Sure. That makes total sense to me. Okay, thank you. Representative Sayers.

REP. SAYERS: May I add one more comment to that. A physician's license per se is not, a physician's office, per se is not licensed. So were they to offer for instance, we have doctors that ban together and that have a practice, like I go to East Granby Family Medicine and there are a number of physicians in there.

If they were to provide psychiatric services on that site in today's, with today's regulations, they would have to have one room designated where that would be offered and that room would have to have a license from the Department of Public Health as a psych outpatient clinic or a substance, whichever license it obtained.

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This would make changes to that.

JEFFREY WALTER: Uh-huh. Yes. Thank you. Thank you very much.

SENATOR GERRATANA: Thank you very much, Jeff. Next is Brunilda Ferraj. There we go.

BRUNILDA FERRAJ: Hi.

SENATOR GERRATANA: Hi.

BRUNILDA FERRAJ: Good afternoon, Senator Gerratana -

SENATOR GERRATANA: Good afternoon.

BRUNILDA FERRAJ: -- and distinguished members of the Public Health Committee. My name is Brunilda Ferraj. I'm a public policy specialist at the Connecticut Community Providers Association and I'm here to provide testimony actually in place of Morna Murray who submitted written testimony.

SENATOR GERRATANA: Oh, okay.

BRUNILDA FERRAJ: CCPA represents community-based organizations that provide health and human services for children, adults and families in multiple areas including mental health and substance abuse disorders and developmental disabilities. Our members serve more than 500,000 people each year.

I am here today to speak in support of Senate Bill 417 AN ACT CONCERNING THE PROVISION OF PSYCHIATRIC AND SUBSTANCE ABUSE TREATMENT SERVICES S.B. 417 would allow community-based behavioral health organizations to provide psychiatric and substance abuse treatment services in primary and other healthcare settings.

Current DPH licensure regulations, as you've already heard from Jeff, restrict clinic

practice to physical locations specifically approved by the department. There is no provision short of full licensing of any site for the development of clinical resources from a licensed clinic to an off-site location.

This bill promotes comprehensive, integrated healthcare. It would allow providers to break down barriers between behavioral health and primary care services by providing them with the opportunity to facilitate the coordination of care and delivery of services in the most appropriate setting for the patient, resulting in better outcomes.

S.B. 417 not only breaks down silos between behavioral health and primary care, but it also supports the whole person centered approach to wellness and health.

Today, individuals are increasingly being diagnosed with co-occurring physical and behavioral health conditions. S.B. 417 aligns this reality with practice.

Furthermore, this collaborative model in which behavioral health services are provided in primary care settings has shown to reap measurable benefits and long-term cost savings by reducing avoidable hospitalization.

These principles are in line with current health initiatives being undertaken by the state, such as behavioral health homes, the SIM model and health neighborhoods. Thank you for your time.

REP. MILLER: Thank you. Did you submit your testimony to us?

BRUNILDA FERRAJ: Yes. It was under Morna Murray, President and CEO of CCPA and she could not be here today.

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REP. MILLER: Okay, thank you. Are there questions from the Committee? No. Thank you for testifying. Next we'll hear from Enrique Yuncadilla, followed by Alyssa Goduti. Welcome. Could you turn on your microphone, sir. There should be a button right in front of you. There we go. Thank you.

ENRIQUE YUNCADILLA: Okay. Thank you for the opportunity to be here today and I want to speak. My name is Enrique Yuncadilla. I am the Director of CommuniCare, which is a community mental health agency in the greater New Haven area.

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As an operator of the South Central Crisis Service, a Latino behavioral health program and we also are pioneers with 11 other agencies around the country in a health integration program five years ago funded by a SAMHSA grant.

So I'm here today and my notes basically address the benefits of integration in terms of the benefits to the consumers and higher quality of care and outcomes and I would like to use my limited time to bring to your attention a couple of aspects that have not been mentioned by my colleagues.

One of them is the fact that integration does have a capability to create jobs, and I think that when you deliberate and you think about the advantages and disadvantages of your options, keep in mind that this is a dynamic engine of our economy and that you should do as much as you can to facilitate that growth opportunity.

In addition, I want to mention that the additional licensing requirement is an administrative and financial burden on organizations. If that's true, the future integration, which is going to happen anyway because it is mandated by ACA, the Accountable

Care Act and it's basically virtually speaking an unfunded mandate because the care coordination and other collateral services are not really billable.

That cost will only be affordable to very large integrated systems, and so a decision you make in terms of the licensing requirement, makes also a decision as to whether only the big players are going to participate in this market or you will open participation to small, independent community-based agencies.

And given that the demand for mental health services is going to grow, you should keep in mind that to maintain access to care, you should try to maximize the opportunity for the public to have as many providers as possible.

In addition, as Jeff pointed out earlier, the integration has proven effective by systems like Kaiser or Vivier for decades, so we know this works.

The only problem has been that the externalities in which the cost is incurred by one party but the benefits accrue to another, has prevented this from becoming universally adopted.

Now the health reform is giving us that chance, and I think you should do as much as possible to minimize the barriers of entry to other providers so that they can contribute to this important progress in the quality of our healthcare. Thank you.

REP. MILLER: Thank you for your testimony. Are there questions from the Committee? Thank you, sir.

ENRIQUE YUNCADILLA: Thank you.

REP. MILLER: And next up is Alyssa Goduti followed by Stephen Lee. Welcome.

ALYSSA GODUTI: Good afternoon. I'm Alyssa Goduti. I'm the Vice-President for Business Development and Communications at CHR Community Health Resources. CHR is one of the most comprehensive behavioral healthcare providers in Connecticut offering a wide range of services including mental health and addiction treatment services for children, adults and families, substance abuse services, child welfare and supportive housing.

We serve 16,000 individuals a year. We've seen dramatic growth in the need for our services on about 40 percent in the last year alone. We have 32 locations, provide services throughout half the state and have more than 650 exceptional staff.

I'm here today to support S.B. 417 and urge your support. As you've heard earlier, this bill helps to address some of the administrative barriers that prevent integrated care. We all know and believe that the best healthcare is healthcare that addresses a person's total needs.

I want to provide an example that really highlights what Representative Miller had asked Jeff earlier. John visits his primary care doctor. He has his annual physical and he talks to his primary care doctor about a number of physical needs, but he also mentions that he's struggling with sleep deprivation and he can't fall asleep and he's having a lot of days where he's feeling sad, lonely. He's recently experienced the loss of a loved one.

John's doctor talks with John, assesses that he might be struggling with depression and maybe could use the help of an out-patient therapy. With this bill, instead of sending John along the way down the street with the referral slip, he's able to walk John down the hall, introduce

him to Maria, who's PHR's licensed social worker. Maria can sit with John, develop a rapport, talk with him and basically start him on that path toward help recovery wellness right then and there.

As it is now, John may have walked out the door. He may not get treatment. He may never decide he wants to make that trip into the behavioral health clinic. There is also the stigma issues, which have certainly improved, but there are some barriers to John receiving care, but that integration really allows for treatment to happen in a much more fluid process that really addresses his whole wellness.

So I urge you to please consider this and try to address some of the barriers that really prevent us from providing quick, immediate, thorough treatment to people that need behavioral healthcare.

REP. MILLER: Thank you for your testimony and also for your work with Community Health Resources. Are there questions from the Committee? Thank you for your testimony. Next up is Stephen Lee and Steven will be followed by Holly Martin. Welcome. I think your mike's on. If you could state your name and we'll take your testimony.

STEPHEN LEE: Thank you.

REP. MILLER: Thank you.

STEPHEN LEE: First off, I apologize. I didn't get a chance to upload on my testimony on line, but I will do that as soon as I'm able to.

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My name is Stephen Lee. I'm a board certified physician assistant practicing both psychiatry and addiction medicine for Rushwood Behavioral Health System.

I'm also an assistant professor at Bay Path College teaching clinical medicine as well as I am also a full-time doctoral student studying behavioral health. Therefore, this bill is directly linked to my profession and my training.

After review of this provision, I believe this bill is an important step to help pave the way for integrated behavioral healthcare.

Why is behavioral health care important? Well, about 60 to 70 percent of medical patients presenting to their PCP complain of physical symptoms with no objective findings by means of objective testing such as lab work, consults and imaging. It is noted that 60, 80 percent of these patients who suffer from anxiety and depression present with some kind of physical symptom.

Why? Patients are translating their effective symptoms into somatic ones.

Increasing the ability of rapid and effective psychotherapy reduces medical costs at at least 40 percent. Why? Somatizers increase medical cost at an estimated 6 to 14 times.

Often treated for physical symptoms that involve multiple testing and consultations, physicians and other providers overlook behavioral problems at the root of physical symptoms.

Furthermore, 70 percent of patients referred for psychotherapy refuse. Studies demonstrate that 81 percent of somatizing patients will accept these services if in a primary care setting. This reduces cost and improves patient well being by increasing the patient's adherence treatment plans.

The behavioral health provider, which is the ideal picture where, our direction that we're

going to, would also work with patients and modify their unhealthy lifestyle; which is at the root of many diseases that we are currently facing today, including obesity.

Some of the other things that we also will work with is patients who are suffering from diabetes, chronic pain, obesity, hypertension and medication compliance.

So how can integrated care benefit patients, physicians and medical community? Patients will have a continuity of care with behavioral health provider that is familiar with their medical and behavioral problems. And I'll keep this brief, so I'll summarize.

Research demonstrates that utilizing behavioral health providers in a primary care center improves adherence to medical health and mental health treatment plans, improves patient outcomes with chronic disease and reduces the use of medical resources.

Therefore, I believe by passing a bill that would allow primary care and behavioral health entities to combine their resources would generate improved care for the people of Connecticut. Thank you.

REP. MILLER: Thank you for your testimony. Are there questions from the Committee? Thank you very much.

STEPHEN LEE: Thank you.

REP. MILLER: Next up is Stephen Lee. Oh, I'm sorry, that was Stephen.

STEPHEN LEE: Yeah.

REP. MILLER: Next up is Holly Martin followed by Ken Ferrucci. Is Holly here? I think the mike is

To: Members of the Public Health Committee

From: Enrique Juncadella, CommuniCare, Inc.

Re: Public Health Committee Public Hearing on SB-417: An Act Concerning The Provision Of Psychiatric And Substance Use Treatment Services

Date: March 19, 2014

The previous experiments with integration show that co-location and other forms of delivery of mental health services in a medical setting are effective in increasing the quality of care and outcomes. Integration enhances the patient experience by improving communication between providers, and it minimizes gaps in the coordination and continuity of care.

There are virtually no negative effects or pitfalls from these arrangements. They have been thoroughly tested in pediatric practices for many years. Consumers appreciate the convenience and receive their healthcare in a holistic manner, in which they are considered as a whole person, a cornerstone of the patient centered medical home model.

Requirements for licensing of facilities make sense in an institutional setting, for organizations that rely on scale and volume of services, and where the health conditions of consumers are addressed in one dimensional isolation. The integration of care is more about people and systems than it is related to infrastructure defined by real estate and facilities.

The mandates of the ACA are driving the changes in the health care services are delivered. We must facilitate the evolution and not hinder it if we are going to reap the rewards from this progress.

Enrique Juncadella
CommuniCare, Inc.

**S.B. No. 417 (RAISED) AN ACT CONCERNING THE PROVISION OF PSYCHIATRIC AND
SUBSTANCE USE TREATMENT SERVICES.**

My Name is Stephen Lee and I am a physician assistant practicing in both psychiatry and addiction medicine. I am also an assistant professor at Bay Path College teaching clinical medicine as well as a full-time doctoral student studying behavioral health. Therefore, this Bill directly linked to my profession and my training. After review of this provision, I believe this Bill is an important step to help pave the way for integrated behavioral health care.

Why is Behavioral Health Integration important?

1. 60 – 70% of medical patients presenting to their PCP complain of physical symptoms with no objective findings noted by means of objective testing such as labwork, consults, or imaging (Cummings & Follette, 1968). It is noted that 60-80% of patients who suffer from anxiety or depression present with some kind of physical symptom (Boles, Pelletier, & Lynch, 2004). Why? Patients translating affective symptoms into somatic ones.
2. Increasing availability of rapid and effective psychotherapy reduces medical costs by at least 40% (Cummings & Follette, 1968; Jones & Vischi, 1979; Friedman, Sobel, Myers, Caudill, & Benson, 1995; Blount et al., 2007). Confirmed by NIMH research. Why? Somatizers increase medical cost an estimated 6 – 14 times!
3. Often treated for physical symptoms that involve multiple testing and consultations. Physicians and other providers often overlook behavioral problems at the root of physical symptoms (McGlynn et al., 2003). Furthermore, 90% of those patients referred out for psychotherapy refuse. Studies have demonstrated that 81% of somatizing patients will accept these services if in the primary care office (Cummings & Cummings, 2012).
4. Reduces cost and improves patient wellbeing by increasing the patient's adherence to treatment plans.
5. BHP works with patients to modify their unhealthy lifestyle. Proven to be helpful in:
 - a. DM
 - b. Chronic pain
 - c. Obesity
 - d. Hypertension
 - e. Medication compliance

How can Integrated Care benefit patients, physicians, and medicine?

1. *Patients:*
 - a. Have continuity of care with Behavioral Health Provider in their Primary Care Office that is familiar with their medical and behavioral problems.
 - b. Can return for treatment at any time (throughout one's lifecycle) which has shown to increase patient satisfaction and improve access.

**S.B. No. 417 (RAISED) AN ACT CONCERNING THE PROVISION OF PSYCHIATRIC AND
SUBSTANCE USE TREATMENT SERVICES.**

2. Physicians:

- a. PCP Stress Reduction. BHP absorbs problematic patients who monopolize PCP clinical time (borderlines, somatizers, and anxious patients).
- b. BHP assists PCP with plan development and makes oneself available for "hallway handoffs".
- c. BHP values a physician-guided-team approach philosophy.
- d. Aids the PCP in screening patients for behavioral and social problems.

3. Medical Community:

- a. Follows emerging PCMH and ACO model
- b. Improves communication between behavioral and primary providers
- c. Utilizes Evidence-Based Psychotherapeutic Interventions to improve somatic symptoms which result in lower amount of unneeded consults to overburdened specialists

BHP Interventions that assist in the management of disease and mental health

1. Conduct group disease programs for those with diabetes, asthma, hypertension, fibromyalgia, and other chronic conditions.
2. Conduct psychotherapy groups for those with anxiety, mood, and personality disorders.
3. Conduct addiction groups which include tobacco, alcohol, and food.
4. Generates revenue by attending to multiple patients in a small timeframe.
5. Allows ability for patients to find social support with those with similar problems and disease processes.
6. Groups are interactive and educational. Will include social support and homework which is assigned at each session. Stress management and coping skills are reviewed as well as self-monitoring tools to improve the patients wellbeing (Cummings, & Cummings, 2012).

I am enrolled in Doctor of Behavioral Health Program which teaches BIODYNE psychotherapy:

1. Amalgam of over 40 years of evidence-based research
2. Brief intervention (20-30 minutes)
3. Patient-centered therapy
4. Utilizes patient feedback to improve outcome, decrease drop-outs, and improve effectiveness.
5. No termination but interruption of care which reduces patient anxiety and decreases the total amount of sessions. Model utilizes effective methods taken from cognitive, behavioral, psychodynamic, strategic, and Gestalt perspectives (Cummings & Cummings, 2012).

S.B. No. 417 (RAISED) AN ACT CONCERNING THE PROVISION OF PSYCHIATRIC AND SUBSTANCE USE TREATMENT SERVICES.

Research demonstrates that utilizing behavioral health providers in primary care centers improves adherence to mental health treatment plans, improves patient outcomes with chronic disease, and reduces the use of medical resources. Therefore, I believe by passing a Bill that would allow primary care and behavioral health entities to combine their resources would generate improved care for the people of Connecticut. THANK YOU.

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Signed: *Stephen E. Lee, M.S, PA-C*

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S.B. No. 417 (RAISED) AN ACT CONCERNING THE PROVISION OF PSYCHIATRIC AND
SUBSTANCE USE TREATMENT SERVICES.



**Testimony of Luis B. Perez President/CEO of MHAC
In Support of SB-417: An Act Concerning The Provision Of Psychiatric And
Substance Use Treatment Services
PHC.Testimony@cga.ct.gov**

For questions please contact: lperez@mhact.org or (860) 529-1970 Ext. 117

Good Morning Senator Gerratana, and Representative Johnson and members of the Public Health Committee. My name is Luis B. Perez LCSW. I am the President and CEO of the Mental Health Association of Connecticut, Inc. an organization dedicated to working and advocating for everyone's mental health for over 106 years. I would like to thank you for the opportunity to speak in support of S.B. -417: An Act Concerning The Provision Of Psychiatric And Substance Use Treatment Services.

1. SB-417 promotes the integration of behavioral health and primary care by allowing community based behavioral health providers to provide psychiatric and substance use disorder treatment services in primary and other health care settings.
2. Current DPH licensure regulations restrict clinic practice to physical locations specifically approved by the department. There is no provision - short of full licensing of a new site - for the deployment of clinical resources from a licensed clinic to an "off-site" location.

- 3. Integration through co-location provides improved care for individuals with co-occurring physical and behavioral health conditions, resulting in better outcomes. Psychotropic medications for conditions such as depression, anxiety, and post traumatic stress disorder (PTSD) are more commonly prescribed by primary care physicians than psychiatrists. We must support primary care physicians by providing them access to behavioral health specialists that can safely and effectively treat patients and to make appropriate referrals**
- 4. Integration breaks down silos and promotes a whole-person approach to wellness and health. The collaborative model, in which behavioral health services are provided in the primary care setting, has been shown to reap measurable benefits in both patient outcomes and long-term cost savings, by reducing avoidable hospitalization. These principles are in line with the ACA and current health initiatives being undertaken by the state, including behavioral health homes, the state innovation model, and health neighborhoods demonstration project.**

Thank you.

To: Members of the Public Health Committee

From: Enrique Juncadella, CommuniCare, Inc.

Re: Public Health Committee Public Hearing on SB-417: An Act Concerning The Provision Of Psychiatric And Substance Use Treatment Services

Date: March 19, 2014

The previous experiments with integration show that co-location and other forms of delivery of mental health services in a medical setting are effective in increasing the quality of care and outcomes. Integration enhances the patient experience by improving communication between providers, and it minimizes gaps in the coordination and continuity of care.

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Requirements for licensing of facilities make sense in an institutional setting, for organizations that rely on scale and volume of services, and where the health conditions of consumers are addressed in one dimensional isolation. The integration of care is more about people and systems than it is related to infrastructure defined by real estate and facilities.

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Enrique Juncadella
CommuniCare, Inc.

**Testimony of Victoria Veltri
State Healthcare Advocate
Before the Public Health Committee
In support of SB 417
March 19, 2014**

Good afternoon, Senator Gerratana, Representative Johnson, Senator Welch, Representative Srinivasan and members of the Public Health Committee. For the record, I am Vicki Veltri, State Healthcare Advocate with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

Thank you for the opportunity to comment on SB 417, AAC The Provision of Psychiatric and Substance Use Treatment Services. Reasonable and timely access to appropriate behavioral health and substance use services remains an ongoing issue for Connecticut residents in need, and SB 417 represents an important and practical measure to begin to mitigate this deficit.

By enhancing provider's ability to treat to areas beyond the facility or clinic, we can significantly increase the likelihood that behavioral health providers will offer their services in settings and areas of the state where they can be most easily accessed and where there is a need. Many individuals are reluctant to receive services in behavioral health settings due to stigma or other barriers, but will take advantage of such services in general medical settings.

In addition, many of the most needy in our state lack adequate resources or capability to travel long distances to receive care, a situation that, given the state of our behavioral health network, is often necessary in order to receive treatment. SB 417 reduces the impact of these barriers by allowing providers to go directly into a variety of settings

and communities with the greatest need. This comports with the philosophy that Connecticut has adopted towards reforming our behavioral health systems of care and it facilitates the integration of behavioral health and primary care, which is a central element of the reforms proposed in Connecticut's Health Care Innovation Plan developed under the State Innovation Model Initiative.

I thank you for providing me the opportunity to deliver OHA's testimony today. If you have any questions concerning my testimony, please feel free to contact me at victoria.velluti@ct.gov.



Wheeler

WHEELER CLINIC
Fostering positive change

To **Public Health Committee**

From **Susan Walkama, LCSW
President and Chief Executive Officer
Wheeler Clinic, Inc.**

Re **Testimony on Raised Bill 417 An Act Concerning the
Provision of Mental Health and Substance Abuse Services**

My name is Susan Walkama I am the President and Chief Executive Officer of Wheeler Clinic, Inc Wheeler Clinic is a large primary care, behavioral health, special education and prevention services provider serving over 30,000 individuals each year We are committed to reducing health disparities and have recently opened two health and wellness centers that provide integrated primary and behavioral healthcare to adults and families that have historically been seriously underserved in the traditional healthcare system

I am here today to support Raised Bill 417, An Act Concerning the Provision of Mental Health and Substance Abuse Services This bill would facilitate primary care and behavioral health integration, and improve access and outcomes for adult healthcare consumers This bill would change DPH regulation and allow adult providers like Wheeler who are licensed by the Department of Public Health to extend their existing mental health and substance abuse licenses to "off site" locations such as primary care physicians' offices to provide co-located and integrated behavioral healthcare services The current DPH adult licensing regulation requires each location be licensed and reviewed under a separate DPH process Providers must go through redundant and duplicative licensing reviews and processes A new license may take many months to fully process for approval This makes it practically impossible for free standing clinics to co-locate adult behavioral health services within adult primary care settings

Under our outpatient clinic licenses for children, which are regulated by DCF, we are permitted to establish our services in the offices of pediatricians and offer behavioral health screening, consultation and treatment to children and their families Wheeler has co-located behavioral health clinicians in the offices of Bristol Pediatric Associates for a number of years In a study of the project in 2007, and subsequent publication in the "Journal of American Psychological Association" in 2012, Wheeler has demonstrated that this type of co-location model improves access to services, generates positive clinical outcomes, and advances practice and systems changes in the primary care setting ^{1 2}

There is a need for new approaches to reach the significant number of adults with unmet behavioral health needs Best practice in healthcare integration is to co-locate and integrate behavioral healthcare within the primary care setting The promotion of collaborative care is consistent with Connecticut's focus on healthcare reform, the proposed State Innovation Model and should not be delayed by outdated regulation that is slow to change

¹ Sutcliffe, M (2007) *A program evaluation of the pediatric behavioral health project A co-location model of integrated behavioral healthcare* (Unpublished doctoral dissertation) University of Hartford, Hartford, CT

² Ward-Zimmerman, B and Cannata, E (2012) Partnering with pediatric primary care lessons learned through collaborative colocation *Professional Psychology Research and Practice* Vol 43 No 6 596-605 American Psychological Association DOI 10.1037/a0028967



March 19, 2014

PUBLIC HEALTH COMMITTEE PUBLIC HEARING
SB 417 – AAC THE PROVISION OF PSYCHIATRIC AND SUBSTANCE USE
TREATMENT SERVICES

Good afternoon. I am Alyssa Goduti, the Vice President for Business Development and Communications at CHR (Community Health Resources.) CHR is the most comprehensive behavioral health provider in Connecticut, offering a wide range of services including mental health and addiction treatment services for children, adults and families, substance use services, child welfare and supportive housing. CHR provides services through contracts with DMHAS, DCF, DSS, DPH and CSSD. We serve 16,000 individuals every year through our 80 programs, 32 locations and more than 650 exceptional staff. We have outpatient clinic sites in Manchester, Enfield, Willimantic, Danielson, Putnam, Mansfield, Bloomfield and Hartford. We believe that real life brings with it real challenges. We strive to help people find real hope.

I am urging you today to support SB 417, An Act Concerning the Provision of Psychiatric and Substance Use Treatment Services. We all know that the best healthcare addresses a person's total needs, focusing on their overall wellness and not just a piece of their health. This bill helps to address some of the administrative barriers that currently prevent more integrated care models from developing, by allowing behavioral health clinical staff to provide care in a primary care location that is "of site" of the officially licensed facility. This bill allows the behavioral health provider to provide essential services at the primary care doctor's office or another appropriate location that is not at the physical address of the DPH licensed facility.

Let me provide an example of how integration of behavioral health and primary health could work and why this legislation is so important. John visits his primary care doctor for his annual physical. During that appointment the doctor learns that John is not sleeping well and feeling sad often. John explains that he has experienced the recent loss of a loved one. His doctor talks with John about his experiences and recognizes that John would benefit from outpatient therapy to address his grief and treat what could be depression. Instead of handing John a referral slip and sending him away, he walks with John down the hall to a connected office where Maria, a CHR Licensed Clinical Social Worker is located to coordinate and provide care. John is able to sit with Maria and immediately make a connection and get help to begin the healing process. If John's doctor handed him a business card and suggested he visit the outpatient behavioral health clinic in a neighboring town, John would not have received such quick access to care. He may not have made an appointment at all.

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Alyssa Goduti - CHR – Page 2 of 2

We know that integrated care for those with co-occurring primary and behavioral health conditions results in better outcomes. Primary care physicians welcome the support of behavioral health specialists in a quick and easily accessible way. Clients benefit from an approach that promotes health and wellness of the whole-person, not a silo approach. The principles of integration are also consistent with the current healthcare reform initiatives occurring in Connecticut, including behavioral health homes, the state innovation model and the health neighborhood demonstration project.

We know that:

- Behavioral health is essential to physical health
- Prevention and early intervention are possible and necessary
- Treatment is effective
- People recover when they have the right help to get them there

We know that our services work but we need to make them as accessible as possible so that people will access care. This bill would address an administrative process that is creating barriers to integration. I ask that you please move this bill forward to allow for the provision of mental health and substance use services in doctor offices and other appropriate locations under the behavioral health provider's primary DPH license.

Thank you for your time and attention.



Alyssa Goduti
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Connecticut Department of Public Health

Testimony Presented Before the Public Health Committee

March 19, 2014

**Commissioner Jewel Mullen, MD, MPH, MPA
860-509-7101**

**Senate Bill 417: An Act Concerning The Provision Of
Psychiatric And Substance Use Treatment Services**

The Department of Public Health (DPH) supports Senate Bill 417. This bill will allow adults with psychiatric and/or substance abuse disorders to receive psychiatric services or substance use disorder treatment services at an alternate location that may not be physically part of a licensed psychiatric outpatient clinic or facility licensed to provide substance use treatment services. While DPH is supportive of this proposed bill, the Department believes that the provision of care at an alternate location should be based on a patient assessment and included in each patient's treatment plan and such language should be included in the bill. Expanding the treatment plan to provide services at an alternative location that is comfortable and convenient for the patient is consistent with current standards of care and patient centered.

Many psychiatric and substance use treatment facilities provide multiple services and maintain multiple licenses. The Department is currently revising these regulations to compress four regulation sets (19a-495-550: Private Freestanding Mental Health Day Treatment Facilities, Intermediate Treatment Facilities and Psychiatric Outpatient Clinics for Adults, 19a-495-551: Private Freestanding Mental Health Residential Living Centers, 19a-495-560: Private Freestanding Community Residences, and 19a-495-570: Private Freestanding Facilities For the Care or the Treatment For Substance Abusive or Dependent Persons) into one set of regulations, therefore requiring one license. The revisions will reflect a patient centric approach to care and revise outdated regulations.

Thank you for your consideration of the Department's views on this bill.

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To: Members of the Public Health Committee

From: Roberta J. Cook, President and CEO, BHcare

Re: Public Health Committee Public Hearings on SB-417, An Act Concerning the Provision of Psychiatric And Substance use Treatment Services

Date: March 19, 2014

Senator Gerratana, Representative Johnson, Senator Slossberg, Representative Miller, and distinguished members of the Public Health Committee, I thank you for your consideration of my testimony. My name is Roberta Cook and I am the President and CEO of BHcare, a regional nonprofit dedicated to improving the lives and health of the communities we serve by providing comprehensive behavioral health, prevention and domestic violence services. BHcare is designated as the Local Mental Health Authority for the towns of Ansonia, Branford, Derby, East Haven, Guilford, Madison, North Branford, North Haven, Oxford, Seymour and Shelton. Each year BHcare provides wraparound mental health and addiction services for more than 2700 Connecticut residents.

I am writing today in support of SB-417, An Act Concerning the Provision of Psychiatric And Substance Use Treatment Services. SB-417 promotes the integration of behavioral health and primary care by allowing community based behavioral health providers to provide psychiatric and substance use disorder treatment services in primary and other healthcare settings.

Current DPH licensure regulations restrict clinical practice to the physical location specifically approved by the department; there is no provision, aside from receiving licensure for a new site, to provide off-site services by the licensed clinic.

Psychotropic medications for conditions such as depression, anxiety, and post traumatic stress disorder (PTSD) are more commonly prescribed by primary care physicians (PCP) than psychiatrists. It is estimated that more than 70 percent of individuals who are prescribed a psychotropic medication never see a mental health professional.

A 2005 Institute of Medicine Report concluded that the only way to achieve true quality (and equality) in the health system is to integrate primary care with mental health and substance abuse services. BHcare has been providing on-site primary care services for its clients with great success since 2009. 45.6 percent of clients who participate in our on-site primary care showed an improvement in body mass index (BMI), and those diagnosed with hypertension saw a significant reduction in systolic and diastolic blood pressure.

Care integration through co-location provides improved care for individuals and will result in better outcomes. The collaborative model, in which behavioral health services are provided in the primary care setting, has been shown to reap measurable benefits in both patient outcomes and long-term costs savings, by reducing avoidable hospitalization.

This legislation offers us the opportunity to reach individuals who are struggling with behavioral health issues, but only being seen by a PCP, while at the same time gives us an opportunity to support PCPs by providing them with access to behavioral health specialist who can safely and effectively treat patients and make appropriate referrals. This legislation is in line with the ACA and current CT health initiatives including behavioral health homes, the state innovation model, and the health neighborhoods demonstration project.

I thank the Public Health Committee for paying attention to this important issue and for drafting a bill that supports individuals who are struggling with mental health and substance abuse disorders and the primary care physicians who treat them.



To: Members of the Public Health Committee

From: Morna Murray, President and CEO, CT Community Providers Association

Re: Public Health Committee Public Hearing on SB-417: An Act Concerning The Provision Of Psychiatric And Substance Use Treatment Services

Date: March 19, 2014

Good afternoon Senator Gerratana, Representative Johnson, and distinguished members of the Public Health Committee:

My name is Morna Murray and I am the President and CEO of the Connecticut Community Providers Association (CCPA). CCPA represents community-based organizations that provide health and human services for children, adults, and families in multiple areas, including mental health, substance use disorders, and developmental disabilities. Our members serve more than 500,000 people each year.

I am here today to speak in support of Senate Bill 417: An Act Concerning The Provision Of Psychiatric And Substance Use Treatment Services. SB-417 promotes the integration of behavioral health and primary care by allowing community based behavioral health organizations to provide psychiatric and substance use disorder treatment services in primary and other health care settings.

Community providers believe that co-location of behavioral health services in primary care and other health care settings (and vice versa) would improve integrated care for individuals with co-occurring physical and behavioral health conditions. In fact, this is the way health and mental health care is moving in our country, as it should. Physical and behavioral health issues are quite often co-occurring.

However, current DPH licensure regulations restrict clinic practice to physical locations specifically approved by the department. There is no provision - short of full licensing of a new site - for the deployment of clinical resources from a licensed clinic to an "off-site" location.

This bill would break down barriers between behavioral health providers and primary care physicians, providing them with the opportunity to facilitate the coordination of care and the delivery of services in the most appropriate setting for the patient. Precedent for the provision of "off-site" services by a licensed clinic exists within the Department of Children and Families' licensure regulations for Outpatient Psychiatric Clinics for Children.

Integration through co-location of behavioral health services in primary and other health care settings provides improved care for individuals with co-occurring physical and behavioral health conditions, resulting in better outcomes. Considering that psychotropic medications for conditions such as depression, anxiety, and post traumatic stress disorder (PTSD) are more commonly prescribed by primary care

CCPA

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physicians than psychiatrists, we must act to support primary care physicians by providing them access to behavioral health specialists that can safely and effectively treat patients and to make appropriate referrals.

This bill promotes health by breaking down silos and supporting a whole-person approach to wellness and health. Furthermore, this collaborative model, in which behavioral health services are provided in the primary care setting, has been shown to reap measurable benefits in both patient outcomes and long-term cost savings, by reducing avoidable hospitalization. These principles are in line with the current health initiatives being undertaken by the state, including behavioral health homes, the state innovation model, and health neighborhoods demonstration project.

Thank you for your time and consideration. I would be happy to answer any questions you may have or provide any additional information. Please feel free to contact me at 860-257-7909 or mmurrav@ccpa-inc.org.



Wheeler

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To **Public Health Committee**

From **Susan Walkama, LCSW
President and Chief Executive Officer
Wheeler Clinic, Inc.**

Re **Testimony on Raised Bill 417 An Act Concerning the
Provision of Mental Health and Substance Abuse Services**

My name is Susan Walkama. I am the President and Chief Executive Officer of Wheeler Clinic, Inc. Wheeler Clinic is a large primary care, behavioral health, special education and prevention services provider serving over 30,000 individuals each year. We are committed to reducing health disparities and have recently opened two health and wellness centers that provide integrated primary and behavioral healthcare to adults and families that have historically been seriously underserved in the traditional healthcare system

I am here today to support Raised Bill 417, An Act Concerning the Provision of Mental Health and Substance Abuse Services. This bill would facilitate primary care and behavioral health integration, and improve access and outcomes for adult healthcare consumers. This bill would change DPH regulation and allow adult providers like Wheeler who are licensed by the Department of Public Health to extend their existing mental health and substance abuse licenses to "off site" locations such as primary care physicians' offices to provide co-located and integrated behavioral healthcare services. The current DPH adult licensing regulation requires each location be licensed and reviewed under a separate DPH process. Providers must go through redundant and duplicative licensing reviews and processes. A new license may take many months to fully process for approval. This makes it practically impossible for free standing clinics to co-locate adult behavioral health services within adult primary care settings.

Under our outpatient clinic licenses for children, which are regulated by DCF, we are permitted to establish our services in the offices of pediatricians and offer behavioral health screening, consultation and treatment to children and their families. Wheeler has co-located behavioral health clinicians in the offices of Bristol Pediatric Associates for a number of years. In a study of the project in 2007, and subsequent publication in the "Journal of American Psychological Association" in 2012, Wheeler has demonstrated that this type of co-location model improves access to services, generates positive clinical outcomes, and advances practice and systems changes in the primary care setting.^{1 2}

There is a need for new approaches to reach the significant number of adults with unmet behavioral health needs. Best practice in healthcare integration is to co-locate and integrate behavioral healthcare within the primary care setting. The promotion of collaborative care is consistent with Connecticut's focus on healthcare reform, the proposed State Innovation Model and should not be delayed by outdated regulation that is slow to change.

¹ Sutcliffe, M. (2007) *A program evaluation of the pediatric behavioral health project: A co-location model of integrated behavioral healthcare* (Unpublished doctoral dissertation) University of Hartford, Hartford, CT

² Ward-Zimmerman, B and Cannata, E. (2012) Partnering with pediatric primary care: lessons learned through collaborative colocation. *Professional Psychology Research and Practice* Vol 43 No 6 596-605 American Psychological Association DOI:10.1037/a0028967



March 18, 2014

**TESTIMONY FOR H.B. 417-
An Act Concerning the Provision of Psychiatric and Substance Use Treatment**

Submitted By: Lois Nesci, CEO
Catholic Charities – Archdiocese of Hartford

Senator Gerrantana, Representative Johnson and esteemed members of the Public Health Committee, Catholic Charities of the Archdiocese of Hartford supports House Bill 417: An Act concerning the Provision of Psychiatric and Substance Use Treatment.

Catholic Charities operates eleven (11) clinic sites licensed to provide behavioral health, substance abuse and psychiatric services to adults and children. Practitioners include master level licensed mental health clinicians and substance abuse clinicians as well as APRNs and Board certified psychiatrists.

This bill is a beginning step to allow practitioners to provide services to individuals experiencing a crisis or immediate need and who are unable to be seen in the clinic or office location for a variety of reasons. This may include a (non-clinical) program site operated by Catholic Charities, in the school, hospital, or other acceptable location.

We understand this is the first step with several areas that require additional planning and design. We would recommend that both licensing and reimbursement processes be addressed so that these become seamless as well.

Thank you for your time and consideration in regards to this bill.

Respectfully submitted,



Lois Nesci, Chief Executive Officer

Testimony in Favor of Raised Bill 417**An Act Concerning the Provision of Psychiatric and Substance use Treatment Services****Jeffrey Walter****March 19, 2014**

My name is Jeffrey Walter and I am here to urge adoption of Raised Bill 417. I recently retired from Rushford Center, one of Connecticut's most comprehensive community providers of mental health and addiction services, where I served for 34 years as its CEO. I currently work with Rushford's parent health system – Hartford HealthCare- to integrate behavioral health services in the primary care setting. Bill 417 is critical to that effort because it would enable licensed psychiatric and substance use treatment clinics to extend their services to locations nearby their licensed sites, such as physician offices.

Integration of behavioral health in primary care is critically important when one considers that, across the country, primary care physicians provide more than 50% of all behavioral health care. They write two-thirds of all prescriptions for psychiatric medication and they manage psychiatric and substance use conditions for more than 50% of so-called "high utilizer" patients – those with co-occurring chronic medical conditions who represent the largest share of health care expenditures. Despite the fact that PCPs are already deeply involved with both primary care and behavioral health problems that are secondary to other medical conditions, many physicians in primary care express that they often feel ill-equipped to play this role and struggle to gain access to specialty psychiatric resources with which they can consult on difficult cases or to which they can refer patients who need services that cannot be offered in the primary care office. Even when a referral resource exists in the community, there often can be long wait times for an appointment. Another problem is that primary care patients who are referred out often do not follow through with their appointments at the behavioral health center.

The advent of health care reform and the Accountable Care Act creates exciting opportunities for closer cooperation between primary care and behavioral health. Both PCPs and behavioral health organizations in Connecticut are very interested in pursuing strategies to improve delivery of effective, coordinated care on site at primary care offices. The current state licensing statute for adult psychiatric and substance use treatment clinics restricts the delivery of services to the physical location of the licensed facility. This creates a barrier to the clinic extending its resources to provide support and services at a nearby primary care, or other health care, office. The clinic must seek a full license to provide services at another location, even if those services will be offered on a part-time basis.

Bill 417 will enable clinics to deploy clinicians at nearby physician offices, as an extension of the clinic's existing license. Licensure requirements that assure quality of care and patient safety- such as clinical documentation, staff qualifications and experience, etc. - would continue to be met, whether the service was provided on-site or off-site. The flexibility to provide licensed services in so-called "off-site" settings currently exists for children's outpatient mental health clinics licensed by the Department of Children and Families. Bill 417 will extend this valuable flexibility to adult clinics licensed by the Department of Public Health.

I urge you to approve this important bill that will improve care for hundreds of Connecticut residents. Thank you.

Jeffrey Walter

Jeff.walter@hhchealth.org

860-972-9058



STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

Dannel P. Malloy
 Governor

Patricia A. Rehmer, MSN
 Commissioner

Memorandum:

TO: Senator Gerratana
 Representative Johnson
 Members of the Public Health Committee

FROM: Commissioner Patricia Rehmer, DMHAS

DATE: March 19, 2014

SUBJECT: Written Testimony on Senate Bill 417 and SWB 471

Good Morning Senator Gerratana, Representative Johnson and distinguished members of the Public Health Committee. I am Commissioner Patricia Rehmer of the Department of Mental Health and Addiction Services (DMHAS), and I want to thank you for the opportunity to submit written testimony on SB 417 AN ACT CONCERNING THE PROVISION OF PSYCHIATRIC AND SUBSTANCE USE TREATMENT SERVICES and SB 471 AN ACT CONCERNING MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES. I want to thank the Committee for giving me the opportunity to address you on these bills.

DMHAS supports the concept outlined in SB 417 which would allow a psychiatric or substance use outpatient clinic to provide services off site to individuals needing behavioral health care. This concept will allow for individuals in nursing homes or other health care settings that cannot get to the clinic, to continue to receive their behavioral health services without an interruption of the clinician/patient therapeutic relationship. We understand that there may need to be some changes made to the language in order to satisfy the Department of Public Health's regulatory requirements and we would support any efforts made to make this concept a reality.

DMHAS does have concerns regarding SB 471. Section 4 in the bill would mandate that DMHAS, in consultation with DCF, provide timely access to regional behavioral consultation and care coordination services for primary care providers who serve all young adults. First, DMHAS already administers a website to provide centralized behavioral health care information and assistance to the public, which can be utilized by primary care providers. Second, regarding patient care coordination and transitional services, DMHAS currently provides these services through Local Mental Health Authorities to unentitled or underinsured young adults with serious behavioral health disorders who

Testimony of Commissioner Patricia Rehmer, DMHAS

Page 2.

are referred from DCF. We do not have the resources to expand those services to young adults who have private insurance.

Currently, DMHAS serves approximately 18,000 young adults with behavioral health needs in our state and private, not-for-profit provider system. We have a sizable budget of over 79 million dollars to serve young adults referred from DCF and other funding in our grant accounts to serve young adults that come in for behavioral health services through the front door.

We are also not sure of the intent in section 5 of the bill but believe it may be duplicative of efforts already available that provide information regarding access to care. As mentioned above, in 2005 the legislature enacted PA 05-80 which provided DMHAS with funding to develop a web site to provide behavioral health care information and assistance. This web site is called the "Network of Care" and it is a single resource web site that provides timely access to behavioral health care information and assistance for children, adolescents and adults. The website includes (1) directory information on available federal, state, regional and community assistance, programs, services and providers; (2) current mental health diagnoses and treatment options; (3) links to national and state advocacy organizations, including legal assistance; and (4) summary information on federal and state mental health law, including private insurance coverage. The website also has an optional, secure personal folder for web site users to manage information concerning their individual mental health care and assistance. The Network of Care site is updated on a regular basis by information provided by 211. We contract with 211 to provide change files to Network of Care on a monthly basis.

Thank you for your time and attention to these matters.