Universal Health Services, Inc.
UHS of Delaware, Inc.

April 15, 2020

Mr. Matthew Gilman, MPPA
Facilities Planning and Safety Program Manager
Health Care Regulation and Quality Improvement | Certificate of Need
Oregon Health Authority
800 NE Oregon Street, Suite 465
Portland OR 97232

Dear Mr. Gilman:

RE: Responses to Oregon Health Authority Questions Regarding NEWCO's Request to Establish a 100-Bed Inpatient Psychiatric Hospital in Washington County (CN #682)

On behalf of Fairfax Behavioral Health and Universal Health Services, I am pleased to provide responses to the Oregon Health Authority ("OHA") questions included in your letter dated January 28, 2020.

I would be happy to answer any questions you have on the above responses. I can be reached at ron.escarda@uhsinc.com or at 425.821.2000 x1547.

Sincerely,

Ron Escarda
CEO & Group Director of the Pacific Northwest
Universal Health Services

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Introduction and Data Discussion

In our November 15 response, we presented admissions and deflections data for persons who requested inpatient psychiatric care at Cedar Hills Hospital between January 2018 and June 2019. Over the course of our efforts to respond to the current set of questions, we have learned that data which we previously presented reflected preliminary and incomplete information. It was preliminary in that it reflected only that information taken at the time of request and did not include subsequent updates based off additional information added to the requestor's record. It was incomplete in that it did not reflect the payer information collected after patients were admitted to Cedar Hills. As per EMTALA, Cedar Hills Hospital does not actively collect payer information from individuals who request care, so this information was not present in the earlier dataset. Furthermore, after review of Cedar Hills Hospital coding procedures, we noted that if payer information was unknown, the coding mechanism at Cedar Hills Hospital defaulted to coding that person as having a carrier titled "Self-Pay." As a result, in Table 4 of our November 15 response, these persons with unknown payer information were inaccurately grouped within the "Self-Pay/Unfunded" category. Lastly, our November 15 response presented patient requests for inpatient psychiatric care only and included special programs for military personnel. However, rehab and detox programs constitute inpatient programs at Cedar Hills Hospital, and the special programs for military personnel are not open to the general population. As such, in the interest of consistency and representativeness of Cedar Hills Hospital inpatient admissions and deflections, we have further revised the inpatient admission/deflection information to include patient requests for inpatient rehab and detox but omit patient requests for special programs tailored towards military personnel. These revisions to the data and the program service codes reflected are applied across the tables presented below.

Our November 15 response included six separate tables. The January 28, 2020 OHA questions referenced four of these, and their revisions are included within the appropriate responses below. In the interest of transparency, we also provide revised versions of Table 1 and Table 2 of our November 15 response, included below.

Table 1: Cedar Hills Hospital Patient Requests, All Ages, by Admission or Deferral Status, January 2018 to June 2019

	Period total			Per Month		
Admission Summary	Requests	Admits	Deflections	Requests	Admits	Deflections
January through June 2018	3,840	1,511	2,329	640	252	388
July through December 2018	3,893	1,285	2,608	649	214	435
January through June 2019	4,253	1,171	3,082	709	195	514
Total	11,986	3,967	8,019	666	220	446

Source: Cedar Hills Hospital Requests by Patient Characteristics

Notes: "Period total" represents the total across the period specified for each row. "Per month" represents the period total divided by the number of months in the period (6). Table includes requests for inpatient psychiatric care, inpatient detox care, and inpatient rehab care for programs open to civilians.

Table 2: Cedar Hills Hospital Patient Admits and Deflections, by Age, January 2018 to June 2019

Age Group	Counts			Ratios		
	Requests	Admits	Deflections	Requests	Admits	Deflections
Unknown	382	0	382	3.2%	0.0%	4.8%
1 to 4	17	0	17	0.1%	0.0%	0.2%
5 to 9	2	0	2	0.0%	0.0%	0.0%
10 to 14	3	0	3	0.0%	0.0%	0.0%
15 to 17	6	0	6	0.1%	0.0%	0.1%
18 to 24	1,739	542	1,197	14.5%	13.7%	14.9%
25 to 29	1,318	424	894	11.0%	10.7%	11.1%
30 to 34	1,183	370	813	9.9%	9.3%	10.1%
35 to 44	2,195	785	1,410	18.3%	19.8%	17.6%
45 to 54	2,180	773	1,407	18.2%	19.5%	17.5%
55 to 64	1,941	735	1,206	16.2%	18.5%	15.0%
65 to 85	1,005	338	667	8.4%	8.5%	8.3%
85+	15	0	15	0.1%	0.0%	0.2%
Subtotal, 18+	11,576	3,967	7,609	96.6%	100.0%	94.9%
Total	11,986	3,967	8,019			

Source: Cedar Hills Hospital Requests by Patient Characteristics

Notes: Table includes requests for inpatient psychiatric care, inpatient detox care, and inpatient rehab care for programs open to civilians. Also “Subtotal 18+” excludes persons who were coded as “Unknown.”

Importantly, although the data presented in Table 1 and Table 2 has changed, qualitatively these tables are consistent with those presented in our November 15 response. From Table 1, between January 2018 and June 2019 patient requests for care increased, which, given the capacity constraints at Cedar Hills Hospital, consequently resulted in an increase in patient deflections. With regards to the age distribution of patient requests presented in Table 2, other than for the child and adolescent age groups, the age distributions of care requests, admissions, and deflections were very similar over the period January 2018 to June 2019.

Oregon Health Authority January 2020 Questions

1. **In response to OHA's question regarding health care organizations you have met with, you provided a list of organizations. Please provide additional details on the outcomes of those meetings regarding the relationship your facility will have with those organizations. Are there tentative agreements between you and these organizations? If yes, what are they and what is entailed in those agreements?**

   We have met with:

   - Unity Center for Behavioral Health– Discussed current relationship and patient transfers with the CEO and Chief Medical Officer, as well as common struggles

with patient flow. Our Assessment Center is in daily communication with the Unity Center discharge planners and Psychiatric Emergency Service team reviewing and accepting requested transfers from the Unity Center to Cedar Hills Hospital. The Unity Center currently represents one of the top three referral sources to Cedar Hills Hospital inpatient services.

- City of Portland – Spoke regarding sobering center closure and how Cedar Hills Hospital could be a part of the new system response to those experiencing a mental health or SUD (substance use disorder) crisis. Toured with acting Captain Lavell from the City of Portland who is managing the sobering center task force with Portland Police.
- City of Wilsonville – Spoke regarding the certificate of need (CON) for the proposed hospital, siting of the proposed hospital, and asked for commitment to help get the CON approved.
- Western Psychological – Current, co-located partner at Cedar Hills Hospital outpatient site. Informed their CEO of our plans to build a new hospital in Wilsonville, post-CON approval. Plans for the build have been approved by the city.
- NAMI – Oregon – We sponsor and support their advocacy work.
- Lines for Life – We contract with them for post discharge follow up at three intervals to help prevent relapse.
- Dual Diagnosis Anonymous – We invited DDA to offer a peer support group out of our outpatient offices, which they did. We also asked for their support with our current CON application.
- Oregon Recovers – We are a sponsor and supporter of their advocacy to address the current addiction crisis.
- Clackamas County – Met with elected officials and Health Housing and Human Services staff to talk about expansion and care quality. Asked for their support as we seek to expand to Wilsonville. The County Board and Department leadership support the project.
- Multnomah County – Met with elected officials and Health Department leadership to discuss our expansion and how it would impact the current access crisis across Oregon in general and the Multnomah metro area, in particular, especially for Medicaid (OHP) members.
- Washington County – Met with county leadership to discuss our proposed expansion with a new hospital. The County Board supports the project. Plans for the build have been approved.
- City of Beaverton – Met with leadership to talk about our plans and how this might impact the access crisis in Oregon and the metro area.
- Mental Health and Addiction Association of Oregon – Shared our common concerns for access to care and our interest in expanding our hospital and outpatient services. We are a conference sponsor.
- Basic Rights Oregon – We serve many who identify as Lesbian, Gay, Bi, Trans and Non-Binary, and met to talk about how we can even better serve the LGBT+ community.
- American Foundation for Suicide Prevention – Oregon Chapter – We met with Oregon leadership and supported their Capitol Day on Feb 12, 2020. We continue to be a part of their work, especially expanding access to care.

- Cascade AIDS Project, Prism clinic – Met with staff about mutual referrals and about our plans to expand.
- Oregon Council for Behavioral Health – We are a member and support the shared mission to address the mental health and addiction crisis in Oregon.
- Kaiser Permanente – We are a contracted commercial and Medicare provider. We meet monthly to discuss patient care and have informed them of our intention to build a new hospital.
- Optum – We are a contracted provider and our local representative has been informed of our intention to expand.
- VA Portland Medical Center– Met with leadership and informed them of our intent to expand. We are a DOD and VA contractor, and one of 12 Centers of Excellence.
- Wounded Warrior – We contract with them for care and have informed them of our intent to expand care.
- CareOregon/HealthShare/Columbia Pacific CCO – We have asked for a contract as we continue to provide care to their members.
- Yamhill County and Yamhill Valley CCO – We have informed leadership of our intent to expand. We are a contracted provider.
- Oregon Integrated Health – We met with them about mutual patients and to inform them of our intention to expand.
- We Can Do Better Oregon – We met with their Executive Director to share our plans and we are a sponsor of their annual conference.
- Trillium CCO – We met with local leadership and are a contracted provider. They support the expansion and have offered letters of support.
- DePaul Treatment – Met with staff about our plans and mutual referrals.
- Legacy ER Social Workers and Various Clinics – Met with line staff about our current relationship and how we plan to grow.
- Tuality ER Social Workers and Various Clinics – Met with line staff about our current relationship and how we plan to grow.
- Providence – We have a patient transfer and business associate agreement between Providence St. Vincent and Cedar Hills Hospital.
- Providence Elder Place – We have met with leadership and are a contracted provider.

In addition to the meetings and discussions detailed above, Cedar Hills Hospital is engaged in the community on many other levels. Our community partnership liaisons make 400+ contacts a month with mental health and SUD professionals, hospital social workers, community health workers, primary care providers, law enforcement, policy makers, and various other healthcare workers. As noted above, we are a sponsor of several important community agencies and actions. We also assist the professional body by offering educational courses approved by the National Association of Social Workers at no cost. The most recent was on “Caring for Trans and Non-binary Patients.” Finally, we volunteer with organizations like Do Good Multnomah where we helped secure hygiene supplies and Potluck in the Park where we sponsored and served a Sunday supper for 400. These community investments will double when the new hospital is operational.

It should also be noted that Cedar Hills Hospital is a member of the Oregon Hospital and Health System Association and Oregon Council on Behavioral Health. The CHH staff are on committees of both groups and work to meet the policy directives of their members in concert with the state. We would plan to do the same with staff from the proposed hospital at Wilsonville, post CON approval, that is, establish and fully integrate into our community and regional health care continuum, just as Cedar Hills Hospital has done.

2. In your November 15 responses to OHA's questions, Table 3 shows that 1,701 requests and 1,055 deflections fall into the "Other" category. Please provide a detailed breakdown of what is included in this category.

As discussed above, the data which we previously presented reflected preliminary and incomplete information and has been revised accordingly.

Table 3 of our November 15 response presented the top 25 referral source agency organizations, ranked according to total requests. In Table 3, using the revised data of patient requests for inpatient care, we present admissions and deflections for the 63 source agency organizations which had at least five admissions and five deflections. We censor organizations which had fewer than five admissions or deflections for patient confidentiality. The 344 organizations not shown averaged about 2.42 patient requests, of which about 0.95 resulted in an admission and 1.47 a deflection.

We present the referral source agency data in a relatively raw form, but for clarity have completed the agency names which we were able to identify and edited for spelling and grammar. Furthermore, as a result of input inconsistencies, some agencies were recorded multiple times under slightly different names. Where possible we have grouped these records together, however there may exist other records which refer to the same source agency but which we were unable to identify.[1]

The data presented in Table 3 reflects the location of the client at time of the request or referral, but not necessarily the source of the request. In some cases, the client location and referral source are the same (and investigation of the data suggests these data fields were often comingled by the patient or intake person), however for others they differ.

“Self-referral, Former Cedar Hills patient” is listed in Table 3 as “Agency Name.” This group is defined to include any individual who has been admitted into any Cedar Hills inpatient or outpatient program since 2009. However, it should be noted that, given referral source and agency name are required fields to be input into the Cedar Hills patient record database, this particular patient group designation has apparently been used as a common default selection if the actual referral source or agency is unknown or

[1] The grouped agencies include missing observations and unknown agency sources grouped into “Unknown,” the agency sources PEACE HEALTH PEACE H and PEACEHEALTH SW MEDIC being grouped into “PeaceHealth Southwest Medical Center,” PROVIDENCE WILLAMETT and WILLAMETTE FALLS HOS being grouped into “Providence Willamette Falls Medical Center,” the agency sources LINCOLN COUNTY HHS and LINCOLN CO HEALTH & being grouped into “Lincoln County Health & Human Services,” the agency sources INSURANCE COMPANY and INSURANCE being grouped into “Insurance Company, Unknown,” and the agency sources ADVENTIST MEDICAL CE, ADVENTIST HEALTH, and ADVENTIST HEALTH ED being grouped into “Adventist Health Portland.” There may exist other agencies which should have been grouped together which were not identified.

unclear. “Self-referral, former Cedar Hills patient,” thus, is likely over-represented in the Agency Name field in Table 3 but it is included, as historically coded into the CHH database, in the interest of transparency.

Table 3: Cedar Hills Hospital Inpatient Psychiatric Stay Admits and Deflections by Source Agency, for Persons Aged 18+, January 2018 to June 2019

Agency Name	Admits	Deflections	Total
Total	**3,967**	**7,609**	**11,576**
Self-referral, former Cedar Hills Hospital patient	693	701	1,394
Self-referral, Other	341	433	774
Adventist Health Portland	212	488	700
OHSU Emergency Department	160	506	666
Providence Portland Hospital	170	447	617
Kaiser Sunnyside Hospital	159	425	584
Providence St. Vincent Hospital	147	361	508
Internet	173	332	505
Providence Milwaukie Hospital	92	299	391
Unity Center	152	212	364
PeaceHealth Southwest Medical Center	76	250	326
Kaiser Westside Hospital	81	215	296
Family Member/Friend	100	187	287
Providence Willamette Falls Medical Center	72	170	242
Legacy Salmon Creek Hospital	83	145	228
Asante Rogue Regional Medical Center	43	156	199
Willamette Valley Medical Center	76	108	184
Legacy Mt. Hood Medical Center	45	125	170
Legacy Emanuel Hospital	47	114	161
Providence Newberg Hospital	65	94	159
Mercy Medical Center	47	104	151
Legacy Good Sam Hospital	45	103	148
Legacy Meridian Park Hospital	35	96	131
PeaceHealth Sacred Heart Medical Center at Riverbend	38	93	131
Lincoln County Health & Human Services	38	78	116
PeaceHealth Sacred Heart Medical Center at Eugene	19	70	89
Tuality Community Hospital	21	57	78
Counselor	25	52	77
Unknown	37	54	91
Insurance Company, Unknown	26	36	62
Providence Medford Hospital	15	46	61
Samaritan North Lincoln Hospital	18	39	57
Providence Seaside Hospital	19	26	45
Providence Emergency Access Line	12	27	39
Providence Health Plan	11	28	39
Asante Three Rivers Hospital	10	28	38
PeaceHealth Sacred Heart Medical Center, University District	11	27	38
Department of Veteran Affairs	14	23	37
Serenity Lane Residential Center	11	25	36
Bay Area Hospital	8	27	35
Columbia Memorial Hospital	13	20	33
Crisis Line	9	24	33
Yamhill County CCO	16	17	33
Good Samaritan Regional Hospital	14	18	32
Salem Hospital	9	23	32
Sky Lakes Medical Center	5	20	25
VA Portland Medical Center	14	10	24

Bridgeway Recovery Services	7	15	22
Buckley House Detox	5	17	22
Klamath Behavioral Health	9	13	22
Canyon Park Treatment	7	14	21
Cigna Insurance	11	9	20
Phonebook	5	15	20
Springfield Family Practice	9	10	19
Hazelden Springbrook	9	9	18
Central City Concern	9	8	17
Lifeways	5	11	16
OHSU Family Medicine	7	9	16
Medicare Insurance	6	9	15
Hooper Detox	8	5	13
Mid-Columbia Medical Center	5	8	13
Blue Cross Blue Shield	7	5	12
DePaul Treatment Center	5	6	11
Agency sources w/ <5 admits or deflections	326	507	833

Source: Cedar Hills Hospital Requests by Patient Characteristics

Notes: Table includes requests for inpatient psychiatric care, inpatient detox care, and inpatient rehab care for programs open to civilians for all agency referral sources with at least five admissions and deflections. Some agencies are grouped into a single category as described in Footnote 1. The Total row corresponds to figures presented in Table 2.

3. Table 4 in the November 15 response letter shows that patients who are "self-pay" or "unfunded" have a higher rate of deflection than any other payer source. Please explain why this category has a higher deflection rate and how their admission request demographics compare to those patients who were accepted for a bed.

In Table 4 of our November 15 response, we presented patient admissions and deflections by likely payer for persons aged 18+. EMTALA requires Cedar Hills Hospital be blind to patient insurance status and financial situation in its assessment process, and these requirements are followed. As described above, after review of Cedar Hills Hospital coding procedures, we found that if payer information was unknown, the coding mechanism for Cedar Hills Hospital's patient record database defaulted to coding that person as having a carrier titled "Self-Pay." As a result, in Table 4 of our November 15 response, these persons with unknown payer information were grouped within the "Self-Pay/Unfunded" category. This coding mechanism explains the higher deflection rate among this patient group, but it was an incorrect group assignment and label.

Cedar Hills Hospital generally receives no payer information for deflected persons, so a greater proportion of deflected persons had an unknown carrier and were classified as "Self-Pay/Unfunded." Based on our revised understanding and analysis of the data files and the coding mechanism in-place at CHH, persons classified with the carrier names "Self-Pay No Ins (TRUE)" and "Unfunded" were true "Self-Pay" persons, while persons classified with the carrier name "Self-Pay" reflected individuals with unknown payer information.

We present admissions by payer in Table 4 below.

Table 4: Cedar Hills Hospital Patient Admits by Payer, Age 18+, January 2018 to June 2019

Carrier Type	Admits
Total Admits, Jan 2018 to June 2019	**3,967**
Medicare	1,600
Medicaid/CCO	655
Commercial	1,486
Other Gov./Special Payer	177
Self-Pay	47
Payer Unknown	2

Source: Cedar Hills Hospital Requests by Patient Characteristics

Notes: Table includes requests for inpatient psychiatric care, inpatient detox care, and inpatient rehab care for programs open to civilians. The Total row corresponds to figures presented in Table 2. Medicaid and CCO payers are equivalent, where CCO represents Medicaid payers for Oregon residents. As such these categories are grouped together under "Medicaid/CCO." "Other Gov./Special Payer" payers include State and County payers, as well as Tricare and Veteran's Affairs.

Using the revised data, which reflects updates to payer information for admitted persons, only a very small proportion, 1.2% of patients, admitted to Cedar Hills Hospital were true Self-Pay patients. Admitted persons labeled as Self-Pay in our November 15 response tended to rather be covered under Medicare, Medicaid, Commercial, or Other Government/Special payers, but did not report their carrier at the time of request.

Although payer information for deflected persons is mostly lacking, it is present for a minority of non-admitted persons. The reasons for this include requestors volunteering payer information at the time of request or requestors who were previously patients of Cedar Hills and existed in the patient database. We present payer information, where it exists, for deflected persons in Table 5 below.

Table 5: Cedar Hills Hospital Patient Deflections by Payer, Age 18+, January 2018 to June 2019

Information Status	Deflections
Total Deflections, Jan 2018 to June 2019	**7,609**
Payer Information Unknown	**4,984**
Payer Information Reported	**2,625**
Medicare	755
Medicaid/CCO	532
Commercial	1,187
Other gov./Special Payer	104
Self-Pay	47

Source: Cedar Hills Hospital Requests by Patient Characteristics

Notes: Table includes requests for inpatient psychiatric care, inpatient detox care, and inpatient rehab care for programs open to civilians by persons age 18 and over. The Total row corresponds to figures presented in Table 2. Medicaid and CCO payers are equivalent, where CCO represents Medicaid payers for Oregon residents. As such these categories are grouped together under "Medicaid/CCO." "Other Gov./Special Payer" payers include State and County payers, as well as Tricare and Veteran's Affairs.

As we present in Table 5, for persons age 18 and over, payer information is present in about 35% of deflected cases (2,625 requests) and absent in about 66% (4,984 requests). Of those deflected persons for which payer information was provided, about 49% were reported as covered under Medicare or Medicaid, about 45% under commercial insurance, about 4% under Other Government/Special Payers, and about 1.8% were true Self-Pay persons.

Please consider Table 4 and Table 5 as the corrected revision to Table 4 of the November 15, 2019 response.

From Table 4 and Table 5, between January 2018 and June 2019 only two admissions had unknown payer information, while payer information was unknown for 4,984 persons age 18 and over who were deflected. Furthermore, comparison of Table 4 above with payer information known at the time of request suggests that persons with commercial insurance were more likely to volunteer payer information.[2]

Because known payer information differs between admitted and deflected persons, their payer distributions are not comparable, and it is not possible to know the number of requests by payer. It is thus also not possible to construct valid "rates of deflection" across the different payer groups.

a. Additionally, the above referenced Table 4 combines Medicare, Medicaid, and CCO patients into one category. Please provide the number of patients in each of these categories.

Please see Table 4 and Table 5 above for admissions and deflections for persons listed as insured under Medicare and Medicaid. Between January 2018 and June 2019 about 40% of admissions were for persons covered under Medicare, and about 16% for persons under Medicaid programs. Since CCO reflects Oregon State Medicaid programs, separating these categories reflects a patient origin distinction rather than a payer distinction.

[2] Of the 3,967 persons admitted to Cedar Hills Hospital between January 2018 and June 2019, 1,934 had payer information recorded at the time of request. Of these 1,934 persons with payer information recorded at the time of request, 963 (about 50%) were listed as being under a commercial insurer. Updating payer information for these admitted persons results in a drop in this proportion to about 34% (see Table 4). This suggests that persons insured under Medicare and Medicaid were less likely to have payer information recorded at the time of request.

4. **According to a 2016 report titled "ED Boarding of Psychiatric Patients in Oregon", a substantial number of patients who are boarded in emergency departments due to unmet behavior health needs are Medicaid or Medicaid-eligible. Please explain how the proposed facility will meet the needs of these patients, especially in light of the "deflections" seen at your currently licensed hospital Cedar Hills.**

   The 2016 report, titled "ED Boarding of Psychiatric Patients in Oregon: A Report to Oregon Health Authority," identified a series of potential causes of psychiatric ED boarding in Oregon. These included a "lack of outpatient treatment capacity, which increases the probability of psychiatric ED visits; lack of crisis response or other alternative treatment options to ED utilization; barriers to discharge from the ED directly to community destinations; and limited availability of inpatient or sub-acute care resources for patients with the most severe psychiatric emergencies" (Yoon et al. 2016, pg. 9). [3]

   Yoon et al. (2016) raise the possibility that Medicaid coverage has been a contributing factor to ED boarding, writing on page 19 that the "Medicaid IMD exclusion provided an incentive to shift the cost of care for mental illness to other care modalities and facilities, where Medicaid matching funding was available, and indirectly contributed to the decrease in the number of publicly funded inpatient psychiatric beds available for emergency services. As a consequence, the Medicaid IMD exclusion may be a contributing factor to psychiatric boarding." However, in a test of this hypothesis, Yoon et al. (2016) find that "Medicaid enrollment status did not affect the probability of ED boarding" (Yoon et al. 2016, pg. 63). ED Boarding is thus a problem that afflicts both Medicaid and non-Medicaid enrollees alike, and research undertaken by Yoon et al. (2016) finds no evidence that persons covered by Medicaid are more likely to be boarded. Furthermore, in a national-level study, Nolan et al. (2015) find that the likelihood of boarding was slightly lower among the uninsured population, and that it did not vary by insurance type, community poverty, or income levels.

   In light of this research, while Medicaid patients absolutely face challenges accessing inpatient psychiatric care, it must be recognized that ED boarding is a system-wide problem that affects individuals across demographic groups, and Medicaid and Medicaid-eligible patients are no more likely to face the problem of ED boarding than other persons with mental health needs.

   As identified by Yoon et al. (2016) and others, there are multiple potential causes to ED boarding, of which one is a limited availability of inpatient psychiatric care. However, although other factors exist, it is undeniable that a limited availability of inpatient psychiatric beds exists within Oregon generally, and the Clackamas-Multnomah-Washington county area in particular. Cedar Hills Hospital admits patients based on medical necessity and its admission criteria, not based on payer type. However, as

[3] Yoon, Jangho, Jeff Luck, Megan Cahn, Lihn Bui, and Diana Govier. "ED Boarding of Psychiatric Patients in Oregon: A Report to Oregon Health Authority." College of Public Health and Human Sciences, Oregon State University. http://www.mentalhealthportland.org/wp-content/uploads/2018/11/OHA-Psychiatric-ED-Boarding-Full-Report-Final.pdf, Accessed February 27, 2020

evidenced by the Cedar Hills Hospital occupancy statistics presented in our July 2019 application, Cedar Hills Hospital is at capacity.

Addition of further inpatient psychiatric bed capacity within the Clackamas-Multnomah-Washington county area will improve access for all Medicaid and non-Medicaid persons needing inpatient psychiatric care and contribute to reductions in ED boarding. Within their 2016 ED Boarding Report, Yoon et al. (2016) find that "a greater supply of psychiatric inpatient and intensive community mental health resources was significantly associated with a reduction in the probability of psychiatric ED visit" (Yoon et al. 2016, pg. 67). Specifically, they find that an increase of 1% of the inpatient mental health system capacity, as measured by the proportion of psychiatric inpatients to persons with severe mental illness (SMI), is associated with a 1.3 percentage-point lower probability of psychiatric ED visit. Correspondingly, this leads to a 1.3 percentage-point lower probability of a person being board in an ED.

This predicted impact from inpatient psychiatric capacity increases can be used to estimate the impact of our proposed project on ED boarding for residents of the Clackamas-Multnomah-Washington county planning area. Based on data from the NSDUH, over the period 2014 to 2016 approximately 5.56% of Multnomah residents and 4.46% of Clackamas and Washington residents over the age of 18 suffered from SMI.[4] These ratios correspond to about 67,861 persons with SMI within the Clackamas-Multnomah-Washington Tri-County area.[5] Given a total number of available patient days within this Tri-County area of 92,068[6] and an increase of the number of available patient days of 29,200 at the proposed Willamette Valley Hospital,[7] our proposed project will increase the service area capacity of inpatient psychiatric care by about 31.7%.

Given a 1% increase in inpatient psychiatric capacity is associated with a 1.3% decline in the probability of an ED visit, and thus a 1.3% decline in the probability of ED boarding, the proposed project is thus predicted to reduce ED boarding by over 40%. The precision of these estimates only holds for relatively small changes in inpatient psychiatric capacity, so caution must be applied in their application to a change as large as 31.7%. However, based on the methodology of Yoon et al. (2016), the proposed project is predicted to have a large and positive impact on reducing area ED boarding rates for all Medicaid and non-Medicaid service area residents.

5. Table 5 in the November 15 response letter refers to the "increase in patient deflections at Cedar Hills attributable to a lack of appropriate beds." Please

[4] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014, 2015, and 2016. Substate Estimates, Table 11. https://www.samhsa.gov/data/report/2014-2016-nsduh-substate-region-estimates-excel-tables-and-csv-files. Accessed March 3, 2020.
[5] This number based on 2014-2016 average population counts of 309,500, 625,502, and 432,134 for Clackamas, Multnomah, and Washington counties, respectively. Multiplying SMI prevalence by these population counts results in about 13,808, 37,778, and 19,275 persons with SMI in Clackamas, Multnomah, and Washington counties, respectively.
[6] In 2016, Clackamas-Multnomah-Washington providers of inpatient psychiatric care provided 92,068 days of care. This includes the 29,352 patient days at Cedar Hills Hospital.
[7] The number 29,200 based on a 100-bed hospital operating at 80% capacity (ADC equal to 80).

provide a definition of "appropriate bed" and explain how the lack of an "appropriate bed" has an effect on the number deflections.

The Table 5 referenced by OHA includes a number of reasons for a deflection, but the most frequently listed reason in that table is "no appropriate bed;" about 26% of the 5,912 deflections listed in that table. When Cedar Hills Hospital is unable to provide an "appropriate bed," it is based on a number of variables. It could simply be there are no available beds, given Cedar Hills Hospital's high occupancy figures. But additionally, the "no appropriate bed" determination includes an assessment of the requestor's age (CHH serves persons 18 + years only), gender, the specific program needed and medical diagnosis, e.g., we have only 5 beds equipped for patients needing CPAP. A request may be for a specific program, from a specific patient age group, from a specific patient gender, or from a patient with a particular acuity, such as aggression.[8] Bed availability and requests must be matched across these variables. Thus, "no appropriate bed" can include more than simply "no bed;" it can also mean the request is not compatible with beds that are available at CHH. The "no appropriate bed" designation, thus, includes a number of reasons for any deflection.

In general, the high occupancy rates at Cedar Hills Hospital, which we documented in Table 30 and 38 of our original application and discussed in our September and November screening responses, have resulted in too few available inpatient beds for persons needing inpatient psychiatric care. Furthermore, as we documented on pages 71-72 of original application and pages 9-10 of our September Screening Response, there has been no movement by any provider within the Clackamas, Multnomah, and Washington Tri-County Area to add adult inpatient psychiatric capacity aside from Cedar Hills Hospital. This situation has placed tremendous pressure on Cedar Hills to meet the service area's inpatient psychiatric demand.

Given that Cedar Hills groups its inpatient beds into gender-specific, age group-specific, special care needs, and program-specific "clusters," as Cedar Hills becomes more capacity constrained, the consequent outcome, over time, will be an increasing number of patients deflected due to the fact there is no appropriate bed, where "appropriate" is determined based on that person's age, gender, requested program, special needs, or medical diagnosis.[9]

As we stated in our November 15 response, "the primary reason for the increase in deflections at Cedar Hills is a lack of appropriate bed." From Table 5 of our November 15 response, persons deflected due to lack of an appropriate bed constituted about 26% of all deflections between January 2018 and July 2019. Updating for the inclusion of inpatient rehab and detox and the exclusion of military patients, presented in Table 6 below, this proportion is now about 21%. As noted in our November 15 response, the increase in deflections between January 2018 and July 2019 was almost entirely driven by the capacity constraints reflected in "no appropriate bed" deflections.

[8] As noted above, we also manage the acuity of the patient census. We have a limited number of CPAP equipped beds, for example, and CHH can only take so many aggressive patients before it becomes unsafe for patients and staff.

[9] "Special needs" clusters include those based on the acuity or specific program required.

Table 6: Cedar Hills Hospital Patient Deflections, by Deflection Reason for Persons Aged 18+, January 2018 to June 2019

Reason not admitted, patient requests for persons aged 18+, Includes Rehab and Detox, No military specific programs	Jan. to June 2018	July to Dec. 2018	Jan. to June 2019	Total
Information Only	123	188	246	557
Not Clinically Qualified, All	167	416	453	1,036
Not Clinically Qualified - Behavior Issues	2	5	66	73
Not Clinically Qualified - Lacks Acuity	72	205	155	432
Not Clinically Qualified - Medical Issues	51	124	144	319
Not Clinically Qualified - Program Not Offered	7	27	60	94
Not Clinically Qualified - Other	35	55	28	118
No appropriate bed	29	442	1,136	1,607
No or insufficient MD coverage	0	0	1	1
No show patient	255	195	254	704
No or insufficient staff	0	0	67	67
Refused Action, All	1,635	1,243	759	3,637
Refused Action - Wants to go elsewhere	101	222	124	447
Refused Action - By Family	5	8	6	19
Refused Action - Financial	34	44	18	96
Refused Action - Other	1,358	846	479	2,683
Refused Action - By Patient	137	123	132	392
Total	**2,209**	**2,484**	**2,916**	**7,609**

Source: Cedar Hills Hospital Calls by Patient Characteristics

Notes: Table includes requests for inpatient psychiatric care, inpatient detox care, and inpatient rehab care for programs open to civilians for persons age 18 and over. The Total row corresponds to figures presented in Table 2.

6. **Table 6 in the November 15 response letter shows that over 4,700 patients who presented at Cedar Hills Hospital were returned to their referral source. Please explain why these patients were not admitted. Are "deflections" defined the same as "returned to referral source"?**

Please see Table 7 for patient intake dispositions reflecting the revised set of service codes.

Table 7: Cedar Hills Hospital Patient Intake Dispositions for Non-Admitted Persons Aged 18+, January 2018 to June 2019

Intake Disposition, patient requests for persons aged 18+, Includes Rehab and Detox, No military programs	Jan. to June 2018	July to Dec. 2018	Jan. to June 2019	Total
Total, Non-Admitted	**2,209**	**2,484**	**2,916**	**7,609**
Non-Clinical Referral - No Clinical Care Recommend	21	45	78	144
Referred To Chemical Dependency Treatment	8	47	9	64
Referred To Inpatient Non-UHS Facility	35	145	115	295
Referred To Managed Care Organization	1	0	1	2
Referred For Medical Clearance / Treatment	5	23	17	45

Referred To Outpatient Non-UHS Facility	51	47	40	138
Referred To Outpatient UHS Facility	21	48	56	125
Referred To Support Group	1	7	0	8
Referred To Inpatient UHS Facility	4	5	7	16
Patient Refused Action - No Referral	393	451	624	1,468
Returned To Referral Source	1,669	1,666	1,969	5,304

Source: Cedar Hills Hospital Calls by Patient Characteristics

Notes: Table includes requests for inpatient psychiatric care, inpatient detox care, and inpatient rehab care for programs open to civilians for persons age 18 and over. The Total row corresponds to figures presented in Table 2.

As in our November 15 response, a large proportion of individuals who were not admitted were classified at being "returned to referral source." Deflections are not defined the same as "returned to referral source, and these individuals were not admitted for one of the reasons listed in Table 6 above.

Given a person is not admitted to Cedar Hills Hospital (deflected), one outcome for these persons is to be returned to their referral source. Returned to referral source means that Cedar Hills admissions staff were asked by a hospital ER staff person, a governmental staff person, a community provider, or another similar referral source, but could not accommodate the request. Between January 2018 and June 2019, of the 7,609 individuals identified as "deflected" in Table 6, 5,304 were "returned to referral source" (Table 7). Other outcomes for deflected persons include a recommendation of no clinical care, referred to selected inpatient or outpatient facilities, referred to other organizations, or no referral as a result of the patient refusing action of the caller seeking information only.

7. Table 37 on page 94 of the application shows that a majority of patients at Cedar Hills Hospital originate from outside the Portland tri-county area; with a substantial number of these patients coming from outside the state (55.8%). Please provide a detailed explanation on how the proposed facility plans to address the "mental health crisis" in the Portland area given that over half of the patients being treated at Cedar Hills are coming from outside Oregon and given Cedar Hills' deflection rate.

Table 37 on page 94 of our application shows that for Cedar Hills Hospital in 2019, 44.2% of patients were residents of the Portland Tri-County Area (Clackamas, Multnomah, and Washington Counties), 34.7% were residents of one of the other 36 Oregon counties, and 21.2% in-migrated from outside Oregon State.

As we wrote in our September 2019 response to a similar question:

> *"These out-of-area Oregon residents, which in 2019 have accounted for over a third of Cedar Hills Hospital's patients, have served to both displace out-of-state patients and constrain the utilization of residents of Clackamas, Multnomah, and Washington counties. This is evidence of undersupply and shortages across other Oregon counties, and illustrates the need for additional mental health facilities across the state, not just in Clackamas, Multnomah, and Washington counties. We applaud the OHA's recent decision to award a Certificate of Need*

for Aspen Springs Hospital in Umatilla County, and hope for future expansions in inpatient psychiatric capacity throughout the state. Until that happens, the proposed WVBH is well situated on the I-5 corridor south of Portland to serve Oregon residents in those counties to the south."

September 16 Response to Screening Question #23

We note that 22 of the 98 beds currently available at Cedar Hills are dedicated to first responders and our service men and women, both active duty and veterans who need a specific cultural approach to their mental health and substance use issues that often have resulted or been exacerbated from their service to our country. As a resource to all parts of the DoD, Wounded Warrior, and VA, we offer specialized care treating combat-related PTSD and PTSD related to sexual assaults while in service, mood disorders, substance use issues and other behavioral health needs and are proud to be one of 12 Centers of Excellence in the nation. Cedar Hills Hospital treats active duty, veterans, and first responders residing within the Portland area as well as elsewhere. The presence of these programs thus accounts for a portion of the out-of-state residents cared for at Cedar Hills, but Oregon Veterans, active duty personnel and Oregon National Guard also represent groups served at Cedar Hills.

As we have stated above, in our application, in our September 2019 Screening Response, and in our November 2019 supplementary response, ***the high deflection rate at Cedar Hills Hospital results from capacity constraints at Cedar Hills Hospital.*** There is no silver bullet to solving the mental health crisis in the Portland Tri-County area specifically, and Oregon State more generally. However, increasing the Clackamas-Multnomah-Washington County planning area capacity of inpatient psychiatric beds will relieve some of the pressure currently being placed on Cedar Hills, increase access to inpatient psychiatric care to planning area residents, and help reduce ED boarding as detailed above.

8. What conditions, if any, would the applicant be willing to accept, to ensure that this new facility takes its share of Medicaid eligible patients?

It is unclear what is meant by "its share" in the phrase "…this new facility takes its share of Medicaid eligible patients." We are unaware of any similar conditions placed upon prior certificate of need applicants.

CHH cares for Medicaid-covered patients ("Oregon Health Plan or "OHP") as we are blind to payer source in the intake process. We have contracts with just two coordinated care organizations ("CCOs"), Trillium and YVCCO (Yamhill Valley Coordinated Care Organization). When a patient from another CCO is admitted and treated, payment is denied as we are out of network. Occasionally, a single case agreement can be negotiated. After seeking contracts repeatedly from each CCO over the past five years, we are being told that their networks are adequate as the chief reason for rejection. We would be very happy to contract with any CCO and provide the same high-quality care, as presently. Aftercare from Cedar Hills Hospital suffers for OHP patients as a result of our lack of CCO contracts, given we do not have ready access to other CCO referral structures, and they cannot access Cedar Hills outpatient services and our full continuum of care.

As is the case at Cedar Hills Hospital, the admission policy for the proposed hospital will be determined by EMTALA and medical necessity subject to the admission criteria provided in Exhibit 14 of our September 2019 Screening Response.

Also provided in our September 2019 Screening Response was a payer mix table for the UHS Fairfax Behavioral Health facilities in Washington State, documenting the potential payer mix when Medicaid organizations are willing to contract with UHS facilities. In Table 8 below, we present this information for 2018 patient days for UHS hospitals in Washington State. Table 8 demonstrates that UHS provides a significant amount of care to Medicaid insureds at its facilities when it can contract with Medicaid Programs.

Table 8: Total 2018 Patient Days by Payer for UHS Fairfax Behavioral Health Hospitals in Washington State

Patient Days by Payer	Medicare	Medicaid	Commercial	All Other
Fairfax, all	**10,395**	**35,618**	**11,294**	**11,300**
Fairfax Behavioral Health Everett	5,904	26,838	7,514	9,329
Fairfax Behavioral Health Kirkland	1,598	5,889	1,304	1,073
Fairfax Behavioral Health Monroe	2,893	2,891	2,476	898

Percent Patient Days by Payer	Medicare	Medicaid	Commercial	All Other
Fairfax, all	**15.2%**	**51.9%**	**16.5%**	**16.5%**
Fairfax Behavioral Health Everett	11.9%	54.1%	15.2%	18.8%
Fairfax Behavioral Health Kirkland	16.2%	59.7%	13.2%	10.9%
Fairfax Behavioral Health Monroe	31.6%	31.6%	27.0%	9.8%

Source: WA DOH Payer Census & Patient Day Comparison From 01/01/2018 To 12/31/2018, Washington State CHARS 2018

9. The applicant has stated that the proposed facility would be managed separately from the Cedar Hills Hospital facility.

a. Does this mean that the proposed facility will not be managed in the same manner as Cedar Hills? If so, please provide a detailed explanation of how the proposed facility will be managed differently than Cedar Hills Hospital.

Universal Health Services Behavioral Health Division Oversight

Both Cedar Hills Hospital and the proposed Wilsonville facility are part of Universal Health Services, Inc. (UHS), which has a large, robust Behavioral Health Division. This Division provides management oversight and audit in the areas of patient care and quality; risk management; legal; human resources; risk management and regulatory compliance; community relations; nursing; and finance. This oversight, audit, and corporate-level support provides critical tools, services, and programs to facilitate efficiency, and most importantly, monitor and improve quality and patient satisfaction. UHS-provided oversight and support are also a critical regulatory compliance resource.

When a facility becomes part of UHS, the benefits from a clinical and quality perspective come in several areas including the ability to compare its performance across a number

of key indicators. These indicators include the use of restraint and seclusion, patient and staff injury, medication errors, and falls. Benchmarks are established across the Division to assist with performance improvement. On an annual basis, these benchmarks are adjusted to continue to improve performance at the facility level. The Behavioral Health Division also monitors regulatory activity and provides ongoing guidance to assure compliance with The Joint Commission accreditation standards, state rules and regulations, and Centers for Medicare and Medicaid Services (CMS) conditions of participation. Maintaining a current understanding of the ever-changing regulatory environment is a key component to exceeding compliance. Each facility benefits from the regulatory experience of more than 177 like facilities as these efforts are coordinated across the Division. This includes assigning a Corporate Clinical Director to every facility. Corporate Clinical Directors are responsible for assisting each facility in developing its overall performance improvement programs, preparing for surveys as well as assisting in corrective action plans to address specific areas of concern.

In 2019, 171 UHS Behavioral Health facilities with 866 distinct programs, captured clinical outcomes measures for approximately 267,263 patients. 91% of children, 88% of adolescents and 81% of adult inpatients experienced meaningful improvement in 2019. UHS has a voluntary opportunity for patients and families to share with our facilities how they are doing 45 days after discharge. From 4,175 follow-up surveys, 82% of respondents had continued meaningful improvement after discharge, 88% of patients reported no suicidal thoughts or attempts, and 89% reported no re-hospitalization.

On a regular basis, there are opportunities for facility-based clinical leadership to network and share best practices with other individuals in the UHS Behavioral Health Division. New program development, staff training and performance improvement are among the initiatives shared throughout the Division to assure that each patient, regardless of location, receives the quality services they need and deserve. We are pleased that patients experience our on-going commitment to providing care in a way that emphasizes high quality, patient safety and a strong sense of service excellence.

Day-to-Day Operations

In terms of day-to-day management, Cedar Hills Hospital and the proposed Wilsonville hospital will be separate and distinct from each other. Each will have (1) its own clinical staff and leadership, (2) executive and management leadership; (3) operating staff; and (4) its own governance, including separate Boards of Directors. There may be shared service agreements and there may also be shared staff training and education, for example. But the two hospitals will not be run as a single entity. However, as stated above, UHS provides integrated management oversight, audit, and organizational resources through its Behavioral Health Division. This integration and oversight would extend to the proposed Wilsonville hospital, just as presently with Cedar Hills Hospital.

b. Please provide specific information on the management practices that will be used to ensure compliance with all state and federal regulations at the proposed hospital, in light of recent compliance issues at Cedar Hills Hospital.

As stated above, Universal Health Services takes its commitment to high quality patient care very seriously, and as such, has a robust audit and compliance program across all

of its facilities. Within its Behavioral Health Division, there is continuous monitoring, oversight and guidance regarding compliance to state and federal regulations across all its facilities. These same services and programs will be utilized at the proposed hospital.

As we stated in our September 15, 2019 letter, in response to question #25, in the interest of full transparency, we detailed a small number of compliance issues at CHH over the past years. Importantly, as we stated in that letter, they have been successfully resolved, and CHH is no longer being monitored by CMS. Below, we repeat the summary information regarding the two events in 2018-2019 we reported in our September 15, 2019 letter.

> In the interest of transparency, there were two issues in 2018 / 2019 that triggered multiple site surveys, an Elopement / Suicide incident in October 2018 and an EMTALA complaint in February of 2019.
>
> 2018-2019
>
> - OHA and CMS surveyed us for the Elopement / Suicide incident. Surveys continued until July of 2019. CHH staff submitted Plans of Correction (POC), which were accepted and approved by both OHA and CMS. We have been cleared by OHA and are no longer being monitored. Although we are no longer being monitored by CMS, we are still in the process of self-auditing and monitoring our compliance with our POCs that were submitted.
> - CMS received an anonymous complaint about not following EMTALA regulations (alleged we were taking funded patients as transfer requests over unfunded patients). Although the allegation could not be substantiated, the surveyors did find noncompliance with several requirements under EMTALA. We submitted our Plan of Correction; it was accepted and approved. We are no longer being monitored by CMS but are still in the process of self-auditing to ensure our on-going compliance.[10]

We certainly do not anticipate any such recurrences or any such events at the proposed Wilsonville facility. However, in the unlikely event such events do occur, they will be fully disclosed to appropriate authorities as quickly as possible, and UHS will aggressively work to address them, in full cooperation with all agencies involved, as was done at CHH.

10. To date, OHA has evidence of a health care worker shortage related to behavior health providers. Page 35 of the application simply states that the proposed hospital will use a mixed employment model. Additionally, Table 5 in the November 15 response letter shows deflections increasing due to "no or insufficient staff." Please provide specific information regarding the actions that have been taken or that will be taken to ensure qualified staff are available to support the proposed facility.

Between January 2019 and June 2019, Cedar Hills Hospital received a total of 4,253 requests for its inpatient psychiatric, detox, and rehab care programs. Cedar Hills admitted 1,171 of these requests. As seen in Table 1, CHH was unable to accommodate 3,082 requests for the reasons listed in Table 6. For 67 of these requests, or 2.3% of deflected requests for persons aged 18 and over (1.6% of total requests), Cedar Hills

[10] Letter from Mr. Escarda to Mr. Gilman, September 15, 2019, p. 15.

listed the deflection reason as “no or insufficient staff.” Thus, the statement that “Table 5 in the November 15 response letter shows deflections increasing due to "no or insufficient staff," while technically correct, devotes an inordinate amount of attention on a factor that, at most, marginally affected deflections over a short period of time.

Furthermore, in the first half of 2019, Cedar Hills Hospital added four beds to its previously 94-bed hospital. Once construction was completed and the beds were added, staff were recruited and hired to handle the additional patients associated with the increased bed capacity. During the recruitment and hiring process of this additional staff, these additional beds were unable to be used as a result of “no or insufficient staff.” Prior to the addition of these beds, the deflection reason would have been classified as “no appropriate bed,” however the deflection reason was shifted while additional staff were added to Cedar Hills. Thus, these 67 requests identified above reflect the bed shortage at Cedar Hills more than any staffing shortage.

That said, medical and technical staffing in an acute psychiatric hospital is difficult in any market. In that regard, we are no different than other local/regional providers. As OHA correctly pointed out, we stated that UHS (or Cedar Hills Hospital) uses a “mixed employment” model. What that means is there are a number of approaches we take. They include, for example:

- At Cedar Hills Hospital, we offer competitive wages, benefits package, and other benefits, such as tuition reimbursement. We know from experience this is absolutely necessary to successfully recruit/retain the needed number and quality of staff.
- The recruitment program at Cedar Hills Hospital includes “growing our own” nursing staff through an incumbent worker program and internships with all area nursing and counseling programs.
- Cedar Hills Hospital recruits using local resources such as advertisements in Oregon’s Nursing News, the Sentinal and Oregon Health Forum.
- Universal Health Services Human Resources Department assists CHH by providing national recruiting personnel to locate/recruit both nursing staff and physicians. This recruitment occurs regionally, nationally and even internationally, as required.
- Cedar Hills Hospital offers sign-on bonuses at all levels and referral bonuses to staff for successful referrals.
- Cedar Hills works with local nursing and clinical schools to assist with training our future healthcare workforce
- UHS encourages transfers within the organization and more than 90,000 UHS employees would be eligible to transfer to the new hospital.

CHH has relationships with several area institutions for higher learning, offering internships and residency placements. These relationships are strongest with Lewis and Clark College, Portland State University, Concordia University, University of Portland, and George Fox University. These relationships will expand as we grow.