



STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

A HEALTHCARE SERVICE AGENCY

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GOVERNOR

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COMMISSIONER

Testimony of Thomas A. Kirk, Jr., Ph.D., Commissioner Department of Mental Health and Addiction Services Before the Public Health and Human Services Committees September 4, 2009

Good Morning Sen. Harris, Sen. Doyle, Rep. Ritter, Rep. Walker and distinguished members of the Public Health and Human Services Committees. I am Commissioner Thomas A. Kirk, Jr., of the healthcare agency formally known as the Department of Mental Health and Addiction Services, and I am here today to speak to you about the changes we are about to embark on as we manage our budget and positions during these difficult fiscal times.

I want to start by thanking you for inviting us here today to talk about our plans and to let you know that we appreciate the concern you have for the people we serve. Let me assure you that we share that concern and that our plan is one which we believe takes into account the needs of the individuals we serve and continues to promote their recovery.

While the action of the legislature on Monday has not yet been fully analyzed by our agency's fiscal unit, we still believe that it makes sense to consolidate our mental health inpatient beds onto one campus. One sample outcome of such a move would be significantly more opportunities for patients to access a wider range of outdoor, mall and therapeutic activities on the Connecticut Valley Hospital campus that are not available due to the interior and exterior space at CedarRidge Hospital (CRH). A number of other factors have also influenced our decision. The retirement incentive program resulted in a loss for DMHAS of 311 positions, many of which were nurses, doctors and other clinical care staff. In addition, we have been unable to fill 149 vacant positions because of the "hard" hiring freeze. The reality is that it is simply not possible to operate accredited inpatient hospital beds without proper clinical care staffing. Among other adverse outcomes: patient care suffers, staff are more prone to injuries, overtime expenses skyrocket to ensure mandated coverage, and federal reimbursement dollars are put in jeopardy.

We also reviewed bonding needs for our state facilities and did an analysis of the dollars we would need, in the short term, to repair the roof at CRH as well as make other more costly and significant improvements to a hospital within the next few years that was designed and intended to be used for acute care. Instead patients are living there for months and yes, years. It seems fiscally prudent that we save those precious bonding dollars to make one campus available to

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serve our patient populations as opposed to struggling along to fix a little here and a little there with no end in sight.

Over a period of months, we have looked at a number of options available to us that would allow us to continue to meet the health care needs of the people we serve, while remaining mindful of the current fiscal realities facing our agency. The option to close CRH will give some individuals the opportunity to live in the community and continue with their recovery. My repeated answer to the following policy question has been "no:" should we invest in bricks and mortar or in people living in the community with proper care and natural supports? For those individuals, we will purchase services from a myriad of community providers. Patients who are not well enough for community placement will be transferred to inpatient beds at other DMHAS facilities. This option will allow us to shift needed clinical staff from CRH to other facilities allowing them to fill critical vacancies.

The CRH piece is as follows: We currently have 103 patients at Cedarcrest Hospital in Newington. Building on extensive patient-care work that Deputy Commissioner Rehmer began many months ago, we are in the process of doing individual assessments of all of our patients in all of our inpatient facilities and expect to be able to transition approximately 60 of them into the community.

To that end, we have filed a letter of intent with the Office of Health Care Access for a Certificate of Need related to the closure of CRH, in accord with an informed plan attentive to the needs of the patients involved and their families. The CON process will require us to show that we are providing the same or better access for the individuals we serve. There will be a public hearing on our plan, at which time the public, families and advocates will have the opportunity to weigh in on this matter.

As we begin to move those patients into the community, we will also start to transition staff and any patients requiring intermediate or longer term inpatient care from CRH to the Connecticut Valley Hospital campus or to other DMHAS facilities. We will open a unit at Merritt Hall that will have 22 beds, and we intend to make renovations to the superintendent's cottage to house 12 additional individuals. Ten inpatient beds at the Greater Bridgeport Community Mental Health Center will also be converted to accept persons with psychiatric disabilities.

Should the need arise for more inpatient beds, we anticipate that we may have some extra capacity at the CVH campus, and we will carefully weigh the need for adjustments there as needed. The CVH campus currently has 520 patients, and the agreement we have with the city of Middletown allows us to have up to 610 beds. We anticipate that we would be at approximately 560 beds once this transition has been completed.

Please understand that there are critical components of this plan that are necessary for its success, i.e. dollars necessary to fund the proposed community placements, giving us the flexibility to use that money to meet the individual needs of the patients we serve, and working with the unions and staff to ensure to the greatest extent possible that therapeutic relationships between patients and staff are minimally disrupted.

The last part of our plan is to move towards the closure of forty-one (41) state-operated detoxification beds and to purchase the capacity for that amount of service in the community. Twenty (20) detox beds would close on the CVH campus and twenty-one (21) beds would close at the Blue Hills site. Our plan will have us continue to provide the current total of 100 addiction rehabilitation beds at these two facilities.

What is unknown to us at this time is whether the budget that was passed will allow us to continue to operate these beds. There are large lapses that will be apportioned to state agencies as well as other cuts that may impact our ability to keep these beds as currently configured. Admittedly, we are still working the numbers on this latter proposal to determine the current detoxification capacity in the community and whether or not that capacity would meet the needs of persons requiring such. As a result of this we have not yet filed a letter of intent with OHCA for a CON application pending completion of our review, in order to make sure and be satisfied that we can meet the statutory requirements. We will be re-evaluating this proposal as we see the net numbers to our budget and would be willing to get back to you if we believe that we should move ahead on its development.

Thank you for the opportunity to address you today on these proposed changes. I would be happy to answer any questions you may have at this time.