

OBER KALER
Attorneys at Law

February 14, 2014

Ober, Kaler, Grimes & Shriver
A Professional Corporation

100 Light Street
Baltimore, MD 21202
410.685.1120 Main
410.547.0699 Fax
www.ober.com

Howard L. Sollins
hlsollins@ober.com
410.347.7369 / Fax: 443.263.7569

Via Hand Delivery and Email

Rebecca Goldman, Health Policy Analyst
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Offices In
Maryland
Washington, D.C.
Virginia

Re: Washington Adventist Hospital, Inc.
Matter No.: 13-15-2349

Response to Additional Completeness Questions

Dear Ms. Goldman:

On behalf of Washington Adventist Hospital, Inc. (WAH), we are hereby submitting the required ten (10) copies of our response to the additional Completeness Questions in your December 10, 2013 letter regarding the above-referenced project. We will also provide an electronic copy of our response and exhibits.

I hereby certify that a copy of this response has also been forwarded to the appropriate local health planning agency, as noted below.

Sincerely,



Howard L. Sollins

HLS:tjr

Enclosures

cc: Kevin McDonald, Chief
Paul Parker, Director
Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
Joel Riklin, Program Manager
Certificate of Need Division
Maryland Health Care Commission
Suellen Wideman, Assistant Attorney General
Maryland Health Care Commission
Ms. Ruby Potter, Health Facilities Coordination Office
Donna Kinzer, Executive Director
Health Services Cost Review Commission

Rebecca Goldman, Health Policy Analyst
Maryland Health Care Commission
February 14, 2014
Page 2

O B E R K A L E R

cc: Ulder Tillman MD, MPH, Health Officer
Montgomery County
William G. Robertson, President & Chief Executive Officer
Adventist HealthCare
Robert E. Jepson, Vice President
Adventist HealthCare
Joyce Newmyer, President
Washington Adventist Hospital

PART I – PROJECT IDENTIFICATION AND GENERAL INFORMATION

- 1. Staff previously requested the applicant to specify the outpatient and clinic services that will be provided at the White Oak campus. WAH responded to this request. Please also specify the outpatient and clinic services that will be provided at the Takoma Park campus after completion of the project and whether these services will be rate regulated.**

APPLICANT RESPONSE:

The following are outpatient services currently planned for the Takoma Park campus after the opening of the new facility on the White Oak campus:

- Outpatient behavioral health services
- Federally Qualified Health Center
- Women’s Center (providing prenatal care, postpartum and related gynecological services)
- Physician offices
- Walk-in primary care services
- Diagnostics (lab, imaging, etc.) in support of the Takoma Park campus services

The Women’s Center, behavioral health services and the Federally Qualified Health Center are already operational. Other outpatient services or clinics such as wound care, may be considered. We do not plan for any outpatient services to be rate regulated, with the possible exception of outpatient behavioral health as part of Adventist Behavioral Health.

- 2. Regarding the response to question 6, please provide additional information about the freestanding comprehensive cancer center planned in a nearby facility for oncology and patients, which is referenced at Exhibit 68.**

- a. What is the planned location and timeframe for the freestanding comprehensive cancer center?**

APPLICANT RESPONSE:

Adventist HealthCare plans to open a freestanding, non-rate regulated cancer center in the White Oak section of Montgomery County later this year at a site close to, but not located on, the new hospital campus. Elements will include physician offices; clinic services; and the Women’s Imaging and Breast Center. Either before or at the same time the new hospital opens in White Oak, these services will move to the new hospital campus as part of the development of a larger, comprehensive cancer center.

- b. Will this center be a program of Washington Adventist Hospital?**

APPLICANT RESPONSE:

Some services of the cancer center will be programmatic elements of Washington Adventist Hospital which may or may not be considered 'at the hospital.' Other services will include space sub-leased to other parties.

- c. Will this center be rate-regulated?**

APPLICANT RESPONSE:

Adventist HealthCare is currently evaluating whether or not some services of the cancer center will be rate regulated.. A final determination has not yet been made, and much of this decision is based upon discussions with the HSCRC about the global budget agreement for Washington Adventist Hospital.

- d. What is the rationale for not including outpatient cancer services in the replacement hospital program as part of the Certificate of Need application?**

APPLICANT RESPONSE:

This was not included in the CON application because a final determination has not yet been made whether the cancer center will be a freestanding, non-rate regulated outpatient service or rate regulated as a part of Washington Adventist Hospital. This decision is pending the final global budget discussions with the HSCRC. Once rate negotiations with the HSCRC are complete, an analysis will be done to determine whether the cancer center will have rate regulated services or be completely non-rate regulated.

- e. Was an analysis done comparing the cost-effectiveness of operating a free-standing, comprehensive cancer center to one that would be part of the relocation project? If so, please provide it.**

APPLICANT RESPONSE:

An analysis will be developed once all aspects of the global budget rate negotiations for Washington Adventist Hospital are complete.

- f. Will the hospital's charity care policy apply to this center? If not, please describe the availability of charity care at this center.**

APPLICANT RESPONSE:

The hospital's charity care policy will apply if the center is a rate regulated part of Washington Adventist Hospital. If the center is non-rate regulated, a charity care policy consistent with the organization's mission and values will be developed to ensure appropriate access to care for patients in need of financial assistance.

g. How will patients be impacted by separating the location from the main hospital?

APPLICANT RESPONSE:

Patients will benefit significantly from development of this comprehensive cancer center. More than 80% of all cancer care is delivered in the outpatient setting¹, and a freestanding, comprehensive, community-based cancer center allows patients to have easy access to sites of care and individualized treatment plans that maximize convenience and enhance care coordination. The length of time from initial diagnosis to treatment is decreased when a patient is able to have tests completed, see their physician and undergo therapy all in one day in the same location.

PART II – PROJECT BUDGET

3. Regarding the response to question 12, please explain why the bond proceeds deposit at Exhibit 69 (\$51,980,476) does not match the bond financing amount in the project budget (\$278,010,000).

APPLICANT RESPONSE:

Exhibit 69 relates to the Capitalized Interest Fund, which is money set aside to pay for the interest payments during the construction period. The \$278,010,000 represents bond proceeds, which covers a portion of the project cost, cost of issuance, capitalized interest and debt service reserve funds. The two amounts are not comparable and should not agree.

**PART III—CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR
10.24.01.08G(3)
Response to State Health Plan for Facilities and Services: Acute Hospital Services,
COMAR 10.24.10**

¹Kuznar W. Community oncology clinics under increasing financial pressure. Association for Value-Based Cancer. <http://www.valuebasedcancer.com/article/community-oncology-clinics-under-increasing-financial-pressure>.

- 4. Regarding COMAR 10.24.10.04A(1), Information Regarding Charges, Staff would like to stress the need to update the list of representative charges at least quarterly. The current posting is dated for a period ending June 30, 2013.**

APPLICANT RESPONSE:

Adventist HealthCare is committed to updating the representative charges timely with respect to COMAR 10.24.10.04A(1). The organization uses the quarterly discharge abstract data tapes as the source for this information, as it is consistent with HSCRC reporting and audited and reconciled annually. The final discharge abstract data tape is due to the HSCRC 90 days after the close of the quarter. This allows for the all of the coding to be complete in order to get accurate patient information. As such, there is a lag in each quarter. AHC's process is to update the representative list of charges on a quarterly basis for a rolling 12 months worth of data. Because the data is not complete immediately, there is approximately a one quarter lag in that data. At the time of the initial filing, the 12 months ending June 30 was the most recent period of final HSCRC discharge abstract data tapes. Since the initial filing, the quarter ending September 2013 data has been finalized and has been uploaded to the website.

- 5. Please send an electronic version of Exhibit 75 to rebecca.goldman@maryland.gov, if available, so that staff can more easily read this information. Alternatively, WAH may provide a more legible version.**

APPLICANT RESPONSE:

A large-scale copy is being sent as an attachment in this submission and will be resubmitted by email today.

- 6. Utilization projections presented in the response to Question 20a address growth rates. Please demonstrate what population-based use rates (discharges per 1,000 population) were assumed in the projections and how those compare to the use rates in the past five years.**

APPLICANT RESPONSE:

The growth rates identified in the response to question 20a represented population growth estimates by age and zip code². By applying population growth rates to historical discharges, we inherently held the base year, or CY2012, use rates by zip code and age cohort constant. We individually projected discharges by zip code and age cohort and summed the totals to determine the overall estimate included in the application.

For example, in Beltsville (zip code 20705), we noted the following use rates by age cohort for CY2012.

² Population growth rates from Nielsen Claritas database

Zip Code 20705 – Actual CY2012 Use Rates by Age Cohort

	Population	Discharges	Use Rate
15-44	11,533	256	22.2
45-64	6,922	522	75.4
65-74	1,583	225	142.1
75+	1,327	254	191.4
Total	21,365	1,257	58.8

We then considered population growth estimates by age cohort and applied the same use rate to determine total discharges within that zip code. We have provided an example for CY2013 and CY2014 below but the same methodology was considered throughout the projection period and for every zip code within the White Oak TSA.

Zip Code 20705 - CY2013 Projection Estimate

	% Growth Rate	Projected Population	Use Rate	Projected Discharges
15-44	-0.3%	11,501	22.2	255
45-64	1.3%	7,014	75.4	529
65-74	6.1%	1,680	142.1	239
75+	1.4%	1,345	191.4	257
Total	0.8%	21,540	59.4	1,280

Zip Code 20705 - CY2014 Projection Estimate

	% Growth Rate	Projected Population	Use Rate	Projected Discharges
15-44	-0.4%	11,458	22.2	254
45-64	0.9%	7,076	75.4	534
65-74	5.9%	1,779	142.1	253
75+	2.3%	1,376	191.4	263
Total	0.7%	21,689	60.1	1,304

As demonstrated above; the use rates by age cohort are consistent with CY2012 levels, but the overall use rate within each zip code has slightly increased due to growth in the older, higher-use populations. The following tables provide detail on population estimates, use rates, and discharges for the zip code 20705 for the entire projection period.

Zip Code 20705 – Population Estimates (CY2013 – CY2022)

	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	CY2019	CY2020	CY2021	CY2022
15-44	11,501	11,458	11,415	11,372	11,329	11,287	11,245	11,203	11,161	11,119
45-64	7,014	7,076	7,138	7,201	7,265	7,329	7,394	7,459	7,525	7,591
65-74	1,680	1,779	1,884	1,994	2,112	2,236	2,368	2,507	2,654	2,811
75+	1,345	1,376	1,408	1,441	1,475	1,509	1,544	1,580	1,617	1,654
Total	21,540	21,689	21,845	22,009	22,181	22,361	22,550	22,748	22,957	23,175
Growth	0.8%	0.7%	0.7%	0.7%	0.8%	0.8%	0.8%	0.9%	0.9%	1.0%

Zip Code 20705 – Use Rates (CY2013 – CY2022)

	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	CY2019	CY2020	CY2021	CY2022
15-44	22.2	22.2	22.2	22.2	22.2	22.2	22.2	22.2	22.2	22.2
45-64	75.4	75.4	75.4	75.4	75.4	75.4	75.4	75.4	75.4	75.4
65-74	142.1	142.1	142.1	142.1	142.1	142.1	142.1	142.1	142.1	142.1
75+	191.4	191.4	191.4	191.4	191.4	191.4	191.4	191.4	191.4	191.4
Total	59.4	60.1	60.8	61.6	62.3	63.1	63.8	64.6	65.4	66.3
Growth	1.0%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.3%	1.3%

Zip Code 20705 – Discharge Estimates (CY2013 – CY2022)

	CY2013	CY2014	CY2015	CY2016	CY2017	CY2018	CY2019	CY2020	CY2021	CY2022
15-44	255	254	253	252	251	251	250	249	248	247
45-64	529	534	538	543	548	553	558	562	567	572
65-74	239	253	268	283	300	318	336	356	377	399
75+	257	263	270	276	282	289	296	302	310	317
Total	1,280	1,304	1,329	1,355	1,382	1,410	1,439	1,470	1,502	1,535
Growth	1.9%	1.9%	1.9%	1.9%	2.0%	2.0%	2.1%	2.1%	2.2%	2.2%

The same process was performed for each zip code within the White Oak TSA and totaled to determine overall discharge projections used in the bed need analysis. The table below summarizes the CY2012 use rate by zip code that was applied in determining the overall projections.

CY2012 Use Rates within the White Oak TSA

Zip Code	15-44	45-64	65-74	75+	Total
20705 - Beltsville	22.2	75.4	142.1	191.4	58.8
20740 - College Park	12.3	74.9	148.0	345.2	46.4
20782 - Hyattsville	19.8	63.2	129.4	305.9	54.0
20783 - Hyattsville	26.6	84.9	152.9	336.3	60.9
20901 - Silver Spring	17.5	55.9	136.0	350.1	59.0
20903 - Silver Spring	28.8	66.8	174.7	432.0	66.6
20904 - Silver Spring	24.3	66.5	161.1	330.4	82.5
20906 - Silver Spring	24.0	66.2	145.9	318.8	91.5
20912 - Takoma Park	24.0	70.9	155.6	392.2	64.6
20011 - Washington	5.0	14.0	29.1	41.9	13.4
20012 - Washington	9.7	21.0	43.5	96.8	26.4
20017 - Washington	7.0	14.6	16.6	20.4	12.0
20706 - Lanham	33.3	91.1	183.7	391.5	83.8
20707 - Laurel	27.5	78.7	212.7	330.4	73.2
20708 - Laurel	33.2	90.9	195.8	362.6	72.6
20710 - Bladensburg	24.7	120.6	184.6	342.3	76.7
20712 - Mount Rainier	14.0	64.9	154.4	223.7	44.7
20715 - Bowie	28.9	71.8	171.1	389.7	90.1
20721 - Bowie	22.2	45.5	124.7	360.4	57.5
20735 - Clinton	29.6	84.5	222.5	492.3	96.3
20737 - Riverdale	33.2	96.2	174.9	316.5	67.5
20743 - Capitol Heights	37.8	111.6	180.7	324.8	92.5
20747 - District Heights	30.8	86.8	176.3	330.0	72.1
20748 - Temple Hills	24.7	79.3	132.5	276.7	69.6
20770 - Greenbelt	29.4	78.3	132.0	337.7	64.0
20772 - Upper Marlboro	23.0	65.4	167.0	366.2	63.9
20774 - Upper Marlboro	25.8	67.3	135.4	257.0	63.7
20781 - Hyattsville	23.9	74.0	133.1	337.7	56.7
20784 - Hyattsville	33.3	89.8	192.4	348.4	73.7
20785 - Hyattsville	46.9	107.8	196.9	373.5	91.9
20850 - Rockville	21.9	55.5	113.6	397.4	72.4
20853 - Rockville	20.0	56.7	119.1	306.2	69.2
20866 - Burtonsville	25.5	62.0	139.8	326.6	58.2
20874 - Germantown	26.7	62.5	171.4	394.9	55.2
20878 - Gaithersburg	19.1	46.8	116.2	350.5	49.9
20886 - Montgomery Village	27.1	66.8	141.1	318.9	61.4
20902 - Silver Spring	23.7	66.2	134.5	319.9	64.7
20905 - Silver Spring	22.3	48.2	125.0	339.1	64.7
20910 - Silver Spring	18.2	58.3	136.5	400.2	58.5
Total	24.4	67.0	142.6	304.3	65.0

* Use rates for Washington DC Zip Codes only reflect the utilization for patients who went to a hospital located in Maryland.

Use rates over the past five years have declined from 69.8 in CY2008 to 65.0 in CY2012. The table below demonstrates population based MSGA use rates for the past five years for adults (older than 15) within the White Oak TSA.

Historical Use Rates within White Oak TSA

	Population	Discharges	Use Rate	YoY Change
CY2008	1,018,421	71,135	69.8	N/A
CY2009	1,030,268	73,286	71.1	1.8%
CY2010	1,042,345	73,818	70.8	-0.4%
CY2011	1,051,950	71,358	67.8	-4.2%
CY2012	1,062,013	69,054	65.0	-4.1%

We discussed in the application that we believe the declining use rates were due to a number of factors, including:

- National shift from inpatient to outpatient services
- Increases in observation and one-day stays
- Loss of insurance coverage due to economic conditions
- Increased emphasis on reduction of readmissions

While we believe it is important to recognize historical trends, given the potential for changes due to the Affordable Care Act legislation and related healthcare reform, we did not only rely on historical trends for estimating future patient needs.

We maintained usage rates at 2012 levels recognizing a decrease in usage rates but also recognizing the Baby Boomer generation is now turning 65 at a rate of 10,000 each day.³ In 2010 this demographic represented 13% of the U.S. population, but is expected to grow to represent 18% of the U.S. population by 2030. In spite of greater access to health-care advancements than previous generations, Baby Boomers actually have more chronic health problems. With almost 40% of Baby Boomers diagnosed as obese, for example, obesity-related conditions such as hypertension, high cholesterol and heart disease are more common – which means a greater need for health-care services as this population ages.⁴

The table below provides a summary of the total projected population, use rates, and discharges within the White Oak TSA. As discussed, we held CY2012 use rates constant by zip code and age cohort. The slight differences between the calculated use rate by age cohort within the White Oak TSA, in total, are due to different population growth rates within each zip code. Within the overall White Oak TSA, the use rate for individuals aged 15 to 74 has declined with the only increase in the 75+ age cohort. The overall use rate for adults within the White Oak TSA has increased solely due to the aging population.

³ Pew Research Center. "Baby Boomers Retire." December 29, 2010.

⁴ King DE, Matheson E, Chirina S, et al. The status of Baby Boomers' health in the United States: The healthiest generation? JAMA Intern Med. 2013;173(5):385-386. doi:10.1001/jamainternmed.2013.2006

Age Cohort	CY2012			CY2022		
	Population	Use Rate	Discharges	Population	Use Rate	Discharges
15-44	562,476	24.4	13,702	547,793	24.1	13,224
45-64	348,524	67.0	23,336	388,839	66.4	25,826
65-74	86,182	142.6	12,287	148,252	142.1	21,073
75+	64,831	304.3	19,729	84,450	307.7	25,987
Total	1,062,013	65.0	69,054	1,169,333	73.6	86,110

Response to State Health Plan for Facilities and Services: Psychiatric Services, COMAR 10.24.07

7. Responding to COMAR 10.24.07 AP6, you have stated that, “The Washington Adventist Hospital Psychiatric Unit has a quality assurance program based upon Adventist Behavioral health’s performance improvement program.” Please clarify whether this program includes “separate written quality assurance programs, program evaluations, and treatment protocols” for the special populations listed that are served are the hospital (patients with a secondary diagnosis of substance abuse and geriatric patients) as specified in the standard. Also please provide a sample of the program’s quality assurance reports.

APPLICANT RESPONSE:

Treatment protocols for the geriatric patients and the substance abuse patients along with the quality assurance program and program evaluation formats, are included as ATTACHMENT 94.

Response to Other Criteria

8. Regarding the response to question 30c, please provide the following clarifications:
- a. Explain why case-mix is not held constant for each projection in Exhibit 80, and explain the assumptions that led the specific mix factor in each projections.

APPLICANT RESPONSE:

In the original projections case-mix was held constant within each major service (MSGa, OB/NUR, and Psych). Because OB and Psych have a significantly lower CMI than MSGa on average, as different rates of growth for MSGa, OB and NUR were applied, the overall CMI of the entire population fluctuates. Under a global arrangement, which is being currently being finalized with the HSCRC, CMI will no longer cause fluctuations in revenue in the short term and therefore the projections will be modified to take this change in assumption into consideration once a finalized agreement is reached.

- b. What is the source of the estimates for market basket referred to on page 38?

APPLICANT RESPONSE:

Source: IHS Global Insight, 2013Q2, Historical Data through 2013Q1; Released by: CMS, OACT, National Health Statistics Group, DNHS@cms.hhs.gov

Found at (also attached):

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html>

9. Your response to question 32 on page 40 states that "...if the HSCRC were to adopt the 50 per cent variable cost factor, adjustments to other rate setting methodologies and assumptions would likely also be made", please respond to the following:
- a. Please identify what rate increase would be required to support the project if indeed HSCRC uses the 50% variable cost factor. Also, for the sake of gaining insight into how the assumption on variable cost reimbursement affects rates, what rate increase would be required if HSCRC used a 100% variable cost factor?
 - b. You are encouraged to present alternative projections of revenues and expenses that include other changes beyond the variable cost factor. If you submit such an alternative, please provide it with inflation and, if possible without inflation. Submit a clear statement of assumptions such as HSCRC update factors, and projected inflationary increases in expenses. Show how key changes in revenues and expenses are calculated.

APPLICANT RESPONSE:

Adventist HealthCare is nearing completion of a negotiated global reimbursement agreement with the HSCRC. We are currently updating the financial pro formas for the Washington Adventist Hospital CON consistent with this revenue agreement and will submit the new information as part of a CON modification that is currently underway.

10. Regarding the response to question 33f, what are the expense deductions projected to begin in 2015 and increase through 2017?

APPLICANT RESPONSE:

These are savings that Washington Adventist Hospital intends to identify and implement in order to be financially viable. They will include any and all of the following:

1. Contracting improvements in medical and surgical supplies
2. Contracting improvements in pharmaceuticals
3. Contracting improvements in purchased services, to include Information Technology, Laboratory testing, Maintenance of Clinical Equipment
4. Utilization improvements: reduced length of stay and related reduction in staffing hours and pharmaceuticals and other variable supplies expenses

5. Utilization improvements: continued reduction of readmissions and MHAC's, and reduction of potentially avoidable utilization, including emergency department visits
6. Sustained improvements in labor productivity

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

 2-12-14

William G. Robertson Date
President and CEO
Adventist Healthcare

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



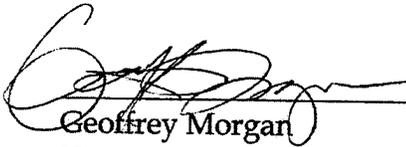
February 12, 2014

Terry Forde
Executive Vice President, and Chief Operating Officer
Adventist HealthCare, Inc.

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



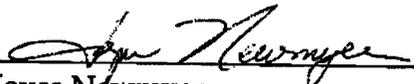
Geoffrey Morgan
Vice President, Expanded Access
Washington Adventist Hospital

2/13/14

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



Joyce Newmyer
President
Washington Adventist Hospital

2.12.14

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



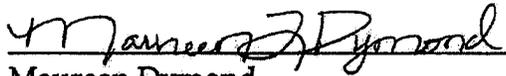
Robert Jepson
Vice President of Business Development
Adventist Healthcare

2/12/14

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



Maureen Dymond
Vice President, Financial Operations
Adventist Healthcare

2/12/14

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



Kristen Pulio
Associate Vice President, Reimbursement
Adventist Healthcare

2/12/14

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Linda Beth Berman

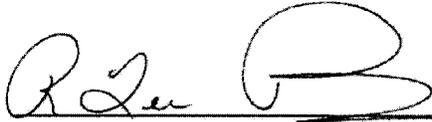
Linda Beth Berman
Grant Manager
Adventist Healthcare

2/12/14

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



R. Lee Piekarz
Deloitte Financial Advisory Services, LLP

2/12/14

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



Pippa Laundry
Deloitte Financial Advisory Services, LLP

2/12/14

Date

Exhibit 75

**This Exhibit is also being provided
in a hard copy, oversized version**

ZIP CODE	Population	4 HCH			Average Time Travel within zip code	Drive Time in Minutes for Population Exceeding 30 min.	7 DCH			Average Time Travel within zip code	Drive Time in Minutes for Population Exceeding 30 min.	6 LRH			Average Time Travel within zip code	Drive Time in Minutes for Population Exceeding 30 min.	8 PGHC			Average Time Travel within zip code	Drive Time in Minutes for Population Exceeding 30 min.	8a Proposed PGHC			Average Time Travel within zip code	Drive Time in Minutes for Population Exceeding 30 min.	Travel Time to ANY hosp					
		Holy Cross Hospital 1500 Forest Glen Road Silver Spring, MD 20910		Miles to			Time to	Doctors Community 8118 Good Luck Road Lanham, MD 20706				Miles to	Time to	Laurel Regional Hospital 7300 Van Dusen Road Laurel, MD 20707			Miles to	Time to	Prince George's 3001 Hospital Drive Cheverly, MD 20785			Miles to	Time to	Prince George's 900 Capital Beltway Largo, MD 20774				Miles to	Time to			
		Miles to	Time to					Miles to	Time to					Miles to					Time to					Miles to						Time to	Miles to	Time to
20783	37,201	6.4 mi.	11 min.	11	13	7.1 mi.	16 min.	16	17	12.2 mi.	19 min.	19	22	10.1 mi.	20 min.	20	18	15.0 mi.	21 min.	21	23	10										
20782	25,569	6.1 mi.	14 min.	14	18	7.0 mi.	15 min.	15	17	10.7 mi.	23 min.	23	26	6.3 mi.	17 min.	17	14	13.0 mi.	21 min.	21	24	10										
20903	17,998	6.8 mi.	14 min.	14	11	8.3 mi.	21 min.	21	20	14.4 mi.	24 min.	24	18	6.3 mi.	17 min.	17	24	17.2 mi.	26 min.	26	20	10										
20910	35,967	7.5 mi.	15 min.	15	7	6.3 mi.	15 min.	15	22	14.8 mi.	25 min.	25	23	5.2 mi.	14 min.	14	24	10.1 mi.	23 min.	23	23	7										
20904	48,587	7.2 mi.	16 min.	16	12	8.0 mi.	19 min.	19	19	14.4 mi.	26 min.	26	19	5.7 mi.	16 min.	16	25	10.5 mi.	26 min.	26	24	7										
20705	22,361	8.2 mi.	17 min.	17	16	6.2 mi.	15 min.	15	17	11.8 mi.	26 min.	26	10	5.0 mi.	14 min.	14	19	10.0 mi.	21 min.	21	19	8										
20902	42,000	6.9 mi.	17 min.	17	9	6.2 mi.	15 min.	15	25	11.8 mi.	26 min.	26	25	4.5 mi.	12 min.	12	27	10.1 mi.	23 min.	23	27	11										
20737	16,357	6.6 mi.	17 min.	17	20	7.3 mi.	17 min.	17	10	13.8 mi.	25 min.	25	23	5.8 mi.	16 min.	16	9	11.2 mi.	24 min.	24	17	8										
20011	57,701	8.2 mi.	22 min.	22	15	7.8 mi.	18 min.	18	26	13.4 mi.	29 min.	29	28	4.7 mi.	14 min.	14	28	9.8 mi.	24 min.	24	28	9										
20770	21,083	5.6 mi.	16 min.	16	17	10.1 mi.	21 min.	21	9	12.2 mi.	19 min.	19	17	12.5 mi.	25 min.	25	13	14.6 mi.	25 min.	25	16	10										
20906	57,059	4.0 mi.	9 min.	9	33	10.3 mi.	24 min.	24	29	13.7 mi.	26 min.	26	29	16.1 mi.	28 min.	28	33	14.6 mi.	26 min.	26	32	14										
20912	20,094	5.5 mi.	9 min.	9	10	9.5 mi.	18 min.	18	22	13.7 mi.	25 min.	25	21	16.1 mi.	27 min.	27	21	18.6 mi.	27 min.	27	22	1										
20740	24,683	4.7 mi.	11 min.	11	14	9.2 mi.	22 min.	22	11	10.3 mi.	21 min.	21	18	11.9 mi.	29 min.	29	13	12.7 mi.	20 min.	20	18	12										
20706	31,128	4.7 mi.	11 min.	11	7	10.3 mi.	21 min.	21	24	12.2 mi.	24 min.	24	24	12.7 mi.	20 min.	20	21	14.0 mi.	20 min.	20	13	8										
20901	30,446	4.7 mi.	11 min.	11	21	10.3 mi.	21 min.	21	21	12.2 mi.	24 min.	24	21	12.7 mi.	20 min.	20	21	14.0 mi.	20 min.	20	22	9										
20905	16,400	4.7 mi.	11 min.	11	32	10.3 mi.	21 min.	21	22	12.2 mi.	24 min.	24	21	12.7 mi.	20 min.	20	21	14.0 mi.	20 min.	20	31	20										
20866	27,712	4.7 mi.	11 min.	11	26	10.3 mi.	21 min.	21	13	12.2 mi.	24 min.	24	13	12.7 mi.	20 min.	20	27	14.6 mi.	26 min.	26	27	12										
20707	28,129	4.7 mi.	11 min.	11	23	10.3 mi.	21 min.	21	8	12.2 mi.	24 min.	24	8	12.7 mi.	20 min.	20	23	14.6 mi.	26 min.	26	25	10										
20708	19,921	4.7 mi.	11 min.	11	16	10.3 mi.	21 min.	21	12	12.2 mi.	24 min.	24	19	12.7 mi.	20 min.	20	19	14.6 mi.	26 min.	26	20	11										
20715	21,283	4.7 mi.	11 min.	11	17	10.3 mi.	21 min.	21	25	12.2 mi.	24 min.	24	25	12.7 mi.	20 min.	20	20	14.6 mi.	26 min.	26	20	19										

Exhibit 94

Adventist Behavioral Health Treatment Protocol for Geriatric Psychiatric Inpatient Populations

Overview

Older adults with psychiatric illness present unique challenges for treatment as compared to younger adults with psychiatric illness (Bartels & Drake, 2005). Further, shortcomings in the mental health service system result in older adults being less likely to optimally engage in primary care and other outpatient mental health services. As a result, older adults are increasingly represented in psychiatric inpatient settings. Elderly or *geriatric* populations are a diverse group for which the U.S. Census Bureau defines Older adults as individuals 55 through 64; Elderly as 65 through 74; Aged as 75 through 84 and the Very Old, 85 and older (Townsend, 2003). Advanced research reveals geriatric psychiatric inpatients most often present with a range of disturbance in mood; thoughts and cognitions; behavior; and physical ailments. Of the 31 million Americans over age 65, 5 million are clinically significant for depressive symptoms. That number increases to 13% in aged adults 80 and older (Blazer, 2009). When anxiety and depression first appear in late life they are frequently associated with other conditions such as physical illness, traumatic event, dementia, medication toxicity or withdrawal (Videbeck, 2011a). Despite the complexities, the presence of these symptoms can be understood and are most often responsive to treatment. Treatment outcomes are enhanced when evidence-based practice guidelines are used to help return older adults to their optimal level of functioning.

Best Practice

Clinical focus in this population is indicated for depression, anxiety, agitation, alcohol use, psychosis, cognitive impairment, Alzheimer's dementia, bipolar and schizophrenia. Medical comorbidities and increased risk of drug-drug interactions are considered and factored into treatment interventions. Patients receive comprehensive assessments to determine medical, psychiatric, behavioral and psychosocial needs. These assessments inform an individualized treatment plan for inpatient implementation as well as to inform outpatient providers for continuity in care. The treatment plan is further specified with goals chosen by the patient after being informed by the physician of individual risks and benefits of treatment options relative to their medical conditions. The decision-making is further shared with the treatment team and strengthened by family or guardian input and participation.

Treatment interventions are diverse and include psychopharmacology, psychoeducation, group therapy, individual and supportive therapies, expressive therapies, and pastoral counseling. The environment of care provides adequate space for ambulation challenges, individualized care that includes a single room, aid for activities of daily living (ADLs), and a therapeutic milieu.

Adventist Behavioral Health System Services

Professional Staff

A multidisciplinary team of psychiatrists, social workers, nurses, nurse practitioners, expressive therapist, and chaplains is involved with delivering patient care. Team members have

experience in diagnosing and treating disorders commonly experienced by older individuals. In addition, other medical or rehabilitation consultations are obtained as necessary.

Phase One A: Comprehensive Assessment

1. Psychiatric Assessments (Psychiatrist)
2. Nursing assessments (Nurse)
3. History & Physical (Nurse Practitioner/Medical Doctor)
4. Dietary & Nutritional, as indicated (Dietitian)
5. Psychosocial Assessment (Social Worker/Therapist)

Psychological Assessments & Outcome Measures

- **Psychosocial:** Multiple sociocultural factors comprise the late-life experience. The Psychosocial Intake and GAIN-Short Screen are used to gather history, including a screen for alcohol use.
- **Cognitive Impairment:** Geriatric populations present with varies levels of functional and cognitive abilities. The Mini-Cognitive (Mini-Cog™) is used to assess for cognitive impairment.
- **Psychosis:** While schizophrenia is not initially diagnosed in elderly patients (Videbeck, 2011b), psychotic symptoms that appear later in life are usually associated with other mental conditions. Further, similar to longer life spans in the general population; older chronically mentally ill patients are increasingly served on inpatient units. The Folstein Mental Mini Status Exam is used to assess for psychosis, mood disturbance and agitation.
- **Depression:** While depression is common in late life, it is not a natural part of aging. The Geriatric Depression Scale-Short Form (GDS-SF) is used to measure depression.
- **Anxiety:** Phobias and generalized are the most common late-life anxiety disorders. The Geriatric Anxiety Inventory (GAI) is used to measure anxiety.

Phase One B: Most Common Psychiatric Diagnosis

- Psychosis
- Depression
- Agitation
- Anxiety

Phase Two: Medical and Psychiatric Stabilization

- Medication management psychopharmacology for psychiatry conditions.
- Management of medical conditions, as necessary for treatment.
- Nursing staff follows practice guidelines in Lippincott (2010) for medical aspects of patient care.
- Nutrition management, as necessary for treatment.

Phase Three: Patient Management

Treatment Interventions

TRACK 1: Treatment interventions for patients, with no indicated cognitive impairment include: Anti-depressant and anti-anxiety medications, Cognitive-behavioral group therapy (CBT). Problem-solving group therapy (PST), individual behavior therapy, supportive group therapy (ST), expressive therapy (ET), and pastoral counseling (PC). These modalities focus on thoughts and emotional distress associated with depressive and other symptoms related to a range of anxiety disorders.

TRACK 2: Treatment interventions for older patients with mild to moderate cognitive impairment and daily functioning challenges include: Mood stabilizing and antipsychotic medications, PST, ST, ET, PC, reminiscence (RT), and skill building (SB) therapies. These modalities focus on behaviors associated with mood disturbance, thought disorder, and schizophrenia spectrum disorders. *See Figure 1.*

Older psychiatric patients frequently present with chronic medical co-morbidities; for example, diabetes, hypertension, Grade 1 and 2 wounds. These conditions are assessed, monitored, and managed by medical and nursing staff using Lippincott nursing guidelines. Treatment interventions for these patients focus on psychoeducation for medication side effects, the effects of interacting medications, and practical problem-solving in the home environment.

Special Populations: Some geriatric patients may present with impairment in daily functioning; for example, intellectual disability or other developmental disorders. Treatment interventions for these individuals include a multidisciplinary team and individualized treatment plan that focuses on assistance with activities of daily living (ADLs), behavioral approaches, and social skill training.

Treatment Monitoring

Treatment Plan

Patients meet with their attending psychiatrist daily. Treatment plan options take into consideration the patient's needs, preferences, and values. Changes are made to the individualized treatment plan as necessary.

Treatment Team

Patients participate in multidisciplinary treatment team meeting twice weekly and as needed to review progress toward successful discharge.

Phase Four: Preparation for Discharge

- The treatment team reviews disposition options and transition plans.
- Patient's participate in family or interagency meetings, when applicable, to determine conditions for discharge.
- Follow-up appointments are secured with primary care and next-level providers.

- Referrals to special services; for example, Electroconvulsive Therapy (ECT) and physical therapy, are made as necessary.
- Discharge care plans are transmitted to next-level providers for continuity in care.

References & Resources

Bartels, S.J., Drake, R.E. (2005). Evidence-Based Geriatric Psychiatry: An Overview. *Psychiatric Clinics of North America* 28, 763-784.

Blazer, D.G. (2009). Depression in late life: Review and Commentary. *FOCUS*, 7(1), 118-136.

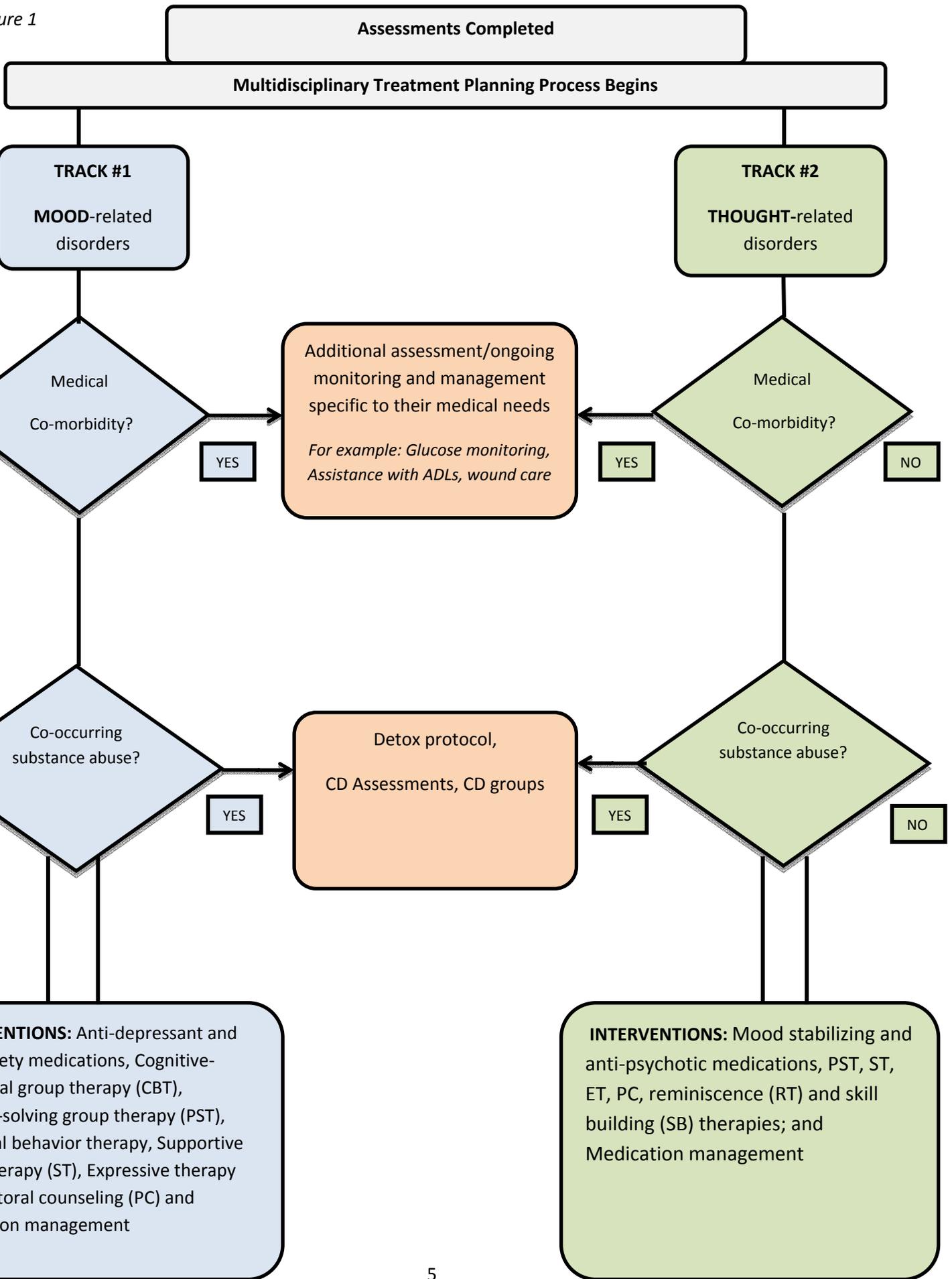
Lippincott Manual of Nursing Practice: Ninth Edition (2010). Philadelphia, PA; Wolters Kluwer Health, Lippincott Williams & Wilkins.

Townsend, M.C. (2003). The Aging Individual. In *Psychiatric Mental Health Nursing* (pp.720), Philadelphia, PA; F.A. Davis Company.

Videbeck, S. L. (2011a). Anxiety, Anxiety Disorders, and Stress-Related illness. In *Psychiatric Mental Health Nursing* (pp. 235). Philadelphia, PA; Wolters Kluwer, Lippincott Williams & Wilkins.

Videbeck, S. L. (2011b). Schizophrenia. In *Psychiatric Mental Health Nursing* (pp. 274). Philadelphia, PA; Wolters Kluwer, Lippincott Williams & Wilkins.

Figure 1



Adventist Behavioral Health
Quality Assurance Program for the Treatment Protocol for Geriatric Psychiatric Inpatient Populations

Scope

Adventist Behavioral Health (ABH) provides inpatient treatment for geriatric adults whose acute mental illnesses require immediate stabilization. The goal of the treatment program is to stabilize the patient through medication management, psychoeducation, individual and supportive therapies, group therapy, family meetings, expressive therapy (art, movement, music and dance) and pastoral care. This quality assurance program is specific to the practice, process and outcomes related to the ABH Geriatric Program.

Purpose

The purpose of the Quality Assurance Program for Geriatric Program is to ensure there is a systematic process in place to measure, assess, evaluate and improve our organizational performance for the geriatric program. This Quality Assurance Program provides for measurements regarding the stability of systems and processes. There is also further evaluation of outcomes to help determine priorities for quality improvement.

Methodology

The Geriatric Program will be reviewed through a random sample of closed medical records, examining the four phases of the Geriatric Program: comprehensive assessment, medical and psychiatric stabilization, patient management and preparation for discharge as well as monitoring the status of outcomes. The two indicators in this program include

- A) *Compliance* as defined by patient completing all four stages the Geriatric Program. The Program is comprised of four phases: 1) comprehensive assessments, 2) medical and psychiatric stabilization, 3) patient management, and 4) preparation of discharge. For this measure each phase will be evaluated for a yes or no response.

- B) *Improved Outcomes* will be defined as positive movement in psychosocial functioning as measured through the assessments completed at admission and then again at discharge.

Psychological Assessments & Outcome Measures

- **Psychosocial:** Multiple sociocultural factors comprise the late-life experience. The Psychosocial Intake and GAIN-Short Screen are used to gather history, including a screen for alcohol use.

- **Cognitive Impairment:** Geriatric populations present with varies levels of functional and cognitive abilities. The Mini-Cognitive (Mini-Cog™) is used to assess for cognitive impairment.

- **Psychosis:** While schizophrenia is not initially diagnosed in elderly patients (Videbeck, 2011b), psychotic symptoms that appear later in life are usually associated with other mental conditions. Further, similar to longer life spans in the general population; older chronically mentally ill patients are increasingly served on inpatient units. The Folstein Mental Mini Status Exam is used to assess for psychosis, mood disturbance and agitation.
- **Depression:** While depression is common in late life, it is not a natural part of aging. The Geriatric Depression Scale-Short Form (GDS-SF) is used to measure depression.
- **Anxiety:** Phobias and generalized are the most common late-life anxiety disorders. The Geriatric Anxiety Inventory (GAI) is used to measure anxiety

Data will be analyzed and presented to the ABH Performance Improvement Committee and other stakeholders for review, feedback and action.

Model (PDCA)

The Quality Assurance Program will follow the continuous improvement model Plan, Do, Check, Act. All collected data will be reviewed at the ABH Performance Improvement Committee. Variance in data or benchmarks will be reviewed by the committee; action plans created and monitored using the PDCA model.

Evaluation

The Quality Assurance Program for the Geriatric Programs will be reviewed during the Program Evaluation for the Geriatric Programs.

Adventist Behavioral Health
Program Evaluation Treatment Protocol for Geriatric Psychiatric Inpatient Populations

I. Executive Summary

To evaluate an inpatient psychiatric program that addresses the specific needs of the geriatric population. The program provides comprehensive assessments to determine medical, psychiatric, behavioral and psychosocial needs of the older adult patient. Treatment interventions are diverse and include psychopharmacology, psycho-education, group therapy, individual and supportive therapies, expressive therapies, and pastoral counseling. The setting and environment of care provides adequate space for ambulation challenges and individualized. This evaluation focuses on structure, process and clinical outcomes for this geriatric psychiatric program.

II. Introduction to the report

A. Purpose of the evaluation

Applying the standards of the geriatric psychiatric program to determine value, quality, utility, effectiveness and significance; which can lead to recommendations intended to inform clinicians about best practice for the older adult psychiatric patient. The evaluation will be completed annually or as needed. In addition; the evaluation can help stakeholders determine the effectiveness of the geriatric psychiatric program and the continuation and/or expansion.

B. Audiences for the evaluation report

Centers for Medicare and Medicaid Services (CMS), Joint Commission (JC), Maryland Office of Health Care Quality (OHCQ), payors, family, patient, community mental health providers, mental health advocacy groups, long term care facility, assisted living, primary care providers, Adventist Healthcare (AHC) and Adventist Behavioral Health (ABH) administrators, ABH employees, and others as identified.

C. Limitations of the evaluation and explanation of disclaimers (if any)

D. Overview of report contents

III. Focus of the evaluation

A. Description of the evaluation object

The geriatric program is comprised of four phases: 1) comprehensive assessments, 2) medical and psychiatric stabilization, 3) patient management, and 4) preparation of discharge.

B. Evaluative questions or objectives used to focus the study
Program goals and objectives focus on medical and psychiatric stabilization; to include comprehensive assessments, medication management, individualized treatment plan, assistance with activities of daily living, behavioral approaches and social skill training.

C. Information needed to complete the evaluation:

- Geriatric program
- Data collection instruments (surveys, observation data, interviews, chart reviews)
- Methods and techniques used to analyze and interpret the data
- Policy and procedures
- Evidence based/clinical guidelines for caring for geriatric psychiatric population

IV. Brief overview of the geriatric program evaluation plan and procedures

V. Presentation of evaluation results

- A. Summary of evaluation findings
- B. Interpretation of evaluation findings

VI. Conclusions and recommendations

- A. Criteria and standards used to judge evaluation object
- B. Judgments about evaluation object (strengths and weaknesses)
- C. Recommendations

VII. Minority reports or rejoinders (if any)

VIII. Appendices

A. Description of evaluation plan/design, instruments, and data analysis and interpretation

Instruments - Psychological Assessments & Outcome Measures:
Psychosocial: Multiple sociocultural factors comprise the late-life experience. The Psychosocial Intake and GAIN-Short Screen are used to gather history, including a screen for alcohol use.

Cognitive Impairment: Geriatric populations present with varies levels of functional and cognitive abilities (Gundeman, et. al., 2004). The Mini-Cognitive (Mini-Cog™) is used to assess for cognitive impairment.

Psychosis: While schizophrenia is not initially diagnosed in elderly patients (Videbeck, 2011), psychotic symptoms that appear later in life are usually associated with other mental conditions. Further, similar to longer life spans in the general population; older chronically mentally ill patients are increasingly served on inpatient units. The Folstein Mental Mini Status Exam is used to assess for psychosis, mood disturbance and agitation.

Depression: While depression is common in late life, it is not a natural part of aging. The Geriatric Depression Scale-Short Form (GDS-SF) is used to measure depression.

Anxiety: Phobias and generalized are the most common late-life anxiety disorders. The Geriatric Anxiety Inventory (GAI) is used to measure anxiety.

- B. Detailed tabulations or analyses of quantitative data, and transcripts or summaries of qualitative data
- C. Other information, as necessary

References

Chen, H. (2005). *Practical Program Evaluation: Assessing and Improving Planning, Implementation and Effectiveness*. Sage Publications. Thousand Oaks, CA.

Fitzpatrick, J., Sanders, J., & Worthen, B. (2004). *Program Evaluation: Alternative Approaches and Practical Guidelines*. 3rd Edition. Pearson Education, Inc. Boston, MA.

Isaac, S. & Michael, W. (1995). *Handbook in Research and Evaluation: For Education and Behavioral Sciences*. 3rd Edition. Educational and Industrial Testing Services. San Diego, CA.

Adventist Behavioral Health Treatment Protocol for Substance Abuse Psychiatric Inpatient Populations

Overview

Treating substance abuse/dependence in the context of co-occurring mental health conditions is an important aspect of treatment in the acute psychiatric inpatient setting. The Substance Abuse & Mental Health Service Administration (SAMHSA) and the Centers for Disease Control (CDC) have complete and comprehensive data available on the incidence of alcohol misuse, illicit drug use, and tobacco use and the relationship of the use of these substances to mental and physical health problems among adults and adolescents (Tusaie & Fitzpatrick, 2013). There are two concepts that have been used to define aspects of dependence to include: behavioral and physical. Some individuals who develop substance related problems do recover without treatment whereas others would require brief or long term interventions. Selecting the best treatment(s) would depend on the nature of the drugs abused and the individuals' stage of readiness for change as precontemplation, contemplation, preparation, action and maintenance (Sadock & Sadock, 2008). There are several valid and reliable psychometric tools available for Providers to use for screening, treatment and management of individuals with substance abuse or dependence.

Best Practices

Clinical focus in the substance use disorder population should be focused on abuse and dependence of alcohol, opioids, inhalants, nicotine, stimulants, and PCP/hallucinogens. Three severity areas of focus on inpatient include abuse, dependence, and withdrawal. Tools used to screen, as well as to evaluate treatment outcome, are crucial aspects of clinical care. Standard operating procedures are used to evaluate and to document intoxication, detoxification, as well as withdrawal prevention.

Adventist Behavioral Health System Services

Professional Staff

A multidisciplinary team comprised of psychiatrists, social workers, nurses, psychiatric nurse practitioners, and expressive therapists is involved with delivering patient care. Team members have experience in diagnosing and treating disorders commonly experienced by patients with psychiatric diagnoses, including substance use disorders. In addition, other medical or rehabilitation consultations are obtained as necessary.

Phase One: Initial Evaluation/Screening

All patients are to be screened for substances of abuse. Several methods that help accomplish this goal are employed and include (but are not necessarily limited to) urine toxicology assessment, standardized screening assessments, as well as the completion of a comprehensive psychiatric/substance abuse history. The following are examples of

these tools and are listed here to provide a concrete demonstration of methods employed, with respect to the substance of abuse:

1. Alcohol: Blood Alcohol Level (BAL) is obtained on admission to the unit, or before admission in the Emergency Department (ED). As part of the history gathered on admission, screening tools such as AUDIT, or other evidenced based tools, are used with the patient. If/when there is a concern that the patient is experiencing Delirium Tremens (DT), a medical consult is obtained for evaluation of a transfer to a medical floor.
2. Opioids: Urine toxicology to assess the presence of opioids is obtained either on admission to the unit, or prior to it in the ED. Screening tools such as the DAST-20, or other evidence based methods, are employed.
3. Cannabis: Urine toxicology to assess the presence of cannabis is obtained either on admission, or prior to it in the ED. Screening tools such as the DAST-20 (or other evidence based tool) are used.
4. Stimulants/Cocaine: Urine toxicology to assess the presence of stimulants such as cocaine is obtained either in the ED, or upon admission to the inpatient unit.
5. Nicotine/tobacco: Patients are screened for tobacco use by means of the collection of a history, as well as by use of other evidenced based screening tools such as the CAGE Questionnaire for tobacco.
6. PCP/Hallucinogens: Urine toxicology is used to identify the presence of these substances either upon admission, or before admission in the ED setting.

Phase Two: Detoxification/Replacement Therapies

All patients identified as being in need of detoxification and treatment for withdrawal prevention will be detoxified according to standardized guidelines and best practice methods. These will be guided by the substance of use and the treatment to which it is most appropriate.

1. Alcohol: Clinical scales to monitor withdrawal symptoms, as well as signs, are employed to ensure that detoxification occurs and to minimize the potential for withdrawal. Examples of such scales include the Clinical Institute Withdrawal Assessment (CIWA) protocol method. These involve the use of benzodiazepines as a treatment for withdrawal.
2. Opioids: Scales used to monitor signs and symptoms of withdrawal from substances such as heroin and prescription narcotic analgesics are used to assist in the detoxification process. Such scales include the Clinical Opiate Withdrawal Scale (COWS) protocol.
3. Cannabis: Detoxification from cannabis involves several supportive and clinical methods that are tailored to each patient according to his/her needs and symptoms. Examples include appropriate pain control or other as needed medications for any associated withdrawal symptom that may be present. Finally, both methadone and suboxone may be used as detoxification and/or

replacement therapies in patients deemed as appropriate candidates for these medications.

4. **Stimulants/Cocaine:** Similar to cannabis, treatment of cocaine withdrawal utilizes mostly supportive care and observation. In addition, an EKG is obtained to mitigate the potential cardiac sequelae of use/intoxication.
5. **Nicotine/Tobacco:** Detoxification/treatments for nicotine cravings involve nicotine patches and gums and serve as forms of replacement therapies. They are also used to help to prevent withdrawal symptoms.
6. **PCP/Hallucinogens:** All patients who screen positively for PCP and/or hallucinogens are provided with supportive measures for detoxification of these substances. This includes close monitoring of their mood, as well as any physical (e.g., vital sign) monitoring that may be helpful to these patients.

Phase Three: Peer/Staff Support as well as Rehabilitation Referral Upon Discharge

1. Alcohol:

- a. During the admission, all patients with alcohol abuse or dependence diagnoses are encouraged to attend AA/NA evening groups on the unit. These are offered once weekly during the week and once on the weekend and serve as adjunctive treatment components of the patient's plan of care.
- b. Upon discharge, all patients with alcohol abuse or dependence who are deemed in need (by the treatment team along with the patient) of inpatient (28 day) rehab are referred there. Those who are deemed appropriate for less intensive programs, or who require less intensive programs based on his/her (work) schedule are referred to community based outpatient programs. These are referred to as Intensive Outpatient Programs or IOP.

2. Opioids:

- a. During the admission, all patients with opioid abuse or dependence are assessed for:
 - i. Replacement therapy. Those who are already on methadone or buprenorphine are kept on it at the dose confirmed by their outpatient prescribing clinic/psychiatrist. Neither methadone detox, nor methadone maintenance therapies are initiated from the inpatient unit. Buprenorphine maintenance therapy is offered to patients who are deemed appropriate candidates.
 - ii. All patients with opioid abuse or dependence diagnoses are encouraged to attend AA/NA evening groups on the unit. These are offered once weekly during the week and once on the weekend.
- b. Upon discharge, all patients with opioid abuse or dependence who are deemed in need (by the treatment team along with the patient) of inpatient (28 day) rehab are referred there. Those who are deemed

appropriate for less intensive programs, or who require less intensive programs based on his/her (work) schedule are referred to community based outpatient programs. These are referred to as Intensive Outpatient Programs or IOP. Those patients who came from a clinic/psychiatrist who provided methadone or buprenorphine therapies are referred back to those clinics/providers.

3. Cannabis:

- a. During the admission, all patients with cannabis abuse or dependence diagnoses are encouraged to attend AA/NA evening groups on the unit. These are offered once weekly during the week and once on the weekend and serve as adjunctive treatment components of the patient's plan of care.
- b. Upon discharge, all patients with cannabis abuse or dependence who are deemed in need (by the treatment team along with the patient) of inpatient (28 day) rehab are referred there. Those who are deemed appropriate for less intensive programs, or who require less intensive programs based on his/her (work) schedule are referred to community based outpatient programs. These are referred to as Intensive Outpatient Programs or IOP.

4. Stimulants/cocaine:

- a. During the admission, all patients with stimulant/cocaine abuse or dependence diagnoses are encouraged to attend AA/NA evening groups on the unit. These are offered once weekly during the week and once on the weekend and serve as adjunctive treatment components of the patient's plan of care.
- b. Upon discharge, all patients with stimulant/cocaine abuse or dependence who are deemed in need (by the treatment team along with the patient) of inpatient (28 day) rehab are referred there. Those who are deemed appropriate for less intensive programs, or who require less intensive programs based on his/her (work) schedule are referred to community based outpatient programs. These are referred to as Intensive Outpatient Programs or IOP.

5. Nicotine/Tobacco:

- a. During the admission, all patients with nicotine/tobacco abuse or dependence diagnoses are encouraged to attend AA/NA evening groups on the unit. These are offered once weekly during the week and once on the weekend and serve as adjunctive treatment components of the patient's plan of care.
 - i. Replacement therapy with the nicotine patch or gum is offered to patients.
 - ii. Medication treatment therapies are offered to the patient. Bupropion therapy is offered to those who are both deemed appropriate, and who desire this form of medication treatment.

- b. Upon discharge, all patients with nicotine/tobacco use are given information on the health implications of smoking.
6. PCP/hallucinogens:
- a. During the admission, all patients with PCP/hallucinogen abuse or dependence diagnoses are encouraged to attend AA/NA evening groups on the unit. These are offered once weekly during the week and once on the weekend and serve as adjunctive treatment components of the patient's plan of care.
 - b. Upon discharge, all patients with PCP/hallucinogen abuse or dependence who are deemed in need (by the treatment team along with the patient) of inpatient (28 day) rehab are referred there. Those who are deemed appropriate for less intensive programs, or who require less intensive programs based on his/her (work) schedule are referred to community based outpatient programs. These are referred to as Intensive Outpatient Programs or IOP.

All substance abuse/dependence rehab referrals are based on the American Society of Addiction Medicine (ASAM) placement criteria.

Outcome Measures

1. Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES 8A): Given to all patients with substance abuse/dependence once on admission and once upon discharge.
2. 30 Day Readmission Rate: Data monitored on all patients as an outcome measure of overall level of treatment success.

References

Tusaie, K. R. & Fitzpatrick, J. J. (2013). *Advanced practice psychiatric nursing: Integrating psychotherapy, psychopharmacology, and complementary and alternative approaches.*

Sadock, B. J. & Sadock, V. A. (2008). *Concise textbook of Clinical Psychiatry.*

Hall, B. (2013). Chapter 5: Depression In *College of Psychiatric and Neurologic Pharmacists (Eds.), BCPP examination review and recertification course Lincoln, Nebraska: College of Psychiatric and Neurologic Pharmacists.*

Miller, W.R. & Tonigan, J.S. (1996). Assessing drinkers' motivation for change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES), *Psychology of Addictive Behaviors*, 10(2), 81-89.

Adventist Behavioral Health
Quality Assurance Program for the Treatment Protocol for Substance Abuse Psychiatric
Inpatient Populations

Scope

Adventist Behavioral Health (ABH) provides inpatient treatment for those patients with mental illness or substance abuse problems or both. The goal of the treatment program is standardized screening assessments; comprehensive psychiatric/substance abuse history; identification of patients in need of detoxification; treatment for withdrawal prevention and peer/staff support as well as rehab referral upon discharge. This quality assurance program is specific to the practice, process and outcomes related to the Treatment Protocol for Geriatric Psychiatric Inpatient Populations.

Purpose

The purpose of the Quality Assurance Program for the Treatment Protocol for Geriatric Psychiatric Inpatient Populations is to ensure there is a systematic process in place to measure, assess, evaluate and improve our organizational performance in this population. This Quality Assurance Program provides for measurements regarding the stability of systems and processes. There is also further evaluation of outcomes to help determine priorities for quality improvement.

Methodology

The Treatment Protocol for Geriatric Psychiatric Inpatient Populations will be reviewed through a random sample of closed medical records, examining the three phases of the protocol: 1) initial evaluation/screening; 2) detoxification/replacement therapies; and 3) peer/staff support as well as rehab referral upon discharge.

The two indicators in this program include:

- A) *Compliance* as defined by patient completing all three stages Treatment Protocol for Geriatric Psychiatric Inpatient Populations program. The Program is comprised of three stages: 1) initial evaluation/screening; 2) detoxification/replacement therapies; and 3) peer/staff support as well as rehab referral upon discharge. For this measure each phase will be evaluated for a yes or no response.

- B) *Improved Outcomes* will be defined as positive movement in outcomes as measured through the assessments completed at admission and then again at discharge and readmission rates.

Outcomes Measures

- Stages of Readiness and Treatment Eagerness Scale (SOCRATES 8A). The SOCRATES will be given to all patients with substance abuse/dependence once on admission and once upon discharge.

- 30 Day Readmission Rate: Data monitored on all patients as an outcome measure of overall level of treatment success

Data will be analyzed and presented to the ABH Performance Improvement Committee and other stakeholders for review, feedback and action.

Model (PDCA)

The Quality Assurance Program will follow the continuous improvement model Plan, Do, Check, Act. All collected data will be reviewed at the ABH Performance Improvement Committee. Variance in data or benchmarks will be reviewed by the committee; action plans created and monitored using the PDCA model.

Evaluation

The Quality Assurance Program for Substance Abuse Disorders in Psychiatric Inpatient Populations will be reviewed during the Program Evaluation for Substance Abuse Disorders in Psychiatric Inpatient Populations.

Adventist Behavioral Health
Program Evaluation for the Treatment Protocol for Substance Abuse Psychiatric Inpatient Populations

I. Executive Summary

To evaluate an inpatient psychiatric program that addresses the specific needs of those patients with substance abuse disorders. The program provides comprehensive assessments to determine medical, psychiatric, behavioral and psychosocial needs of those patients with substance abuse disorders. Treatment interventions are diverse and include initial evaluation/screening for drugs and alcohol, detoxification/replacement therapies, peer/staff support, and rehab referral upon discharge. This evaluation focuses on structure, process and clinical outcomes for those inpatient psychiatric patients with substance abuse disorders.

II. Introduction to the report

A. Purpose of the evaluation

The purpose of this evaluation is to apply the standards of the Program for substance abuse disorders in psychiatric inpatients to determine value, quality, utility, effectiveness and significance; which can lead to recommendations intended to inform clinicians about best practice for the patient with a co-occurring psychiatric diagnoses and a substance use disorders. The evaluation will be completed annually or as needed. In addition; the evaluation can help stakeholders determine the effectiveness of the program for substance abuse disorders in psychiatric inpatients and the continuation and/or expansion.

B. Audiences for the evaluation report

Centers for Medicare and Medicaid Services (CMS), Joint Commission (JC), Maryland Office of Health Care Quality (OHCQ), payors, family, patient, community mental health providers, mental health advocacy groups, State or Federal agencies such as Substance Abuse and Mental Health Services Administration (SAMHSA), primary care providers, Adventist Healthcare (AHC) and Adventist Behavioral Health (ABH) administrators, ABH employees, and others as identified.

C. Limitations of the evaluation and explanation of disclaimers (if any)

D. Overview of report contents

III. Focus of the evaluation

A. Description of the evaluation object

The Clinical Guidelines for Substance Use Disorders In Psychiatric Inpatient Populations, is comprised of three stages: 1) Initial Evaluation/Screening 2)

Detoxification/Replacement Therapies and 3) Peer/Staff Support as well as Rehabilitation Referral upon Discharge.

B. Evaluative questions or objectives used to focus the study
Program goals and objectives focus on abuse and dependence of alcohol, opioids, inhalants, nicotine, stimulants, and PCP/hallucinogens. Standard operating procedures are used to evaluate and to document intoxication, detoxification, as well as withdrawal prevention.

C. Information needed to complete the evaluation

- Clinical guidelines for substance use disorders on psychiatric inpatient populations
- Data collection instruments (surveys, observation data, interviews, chart reviews)
- Methods and techniques used to analyze and interpret the data
- Policy and procedures
- Evidence based/clinical guidelines for caring for inpatient psychiatric patients with substance abuse disorders

IV. Brief overview of evaluation plan and procedures

V. Presentation of evaluation results

A. Summary of evaluation findings

B. Interpretation of evaluation findings

VI. Conclusions and recommendations

A. Criteria and standards used to judge evaluation object

B. Judgments about evaluation object (strengths and weaknesses)

C. Recommendations

VII. Minority reports or rejoinders (if any)

VIII. Appendices

A. Description of evaluation plan/design, instruments, and data analysis and interpretation

1. Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES 8A): Given to all patients with substance abuse/dependence once on admission and once upon discharge.
 2. 30 Day Readmission Rate: Data monitored on all patients as an outcome measure of overall level of treatment success.
- B. Detailed tabulations or analyses of quantitative data, and transcripts or summaries of qualitative data
- C. Other information, as necessary

References

Chen, H. (2005). *Practical Program Evaluation: Assessing and Improving Planning, Implementation and Effectiveness*. Sage Publications. Thousand Oaks, CA.

Fitzpatrick, J., Sanders, J., & Worthen, B. (2004). *Program Evaluation: Alternative Approaches and Practical Guidelines*. 3rd Edition. Pearson Education, Inc. Boston, MA.

Isaac, S. & Michael, W. (1995). *Handbook in Research and Evaluation: For Education and Behavioral Sciences*. 3rd Edition. Educational and Industrial Testing Services. San Diego, CA.

Measures

Wadlington Adventist Hospital Acute Care-HBIPS

HB-1 Admission screening for violence risk, substance abuse, psychological trauma and patient strengths completed

HBIPS-1a Admission Screening- Overall Rate

HBIPS-1d Admission Screening- Adult (18 through 64 years)

HBIPS-1e Admission Screening- Older Adult (≥ 65 years)

HB-2 Hours of physical restraint use

HBIPS-2a Physical Restraint- Overall Rate

HBIPS-2d Physical Restraint- Adult (18 through 64 years)

HBIPS-2e Physical Restraint- Older Adult (≥ 65 years)

HB-3 Hours of seclusion

HBIPS-3a Seclusion- Overall Rate

HBIPS-3d Seclusion- Adult (18 through 64 years)

HBIPS-3e Seclusion- Older Adult (≥ 65 years)

HB-4 Patients discharged on multiple antipsychotic meds

HBIPS-4a Multiple Antipsychotic Medications at Discharge- Overall Rate

HBIPS-4d Multiple Antipsychotic Medications at Discharge- Adult (18 through 64 years)

HBIPS-4e Multiple Antipsychotic Medications at Discharge- Older Adult (≥ 65 years)

HB-5 Patients d/c on multiple antipsychotic meds with appropriate justification

HBIPS-5a Multiple Antipsychotic Medications at Discharge with Appropriate Justification-Overall Rate

HBIPS-5d Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Adult (18 through 64 years)

HBIPS-5e Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Older Adult (≥ 65 years)

HB-7 Post discharge continuing care plan transmitted to next level of care

HBIPS-7a Post Discharge Continuing Care Plan Transmitted- Overall Rate

HBIPS-7d Post Discharge Continuing Care Plan Transmitted - Adult (18 through 64 years)

HBIPS-7e Post Discharge Continuing Care Plan Transmitted - Older Adult (≥ 65 years)