Audio file

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Transcript

00:00:06 Speaker 2

Wonderful. Thank you. Bye. Can you see my slides?

00:00:09 Speaker 1

We can't in the room.

00:00:11 Speaker 2

Fantastic. So I will do a little bit of introduction and and then get to the kind of set of discussion questions and topics we'd like to talk through today and open up the floor to the advisory Committee to provide feedback. So thank you. First and foremost for everybody taking the time to be a part of this today, we're very much looking forward to your comments and your responses to what we put out in the behavioral health sections of the current facility and services plan.

00:00:33 Speaker 2

Grab.

00:00:35 Speaker 2

Just as a really quick overview, in case we have some new folks in the room today, this is an overview of what the Connecticut facility and services plan is. This plan is a blueprint for healthcare delivery within the state of Connecticut and it's a document that serves as a kind of a dual purpose role. It serves both as a resource for policymakers and those involved in the certificate of Need Process and also as a document for the public.

00:00:56 Speaker 2

To inform them about what's going on with the provision of healthcare facilities and services within the state and provides information policies and projections of need to help guide planning for the provision of future healthcare facilities and services within Connecticut.

00:01:12 Speaker 2

The goals of this facility and services plan is to provide information, provide background and data and an understanding and advisory language for OS to first and foremost prevent excess capacity and duplication of services that are provided within the state to identify gaps in services and unmet need, and where those gaps and unmet need.

00:01:32 Speaker 2

Exist in the state, both across different populations and different geographic regions. Provide guidelines for adding services and to support the certificate of need application.

00:01:40 Speaker 2

Test to foster fair competition and a level playing field for entry into the healthcare market within the state of Connecticut and particularly within certain service categories that fall underneath the certificate of need guidelines and regulations within the state of Connecticut. And then and then providing better access to services through by providing transparency and data on the geographic distribution of both the existing supply of healthcare facility and services.

00:02:03 Speaker 2

And the need for those healthcare facilities and services across the state.

00:02:07 Speaker 2

So today we're going to spend some time talking about behavioral health and the sections in the facility and services plan draft that's been released that relate to behavioral health. But I want to give you a general overview of what also exists within the facility and services plan. You can see here the 10 different chapters as the current draft has beginning with an introduction and an overview of the certificate of Need Process.

00:02:27 Speaker 2

Going secondarily to some overarching trends and some policy trends that we see going on within the state of Connecticut Chapter 3 then detailing acute care and acute care bed need modeling that's done in the facility and services plan, Chapter 4 looking at outpatient surgery and outpatient surgery facilities within the state of.

00:02:44 Speaker 2

Get.

00:02:45 Speaker 2

Chapter 5 looking at imaging and new technology Chapter 6, which is the chapter we're going to focus on today.

00:02:51 Speaker 2

Around.

00:02:51 Speaker 2

Behavioral health Chapter 7. Looking at primary care and physician services within the state and then Chapter 8 looking at long term services and supports and post acute care. Then Chapter 9 and 10 containing some summary recommendations, data and next steps for OHSU to consider.

00:03:06 Speaker 2

So as I mentioned, we're going to spend most of the day focusing on the behavioral healthcare chapter. I would encourage folks to have that open and and make comments specific to sections within that area of the report. But if there are other sections of the report that relate to behavioral healthcare topics, those are also welcome for for comment today, as Boyd mentioned, there are some other sections of this report we have a.

00:03:25 Speaker 2

Six or seven different advisory committee meetings that are occurring. So if you comments in other sections of the report, we are happy to take those during some of the other meeting.

00:03:34 Speaker 2

Just to give you a little bit of an overview of the behavioral healthcare chapter, there are 7 sections to that chapter as written in the current draft. The first section relates to how the certificate of need process relates to behavioral healthcare services when the state as as regulated by the statutes as far as what behavioral healthcare services fall underneath the certificate of need.

00:03:53 Speaker 2

Overview and purview for that process and what's that? What sections of behavioral healthcare do not fall underneath that that those guidelines.

00:04:01 Speaker 2

Section 6.2 that provides an overview of mental health and substance use disorder treatment facilities and providers within the state of Connecticut.

00:04:09 Speaker 2

6.3 that describes the treatment environment and the types of services that are offered and where those services are offered within the state of Connecticut.

00:04:16 Speaker 2

6.4 that details our analysis and data that's been collected on the prevalence of mental health needs within the state of Connecticut and the remaining unmet needs based on what has been observed in the data for adult mental illness.

00:04:29 Speaker 2

6.5 details what we know about child mental illness within the state and and data that's been collected in in that realm.

00:04:36 Speaker 2

Section 6.6 looks at substance use disorder needs and the current prevalence of substance use disorder conditions within the state of Connecticut and where unmet needs exist for those services. And lastly, 6.7 provides standards and guidelines and language to help guide OHS in their determination of certificate and need applications related to behavioral healthcare services. So we look forward to comment on all these sections of the report.

00:04:56 Speaker 2

I just want to give you a couple of highlights of some things that are important as we go through these discussions. The first here is in 6.1, which is the relationship of behavioral healthcare services to the certificate of need process.

00:05:06 Speaker 2

And noting here that there's a relatively limited role for OS to receive certificate of need applications related to behavioral health. I know that Boyd said. And we certainly know that this is a an area where we there's a lot of questions and a lot of topics right now within the state of Connecticut around expanding services. I think it's really important to highlight what types of services and what categories of services fall underneath the certificate of need process and.

00:05:28 Speaker 2

Particularly noted within the statute is that the establishment or transfer of ownership for a for profit behavioral healthcare facility or termination of hospital operated healthcare behavioral healthcare services requires a certificate of need application within the state of Connecticut.

00:05:43 Speaker 2

But there are components of behavioral health services that are exempt from certificate of need applications, and those include nonprofit facilities that contract with state agencies or programs that are licensed or funded by DCF. So there are some sections of the behavioral healthcare services and facilities within the state that require certificate of need applications. There are some that do not.

00:06:04 Speaker 2

This is detailed in this section of the report, so certainly want to make sure folks agree that this is accurate and just wanted to help. Use this as a framing discussion for what requires certificate of need versus what.

00:06:13 Speaker 2

Does not within the state of Connecticut.

00:06:16 Speaker 2

There are also a couple temporary exemptions that have been called out to the certificate of Need Process as pursuant to some recent legislation that's been passed. We call it 2 examples here, one related to licensed bed capacity through June 30th, 2026, and another exemption that's currently been laid out around harm reduction centers that does not have a.

00:06:35 Speaker 2

A current date right now, but is associated with a pilot program that will be ongoing in future years within the state of Connecticut.

00:06:46 Speaker 2

I want to highlight just a couple key findings. Uh, to orientate this discussion, and then we'll we'll move on to your comments. First and foremost, what we represent in the data that we find within chapter six of the facility and services plan is that we see a growing need for mental health and substance use disorder treatment within the state of Connecticut. When we look at the overall need and condition prevalence for both mental illness and substance use disorder.

00:07:07 Speaker 2

Needs we see a growing need over the years across many populations, and particularly for younger age populations within the state of Connecticut. Over time, you can see trends here shown in data that we collected from Samsa and their state based surveys of the Connecticut population looking at needs for.

00:07:23 Speaker 2

Both mental illness treatment based on those that have a condition, prevalence of any mental illness, or serious mental illness, and then also different types of substance use disorder, including alcohol use disorder and illicit drug use disorder over time. You can see increasing need here across the state and potentially indicating a need for more services.

00:07:43 Speaker 2

And and more treatment capacity for these needs within the state of Connecticut over.

00:07:47 Speaker 2

We also highlight in this report section that alongside this growing need, we see that when you look at the populations with need for any mental illness and substance use disorder treatment within the state, that there is a levels of unmet need for different types of care in different regions of the state and we calculate this using our analysis of Samson data. This is the national Survey on Drug use and health.

00:08:08 Speaker 2

Where we look specifically within Connecticut and across different regions of Connecticut.

00:08:12 Speaker 2

Where the current population of those with mental illness and substance use disorder needs exist, and how those needs compare to those that reported receiving treatment over different periods of.

00:08:20 Speaker 2

Time within the.

00:08:21 Speaker 2

State. So we report data in 2021 and include data again from the National Survey on Drug Use and Health.

00:08:29 Speaker 2

We also report here information on the need and unmet need for illicit drug use disorder and specifically the the use of of services at specialty facilities, as collected by Samsa in their national survey on drug use and health.

00:08:43 Speaker 2

And and highlight again significant need and greater need for substance use disorder treatment relative to mental illness treatment across the state and where the that need exists across different parts of the state and different regions. So we look forward to your feedback on the data we've included here and and the overall trends that we're seeing in the state in relationship to these needs.

00:09:00 Speaker 2

The last component I want to highlight here is then the standards and guidelines that we've developed alongside OS, some of which are new to this report. They're in helping guide OS in making certificate of Need application.

00:09:13 Speaker 2

Decisions and the type of language that we've included in how OHSU should decide whether or not certificate or need applications should be considered alongside all the other rules that exist within the statute. So included now in the facility and services plan. Are these languages around these six different components. The first three here being relating to first and foremost, whether or not behavioral health.

00:09:34 Speaker 2

Certificate of need represents a a meeting of clear public need for a new healthcare facility or services and whether or not that need has been demonstrated within a particular facility service area and whether or not additional capacity is need.

00:09:46 Speaker 2

The second whether or not the applicant has satisfactory, identified the population, it's going to serve and the need of which that population within the region where services are going to be available.

00:09:57 Speaker 2

3rd whether or not the applicant has demonstrated that the proposal will include will improve quality and access to mental illness or substance use disorder treatment within the region, and that the applicant commits to providing the highest quality treatment modalities that are available for different types of behavioral health conditions. An example here being providing medication assisted treatment where where.

00:10:17 Speaker 2

Called for.

00:10:20 Speaker 2

The 4th component of these recommendations of two HS in the facility and services plan being whether or not the applicants passed and proposed provision of healthcare services will promote access for individuals with all types of health insurance and a commitment to build robust provider in network options for access to services provided at that new facility.

00:10:38 Speaker 2

The 5th component being whether or not an applicant has demonstrated that proposed project will not be an unnecessary duplication of existing services within a service area.

00:10:47 Speaker 2

And the 6th component being the consideration of any other certificate of need application decisions that have been made during the time period prior to when the new application was submitted.

00:10:57 Speaker 2

So these are 6 components that are included. We look forward to any feedback on this language. A lot of this is new language that was not included in the 2012 plan, so it was new to the 2024 plan. So we look forward to both your feedback on the data that we provided in the report, the insights that we provided on the need for substance use disorder treatment and mental illness treatment within Connecticut and also these recommendations for standards and guidelines to be considered by OHSU and their certificate of need.

00:11:18 Speaker 2

Processes. So I've got some specific discussion questions if we need them, but more first and foremost, I think we want to hear from you as the larger group around what your interest areas are in this in the sections of the report that have been provided. And we I think open the Florida feedback, but boy, I'll turn it over to you.

00:11:34 Speaker 1

Thank you, Corey, for walking through those key takeaways and and the proposed kind of how we would think about this in a certificate of need. I'll, I'll note especially you know one of the one of the challenges that OHS has is with what data exists.

00:11:53 Speaker 1

And Julianne from Demis might be able to speak to some of the challenges that we've had because of course we work closely with our sister agencies on what data is available and sometimes that can be a challenge and.

00:12:10 Speaker 1

A big part of our main pay and OHS and the coin program is determining need and how do we think about that? We, Corey presents some charts that show regional need and I think every region in the state shows a need for behavioral health. But within those regions, when we look at the.

00:12:30 Speaker 1

Primary.

00:12:31 Speaker 1

Area. That's where things start changing around and there are some smaller regions, some sub regions where services may be more heavily.

00:12:43 Speaker 1

Created and So what? What data is available to to look at if there's over saturation in a particular primary service area versus the rest of a region, how do you all as providers think about that? What are you seeing on the ground? So those are some of the just to highlight some of the key.

00:13:03 Speaker 1

Issues that OHS faces when we're looking at a certificate of need, but of course as Corey said, the point of the plan is is broader than just certificate needs. So don't feel limited by those comment.

00:13:16 Speaker 1

Plus, so again, we are in the portion for the advisory group members. So if anyone wants to kick off either in the room or if anyone wants to raise their hand in the virtual room.

00:13:38 Speaker 1

I've been assured by people in the provider community that this is going to be a very active and, you know, opinion, opinion filled group so.

00:13:51 Speaker 1

All right. Thank you for kicking us off.

00:13:56 Speaker 3

Good afternoon. I wanted to point out on page 155.

00:14:01

Yes.

00:14:03 Speaker 3

I know Dimas provided some feedback before and our apologies if this wasn't included before, but.

00:14:15 Speaker 3

And Connecticut Valley Hospital. We also have an addiction services division.

00:14:21 Speaker 3

And that includes 152.

00:14:25 Speaker 3

Beds.

00:14:27 Speaker 3

Across withdrawal management and residential treatment, so just wanted to make sure that.

00:14:35 Speaker 3

Was added.

00:14:39 Speaker 1

Thank you for that.

00:14:56 Speaker 1

And Julian, can you speak a little bit about?

00:15:00 Speaker 1

The the difficulties with.

00:15:02 Speaker 1

Data that we've discussed several times and reporting and you know what, what we have access to versus what our limitations are.

00:15:15 Speaker 3

Sure. So you know in reading the the report, the Behavioral health section, there's multiple data sources. You know the OHSU inventory data, the sum survey, the Samson treatment locator, the demons statistical report and.

00:15:35 Speaker 3

Some utilization reporting from our statewide system and I think there's others, it's a little.

00:15:47 Speaker 3

Card to go through the chapter I think and really digest the results from the different sources, so I don't know if there's a way to.

00:15:59 Speaker 3

Maybe keep what's there, but then summarize.

00:16:03 Speaker 3

Some of the data from the different sources in a summary grid, so you can look at the results.

00:16:11 Speaker 3

Together, I don't know if I'm making sense, but.

00:16:22 Speaker 2

Yeah, that's that. That that's fair feedback. We can we can take that away and and see I think the challenge is of course that we have different sources of data that sometimes represent different components of the behavioral healthcare system. And so trying to overlay them on top of each other, I agree would be useful, but they don't always overlay.

00:16:23 Speaker 1

So.

00:16:38 Speaker 2

That they're that we're not duplicating often, it's that we're kind of representing different pieces at the same time, but trying to consolidate maybe at different, you know, kind of geographic levels to show that for us in your geographic level, the different data sources that we have.

00:16:50 Speaker 2

And the findings for that region could be something that we could consider rather than what we've organized right now, which is more so taking each of those individual data sources and then showing the result for each region within those sections. But you're right, it's not able to kind of be crosswalked what multiple data sources say at a particular level for a particular population or a particular region, so that that's good advice. Well, let's try and take that back and and see what we can do.

00:17:11 Speaker 2

Thank you.

00:17:14 Speaker 4

So I'll offer some. Oh, I'm sorry.

00:17:19 Speaker 1

Since we didn't go around the full group and do introductions, I'll just ask that when you contribute, if you could briefly introduce yourself.

00:17:29 Speaker 1

And let us know.

00:17:30 Speaker 1

Where you're from.

00:17:32 Speaker 4

So so I'm getting all Morgan. I'm a psychiatric nurse practitioner. I've been practicing for about 30 years here in Connecticut and all over the state in various forums, primarily with the post incarcerated population.

00:17:47 Speaker 4

In New Haven and Bridgeport and Hartford, I'm going to defend my dissertation in two weeks, so I'm a novice research scientist as well studying the suicide of psychiatric providers. So I'm very invested in our workforce shortage as well. And looking at data, just looking at data.

00:18:07 Speaker 4

I was impressed and maybe I'm misreading this course so so please like help me with having been a provider for so long all over the state with.

00:18:20 Speaker 4

What was represented as seemingly like we have an ample amount of services in the state and that's just not been my experience as a provider in the state. Again across all populations. So I've treated children, I've treated adults I've treated.

00:18:41 Speaker 4

Various segments of the population I.

00:18:43 Speaker 4

Have a private practice that I've.

00:18:45 Speaker 4

Had for 20 years, so I do psychotherapy and medication with.

00:18:48 Speaker 4

High functioning people. And again, I treat them very marginalized and in various pockets of this state.

00:18:54 Speaker 4

And people have a very hard time accessing inpatient services, higher levels of care, whether they're children, whether they're adults, whether they're insured or uninsured, whether they're documented or undocumented. So I was really impressed that.

00:19:14 Speaker 4

This showed such a robust service availability and I so as a scientist I was drawn back to, you know, the data collection methods and.

00:19:29 Speaker 4

How we're gathering that and as, as I've commented with you before, some of how we are capturing or not capturing sort of the missingness data, which in the world of science is like what's excluded and and so as I think about it, clinical practice, when I send someone to the hospital.

00:19:49 Speaker 4

And they wait for 12 hours and they're not seen and they leave.

00:19:55 Speaker 4

That's not like an effective service capture, or someone who has made it successfully to the.

00:20:02 Speaker 4

Next level of.

00:20:02 Speaker 4

Care. But they're also not captured anywhere in here. And I think that there's a lot of that that happens in, in this state as it does nationally. And those are the the people that I'm like very concerned about.

00:20:16 Speaker 4

As not representing what we need to do for our workforce, for our patient population and for our sort of ontological.

00:20:23 Speaker 4

Reckoning that we have to wrestle with the psychiatric.

00:20:25 Speaker 4

Fighters.

00:20:26 Speaker 4

As well as the payment crisis that we're in across the board. So that's just some of my initial thoughts.

00:20:37 Speaker 1

Yeah. Thank you. That, that's helpful. I I guess I.

00:20:41 Speaker 2

Would it if you have specific sections right where you feel that we have represented this as there being sufficient supply and capacity for these types of services, I'd be interested in knowing more of what of what you're referring to. I I think we do call out certainly unmet need both for mental illness and for substance use disorder treatment in particular across the state. I think it's a fair point in what you're saying.

00:21:01 Speaker 2

And.

00:21:02 Speaker 2

We do represent that there are sufficient number of facilities and kind of potential capacity in, in many regions of the state. I would be interested in knowing more about what data we think might be available to track where there may be shortages and being able to provide that care, whether or not it's workforce shortages, whether or not it's available, supply within the existing facilities or whether or not it's a need for more facility.

00:21:23 Speaker 2

Or more capacity within different areas or potentially across different treatment modalities where there may be an available supply of a particular type of provider or a particular type of facility that doesn't align with what the needs are of the population that that's there. So I think we do try and identify unmet needs where they exist. I think we do show that unmet needs exist in many regions across the state.

00:21:43 Speaker 2

If you feel that that's misrepresented or there's other data that we can bring to bear to demonstrate that, we certainly know that behavioral Healthcare is is a is a huge need across different areas and and there are many restrictions.

00:21:54 Speaker 2

To which an individual might not be able to get effective treatment for their behavioral health care needs, some of which may be the existing capacity or or or existing providers to be able to provide that treatment. There are other restrictions that include financial restrictions, a willingness to seek care, you know, other components that may limit individuals access to care more.

00:22:14 Speaker 2

Broadly, we do try to identify those in this chapter and also in some of the more population based chapters of the report. So if there's more ways to bring that information into the section such that we can better account for what you are seeing as an overall need, that's not being represented here. We certainly want to try and capture that as best we can.

00:22:34 Speaker 1

Thank you, Cory. Julianne.

00:22:38 Speaker 3

Julianne Giard, section chief for community services in the Office of the Commissioner at the Department of Mental Health and Addiction Services, or Demus, just expanding on the last speaker.

00:22:53 Speaker 3

I don't know if it's a perfect fit for this report, but it might be helpful to include.

00:23:00 Speaker 3

It would be a page or less in this chapter of the various public facing.

00:23:08 Speaker 3

Kind of navigator.

00:23:13 Speaker 3

Resources, you know, Demus has two real time bed availability websites for the services. Some of the services that are listed in here and then you know and this is just diminish, I mean we funded 24/7 access line for substance use services.

00:23:33 Speaker 3

Refund United Way 211 and 988. So there are a lot of resources and.

00:23:43 Speaker 3

I think TCF genius and perhaps providers have tried to have developed resources to help people find them and know if they're available at any given time.

00:24:00 Speaker 1

Thank you, Howard.

00:24:03 Speaker 5

Yeah, Howard Zebroski, I'm the chief behavioral health officer at Connecticut children's, sort of new to this. I was just looking through and I noticed section 6.5 explicitly says that children's behavioral health prevalence data is not included given the dramatic rise in demand for children's mental health.

00:24:24 Speaker 5

I'm wondering if you can comment about how you're gonna go about incorporating prevalent status for kids in this report.

00:24:33 Speaker 2

Yeah, the the note there is referring that that data is is not available. So it's not that it's not included, it's that it's not collected by the National Survey on Drug Use and Health. That was a primary source that was used in those prevalent sections. I would look to this advisory committee if there perhaps other sources that may be able to help us provide an understanding of need among the youth populations. Unfortunately those those mental mental health questions.

00:24:54 Speaker 2

Are only asked of the adult population in that survey, and so I'm kind of relying on Samsa to provide the best data that I can in that sense. But if there are other Connecticut based sources, this would certainly be the time to let us.

00:25:03 Speaker 2

Know what they are and we will try and include them.

00:25:06 Speaker 5

Have you been in contact with Caroline? Who was the ASO?

00:25:10 Speaker 5

That collects all of the at least the Medicaid claims data for behavioral health.

00:25:16 Speaker 2

No, that's not a connection we've made.

00:25:18 Speaker 2

Yet.

00:25:19 Speaker 2

So that that may be a that that may be a pathway.

00:25:19 Speaker 5

That's close.

00:25:26 Speaker 4

There, there are also four urgent children's urgent crisis centers that have been set up in the state that are Denis funded and they collect a lot of data as well. Denis could probably.

00:25:39 Speaker 4

And.

00:25:41 Speaker 4

Be a good.

00:25:43 Speaker 4

Actually to collect information.

00:25:48 Speaker 1

Thank you. Yeah, we we got several data recommendations on Monday. So if you have for for different topics, so on this one, if you have specific resources that might be useful, pointing us to them, here is great submitting citations in.

00:26:07 Speaker 1

Comments is wonderful if you have data sets or access to data that you can share. All the better you can.

00:26:17 Speaker 1

The the report and the releases that went out with it have contact information for submitting the comments and they say how to do that. You received the invitation from Andrea and Orman. You can reply to them. You can also go directly to me with.

00:26:38 Speaker 1

Jackson, but.

00:26:41 Speaker 1

Done.

00:26:43 Speaker 1

I'll I will pass along to Cory and everything that comes in, yeah.

00:26:51 Speaker 6

Hi everybody, Jeff Vanderbeek, I'm the CEO at the child Health and Development Institute.

00:26:56 Speaker 6

And just picking up on on Howard's comments and others around youth, I I just wonder if you had considered, you know, given the crisis that we're experiencing in the youth mental health world.

00:27:09 Speaker 6

You know, I noticed as I was reading through Chapter 6 that there's some youth information that's interspersed within mostly adult sections. And then there's sort of a short section on on youth needs and then it kind of goes back to adult needs after that. I guess just for the purposes of really underscoring highlighting.

00:27:28 Speaker 6

Bringing attention to the use youth specific issues in the system, whether you all considered, you know more, really carving out a more robust section on youth.

00:27:41 Speaker 6

You know, it's sort of like, you know, separating it out. I mean, especially in a state where we do have a a bifurcated or one of the few states in the country that has a bifurcated adult and youth behavioral health system. So just wondering if you thought about that kind of really just really clearly separating the adult behavioral health section from a youth section and then.

00:28:01 Speaker 6

So that's one comment and then I have a couple of more specific things. One, I'll circle back circle back to the question on data.

00:28:08 Speaker 6

Outside of the survey that Samson collected that you mentioned, I think Samsa reports a lot of other data. You could probably find it easily on their website looking at overall prevalence rates of youth mental health needs overall and specific to various conditions. And the CDC would be another source that's got pretty strong prevalence national prevalence.

00:28:28 Speaker 6

Estimates on youth mental health needs, so those are a couple of data sources.

00:28:31 Speaker 6

At the national prevalence level, and then in addition to Howard's good suggestion to talk with Caroline about Medicaid utilization data, you could also talk further with DCF because they have a Pi data system, it's provider information exchange that collects a lot of service utilization data for young people.

00:28:52 Speaker 6

For their contracted behavioral health service array. So that's another data source you could look to for both, not necessarily for prevalence, but for service utilization.

00:29:02 Speaker 6

And then I guess I I could, there's a lot of things and I think I'll submit most of it just in writing, but one other suggestion I would highlight is that when you get to that youth specific section that is there, I would, I would recommend expanding on it significantly as I as I mentioned earlier, one of the things I noticed is that it mentions that there are 70 license.

00:29:21 Speaker 6

Outpatient clinics, opcs and then ten EDT facilities.

00:29:25 Speaker 6

And that kind of gives the impression that that's like, that's the scope of the youth Mental Health Service system. And the reality is that's much, much, much broader than that from inpatient and PRTF to residential group home, intermediate center based services like extended day but also IOP's, PHP's.

00:29:44 Speaker 6

There's intensive in home services. There's an array of outpatient. There's school based services. So there's a lot that could be mentioned in that section that that could really give a a much better description and scope of the Youth Service Array. And I would say just final as a final comment that I would agree with what others are saying that.

00:30:04 Speaker 6

UM.

00:30:05 Speaker 6

That there's certainly a lot of unmet treatment need in the youth system as it appears that there is in the adult system well captured well in this report for the adult side. But I think we could probably capture it better on the use side. So I'll stop there.

00:30:21 Speaker 1

Thank you. That's helpful.

00:30:24 Speaker 1

Mark Sevilla.

00:30:27 Speaker 7

Hi, Mark savella. I'm the vice president for behavioral health and emergency services at Yale, and I will give the caveat that I'm on the call because all of the qualified people weren't available. So I know just enough to be dangerous, but just actually tagging on to Jeff's comment about how things are displayed.

00:30:48 Speaker 8

Uh.

00:30:51 Speaker 7

I think #1 it would be nice to have an area that just calls out use and and kind of clusters. All that information and then the other is. Have you looked at on 163 and I just fall generously sent me the link to this just a little bit ago. The estimated unmet need. Have you plotted out or is there a way to display any information?

00:31:13 Speaker 7

By region.

00:31:15 Speaker 7

What?

00:31:17 Speaker 7

Perhaps give treated estimate, untreated estimate and.

00:31:23 Speaker 7

Estimated capacity.

00:31:25 Speaker 7

And then gap, or are we just assuming that everybody's at capacity, uh?

00:31:32 Speaker 7

It would be nice from my perspective to be able to look at this and say in the Capital Region.

00:31:37 Speaker 7

This is what's going on. Here's where their gaps are, and you've got to kind of got that in other things, but it and kind of one, you know, visual to be able.

00:31:46 Speaker 7

To.

00:31:47 Speaker 7

Look at it and say OK, here's what they got a lot of. Here's what they don't have enough of. And then what are we think the estimated gaps in those things are?

00:31:55 Speaker 2

Yeah, it it's a good question. And I think we're limited by the data here. I would agree with you that what would be really nice to be able to show would be not only looking at the population that's there, the treated population and the untreated population, but then what the capacity of the services are within that region as well. OHSU does collect through their inventories the existence of.

00:32:15 Speaker 2

Different types of behavioral healthcare services and behavioral health specific facilities within those regions.

00:32:21 Speaker 2

I, as far as I'm aware of, don't have the ability to estimate what the service capacity is of those facilities, both from the at the capacity of the facilities themselves or from the workforce population. You know that is able to treat individuals within those regions. If folks on this call are aware of that data or there's a way to generate estimates of that, I think that would be fantastically helpful.

00:32:41 Speaker 2

This is just a limitation of the data. In what OS is able to collect and I can make a comparison to what we're able to do in other chapters where for example, we do have an estimation of the number of hospital beds that are available and the capacity within those those areas for a particular type of acute care bed service.

00:32:56 Speaker 2

The behavioral healthcare section is harder in that the the diversity of services that are used for behavioral health care needs are much broader, ranging all the way from the inpatient side to outpatient services to, you know, kind of lower acuity services. And I think there's not a difficulty in even knowing the existence of a facility within a region of what the capacity of that facility is.

00:33:16 Speaker 2

We can often identify the number of beds that a facility has, but knowing what they're total treatment.

00:33:21 Speaker 2

It is across all modalities. Is is much much harder. So if folks in the state are aware or or, you know, private folks are doing this and trying to estimate that, I think that's data we would love to be able to include. It just wasn't included just because I wasn't able to find it at the time of generating this with OS so far. But if we can work in that direction, I agree that would be a huge benefit to this section if we can find that data.

00:33:41 Speaker 7

And and just an anecdotal comment I on my ER side of life, there's an organization, emergency Department benchmarking alliance that released there. They actually it's it's updated annually, it's the most current operational data for ID's in the United States.

00:33:59

Uh.

00:33:59 Speaker 7

But one of the things that came up is, as we all know, but they they validated it as an increase nationally in the number of visits to Ed's for mental health.

00:34:10 Speaker 7

Reasons.

00:34:16 Speaker 1

Thank you. And yeah to to to reiterate Corey's point, when we look at our inventory of services available, we're looking at the facility level and often don't know you know the.

00:34:30 Speaker 9

Uh.

00:34:31 Speaker 1

Necessarily the the size and scope.

00:34:33 Speaker 1

Of services and capacity and that really hinders our ability to determine need in a certificate of need process. And so often you know, we'll turn to the folks that deem us and say what day do you have? Often they're only receiving data from.

00:34:55 Speaker 1

Facilities with which with whom they have contracts. Other facilities are supposed to be reporting data that's hit or miss, and so the states data is incomplete because of the participation issues. You know, national data is often not regular enough to know, so that represented a real challenge.

00:35:15 Speaker 1

And and that's one of the things that we're trying to get.

00:35:17 Speaker 1

In this section.

00:35:18 Speaker 1

Is how are we looking at need in the CEO process to really understand, you know, on the ground a lot of times we'll have.

00:35:28 Speaker 1

Community providers submit letters that basically say look the same big report in 2016 and said there was a big need and I'm here to tell you I'm trying to place patients in a IOP or a PHP and I can't get my people in. So I'm telling you that I'm experiencing a need, but.

00:35:47 Speaker 1

The the data limitations here have been a real challenge and so as Corey said, as we've said several times, any thoughts on how we might be able to pull some more of that to really understand the need because I know it's important for us to make decisions. Also important for folks who want to open.

00:36:04 Speaker 1

Stories you've got to you have to provide information in an application and so if you don't.

00:36:10 Speaker 1

Have.

00:36:10 Speaker 1

Those resources, how are you able to demonstrate me and get through that administrative process? So any, any insight that folks have it to have the data that shows what's going on on the ground, we are all ears, James.

00:36:22 Speaker 7

I'm sorry I'm going to cut back on line for just a second because this is related, so if.

00:36:28 Speaker 7

If.

00:36:30 Speaker 7

So we were looking at a new site facility pre COVID for Yale New Haven. We currently have 117 beds.

00:36:39 Speaker 7

Based on extensive work with a company that looks at, you know.

00:36:44 Speaker 7

Determining bad needs and all that we came up with a a total number of about 2:35.

00:36:50 Speaker 7

So then how would the state work with that?

00:36:54 Speaker 7

To validate that.

00:36:57 Speaker 7

If you're saying on on the state side, you don't necessarily.

00:37:02 Speaker 7

Are able to get that type of information.

00:37:05 Speaker 7

Does that make sense?

00:37:09 Speaker 1

Well.

00:37:11 Speaker 1

Were these inpatient beds or?

00:37:14 Speaker 1

Because different different things you know through different processes is by that matters, but.

00:37:18 Speaker 7

The yeah, those were inpatient beds.

00:37:20 Speaker 1

Yeah. So inpatient beds are all all fall under the acute care inpatient bending methodology because vice because beds are licensed as just hospital beds and then can get moved around on the behavioral health side, you know.

00:37:36 Speaker 1

We're going to evaluate the data that's presented and you know, see what was used, how it was done. We would look at the methodology and all of that to determine.

00:37:48 Speaker 1

You know how how confident we are in the data.

00:37:52 Speaker 1

Does that make sense?

00:37:54 Speaker 7

Yes, thank you.

00:37:56 Speaker 1

Yeah. So the inpatient side gets a little different from hospital because those are hospital licensed beds, but for.

00:38:05 Speaker 1

Behavioral health specific it's going to go to this whole process of trying to understand what they presented to the agency.

00:38:14 Speaker 1

James, back to you.

00:38:17 Speaker 10

Thank you, Sir. Jim O'Day, the senior vice president of behavioral healthcare for Hartford Healthcare, to a couple observations and maybe an area of discussion #1 to go back to both Jeff and Howard, you know, since this was updated, there have been significant changes in the access.

00:38:38 Speaker 10

Regarding psychiatric urgent care centers as well as subacute residential programs.

00:38:43 Speaker 10

That are funded by DCF. There's no mention in the youth section regarding some of those others. One of those, the subacute stuff, is is clearly facility based, so that's probably an omission that might be worth looking at #2 you know, I I think about this report and I like the way that it's presented.

00:39:04 Speaker 10

In terms of being a resource primarily to legislators and maybe people who are not so much inside baseball as the people on this call.

00:39:13 Speaker 10

But I I think it it raises a question that is a perennial issue for us in psychiatry when we simply count up beds like every bed is the same kind of bed and the reality is given the nature of the conditions that we treat, every bed is not the same as every other bed. So simply accumulative.

00:39:33 Speaker 10

Total of beds without understanding what their allocation, what their, what they're really designed to do is probably a gap.

00:39:42 Speaker 10

And even if it's described in some way in the narrative section, that given the nature of the conditions, there are people who do need longer term care. There are people who need intermediate care. There are people who are able to be, you know, benefited by acute care settings, a simple total of beds itself without understanding.

00:40:03 Speaker 10

The complexities within care is provided.

00:40:06 Speaker 10

Is a gap. Those of us in the industry understand it. But if I'm a legislator and I'm reading this and I'm simply summing up beds, that that's something that doesn't really give the the nuance to the way care is provided in the state and the kind of interdependencies that say acute care general hospitals have with Solnit.

00:40:27 Speaker 10

On the child adolescent side, the partnership that we all have with demos regarding access to state operated beds, these are things that need to be.

00:40:36 Speaker 10

We brought into the discussion because otherwise we're constantly educating people about stuff that is basic one-on-one information that should be available in my view in a document like this and then finally.

00:40:53 Speaker 10

Bringing, you know, one of the knowing that this document is not in any way designed to talk about healthcare financing. I'm sure there's a whole lot of other subgroups designed to talk about that conversation not in the facility side. There's no way for us to contemplate.

00:41:10 Speaker 10

Facility and CON issue without being mindful about the fact that the cost shift that goes on between the underpayment of government based insurances like Medicare and Medicaid and the impact that it has on the commercial market and the way that we all design that and my question about that issue about the relationship.

00:41:32 Speaker 10

Has to do with the CON process that is germane to this document. So I'm page 168 section #4 Corey who speaks faster than anybody I've ever heard in my life. You know, you, you read something in there and I just like to bring attention to this.

00:41:49 Speaker 10

Section 4 on page 168 that talks about the CON for for profit entities.

00:41:56 Speaker 10

And the sentence reads.

00:41:59 Speaker 10

Particular focus and access to care treatment for all types of health insurance and a commitment to build robust provider in network options for patients served at a new facility.

00:42:13 Speaker 10

So this raises a question for all of us who take care of both private nonprofit, you know, ventures, the the emergence of for profit entities that don't take Medicaid creates a risk for the overall healthcare system. And that's not to impugn their good work. I think they do amazing work in the settings that they're in, but I I don't know that we can look at this without recognizing the interdependencies.

00:42:37 Speaker 10

Of what happens between those that take all insurance?

00:42:40 Speaker 10

Is and those who don't. And for somebody who's been doing this stuff for 35 years in Connecticut, I'm foggy about what number four is actually intended to say for a for profit entity. So I would ask for clarity on that point. Those are handful of comments. Thank you very much.

00:43:02 Speaker 2

Thank you all. Good comments there. I I think taking back the point specifically around the language and four is something we would appreciate feedback on if you have specific feedback there, I think specific to your question around what is meant to be said there, the the limitation around the for profit description is due to the purview that we understand that what falls underneath the certificate of need process, right? So only for profit.

00:43:24 Speaker 2

Entities fall underneath that process, so I'm not in that language an OS, and that language is not attempting to limit that. This should be a goal for all providers. It is simply saying for for profit providers because.

00:43:33 Speaker 2

Because that is the nature of the entity that falls underneath the the standards and guidelines that are written here. So. And when we're talking about, you know, maintaining access for all types of insurance and and robust provider in network options, that is that is for those entities to I think exactly address the point that you're making, which is that when entities are looking to expand.

00:43:54 Speaker 2

Capacity. It should be under OHSU's kind of breadth of knowledge.

00:44:00 Speaker 2

To look at whether or not that entity is looking to provide access and should prioritize applications that commit to providing access to folks that provide cover, you know, provide access to patients with all types of insurance and making sure that when they take insurance that they're providing in network options for their providers at that facility as well. That's what we're trying to say with that. I'm open to your opinions.

00:44:20 Speaker 2

You know comments of whether you think that that's well reflected and also whether or not that's a goal of what OS should be taking into account in conversations with OS, we decided that was something that we thought was a priority that they should consider and we're trying to reflect that there. But but open your comments on that.

00:44:35 Speaker 10

Yeah, I would. I would just share. So just to feed just response to Corey. Thank you. Yeah, I actually think it is absolutely within the purview of OHS to actually make sure that that is a consideration and frankly to develop a process that doesn't require someone to seek intervener status.

00:44:56 Speaker 10

As a way to highlight that risk in a given geography, you know we have a situation where somebody submits a con application unless someone seeks intervention intervener status as a way to raise that question and concern, it could go unchallenged.

00:45:13 Speaker 10

And I would, I would hope and expect that the department's going to look at this through the lens that you're describing. I think what you're inferring about, #4, is they should take all sources of insurance. I think we can be much more direct and specific about that, to communicate exactly what the intention is. I think that will make it.

00:45:34 Speaker 10

Clearer for anybody who is considering doing a new for profit venture. Thank you.

00:45:42 Speaker 1

Yeah. And I just want to, we'll, we'll take a look at exactly how we're describing.

00:45:49 Speaker 1

To whom? Our for whom a feeling is required. So as a disclaimer, as with all of these presentations, nothing should be taken at legal advice. And you know we're not articulating new statutory requirements. All the who's required to have a seal is in 19 a.

00:46:09 Speaker 1

Dash 638 a good example is in 1980 Dash 638.

00:46:14 Speaker 1

Me and the the specific provision for behavioral health services IS19A-638-B14, so it's nonprofit entities that have a contract with the state or an agency or department to deliver services that would otherwise.

00:46:34 Speaker 1

Hire a certificate of need so it's not just nonprofit versus for profit status. There's also this contracting piece that's involved. I know many on the call are familiar with this, but just want to lay that out and.

00:46:48 Speaker 1

Clarifying that it's, you know, it's debt for provision there for the other piece. Yes, Jim, thank you for the comments on considering payer mix that has been a focus of the agency and we'll note as we discussed in testimony actually this year.

00:47:08 Speaker 1

Before the legislature, we discussed precisely this issue of whether OHSU has the statutory authority to consider whether an entity accepts Medicaid or not, which is sprinkled throughout the Co criteria, which is 19 eight dash 639.

00:47:28 Speaker 1

That is not the criteria, and throughout we think that it emphasizes the necessity for OHSU to consider.

00:47:36 Speaker 1

How an entity is serving indigent populations and Medicaid beneficiaries, but we'll we'll take a look at that and appreciate any additional comments on that piece, Mark Brunetti.

00:47:53 Speaker 8

I'm sorry, I I was on mute. I just want to just echo what everyone was saying in regards to the Youth Services. I mean here we're in hospital special care we we treat.

00:48:07 Speaker 8

Patients on the autism spectrum inpatient, outpatient in PHP and we see that definite need, but I'd love to get more data just on the behavioral health.

00:48:15 Speaker 8

Sector in terms of the adolescents and youth, not only from the capacity of the hospitals, but also in the Community. You know, school systems, programs on the, on the, on the outside. I just think it's a, it's a a big need. We see a lot of we get a lot of patients from various hospitals in the state.

00:48:35 Speaker 8

About patients that are in their Ed's you know, coming to us, so you know I just think that it would be very important to look at that population and just ensure we're meeting those needs just from a state perspective, we're very similar to what everyone else was talking about.

00:48:52 Speaker 1

Thank you.

00:48:56 Speaker 1

Our.

00:48:58 Speaker 5

Yeah, Mark and I did not speak, but.

00:49:01 Speaker 5

Mike actually completely tied into what he was saying. I just wanted to raise the visibility of kids with comorbid conditions. Let's also tap into what you know, Jim was talking about.

00:49:13 Speaker 5

In terms of.

00:49:14 Speaker 5

Really doing a deeper dive into the different types of inpatient units we have in the.

00:49:19 Speaker 5

They and they need to recognize that there are kids that need treatment that sometimes sit outside of what we might consider the traditional behavioral health bucket and as a pediatric hospital, we see more and more kids coming in, both on the spectrum, both with chronic medical conditions that do need specialized care.

00:49:41 Speaker 5

And I just don't want that population to go unrecognized as we talk about planning for a robust system of care.

00:49:50 Speaker 5

Thanks.

00:49:52 Speaker 1

Thank you, Howard.

00:49:57 Speaker 1

Mark Sevilla.

00:50:00 Speaker 7

Thank you. Just wanted to under score the comment from Jim.

00:50:06 Speaker 7

If you can do any kind of a thing graphic or something that.

00:50:11 Speaker 7

Illuminates the interconnected of this because I think if this is a document that's going out for not just people that know it and and understand it and and know what the complexity of it is, but as a

means of of helping other people understand, because the fact that I may have enough inpatient beds.

00:50:33 Speaker 7

Doesn't mean anything if I can't get patients out to all of these other services or or how they're coming in. And I think that's a piece a lot of people miss sometimes is it's like, well, you have enough of, you know, XYZ type of service and it's like well, I would have enough if I could move it during a timely manner. And and I think that just.

00:50:54 Speaker 7

It's not an apparent.

00:50:55 Speaker 7

Bang, I would relate it to to Eddie boarding, which is on the face of it, you can say, well, the hospital's inefficient. It's like, well, certainly that's a part of it. But there are many other things that contribute to to Ed boarding that that you don't know unless you're in the thick of it. And when you're trying to explain it to people, it gets to be difficult if you.

00:51:15 Speaker 7

We don't have all the pieces to put in front of them and say, you know, this is really not the simple problem that seems on the face of it, but there's a lot of complexity to behavioral health that that needs to be accounted for for capacities.

00:51:29 Speaker 7

Thank you.

00:51:32 Speaker 1

Thank you. And I don't know if if Corey has a follow up to that, but.

00:51:38 Speaker 1

Are there standard measures of?

00:51:42 Speaker 1

You know, challenges in accessing step down or or or discharge care in that sense. So you know you're trying to put someone in in a lower level of care. Are there any industry standard measures for for that kind of?

00:51:58 Speaker 1

Issue that we could consider or is it just more anecdotal and and understanding the experience that folks have had?

00:52:09 Speaker 7

Well, I think and I'm going to again I am, I am not the expert in behavioral health, but the the Ed is where I was born and grew up. So from that perspective we look at well, I can tell you in our psyche, the psyche, emergency services in the Ed, our average length of stay there is about 3 days waiting for an end patient.

00:52:29 Speaker 7

And and then if I go to the inpatient folks and I say what's going on?

00:52:34 Speaker 7

They may say that while we're having trouble placing 2, you know a state facility or a private facility or whatever. So we keep track of that data so that we understand where the the delays are as we do on the the Ed side, I mean, we measure Ed's a lot, obviously a little easier, but we measure.

00:52:54 Speaker 7

A series of timestamps throughout the AD stay in the hospital stay and all of that so we understand where we're getting bogged down and and what's slowing us down at least.

00:53:06 Speaker 7

Hopefully that made sense.

00:53:08 Speaker 1

Yes, absolutely. And and I am hearing.

00:53:12 Speaker 1

Throughout the conversation about the intersection of the need for behavioral health and and how that intersects with overall hospital bed need and the acute care piece. So you know, please do in your written comments.

00:53:31

And.

00:53:32 Speaker 1

You know, feel free to to kind of discuss that section if if you're able to attend the.

00:53:40 Speaker 1

The inpatient bed need acute care. Conversation is on July 29th at 1:00 PM, so it may be of interest to some folks on this call. I know that some of you are from institutions that are also coming to that meeting, so you may share your thoughts through those people as well.

00:54:00 Speaker 1

But but to the extent that some folks on this call have emphasized that intersection, I'm helping to highlight that in your comments and think would be useful.

00:54:10 Speaker 9

Oh, Julian.

00:54:10

Figure.

00:54:13

Yeah, I'm not.

00:54:16 Speaker 3

Thank you. So I there was a reference to this data collection earlier and I I just wanted to look back to that so.

00:54:24 Speaker 3

Ademas does collect a lot of service utilization data from the programs we operate and the ones we contract with. There is a statute on the books that.

00:54:39 Speaker 3

Directs non funded demos, non funded programs to report the utilization data to dealers and we certainly put forth concerted effort to do that. Data collection of non funded programs. But the compliance is is low. So that's something we've talked about.

00:55:01 Speaker 3

War with OHSU and just wanted to explain that.

00:55:04 Speaker 3

A little bit more.

00:55:09 Speaker 1

Thank you. Yes, we.

00:55:14 Speaker 1

We need folks to be submitting their data and that's that's another piece that we've incorporated into some of our review through the CEO and to ensure that folks will be dissipating there because all of that data.

00:55:28 Speaker 1

Helps us to.

00:55:29 Speaker 1

Do activities like the facilities and services plan and to reduce Co and applications?

00:55:36 Speaker 1

Mark.

00:55:40 Speaker 9

Yeah.

00:55:51 Speaker 1

Mark Brunetti.

00:55:58 Speaker 1

You're now back on mute. I don't know if you're trying to speak.

00:56:17 Speaker 9

Ohh yeah.

00:56:19 Speaker 10

Yeah. Thanks again. So on page and I can only speak with, I appreciate one of our colleagues mentioning not the most expert. I'm not the most expert on all of the hospitals and their bed circumstances.

00:56:38 Speaker 10

But I can speak for example on page. I'm sort of curious more about the process Cory. So on page 155, you happen to.

00:56:46 Speaker 10

You know the the toots for mental disease or hospitals for mentally ill persons, both really stigma inducing terms.

00:56:57 Speaker 10

But that is what we're left with. But I'm not. For example natchaug, which I am responsible for, is actually 59 beds, and I know that's like super granular, but I'm sort of, I don't recall anybody querying me about our current bed capacity and I don't know where that information would have come from. I'm quite confident that the Silver Hill Hospital.

00:57:17 Speaker 10

Is probably not accurate. I'd be surprised if that's accurate.

00:57:22 Speaker 10

And to the best of my knowledge, I'm pretty sure, for example, in the prospect health system, and maybe they're here on page on one of the pages where you list the hospitals, I'm pretty sure that.

00:57:36 Speaker 10

Manchester moved most of their psychiatric beds to the Rockville setting and and so I just want to make sure that there's a process in place that we have validated and verified that the numbers that are listed here and the checks in the right boxes are are accurate. Again, I look at that through the lens of the legislator who's going to be looking at this.

00:57:56 Speaker 10

And I want to make sure that we're providing the the most.

00:57:59 Speaker 10

You know correct data. Thank you.

00:58:03 Speaker 2

Yeah, thank you. So the sources for the hospitals in particular are are coming from OS inventory data and the service lines that were identified within those, those individual hospitals. And then for the the state operated facilities and and I believe yeah, hospitals, hospitals for mentally ill persons is still the current term of art but.

00:58:24 Speaker 2

If there's something better that we should be using, I I would like to use it, so please let us know. Yeah, those counts were were taken either directly from state data or things that were collected with DHS. So if they are inaccurate, we should definitely seek to update them.

00:58:36 Speaker 2

I will take those two specific cases back that you mentioned and and if it is required that we reach out to those each individual hospitals, we did not do that we we could reach out to each of those individual facilities to get updated VET counts, but it was just based on on the inventory data that that had already been collected or had previously been held at at at OHS.

00:58:56 Speaker 1

Yeah, the.

00:58:59 Speaker 1

I I believe this is another place and I I should have said, this is the beginning.

00:59:05 Speaker 1

Some of the data sources throughout, we only have 2022 data at the time of doing the analysis and so during this review process, we're also incorporating this budget 2023 days as possible. I think that that's true of the.

00:59:23

Form for him.

00:59:23 Speaker 1

400 which is where hospitals report the number of beds and staff beds in their out allotment of.

00:59:29 Speaker 1

That's OK. Just just received some hospitals within the last few weeks. So one, yes, we'll update and make sure that we're incorporating the most recent filings, 2 something that we can take back there

also is, for example, if we know something has changed such as with the prospect hospitals and a redistribution.

00:59:52 Speaker 1

In the time after the data was collected, we can at least footnote that and clarify that while.

01:00:00 Speaker 1

We're presenting the data accurately for what it's saying it is, which may be 2022 data that we have knowledge of specific abnormalities or changes that have happened since then, so that's an excellent comment. And again, invite anyone who sees something that.

01:00:20 Speaker 1

Maybe different from you know that the reality has changed. Please flag that and and we'll make sure that we're discussing internally tied dentify those things with our partners at Demus NGH to get you know as clear of a picture because that's an excellent point.

01:00:38 Speaker 1

I just one of the things that we've talked about is a challenge of the facilities and services plan. Is it kind of it's a, it's a document that's supposed to be all things to all people. It explains how OS is going to do allow the COM analysis explains to.

01:00:56 Speaker 1

To the public, the current state and the future of healthcare, it's intended to help guide policy with legislators, so it does a lot of different audiences and we want to make sure that everyone gets as clear and precise a picture as possible in an adjustable way so that that's a really helpful comment. Thanks.

01:01:03 Speaker 9

OK.

01:01:15 Speaker 1

Jim.

01:01:18 Speaker 9

Absolutely. So I'm Jason and I and I think programs. So most of the data and information that you have here is based on beds and inpatient services. And there's very little information.

01:01:38 Speaker 9

That's reported me sharing about outpatient service.

01:01:42 Speaker 9

And you can't have one without the other. And you're you're saying that there's robust inpatient services available, but you have to support those patients once they come out of the hospital. And none of that information is gathered here, running a very large outpatient facility.

01:02:01 Speaker 9

We struggle with being able to take our patients when they're discharged from the hospital and getting them in immediately, which puts them at.

01:02:12 Speaker 9

Yes, the other part of that is that you have patients who want psychotherapy, and psychotherapy is not talked about in this document, and that's one of the hugest needs of these patient populations. Most of them want psychotherapy, but some most outpatient programs.

01:02:32 Speaker 9

Offer medication manager.

01:02:34 Speaker 9

And they offer outpaced medication management without the psychotherapy. So we are creating a vicious cycle trying to take care of and manage these patients. But this is something that needs to be addressed and we're going to talk about a statewide plan to help manage these patients. I I just thought.

01:02:52 Speaker 9

We needed to.

01:02:54 Speaker 9

Drop that in socks because that's where Michael.

01:02:57 Speaker 9

Is that is this inpatient stuff?

01:03:00 Speaker 9

Yeah, I get it. We have 18 bed hospital. That's always full. That's always their capacity. There's always people in the emergency department waiting to get a bed. I get it. That is serious. And people are acutely ill. They are struggling, especially since COVID has highlighted people's anxiety and depression.

01:03:21 Speaker 9

To a level that we've never experienced before and we don't have the capacity to manage all of this, but we would be remiss if we don't talk about it in this document.

01:03:32 Speaker 9

Say that.

01:03:33 Speaker 1

No, I appreciate that. And so two questions that I have specifically about some of the outpatient care, because that is where we see a lot of the CEO's come in. So I'm familiar with kind of what gets presented.

01:03:50 Speaker 1

The on the on the one hand it is. Do you have any ideas for how to think about demonstrating need besides just saying I want to put a facility here to?

01:04:02 Speaker 1

Offer nurses and there's a need because there's just a need generally, which may be true, but how can we think about local need and?

01:04:15 Speaker 1

Well, I'll, I'll stop there if you have thoughts.

01:04:17

So.

01:04:17 Speaker 9

About that. So so I do when we have patients who we can't find a place for them, we refer them to Psychology Today or we refer them to their insurance to see.

01:04:30 Speaker 9

We have a place that they can recommend for them to get care which is.

01:04:33 Speaker 9

Not what to.

01:04:33 Speaker 9

Do or somebody might say. OK, let's reach out to 211, which is as easy, even further down the list of being helpful for this preaching population. So I think what would be an acceptable way to look at how you try to manage this?

01:04:50 Speaker 9

Just what is your weakness look like? How long does it take for a person to actually get an appointment if it takes more than three months for them to get an appointment, then we need to create access because that's clearly an indicator that there's a problem. And if you have more than 100.

01:05:06 Speaker 9

People on that.

01:05:08 Speaker 9

It was that just exemplifies the fact that there is a problem because we don't have the capacity to take care of those patients. And I think that we need to talk about what does that mean? Look like, you know, my wait.

01:05:21 Speaker 9

List I've got.

01:05:22 Speaker 9

150 patients and I have somebody who's looking at that wait list every single day. Who's screaming? Those patients who are trying to help them.

01:05:29 Speaker 9

Get into care because we know that there's a need and that they're acutely ill. They've reached over.

01:05:35 Speaker 9

Health and you.

01:05:35 Speaker 9

Have to try.

01:05:37 Speaker 9

Most places aren't trying, they just say we don't have capacity and there's like no. So you don't get an appointment. So then they're not thrown back into the pond and they're swimming, swimming, swimming and they don't have a life racks.

01:05:50 Speaker 9

Are those weightless?

01:05:51 Speaker 9

Publicly available, how would we access that?

01:05:53 Speaker 1

Yes, exactly. So that's my follow up is.

01:05:59 Speaker 1

When a new facility, when someone in Appleton comes in and says I want to establish, you know, I don't PHP day treatment outpatient services in a new facility and one of the criteria is demonstrate a need for this.

01:06:17 Speaker 1

How can that new provider, you know, maybe it's engaging with existing providers and gathering letters that say my wait list is 100, but how how would you advise that person to demonstrate need? What kind of questions would you advise?

01:06:33 Speaker 1

OHSU to be asking them to help get that because it has to be documented on the record. We have to get evidence that says there's a need. How would you pull that out?

01:06:43 Speaker 9

So in in struggling to try to provide those services because I again my capacity is capped, I have this building so I wouldn't have so much space. So I can only put so many people in that space, whether it's providers hand or points.

01:07:01 Speaker 9

So do I first look at increasing my space to add providers or do?

01:07:08 Speaker 9

I look at.

01:07:09 Speaker 9

Do I bring on patients and then getting out the space so?

01:07:14

If you.

01:07:15 Speaker 9

It's difficult session to be in for me how I'm trying to tackle it is like like I need the provider. So if you give me the providers I'm going to plan.

01:07:24 Speaker 9

Yes.

01:07:25 Speaker 9

And so I'm seeking psychotherapy because I know that's the biggest need. Patients are saying that's what they're telling us that they need when they're calling, and they're asking for appointments and won't.

01:07:38 Speaker 9

Say what? They.

01:07:39 Speaker 9

I'm OK with medication management, but I want psychotherapy and so if we can collectively offer what they're asking for, then we we are now at least the very typical iceberg trying to mitigate some of the issues that they have because the longer they go without services, the more they.

01:08:00 Speaker 9

To generate.

01:08:03 Speaker 9

I can't even.

01:08:03 Speaker 9

Make him some work decompensate and end up hospitalized, which again is only adding to this limitation in hospital beds and services, but we are state institutions, so the information that we have is available.

01:08:20 Speaker 9

So. So it's not a secret that we have a wait list or that people have difficulty getting in. You might not be able to get that signed information, say from Yale or from Harvard Hospital. But as a state institution, that information is readily.

01:08:36 Speaker 1

Yeah, that's helpful. The second part of my question was one of the things that came up in our discussion on Monday about primary care was there. Generally the data show the state as a whole is about is positioned about right with the number of.

01:08:56 Speaker 1

Uh, primary care providers. If you take a broadview of that.

01:09:04 Speaker 1

OK, we'll come back to the writing of it. So we have, we have the right number kind of overall, if you take a broad look at that. But when you look at individual pockets, you have geographic maldistribution and people may not have access because of the geographic distribution. And you know, I've been here since December.

01:09:25 Speaker 1

That I can I have seen in applications that you have certain pockets of the state.

01:09:32 Speaker 1

Who have lots of newcomers, providers coming in and saying I want to offer services here, but maybe other areas, especially areas that have high need, may not have as many entrants and and people coming in and that's one of the things that we're really interested from LHS perspective in the distribution of resources.

01:09:53 Speaker 1

Across the state, even more granular level than region, but you know.

01:09:59 Speaker 1

We define primary service area where you're drawing patients from. What's your experience been in practice? Do. Do you find that you know Parker, for example, has a lot of need and may not have proportionately the same amount of providers as some other communities.

01:10:19 Speaker 9

Definitely see that. And so one of the ways that we've been trying to address it is in those primary care offices is to embed psychiatry so that when they come in and they're talking about their anxiety because they're menopausal, that they can have access to somebody who can address the anxiety part of the.

01:10:39 Speaker 9

Women in positions that.

01:10:40 Speaker 9

Having one of the big just discovering.

01:10:42 Speaker 9

That they now may have prostate.

01:10:44 Speaker 9

Issues and they have depression. And so when you when you embed or you combine those services together and it's immediately available, you're providing a service for the patient that doesn't now put them into a behavioral health somewhat cycle where they're waiting to get services.

01:11:04 Speaker 9

Versus addressing them now. So we're trying to embed as many of our primary care clinics as possible with psychiatric services there, whether it's a psychologist, nurse practitioner, retired physician who wants to just pick up part time.

01:11:19 Speaker 9

But it gives them some access versus 0 access and that's helped to create more access because these are in more remote areas.

01:11:30 Speaker 1

Thank you, Mark, Celia, Sevilla.

01:11:35 Speaker 7

Whichever way you'd like. Yeah, actually, Jeff caught it in the thing, but I was going to say this goes back to the you really have to understand capacity in these areas in these programs to understand.

01:11:50 Speaker 7

Because it's different from unmet need, unmet need may be people that aren't getting it, but capacity may be there to do it, but they're just not taking advantage for whatever reason. Then you have to understand that. But I I think you really have to look at and and he had some of the things I was going to say as well. And I think you you might want to talk to CHA because a lot.

01:12:10 Speaker 7

Of the hospitals I know we are.

01:12:12 Speaker 7

Looking at access, we're looking at wait times and and you, I mean at its simplest it becomes an equation, right? Because if I'm a physician seeing 4 patients an hour and I'm a only physician in the office.

01:12:23 Speaker 7

And I'm going to see four patients every hour for eight hours, I can see 32 patients a day. So I know that when I get to 40.

01:12:32 Speaker 7

Either I'm going to work faster or I've got to expand my capacity and for a lot of these things, I think there's there's metrics out there that you can easily back into. And I know, like I said, we I'm not as familiar with it, but the organization's been working a lot on primary care access and looking at what are the wait times, what are the wait times they want to get to.

01:12:54 Speaker 7

And then understanding their known capacity and then saying, OK, here's the gap we need to hire, you know, 50 more hospitalists to be able to.

01:13:02 Speaker 7

To get the wait time down to a reasonable period. So I would just suggest maybe work with CHA and maybe they could work with the hospitals because it's I think at the end of the day it's some brilliant MBA's just doing basic math.

01:13:19 Speaker 1

Thank you.

01:13:20 Speaker 1

I I do want to note that we have entered the public comment time and we have a number of folks on the call who are not officially members of the advisory group. And if you have comments from.

01:13:39 Speaker 1

Well, the general public, we welcome that and we so far did not have any on Monday. So hoping that maybe some members of the public have comments on behavioral health. But while we wait to see if any folks from the public raise their hand to join the conversation, we can certainly.

01:13:44 Speaker 9

For.

01:13:50

Yes.

01:14:00 Speaker 1

Continue the conversation amongst the advisory body and continue to receive some more thoughts.

01:14:26 Speaker 2

Void. I can pose a question that builds a little bit on you.

01:14:30 Speaker 1

Hold on. We have. We just have one comment in the room, but they won't come back to to discussion.

01:14:36 Speaker 4

Questions. Thank you. I just I'll probably send it along in comments too. Earlier in the summary, I read that we don't in Connecticut, we don't have the 1115 waiver.

01:14:48 Speaker 4

And maybe I don't know if that was because this was earlier, but we do have 1115 waivers here in Connecticut.

01:14:55 Speaker 4

Yeah, and. And then just building up the Community service comment to, we do have several mobile healthcare bands that offer primary care and substance use and mental health services throughout the state too. So I don't know how we capture that data, but that that could be meaningful as well.

01:15:25 Speaker 2

Thank you for that comment. Around 11:15, we'll make sure language in the report is that in the behavioral house chapter or are you looking in a broader in in the in another?

01:15:32 Speaker 2

Section of the report.

01:15:34 Speaker 4

No, I think it was like in the chapter one. The summary, yeah.

01:15:40 Speaker 2

Thank you for flagging that. We'll double check it could have been language that was pre-existing before a waiver was submitted. So we will make sure that's accurate.

01:15:48 Speaker 4

Yeah, they're just new in the last few years. I think they, they've been here.

01:15:53 Speaker 2

Great.

01:15:56 Speaker 2

And thanks for the comment, Lee, regarding mobile mental health services, umm, we can try and capture that. That's probably gonna be a harder one to have data on and to understand the level of capacity that that provides. But noting that it is a treatment modality you know like you know a flavor of treatment.

01:16:09 Speaker 2

That's being offered. We can definitely highlight in this report.

01:16:12 Speaker 4

Yeah, Sanders springers man in New Haven is, you know, huge NIH grant. So if you were to.

01:16:21 Speaker 4

Amazing, amazing work going on.

01:16:31 Speaker 9

CHD I also has a mobile crisis numbers for youth.

01:16:37 Speaker 6

Yeah, that is true. We have that. So feel free to reach out if you'd like.

01:16:42 Speaker 6

To take a look at those.

01:16:49 Speaker 1

All right, Corey, I think you mentioned.

01:16:52 Speaker 1

Additional discussion questions. So now we we can.

01:16:55 Speaker 1

Move on to that.

01:16:57 Speaker 2

Yeah, regarding your comment, Boyd, around the geographic distribution of services and different types of services that are offered for behavioral healthcare. One thing that we didn't do a lot of in this chapter that we've tried to do in other chapters to help, OH, guide OS decisions is understanding where there might be.

01:17:15 Speaker 2

Standards or guidelines that have already been developed around, for example, the distance that an individual should be from an available type of service, or the the amount of wait time that is acceptable for them to receive a certain type of service. These could come from professional societies. These could be standards or guidelines that come from government agencies that exist outside of Connecticut, either federal government or other.

01:17:36 Speaker 2

State or state government. You know, recommendations that have been made. I think providing that level of clarity to a waitress and then understanding across different regions of the state, how well those particular standards or guidelines are being met would be an ability to try and better under.

01:17:50 Speaker 2

And where there are areas of the state that have an acceptable capacity of of supply, and where folks are, for example, traveling to access that supply, that may be in an ideal situation, they would not have to travel to or would have more local access so would be willing to take that here or or in written comments where folks have information on where those standards might exist.

01:18:10 Speaker 2

And how we can better highlight that for OHS to improve their decision making?

01:18:15 Speaker 1

Yeah, that is an excellent point and question that we have asked a lot of times, Jeff.

01:18:22 Speaker 6

Yeah. So to that question comes to mind for me immediately is the ECC standards for outpatient clinics in the community, is the Enhanced Care Clinic standards I.

01:18:33 Speaker 6

And unless they've changed, it's been a little while since I've heard or talked about it, but it always had been 2-2 and two. So emergent needs need to be responded to within two hours.

01:18:45 Speaker 6

Two days for for urgent cases, and then two weeks for routine referrals. Those standards only apply to licensed outpatient clinics that are part of the EC.

01:19:02 Speaker 6

You know, process and and exchange for meeting those access standards. I believe they still get a 25.

01:19:07 Speaker 6

Percent rate bump on Medicaid.

01:19:09 Speaker 6

To their outpatient clinics. So that's one example of a set of standards and guidelines that you could speak about, Lisa as an.

01:19:15 Speaker 6

Yep, somebody mentioned that we were involved. There's another small example, but in the mobile crisis realm for youth, which we have a role in helping oversee here at HDI, and we have standards for 90% or higher rates of face to face mobility for referrals and also a 45 minute.

01:19:35 Speaker 6

Response time when they're going out into the community, responding to calls for service on mobile crisis and our provider network in the state is meeting that 45 minute response time standard.

01:19:46 Speaker 6

They're somewhere around the neighborhood of 85% of all mobile responses. So again, just another example of a standard and guideline applied to a specific programming service not aware of though, you know an overarching set of standards and guidelines that cut across all programs and services in the state outside of, I think the ECC might be the kind of.

01:20:06 Speaker 6

Example that is most cross cutting, but providers may have awareness of others that.

01:20:11 Speaker 6

Are relevant there.

01:20:14 Speaker 2

Fantastic. Thank you.

01:20:37 Speaker 1

Or did you have other?

01:20:39 Speaker 1

Discussion questions or or focus topics for for this group.

01:20:44 Speaker 2

Yeah, I can take a look at. I have some notes and some of my slides here of.

01:20:47 Speaker 2

Other.

01:20:47 Speaker 2

Things we can talk about. Let's jump to talking about the way we and I think there's been a lot of good comments today around the way that we track treatment capacity and and the data that we've collected so.

01:21:00 Speaker 2

Are from Samsa related to inpatient beds and bed availability? Great comments here around trying to do a better job and track tracking outpatient capacity. You know we're aware of. Obviously the sample surveys that look at the availability of of inpatient care, curious if folks on the call have any knowledge of how we can do a better job.

01:21:20 Speaker 2

Tracking the availability and capacity of some of those other more outpatient, you know related treatment types or other types of measures that we can use to try and understand.

01:21:31 Speaker 2

What are the the main limitations in ability to access care across the state so you know again, I think we're trying to be data-driven and what we provide from an OS perspective and towards an OS perspective, if there is a publicly available data on some of these other types of treatment that are available outside of what we've already captured from demos and what site is already available from.

01:21:51 Speaker 2

The national surveys, you know, we would like to incorporate that here. So just kind of open the floor one more time. If folks are aware of data that we're missing or or happy to receive that in in written comment as well.

01:22:21 Speaker 1

Yep.

01:22:22

Yep.

01:22:23 Speaker 10

It's probably a question for julene a little bit, but julene, do you think that and and I know you can't speak about the DCF side of this, but the discharge delay data that we do track, would that be a valuable resource for Corey? And again probably most of that data is for the state operated or the Medicaid patients?

01:22:44 Speaker 10

From Caroline. But I, but I I do think there is data that exists and Howard's point about reaching out to Caroline is the ASO for what represents a significant percentage of the behavioral health business.

01:22:57 Speaker 10

That probably is as good a proxy as any other in terms of thinking about.

01:23:04 Speaker 10

You know, people waiting on inpatient programs because they're not able to access the PRTF that kind of gets it. Mark's point earlier that, you know, we've got people who either stuck in Ed's on our inpatient programs because we can't access either a higher level of care, state operated bed or PRTF Foster Home group home.

01:23:24 Speaker 10

Those kind of things, I think Caroline has that data. Most of us probably if we're honest with each other would say.

01:23:32 Speaker 10

That those those are demands that do impact negatively on the Husky population disproportionately compared to the commercially insured folks where you know maybe there's somewhat more resource rich and they're able to tap into some of the other more private activities. But I would think Corey.

01:23:52 Speaker 10

Trying to see what we could get from the ASO that would inform this, acknowledging that you'd have to footnote it, that it probably is a proxy that represents.

01:24:02 Speaker 10

In total, but there's good information from Carolina around discharge delay data, both in terms of access to state operated beds at the higher level of care or longer term care or because we just can't get them into a subacute setting. Thanks.

01:24:19 Speaker 2

Great. Thank you. Yeah, we would be happy to work with you on that. Umm, not data that OS has taken in before or used in this document before, but I think this is the time to try and incorporate where it exists, with the appropriate caveats as you know so.

01:24:30 Speaker 2

Boyd and I will work with you and and and other folks trying to access that and see.

01:24:34 Speaker 2

What we can do?

01:24:37 Speaker 1

Yeah.

01:24:38 Speaker 1

Howard.

01:24:40 Speaker 5

Yeah, I also want to suggest maybe that you reach out to the folks in your primary care group because there may be data in in claims data in primary care that will capture the incidence of behavioral health demands amongst pediatricians and other primary care providers.

01:25:00 Speaker 5

That might give you some glimpse about demand and prevalence.

01:25:06 Speaker 5

That may not get picked up in the Carlon data and maybe just cross reference those data sets. We might be able to, you know, make some correlation between those two streams of work.

01:25:22 Speaker 9

You.

01:25:28 Speaker 1

Thanks.

01:25:35 Speaker 2

I will flag for folks in the sections where we talk about treated versus untreated populations and specifically those populations for substance use disorder. Again, we rely on some of the Samson data to look at populations in different regions across China.

01:25:51 Speaker 2

The cat and noting that when we we define treatment versus those remaining untreated, we're using this terminology and this definition from Samsa that looks at the population that received treatment at a specialty facility, which I'll note is a little bit of a limitation that I would be interested from this group and knowing if we could try and bridge that gap a little bit because there certainly are folks that could be receiving different forms of treatment.

01:26:13 Speaker 2

Maybe not at a specialty facility as defined by Samsa, but still receiving treatment for substance use disorder.

01:26:19 Speaker 2

Sure, carious, if there are other definitions or other ways to track this. Again, this was a limitation and more of what I was able to capture in the data. Trying to understand the treated versus untreated population for substance use disorder, curious maybe edemas may have some of the

specific to their facilities, but how we can get a population based estimate of those remaining untreated for substance use disorder outside of this.

01:26:30

But.

01:26:39 Speaker 2

Kind of narrow definition of stamp so that I understand is limited based on the data that we had.

01:26:51 Speaker 1

Yeah, screen.

01:26:54 Speaker 3

So this this is an important point. At the end of this chapter, it notes that.

01:27:04 Speaker 3

I think it says 90% of all Connecticut adult residents who had a substance use disorder condition did not receive treatment.

01:27:14 Speaker 3

For the substance use disorder needs. So that's a pretty big statement and we would argue that.

01:27:25 Speaker 3

There are.

01:27:27 Speaker 3

Plenty of services.

01:27:29 Speaker 3

That are.

01:27:31 Speaker 3

Helping people with substance use disorders that don't fit into this.

01:27:36 Speaker 3

Category of treatment and specialty facility.

01:27:40 Speaker 3

So.

01:27:45 Speaker 3

Would be good to try to unpack that a little bit, so I'd be happy to follow up and.

01:27:56 Speaker 2

Thank you. Yeah, that's that's the exact point that I'm trying to draw out here. If there's there's other data, other ways to represent those, those different types of treatment that may be being received, I think that is a very stark number in the way it gets pointed out. But we're trying to do the best we can with what we can capture from the data. So there's other ways represented for maybe subpopulations to look at what treatment rates might be or treatment rates among different types of treatment.

01:28:16 Speaker 2

And of course, this is the difficulty and this is runs across all types of healthcare services, but it's particularly important in behavioral health around looking at the types of treatment that individuals want to seek out. And there are different ways that they can try and manage these conditions.

01:28:28 Speaker 2

And a specialty treatment facility may be right for some, but it's not right for all. This is of course very difficult for us to track, to try and understand who wants treatment and what type of facility and how many are able to access those different types of treatments. So I would love to help with this group to try and move this chapter in that direction as best we can.

01:28:46 Speaker 4

Well, and I think this was the the point of sort of that, you know removing the the ex waver and you know widening the availability of access to services this way. So you know people are seeking treatment from their primary care providers, people are seeking treatment you know from community based specialty providers perhaps in an office.

01:29:04 Speaker 4

That they're they're, you know, love with great, robust, wonderful, the access that everywhere. So like you said it it can you go down the clinic or a mental health clinic or, you know a more wrap around type of services.

01:29:19 Speaker 4

But it may be seeing your primary care provider that may also be where you get your specialty services. So I don't know how you call that data. I don't know if it's just by diagnosis that you know that's certainly a very sure way to do it.

01:29:35 Speaker 4

You know, pay always there.

01:29:36 Speaker 1

Right, that's that was going to be my follow-up and this comes from ignorance of how claims are paid in this specific context. Would there be a code in the ABCD for a primary care visit that you were addressing some of the substance use, so, so Corey, maybe that's something that we can think about is you know?

01:29:45 Speaker 4

OK. Yeah.

01:29:56 Speaker 4

10.

01:29:59 Speaker 1

Yeah. Or is there like that big picture?

01:30:00 Speaker 4

Yeah, yeah.

01:30:03 Speaker 9

Of CPT.

01:30:04 Speaker 1

Yeah. Yeah. So if we look through the ABC D, is there anything that we can?

01:30:12 Speaker 1

Any knowledge wisdom making get from looking at kind of a primary care visit where there's some type of substance use treatment coded on that claim, yeah.

01:30:25 Speaker 1

Can't guarantee that that's going to solve this data analysis problem, but maybe that's one Ave. to pursue.

01:30:33 Speaker 9

Chanting might people might be helpful in that too.

01:30:36 Speaker 9

Is that China time?

01:30:41 Speaker 1

Jim.

01:30:44 Speaker 10

Yes, thank you. And and Julene and Corey, thank you for raising visibility to that issue on page 166 and such.

01:30:54 Speaker 10

I I think you know recognizing the scope of this work, which is a facilities and services document, it's it's obviously very difficult for you to also then edit so much that you're going to describe the

nature of the conditions that we're actually treating that's sort of germane to my earlier point about psychiatric illnesses and a bed.

01:31:16 Speaker 10

Is not a bed. Is not a bed. They're like, just like we.

01:31:18 Speaker 10

Need ICU beds?

01:31:20 Speaker 10

And stepped on beds and emergency department beds. We need different kinds of beds at times, given the nature of the conditions. But I agree with you, Corey, this data so grossly misrepresents what's actually happening in reality that it it would be super alarming to any legislator who's going to read it.

01:31:40 Speaker 10

So perhaps.

01:31:41 Speaker 10

Apps, some paragraph that talks about the way care is delivered and offered to people who say substance use conditions and it is 12 step programming peer supports. There are so many other parts of how services are provided that somehow we have to qualify.

01:32:02 Speaker 10

This piece so it doesn't read that 90% of the people who need substance abuse care are not getting it. Because while most of us believe that the number is closer.

01:32:12 Speaker 10

Four of the 10 people who really need some level of care, probably less than five, you know, probably around 5 are getting access to something which isn't great, but it's far better than we're nine out of 10 missing the boat. So I I do think there's probably a way that we have to create some sort of introductory language.

01:32:35 Speaker 10

To recognise that the way care is provided ranges all the way from peer supports recovery support specialists, 12 step programming, sober living environments. All the rest of it, and then for a small a certain population.

01:32:50 Speaker 10

Residential rehab detox or medical withdrawal treatment. This comes across that as it should. It's a facility document, but it's also a services document. So we you have the best data for facilities. So I totally understand why that's there, but we probably have to.

01:33:10 Speaker 10

Describe the way care is delivered in a way so that a reader is not totally overwhelmed by what they're reading. Thank you.

01:33:21 Speaker 1

Thank you, Jen. That that's helpful. And I will say we, Julian and and her demons colleagues raised this point in some of the drafting phase and we worked to incorporate some of that. But I I hear about it clear that it needs some more contextualization and.

01:33:40 Speaker 1

You know, a continued thought on some of the data that may be available to help contextualize this. So we'll take that back.

01:33:49 Speaker 1

And incorporate it where we can.

01:33:56 Speaker 1

Corey, it looks like.

01:33:57 Speaker 1

You have a couple more slides. If there are anymore discussion questions you have.

01:34:01 Speaker 2

Yeah, I can take us to just one more section here and this is specific to to 6.7 around the the six different examples of particular attention of CON application components that is recommended OS take into consideration for behavioral health expansion. I'm noting the six of them here. I I also read them rather quickly earlier before.

01:34:22 Speaker 2

Curious if folks think that we're missing anything among this outside of this list of other things that should be umm.

01:34:29 Speaker 2

That could be put into the facility and services and plan to describe how to make sure that we're adding.

01:34:35 Speaker 2

Capacity in a way that is reasonable, that is ensuring high quality and and and is accessible to folks within the state of Connecticut. So there's anything that folks on this call think that we're missing. This would be the time to to provide comment to us around how we could expand this description of standards and guidelines for for guiding OS decisions on behavioral health applications.

01:35:12 Speaker 1

Yeah, go ahead, Jim.

01:35:14 Speaker 10

I'm just going to keep going, boy. I guess at at the risk of sounding a little bit like an English major, which I'm not and wasn't, but I I will say that demonstrating not an unnecessary is rather torture syntax.

01:35:17 Speaker 1

Appreciate it.

01:35:32 Speaker 10

And I I don't know if you actually even need the word unnecessary. I mean that would come out in the overarching CON application itself, but the the quasi double negative there makes it I think, cumbersome and perhaps confusing for people. I think you know exactly what you're trying to say. I think in places it.

01:35:53 Speaker 10

Where we can simplify it, I think we should probably see simplicity.

01:36:00 Speaker 1

I appreciate that.

01:36:04 Speaker 1

Yes, there were. There was much conversation in the last legislative session about.

01:36:10 Speaker 1

The drafting of some of these criteria and the the difficulty that that presents both for applicants trying to figure out how in the world to fill out an application and for OHS in figuring out how to write a decision that people can actually comprehend, and so.

01:36:30 Speaker 1

You know, as we've been discussing, trying to balance the document to where it is.

01:36:36 Speaker 1

Perfectly accurate and able to be read is that real? That's that fine line that we're dancing over. So maybe there's an opportunity to kind of.

01:36:47 Speaker 1

Express in the statutory language, but it actually says and then have some more description of what that means in a way that humans can read and and not just kind of the the challenge of the statute as they are. So that's that. We hear you laughing clear on the the difficulty of the.

01:37:08 Speaker 1

Sometimes double, sometimes triple. Who knows how many negatives we can squeeze into a sentence.

01:37:15 Speaker 1

Julianne.

01:37:18 Speaker 3

So I'm interested in that third bullet there about treatment quality and recommended treatment modalities. So the example there, medications for addiction treatment is certainly a good one and we would want that to be included. There's a question there what sources should be referenced and so.

01:37:37 Speaker 3

Are you are you asking this group for sources of treatment modalities that you would include in the CON application for applicants to refer to?

01:37:41 Speaker 2

I am.

01:37:51 Speaker 2

Yeah, I think what we've provided so far has been examples of types of sources that applicants could provide. We always encourage applicants to provide, you know, the the best available, you know, kind of professionally recognized, you know, set of information that they can when submitting these applications. So you know, if we could provide some examples of where some of these standards might exist or what sources applicants could use.

01:38:11 Speaker 2

To demonstrate this to HS, it improves the quality of data that OS gets from the applicants and helps guide the applicants at the same time. So yeah that that's a question where I have not included a lot of specificity yet, but I think we could include more on this document if folks at this advisory group have recommendations for us.

01:38:29 Speaker 3

I'll send some over from Demus for adults.

01:38:33 Speaker 2

Great. Thank you.

01:38:50 Speaker 2

Barring any others here, Boyd, my my last slide is just other comments, questions and feedback. So we can open the door if there's something that didn't fall into the categories that we've talked about so far or any other topics folks want to bring out.

01:39:00

Hmm.

01:39:02 Speaker 1

Great. And I I'm going to try to share.

01:39:08 Speaker 1

One of my windows just so that people know.

01:39:13 Speaker 1

What else is coming in this process? So let me know if you can now see. Well, I the joy of having multiple monitors in this room is that I can see what's being displayed. So let me zoom properly.

01:39:32 Speaker 1

And so as I mentioned, this is one of.

01:39:38 Speaker 1

Six advisory bodies across 7 meetings.

01:39:44 Speaker 1

So this is the second of the six by seven meetings. So next week we have a full week with cardiac reproductive health, which includes labor and delivery services across the state and imaging services, all things imaging. And then the following week we have.

01:40:04 Speaker 1

But.

01:40:05 Speaker 1

On Monday, the acute care and inpatient bed need conversation, and then we'll wrap up with just kind of a full anyone who wants to come and share general overview, general comments, thoughts about some of the trajectories and and future of healthcare that we've identified.

01:40:26 Speaker 1

Any general comments there? So I just wanted to make sure everyone was aware of this. I know as I mentioned earlier, many of you are.

01:40:33 Speaker 1

From organizations who are represented on these upcoming bodies, but certainly everyone's invited to join, participate as a public participant, you know we welcome any thoughts and feedback, especially at some of these intersections. You know, as as the report is written.

01:40:53 Speaker 1

Have a bunch of separate chapters, but we know that a lot of things are related and intertwined, so highlighting those is definitely welcome, and we appreciate that.

01:41:03 Speaker 1

As we've said several times, we definitely encourage folks to submit written comments besides just what we have today. But I've been taking multiple pages of notes. We have other OHSU staff here. I know Tori has been taking notes and others from Altera. So you know, we, I I really hope everyone.

01:41:24 Speaker 1

Knows how much we appreciate you taking the time to.

01:41:27 Speaker 1

Even talk with us today and highlight some of these issues because you know, we've talked about the plan, covers a lot of material and a lot of issues and no one can highlight kind of the intricacies and nuances like you all who do this every day so.

01:41:45 Speaker 1

Truly, truly grateful from all of us at OHS and from our town. I'll speak on behalf of Cory. We we appreciate this insight.

01:41:55 Speaker 1

Uh.

01:41:56 Speaker 1

And and do reach out if you have any clarifying questions. Any suggestions, resources. We really appreciate all of this work.

01:42:06

So.

01:42:07 Speaker 1

Unless anyone has any concluding remarks, we will go ahead and wrap it up and look forward to any written comments.

01:42:15 Speaker 1

Thank you all very much.