CERTIFICATE OF NEED APPLICATION

INTERMEDIATE CARE FACILITY

11100 Billingsley Road
Waldorf, Maryland

RECOVERY CENTERS OF AMERICA

Applicant: 11100 Billingsley Road OPCO, LLC
March 27, 2015

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MARYLAND HEALTH CARE COMMISSION

For internal staff use

_____

MATTER/DOCKET NO.

_____

DATE DOCKETED

APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Recovery Centers of America Billingsley Road Facility

Address:

11100 Billingsley Road	Waldorf	20602	Charles
Street	City	Zip	County

2. NAME OF OWNER The Owner will be Billingsley Road LLC. Please see Exhibit 2 for an organizational chart.

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

3. APPLICANT. ***If the application has a co-applicant, provide the following information in an attachment.***

Legal Name of Project Applicant (Licensee or Proposed Licensee): 11100 Billingsley Road OPCO LLC

Address:

11100 Billingsley Road	Waldorf	20602	Charles	MD
Street	**City**	**Zip**	**County**	**State**
Telephone:	610-205-1562			

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from the applicant:

Applicant will be the Licensee.

5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☐	
	(2) For-profit	☒	
	(3) Close	☐	State & Date of Incorporation DE, 8/7/2014
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited Liability Partnership	☐	
	Limited Liability Limited Partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☒	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☒	

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: JP Christen, Chief Operating Officer

Company Name: Recovery Centers of America LLC

Mailing Address:

2701 Renaissance Boulevard, 4th Fl	King of Prussia	19406	PA
Street	City	Zip	State

Telephone: 610-205-1562

E-mail Address (required): jpchristen@recoverycoa.com

Fax: 410-468-2786

If company name is different than Recovery Centers of America LLC is an affiliated

applicant briefly describe the relationship company of the Applicant.

B. Additional or alternate contacts:

Name and Title: Kevin McClure, Chief Financial Officer

Company Name: Recovery Centers of America LLC

Mailing Address:

2701 Renaissance Boulevard, 4th Fl	King of Prussia	19406	PA
Street	City	Zip	State

Telephone: 610-205-1562

E-mail Address (required): kmcclure@recoverycoa.com

Fax: 410-468-2786

If company name is different than applicant briefly describe the relationship Recovery Centers of America LLC is an affiliated company of the Applicant.

Name and Title: Thomas C. Dame, Esq

Company Name: Gallagher Evelius & Jones LLP

218 N. Charles St. Ste. 400	Baltimore	21201	MD
Street	City	Zip	State

Telephone: 410-347-1331

E-mail Address (required): tdame@gejlaw.com

Fax: 410-468-2786

If company name is different than applicant briefly describe the relationship Legal Counsel

Name and Title: Ella R. Aiken, Esq.

Company Name: Gallagher Evelius & Jones LLP

Mailing Address:

218 N. Charles St. Ste. 400	Baltimore	21201	MD
Street	City	Zip	State

Telephone: 410-951-1420

E-mail Address (required): eaiken@gejlaw.com

Fax: 410-468-2786

If company name is different than applicant briefly describe the relationship Legal Counsel

Name and Title: Andrew L. Solberg

Company Name: A.L.S Healthcare Consultant Services

Mailing Address:

5612 Thicket Lane	Columbia	21044	MD
Street	City	Zip	State

Telephone: 410-730-2664

E-mail Address (required): asolberg@earthlink.net

Fax: 410-730-6775

If company name is different than applicant briefly describe the relationship Consultant

7. TYPE OF PROJECT

The following list includes all project categories that require a CON pursuant to COMAR 10.24.01.02(A). Please mark all that apply in the list below.

If approved, this CON would result in (check as many as apply):

(1) A new health care facility built, developed, or established ☒
(2) An existing health care facility moved to another site ☐
(3) A change in the bed capacity of a health care facility ☐
(4) A change in the type or scope of any health care service offered by a health care facility ☐
(5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: ☐
http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf

8. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is, why you need to do it, and what it will cost. A one-page response will suffice. Please include:

(1) Brief Description of the project – what the applicant proposes to do
(2) Rationale for the project – the need and/or business case for the proposed project
(3) Cost – the total cost of implementing the proposed project

11100 Billingsley Road OPCO, LLC proposes to establish an alcohol and drug abuse intermediate care facility in Charles County, Maryland. The proposed facility will include 21 Detox / Assessment beds subject to a Certificate of Need review, and an additional 145 residential beds for services that Applicant expects to certify at level III.5 or lower according under the American Society of Addiction

Medicine (ASAM) Patient Placement Criteria

Thousands of Maryland residents who are suffering from addiction need treatment today. Relying on data from Maryland Department of Health and Mental Hygiene (DHMH), the Washington Post reported that "Heroin-related deaths in Maryland spiked 88 percent from 2011 to 2013… and intoxication overdoses of all types now outnumber homicides in the state." *See* Exhibit 3. Joshua Sharfstein, former DHMH Secretary, has remarked "Overdose is a public-health crisis in Maryland, as it is in many states…and we are bringing everything we can to bear against this challenge." *Id.*

Maryland's existing portfolio of treatment facilities cannot begin to solve this problem. The most recently approved CON for bed expansion at Father Martin's Ashley, dated September 19, 2013, noted need for 107 to 152 Private ICF/CD beds for the Central Maryland Region alone. Additionally, Applicant's calculations indicate a need for new treatment beds in the range of 468 to 619, using 2014 population data, and 491 to 648 using projected 2019 population data. The Southern Maryland Region has a net bed need of 171 to 201 using 2014 population data, and 177 to 209 using 2019 projected population.

Applicant, together with its investors, is prepared to devote significant financial and clinical resources to not only developing the facility and treatment regimens, but to providing education and support to its surrounding communities. The total project cost is $21,193,277. Because Applicant will fund the project entirely through private channels, rather than seek state or local, or charitable funding, this cost represents a significant gain to the State and its efforts to combat the current addiction crises.

B. Comprehensive Project Description: The description should include details regarding:

(1) Construction, renovation, and demolition plans
(2) Changes in square footage of departments and units
(3) Physical plant or location changes
(4) Changes to affected services following completion of the project
(5) Outline the project schedule.

I. THE RECOVERY CENTERS OF AMERICA 11100 BILLINGSLEY ROAD FACILITY

A. The 11100 Billingsley Road Facility

The site consists of approximately 20 acres fronting on Billingsley Road in Charles County, Maryland. The facility consists of a main building and three ancillary buildings, providing a campus setting. The buildings were constructed in in 1988 and exhibit physical obsolescence. In response to the physical condition the Applicant's renovation plans include the removal of all interior finishes, including mechanical, electrical, life safety and plumbing systems. Construction will occur in two phases. The first phase includes the renovations described above and, if the project is approved, could begin mid-summer 2015 and could be completed by the end of the year. Phase II includes the erection of a new 29,000 square foot

three story addition. Construction of Phase II is scheduled to begin spring 2016 and be completed late summer 2016. The total size of the facilities following Phase II will be approximately 91,000 square feet.

The facility will be on a secluded campus setting on forested property. There are trails through the woods that may be utilized by patients for Adventure Therapy and Guided Meditation Walks.

B. Recovery Centers of America

Recovery Centers of America ("RCA") will be the operator of the facility. RCA is a privately held company that will provide services for individuals with substance use disorder and their families. The RCA Executive Team represents an average of 22 years of experience managing facilities that treat up to 40,000 individuals daily. The Executive Team's experience is in the following sectors:

- Residential and Outpatient Treatment Facilities
- Acute Care Hospitals
- Behavioral Health Services
- Academic Research
- Governmental Drug Policy Initiatives

RCA has developed a continuum of care model that is tailored to the unique needs of each patient and their families. The proposed project mission is to provide neighborhood-based, world class treatment with immediate solutions and a commitment to supporting lifelong recovery. RCA will offer clinical excellence to its patients, family, alumni, and the larger community through a continuum of care. RCA's model will include the following services, as the market demands:

- Residential/Inpatient Treatment
- Partial Hospitalization Program (PHP)
- Intensive Outpatient (IOP)
- Traditional Outpatient (OP)
- Family Therapy
- Support Groups (AA/NA/12-Step Groups)
- Community Groups
- Spiritual Services
- Contact Center

RCA plans to utilize a technologically advanced, scientific treatment approach. RCA will treat everyone who walks through the doors of its state-of-the-art facilities with respect and dignity. RCA employees truly care about the recovery of patients and will provide the quality communication, long-term monitoring, and accountability.

II. RCA'S TALENTED WORKFORCE

A. RCA Chief Clinical Officer

RCA's clinical care will be overseen by Deni Carise, Ph.D., Chief Clinical Officer for all RCA facilities. Dr. Carise, a clinical psychologist, will live at each RCA facility for the month

prior to and following the facility's opening, and will remain involved in each RCA facility after opening, setting standards for clinical care, measuring effectiveness, and being available to the RCA staff.

Dr. Carise has worked in the field of substance abuse and behavioral healthcare, as a researcher and clinician, for more than 28 years. She has extensive personal knowledge, know-how, and experience with regard to the types of activities she will be undertaking for RCA. Dr. Carise's areas of expertise include:

- Development, implementation and measurement of treatment tools and evidence-based practices such as computer software, clinical toolkits, program descriptors, assessment, intake and treatment planning instruments and procedures, continuing care, fidelity assessment, relapse prevention, family therapy, 12-step support, decreasing paperwork burden, diagnosing systems, psychodrama;
- Developing systems of care and partnerships such as performance-based contracting, concurrent recovery monitoring, implementation science, developing partnerships in the field, working with State directors, instrument and methods development;
- Tracking trends in alcohol and drug addiction;
- Eliciting positive public opinion and support for treatment.

A list of journal articles and other research and publications authored by Dr. Carise in each of these areas is attached as Exhibit 4. Dr. Carise also is an Adjunct Clinical Professor at the University of Pennsylvania School of Medicine. She is a frequent contributor to Huffington Post's Healthy Living blog – a list of her contributions is included in Exhibit 4, together with additional news and media contributions or appearances by Dr. Carise. Exhibit 4 also lists various lectures Dr. Carise has given, and other relevant professional activities.

B. RCA Staff

To implement its services, RCA will employ talented, licensed clinical staff including Clinical Directors, Clinical Supervisors, Primary Therapists, Case Managers, and Recovery Support Staff. These skilled clinicians will receive rigorous training and ongoing monitoring for competencies including Motivational Interviewing, Co-Occurring Disorders, Cognitive Behavioral Therapy, and Dialectical Behavioral Therapy.

RCA will maintain a medical team 24 hours a day, 7 days a week. RCA plans to employ Registered and Licensed Practical Nurses who will work closely with Nurse Practitioners, Psychiatric Nurse Practitioners, Physician Assistants and Psychiatrists.

C. RCA Collaboration

RCA staff collaborates with colleagues from the top research institutions and with the top innovators in the field, including the following.

Research groups: UPENN, Yale, Hopkins, Harvard, Brown, Dartmouth, UMDNJ, Treatment Research Institute.

Top innovators: Tom McLellan, Herbert Kleber, Amelia Arria, Charles O'Brien, Maxine Stitzer, Kathy Carroll, Bill Miller, William White, Kathleen Brady, Rick Rawson, Lisa Marsch.

III. TREATMENT AND PROGRAMMING

A. Approach to Treatment and Recovery

Getting a patient into treatment has historically been difficult and included numerous break-points or times when the patient finds it easier to walk away from treatment than to engage in or continue treatment. Some of these breakpoints include:

- The inability to identify the correct program;
- The inability to find quality treatment close to home;
- Treatment programs that do not answer phones or return calls;
- Difficulty identifying if the treatment provider accepts their health insurance;
- Lack of immediate transportation to the program; and
- Difficulty transitioning from residential to a new outpatient treatment center.

RCA insists on having a full continuum of care at its facilities. The National Institute on Drug Abuse – Principles of Drug Addiction Treatment: A Research Based Guide (Third Edition) ("NIDA Guide"), reports that good outcomes are contingent on adequate treatment length. Exhibit 5 at p. 12.

One of the most common break-points or times when patients leave treatment occurs when they need to transition from one facility to another, such as from residential to intensive outpatient or step-down care. If a patient has to develop new treatment relationships and start over in a new system with new peers, they rarely show up for the next, lower level of services. However, it the patient gets that service in the same system, or better yet, the same place, where the patient received residential care, the patient is more to continue in treatment and recovery.

The NIDA Guide remarks:

> Individuals progress through drug addiction treatment at various rates, so there is no predetermined length of treatment. However, research has shown unequivocally that good outcomes are contingent on adequate treatment length. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited effectiveness, and treatment lasting significantly longer is recommended for maintaining positive outcomes. For methadone maintenance, 12 months is considered the minimum, and some opioid-addicted individuals continue to benefit from methadone maintenance for many years.
>
> Treatment dropout is one of the major problems encountered by treatment programs; therefore, motivational techniques that can keep patients engaged will also improve outcomes. By viewing addiction as a chronic disease and offering continuing care and monitoring, programs can succeed, but this will often require multiple episodes of treatment and readily readmitting patients that have relapsed.

Exhibit 5 at p. 12.

RCA will give patients the highest likelihood of making the 90-day mark and increasing positive long-term outcomes. In an effort to create a program where patients will have better

treatment outcomes and better enable patients to have a meaningful, continued recovery, RCA will:

- Eliminate breakpoints for getting patients into treatment;
- Have a full continuum of care to extend gains made in all levels of treatment;
- Deliver services by highly trained, educated staff;
- Utilize evidence-based / best practices;
- Involve the family and other support systems;
- Provide individualized, tailored treatment including treatment plans, services, etc.; and
- Measure success rates.

In addition, RCA will participate in the NIDA Clinical Trials Network (CTN). In the CTN, the National Institute on Drug Abuse, treatment researchers, and community-based service providers cooperatively develop, validate, refine, and deliver new treatment options to patients in treatment. Members of RCA's leadership have long-standing involvement in the NIDA Clinical Trials Network.

B. Clinical Programming

RCA Clinical Programming will include common elements for all patients, but will also allow each patient to develop special services that are unique to his or her needs and interests. Examples of planned programming within the Clinical Services are:

- Individual Therapy
- Lectures/Workshops
- Small Groups (Primary Group Therapy, Gender groups, LGBT)
- Psychodrama
- Creative Art Therapies (Art, Dance, Music)
- Recreation Therapies (Challenge/Ropes Course)
- Stress Management
- Body/Central Nervous System Management (Meditation, Yoga, Progressive relaxation)

Clinical programming at RCA will be comprised of scientifically proven effective practices, known as Evidence-Based Practices (EBPs). EBPs examine reasons why specific procedures, treatments and medicine are given in an effort to meet two important goals: providing the most effective treatments and ensuring patient safety. RCA's clinical programming will consist of EBPs registered by the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP), including:

- Motivational Interviewing (Wm. Miller/MINT model)
- Relapse Prevention (TRI Toolkit and Matrix Models)
- 12-Step Facilitation (Project Match, TRI Toolkit)
- Dialectical Behavior Therapy (University of Washington Model)
- Cognitive Behavioral Therapies
- Behavioral Couples Therapy (Harvard University Model)
- The Matrix Model (selected sites)
- Trauma-Support Therapies (Boston, HWR & Seeking Safety)

- Supportive-Expressive Psychotherapy (University of Pennsylvania Model)
- Social Skills Training (Texas Christian University Model)

C. Patient Treatment Path

RCA will provide the following support and services to patients as they engage on their path to treatment and rehabilitation.

1. Contact Center

RCA will operate 24/7, 365 day a year Contact Center, through which individuals can access services by calls, texts, web chat, or emails. The Contact Center will be available to all Marylanders without limitation. Based on inquiries and medical necessity, every inbound contact will be assessed and referred within a close proximity to assure accessibility. RCA is in the process of obtaining referral agreements in the state of Maryland within a 30 mile radius that include but are not limited to residential, both inpatient and outpatient, sober living, half way houses, and other support groups related to addiction services. The Contact Center will be an asset to individuals and entities that will be available 24/7 with access to professionals trained and knowledgeable in regard to its callers and access to neighborhood resources. It will also offer insurance advocacy, and will be dedicated and committed to helping anyone who suffers from the disease of addiction.

The Contact Center will be staffed with RCA Care Advocates – clinically trained counselors who will specialize in assisting individuals navigate through the barriers to treatment. Care Advocates will act as a liaison for the patient, patient's family, and loved ones. Care Advocates will also verify insurance benefits and obtain authorization and case manage all inbound contacts regardless of their ability to pay. Care Advocates will dispatch Interventionists and transportation to an RCA facility if appropriate, and refer patients to appropriate levels of care based on medical necessity. Referrals will include, but will not be limited to, RCA facilities, RCA partners, and any other resources available to meet the caller's needs. RCA will place patients into meaningful recovery in their own neighborhoods, regardless of insurance or economic barriers.

The Contact Center will have full integration of all RCA systems, including its CRM (Salesforce), telephonic system and EMR (electronic medical record system). The integration of RCA systems is mission critical and will allow RCA Care Advocates to see real time facility data, the location of the individual who is calling in, and any history of the caller if they have called RCA before. This will allow for seamless transition of patient information when the patient is admitted into an RCA treatment program. RCA will have a robust database with a variety of treatment options, support groups, and educational information to meet our customers' every need.

2. Intervention

RCA's team of trained Interventionists will conduct an intervention on-site or in a patient's home when needed. The Interventionist will facilitate the intervention from start to finish. They will arrange the intervention, prepare the family and friends, and lead the discussions during the intervention. The Interventionist will then prepare a clinical assessment, address payment options, accompany the patient to the treatment program, provide transportation via black car service if needed, and provide family counseling to begin the healing process for the patient and their loved ones.

3. Detoxification

Upon admission, all patients will undergo a comprehensive medical evaluation. When medically indicated, patients will receive detoxification services, including medications to ensure a medically safe withdrawal and help ease the pain associated with withdraw symptoms. Patients are closely monitored 24 hours a day by physicians and other medical staff. The second goal of Detoxification is to ensure transition into the next level of care – residential or some form of outpatient. Detoxification alone is never considered a full course of treatment.

4. Inpatient/Residential Treatment

Intensive, structured residential care will be available. A patient's care will begin with a series of medical and clinical assessments, the results of which will be used to determine the patient's schedule, services and length of stay. Patients will be actively engaged in clinical services from 7:30 AM to 9:30 PM every day. Patient services include: daily group therapy and education seminars; individual therapy sessions one or two times per week; family program along with family and couples counseling; multiple choices for patient to select types of additional services such as art therapy, music therapy, relapse prevention. Some of these programs will be required, and some will be elective.

5. Partial Hospitalization/Day Program (PHP)

RCA will provide PHP services to individuals needing extended daily treatment in an outpatient setting. Clinical programming for PHP occupies 20 hours per week and includes the following: Daily group therapy and educational seminars, weekly individual therapy sessions, bi-weekly family therapy sessions, and psychiatric and medical services available as need.

6. Intensive Outpatient (IOP)

The RCA IOP treatment model will provide primary, organized treatment program to patients who are able to establish abstinence and recovery within the context of their usual daily activities. Treatment consists of educational and group therapy sessions three days per week, three hours per day. It also includes ongoing individual, family and couples therapy sessions. Psychiatric and medical services are available as needed.

7. Traditional Outpatient Treatment (OP)

The RCA OP treatment model will include individual, family, couples and group counseling. Patients likely will attend one to three times a week in 45-90 minute sessions. Psychiatric and medical services will be available as needed.

8. Recovery Support Services

RCA will offer Recovery Support Services (RSS) that are designed and delivered by people who have experienced both substance use disorder and recovery. RSS will help people become and stay engaged in the recovery process, reduce the likelihood of relapse, and focus on strength and resilience. The four major types of RSS are: (1) peer mentoring or coaching, (2) recovery resource connecting, (3) facilitating and leading recovery groups, and (4) building community. Examples of RSS include but are not limited to: peer-led support groups, parenting classes, Job Readiness training, assistance accessing community health and social services, alcohol- and drug-free social events and opportunities.

9. Concurrent Recovery Monitoring

Concurrent Recovery Monitoring (CRM) will provide patients monthly support for one year post-discharge from a RCA residential treatment program. Based on chronic disease medical models, CRM will provide clinically-relevant evaluation and recovery support for the patient. The monthly evaluation will include a standardized assessment of physical and behavioral health, societal/familial function, reduction in substance use and cravings. Based on the patient's assessment response, the counselor will:

- Provide recommendations for continuing care, such as outpatient treatment.
- Connect patient to support groups in the local area
- Provide accountability and recovery support

10. Post-Treatment Alumni Services

RCA's Alumni Program is built on the foundation that offering continued support for those in recovery is a necessary service. The program will provide patients with the necessary support and resources to maintain sobriety close to home. The services will offer patients and their families a safe environment where they can come to talk, build relationships, attend Recovery Support Meetings, receive continued education, participate in fun events and activities, and more. RCA Alumni Program Activities will include Sober Events, 12-Step Meetings, cookouts, group activities such as hiking trips, family activities, and fundraising events.

D. Elective Patient and Community Programming

RCA will provide educational, spiritual, and community support programming to its patients, some of which will be available to the surrounding community.

1. Self-Help Groups

Also known as mutual help, mutual aid, or support groups, these groups will be comprised of people who share a common problem or addiction and provide mutual support to help each other to cope with and heal or recover from, their problems. RCA will provide space on the grounds of its programs for numerous self-help groups to meet on a regular basis. Patients can attend these meetings before, during, and after their treatment to help develop their support network and provide the highest likelihood of maintaining recovery. Examples of Mutual or Self-Help Groups include: Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous, Secular Organization for Sobriety, SMART Recovery, Adult Children of Alcoholics, Al-Anon, Alateen, Debtors Anonymous, Gamblers Anonymous, Emotions Anonymous, and Overeaters Anonymous.

2. Spiritual Services

All RCA Treatment Programs will have spiritual staff dedicated to helping others find recovery. These staff may be from any one of a number of various religious affiliations, with the common their belief that any spiritual basis can be of help in the maintenance and continuation of a rewarding life in recovery. Part of their job will be to provide services for RCA patients, family, staff, alumni, and anyone the community who may be attracted to our particular blend of spiritual services that include exceptional discussions and musical performances amid prayer and meditation.

3. Speaker Series

The RCA Speaker Series serves will provide information and opportunity for dialogue to the local community, families of patients, alumni and professionals. Speakers will include RCA employees, researchers and other experts in the field. Topics may include but are not limited to:

- What To Do If You Suspect A Loved One Is Abusing Drugs
- Does Treatment For Substance Use Disorder Work? Compared To What?
- The Impact of Affordable Care Act & Healthcare Reform on Substance Abuse Treatment
- Why Say No to Marijuana Legalization?
- How to Talk to Your Kids About Drugs and Alcohol
- Reconsidering Addiction Treatment
- The Science of Addiction
- Is Alcohol a Drug?
- How to Find the Right Treatment Program – Ten Questions to Ask

IV. CONCLUSION

There is no greater problem facing Maryland today than the scourge of drug and alcohol addiction, and the deplorable shortage of facilities needed to help thousands of individuals and families return to healthy, productive lives. Applicant believes that 11100 Billingsley Road is the ideal location for a top-quality, state of the art facility to help those in need and reduce the state's deficit in care.

9. Complete Table A of the CON Table Package.

10. Identify any community based services that are or will be offered at the facility and explain how each one will be affected by the project.

Applicant will provide space on the facility grounds for various self-help groups, and will provide information and an opportunity for dialogue to the local community through its Speakers Series. These programs are described more fully in the Project Description, pp. 5-13.

11. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: approximately 20 acres

B. Have all necessary State and local land use and environmental approvals, including zoning and site plan, for the project as proposed been obtained? YES_____ NO __x__ (If NO, describe below the current status and timetable for receiving each of the necessary approvals.)

This property is located in Charles County, Maryland in the land use area identified as "North/Mid". Hospitals are a permitted use in land use area North/Mid.

There are no site plan approvals required for Phase I. Phase II will require a site plan be submitted to and approved by Charles County. Because the footprint of the addition is relatively small, the major issue to address in the site plan application process is storm water management. County officials and several vendors indicate that this process will take from five to six months.

C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

(1) Owned by: Changing Point, Inc

(2) Options to purchase held by: Recovery Centers of America LLC
Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: _____
Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: _____
Please provide a copy of the option to lease as an attachment.

(5) Other: _____
Explain and provide legal documents as an attachment.

12. PROJECT SCHEDULE

(INSTRUCTION: IN COMPLETING THE APPLICABLE OF ITEMS 10, 11 or 12, PLEASE CONSULT THE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

For new construction or renovation projects.

Project Implementation Target Dates

A. Obligation of Capital Expenditure 2 months from approval date.
B. Beginning Construction 1 months from capital obligation.
C. Pre-Licensure/First Use 15 months from capital obligation.
D. Full Utilization 14 months from first use.

For projects not involving construction or renovations.

Project Implementation Target Dates

A. Obligation or expenditure of 51% of Capital Expenditure _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from capital obligation.
C. Full Utilization _____ months from first use.

For projects not involving capital expenditures.

Project Implementation Target Dates

A. Obligation or expenditure of 51% Project Budget _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from CON approval.
C. Full Utilization _____ months from first use.

13. PROJECT DRAWINGS

Projects involving new construction and/or renovations should include scalable schematic drawings of the facility at least a 1/16" scale. Drawings should be completely legible and include dates.

These drawings should include the following before (existing) and after (proposed), as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, number of beds, location of bath rooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space".

B. For projects involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. Specify dimensions and square footage of patient rooms.

Applicant Response

See Exhibit 6.

14. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction and Renovation Square Footage worksheet in the CON Table Package (Table B)

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project and identify the provider of each utility. Specify the steps that will be necessary to obtain utilities.

The property is served by public water and sewer provide by Charles County. Capacity for both water and sewer exceeds our projected needs. Natural gas and electricity are provided by Washington Gas & Light.

PART II - PROJECT BUDGET

Complete the Project Budget worksheet in the CON Table Package (Table C).

Note: Applicant should include a list of all assumptions and specify what is included in each budget line, as well as the source of cost estimates and the manner in which all cost estimates are derived. Explain how the budgeted amount for contingencies was determined and why the amount budgeted is adequate for the project given the nature of the project and the current stage of design (i.e., schematic, working drawings, etc.).

Applicant Response

Please see Exhibit 1, Table E for the Project Budget and statement of assumptions.

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. List names and addresses of all owners and individuals responsible for the proposed project and its implementation.

   John Paul Christen
   Chief Operating Officer
   Recovery Centers of America, LLC
   2701 Renaissance Blvd. 4th Fl.
   King of Prussia PA 19406

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2. Are the applicant, owners, or the responsible persons listed in response to Part 1, questions 2, 3, 4, 7, and 9 above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

   Universal Health Services of Delaware, Inc., King of Prussia PA—Vice President, Acute Finance (2004-2014)
   The Valley Health System (5 hospitals), Las Vegas NV—Market Chief Financial Officer (2001-2003)
   Manatee Memorial Hospital, Bradenton FL—Chief Financial Officer (1995-2001)
   Valley Hospital Medical Center, Las Vegas NV—Chief Financial Officer (1992-1995)
   Humana, Inc., Louisville KY (1987-1992)
   - Humana Hospital Aurora—Chief Financial Officer/Associate Executive Director (1990-1992)
   - Humana Hospital San Leandro—Chief Financial Officer/Associate Executive Director (1989-1990)
   - Humana Hospital Desert Valley—Controller/Assistant Executive Director, Finance (1987-1988)

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3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Question 2, above, been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owners or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

   Mr. Christen has not been involved with any of the facilities listed in response to number two in the last 5 years, except for Universal Health Services of Delaware, Inc. ("UHS"). Mr. Christen was the CFO for the corporate office of UHS, which oversees more than 25 facilities. Mr. Christen does not have any personal knowledge that any UHS facilities have had their certification suspended or revoked within the last 5 years. Disciplinary actions, and any suspension or revocation, would be identified in UHS' annual filings, available at: http://ir.uhsinc.com/phoenix.zhtml?c=105817&p=irol-sec.

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4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which

any applicant has in the past been involved (listed in response to Question 2, above) received inquiries in last from 10 years from any federal or state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with any state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

No

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5. Have the applicant, owners or responsible individuals listed in response to Part 1, questions 2, 3, 4, 7, and 9, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

   No

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the proposed or existing facility.

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.

3/26/15
Date

Signature of Owner or Board-designated Official

Authorized agent of Applicant
Chief Operating Officer of RCA
Position/Title

John Paul Christen
Printed Name

PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and to the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

10.24.01.08G(3)(a). <u>THE STATE HEALTH PLAN</u>.

Every applicant must address each applicable standard in the chapter of the State Health Plan for Facilities and Services[1]. Commission staff can help guide applicants to the chapter(s) that applies to a particular proposal.

Please provide a direct, concise response explaining the project's consistency with each standard. Some standards require specific documentation (e.g., policies, certifications) which should be included within the application as an exhibit.
THE STATE HEALTH PLAN FOR FACILITIES AND SERVICES: ALCOHOLISM AND DRUG ABUSE INTERMEDIATE CARE FACILITY TREATMENT SERVICES.

10.24.14.05 Certificate of Need Approval Rules and Review Standards for New Substance Abuse Treatment Facilities and for Expansions of Existing Facilities

.05A. <u>Approval Rules Related To Facility Size.</u>

Unless the applicant demonstrates why a relevant standard should not apply, the following standards apply to applicants seeking to establish or to expand either a Track One or a Track Two intermediate care facility.

(1) The Commission will approve a Certificate of Need application for an intermediate care facility having less than 15 beds only if the applicant dedicates a special population as defined in Regulation .08.

(2) The Commission will approve a Certificate of Need application for a new intermediate care facility only if the facility will have no more than 40 adolescent or 50 adult intermediate care facility beds, or a total of 90 beds, if the applicant is applying to serve both age groups.

[1] Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here:http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp.

(3) The Commission will not approve a Certificate of Need application for expansion of an existing alcohol and drug abuse intermediate care facility if its approval would result in the facility exceeding a total of 40 adolescent or 100 adult intermediate care facility beds, or a total of 140 beds, if the applicant is applying to serve both age groups.

Applicant Response

Not applicable. Applicant is applying for no more than 21 adult ICF treatment beds.

.05B. Identification of Intermediate Care Facility Alcohol and Drug Abuse Bed Need.

(1) An applicant seeking Certificate of Need approval to establish or expand an intermediate care facility for substance abuse treatment services must apply under one of the two categories of bed need under this Chapter:

(a) For Track One, the Commission projects maximum need for alcohol and drug abuse intermediate care beds in a region using the need projection methodology in Regulation .07 of this Chapter and updates published in the Maryland Register.

(b) For Track Two, as defined at Regulation .08, an applicant who proposes to provide 50 percent or more of its patient days annually to indigent and gray area patients may apply for:

(i) Publicly-funded beds, as defined in Regulation .08 of this Chapter, consistent with the level of funding provided by the Maryland Medical Assistance Programs (MMAP), Alcohol and Drug Abuse Administration, or a local jurisdiction or jurisdictions; and

(ii) A number of beds to be used for private-pay patients in accordance with Regulation .08, in addition to the number of beds projected to be needed in Regulation .07 of this Chapter.

(2) To establish or to expand a Track Two intermediate care facility, an applicant must:

(a) Document the need for the number and types of beds being applied for;

(b) Agree to co-mingle publicly-funded and private-pay patients within the facility;

(c) Assure that indigents, including court-referrals, will receive preference for admission, and

(d) Agree that, if either the Alcohol and Drug Abuse Administration, or a local jurisdiction terminates the contractual agreement and funding for the facility's clients, the facility will notify the Commission and the Office of Health Care Quality within 15 days that that the facility is relinquishing its certification to operate, and will not use either its publicly- or privately-funded intermediate care facility beds for private-pay patients without obtaining a new Certificate of Need.

Applicant Response

I. Drug and Alcohol Addiction as a National Problem

The need for additional beds is supported by the 2013 National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the United States Department of Health and Human Services.[2] The survey is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the civilian, noninstitutionalized population of the United States aged 12 years old or older. The following are key results of the survey:

A. Illicit Drug Use

- In 2013, an estimated 24.6 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 9.4 percent of the population aged 12 or older. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics (pain relievers, tranquilizers, stimulants, and sedatives) used nonmedically.

- The rate of current illicit drug use among persons aged 12 or older in 2013 (9.4 percent) was similar to the rates in 2010 (8.9 percent) and 2012 (9.2 percent), but it was higher than the rates in 2002 to 2009 and in 2011 (ranging from 7.9 to 8.7 percent), showing significant increase in use over the past several years.

- Marijuana was the most commonly used illicit drug in 2013. There were 19.8 million current (past month) users in 2013 (7.5 percent of those aged 12 or older), which was similar to the number and rate in 2012 (18.9 million or 7.3 percent). The 2013 rate was higher than the rates in 2002 to 2011 (ranging from 5.8 to 7.0 percent). Marijuana was used by 80.6 percent of current illicit drug users in 2013.

- Daily or almost daily use of marijuana (used on 20 or more days in the past month) increased from 5.1 million persons in 2005 to 2007 to 8.1 million persons in 2013.

- In 2013, there were 1.5 million current cocaine users aged 12 or older, or 0.6 percent of the population. These estimates were similar to the numbers and rates in 2009 to 2012 (ranging from 1.4 million to 1.7 million or from 0.5 to 0.7 percent), but they were lower than those in 2002 to 2007 (ranging from 2.0 million to 2.4 million or from 0.8 to 1.0 percent).

- The number of past year heroin users in 2013 (681,000) was similar to the numbers in 2009 to 2012 (ranging from 582,000 to 669,000) and was higher than the numbers in 2002 to 2005, 2007, and 2008 (ranging from 314,000 to 455,000).

- An estimated 1.3 million persons aged 12 or older in 2013 (0.5 percent) used hallucinogens in the past month. The number of users in 2013 was similar to that in 2012 (1.1 million), but it was higher than in 2011 (1.0 million).

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[2] The survey is available at http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf (last accessed 3/5/2015).

- The percentage of persons aged 12 or older who used prescription-type psychotherapeutic drugs nonmedically in the past month in 2013 (2.5 percent) was similar to the percentages in 2010 to 2012 (ranging from 2.4 to 2.7 percent).

- The number and percentage of past month methamphetamine users in 2013 (595,000 or 0.2 percent) were similar to those in 2012 (440,000 or 0.2 percent) and 2011 (439,000 or 0.2 percent), but they were higher than the estimates in 2010 (353,000 or 0.1 percent).

- Among youths aged 12 to 17, the rate of current illicit drug use was lower in 2013 (8.8 percent) than in 2002 to 2007 (ranging from 9.6 to 11.6 percent) and in 2009 to 2012 (ranging from 9.5 to 10.1 percent).

- The rate of current marijuana use among youths aged 12 to 17 in 2013 (7.1 percent) was similar to the 2012 rate (7.2 percent) and the rates in 2004 to 2010 (ranging from 6.7 to 7.6 percent); however, it was lower than the rates in 2002, 2003, and 2011 (ranging from 7.9 to 8.2 percent).

- Among youths aged 12 to 17, the rate of current nonmedical use of prescription-type drugs declined from 4.0 percent in 2002 and 2003 to 2.2 percent in 2013. The rate of nonmedical pain reliever use among youths also declined from 3.2 percent in 2002 and 2003 to 1.7 percent in 2013.

- The rate of current use of illicit drugs among young adults aged 18 to 25 in 2013 (21.5 percent) was similar to the rates in 2009 to 2012 (ranging from 21.3 to 21.6 percent), which was consistent with the steady rate of current marijuana use in this age group during this time (19.1 percent in 2013 and ranging from 18.2 to 19.0 percent in 2009 to 2012).

- Among young adults aged 18 to 25, the rate of current nonmedical use of prescription-type drugs in 2013 was 4.8 percent, which was similar to the rates in 2011 (5.0 percent) and 2012 (5.3 percent), but it was lower than the rates in the years from 2002 to 2010 (ranging from 5.5 to 6.5 percent).

- The rate of current cocaine use in 2013 among young adults aged 18 to 25 was 1.1 percent, which was similar to the rates in 2009, 2011, and 2012, but it was lower than the rates from 2002 to 2008 and in 2010.

- Among adults aged 26 or older, the rate of current illicit drug use in 2013 (7.3 percent) was similar to the rate in 2012 (7.0 percent), but it was higher than the rates in 2002 to 2011 (ranging from 5.5 to 6.6 percent). This was driven by rates of current marijuana use, which also remained steady between 2013 and 2012 (5.6 and 5.3 percent, respectively). However, the rate of current marijuana use in 2013 was higher than the rates in 2002 to 2011 (ranging from 3.9 to 4.8 percent).

- Among adults aged 50 to 64, the rate of current illicit drug use increased from 2.7 percent in 2002 to 6.0 percent in 2013. For adults aged 50 to 54, the rate increased from 3.4 percent in 2002 to 7.9 percent in 2013. Among those aged 55 to 59, the rate of current illicit drug use increased from 1.9 percent in 2002 to 5.7 percent in 2013. Among those aged 60 to 64, the rate of current illicit drug use increased from 1.1 percent in 2003 and 2004 to 3.9 percent in 2013.

- Among unemployed adults aged 18 or older in 2013, 18.2 percent were current illicit drug users, which was higher than the rates of 9.1 percent for those who were employed full time and 13.7 percent for those who were employed part time. However, most illicit drug users were employed. Of the 22.4 million current illicit drug users aged 18 or older in 2013, 15.4 million (68.9 percent) were employed either full or part time.

- In 2013, 9.9 million persons (3.8 percent of those aged 12 or older) reported driving under the influence of illicit drugs during the past year, which was similar to the rate in 2012 (3.9 percent). In 2013, the rate was highest among young adults aged 18 to 25 (10.6 percent), although this rate was lower than the rate in 2012 for this age group (11.9 percent).

- Among persons aged 12 or older in 2012-2013 who used pain relievers nonmedically in the past 12 months, 53.0 percent got the drug they used most recently from a friend or relative for free, and 10.6 percent bought the drug from a friend or relative. Another 21.2 percent reported that they got the drug through a prescription from one doctor. An annual average of 4.3 percent got pain relievers from a drug dealer or other stranger, and 0.1 percent bought them on the Internet.

B. Alcohol Use

- Slightly more than half (52.2 percent) of Americans aged 12 or older reported being current drinkers of alcohol in the 2013 survey, which was similar to the rate in 2012 (52.1 percent). This translates to an estimated 136.9 million current drinkers in 2013.

- In 2013, nearly one quarter (22.9 percent) of persons aged 12 or older were binge alcohol users in the past 30 days. This translates to about 60.1 million people. The rate in 2013 was similar to the estimate in 2012 (23.0 percent). Binge drinking is defined as having five or more drinks on the same occasion on at least 1 day in the 30 days prior to the survey.

- In 2013, heavy drinking was reported by 6.3 percent of the population aged 12 or older, or 16.5 million people. This rate was similar to the rate of heavy drinking in 2012 (6.5 percent). Heavy drinking is defined as binge drinking on at least 5 days in the past 30 days.

- Among young adults aged 18 to 25 in 2013, the rate of binge drinking was 37.9 percent, and the rate of heavy drinking was 11.3 percent. These rates were lower than the corresponding rates in 2012 (39.5 and 12.7 percent, respectively).

- The rate of current alcohol use among youths aged 12 to 17 was 11.6 percent in 2013. Youth binge and heavy drinking rates in 2013 were 6.2 and 1.2 percent, respectively. The rates for current and binge alcohol use were lower than those reported in 2012 (12.9 and 7.2 percent, respectively).

- In 2013, an estimated 10.9 percent of persons aged 12 or older drove under the influence of alcohol at least once in the past year. This percentage was lower than in 2002 (14.2 percent), but it was similar to the rate in 2012 (11.2 percent). The rate was highest among persons aged 21 to 25 and persons aged 26 to 29 (19.7 and 20.7 percent, respectively). Among persons aged 12 to 20 and those aged 21 to 25,

the rates of driving under the influence of alcohol were lower in 2013 (4.7 and 19.7 percent, respectively) than in 2012 (5.7 and 21.9 percent, respectively).

- An estimated 8.7 million underage persons (aged 12 to 20) were current drinkers in 2013, including 5.4 million binge drinkers and 1.4 million heavy drinkers. Corresponding percentages of underage persons in 2013 were 22.7 percent for current alcohol use, 14.2 percent for binge alcohol use, and 3.7 percent for heavy use. All of these percentages were lower than those in 2012. 4

- Past month, binge, and heavy drinking rates among underage persons declined between 2002 and 2013. Past month alcohol use declined from 28.8 to 22.7 percent, binge drinking declined from 19.3 to 14.2 percent, and heavy drinking declined from 6.2 to 3.7 percent.

- In 2013, 52.2 percent of current underage drinkers reported that their last use of alcohol occurred in someone else's home, and 34.2 percent reported that it had occurred in their own home. Most current drinkers aged 12 to 20 (77.6 percent) were with two or more other people the last time they drank alcohol. The rate of drinking alone the last time that underage persons drank alcohol was highest among youths aged 12 to 14 (14.5 percent).

- Among current underage drinkers, 28.7 percent paid for the alcohol the last time they drank, including 7.8 percent who purchased the alcohol themselves and 20.5 percent who gave money to someone else to purchase it. Among those who did not pay for the alcohol they last drank, 36.6 percent got it from an unrelated person aged 21 or older; 24.5 percent got it from a parent, guardian, or other adult family member; and 16.4 percent got it from another person younger than 21 years old.

- In 2013, underage current drinkers were more likely than current alcohol users aged 21 or older to use illicit drugs within 2 hours of alcohol use on their last reported drinking occasion (19.9 vs. 5.7 percent, respectively). The most commonly reported illicit drug used by underage drinkers in combination with alcohol was marijuana.

II. Maryland Bed Need

Thousands of Maryland residents who are suffering from addiction need treatment today Relying data from Maryland Department of Health and Mental Hygiene (DHMH), the Washington Post reported that “Heroin-related deaths in Maryland spiked 88 percent from 2011 to 2013 . . . and intoxication overdoses of all types now outnumber homicides in the state.” *See* Exhibit 14. Joshua Sharfstein, former DHMH Secretary, has remarked “Overdose is a public-health crisis in Maryland, as it is in many states…and we are bringing everything we can to bear against this challenge.” *Id.*

Maryland’s existing portfolio of treatment facilities cannot begin to solve this problem. The most recently approved CON for bed expansion at Father Martin’s Ashley dated September 19, 2013 noted need for Private ICF/CD beds 107 to 152 for the Central Maryland Region alone. Additionally, Applicant’s calculations indicate a need for new treatment beds in the range of 448 to 551, using 2014 population data, and 468 to 575 using projected 2019 population data. Southern Maryland Region has a net bed need of 105 to 126 using 2014 population data, and 110 to 132 using 2019 projected population.

A. Methodology

Applicant calculated bed need for the state of Maryland using the methodology outlined in the State Health Plan, COMAR 10.24.14.07B, with a few adjustments. A summary of this process and the results follow.

Population Data

Applicant selected population data for the years 2010 and 2014, and projected population for 2019. Such figures were derived from two different sources, the 2010 data is from Maryland's Department of Planning database, and Data Analysis, which was sourced by the 2010 US Census. The 2014 population and 2019 projected population were sourced by ESRI Geographic Information Systems (GIS) software.

Table 1
2010 and projected 2014, 2019 Population
Southern Maryland Region

St. Mary's County, MD

	2014	2019
18-19	3,142	3,317
20-24	7,784	7,286
25-34	15,041	16,212
35-44	14,076	15,923
45-54	17,130	15,991
55-64	13,381	15,772
65-74	7,793	9,393
75-84	3,670	4,432
85+	1,389	1,512
Total 18+	***83,406***	***89,838***

Prince George's County, MD

	2014	2019
18-19	24,810	24,871
20-24	70,619	63,545
25-34	130,938	136,093
35-44	118,800	124,125
45-54	123,937	118,046
55-64	105,545	112,568
65-74	62,713	76,282
75-84	26,740	34,131
85+	9,172	10,790
Total 18+	***673,274***	***700,451***

Charles County, MD

	2014	2019
18-19	4,337	4,196
20-24	10,149	9,099
25-34	19,824	23,330
35-44	21,202	22,474
45-54	25,848	24,578
55-64	18,647	21,897
65-74	10,924	13,249
75-84	4,536	5,774
85+	1,632	1,897
Total 18+	***117,099***	***126,494***

Calvery County, MD

	2014	2019
18-19	2,598	2,546
20-24	5,398	4,727
25-34	10,376	11,326
35-44	10,836	11,841
45-54	16,144	14,040
55-64	12,764	14,546
65-74	7,100	8,709
75-84	3,130	3,724
85+	1,350	1,470
Total 18+	***69,696***	***72,929***

State Calculated Southern Region Population (18+)

	2010
Saint Mary's	77,565
Charles	107,667
Prince George's	657,421
Calvert	65,506
Total	***908,159***

RCA Calculated Southern Region Population (18+)

	2014	2019
Saint Mary's	83,406	89,838
Charles	117,099	126,494
Prince George's	673,274	700,451
Calvert	69,696	72,929
Total	***943,475***	***989,712***

Privately Insured MD Residents:

The first notable change the Applicant made to the State Health Plan methodology is that Applicant adjusted the methodology to remove the distinction between indigent and non-indigent patients and instead calculated bed need for Maryland residents over the age of 18 with private insurance – which makes up 95% of Applicant's target population. After projecting bed need for privately insured residents, Applicant then calculated bed need for the entire population, which includes privately insured residents, as well as residents with Medicare, Medicaid, Military insurance, or no insurance. Applicant used the national average for the insurance calculations, based on the 2013 National Health Interview Survey, available on the website of the CDC, http://www.cdc.gov/nchs/fastats/health-insurance.htm.

Discharge from out-of-state:

Applicant also modified the discharges from out-of-state, choosing to remove the line item in the State Health Plan methodology. Instead, the Applicant projected bed need for the region population without taking out of state discharges into account. After fully defining this bed need, Applicant then determined what proportion of its beds would be used by Maryland residents versus out-of-state residents by utilizing a 90mile catchment area around the facility, deducting, areas of the state that do not fall within its catchment to derive a total of number of Maryland residents it its catchment area. To find the percent of MD residents that fall within the catchment area, Applicant divided the MD population figure from the total catchment population. Applicant then used the MD population percent and multiplied it by the total detox beds Applicant is seeking. Applicant believes that the resulting percent of out-of-state population is in line with other providers, on the basis that Father Martin's Ashley states on page 22 of its 2013 Application that 52% of its patient population is from out-of-state.

Table 2
Waldorf Catchment Area, 2014

	2014 Estimate	MD 2014 Population		NOT MD CALC	RCA MD Catchment
Total Market Area	**12,591,421**			**107,129**	
18-24	1,185,061			8,180.00	
25-34	1,688,719			12,934	
35-44	1,716,031			12,322	
45-54	1,868,356			14,685	
55-64	1,443,987			14,783	
65-74	805,236			11,465	
75-84	449,740			6,484	
85+	191,565			2,905	
Total Population over 18	9,348,695		4,612,691	83,758	**4,528,933**

% of out-of-state patients	Detox Beds for out-of-state	% of beds for MD Residents	Beds for MD Residents
51.6%	10	48.4	11

Table 3
Waldorf Catchment Area, 2019

	2019 Estimate	MD 2019 Population		NOT MD CALC	RCA MD Catchment
Total Market Area	**13,265,612**			**107,020**	
18-24	1,136,125			7,146.00	
25-34	1,838,843			13,389	
35-44	1,775,373			11,955	
45-54	1,743,961			13,374	
55-64	1,744,713			15,202	
65-74	1,213,357			12,913	
75-84	577,928			7,463	
85+	234,504			3,014	
Total Population over 18	10,264,804		4,793,500	84,456	**4,709,044**

% of out-of-state patients	Detox Beds for out-of-state	% of beds for MD Residents	Beds for MD Residents
51.8%	11	45.2%	10

Applicant also asks that the Commission note the lack of providers that will directly compete with Applicant's locations. The graphic below demonstrates the low amount of direct competition in the Mid-Atlantic Region, and provides a better understanding of Applicant's 'neighborhood' model. Applicant's 'neighborhood' model is defined as 90 miles reach from the facility, or roughly an hour and half drive.

Table 4
Neighboring Providers

						Distance in miles from Facility		
	Name of Facility	Address	Beds	Detox Offered	Private Pay Daily Rate	From Earleville	From Upper Marlboro	From Waldorf
1	Williamsville Wellness	Hanover, VA	16	No	$ 833	182	92	78
2	Sagebrush	Great Falls, VA	N/Av	N/Av	$ 1,167	113	45	49
3	Hudson Health Services	Salisbury, MD	N/Av	Yes	$ 575	92	109	123
4	Father Martin's Ashley (28 Day Program)	Havre De Grace, MD	100	Yes	$ 857	32	70	86
5	Serenity Acres	Crownsville, MD	35	Yes	$ 667	69	22	49
6	Clarity Way	Hanover, PA	23	Yes	$ 1,000	89	76	98
7	Caron Treatment Centers Adult Primary Care Services	Wernersville, PA	257	Yes	$ 1,167	76	141	160
8	Retreat: Lancaster	Lancaster, PA	150	Yes	$ 1,000	64	108	139
9	Malvern Institute	Malvern, PA & Willow Grove, PA	172	Yes	$ 680	61	126	148
10	Mirmount	Media, PA	115	Yes	$ 625	59	127	137
11	Meadowwood	New Castle, DE	58	Yes	$ 800	30	103	42
	Total / Average		**431**		**$852**			

Existing Track One Beds in Maryland

Applicant modified the calculation of Track one beds provided in Table 3 in the State Health Plan. Because the CON requirement only applies to Applicant's Detox and Assessment beds, which are those that will provide intermediate care, or Level III.7 and III.7-D under the American Society of Addiction Medicine (ASAM) Patient Placement Criteria, rather than to all beds that provide lower levels of care.

Applicant assumes that existing providers use 20% of their licensed beds as 'true' detox beds and the remaining 80% as inpatient beds. The Applicant concluded the 20% assumption from internal discussions with RCA's clinical and operations team who have extensive experience in the field.

Table 5
Existing Track One Detox Beds
Maryland State

	All Beds	Detox Beds (20%)
Mountain Manor	111	23
Father Martin Ashley	100	20
Montgomery General	10	2
Warrick Manor	8	2
Total	229	47

There are no existing track one beds in the Southern Region.

B. Results – Bed Need by Region and Statewide

Applying this methodology, Applicant has calculated the following bed need for the Southern Maryland region:

Table 6
Regional Bed ICF Need Projection
Southern Maryland Region

				MD Population 2010-Development (3)	RCA 2014 Population (2)	RCA Projected 2019 (2)
	Projected Population for 18 Years and older - Projected 2018			908,159	943,475	989,712
a	**Estimated # of privately insured (1)**	*64.2%*		583,038 (1)	605,711 (1)	635,395 (1)
b	**Estimated # of Substance Abuse Users**	*8.64%*		50,374	52,333	54,898
c1	**Estimated Annual Target Population**	*25.00%*		12,594	13,083	13,725
c2	**Estimated # requiring Treatment**	*95.00%*		11,964	12,429	13,038
d	**Estimated Population requiring ICF (12.5-15%)**					
d1	Min %	*12.50%*		1,495	1,554	1,630
d2	Max %	*15.00%*		1,795	1,864	1,956
e	**Estimated Range requiring Readmission**					
e1	Min %	*10.00%*		150	155	163
e2	Max %	*10.00%*		179	186	196
		(4)				
f	**Range of Adults requiring ICF/CD Care**					
	Min = (d1+e1)			1,645	1,709	1,793
	Max = (d2+e2)			1,974	2,051	2,151
g	**Gross # of Adult ICF Bed Needed**					
g1	Min = ((f*14 ALOS))/365)/0.85		14	74	77	81
g2	Max = ((f*14 ALOS))/365)/0.85		14	89	93	97
h	**Existing Track One Inventory ICF/CD beds**			-	-	-
i	**Net Private ICF/CD Bed Needed**					
	Min = (g1-h)			**74**	**77**	**81**
	Max = (g2-h)			**89**	**93**	**97**
j	**Net <u>All</u> ICF Bed Needed**					
	Min = (iMin x(1 + % of population w/out private insurance))	*35.8%*		**101**	**105**	**110**
	Min = (iMax x (1 + % of population w/out private insurance))	*35.8%*		**121**	**126**	**132**

Notes:

(1) 2013 National Health Interview Survery - CDC
(2) Numbers based off ESRI data
(3) State calculation based off State of MD Development Census numbers
(4) Out-of-state need accounted for in the beds requested, details regarding the calculation to come later in report
(5) Percentages for b-e from COMAR 10.24.14

Table 7
RCA Beds Requested, Maryland and out-of-State Patients
Southern Maryland Region

RCA Requested Detox / Assessment Beds	Total
Waldorf, MD	21
Upper Marlboro, MD	25
Total Detox / Assesment Beds	**46**

Waldorf, MD		**Upper Marlboro, MD**	
Total Detox / Assesment Beds	*21*	Total Detox / Assesment Beds	25
2014		***2014***	
Individuals 18 + in facility catcment area	*9,348,695*	Individuals 18 + in facility catcment area	9,524,374
Individuals 18 + in MD in facility catchment area	*4,528,933*	Individuals 18 + in MD in facility catchment area	4,513,229
% of patients from MD in catchment area	*48.4%*	% of patients from MD in catchment area	*47.4%*
Detox / Assement Beds for MD Residents	*11*	Detox / Assement Beds for MD Residents	*12*
2019		***2019***	
Individuals 18 + in facility catcment area	*10,264,804*	Individuals 18 + in facility catcment area	10,371,320
Individuals 18 + in MD in facility catchment area	*4,709,044*	Individuals 18 + in MD in facility catchment area	4,689,719
% of patients from MD in catchment area	*45.9%*	% of patients from MD in catchment area	*45.2%*
Detox / Assement Beds for MD Residents	*10*	Detox / Assement Beds for MD Residents	*12*

Requested Beds to serve MD population	2010	2014	2019
Waldorf, MD	N/A	11	10
Upper Marlboro, MD	N/A	12	12
Total MD	**N/A**	**23**	**22**

Table 8
Regional Bed ICF Need Projection
Maryland State

				MD Population 2010-Development (3)	RCA 2014 Population (2)	RCA Projected 2019 (2)
	MD Population for 18 Years and older			4,420,588	4,612,691	4,793,500
	E. Shore Region Population for 18 Years and older			350,176	407,905	418,847
	MD Population 18 and older excluding E. Shore Region			4,770,764	5,020,596	5,212,347
a	**Estimated # of privately insured (1)**	*64.2%* (1)		3,062,830	3,223,222	3,346,327
b	**Estimated # of Substance Abuse Users**	*8.64%*		264,629	278,486	289,123
c1	**Estimated Annual Target Population**	*25.00%*		66,157	69,622	72,281
c2	**Estimated # requiring Treatment**	*95.00%*		62,849	66,141	68,667
d	**Estimated Population requiring ICF (12.5-15%)**					
d1	Min % - All Regions excluding E. Shore	*12.50%*		7,856	8,268	8,583
d2	Max % - All Regions excluding E.Shore	*15.00%*		9,427	9,921	10,300
d3	Min % - E. Shore Region	*25.00%*		1,153	1,343	1,379
d4	Max % - E. Shore Region	*35.00%*		1,615	1,881	1,931
e	**Estimated Range requiring Readmission**					
e1	Min %	*10.00%*		901	961	996
e2	Max %	*10.00%*		1,104	1,180	1,223
		(5)				
f	**Range of Adults requiring ICF/CD Care**					
	Min = (d1+d3+e1)			9,910	10,572	10,959
	Max = (d2+d4+e2)			12,146	12,982	13,454
g	**Gross # of Adult ICF Bed Needed**					
g1	Min = ((f*14 ALOS))/365)/0.85		14	447	477	495
g2	Max = ((f*14 ALOS))/365)/0.85		14	548	586	607
h	**Existing Track One Inventory ICF/CD beds**	*(4)*		47	47	47
i	**Net Private ICF/CD Bed Needed**					
	Min = (g1-h)			**400**	**430**	**448**
	Max = (g2-h)			**501**	**539**	**560**
j	**Net <u>All</u> ICF Bed Needed**					
	Min = (iMin x(1 + % of population w/out private insurance))	*35.8%*		**543**	**584**	**608**
	Min = (iMax x (1 + % of population w/out private insurance))	*35.8%*		**680**	**732**	**761**

Notes:

(1) 2013 National Health Interview Survery - CDC

(2) Numbers based off ESRI data

(3) State calculation based off State of MD Development Census numbers

(4) Track One calculation based on 20% of existing beds in region being 'true' detox beds

(5) Out-of-state need accounted for in the beds requested, details regarding the calculation to come later in report

(6) Percentages for b-e from COMAR 10.24.14

Table 9
RCA Beds Requested, Maryland and out-of-State Patients
Maryland State

RCA Requested Detox / Assessment Beds	Total
Earleville, MD	17
Queenstown, MD	18
Waldorf, MD	21
Upper Marlboro, MD	25
Total Detox / Assesment Beds	**81**

Earleville, MD	
Total Detox / Assesment Beds	*17*
2014	
Individuals 18 + in facility catcment area	*15,054,302*
Individuals 18 + in MD in facility catchment area	*4,528,933*
% of patients from MD in catchment area	*30.1%*
Detox / Assement Beds for MD Residents	*6*
2019	
Individuals 18 + in facility catcment area	*16,470,407*
Individuals 18 + in MD in facility catchment area	*4,584,056*
% of patients from MD in catchment area	*27.8%*
Detox / Assement Beds for MD Residents	*5*

Queenstown, MD	
Total Detox / Assesment Beds	18
2014	
Individuals 18 + in facility catcment area	11,845,578
Individuals 18 + in MD in facility catchment area	4,422,484
% of patients from MD in catchment area	*37.3%*
Detox / Assement Beds for MD Residents	*7*
2019	
Individuals 18 + in facility catcment area	12,364,701
Individuals 18 + in MD in facility catchment area	4,599,466
% of patients from MD in catchment area	*37.2%*
Detox / Assement Beds for MD Residents	*7*

Waldorf, MD	
Total Detox / Assesment Beds	*21*
2014	
Individuals 18 + in facility catcment area	*9,348,695*
Individuals 18 + in MD in facility catchment area	*4,528,933*
% of patients from MD in catchment area	*48.4%*
Detox / Assement Beds for MD Residents	*11*
2019	
Individuals 18 + in facility catcment area	*10,264,804*
Individuals 18 + in MD in facility catchment area	*4,709,044*
% of patients from MD in catchment area	*45.9%*
Detox / Assement Beds for MD Residents	*10*

Upper Marlboro, MD	
Total Detox / Assesment Beds	25
2014	
Individuals 18 + in facility catcment area	9,524,374
Individuals 18 + in MD in facility catchment area	4,513,229
% of patients from MD in catchment area	*47.4%*
Detox / Assement Beds for MD Residents	*12*
2019	
Individuals 18 + in facility catcment area	10,371,320
Individuals 18 + in MD in facility catchment area	4,689,719
% of patients from MD in catchment area	*45.2%*
Detox / Assement Beds for MD Residents	*12*

RCA Requested Detox / Assesment Beds to serve MD population	2010	2014	2019
Earleville, MD	N/A	6	5
Queenstown, MD	N/A	7	7
Waldorf, MD	N/A	11	10
Upper Marlboro, MD	N/A	12	12
Total Detox / Assesment Beds	**N/A**	**36**	**34**

.05C. Sliding Fee Scale..

An applicant must establish a sliding fee scale for gray area patients consistent with the client's ability to pay.

Applicant Response

The facility will utilize a sliding fee scale for gray area patients consistent with the patient's ability to pay. The fee schedule is summarized as follows, and represents discount percentages from the standard billing rate charged to insurance carriers for each service:

<100% of Federal Poverty Level	75%
<150% but >100% of Federal Poverty Level	50%
<200% but >150% of Federal Poverty Level	25%

.05D. Provision of Service to Indigent and Gray Area Patients.

(1) Unless an applicant demonstrates why one or more of the following standards should not apply or should be modified, an applicant seeking to establish or to expand a Track One intermediate care facility must:

(a) Establish a sliding fee scale for gray area patients consistent with a client's ability to pay;

(b) Commit that it will provide 30 percent or more of its proposed annual adolescent intermediate care facility bed days to indigent and gray area patients; and

(c) Commit that it will provide 15 percent of more of its proposed annual adult intermediate care facility bed days to indigent or gray area patients.

(2) A existing Track One intermediate care facility may propose an alternative to the standards in Regulation D(1) that would increase the availability of alcoholism and drug abuse treatment to indigent or gray area patients in its health planning region.

(3) In evaluating an existing Track One intermediate care facility's proposal to provide a lower required minimum percentage of bed days committed to indigent or gray area patients in Regulation D(1) or an alternative proposal under Regulation D(2), the Commission shall consider:

(a) The needs of the population in the health planning region; and

(b) The financial feasibility of the applicant's meeting the requirements of Regulation D(1).

(4) An existing Track One intermediate care facility that seeks to increase beds shall provide information regarding the percentage of its annual patient days in the preceding 12 months that were generated by charity care, indigent, or gray area patients, including publicly-funded patients.

Applicant Response

Applicant requests a modification of subsection (1)(c) as the healthcare insurance landscape has changed dramatically since this standard was promulgated.

A. Increased Medicaid and Private Insurance Coverage Under the Affordable Care Act.

As discussed in the Henry J. Kaiser Family Foundation report dated January 6, 2014, attached as Exhibit 7, the 2010 Affordable Care Act (ACA) has the potential to extend coverage

to many of the 47 million nonelderly uninsured people nationwide, including 756,000 uninsured Marylanders. The ACA establishes coverage provisions across the income spectrum, with the expansion of Medicaid eligibility for adults serving as the vehicle for covering low-income individuals and premium tax credits to help people purchase insurance directly through new Health Insurance Marketplaces serving as the vehicle for covering people with moderate incomes. The 2012 ruling of the United States Supreme Court in *Nat'l Federation of Independent Business v. Sebelius*, 567 U.S. ___ (2012), made the Medicaid expansion optional for states. Maryland implemented the expansion in 2014. As a result, almost all nonelderly uninsured, most of whom are adults, are now eligible for coverage expansions.

With Maryland deciding to implement the Medicaid expansion, nearly six in ten (59%) uninsured nonelderly people in the state are eligible for financial assistance to gain coverage through either Medicaid or the marketplaces. Given the income distribution of the uninsured in the state, the main pathway for coverage is Medicaid, with four in ten (40%) uninsured Marylanders eligible for either Medicaid or CHIP as of 2014. While some of these people (such as eligible children) are eligible under pathways in place before the ACA, most adults are newly-eligible through the ACA expansion. One in five (20%) uninsured people in Maryland are eligible for premium tax credits to help them purchase coverage in the marketplace.

Other uninsured Marylanders may gain coverage under the ACA but will not receive direct financial assistance. These people include the 23% with incomes above the limit for premium tax subsidies or who have an affordable offer of coverage through their employer. Some of these people are still able to purchase unsubsidized coverage in the Marketplace, which may be more affordable or more comprehensive than coverage they could obtain on their own through the individual market. Lastly, the approximately 17% of uninsured people in Maryland who are undocumented immigrants are ineligible for financial assistance under the ACA and barred from purchasing coverage through the marketplaces. This group is likely to remain uninsured, though they will still have a need for health care services.

The ACA will help many currently uninsured Marylanders gain health coverage by providing coverage options across the income spectrum for low and moderate-income people. While almost all of the uninsured in Maryland are eligible for some type of coverage under the ACA, the impact of the ACA will depend on take-up of coverage among the eligible uninsured, and outreach and enrollment efforts will be an important factor in decreasing the uninsured rate. The ACA includes a requirement that most individuals obtain health coverage, but some people (such as the lowest income or those without an affordable option) are exempt and others may still remain uninsured.

Medicaid's role in purchasing and delivering substance abuse services is changing dramatically. Prior to the implementation of the ACA, most state Medicaid programs did not cover childless adults and covered only a limited number of parents. Moreover, coverage of substance abuse services has traditionally been an optional Medicaid benefit and, as a result, many states have provided only limited substance abuse service coverage. Twenty-five states plus Washington, DC, are expanding Medicaid in 2014 and will collectively cover as many as 5 million adults with incomes up to 133 percent of the federal poverty level (FPL). Benefits extended to these newly covered adults must include mental health and substance abuse services that meet the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). Taken together, these changes are a major catalyst for transformation of substance abuse service coverage and delivery in Medicaid.

B. The Applicant's Commitment to Provide Care for Indigent and Gray Area Patients.

Notwithstanding the greater availability of coverage for Marylanders, the Applicant is committed to providing care to indigent and gray area patients. However, the level of commitment set forth in Standard .05D(1)(c) (*i.e.*, 15 percent or more of bed days) is not reasonable in light of the increased number of covered patients. In fact, prior to the expansive effect of the ACA, the Commission staff had already expressed concern that the level of care called for in Standard .05D(1)(c) is too high. See September 19, 2013 Transcript of Proceedings before the Commission on Father Martin's Ashley CON Application for Bed Expansion, Exhibit 8 at 7. In connection with the expansion of the Father Martin's Ashley facility, the Commission permitted Father Martin's Ashley to commit to provide 6.3% of its total patient days for indigent and gray area patients in 2017 (at the time of application, Father Martin's Ashley provided only 3.4% of patient days for indigent and gray area patients).

Given that the Affordable Care Act has expanded Medicaid and private insurance coverage for an estimated 59% of previously uninsured Marylanders, Applicant believes it would be reasonable to reduce the amount of indigent care required in the Father Martin's Ashley decision, which preceded the effect of the ACA act, by 41%. Applying this figure, it would be reasonable to provide 2.6% of patient days for indigent and gray area patients. (2.6% = 6.3% x 41%). However, recognizing the importance of care for indigent and gray area care to the Commission and the State, Applicant is willing to commit up to 5% of its patient bed days for indigent and gray area patient care.

.05E. Information Regarding Charges.

An applicant must agree to post information concerning charges for services, and the range and types of services provided, in a conspicuous place, and must document that this information is available to the public upon request.

Applicant Response

The Applicant will post charges for services, and the range and types of services provided in a conspicuous place. This information will be available to the public.

.05F. Location.

An applicant seeking to establish a new intermediate care facility must propose a location within a 30-minute one-way travel time by automobile to an acute care hospital.

Applicant Response

The proposed is within 30 minutes driving time from University of Maryland Charles Regional Medical Center, 5 Garrett Avenue, La Plata, MD 20646 (10 minutes without traffic/11 minutes with traffic, according to Google Maps).

.05G. Age Groups.

(1) An applicant must identify the number of adolescent and adult beds for which it is applying, and document age-specific treatment protocols for adolescents ages 12-17 and adults ages 18 and older.
(2) If the applicant is proposing both adolescent and adult beds, it must document that it will provide a separate physical, therapeutic, and educational environment consistent with the treatment needs of each age group including, for adolescents, providing for continuation of formal education.
(3) A facility proposing to convert existing adolescent intermediate care substance abuse treatment beds to adult beds, or to convert existing adult beds to adolescent beds, must obtain a Certificate of Need.

Applicant Response

The applicant is applying for 21 adult ICF treatment beds. The project will include 145 other residential beds.

.05H. Quality Assurance.

(1) An applicant must seek accreditation by an appropriate entity, either the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), in accordance with CFR, Title 42, Part 440, Section 160, the CARF…The Rehabilitation Accreditation Commission, or any other accrediting body approved by the Department of Health and Mental Hygiene. The appropriate accreditation must be obtained before a Certificate of Need-approved ICF begins operation, and must be maintained as a condition of continuing authority to operate an ICF for substance abuse treatment in Maryland.

(a) An applicant seeking to expand an existing ICF must document that its accreditation continues in good standing, and an applicant seeking to establish an ICF must agree to apply for, and obtain, accreditation prior to the first use review required under COMAR 10.24.01.18; and
(b) An ICF that loses its accreditation must notify the Commission and the Office of Health Care Quality in writing within fifteen days after it receives notice that its accreditation has been revoked or suspended.
(c) An ICF that loses its accreditation may be permitted to continue operation on a provisional basis, pending remediation of any deficiency that caused its accreditation to be revoked, if the Office of Health Care Quality advises the Commission that its continued operation is in the public interest.

(2) A Certificate of Need-approved ICF must be certified by the Office of Health Care Quality before it begins operation, and must maintain that certification as a condition of continuing authority to operate an ICF for substance abuse treatment in Maryland.

(a) An applicant seeking to expand an existing ICF must document that its certification continues in good standing, and an applicant seeking to establish an ICF must agree to apply for certification by the time it requests that Commission staff perform the first use review required under COMAR 10.24.01.18.

(b) An ICF that loses its State certification must notify the Commission in writing within fifteen days after it receives notice that its accreditation has been revoked or suspended, and must cease operation until the Office of Health Care Quality notifies the Commission that deficiencies have been corrected.
(c) Effective on the date that the Office of Health Care Quality revokes State certification from an ICF, the regulations at COMAR 10.24.01.03C governing temporary delicensure of a health care facility apply to the affected ICF bed capacity.

Applicant Response

The Applicant will be applying for accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) once the facility is licensed and operational.

.05I. Utilization Review and Control Programs.

(1) An applicant must document the commitment to participate in utilization review and control programs, and have treatment protocols, including written policies governing admission, length of stay, discharge planning, and referral.
(2) An applicant must document that each patient's treatment plan includes, or will include, at least one year of aftercare following discharge from the facility.

Applicant Response

(1) The Applicant commits to patient care provided by competent staff in a safe environment, as determined in part by admission and continued stay criteria. Objective monitoring and evaluation processes will assure that resources are utilized sufficiently to provide quality patient care and efficiency of financial and personal resources. The utilization management plan applies to all patients, regardless of payment source, and encompasses all departments and services providing direct patient care. Applicant commits to participating in utilization review, which includes the following standard minimum components:

- Evaluation of the utilization of services provided, as related to over/under-utilization of services.
- Periodic evaluation of documentation.
- Ongoing review of clinical appropriateness for Admission, Continued Stay and Discharge, in accordance with RCA Policy and Procedures Manual.

(2) The Applicant commits to include at least one year of aftercare following treatment in each patient's treatment plan. Aftercare planning includes the following standard minimum components:

- Enrollment in Concurrent Recovery Monitoring (CRM), which is a 12-month program designed to provide clinically –relevant evaluation and recovery support for the patient. CRM includes a monthly standardized assessment of the patient's physical

and behavioral health, societal/familial function, reduction in substance use and cravings. Based on the patient's assessment response, a Continuing Care counselor will:

  - Provide recommendations for continuing care, such as outpatient treatment.
  - Connect patient to support groups in the local area
  - Provide accountability and recovery support

- Patient Aftercare Planning begins at the time of admission. In adherence to RCA policies and procedures, discharge planning includes:
  - Clinical Issues to be addressed in Continuing Care
  - A description of the services to be provided which will assist the patient in maintaining long-term sobriety
  - A specific point of contact to facilitate the patient in obtaining the needed services
  - Dates, times and address of continuing care appointments
  - Re-entry criteria

Applicant has attached in Exhibit 9 draft policy and procedures for:

- Admissions Exclusion Criteria
- Discharge Procedures
- Initial Patient Care
- Utilization Reviews and Continued Stay
- Continued Stay Criteria

.05J. <u>Transfer and Referral Agreements.</u>

(1) An applicant must have written transfer and referral agreements with facilities capable of managing cases which exceed, extend, or complement its own capabilities, including facilities which provide inpatient, intensive and general outpatient programs, halfway house placement, long-term care, aftercare, and other types of appropriate follow-up treatment.
(2) The applicant must provide documentation of its transfer and referral agreements, in the form of letters of agreement or acknowledgement from the following types of facilities:
(a) Acute care hospitals;
(b) Halfway houses, therapeutic communities, long-term care facilities, and local alcohol and drug abuse intensive and other outpatient programs;
(c) Local community mental health center or center(s);
(d) The jurisdiction's mental health and alcohol and drug abuse authorities;

(e) The Alcohol and Drug Abuse Administration and the Mental Hygiene Administration;
(f) The jurisdiction's agencies that provide prevention, education, driving-while-intoxicated programs, family counseling, and other services; and,
(g) The Department of Juvenile Justice and local juvenile justice authorities, if applying for beds to serve adolescents.

Applicant Response

On Applicant's behalf, RCA has requested written transfer and referral agreements from facilities capable of managing cases which exceed, extend, or complement its own capabilities, including facilities which provide inpatient, intensive and general outpatient programs, halfway house placement, long-term care, aftercare, and other types of appropriate follow-up treatment.

The Applicant has contacted and has transmitted transfer and referral agreements to the following:

(a) Acute Care hospitals: University of Maryland Charles Regional Medical Center in La Planta, Maryland and MedStar Southern Maryland Hospital Center in Clinton, Maryland.

(b) Halfway houses, therapeutic communities, long-term care facilities, and local alcohol and drug abuse intensive and other outpatient programs: CARE Consultants Treatment Center, Walden Behavioral Health in Waldorf, Living Waters Program in Huntington, Open Arms Inc. in Waldorf.

(c) The local community health center: Core Service Agency (CSA) in Charles County, MD.

(d) Prince Georges County Health Department in Clinton, MD.

(e) Maryland Department of Health and Mental Hygiene in Annapolis

(f) Charles County Department of Health in White Plains, MD

(g) Maryland Department of Juvenile Justice

To date, Applicant has received one acknowledged referral agreement for the facility. See Exhibit 10.

.05K. Sources of Referral.

(1) An applicant proposing to establish a new Track Two facility must document to demonstrate that 50 percent of the facility's annual patient days, consistent with Regulation .08 of this Chapter, will be generated by the indigent or gray area population, including days paid under a contract with the Alcohol and Drug Abuse Administration or a jurisdictional alcohol or drug abuse authority.
(2) An applicant proposing to establish a new Track One facility must document referral agreements to demonstrate that 15 percent of the facility's annual patient days required by Regulation .08 of this Chapter will be incurred by the indigent or

gray area populations, including days paid under a contract with the Alcohol or Drug Abuse Administration or a jurisdictional alcohol or drug abuse authority, or the Medical Assistance program.

Applicant Response

For the reasons described in response to Standard .05D, Applicant seeks a modification of subsection (2) as the indigent and/or gray area patient population has changed dramatically since the standard was established.

.05L. In-Service Education.

An applicant must document that it will institute or, if an existing facility, maintain a standardized in-service orientation and continuing education program for all categories of direct service personnel, whether paid or volunteer.

Applicant Response

It is the policy of Recovery Centers of America to ensure that the mission of the organization and each affiliated facility is met by providing appropriately qualified staff to deliver services to patients and by ensuring that ongoing education and training needs are identified and provided.

The RCA Human Resources Department oversees the Onboarding Orientation. Orientation curriculum includes but is not limited to:

A. RCA Mission and Philosophy
B. Patient Rights
C. Confidentiality
D. Patient or Employee Accident/Injury
E. Employee Personal Safety
F. Ethics
G. HIPAA
H. Diversity/Cultural Awareness
I. Incident Reporting
J. Customer Service
K. Medication Management
L. Fire Safety & Prevention
M. Emergency Evacuation Procedures
N. Suicide Precautions
O. Use of Hazardous Chemicals
P. Infection Control, Communicable Diseases, Blood borne Pathogens

The RCA Training Institute oversees the Clinical Core Trainings for clinical supervisors, primary therapists, case managers, and recovery support staff. Clinical core curriculum includes but is not limited to:

A. Co-Occurring Disorders
B. Motivational Interviewing

C. Relapse Prevention
D. Cognitive Behavioral Therapy
E. Trauma Support Therapy
F. Social Skills Training
G. Group Facilitation Skills
H. Effective Documentation on EMR

Additional Staff Training and educational opportunities are offered throughout the year, as well as ongoing supervision, support and social gatherings.

The Human Resources Department is responsible for tracking attendance at in-service education sessions and ensuring that continuing education units are awarded when possible.

In Exhibit 11, Applicant has attached drafts of RCA's Addiction Severity Index Training Agenda, Motivational Interviewing Training Agenda, and Training on Evidence Based Practices.

.05M. Sub-Acute Detoxification.

An applicant must demonstrate its capacity to admit and treat alcohol or drug abusers requiring sub-acute detoxification by documenting appropriate admission standards, treatment protocols, staffing standards, and physical plant configuration.

Applicant Response

RCA has developed an Admissions Criteria policy and procedure and Detoxification Treatment Protocols for the evaluation, treatment and detoxification for patients in the Applicant's care. The Admissions Criteria Policy and Detoxification Treatment Protocols are attached as Exhibit 12. The Detoxification unit will be a separate unit staffed 24 hours a day, 7 days a week by nursing personnel. A physician or physician assistant will assess each patient on the detoxification unit within 24 hours of admission. A physician or physician assistant will also provide on-site monitoring and evaluation of patients in the detoxification unit on a daily basis, if medically necessary. All patients in the detoxification program will be provided treatment for coexisting medical, emotional, or behavioral problems. The Detoxification unit is labeled on the project drawings in Exhibit 4.

.05N. Voluntary Counseling, Testing, and Treatment Protocols for Human Immunodeficiency Virus (HIV).

An applicant must demonstrate that it has procedures to train staff in appropriate methods of infection control and specialized counseling for HIV-positive persons and active AIDS patients.

Applicant Response

The facility will be staffed through RCA. RCA's Safety and Infection Control Committee will ensure that all staff receives training in infection control. RCA staff will be trained on RCA's Infection Control policy upon hire and annually thereafter. In addition, RCA will offer HIV testing

and counseling with patient consent per RCA's policy on HIV Testing and Counseling. RCA's draft HIV Testing and Counseling, and Infection Control policies are attached as Exhibit 13.

.05O. Outpatient Alcohol & Drug Abuse Programs.

(1) An applicant must develop and document an outpatient program to provide, at a minimum: individual needs assessment and evaluation; individual, family, and group counseling; aftercare; and information and referral for at least one year after each patient's discharge from the intermediate care facility.
(2) An applicant must document continuity of care and appropriate staffing at off-site outpatient programs.
(3) Outpatient programs must identify special populations as defined in Regulation. 08, in their service areas and provide outreach and outpatient services to meet their needs.
(4) Outpatient programs must demonstrate the ability to provide services in the evening and on weekends.
(5) An applicant may demonstrate that outpatient programs are available to its patients, or proposed patient population, through written referral agreements that meet the requirements of (1) through (4) of this standard with existing outpatient programs.

Applicant Response

Applicant will offer outpatient services including Partial Hospitalization, Intensive Outpatient and Outpatient Programs. RCA's Partial Hospitalization program will provide treatment five days a week for four hours each day and will be offered Monday through Friday. This five day a week program will provide education, group therapy, and individual therapy to patients. The Intensive Outpatient Program will offer group therapy three days a week for three hours each session. The Outpatient Program will offer group therapy two times per week for two hours each session. Both the Intensive Outpatient Program and the Outpatient Program will be offered during the day, evening hours, and on weekends. In addition all patients in the outpatient programs will receive assessment upon admission, participate in a psychosocial evaluation process, and receive an individualized treatment plan from their primary therapist. Individual and family sessions will also be provided to all patients as clinically indicated. RCA's draft Outpatient Services policy is attached as Exhibit 14.

.05P. Program Reporting.

Applicants must agree to report, on a monthly basis, utilization data and other required information to the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) program, and participate in any comparable data collection program specified by the Department of Health and Mental Hygiene.

Applicant Response

Applicant will report utilization data and required information to the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) program on a monthly basis. Applicant will also participate in the comparable data collection program specified by the Department of Health and Mental Hygiene.

10.24.01.08G(3)(b). Need.

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

INSTRUCTIONS: Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. If the relevant chapter of the State Health Plan includes a need standard or need projection methodology, please reference/address it in your response. For applications proposing to address the need of special population groups, please specifically identify those populations that are underserved and describe how this Project will address their needs.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified. List all assumptions made in the need analysis regarding demand for services, utilization rate(s), and the relevant population, and provide information supporting the validity of the assumptions.

Complete the Statistical Projection (Tables D and E, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Table D must be completed if the applicant is an existing facility. Table E must be completed if the application is for a new facility or service or if it is requested by MHCC staff.

Applicant Response

Please see Applicant's response to standard .05B, *supra*, pp. 21-32.

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing facilities.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development cost to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective goal and objective achievement or the most effective solution to the identified problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Applicant Response

The proposed project involves renovating existing structure to create an efficient and modern Intermediate Care Facility for Alcohol and Drug Abuse treatment. RCA has selected the proposed site based on the shortage of quality provider beds in the State of Maryland (and across the country). Many Maryland residents are suffering from addiction and need treatment today. *See* Exhibit 14.

At a State House news conference, Maryland Governor Larry Hogan described how pervasive he found the problem as he traveled around the state last year. "'This used to be considered an urban problem, but it's not anymore,' he said. All over the state, he said, local officials told him heroin had become their No. 1 problem." Exhibit 15. Applicant's bed need calculations demonstrate that existing providers do not have enough capacity to meet the growing need and RCA brings a solution to a massive problem.

Acquisition of existing providers does not address the need for incremental new beds and produces no net benefit to residents of the State of Maryland. Additionally, limiting sites of service and increasing bed size does not provide the necessary breadth of coverage residents of Maryland require to address the growing population suffering from addiction

Accordingly, RCA determined to build new treatment facilities of a scope that could begin to address the dire need in the State of Maryland. It looked at existing properties in the $1M to $20M price range across the State, and targeted locations with dense populations and commensurate bed need. To the extent possible, RCA looked to repurpose existing structures

in order to minimize environmental impacts. The charts below demonstrate RCA's demographic analysis that contributed to its site selection and subsequent CON applications.

Site Selection

The Applicant selected the property at 11100 Billingsley Road , Waldorf, MD as a future location for the company's Inpatient Substance Abuse program. The Applicant reviewed many different sites across the state of Maryland, considering many factors. Such factors included, but were not limited to, zoning parameters by right and special exception, site size, points of access to major roadways, and interchanges, among others.

Of the factors reviewed that have not been previously discussed in the application is the time the Applicant spent observing the demographics of the site. The Applicant used a 90 mile catchment area to determine if the site was viable on the basis of being able to capture a patient who was able to afford the Applicants services. The Applicant concluded the site was viable. Below is a summary of the site's demographic.

Table 10
Summary of Site Demographic

	Census 2010	Growth	2014	Growth	2019
Population	10,953,703	3.5%	11,332,437	5.5%	11,959,127
Households	4,134,421	3.5%	4,280,337	5.6%	4,518,263

Household Incomes	2014	% of Households	2019	% of Households	Growth
$75,000 - $99,999	543,119	12.7%	628,117	13.9%	15.6%
$100,000 - $149,000	813,517	19.0%	867,787	19.2%	6.7%
$150,000 - $199,000	394,279	9.2%	515,384	11.4%	30.7%
$200,000 +	399,295	9.3%	544,269	12.0%	36.3%
Average Houshold Income	**$99,275**		**$115,376**		**16.2%**

	Census 2010	%	2014	%	2019	%
18-19	298,004	2.7%	288,310	2.5%	297,306	2.5%
20-24	735,775	6.7%	765,075	6.8%	713,521	6.0%
25-34	1,545,412	14.1%	1,608,116	14.2%	1,679,154	14.0%
Target Population	*2,579,191*	23.5%	*2,661,501*	23.5%	*2,689,981*	22.5%
35-44	1,558,492	14.2%	1,514,009	13.4%	1,622,729	13.6%
45-54	1,685,523	15.4%	1,647,153	14.5%	1,576,449	13.2%
55-64	1,289,500	11.8%	1,430,303	12.6%	1,562,343	13.1%
65-74	705,779	6.4%	882,947	7.8%	1,072,797	9.0%
75-84	391,689	3.6%	419,769	3.7%	505,919	4.2%
85+	168,775	1.5%	187,946	1.7%	206,216	1.7%

Source – ESRI

10.24.01.08G(3)(d). Viability of the Proposal.

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- Complete applicable Revenue & Expense Tables and the Workforce and Bedside Care Staffing worksheets in the CON Table Package, as required. Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item. Instructions are provided in the cover sheet of the CON package and on each worksheet. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable. If the projections are based on Medicare percentages above the median for the jurisdiction in which the nursing home exists or is proposed, explain why the projected Medicare percentages are reasonable.

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.

- If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.

- Describe and document relevant community support for the proposed project.

- Identify the performance requirements applicable to the proposed project (see question 12, “Project Schedule”) and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).

Applicant Response

Project Financing

The funding plan for the project is summarized as follows:

Equity	$12,468,649
Senior bank debt	14,268,875
Total project cost	$26,737,524

Of the total project cost, 13% is attributable to the detoxification treatment component requiring CON approval.

RCA has engaged Stifel Nicolaus and Company, an investment banking firm, to facilitate the capital raise for all RCA projects. It has received a term sheet and has executed an engagement letter with an equity partner to fund the equity portion of the project. Due diligence is underway and is anticipated to conclude by the end of March 2015, with funding concurrent with the closing of the senior bank debt.

RCA is in negotiations with multiple banks and other financing institutions to place the senior bank debt. This debt will be structured either as mortgage debt or a senior term loan, depending upon the institution selected for funding.

This financing plan was developed based on the advice of outside consultants and the internal experience of RCA personnel in raising capital. The RCA executive management team has significant experience in both types of financing, with total financing obtained and placed for their respective businesses in the billions of dollars. Under current market conditions in the industry, as well as in the overall financing marketplace, both management and the investment banking team are confident that the projects will be funded within the expected timelines.

RCA will advise the Commission of its progress in financing the project.

Project Design

Recognizing the critical need for timely and effective conversion of significant capital resources into facilities that support the clinical program, RCA recruited senior real estate team members with significant and complementary experience. RCA's team excels in two critical areas in developing real estate for a specialized application such as this. First, RCA recognizes that the real estate team must understand the requirements, programs, adjacencies, and appropriate staffing levels of the facility's clinical program. To that extent, RCA created a prototype facility designed to optimally support the patient as s/he migrates through our continuum of care. Second, RCA recognized the importance of working with local officials and local vendors to develop and execute on an efficient timeline for navigating the permitting approval processes. RCA met with local officials and local vendors to identify activities and timeframes required to achieve municipal approvals for the project. RCA's real estate team has consistently executed programs and projects with previous employers and has developed a plan to successfully execute Applicants project and programs.

The buildings at this facility consist of a main building and three ancillary buildings providing a campus setting. Although exhibiting physical obsolescence the footprint of the existing buildings lend themselves well the proposed clinical program. In response to significant

physical obsolescence, RCA's renovation plans include the removal of all interior finishes including mechanical, electrical, life safety and plumbing systems. Construction will occur in two phases. The first phase includes the aforementioned renovations and could begin mid-summer 2015 and could be completed by the end of the year. Phase II includes the erection of a new 29,000 square foot three story addition. Construction of Phase II is scheduled to begin spring 2016 and be completed late summer 2016. The total size of the facilities post Phase II is approximately 91,000 square feet.

Revenue & Expense, and Workforce Projections

Please see Exhibit 1. The statements of assumptions for those projections, included within Exhibit 1, outlines the assumptions utilized to prepare the tables that exist as part of the application. These tables included in Exhibit 1 demonstrate the ability for RCA to create a sustainable project. The use of projected staffing was based on research on market comparable positions and salary levels as well as demographics of individuals in the area.

Community Support

Applicant is in the process of seeking letters of support from various organizations and community members in 11100 Billingsley Road's service area, and expects to receive letters of support throughout the CON application process. Applicant will keep the Commission informed of its progress.

Applicable Performance Requirements

Pursuant to COMAR § 10.24.01.12, once the Commission grants a Certificate of Need, Applicant will have 18 months to obligate not less than 51 percent of the approved capital expenditure, as documented by a binding construction contract or equipment purchase order. Applicant will have four months from the effective date of the construction contract to break ground, and must complete the project 18 months thereafter. COMAR § 10.24.01.12.B(1),(2), C(1)(c).

Applicant will meet the Performance Requirements of COMAR § 0.24.01.12. Applicant expects to obligate not less than 51% of the approved capital expenditure within two months of CON approval. Applicant expects to break ground one month thereafter, and to complete construction within 14 months after breaking ground.

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

INSTRUCTIONS: List all of the Maryland Certificates of Need that have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years, including their terms and conditions, and any changes to approved Certificates that needed to be obtained. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Applicant Response

Not applicable. No Maryland Certificates of Need that have been issued to the Applicant, its parent, or its affiliates or subsidiaries over the prior 15 years.

10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant for a new nursing home claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.

c) On access to health care services for the service area population that will be served by the project. (State and support the assumptions used in this analysis of the impact on access);

d) On costs to the health care delivery system.

If the applicant is an existing facility or program, provide a summary description of the impact of the proposed project on the applicant's costs and charges, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

Applicant Response

This project is aimed at improving access to care for residents of Maryland and others in need of treatment from across the country. Officials across Maryland, including Governor Hogan, have made it clear that the State of Maryland has an inadequate substance abuse treatment system to treat the rising numbers of Maryland residents that suffer from addiction. See Exhibit 14. Applicant's bed need analysis further demonstrates the lack of significant treatment services. RCA and Applicant are prepared to commit significant resources to provide Maryland residents with the treatment and care they need and deserve.

RCA does not view other providers as competitors – quite the contrary, they are potential partners to achieve RCA's goal of getting 1,000,000 Americans into meaningful recovery, and to provide Maryland residents with the care and treatment that the current system. RCA will work with other Maryland providers to establish transfer and referral relationships for patients that do not qualify for care at RCA's facilities.

Table of Exhibits

Table of Tables

AFFIRMATIONS

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.

3/25/15
Date

J.P. Christen
Chief Operating Officer
Recovery Centers of America

#523621
013522-0001

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.

3/20/15
Date

Kevin McClure
Chief Financial Officer
Recovery Centers of America

#523621
013522-0001

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.

3/26/15
Date

Deanna Telese
Corporate Controller
Recovery Centers of America

#523621
013522-0001

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.

3/25/15
Date

Deni Carise
Chief Clinical Officer
Recovery Centers of America

#523621
013522-0001

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.

3/25/15
Date

Darcy Brazzle
Director Regulatory Compliance
Recovery Centers of America

#523621
013522-0001

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.

3/5/2015
Date

John Evans
Facilities Manager
Recovery Centers of America

#523621
013522-0001

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.

3.25.15
Date

Ashley Alberta
Director of Training
Recovery Centers of America

#523621
013522-0001

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.

3/25/15
Date

Bryan Kennedy
Junior Financial Analyst
Recovery Centers of America

#523621
013522-0001

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.

25 MAR 15
Date

Thomas Hall
Architect
Thomas E. Hall & Associates Inc.

#523621
013522-0001

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.

3/25/15
Date

Andrew S. Solberg
A.L.S. Healthcare Consultant Services

#523621
013522-0001

EXHIBIT 1

CON TABLE PACKAGE FOR HOSPITAL APPLICATIONS

Name of Applicant: 11100 Billingsley Road OPCO, LLC

Date of Submission: March 27, 2015

Applicants should follow additional instructions included at the top of each of the following worksheets. Please ensure all green fields (see above) are filled.

Table	Table Title	Instructions
Table A	**Physical Bed Capacity Before and After Project**	All applicants whose project impacts any nursing unit, regardless of project type or scope, must complete Table A.
Table B	**Departmental Gross Square Feet**	All applicants, regardless of project type or scope, must complete Table B for all departments and functional areas affected by the proposed project.
Table C	**Construction Characteristics**	All applicants proposing new construction or renovation must complete Table C.
Table D	**Site and Offsite Costs Included and Excluded in Marshall Valuation Costs**	All applicants proposing new construction or renovation must complete Table D.
Table E	**Project Budget**	All applicants, regardless of project type or scope, must complete Table E.
Table F	**Statistical Projections - Entire Facility**	Existing facility applicants must complete Table F. All applicants who complete this table must also complete Tables G and H.
Table G	**Revenues & Expenses, Uninflated - Entire Facility**	Existing facility applicants must complete Table G. The projected revenues and expenses in Table G should be consistent with the volume projections in Table F.
Table H	**Revenues & Expenses, Inflated - Entire Facility**	Existing facility applicants must complete Table H. The projected revenues and expenses in H should be consistent with the projections in Tables F and G.
Table I	**Statistical Projections - New Facility or Service**	Applicants who propose to establish a new facility, existing facility applicants who propose a new service, and applicants who are directed by MHCC staff must complete Table I. All applicants who complete this table must also complete Tables J and K.
Table J	**Revenues & Expenses, Uninflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant who completes a Table I must complete Table J. The projected revenues and expenses in Table J should be consistent with the volume projections in Table I.
Table K	**Revenues & Expenses, Inflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant that completes a Table I must complete Table K. The projected revenues and expenses in Table K should be consistent with the projections in Tables I and J.
Table L	**Work Force Information**	All applicants, regardless of project type or scope, must complete Table L.

TABLE A. BED CAPACITY BY FLOOR AND NURSING UNIT BEFORE AND AFTER PROJECT

INSTRUCTION: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project.
Applicants should add columns and recalculate formulas to address any rooms with 3 and 4 bed capacity. See additional instruction in the column to the right of the table.

Before the Project						After Project Completion					
		Based on Physical Capacity					Based on Physical Capacity				
		Room Count			Physical		Room Count			Physical
Service Location (Floor/Wing)	Current Licensed Beds	Private	Semi-Private	Total Rooms	Bed Capacity	Service Location (Floor/Wing)	Private	Semi-Private	Total Rooms	Bed Capacity
DETOX						**DETOX**				
	N/A	N/A	N/A	0	0		7	7	14	21
				0	0				0	0
				0	0				0	0
				0	0				0	0
				0	0				0	0
SUBTOTAL Detox						**SUBTOTAL Detox**	**7**	**7**	**14**	**21**
RESIDENTIAL						**RESIDENTIAL**				
	N/A	N/A	N/A				**4**	**66**	**70**	**145**
TOTAL RESIDENTIAL						**TOTAL RESIDENTIAL**	**4**	**66**	**70**	**145**
Other *(Specify/add rows as needed)*				0	0	**Other** *(Specify/add rows as needed)*			0	0
TOTAL OTHER						**TOTAL OTHER**				
FACILITY TOTAL	**0**	**0**	**0**	**0**	**0**	**FACILITY TOTAL**	**11**	**73**	**84**	**166**

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT									
INSTRUCTION : Add or delete rows if necessary. See additional instruction in the column to the right of the table.									
DEPARTMENT/FUNCTIONAL AREA	**BILLINGSLEY ISSUE No11 MARCH 18 2015 - DEPARTMENTAL GROSS SQUARE FEET**								*Additional Instruction*
	Current	**To be Added Thru New Construction Detox**	**To Be Renovated Detox**	**To Remain As Is Detox**	**To be Added Thru New Construction Residential**	**To Be Renovated Residential**	**To Remain As Is Residential**	**Total (Shared) After Project Completion**	*Total After Project Completion should equal square feet to be added, renovated, and remain as is*
Gnd Floor Counseling								**0**	
Gnd Floor Nursing								**0**	
Gnd Floor Admissions								**0**	
Gnd Floor Medical & Psychiatric								**0**	
Gnd Floor Adjunctive/Ancillary (Yoga, Fitness, etc.)								**0**	
Gnd Floor Administrative								**0**	
Inpatient Rooms w/ bathrooms								**0**	
Common Areas								**0**	
Circulation								**0**	
Building Mechanical/Electrical								**0**	
Int & Ext. Wall Thicknesses								**0**	
Gnd Floor Kitchen/Dining								**0**	
1st Floor Counseling		261	1,262		1,803	8,715		**12,041**	
1st Floor Nursing			708		637	769		**2,114**	
1st Floor Admissions			115			794		**909**	
1st Floor Medical & Psychiatric			154			1,159		**1,313**	
1st Floor Adjunctive/Ancillary (Yoga, Fitness, etc.)		6	543		42	3,752		**4,343**	
1st Floor Administrative			89			617		**706**	
Inpatient Rooms w/ bathrooms			2,290		5,404	8,340		**16,034**	
Common Areas		86	874		596	6,036		**7,592**	
Circulation		299	1,108		2,066	7,654		**11,127**	
Building Mechanical/Electrical		15	84		101	577		**777**	
Int & Ext. Wall Thicknesses		196	808		1,353	5,578		**7,935**	
1st Floor Kitchen/Dining			601			4,150		**4,751**	
2nd Floor Counseling					1,630	0		**1,630**	
2nd Floor Nursing					637	0		**637**	
2nd Floor Admissions						0		**0**	
2nd Floor Medical & Psychiatric						352		**352**	
2nd Floor Adjunctive/Ancillary (Yoga, Fitness, etc.)								**0**	
2nd Floor Administrative						1,343		**1,343**	
Inpatient Rooms w/ bathrooms					3,775	0		**3,775**	
Common Areas					784	649		**1,433**	
Circulation					1,794	813		**2,607**	
Building Mechanical/Electrical						126		**126**	
Int & Ext. Wall Thicknesses					991	408		**1,399**	
2nd Floor Kitchen/Dining								**0**	
3rd Floor Counseling					1,630			**1,630**	
3rd Floor Nursing					637			**637**	
3rd Floor Admissions								**0**	

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT									
INSTRUCTION : Add or delete rows if necessary. See additional instruction in the column to the right of the table.									
DEPARTMENT/FUNCTIONAL AREA	**BILLINGSLEY ISSUE No11 MARCH 18 2015 - DEPARTMENTAL GROSS SQUARE FEET**								*Additional Instruction*
	Current	**To be Added Thru New Construction Detox**	**To Be Renovated Detox**	**To Remain As Is Detox**	**To be Added Thru New Construction Residential**	**To Be Renovated Residential**	**To Remain As Is Residential**	**Total (Shared) After Project Completion**	*Total After Project Completion should equal square feet to be added, renovated, and remain as is*
3rd Floor Medical & Psychiatric								**0**	
3rd Floor Adjunctive/Ancillary (Yoga, Fitness, etc.)								**0**	
3rd Floor Administrative								**0**	
Inpatient Rooms w/ bathrooms					3,775			**3,775**	
Common Areas					784			**784**	
Circulation					1,794			**1,794**	
Building Mechanical/Electrical								**0**	
3rd Floor Kitchen/Dining								**0**	
Int. & Ext. Wall Thicknesses			0		991			**991**	
Total		**863**	**8,637**		**31,224**	**51,831**	**0**	**92,555**	*Calculate sum of all rows*

TABLE C. CONSTRUCTION CHARACTERISTICS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.

	DETOX NEW CONSTRUCTION	RESIDENTIAL NEW CONSTRUCTION	DETOX RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**		
Class of Construction (for renovations the class of the building being renovated)*			
Class A	☐	☐	☐
Class B	☐	☐	☐
Class C	☐	☐	☐
Class D	☐	☐	☐
Type of Construction/Renovation*			
Low	☐	☐	☐
Average	☐	☐	☐
Good	☐	☐	☐
Excellent	☐	☐	☐
Number of Stories	3	3	2

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**		
Total Square Footage	**Total Square Feet**		
Basement			
First Floor	863	12,002	8,036
Second Floor		9,611	
Third Floor		9,611	
Fourth Floor			
Average Square Feet	**863**	**10,408**	**8,036**
Perimeter in Linear Feet	**Linear Feet**		
Basement	1,727		
First Floor	1,166	1,166	3,121
Second Floor	464	464	314
Third Floor	464	464	
Fourth Floor			
Total Linear Feet	**3,821**	**2,094**	**3,435**
Average Linear Feet	**955**	**698**	**1,718**
Wall Height (floor to eaves)	**Feet**		
Basement			
First Floor	12	12	10
Second Floor	12	12	9
Third Floor	12	12	
Fourth Floor			
Average Wall Height	**12**	**12**	**9**
OTHER COMPONENTS			
Elevators	**List Number**		
Passenger	1	1	1
Freight			
Sprinklers	**Square Feet Covered**		
Wet System			
Dry System			
Other	**Describe Type**		
Type of HVAC System for proposed project			
Type of Exterior Walls for proposed project			

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table D for each structure.

	NEW CONSTRUCTION COSTS DETOX	NEW CONSTRUCTION COSTS RESIDENTIAL	RENOVATION COSTS DETOX	RENOVATION COSTS RESIDENTIAL
SITE PREPARATION COSTS				
Normal Site Preparation	$11,377	$76,139		
Utilities from Structure to Lot Line	$16,253	$108,771		
Subtotal included in Marshall Valuation Costs	**$27,630**	**$184,910**	**$0**	**$0**
Site Demolition Costs	$16,253	$108,771	$738	$4,940
Storm Drains	$21,129	$141,402		
Rough Grading	$26,005	$174,033		
Hillside Foundation				
Paving	$24,380	$163,155		
Exterior Signs	$4,876	$32,631	$3,690	$24,698
Landscaping	$19,504	$130,524	$22,142	$148,183
Walls				
Yard Lighting	$3,251	$21,754	$7,381	$49,394
Other: Curbs, hardscaping, site amenities.	$19,504	$130,524	$2,952	$19,758
Subtotal On-Site excluded from Marshall Valuation Costs	**$134,902**	**$902,793**	**$36,903**	**$246,972**
OFFSITE COSTS				
Roads				
Utilities				
Jurisdictional Hook-up Fees				
Other *(Specify/add rows if needed)*				
Subtotal Off-Site excluded from Marshall Valuation Costs				
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$134,902**	**$902,793**	**$36,903**	**$246,972**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$162,532**	**$1,087,703**	**$36,903**	**$246,972**

*The combined total site and offsite cost included and excluded from Marshall Valuation Service should typically equal the estimated site preparation cost reported in Application Part II, Project Budget (see Table E. Project Budget). If these numbers are not equal, please reconcile the numbers in an explanation in an attachment to the application.

TABLE E. PROJECT BUDGET

INSTRUCTION : Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application. See additional instruction in the column to the right of the table.

NOTE : Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.a as a use of funds and on line B.8 as a source of funds

			DETOX	RESIDENTIAL	Total
A.	**USE OF FUNDS**				
1.	**CAPITAL COSTS**				
a.	**Land Purchase**		**$617,500**	**$4,132,500**	**$4,750,000**
b.	**New Construction**				
(1)	Building		$605,343	$4,051,139	**$4,656,482**
(2)	Fixed Equipment				**$0**
(3)	Site and Infrastructure		$162,531	$1,087,704	**$1,250,235**
(4)	Architect/Engineering Fees		$26,225	$175,507	**$201,732**
(5)	Permits (Building, Utilities, Etc.)		$15,162	$101,465	**$116,627**
	SUBTOTAL		**$809,261**	**$5,415,815**	**$6,225,076**
c.	**Renovations**				
(1)	Building		$710,988	$4,758,148	$5,469,136
(2)	Fixed Equipment (not included in construction)			$0	$0
(3)	Architect/Engineering Fees		$24,208	$162,006	$186,214
(4)	Permits (Building, Utilities, Etc.)		$14,034	$93,916	$107,950
	SUBTOTAL		**$749,230**	**$5,014,070**	**$5,763,300**
d.	**Other Capital Costs**				
(1)	Movable Equipment		$189,904	$1,270,896	$1,460,800
(2)	Contingency Allowance		$132,132	$884,268	$1,016,400
(3)	Gross interest during construction period				$0
(4)	Legal Fees		$32,500	$217,500	$250,000
(5)	Property Due Diligence		$6,500	$43,500	$50,000
	SUBTOTAL		***$361,036***	***$2,416,164***	**$2,777,200**
	TOTAL CURRENT CAPITAL COSTS		**$2,537,027**	**$16,978,549**	**$19,515,576**
e.	**Inflation Allowance**				$0
	TOTAL CAPITAL COSTS		**$2,537,027**	**$16,978,549**	**$19,515,576**
2.	**Financing Cost and Other Cash Requirements**				
a.	**Loan Placement Fees**				$0
b.	**Bond Discount**				$0
c.	**Legal Fees**				$0
d.	**Non-Legal Consultant Fees**				$0
e.	**Liquidation of Existing Debt**				$0
f.	**Debt Service Reserve Fund**				$0
g.	**Transaction Costs**		**$143,026**	**$957,176**	$1,100,202
h.	**Acquisition Costs**		**$55,575**	**$371,925**	$427,500
i	**Due Diligence Costs**		**$19,500**	**$130,500**	$150,000
	SUBTOTAL		***$218,101***	***$1,459,601***	**$1,677,702**
3.	**Working Capital Startup Costs**				$0
	TOTAL USES OF FUNDS		***$2,755,128***	***$18,438,150***	***$21,193,278***
B.	**Sources of Funds**				
1.	**Cash**				$0
2.	**Philanthropy (to date and expected)**				$0
3.	**Authorized Bonds**				$0
4.	**Interest Income from bond proceeds listed in #3**				$0
5.	**Mortgage**		$1,790,832	$11,984,798	$13,775,630
6.	**Working Capital Loans**				$0
7.	**Grants or Appropriations**				
	a.	**Federal**			$0
	b.	**State**			$0
	c.	**Local**			$0
8.	**Equity funding**		$964,294	$6,453,353	$7,417,647
	TOTAL SOURCES OF FUNDS		***$2,755,126***	***$18,438,151***	**$21,193,277**
Annual Lease Costs (if applicable)					
1.	**Land**				$0
2.	**Building**				$0
3.	**Major Movable Equipment**				$0
4.	**Minor Movable Equipment**				$0
5.	**Other *(Specify/add rows if needed)***				$0

Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Calendar Year	**N/A**	**N/A**	**2015**	**2016**	**2017**	**2018**				
1. DISCHARGES										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Residential	N/A	N/A	27	1,013	1,791	1,799				
i. Detox	N/A	N/A	20	733	1,297	1,303				
TOTAL DISCHARGES	***0***	***0***	***47***	***1,746***	***3,088***	***3,102***	***0***	***0***	***0***	***0***
2. PATIENT DAYS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Residential	N/A	N/A	674	25,314	44,774	44,987				
i. Detox	N/A	N/A	98	3,666	6,484	6,515				
TOTAL PATIENT DAYS	***0***	***0***	***772***	***28,980***	***51,258***	***51,502***	***0***	***0***	***0***	***0***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Calendar Year	**N/A**	**N/A**	**2015**	**2016**	**2017**	**2018**				
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Residential	N/A	N/A	25.0	25.0	25.0	25.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
i. Detox	N/A	N/A	5.0	5.0	5.0	5.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	#DIV/0!	#DIV/0!	30.0	30.0	30.0	30.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*										
b. ICU/CCU										
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric										
d. Obstetric										
e. Acute Psychiatric										
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation										
g. Comprehensive Care										
h. Residential			145	145	145	145				
i. Detox	N/A	N/A	21	21	21	21				
TOTAL LICENSED BEDS	***0***	***0***	***166***	***166***	***166***	***166***	***0***	***0***	***0***	***0***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.						
Calendar Year	**N/A**	**N/A**	**2015**	**2016**	**2017**	**2018**				
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total MSGA	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Residential	N/A	N/A	15.0%	47.7%	84.6%	85.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
i. Detox	N/A	N/A	15.1%	47.7%	84.6%	85.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**#DIV/0!**	**#DIV/0!**	**1.3%**	**47.7%**	**84.6%**	**85.0%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS										
a. Emergency Department										
b. Same-day Surgery										
c. Laboratory										
d. Imaging										
h. Residential	N/A	N/A	492	6,396	6,396	6,396				
i. Detox	N/A	N/A	N/A	N/A	N/A	N/A				
TOTAL OUTPATIENT VISITS	***0***	***0***	***492***	***6,396***	***6,396***	***6,396***	***0***	***0***	***0***	***0***
7. OBSERVATIONS**										
a. Number of Patients	N/A	N/A	N/A	N/A	N/A	N/A				
b. Hours	N/A	N/A	N/A	N/A	N/A	N/A				

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the “Observation Center”, direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital’s premises, including use of a bed and periodic monitoring by the hospital’s nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

Table F - Statistical Projections
Explanation/Assumptions

1. At stabilization, the facility will reach a maximum occupancy of 85%.
2. The facility will reach stabilization after month 14. This assumption is based on the need in the market for rehabilitation beds for self-pay and commercially insured patients.
3. Average length of stay of 30 days with 5 in detoxification and 25 inpatient rehabilitation.
4. Anticipated opening date 12/1/2015.

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	**N/A**	**N/A**	**2015**	**2016**	**2017**	**2018**				
1. REVENUE										
a. Inpatient Services			$ 581,125	$ 21,817,643	$ 38,589,309	$ 38,772,904				
b. Outpatient Services			$ 40,092	$ 2,806,440	$3,207,360	$3,207,360				
Gross Patient Service Revenues	***$ -***	***$ -***	***$ 621,217***	***$ 24,624,083***	***$ 41,796,669***	***$ 41,980,264***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt			$ 59,256	$ 2,058,515	$3,072,214	$3,085,304				
d. Contractual Allowance										
e. Charity Care			$ 28,657	$ 1,075,885	$ 1,902,940	$ 1,911,993				
Net Patient Services Revenue	***$ -***	***$ -***	***$ 533,304***	***$ 21,489,683***	***$ 36,821,515***	***$ 36,982,967***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)										
NET OPERATING REVENUE	***$ -***	***$ -***	***$ 533,304***	***$ 21,489,683***	***$ 36,821,515***	***$ 36,982,967***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)			$ 739,528	$ 6,219,316	$10,174,767	$10,184,525				
b. Contractual Services			$ 16,333	$ 622,378	$ 1,285,185	$ 1,306,679				
c. Interest on Current Debt										
d. Interest on Project Debt										
e. Current Depreciation										
f. Project Depreciation										
g. Current Amortization										
h. Project Amortization										
i. Supplies			$ 811	$ 30,921	$ 63,850	$ 64,918				
j. Other Expenses: Administrative Allocation, Maintenance, Office Operations, Utilities, License and Legal, Marketing Expense, Food, Liability Insurance (Medical and General), Rent & Real Estate Taxes			$ 1,710,803	$ 7,257,555	$9,773,472	$9,875,168				
TOTAL OPERATING EXPENSES	**$ -**	**$ -**	**$ 2,467,476**	**$ 14,130,170**	**$ 21,297,275**	**$ 21,431,290**	**$ -**	**$ -**	**$ -**	**$ -**

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	**N/A**	**N/A**	**2015**	**2016**	**2017**	**2018**				
3. INCOME										
a. Income From Operation	**$ -**	**$ -**	**$ (1,934,171)**	**$ 7,359,514**	**$ 15,524,241**	**$ 15,551,676**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income										
SUBTOTAL	***$ -***	***$ -***	***$ (1,934,171)***	***$ 7,359,514***	***$ 15,524,241***	***$ 15,551,676***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ -***	***$ -***	***$ (1,934,171)***	***$ 7,359,514***	***$ 15,524,241***	***$ 15,551,676***	***$ -***	***$ -***	***$ -***	***$ -***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare										
2) Medicaid										
3) Blue Cross										
4) Commercial Insurance				85.0%	85.0%	85.0%				
5) Self-pay				10.0%	10.0%	10.0%				
6) Other				5.0%	5.0%	5.0%				
TOTAL	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare										
2) Medicaid										
3) Blue Cross										
4) Commercial Insurance				85.0%	85.0%	85.0%				
5) Self-pay				10.0%	10.0%	10.0%				
6) Other				5.0%	5.0%	5.0%				
TOTAL	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	**N/A**	**N/A**	**2015**	**2016**	**2017**	**2018**				
1. REVENUE										
a. Inpatient Services			$ 581,125	$ 21,963,391	$ 40,691,659	$ 42,928,656				
b. Outpatient Services			$ 40,092	2,946,762	$ 3,536,114	$ 3,712,920				
Gross Patient Service Revenues	***$ -***	***$ -***	***$ 621,217***	***$ 24,910,153***	***$ 44,227,774***	***$ 46,641,576***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt			$ 59,256	$ 2,382,708	$ 3,254,990	$ 3,432,172				
d. Contractual Allowance										
e. Charity Care			$ 28,657	$ 1,083,072	$ 2,006,612	$ 2,116,924				
Net Patient Services Revenue	***$ -***	***$ -***	***$ 533,304***	***$ 21,444,373***	***$ 38,966,172***	***$ 41,092,480***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)			$ -	$ -	$ -	$ -				
NET OPERATING REVENUE	***$ -***	***$ -***	***$ 533,304***	***$ 21,444,373***	***$ 38,966,172***	***$ 41,092,480***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)			$ 739,528	$ 8,672,887	$ 13,711,314	$ 14,428,046				
b. Contractual Services			$ 16,334	$ 626,474	$ 1,355,162	$ 1,446,616				
c. Interest on Current Debt										
d. Interest on Project Debt										
e. Current Depreciation										
f. Project Depreciation										
g. Current Amortization										
h. Project Amortization										
i. Supplies			$ 811	$ 31,125	$ 67,326	$ 71,870				
j. Other Expenses: Administrative Allocation, Maintenance, Office Operations, Utilities, License and Legal, Marketing Expense, Food, Liability Insurance (Medical and General), Rent & Real Estate Taxes			$ 3,482,659	$ 10,303,980	$ 13,614,346	$ 14,357,695				
TOTAL OPERATING EXPENSES	**$ -**	**$ -**	**$ 4,239,332**	**$ 19,634,466**	**$ 28,748,149**	**$ 30,304,227**	**$ -**	**$ -**	**$ -**	**$ -**

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	**N/A**	**N/A**	**2015**	**2016**	**2017**	**2018**				
3. INCOME										
a. Income From Operation	**$ -**	**$ -**	**$ (3,706,028)**	**$ 1,809,907**	**$ 10,218,023**	**$ 10,788,253**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income										
SUBTOTAL	***$ -***	***$ -***	***$ (3,706,028)***	***$ 1,809,907***	***$ 10,218,023***	***$ 10,788,253***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ -***	***$ -***	***$ (3,706,028)***	***$ 1,809,907***	***$ 10,218,023***	***$ 10,788,253***	***$ -***	***$ -***	***$ -***	***$ -***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare				0.0%	0.0%	0.0%				
2) Medicaid				0.0%	0.0%	0.0%				
3) Blue Cross				0.0%	0.0%	0.0%				
4) Commercial Insurance				85.0%	85.0%	85.0%				
5) Self-pay				10.0%	10.0%	10.0%				
6) Other				5.0%	5.0%	5.0%				
TOTAL	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare										
2) Medicaid		**Projected Years (ending five years after completion) Add columns if needed.**								
3) Blue Cross										
4) Commercial Insurance				85.0%	85.0%	85.0%				
5) Self-pay				10.0%	10.0%	10.0%				
6) Other				5.0%	5.0%	5.0%				
TOTAL	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - DETOX - Billingsley

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	**2015**	**2016**	**2017**	**2018**			
1. REVENUE - DETOX							
a. Inpatient Services	$ 85,502	$ 3,210,084	$ 5,677,740	$ 5,704,753			
b. Outpatient Services	N/A	N/A	N/A	N/A			
Gross Patient Service Revenues	***$ 85,502***	***$ 3,210,084***	***$ 5,677,740***	***$ 5,704,753***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 8,121	$ 304,877	$ 404,432	$ 406,356			
d. Contractual Allowance							
e. Charity Care	$ 4,297	$ 161,311	$ 285,314	$ 286,671			
Net Patient Services Revenue	***$ 73,084***	***$ 2,743,896***	***$ 4,987,994***	***$ 5,011,726***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	***$ 73,084***	***$ 2,743,896***	***$ 4,987,994***	***$ 5,011,726***	***$ -***	***$ -***	***$ -***
2. EXPENSES - DETOX							
a. Salaries & Wages (including benefits)	$ 109,018	$ 1,108,043	$ 1,722,101	$ 1,803,490			
b. Contractual Services	$ 2,123	$ 80,909	$ 167,074	$ 169,868			
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 105	$ 4,020	$ 8,301	$ 8,439			
j. Other Expenses: Administrative Allocation, Maintenance, Office Operations, Utilities, License and Legal, Marketing Expense, Food, Liability Insurance (Medical and General), Rent & Real Estate Taxes	$ 424,815	$ 1,203,913	$ 1,566,448	$ 1,585,025			
TOTAL OPERATING EXPENSES	**$ 536,062**	**$ 2,396,885**	**$ 3,463,923**	**$ 3,566,823**	**$ -**	**$ -**	**$ -**
3. INCOME - DETOX							
a. Income From Operation	**$ (462,978)**	**$ 347,011**	**$ 1,524,071**	**$ 1,444,903**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (462,978)***	***$ 347,011***	***$ 1,524,071***	***$ 1,444,903***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ (462,978)***	***$ 347,011***	***$ 1,524,071***	***$ 1,444,903***	***$ -***	***$ -***	***$ -***
4. PATIENT MIX - DETOX							
a. Percent of Total Revenue							
1) Medicare							
2) Medicaid							
3) Blue Cross							
4) Commercial Insurance	89.7%	89.7%	89.7%	89.7%			
5) Self-pay	10.3%	10.3%	10.3%	10.3%			
6) Other							
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare							
2) Medicaid							
3) Blue Cross							
4) Commercial Insurance	85.0%	85.0%	85.0%	85.0%			
5) Self-pay	10.0%	10.0%	10.0%	10.0%			
6) Other	5.0%	5.0%	5.0%	5.0%			
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - Billingsley Detox

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Calendar Year	**2015**	**2016**	**2017**	**2018**			
1. REVENUE							
a. Inpatient Services	$ 85,502	$ 3,231,528	$ 5,987,064	$ 6,316,199			
b. Outpatient Services	N/A	N/A	N/A	N/A			
Gross Patient Service Revenues	***$ 85,502***	***$ 3,231,528***	***$ 5,987,064***	***$ 6,316,199***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 8,121	$ 306,914	$ 426,465	$ 449,910			
d. Contractual Allowance							
e. Charity Care	$ 4,297	$ 162,388	$ 300,858	$ 317,397			
Net Patient Services Revenue	***$ 73,084***	***$ 2,762,226***	***$ 5,259,741***	***$ 5,548,892***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)							
NET OPERATING REVENUE	***$ 73,084***	***$ 2,762,226***	***$ 5,259,741***	***$ 5,548,892***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 109,018	$ 1,114,792	$ 1,815,758	$ 1,907,445			
b. Contractual Services	$ 2,123	$ 84,117	$ 181,957	$ 194,237			
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 105	$ 4,046	$ 8,752	$ 9,343			
j. Other Expenses: Administrative Allocation, Maintenance, Office Operations, Utilities, License and Legal, Marketing Expense, Food, Liability Insurance (Medical and General), Rent & Real Estate Taxes	$ 424,815	$ 1,220,926	$ 1,638,464	$ 1,727,300			
TOTAL OPERATING EXPENSES	**$ 536,062**	**$ 2,423,880**	**$ 3,644,932**	**$ 3,838,325**	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ (462,978)**	**$ 338,346**	**$ 1,614,809**	**$ 1,710,567**	***$ -***	***$ -***	***$ -***
b. Non-Operating Income							
SUBTOTAL	***$ (462,978)***	***$ 338,346***	***$ 1,614,809***	***$ 1,710,567***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ (462,978)***	***$ 338,346***	***$ 1,614,809***	***$ 1,710,567***	***$ -***	***$ -***	***$ -***
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare							
2) Medicaid							
3) Blue Cross							
4) Commercial Insurance	89.7%	89.7%	89.7%	89.7%			
5) Self-pay	10.3%	10.3%	10.3%	10.3%			
6) Other							
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare							
2) Medicaid							
3) Blue Cross							
4) Commercial Insurance	85.0%	85.0%	85.0%	85.0%			
5) Self-pay	10.0%	10.0%	10.0%	10.0%			
6) Other	5.0%	5.0%	5.0%	5.0%			
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE L. WORK fORCE INFORMATION

1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Site Director			$0	0.26	$185,250	$48,165			$0	0.3	$48,165
Admissions				1.21	$55,449	$67,093			$0	1.2	$67,093
Administrative Support				0.78	$52,000	$40,560			$0	0.8	$40,560
Medical Records				0.82	$57,316	$46,999			$0	0.8	$46,999
Operations Manager				0.13	$91,000	$11,830			$0	0.1	$11,830
Total Administration			$0	3.20	$441,015	$214,647		$0	$0	3.2	$214,647
Direct Care Staff *(List general categories, add rows if needed)*											
Psychiatrist				0.43	$253,660	$109,074			$0	0.4	$109,074
Nurse Practitioner				0.72	$129,879	$93,513			$0	0.7	$93,513
Nursing Director				0.13	$105,300	$13,689			$0	0.1	$13,689
Case Manager				1.11	$49,900	$55,389			$0	1.1	$55,389
Nursing - LPN				12.43	$51,530	$640,516			$0	12.4	$640,516
Nursing - RN				4.21	$78,525	$330,589			$0	4.2	$330,589
Recovery Support				5.55	$39,288	$218,048			$0	5.6	$218,048
Second Shift Supervisor*				0.13	$84,500	$10,985			$0	0.1	$10,985
Site Medical Director				0.13	$325,000	$42,250			$0	0.1	$42,250
Spiritual Advisor				0.22	$53,459	$11,761			$0	0.2	$11,761
Total Direct Care			$0	25.06	$1,171,041	$1,525,814	0.0	$0	$0	25.1	$1,525,814
Support Staff *(List general categories, add rows if needed)*											
Administrative Support			$0	1.19	$37,554	$44,689			$0	1.2	$44,689
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support			$0	1.19	$37,554	$44,689		$0	$0	1.2	$44,689
REGULAR EMPLOYEES TOTAL			$0	***29.45***	***$1,649,610***	$1,785,150		***$0***	$0	29.5	$1,785,150
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0	0.00	$0	$0		$0	$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
Medical			$0	0.01		$10,140			$0	0.0	$10,140
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0	0.01	$0	$10,140		$0	$0	0.0	$10,140
Support Staff *(List general categories, add rows if needed)*											
Activities			$0	0.22		$8,200			$0	0.2	$8,200
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0	0.22	$0	$8,200		$0	$0	0.2	$8,200
CONTRACTUAL EMPLOYEES TOTAL			$0	***0.23***	***$0***	$18,340		***$0***	$0	0.2	$18,340
Benefits *(State method of calculating benefits below)* **:**											
Benefits and taxes have been applied to employed staff based on management experience with the costs for similar benefit packages at other organizations at a rate of approximately 30%.											
TOTAL COST	***0.0***		***$0***	***29.68***		***$1,803,490***	***0.0***		***$0***		***$1,803,490***

Detox Only
Rehab Only

Inpatient

			Melwood				Billingsley				Earleville			
Regular Employees	**Type**	**General Category**		Number of Staff	Annual Salary W/ Taxes	Detox % - FTE	Detox % - Salary		Number of Staff	Annual Salary W/ Taxes & Benefits	Detox % - FTE	Detox % - Salary		Number c	Annual Salary W/	Detox % - FTE	Detox % - Salary
Administrative Assistant	Admin	Administrative Support	Administrative Assistant	1.00	71,500	0.17	12,155	Administrative Assistant	1.00	71,500	0.13	9,295	Administrative Assistan	1.00	71,500	0.35	25,025
Financial Counselor	Admin	Administrative Support	Financial Counselor	1.00	52,000	0.17	8,840	Financial Counselor	1.00	52,000	0.13	6,760	Financial Counselor	1.00	52,000	0.35	18,200
Marketing	Admin	Administrative Support	Marketing	1.00	67,600	0.17	11,492	Marketing	1.00	67,600	0.13	8,788	Marketing	1.00	67,600	0.35	23,660
Adventure Therapist	Support	Activities	Adventure Therapist	3.00	202,373			Adventure Therapist	4.15	279,949			Adventure Therapist	1.23	82,635		
Art/Music/Dance Therapy	Support	Activities	Art/Music/Dance Therapy	2.00	158,954			Art/Music/Dance Therapy	2.77	219,887			Art/Music/Dance Thera	0.82	64,906		
Receptionist*	Admin	Administrative Support	Receptionist	3.00	120,900	0.51	20,553	Receptionist	3.00	120,900	0.39	15,717	Receptionist	3.00	120,900	1.05	42,315
Case Manager - Detox	Direct Care	Case Manager	Case Manager - Detox	0.80	40,040	0.80	40,040	Case Manager - Detox	1.11	55,389	1.11	55,389	Case Manager - Detox	0.33	16,350	0.33	16,350
Case Manager - Rehab	Direct Care	Case Manager	Case Manager - Rehab	4.00	200,200			Case Manager - Rehab	5.53	276,943			Case Manager - Rehab	1.63	81,748		
Admissions Manager*	Admin	Admissions	Admissions Manager	1.00	84,500	0.17	14,365	Admissions Manager	1.00	84,500	0.13	10,985	Admissions Manager	1.00	84,500	0.35	29,575
Clinical Supervisor	Direct Care	Clinical Supervisor	Clinical Supervisor	3.00	292,500			Clinical Supervisor	4.00	390,000			Clinical Supervisor	2.00	195,000		
Nurse Practitioner*	Direct Care	Nurse Practitioner	Nurse Practitioner	2.40	312,000	0.41	53,040	Nurse Practitioner	3.32	431,600	0.43	56,108	Nurse Practitioner	0.98	127,400	0.34	44,590
Driver	Support	Administrative Support	Driver	1.20	39,240	0.20	6,671	Driver	1.66	54,282	0.2	7,057	Driver	0.49	16,023	0.17	5,608
Pych Nurse Practioner	Direct Care	Nurse Practitioner	Pych Nurse Practioner	1.60	208,000	0.27	35,360	Pych Nurse Practioner	2.21	287,733	0.29	37,405	Pych Nurse Practioner	0.65	84,933	0.23	29,727
Admissions*	Admin	Admissions	Admissions	6.00	312,000	1.02	53,040	Admissions	8.30	431,600	1.08	56,108	Admissions	2.45	127,400	0.86	44,590
Grounds Keeper	Support	Administrative Support	Grounds Keeper	1.40	42,728	0.24	7,264	Grounds Keeper	2.32	70,806	0.3	9,205	Grounds Keeper	(0.02)	(610)	(0.0)	(214)
Maintenance Manager	Support	Administrative Support	Maintenance Manager	1.00	67,600	0.17	11,492	Maintenance Manager	1.00	67,600	0.1	8,788	Maintenance Manager	1.00	67,600	0.35	23,660
MR Clerk	Admin	Medical Records	MR Clerk	1.00	41,600	0.17	7,072	MR Clerk	1.00	41,600	0.13	5,408	MR Clerk	1.00	41,600	0.35	14,560
QM/MR	Admin	Medical Records	QM/MR	1.00	65,000	0.17	11,050	QM/MR	1.00	65,000	0.13	8,450	QM/MR	1.00	65,000	0.35	22,750
Nurses - LPN Detox	Direct Care	Nursing - LPN	Nurses - LPN Detox	7.82	402,905	7.82	402,905	Nurses - LPN Detox	12.43	640,516	12.43	640,516	Nurses - LPN Detox	0.70	36,158	0.70	36,158
Nurses - LPN Rehab	Direct Care	Nursing - LPN	Nurses - LPN Rehab	22.11	1,138,982			Nurses - LPN Rehab	32.20	1,658,756			Nurses - LPN Rehab	6.54	336,723		
Nurses - RN Detox	Direct Care	Nursing - RN	Nurses - RN Detox	4.21	334,721	4.21	334,721	Nurses - RN Detox	4.21	330,589	4.21	330,589	Nurses - RN Detox	4.21	330,589	4.21	330,589
Nurses - RN Rehab	Direct Care	Nursing - RN	Nurses - RN Rehab	4.21	334,721			Nurses - RN Rehab	4.21	330,589			Nurses - RN Rehab	4.21	330,589		
Nursing Director (ADON)*	Direct Care	Nursing Director	Nursing Director (ADON)	1.00	105,300	0.17	17,901	Nursing Director (ADON)	1.00	105,300	0.13	13,689	Nursing Director (ADON	1.00	105,300	0.35	36,855
Psychiatrists*	Direct Care	Psychiatrist	Psychiatrists	2.40	606,528	0.41	103,110	Psychiatrists	3.32	839,030	0.43	109,074	Psychiatrists	0.98	247,666	0.34	86,683
UM Coordinator	Admin	Medical Records	UM Coordinator	1.00	71,500	0.17	12,155	UM Coordinator	1.00	71,500	0.13	9,295	UM Coordinator	1.00	71,500	0.35	25,025
Recovery Support Staff*	Direct Care	Recovery Support	Recovery Support Staff	29.65	1,134,498	5.04	192,865	Recovery Support Staff	41.01	1,569,389	5.33	204,021	Recovery Support Staff	12.11	463,253	4.24	162,139
Recovery Support Supervisor	Direct Care	Recovery Support	Recovery Support Supervisor	1.20	78,000	0.20	13,260	Recovery Support Supervisor	1.66	107,900	0.22	14,027	Recovery Support Supe	0.49	31,850	0.17	11,148
UM Reviewer	Admin	Medical Records	UM Reviewer	2.40	132,600	0.41	22,542	UM Reviewer	3.32	183,430	0.43	23,846	UM Reviewer	0.98	54,145	0.34	18,951
Operations Manager	Admin	Operations Manager	Operations Manager	1.00	91,000	0.17	15,470	Operations Manager	1.00	91,000	0.13	11,830	Operations Manager	1.00	91,000	0.35	31,850
Second Shift Supervisor*	Direct Care	Second Shift Supervisor	Second Shift Supervisor	1.00	84,500	0.17	14,365	Second Shift Supervisor	1.00	84,500	0.13	10,985	Second Shift Supervisor	1.00	84,500	0.35	29,575
Site Medical Director	Direct Care	Site Medical Director	Site Medical Director	1.00	325,000	0.17	55,250	Site Medical Director	1.00	325,000	0.13	42,250	Site Medical Director	1.00	325,000	0.35	113,750
Spiritual Advisor	Direct Care	Spiritual Advisor	Spiritual Advisor	1.20	65,400	0.20	11,118	Spiritual Advisor	1.66	90,470	0.22	11,761	Spiritual Advisor	0.49	26,705	0.17	9,347
Security	Support	Administrative Support	Security	4.20	151,074	0.71	25,683	Security	4.20	151,074	0.5	19,640	Security	4.20	151,074	1.47	52,876
Counselors/ Therapist*	Direct Care	Therapist	Counselors/ Therapist	12.50	1,020,448			Counselors/ Therapist	17.29	1,411,620			Counselors/ Therapist	5.10	416,683		
Family Therapist	Direct Care	Therapist	Family Therapist	6.25	496,733			Family Therapist	8.65	687,147			Family Therapist	2.55	202,832		
Assistant Executive Director*	Admin	Site Director	Assistant Executive Director	1.00	214,500	0.17	36,465	Executive Director	1.00	214,500	0.13	27,885	Executive Director	1.00	214,500	0.35	75,075
Clinical Director	Admin	Site Director	Clinical Director	1.00	156,000	0.17	26,520	Clinical Director	1.00	156,000	0.13	20,280	Clinical Director	1.00	156,000	0.35	54,600
Contractual Employees																	
Yoga Instructor	Support	Activities	Yoga Instructor	1.20	45,600	0.20	7,752	Yoga Instructor	1.66	63,080	0.22	8,200	Yoga Instructor	0.49	18,620	0.17	6,517

On-site Outpatient

Regular Employees	**Type**	**General Category**	**FTEs**	**Annual**	
Office Manager	Admin	Operations Manager	1.0	52,000	
Clinical Supervisor	Direct Care	Counseling	1.0	78,000	
PHP Counselors - Fixed	Direct Care	Counseling	2.0	135,200	
PHP Counselors - Variable	Direct Care	Counseling	2.0	135,200	
IOP Counselors	Direct Care	Counseling	4.0	270,400	
OP Counselors	Direct Care	Counseling	1.5	135,200	
Family Therapist	Direct Care	Counseling	1.0	67,600	
Drivers	Support	Administrative Support	4.0	156,000	
Contractual Employees					
Contracted Physician	Direct Care	Medical	0.1	78,000	
			16.6	**1,107,600**	**Outpatient Total**
			141.75	9,368,745	Melwood inpatient total (excluding admin alloc)
			158.3	**$ 10,476,345**	**Total Melwood**
			16.6	**1,107,600**	**Outpatient Total**
			188.2	12,180,279	Billingsley inpatient total (excluding admin alloc)
			204.8	**$ 13,287,879**	**Total Billingsley**
			70.6	5,061,173	Earleville inpatient total (excluding admin alloc)

Administrative Assistant	Admin	Administrative Support						Administrative Assistant	1.00	71,500	0.13	9,295					
Financial Counselor	Admin	Administrative Support						Financial Counselor	1.00	52,000	0.13	6,760					
Marketing	Admin	Administrative Support						Marketing	1.00	67,600	0.13	8,788					
Adventure Therapist	Support	Activities						Adventure Therapist	4.15	279,949							
Art/Music/Dance Therapy	Support	Activities						Art/Music/Dance Therapy	2.77	219,887							
Receptionist*	Admin	Administrative Support						Receptionist	3.00	120,900	0.39	15,717					
Case Manager - Detox	Direct Care	Case Manager						Case Manager - Detox	1.11	55,389	1.11	55,389					
Case Manager - Rehab	Direct Care	Case Manager						Case Manager - Rehab	5.53	276,943							
Admissions Manager*	Admin	Admissions						Admissions Manager	1.00	84,500	0.13	10,985					
Clinical Supervisor	Direct Care	Clinical Supervisor						Clinical Supervisor	4.00	390,000							
Nurse Practitioner*	Direct Care	Nurse Practitioner						Nurse Practitioner	3.32	431,600	0.43	56,108					
Driver	Support	Administrative Support						Driver	1.66	54,282	0.2	7,057					
Pych Nurse Practioner	Direct Care	Nurse Practitioner						Pych Nurse Practioner	2.21	287,733	0.29	37,405					
Admissions*	Admin	Admissions						Admissions	8.30	431,600	1.08	56,108					
Grounds Keeper	Support	Administrative Support						Grounds Keeper	2.32	70,806	0.3	9,205					
Maintenance Manager	Support	Administrative Support						Maintenance Manager	1.00	67,600	0.1	8,788					
MR Clerk	Admin	Medical Records						MR Clerk	1.00	41,600	0.13	5,408					
QM/MR	Admin	Medical Records						QM/MR	1.00	65,000	0.13	8,450					
Nurses - LPN Detox	Direct Care	Nursing - LPN						Nurses - LPN Detox	12.43	640,516	12.43	640,516					
Nurses - LPN Rehab	Direct Care	Nursing - LPN						Nurses - LPN Rehab	32.20	1,658,756							
Nurses - RN Detox	Direct Care	Nursing - RN						Nurses - RN Detox	4.21	330,589	4.21	330,589					
Nurses - RN Rehab	Direct Care	Nursing - RN						Nurses - RN Rehab	4.21	330,589							
Nursing Director (ADON)*	Direct Care	Nursing Director						Nursing Director (ADON)	1.00	105,300	0.13	13,689					
Psychiatrists*	Direct Care	Psychiatrist						Psychiatrists	3.32	839,030	0.43	109,074					
UM Coordinator	Admin	Medical Records						UM Coordinator	1.00	71,500	0.13	9,295					
Recovery Support Staff*	Direct Care	Recovery Support						Recovery Support Staff	41.01	1,569,389	5.33	204,021					
Recovery Support Supervisor	Direct Care	Recovery Support						Recovery Support Supervisor	1.66	107,900	0.22	14,027					
UM Reviewer	Admin	Medical Records						UM Reviewer	3.32	183,430	0.43	23,846					
Operations Manager	Admin	Operations Manager						Operations Manager	1.00	91,000	0.13	11,830					
Second Shift Supervisor*	Direct Care	Second Shift Supervisor						Second Shift Supervisor	1.00	84,500	0.13	10,985					
Site Medical Director	Direct Care	Site Medical Director						Site Medical Director	1.00	325,000	0.13	42,250					
Spiritual Advisor	Direct Care	Spiritual Advisor						Spiritual Advisor	1.66	90,470	0.22	11,761					
Security	Support	Administrative Support						Security	4.20	151,074	0.5	19,640					
Counselors/ Therapist*	Direct Care	Therapist						Counselors/ Therapist	17.29	1,411,620							
Family Therapist	Direct Care	Therapist						Family Therapist	8.65	687,147							
Assistant Executive Director*	Admin	Site Director						Executive Director	1.00	214,500	0.13	27,885					
Clinical Director	Admin	Site Director						Clinical Director	1.00	156,000	0.13	20,280					
Contractual Employees																	
Yoga Instructor	Support	Activities						Yoga Instructor	1.66	63,080	0.22	8,200					
											0.0	10,140				0.03	4,641

Statement of Assumptions for Financial Projections

Expenses

Applicant has budgeted its expenses based on a variety of factors, including but not limited to the following:

- Staffing ratio requirements of the state
- Industry comparable information, when available
- Experience of executive program and clinical personnel from other facilities
- Experience of executive finance personnel with costs associated for expenses and services in similar type facilities

The RCA salaries are based on detail rosters by location that comply with or exceed the staffing requirements for the respective services. Benefit and taxes have been applied based on management experience with the costs for similar benefit packages at other organizations. Estimates for utilities, maintenance, and other facility related costs are based on both the experience of RCA management from other similar facilities, as well as estimates from personnel familiar with facility costs from similar sized facilities in their hospitality portfolio. Food costs were estimated based on the experience of RCA management at other residential facilities, and were increased nearly twofold in order to ensure that RCA will be able to deliver the high quality of food that will be required in its world class facilities. Liability, property and other insurance costs are based on estimates received from RCA's insurance brokers, who have done preliminary pricing with a variety of insurance carriers ahead of actual binding of insurance coverages. Finally, other patient based expenses (i.e. program activities, etc.) were also based on the RCA management team's experience at other similar facilities.

In general, Applicant based the expenses of its budget on known factors where available, and on the significant past experience of its executive program, clinical and financial teams in order to provide what it believes to be the most accurate, and if unknown then conservative, expense projections available at this time.

Revenue

Applicant used various forms of data to support the average daily rate assumptions used in schedules G and H to calculate annual revenue. Applicant examined data from multiple payors that includes out-of-network (OON) claims processed, in-network negotiated rates from proprietary sources, databases that provide claims paid representing a population mix of OON and in-network data, as well as self-pay rates. Applicant focused on four key information sources: (i) Medivance Billing Service data (OON claims processed), (ii) TruVen Health Analytics data (claims paid, thus representing a mix of OON and in-network), (iii) American Addiction Centers (NYSE: AAC) public metrics (primarily OON, with small portion of self-pay), and (iv) internal employee confidential rate data (in-network negotiated rates). The summary of Applicant's data analysis by source is below, with the results supporting its assumptions and serving to triangulate around RCA's average daily rates.

Summary Matrix

	RCA Model Average Daily Rate (1)	Medivance Billing Average Payment	Truven Health Analytics	American Addiction	RCA Proprietary In-Network Rates
Detox	$860	$1,618			$752
Inpatient	$724	$1,135	$1,057 (2)	$966 (3)	$597
Partial Hospitalization	$325	$989			$350
Intensive Outpatient	$150	$610			
General Outpatient	$75	$193			

Notes:

(1) Represents the weighted average (by bed) daily rate for RCA, before bad debt provision.

(2) Represents payments to hospitals for similar services provided by RCA.

(3) Represents AAC's average gross daily revenue for the 4th quarter of 2014.

(i) Medivance Billing Service (MBS) specializes in offering comprehensive substance abuse billing, collections and revenue cycle management services to substance abuse rehab facilities. It provided Applicant with a comprehensive proposal for providing services to RCA. Throughout that process, Applicant has been gathering data from MBS' billing base of 45 clients (representing 60 facilities) and over $60 million worth of claims data each month, 95% of which is out-of-network insurance claims. MBS has provided 2014 data with regard to average payment rates, all from their proprietary information of claims. The average payment rate represents the actual amount paid by the insurance provider to the rehabilitation facility, which is after the patient responsibility portion of the bill (including coinsurance, deductibles, etc.). The data includes individual claim data from 50+ different insurance providers and over 2000 individual data points. The summary of the MBS average daily payment data for OON claims paid to substance abuse facilities is as follows:

Level of Service Provided	**Average Daily Payment**
Detox	$1,618
Inpatient Rehab / Residential	$1,135
Partial Hospitalization (PHP)	$989
Intensive Outpatient (IOP)	$610
General Outpatient (GOP)	$193

(ii) TruVen Health Analytics (TruVen) has a proprietary and confidential database called Reimbursement Benchmarks, which represents 350 insurance carriers and 67 million covered lives. TruVen has provided data that represent the same services Applicant will be providing, although from a hospital standpoint, and not a "free-standing" rehabilitation facility (i.e. a different site service). Applicant views this data as an indirect confirmation that the value of Applicant's services is commensurate with the TruVen summary data below. Applicant is in consistent dialog with the TruVen Health team to fine tune its relevant claims data.

	Average Daily Rate	
	Inpatient Services (MS_DRG 895)	
State	2012	2013
Rhode Island	$ 1,287	$ 1,326
Pennsylvania	$ 921	$ 956
New Jersey	$ 950	$ 1,001
Massachusetts	$ 1,107	$ 1,128
Maryland	$ 866	$ 872
Average	***$ 1,026***	***$ 1,057***

(iii) American Addiction Centers (NYSE: AAC), the pure play substance abuse public comparable, generates revenues through out-of-network insurance reimbursements (90%) and self-pay clients (10%). AAC publishes several select metrics that Applicant tracks closely, among those being average gross daily revenue and average net daily revenue both quarterly and annually. AAC is achieving substantially higher daily rates than we are forecasting in our model and they are summarized below.

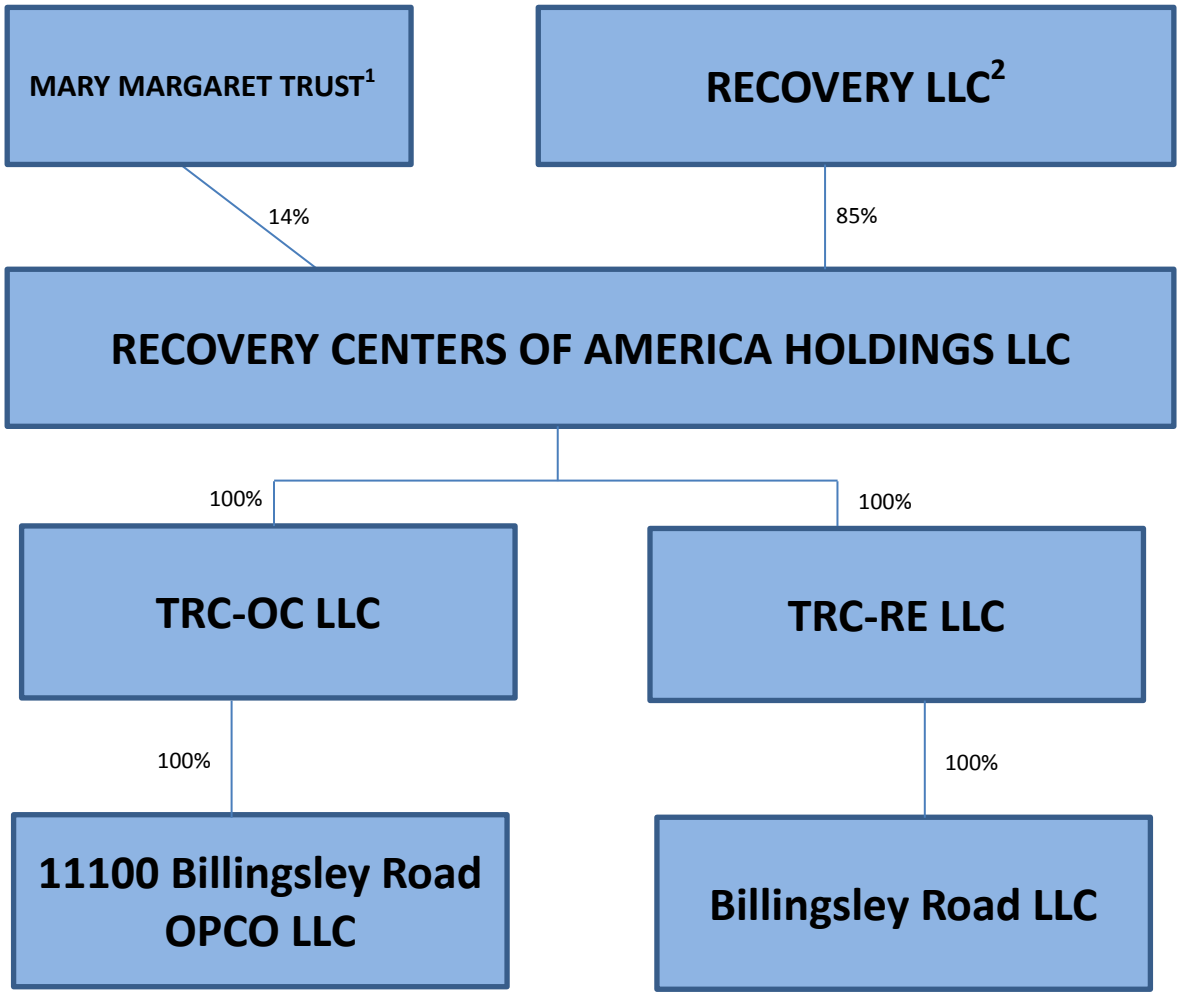
	2013	2014	3rdQ2014	4thQ2014
Avg Gross Daily Revenue:	$935	$922	$963	$966
Avg Net Daily Revenue:	$847	$890	$906	$890

(iv) In-Network Rates – RCA Proprietary: The following rates represent negotiated in-network daily rates for a west coast-based substance abuse facility. These rates are averages from over 15 major regional and national payors and are primarily based on "all-inclusive" per diem fee schedules. In some instances, rates were exclusive of Physician Fees, Radiology and other ancillary services.

Detox	$752
Inpatient Rehab	$597
Partial Hospitalization	$350

EXHIBIT 2

ORGANIZATIONAL CHART
Billingsley Road Facility



[1] The full name of the trust is "The Mary Margaret Trust FBO The Family of J. Eustace Wolfington." J. Eustace Wolfington is Trustee.

[2] J. Brian O'Neill is the current owner of Recovery LLC. Ownership may change during the CON process to include Miriam O'Neill and/or Brian O'Neill and Miriam O'Neill in their capacities as Trustees of the "J. Brian O'Neill and Miriam O'Neill Trust FBO their Children."

EXHIBIT 3

Local

Heroin deaths spike in Maryland

By Susan Svrluga June 27, 2014

Heroin-related deaths in Maryland spiked 88 percent from 2011 to 2013, according to figures released Friday by the state's Department of Health and Mental Hygiene, and intoxication overdoses of all types now outnumber homicides in the state.

"Overdose is a public-health crisis in Maryland, as it is in many states," said the agency's secretary, Joshua Sharfstein, "and we are bringing everything we can to bear against this challenge."

Cyndi Glass of Brookeville, whose son Jeremy died of a heroin overdose in 2008, gasped when she heard the statistics. "That is shocking. I knew it would increase, but I didn't know it would increase that much," she said.

Glass has been raising money for treatment, prevention and awareness programs because she had no idea, when her son was prescribed opioid painkillers after a football injury led to three knee surgeries, that it could possibly lead one day to a heroin addiction.

"He would have turned 26 yesterday," she said.

Heroin use has been surging across the country — often as people addicted to prescription

opiates switch to a similar, but cheaper and more readily available, high — with fatalities rising along with it.

In Virginia, heroin-related deaths more than doubled from 2011 through 2013, for a total of 213. In 2013 in Maryland, which has a more comprehensive system for tracking deaths, there were 464 — an 18 percent increase from the previous year.

Both states began training programs this year to help family members or friends learn to administer naloxone, a drug that can sometimes prevent an overdose. In Maryland, 2,000 people have been trained already in addition to the first-responders, Sharfstein said, and by July 1 all ambulances will carry naloxone.

Maryland saw a dramatic jump in the number of deaths from heroin spiked with non-prescription fentanyl. Typically they had seen two or three a month, Sharfstein said, "but in October we started to see 10, 15, 20 a month … and that has persisted, to a certain extent, into this year. That is a huge increase. Fentanyl is highly potent and definitely dangerous in combination with heroin. That is a huge challenge."

Gov. Martin O'Malley (D) created an interagency council to try to prevent overdose deaths, using some of the same techniques the state has used to understand and reduce the number of homicides.

One of his main goals has been to reduce intoxication deaths by 20 percent by the end of next year. (A graphic of a meter on a state Web site shows negative 7.4 percent progress toward that goal, since all intoxication deaths increased from 799 to 858 in 2013.)

Heroin-related deaths increased in western and central Maryland and on the Eastern

Shore. And they more than doubled in Frederick County, from 10 in 2012 to 21 in 2013.

Over the past five to 10 years, heroin, once mainly associated with urban centers such as Baltimore, has spread throughout the state, Sharfstein said. (Baltimore had a large increase in heroin deaths from 2012 to 2013, as well.)

The state has launched a public-information campaign to counter opioid overdoses, trying to erase stigmas about treatment such as methadone and looping in the 211 call centers so that people can ask where to find help.

Officials hope to provide everyone leaving detention centers with information warning about overdose deaths: Former inmates can easily overdose after being off the drug if they go back to their original dose once they're freed from incarceration because of lost tolerance. And officials will study cases, looking for common factors (such as certain doctors, in the case of prescription-drug overdoses), recent release from prison and so on.

The governor is also asking the boards that oversee prescribers to require all practitioners to take continuing education in two areas: Appropriate opioid prescribing and addiction treatment.

“It may be that we’re making some progress,” Sharfstein said. “It’s just hard to say, given the enormous increases affecting the East Coast right now. Everything we’re doing is really not enough to turn the corner.”

Susan Svrluga is a reporter for the Washington Post, covering higher education for the Grade Point blog.

EXHIBIT 4

Profile of Dr. Deni Carise, Chief Clinical Officer

Dr. Carise (hereafter "Executive") has been in the field of substance abuse and behavioral healthcare, as a researcher and clinician, for more than 28 years and as such has extensive personal knowledge, know-how and experience with regard to the types of activities she will be undertaking for RCA. The following list includes the types of materials Executive has produced in the past, media outlets that have featured Executive and Executive's work, public presentations made and products Executive has developed. Nothing on this list shall prohibit Executive from developing similar products for RCA which RCA would have full ownership rights to, however, neither shall she be prohibited from developing similar products in the future based on her experience and know how.

I. Areas of Expertise:

A. Development, implementation and measurement of treatment tools and evidence-based practices such as computer software, clinical toolkits, program descriptors, assessment, intake and treatment planning instruments and procedures, continuing care, fidelity assessment, relapse prevention, family therapy, 12-step support, decreasing paperwork burden, diagnosing systems, psychodrama. Support for specific topics is as follows:

1. Carise, D, McLellan, A.T., & Gifford, L. (2000) Development of a "Treatment Program" Descriptor – The Addiction Treatment Inventory. Substance Use and Misuse, 35(12-14), 1797-1818.
2. Carise, D., Gurel, O., Festinger, D., & McLellan, A.T. (2001). Linking assessment to services provided with the Addiction Severity Index and new technology transfer systems. Drug and Alcohol Dependence 63(1), 24.
3. Gurel, O., Carise, D., Kendig, C., & McLellan, A.T. (2001). Research to practice: Development, validation and use of a resource guide and software to link assessment to services. Drug and Alcohol Dependence 63(1), 60.
4. Carise, D., McLellan, A.T., Cacciola, J., Love, M., Cook, T., Bovasso, G., Lam, V. (2001). Suggested specifications for a standardized Addiction Severity Index database. Journal of Substance Abuse Treatment 20, 239-244
5. Gurel, O., Carise, D., Kendig, C., McLellan, A.T. (2005). Developing CASPAR: A computer-assisted system for patient assessment and referral. Journal of Substance Abuse Treatment, 28(3), 281-289.
6. Carise, D., Gurel, O., McLellan, A.T., Dugosh, K. & Kendig, C. (2005). Getting patients the services they need using a computer-assisted system for patient assessment and referral – CASPAR. Drug and Alcohol Dependence. 80(2), 177-189.
7. McLellan, A.T., Cacciola, J.C., Alterman, A. I., Rikoon, S. & Carise, D. (2006). The Addiction Severity Index at 25: Origins, contributions, and transitions, American Journal on Addictions, 15(2).
8. Rikoon, S.H., Cacciola, J.S., Carise, D, Alterman, A.I., & McLellan, A.T. (2006). Predicting DSM-IV dependence diagnoses from ASI composite scores. Journal of Substance Abuse Treatment. 31 (1), 17-24.
9. Cacciola, J., Camilleri, A., Carise, D., Rikoon, S., McKay, J., McLellan, T., Wilson, C., and Schwarzlose, J. (2008). Extending residential care through telephone counseling: Initial results from the Betty Ford Center Focused Continuing Care protocol. Addictive Behaviors, 33(9), 1208-1216.
10. Carise D., Brooks A., Alterman, A. McLellan A. T., Forman R. and Hoover V. (2009) Implementing Evidence Based Practices in Community Treatment Programs: Initial feasibility of a Counselor Toolkit. Substance Abuse. 30 (3) 239-243.

11. Carise, D. (2000) Effects of Family Involvement on Length of Stay and Treatment Completion Rates with Cocaine and Alcohol Abusers. Journal of Family Social Work, V4(4), 79-94.
12. Carise, D., Love, M., Zur, J., McLellan, A.T., Kemp, J. (2009). Results of a State-Wide Evaluation of "Paperwork Burden" in Addiction Treatment. Journal of Substance Abuse Treatment, 37(1).
13. McKay, J.R., Carise, D., Dennis, M., DuPont, R.., Humphreys, K., Kemp, J., et al. (2009). Extending the benefits of addiction treatment: Practical strategies for continuing care and recovery. Conference position statement. Journal of Substance Abuse Treatment, 36, 127-130.
14. McKay, J.R. & Carise, D. (2009). State of the Science: Extending the benefits of addiction treatment. Journal of Substance Abuse Treatment, 36, 172-173.
15. Brooks, A.C., Ryder, D., Carise, D., Kirby, K.C. (2010) Feasibility and effectiveness of computer-based therapy in community treatment. Journal of Substance Abuse Treatment, 39(3), 227-235.
16. Brooks, A., DiGuiseppi, G., Laudet, A., Rosenwasser, B., Knoblach, D., Carpenedo, C., Carise, D. & Kirby, KC. (2012). Developing an evidence-based, multimedia group counseling curriculum toolkit. Journal of Substance Abuse Treatment, 43(2012), 178-189.
17. Carise D, Forman R, Randall. (1995). Effect of Drug of Choice, Family Involvement, and Employer Involvement on Treatment Completion Rates Of Substance Abusers. NIDA Research Monograph Series. Problems of Drug Dependence, 152(2), 352.
18. Carise D, McLellan, AT. (1996). The "Paved-Way"; Effects of Linking In-Treatment Addicts with 12-Step Program Volunteers. NIDA Research Monograph Series. Problems of Drug Dependence, 162, 268.
19. S. Rikoon, J. Cacciola, D. Carise, and McLellan A.T. (2004). Assessing severity: predicting DSM-IV dependence diagnosis from ASI composite scores. NIDA Research Monograph Series. Problems of Drug Dependence, 185(9), 25.
20. Carise D, McLellan AT. (1997). Assessing Outcomes with Special Populations. NIDA Research Monograph Series. Problems of Drug Dependence, 174, p. 283.
21. Carise D., Gurel O., Kendig C., McLellan A.T. (2002). Computer-Assisted Admission Assessment Treatment Planning and Service Referral: Effects on Counselors and Patients. NIDA Research Monograph Series. Problems of Drug Dependence, 183, p. 129.
22. Carise, D. & McLellan, A.T. (1999). Increasing Cultural Sensitivity of the Addiction Severity Index (ASI): An Example with Native Americans in North Dakota. Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment.
23. Carise, D. (1992).
24. Alcoholism: Family disease/Family treatment. In W. McCown (Ed.). Treatment with high-risk families: A consultation/crisis intervention paradigm. New York: Hayworth.
25. Carise, D & Gűrel, O. (2003). Benefits of Integrating Technology with Treatment–the DENS Project. In J. L. Sorensen, R. Rawson, J. Guydish, & J. E. Zweben (Eds.). Drug Abuse Treatment Through collaboration; Practice and Research Partnerships That Work. Chapter 11, 181-195.
26. Carise, D: Software Specification Development for Addiction Severity Index – 5th Edition. Treatment Research Institute, 1999
27. Carise, D & Love, M.: Software Specification Development for Addiction Severity Index: Self-Administered Version. Treatment Research Institute, 2000
28. Video: An ASI Interview: Instructional training video for clinicians. Treatment Research Institute, 1999

29. Mericle, A. A., Festinger, D., Carise, D., (2009). Detection, advice, referral to services (DARTS): A guide for public defenders to assist clients with alcohol and drug problems. Unpublished manual, Treatment Research Institute (TRI).
30. Stilen, P., Carise, D., Roget, N., & Wendler, A. (2007). Treatment planning M.A.T.R.S. Utilizing the Addiction Severity Index (ASI) to make required data collection useful. Kansas City, MO: Mid-America Addiction Technology Transfer Center in residence at the University of Missouri-Kansas City.

B. Developing systems of care and partnerships such as performance-based contracting, concurrent recovery monitoring, implementation science, developing partnerships in the field, working with State directors, instrument and methods development,

1. Carise, D, Cornely, W., & Gűrel, O. (2002). A Successful Researcher-Practitioner collaboration in substance abuse treatment. Journal of Substance Abuse Treatment. 23 (2).
2. Carise, D., McLellan, A.T., Festinger, D.S., & Kleber, H.D. (2004). Identifying United States Substance Abuse Treatment Programs: A Test in One Mid-Sized City. Substance Abuse, 25(2), 21-29.
3. Simeone R., McLellan A.T. and Carise D. (2005) The Reliability and Validity of Retrospective Self-Reported Drug Use. Journal of Medical Statistics.
4. McLellan, A.T., Kemp, J., Brooks, A.C. & Carise, D. (2008) Improving Public Addiction Treatment Through Performance Contracting: The Delaware Experiment. Health Policy, 87(3), 296-308.
5. McLellan A.T., Carise D. and Kleber H.D. (2003) Problems with the national addiction treatment infrastructure. In. J. Jaffe and D. Rosenbloom (Eds) Contemporary Issues in Addiction Treatment. Haworth Press.
6. Carise, D. & Brooks, A. (2008). Linking Drug Court Participants to Needed Services. In Hardin, C and Kushner J.N (Eds).Quality Improvement for Drug Courts: Evidence-Based Practices. National Drug Court Institute. Chapter 9, 87-97.

C. Tracking Trends:

1. Carise, D, McLellan, A.T., Gifford, L., & Kleber, H.D. (1999) Developing a National Addiction Treatment Information System. An Introduction to The Drug Evaluation Network System. Journal of Substance Abuse Treatment. V17 (1-2), 67-77.
2. Carise, D., Dugosh, K., McLellan, A.T., Camilleri, A, Woody, G., Lynch, K.G. (2007). Prescription OxyContin Abuse Among Patients Entering Addiction Treatment. American Journal of Psychiatry 164(11), 1750-1756.
3. Johnson, P.B., Richter, L, Carise, D., McLellan, A.T. & Kleber, H.D. (2002). Alcohol Use Patterns Before and After September 11th. Am Clin Lab 2002 Aug-Sep;21(7):25-27.
4. Johnson, P. B.; Richter, L.; Kleber, H. D.; McLellan, A. T.; Carise, D. (2005). Telescoping of Drinking-Related Behaviors: Gender, Racial/Ethnic, and Age Comparisons. Substance Use & Misuse, 40, 1139-1151.
5. Eyrich-Garg KM, Cacciola JS, Carise D, Lynch KG, McLellan AT. (2008). Individual characteristics of the literally homeless, marginally housed, and impoverished in a US substance abuse treatment-seeking sample. Social Psychiatry/Psychiatry Epidemiology. Oct 2008; 43(10), 831-842.
6. Khalil, A., Okasha, T., Shawky, M., Haroon, A., Elhabiby, M., Carise, D, Annon, J, Hasson, A., Rawson, R. (2009) **Characterization of Substance Abuse Patients**

Presenting for Treatment at a University Psychiatric Hospital in Cairo, Egypt. Addictive Disorders & Their Treatment. 7(4), 199-209.

7. Carise D, McLellan AT, Kleber H, Petro C. (1998) "The TRI-Net" Study: Electronic Tracking of National Trends in Substance Abuse Treatment. Problems of Drug Dependence, 178, p. 331.
8. Love, M., Carise, D., McLellan, A.T., Kleber, H.D., Edwards, M., Eshelman, H., Lam, V., Rolay, K., Ackerson, T., & Kendig, C. (2001). An update on the Drug Evaluation Network System. Drug and Alcohol Dependence 63(1), 93.

D. Eliciting positive public opinion and support for Treatment:

1. Carise D. (1997). Making the Case with Public Stakeholders to Support Substance Abuse Treatment. Behavioral Health Outcomes, 2(9), p. 4.
2. McLellan, A.T., Carise, D., and Kleber, H.D. (2003). Can the national addiction treatment infrastructure support the public's demand for quality care? Journal of Substance Abuse Treatment, 25, 117-121.
3. Tomás-Rosselló J, Rawson RA, Zarza MJ, Bellows A, Busse A, Saenz E, Freese T, Shawkey M, Carise D, Ali R, Ling W. (2010) . United Nations Office on Drugs and Crime International Network of Drug Dependence Treatment and Rehabilitation Resource Centres: Treatnet. Substance Abuse. Oct;31(4), 251-263.

II. News Media involvement to show history and support for areas of expertise

1. Nightline: 2 segments featuring the Drug Evaluation Network System. Featuring: Carise, D., McLellan, A. T., Kleber, H.K. ABC 1999
2. Office of National Drug Control, Executive Offices of the White House, Video: The Drug Evaluation Network System, Symposium, San Diego, CA, 2001
3. Webcast: Substance Abuse and Mental health Services Administration (SAMHSA). Treatment 101: The Science and Methodologies of Treating Alcohol and Drug Use Disorders, Available at: http://www.recoverymonth.gov/2005/multimedia/w.aspx?ID=389. 2005.
4. US News and World Report. Quoted in: Rehab, Relapse, Repeat (Lindsay Lohan, Take Note!). By Katherine Hobson. August 21, 2007
5. Fox News interview: (2010). www.myfoxny.com/dpp/health/100104-nyc-health-department-issues-heroin-use-booklet 2010.
6. CBS News: Troubled Sheen Back in Rehab. Available at: http://newyork.cbslocal.com/category/video-on-demand-news/?clipId=5514591&flvUri&partnerclipid&topVideoCatNo=0&c&autoStart=true&activePane=info&LaunchPageAdTag=homepage&clipFormat=flv January 28th 2011.
7. CBS News 2 New York Booming Addiction: Baby Boomers Using Drugs In Record Numbers Available at: http://www.youtube.com/watch?v=JYcONzUfUng&feature=player_embedded May 20th 2011.
8. WABC TV – Viewpoint, hosted be Eyewitness News Anchor, Ken Rosato. Healthcare Reform and the Substance Abuse Treatment field. November 2011.
10. SIRIUS XM's Doctor Radio interview: Guest on Perri Peltz's program "Is Your Kid High?" www.sirius.com/doctorradio January 2012.
10. CBS NY Morning News Charlie Sheen Checks Into Rehab After Hospitalization Available at: http://abcnews.go.com/Entertainment/charlie-sheen-checks-rehab-half-men-hiatus/story?id=12792384 Jan 14th 2012.

11. CBS News New York Deni Carise Offers Tips on How to Help Someone Struggling With Prescription Drug Addiction. Available at: http://newyork.cbslocal.com/2012/01/14/expert-offers-tips-on-how-to-help-someone-struggling-with-prescription-drug-addiction/ January 14, 2012.
12. Good Morning America (ABC) . Whip-Its: Brief Highs, Big Dangers for Demi Moore? Available at: http://abcnews.go.com/Health/whip-highs-big-dangers-demi-moore/story?id=15456104 Jan 24th 2012.
13. Good Morning America (ABC) online. Whip-Its: Brief Highs, Big Dangers for Demi Moore? (Available online at http://abcnews.go.com/Health/whip-highs-big-dangers-demi-moore/story?id=15456104#.TyazlmHzLAw Jan 27th 2012. Article by Jane Allen (@JaneEAllenABC) , ABC News Medical Unit Jan. 27, 2012
14. Op-Ed in The METRO. Carise, D. Whitney Houston and the struggle of addiction. Available at http://www.metro.us/ArticlePrint/1095677?language=en. 12 February 2012 07:08.
15. Good Morning America (ABC): Charlie Sheen can't do it Alone. Available at: http://abcnews.go.com/GMA/video/charlie-sheen-im-anti-semite-13006903 February 28th, 2012
16. http://www.dailymail.co.uk/news/article-2121578/Driver-arrested-staggering-blood-alcohol-level-nearly-FIVE-TIMES-legal-limit.html
17. Daily Mail Reporter UK. Driver arrested with staggering blood alcohol level nearly FIVE TIMES the legal limit. http://www.dailymail.co.uk/news/article-2121578/Driver-arrested-staggering-blood-alcohol-level-nearly-FIVE-TIMES-legal-limit.html#ixzz3AZPQWEGh March 28th 2012.
18. ABC Eyewitness News: Children and Prescription Drug Abuse. Available at: http://abclocal.go.com/wabc/story?section=news/health&id=8643816 May 1st 2012.
19. Addiction Professional: Leaders Express Relief ACA Survives. Available at http://www.addictionpro.com/article/addiction-leaders-express-relief-aca-survives June 28th 2012
20. Behavioral Healthcare: National Conference on Addiction Disorders Attendees Told to Refine Their Market. Available at http://www.behavioral.net/article/ncad-attendees-told-redefine-their-market September 29th 2012.
21. The Conversation with Amanda De Cadenet: When the Pressures of Perfection Lead to a chemical Addiction. Available at: http://www.theconversation.tv/wellness/when-the-pressures-of-perfection-lead-to-a-chemical-addiction/ October 25th 2012.
22. Op-Ed in Vitamin W. Carise, D. Alcohol Abuse Prevention Should Start Long Before Prom. Available at: http://vitaminw.co/health/alcohol-abuse-prevention-should-start-long-prom November 2nd, 2012.
23. NY Daily News. Hailed by rap stars like Lil Wayne, Sizzurp, or 'purple drank,' is accessible, addictive -- and dangerous. Available at: http://www.nydailynews.com/life-style/health/party-drink-sizzurp-accessible March 27th, 2013.
24. Pininterest. Sizzurp and Stigmatizing Lindsey. Available at: http://pinterest.com/urlinked/deni-carise-crc/ March 2013.
25. Managed Care Outlook (Web and Print Journal). More Prgeventive Steps are Needed to Address the Continued Rise in Overdose Deaths. Available online with subscription.
26. Salemleader (online and print). Six Facts for Alcohol Awareness Month. Available at: http://www.salemleader.com/main.asp?Search=1&ArticleID=6 April 20, 2013.
27. MSN Healthy Living. Pot and Your Health. Available at: http://healthyliving.msn.com/health-wellness/pot-and-your-health?_p=2a61f52a-cf06-4d42-993a-e767b37bf92f&_rp=854c7720-95cd-4fe8-a282-17dce3ccfb29 May 8, 2013.
28. Starcasm.news: Lil Wayne's rumored drug of choice, Sizzurp, Is both popular and deadly. May 15th 2013

29. Social Work Today (May/June 2013). Living with Co-Occurring Disorders - The Rocky Road to Recovery. 13:3, p18.
30. Time (Health & Family). Smoking Alcohol: The Dangerous Way People are Getting Drunk. Available at: http://healthland.time.com/2013/06/05/smoking. June 5, 2013
31. CBS News Online. Inhaling Alcohol Vapor puts you at risk of overdose. Available at: http://www.cbsnews.com/8301-204_162-57587679/inhaling-alcohol-vapor-puts-you-at-risk-of-overdose/ June 5th 2013.
32. International Business Times. Smoking Alcohol Vapors: Is The Latest 'Drunkorexia' Trend Dangerous. Available at http://www.ibtimes.com/smoking-alcohol-vapors-latest-drunkorexia-trend-dangerous-video-1294695 June 6th 2013.
33. Examiner.com. Some resorting to smoking alcohol to avoid calories. Available at: http://www.examiner.com/article/some-resorting-to-smoking-alcohol-to-avoid-calories June 7th 2013.
34. Counsel & Heal. The New and Dangerous Way to Get Drunk: Smoking Alcohol. Available at: http://www.counselheal.com/articles/5669/20130607/new-dangerous-way-drunk-smoking-alcohol.htm June 7th 2013.
35. Wolf of Wall Street – Technical Consultant on Substance Abuse Issues. Consulted on accurate portrayal by primary actors of characters under the influence of cocaine and other drugs.
36. NY Daily News. Philip Seymour Hoffman dead at 46: Why is drug relapse so easy, even after decades of sobriety? http://www.nydailynews.com/life-style/health/drug-relapse-happen-decades-sobriety-article-1.1600544 February 4, 2014.
37. Newsweek. Flappy Bird Creator Says His Game Was Too Addictive. http://www.newsweek.com/flappy-bird-creator-says-his-game-was-too-addictive-228803. February 11th 2014.
38. The Today Show. Interview with Maria Shriver. Hitting the mommy juice too hard? Experts warn of alcohol abuse by moms. http://www.today.com/moms/hitting-mommy-juice-too-hard-experts-warn-alcohol-abuse-moms-2D79473508 Aired April, 2, 2014
39. Babble. Bottoms Up? New Survey Shows 40 Percent of Mothers Claim That Alcohol Helps Them Parent. http://www.babble.com/toddler/bottoms-up-new-survey-shows-40-percent-of-mothers-claim-that-alcohol-helps-them-parent/ April 2014.
40. The Boston Globe. Bain Capital sees opportunity in treatment business. http://www.bostonglobe.com/business/2014/04/12/while-heroin-epidemic-rages-bain-seeks-profit-drug-treatment-centers/SVDjqnSOcsZKzhoTm6imKJ/story.html April, 13th, 2014.
42. The Wall Street Journal. Legal Marijuana's Unintended Business Opportunities. http://blogs.wsj.com/riskandcompliance/2014/07/31/legal-marijuanas-unintended-business-opportunities/ July 31st 2104.

III. Huffington-Post Blog Topics (Updated 03/06/15):

1. Stiletto Stoners: Is Their Habit Really Harmless? October 23, 2009
2. A Good Idea Gone Wrong January 21, 2010
3. A Stronger Case for Vancouver's Drug 'Safe House' February 24, 2010
4. What Healthcare Reform Means for Substance Abuse Treatment March 26, 2010
5. Addiction and the Perils of Intellectual Thinking June 2, 2010
6. The New Face of Heroin June 10, 2010
7. The Price Mexico Pays for America's 'Insatiable' Demand for Drugs July 12, 2010
8. The Real "Dream Team" Lindsay Lohan Needs July 22, 2010
9. Examining the Viability of Substance Abuse Treatment Today August 16, 2010

10. Prop 19 Rejected: California Doesn't Judge a Book By Its Cover November 11, 2010
11. Alcoholics Aren't the Only Ones With Drinking Problems December 2, 2010
12. Ted Williams: Why We Should Still Believe in 'The Golden Voice' January 22, 2011
13. Even for Sheen, Recovery Is Possible March 1, 2011
14. Why I'm Rooting for Erik Ainge April 5, 2011
15. Prescription Drug Abuse: When Talking About the Problem Isn't Enough April 27th 2011
16. Addiction Recovery at Any Age: Looking at John Gallianohttp://www.huffingtonpost.com/deni-carise/addiction-recovery_b_856499.html May 2, 2011
17. Are Wet Houses a Solution for Alcoholics? May 25, 2011
18. Substance Abuse Centers: Does Higher Cost Mean Higher Quality Treatment? June 15, 2011
19. Response to 2011 National Drug Control Strategy July 13, 2011
20. Prohibition: Not Repeatable, But Not a Failure October 13th 2011
21. Can a New 'Mother's Little Helper' Solve Our Sleep Struggles? December 6th 2011
22. Alcohol Crackdown: Brilliant or Insane? January 30th 2012
23. Addiction: Not a Laughing Matter February 13th 2012
24. Keeping Alcohol in the Spotlight: 6 Facts March 2nd 2012
25. Never Fear, the New DSM Won't 'Create More Addicts', May 17th 2012
26. In Defense of the Drinking Age June 6th 2012
27. Affordable Care Act Upheld: A Big Win for Addiction Treatment, July 2nd 2012
28. Can we please stop stigmatizing Addiction, Recovery and Lindsay Lohan?, April 24th 2013
29. Waiting to Hit the Elusive 'Rock Bottom', June 24th, 2013
30. Legalizing Marijuana -- The Real Costs, July 23rd, 2013
31. Baseball and Steroids: What's the big deal?, September 12th, 2013
32. It's the Most Wonderful Time of the Year – Or is it?, December 6th, 2013
33. A Note on New Year's Resolutions, Akrasia and Accountability, February 5th, 2014
34. The Million-Person Challenge, February 23rd, 2015

IV. Invited Lectures (most Keynote or Plenary) in support of areas of expertise and topic knowledge

Statewide Science-based Concurrent Recovery Monitoring (CRM) in Delaware. NIDA DESPR Promoting State Research on Using Financing and Payment Mechanisms to Improve Treatment Services. Bethesda, MD

Addressing Paperwork Burden and Performance Improvement Strategies: Continuous Recovery Monitoring During Treatment. Summit: Using Performance & Outcomes Measures to Improve Treatment. Los Angeles, CA.

Keynote: Addiction & Recovery in the 21st Century Looking Through a New Lens. Minnesota Drug Court Conference. Brooklyn Park MN.

Building a Recovery Oriented System of Care & Research Agenda for Recovery. IRETA, ATTC's FAVOR, & Phil. Dept. of Human Svcs. Philadelphia, PA.

Focused Continuing Care and Beyond. Betty Ford Center Board Presentation. Palm Springs, CA.

Eileen Pencer Memorial Award Lecture: The Power of Science and the Practice of Treatment. 2008 NIDA Blending Conference. Cincinnati, OH.

Toolkits-Will Implementing an Evidence-Based Curriculum Improve Group Counseling Results? 2008 College of Problems on Drug Dependence, NIDA International Forum. San Juan, PR.

System Barriers to Replicating an Innovative Technology System: The Need to Adjust for Organizational Differences (CASPAR). SAAS/NIATx Summit. Orlando, FL.

Opening Address at Building a Recovery Oriented System of Care and A Research Agenda for Recovery. Symposium by IRETA, ATTC's FAVOR, and the Phil. Dept. of Human Services. Philadelphia, PA

Keynote Address: Addiction, Treatment and Recovery: Costs, Effectiveness & Benefits. NY State Recovery Month Conf. Albany NY.

Reconsidering Addiction Treatment – Letting Technology Work for You.

NIDA Clinical Trials Network; Southern Consortium Node & SE Addiction Technology Network, Charleston, SC

Measuring Treatment Results - An example in Addiction Treatment. Batterer Intervention Meeting. Washington DC.

Addiction Studies Program for Journalists, Reno, NV

Results of State-Wide Evaluation of "Paperwork Burden" in Addiction Tx. SAAS Conference/NIATx Summit

Results of a State-Wide Evaluation of "Paperwork Burden" in Addiction Treatment. Federal Consortium Addressing the Substance Abusing Offender

Improving Lives; From Paperwork Burden to Technology Interventions. CTN/OETAS/CEATTC Symposium, MD

Keynote Address: Addiction, Treatment and Recovery: Costs, Effectiveness and Benefits. Institute for Addiction Recovery at Rhode Island College.

Keynote: Reconsidering Addiction Treatment. National Psychiatric Nursing Conference. February 2010 Phila, PA

Does Addiction Treatment Work? Addiction Studies Program for Journalists, June 2010, Scottsdale, Arizona

State Views on the Impact of Healthcare Reform. 2010 SAAS National Conference and NIATx Annual Summit. July 2010, Scottsdale, AZ

Healthcare Reform, Continuum of Care, Strategic Planning and Our Best Guess. 2010 SAAS National Conference and NIATx Annual Summit. July 2010, Scottsdale, AZ

The Future of our Field: Evidence-Based Practices and Practice-Based Evidence. UCLA Summer Institute on Longitudinal Research & CTN Dissemination Conference, August 2010. Los Angeles, CA

Keynote address: The Future of the Field – Improving Treatment and Accountability. Addictions 2010 Conference; Oct. 2010, Sheraton National, Arlington, VA, USA

Keynote: Healthcare Reform and the Future of our Field – What to do, Where to Start. Granite State Conference on Addiction. October 2010, Manchester, NH

Keynote: On Addiction, Treatment, Family and Recovery – or "If I knew then, what I know now…" North Carolina Physicians Health Program, Oct 2010. Greensboro, NC.

Addiction, Treatment and Recovery: Cost, Effectiveness & Benefits in the 21st Century. 2011 Drug Policy, Psychosocial Intervention, Rehabilitation and Recovery Conference. May 2011. Zhunan County, Taiwan.

Does Addiction Treatment Work? Compared to What? At Addiction Studies Program for Journalists, June 2011, Ft Lauderdale, Florida

Keynote: Healthcare Reform: Opportunities and Threats. NYU Substance Abuse Conf., 2011, New York, NY

Healthcare Reform and the Future of our Field – What to do, Where to Start? Delivered for Dartmouth Psychiatric Research Center, Center for Technology and Behavioral Health, June 2012, Lebanon, NH.

Systems changes: Integrating therapeutic tools and performance monitoring in an electronic health records systems for 120 treatment programs. College on Problems of Drug Dep. Mtg, 2012, Palm Springs, CA

Keynote: Addiction Treatment at a Crossroads: How Can Programs Embrace the "New" but Not Lose Their Identity? At National Conference on Addictive Disorders and the Behavioral Healthcare Leadership Summit, September 29th 2012, Orlando, Florida

V. Other Professional Activities supporting areas of expertise, topical knowledge, etc.

2006 -Present	United Nations Office on Drugs & Crime – Contracted Consultant, Trainer and Adviser, Vienna, Austria, Nigeria, Egypt & Mexico
1994-1997	Critical Incidence Stress Debriefing
	Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) Expert Committee Panel –Drug Abuse Warning Network
1998-1999	SAMHSA, CSAT Review Group - State Needs Assessment grant proposal
2001-2002	SAMHSA, CSAT Review Group, Recovery Community Support Grants & Targeted Capacity Expansion Grants
2001-2002	SAMHSA, CSAT Ongoing Review Panel, National Evaluation Data Services
2004-2009	SAMHSA, CSAT. Reviewer for National Registry of Effective Programs and Practice (NREPP)
2005-2009	Association for Health Services Research
2006-2009	National Institute on Drug Abuse- NIDA – F Review Committee, ad hoc
2008-Present	NIDA R01 Review Group for Screening and Brief Interventions and Referral to Treatment (SBIRT) grant applications
2011-Present	NIDA, Special Interest Group on Electronic Medical Records**.** Development of NIDA/CTN Common Data Elements (CDEs) for use in the SUD Electronic Health Record (EHRs) for both hospital and Specialty Care settings. March 2011, Bethesda, MD
2011-Present	Substance Abuse and Mental Health Services Administration (SAMHSA): Federal Expert Panel on Parity to advise federal government
2012	NIDA Clinical Trials Network (CTN) Panel: Leveraging Electronic Health Record Systems: Developing Brief and Standardized Screening and Assessment of Substance Use in General Medical Settings
2012	NIDA Review Group for "Integration of DA Prevention & Treatment in Primary Care Settings (R01)" March 2012, Bethesda, M
2007-2010	Philadelphia Mayor's Commission to End Homelessness – Behavioral Health Committee

EXHIBIT 5

PRINCIPLES OF DRUG ADDICTION TREATMENT

A RESEARCH-BASED GUIDE

THIRD EDITION

National Institute on Drug Abuse
National Institutes of Health
U.S. Department of Health and Human Services

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Contents

Preface

Drug addiction is a complex illness. It is characterized by intense and, at times, uncontrollable drug craving, along with compulsive drug seeking and use that persist even in the face of devastating consequences. This update of the National Institute on Drug Abuse's *Principles of Drug Addiction Treatment* is intended to address addiction to a wide variety of drugs, including nicotine, alcohol, and illicit and prescription drugs. It is designed to serve as a resource for healthcare providers, family members, and other stakeholders trying to address the myriad problems faced by patients in need of treatment for drug abuse or addiction.

Addiction affects multiple brain circuits, including those involved in reward and motivation, learning and memory, and inhibitory control over behavior. That is why addiction is a brain disease. Some individuals are more vulnerable than others to becoming addicted, depending on the interplay between genetic makeup, age of exposure to drugs, and other environmental influences. While a person initially chooses to take drugs, over time the effects of prolonged exposure on brain functioning compromise that ability to choose, and seeking and consuming the drug become compulsive, often eluding a person's self-control or willpower.

But addiction is more than just compulsive drug taking—it can also produce far-reaching health and social consequences. For example, drug abuse and addiction increase a person's risk for a variety of other mental and physical illnesses related to a drug-abusing lifestyle or the toxic effects of the drugs themselves. Additionally, the dysfunctional behaviors that result from drug abuse can interfere with a person's normal functioning in the family, the workplace, and the broader community.

Because drug abuse and addiction have so many dimensions and disrupt so many aspects of an individual's life, treatment is not simple. Effective treatment programs

typically incorporate many components, each directed to a particular aspect of the illness and its consequences. Addiction treatment must help the individual stop using drugs, maintain a drug-free lifestyle, and achieve productive functioning in the family, at work, and in society. Because addiction is a disease, most people cannot simply stop using drugs for a few days and be cured. Patients typically require long-term or repeated episodes of care to achieve the ultimate goal of sustained abstinence and recovery of their lives. Indeed, scientific research and clinical practice demonstrate the value of continuing care in treating addiction, with a variety of approaches having been tested and integrated in residential and community settings.

As we look toward the future, we will harness new research results on the influence of genetics and environment on gene function and expression (i.e., epigenetics), which are heralding the development of personalized treatment interventions. These findings will be integrated with current evidence supporting the most effective drug abuse and addiction treatments and their implementation, which are reflected in this guide.

Nora D. Volkow, M.D.
Director
National Institute on Drug Abuse

Nearly four decades of scientific research and clinical practice have yielded a variety of effective approaches to drug addiction treatment.

Principles of Effective Treatment

1. **Addiction is a complex but treatable disease that affects brain function and behavior.** Drugs of abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased. This may explain why drug abusers are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences.

2. **No single treatment is appropriate for everyone.** Treatment varies depending on the type of drug and the characteristics of the patients. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

3. **Treatment needs to be readily available.** Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.

4. **Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.** To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.

5. **Remaining in treatment for an adequate period of time is critical.** The appropriate duration for an individual depends on the type and degree of the patient's problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6. **Behavioral therapies—including individual, family, or group counseling—are the most commonly used forms of drug abuse treatment.** Behavioral therapies vary in their focus and may involve addressing a patient's motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problem-solving skills, and facilitating better interpersonal relationships. Also, participation in group therapy and other peer support programs during and following treatment can help maintain abstinence.

7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** For example, methadone, buprenorphine, and naltrexone (including a new long-acting formulation) are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Acamprosate, disulfiram, and naltrexone are medications approved for treating alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (available as patches, gum, lozenges, or nasal spray) or an oral medication (such as bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioral treatment program.

8. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services. For many patients, a continuing care approach provides the best results, with the treatment intensity varying according to a person's changing needs.

9. **Many drug-addicted individuals also have other mental disorders.** Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.

10. **Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.** Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal and can, for some, pave the way for effective long-term addiction treatment, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification. Motivational enhancement and incentive strategies, begun at initial patient intake, can improve treatment engagement.

11. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.

12. **Drug use during treatment must be monitored continuously, as lapses during treatment do occur.** Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.

13. **Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary.** Typically, drug abuse treatment addresses some of the drug-related behaviors that put people at risk of infectious diseases. Targeted counseling focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Counseling can also help those who are already infected to manage their illness. Moreover, engaging in substance abuse treatment can facilitate adherence to other medical treatments. Substance abuse treatment facilities should provide onsite, rapid HIV testing rather than referrals to offsite testing—research shows that doing so increases the likelihood that patients will be tested and receive their test results. Treatment providers should also inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations, and help link them to HIV treatment if they test positive.

Treatment varies depending on the type of drug and the characteristics of the patient. The best programs provide a combination of therapies and other services.

Frequently Asked Questions

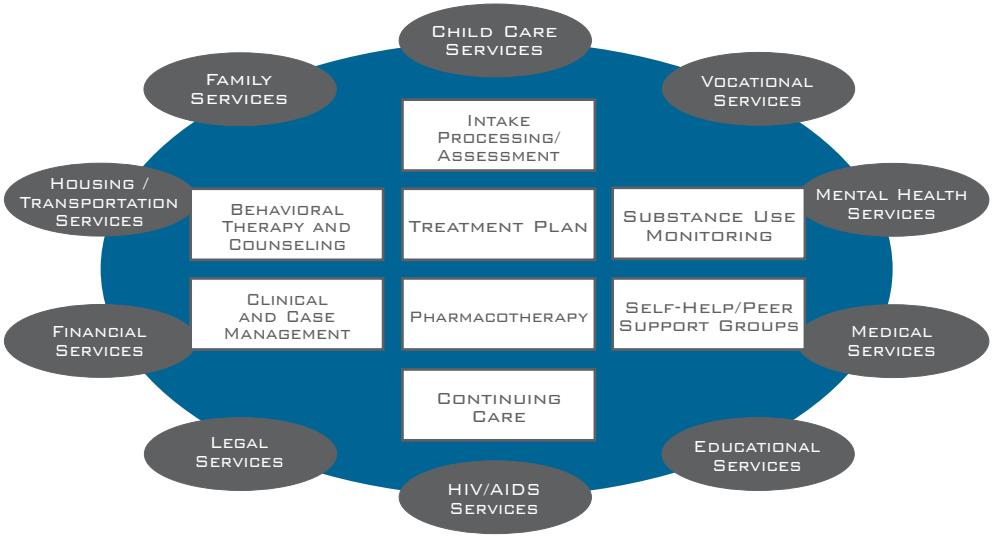
1. Why do drug-addicted persons keep using drugs?

Nearly all addicted individuals believe at the outset that they can stop using drugs on their own, and most try to stop without treatment. Although some people are successful, many attempts result in failure to achieve long-term abstinence. Research has shown that long-term drug abuse results in changes in the brain that persist long after a person stops using drugs. These drug-induced changes in brain function can have many behavioral consequences, including an inability to exert control over the impulse to use drugs despite adverse consequences—the defining characteristic of addiction.

Long-term drug use results in significant changes in brain function that can persist long after the individual stops using drugs.

Understanding that addiction has such a fundamental biological component may help explain the difficulty of achieving and maintaining abstinence without treatment. Psychological stress from work, family problems, psychiatric illness, pain associated with medical problems, social cues (such as meeting individuals from one's drug-using past), or environmental cues (such as encountering streets, objects, or even smells associated with drug abuse) can trigger intense cravings without the individual even being consciously aware of the triggering event. Any one of these factors can hinder attainment of sustained abstinence and make relapse more likely. Nevertheless, research indicates that active participation in treatment is an essential component for good outcomes and can benefit even the most severely addicted individuals.

Components of Comprehensive Drug Abuse Treatment



The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.

2. What is drug addiction treatment?

Drug treatment is intended to help addicted individuals stop compulsive drug seeking and use. Treatment can occur in a variety of settings, take many different forms, and last for different lengths of time. Because drug addiction is typically a chronic disorder characterized by occasional relapses, a short-term, one-time treatment is usually not sufficient. For many, treatment is a long-term process that involves multiple interventions and regular monitoring.

There are a variety of evidence-based approaches to treating addiction. Drug treatment can include behavioral therapy (such as cognitive-behavioral therapy or contingency management), medications, or their combination. The specific type of treatment or combination of treatments will vary depending on the patient's individual needs and, often, on the types of drugs they use.

Drug addiction treatment can include medications, behavioral therapies, or their combination.

Treatment medications, such as methadone, buprenorphine, and naltrexone (including a new long-acting formulation), are available for individuals addicted to opioids, while nicotine preparations (patches, gum, lozenges, and nasal spray) and the medications varenicline and bupropion are available for individuals addicted to tobacco. Disulfiram, acamprosate, and naltrexone are medications available for treating alcohol dependence,[1] which commonly co-occurs with other drug addictions, including addiction to prescription medications.

Treatments for prescription drug abuse tend to be similar to those for illicit drugs that affect the same brain systems. For example, buprenorphine, used to treat heroin addiction, can also be used to treat addiction to opioid pain medications. Addiction to prescription stimulants, which affect the same brain systems as illicit stimulants like cocaine, can be treated with behavioral therapies, as there are not yet medications for treating addiction to these types of drugs.

Behavioral therapies can help motivate people to participate in drug treatment, offer strategies for coping with drug cravings, teach ways to avoid drugs and prevent relapse, and help individuals deal with relapse if it occurs. Behavioral therapies can also help people improve communication, relationship, and parenting skills, as well as family dynamics.

[1] Another drug, topiramate, has also shown promise in studies and is sometimes prescribed (off-label) for this purpose although it has not received FDA approval as a treatment for alcohol dependence.

Many treatment programs employ both individual and group therapies. Group therapy can provide social reinforcement and help enforce behavioral contingencies that promote abstinence and a non-drug-using lifestyle. Some of the more established behavioral treatments, such as contingency management and cognitive-behavioral therapy, are also being adapted for group settings to improve efficiency and cost-effectiveness. However, particularly in adolescents, there can also be a danger of unintended harmful (or iatrogenic) effects of group treatment—sometimes group members (especially groups of highly delinquent youth) can reinforce drug use and thereby derail the purpose of the therapy. Thus, trained counselors should be aware of and monitor for such effects.

Because they work on different aspects of addiction, combinations of behavioral therapies and medications (when available) generally appear to be more effective than either approach used alone.

Finally, people who are addicted to drugs often suffer from other health (e.g., depression, HIV), occupational, legal, familial, and social problems that should be addressed concurrently. The best programs provide a combination of therapies and other services to meet an individual patient's needs. Psychoactive medications, such as antidepressants, anti-anxiety agents, mood stabilizers, and antipsychotic medications, may be critical for treatment success when patients have co-occurring mental disorders such as depression, anxiety disorders (including post-traumatic stress disorder), bipolar disorder, or schizophrenia. In addition, most people with severe addiction abuse multiple drugs and require treatment for all substances abused.

Treatment for drug abuse and addiction is delivered in many different settings using a variety of behavioral and pharmacological approaches.

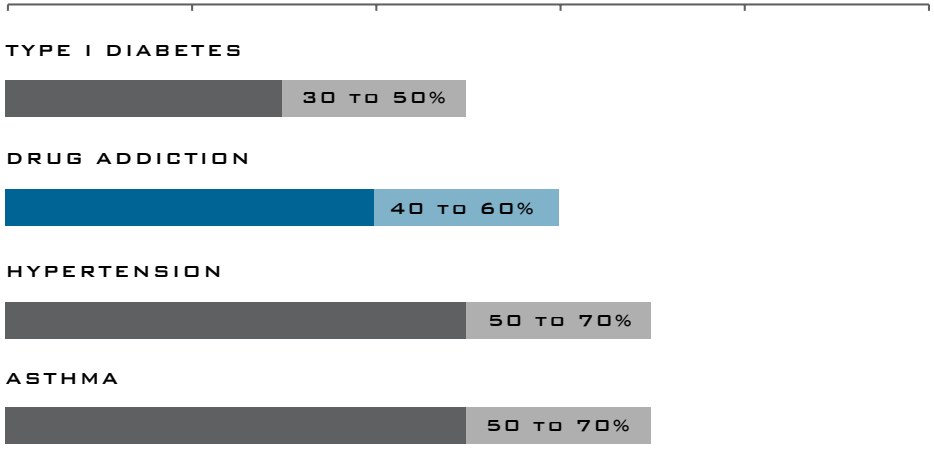
3. How effective is drug addiction treatment?

In addition to stopping drug abuse, the goal of treatment is to return people to productive functioning in the family, workplace, and community. According to research that tracks individuals in treatment over extended periods, most people who get into and remain in treatment stop using drugs, decrease their criminal activity, and improve their occupational, social, and psychological functioning. For example, methadone treatment has been shown to increase participation in behavioral therapy and decrease both drug use and criminal behavior. However, individual treatment outcomes depend on the extent and nature of the patient's problems, the appropriateness of treatment and related services used to address those problems, and the quality of interaction between the patient and his or her treatment providers.

Relapse rates for addiction resemble those of other chronic diseases such as diabetes, hypertension, and asthma.

Like other chronic diseases, addiction can be managed successfully. Treatment enables people to counteract addiction's powerful disruptive effects on the brain and behavior and to regain control of their lives. The chronic nature of the disease means that relapsing to drug abuse is not only possible but also likely, with symptom recurrence rates similar to those for other well-characterized chronic medical illnesses—such as diabetes, hypertension, and asthma (see figure, "Comparison of Relapse Rates Between Drug Addiction and Other Chronic Illnesses")—that also have both physiological and behavioral components.

Comparison of Relapse Rates Between Drug Addiction and Other Chronic Illnesses

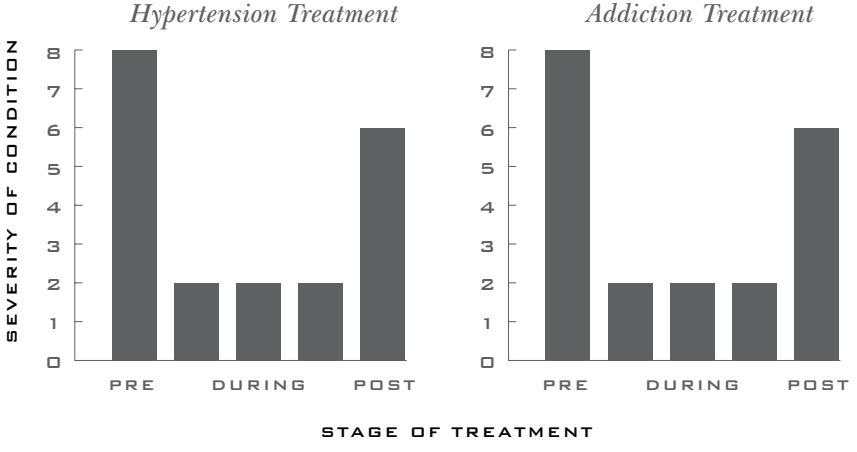


Unfortunately, when relapse occurs many deem treatment a failure. This is not the case: Successful treatment for addiction typically requires continual evaluation and modification as appropriate, similar to the approach taken for other chronic diseases. For example, when a patient is receiving active treatment for hypertension and symptoms decrease, treatment is deemed successful, even though symptoms may recur when treatment is discontinued. For the addicted individual, lapses to drug abuse do not indicate failure—rather, they signify that treatment needs to be reinstated or adjusted, or that alternate treatment is needed (see figure, "Why is Addiction Treatment Evaluated Differently?").

4. Is drug addiction treatment worth its cost?

Substance abuse costs our Nation over $600 billion annually and treatment can help reduce these costs. Drug addiction treatment has been shown to reduce associated

Why is addiction treatment evaluated differently? Both require ongoing care



health and social costs by far more than the cost of the treatment itself. Treatment is also much less expensive than its alternatives, such as incarcerating addicted persons. For example, the average cost for 1 full year of methadone maintenance treatment is approximately $4,700 per patient, whereas 1 full year of imprisonment costs approximately $24,000 per person.

Drug addiction treatment reduces drug use and its associated health and social costs.

According to several conservative estimates, every dollar invested in addiction treatment programs yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to healthcare are included, total savings can exceed costs by a ratio of 12 to 1. Major savings to the individual and to society also stem from fewer interpersonal conflicts; greater workplace productivity; and fewer drug-related accidents, including overdoses and deaths.

5. How long does drug addiction treatment usually last?

Individuals progress through drug addiction treatment at various rates, so there is no predetermined length of treatment. However, research has shown unequivocally that good outcomes are contingent on adequate treatment length. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited effectiveness, and treatment lasting significantly longer is recommended for maintaining positive outcomes. For methadone maintenance, 12 months is considered the minimum, and some opioid-addicted individuals continue to benefit from methadone maintenance for many years.

Good outcomes are contingent on adequate treatment length.

Treatment dropout is one of the major problems encountered by treatment programs; therefore, motivational techniques that can keep patients engaged will also improve outcomes. By viewing addiction as a chronic disease and offering continuing care and monitoring, programs can succeed, but this will often require multiple episodes of treatment and readily readmitting patients that have relapsed.

6. What helps people stay in treatment?

Because successful outcomes often depend on a person's staying in treatment long enough to reap its full benefits, strategies for keeping people in treatment are critical. Whether a patient stays in treatment depends on factors associated with both the individual and the program. Individual factors related to engagement and retention typically include motivation to change drug-using behavior; degree of support from family and friends; and, frequently,

pressure from the criminal justice system, child protection services, employers, or family. Within a treatment program, successful clinicians can establish a positive, therapeutic relationship with their patients. The clinician should ensure that a treatment plan is developed cooperatively with the person seeking treatment, that the plan is followed, and that treatment expectations are clearly understood. Medical, psychiatric, and social services should also be available.

Whether a patient stays in treatment depends on factors associated with both the individual and the program.

Because some problems (such as serious medical or mental illness or criminal involvement) increase the likelihood of patients dropping out of treatment, intensive interventions may be required to retain them. After a course of intensive treatment, the provider should ensure a transition to less intensive continuing care to support and monitor individuals in their ongoing recovery.

7. How do we get more substance-abusing people into treatment?

It has been known for many years that the "treatment gap" is massive—that is, among those who need treatment for a substance use disorder, few receive it. In 2011, 21.6 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem, but only 2.3 million received treatment at a specialty substance abuse facility.

Reducing this gap requires a multipronged approach. Strategies include increasing access to effective treatment, achieving insurance parity (now in its earliest phase of implementation), reducing stigma, and raising awareness

among both patients and healthcare professionals of the value of addiction treatment. To assist physicians in identifying treatment need in their patients and making appropriate referrals, NIDA is encouraging widespread use of screening, brief intervention, and referral to treatment (SBIRT) tools for use in primary care settings through its NIDAMED initiative. SBIRT, which evidence shows to be effective against tobacco and alcohol use—and, increasingly, against abuse of illicit and prescription drugs—has the potential not only to catch people before serious drug problems develop but also to identify people in need of treatment and connect them with appropriate treatment providers.

8. How can family and friends make a difference in the life of someone needing treatment?

Family and friends can play critical roles in motivating individuals with drug problems to enter and stay in treatment. Family therapy can also be important, especially for adolescents. Involvement of a family member or significant other in an individual's treatment program can strengthen and extend treatment benefits.

9. Where can family members go for information on treatment options?

Trying to locate appropriate treatment for a loved one, especially finding a program tailored to an individual's particular needs, can be a difficult process. However, there are some resources to help with this process. For example, NIDA's handbook *Seeking Drug Abuse Treatment: Know What to Ask* offers guidance in finding the right treatment program. Numerous online resources can help locate a local program or provide other information, including:

- The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains a Web site (*findtreatment.samhsa.gov*) that shows the location of residential, outpatient, and hospital inpatient treatment programs for drug addiction and alcoholism throughout the country. This information is also accessible by calling 1-800-662-HELP.
- The National Suicide Prevention Lifeline (1-800-273-TALK) offers more than just suicide prevention—it can also help with a host of issues, including drug and alcohol abuse, and can connect individuals with a nearby professional.
- The National Alliance on Mental Illness (*nami.org*) and Mental Health America (*mentalhealthamerica.net*) are alliances of nonprofit, self-help support organizations for patients and families dealing with a variety of mental disorders. Both have State and local affiliates throughout the United States and may be especially helpful for patients with comorbid conditions.
- The American Academy of Addiction Psychiatry and the American Academy of Child and Adolescent Psychiatry each have physician locator tools posted on their Web sites at *aaap.org* and *aacap.org*, respectively.
- Faces & Voices of Recovery (*facesandvoicesofrecovery.org*), founded in 2001, is an advocacy organization for individuals in long-term recovery that strategizes on ways to reach out to the medical, public health, criminal justice, and other communities to promote and celebrate recovery from addiction to alcohol and other drugs.
- The Partnership at Drugfree.org (*drugfree.org*) is an organization that provides information and resources on teen drug use and addiction for parents, to help them prevent and intervene in their children's drug use or find treatment for a child who needs it. They offer a toll-free helpline for parents (1-855-378-4373).

- The American Society of Addiction Medicine (*asam.org*) is a society of physicians aimed at increasing access to addiction treatment. Their Web site has a nationwide directory of addiction medicine professionals.
- NIDA's National Drug Abuse Treatment Clinical Trials Network (*drugabuse.gov/about-nida/organization/cctn/ctn*) provides information for those interested in participating in a clinical trial testing a promising substance abuse intervention; or visit *clinicaltrials.gov*.
- NIDA's DrugPubs Research Dissemination Center (*drugpubs.drugabuse.gov*) provides booklets, pamphlets, fact sheets, and other informational resources on drugs, drug abuse, and treatment.
- The National Institute on Alcohol Abuse and Alcoholism (*niaaa.nih.gov*) provides information on alcohol, alcohol use, and treatment of alcohol-related problems (*niaaa.nih.gov/search/node/treatment*).

10. How can the workplace play a role in substance abuse treatment?

Many workplaces sponsor Employee Assistance Programs (EAPs) that offer short-term counseling and/or assistance in linking employees with drug or alcohol problems to local treatment resources, including peer support/recovery groups. In addition, therapeutic work environments that provide employment for drug-abusing individuals who can demonstrate abstinence have been shown not only to promote a continued drug-free lifestyle but also to improve job skills, punctuality, and other behaviors necessary for active employment throughout life. Urine testing facilities, trained personnel, and workplace monitors are needed to implement this type of treatment.

11. What role can the criminal justice system play in addressing drug addiction?

It is estimated that about one-half of State and Federal prisoners abuse or are addicted to drugs, but relatively few receive treatment while incarcerated. Initiating drug abuse treatment in prison and continuing it upon release is vital to both individual recovery and to public health and safety. Various studies have shown that combining prison- and community-based treatment for addicted offenders reduces the risk of both recidivism to drug-related criminal behavior and relapse to drug use—which, in turn, nets huge savings in societal costs. A 2009 study in Baltimore, Maryland, for example, found that opioid-addicted prisoners who started methadone treatment (along with counseling) in prison and then continued it after release had better outcomes (reduced drug use and criminal activity) than those who only received counseling while in prison or those who only started methadone treatment after their release.

Individuals who enter treatment under legal pressure have outcomes as favorable as those who enter treatment voluntarily.

The majority of offenders involved with the criminal justice system are not in prison but are under community supervision. For those with known drug problems, drug addiction treatment may be recommended or mandated as a condition of probation. Research has demonstrated that individuals who enter treatment under legal pressure have outcomes as favorable as those who enter treatment voluntarily.

The criminal justice system refers drug offenders into treatment through a variety of mechanisms, such as

diverting nonviolent offenders to treatment; stipulating treatment as a condition of incarceration, probation, or pretrial release; and convening specialized courts, or drug courts, that handle drug offense cases. These courts mandate and arrange for treatment as an alternative to incarceration, actively monitor progress in treatment, and arrange for other services for drug-involved offenders.

The most effective models integrate criminal justice and drug treatment systems and services. Treatment and criminal justice personnel work together on treatment planning—including implementation of screening, placement, testing, monitoring, and supervision—as well as on the systematic use of sanctions and rewards. Treatment for incarcerated drug abusers should include continuing care, monitoring, and supervision after incarceration and during parole. Methods to achieve better coordination between parole/probation officers and health providers are being studied to improve offender outcomes. (For more information, please see NIDA's *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide* [revised 2012].)

12. What are the unique needs of women with substance use disorders?

Gender-related drug abuse treatment should attend not only to biological differences but also to social and environmental factors, all of which can influence the motivations for drug use, the reasons for seeking treatment, the types of environments where treatment is obtained, the treatments that are most effective, and the consequences of not receiving treatment. Many life circumstances predominate in women as a group, which may require a specialized treatment approach. For example, research has shown that physical and sexual trauma followed by post-traumatic stress disorder (PTSD) is more common

in drug-abusing women than in men seeking treatment. Other factors unique to women that can influence the treatment process include issues around how they come into treatment (as women are more likely than men to seek the assistance of a general or mental health practitioner), financial independence, and pregnancy and child care.

13. What are the unique needs of pregnant women with substance use disorders?

Using drugs, alcohol, or tobacco during pregnancy exposes not just the woman but also her developing fetus to the substance and can have potentially deleterious and even long-term effects on exposed children. Smoking during pregnancy can increase risk of stillbirth, infant mortality, sudden infant death syndrome, preterm birth, respiratory problems, slowed fetal growth, and low birth weight. Drinking during pregnancy can lead to the child developing fetal alcohol spectrum disorders, characterized by low birth weight and enduring cognitive and behavioral problems.

Prenatal use of some drugs, including opioids, may cause a withdrawal syndrome in newborns called neonatal abstinence syndrome (NAS). Babies with NAS are at greater risk of seizures, respiratory problems, feeding difficulties, low birth weight, and even death.

Research has established the value of evidence-based treatments for pregnant women (and their babies), including medications. For example, although no medications have been FDA-approved to treat opioid dependence in pregnant women, methadone maintenance combined with prenatal care and a comprehensive drug treatment program can improve many of the detrimental outcomes associated with untreated heroin abuse. However, newborns exposed to methadone

during pregnancy still require treatment for withdrawal symptoms. Recently, another medication option for opioid dependence, buprenorphine, has been shown to produce fewer NAS symptoms in babies than methadone, resulting in shorter infant hospital stays. In general, it is important to closely monitor women who are trying to quit drug use during pregnancy and to provide treatment as needed.

14. What are the unique needs of adolescents with substance use disorders?

Adolescent drug abusers have unique needs stemming from their immature neurocognitive and psychosocial stage of development. Research has demonstrated that the brain undergoes a prolonged process of development and refinement from birth through early adulthood. Over the course of this developmental period, a young person's actions go from being more impulsive to being more reasoned and reflective. In fact, the brain areas most closely associated with aspects of behavior such as decision-making, judgment, planning, and self-control undergo a period of rapid development during adolescence and young adulthood.

Adolescent drug abuse is also often associated with other co-occurring mental health problems. These include attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder, and conduct problems, as well as depressive and anxiety disorders.

Adolescents are also especially sensitive to social cues, with peer groups and families being highly influential during this time. Therefore, treatments that facilitate positive parental involvement, integrate other systems in which the adolescent participates (such as school and athletics), and recognize the importance of prosocial peer relationships are among the most effective. Access to comprehensive

assessment, treatment, case management, and family-support services that are developmentally, culturally, and gender-appropriate is also integral when addressing adolescent addiction.

Medications for substance abuse among adolescents may in certain cases be helpful. Currently, the only addiction medications approved by FDA for people under 18 are over-the-counter transdermal nicotine skin patches, chewing gum, and lozenges (physician advice should be sought first). Buprenorphine, a medication for treating opioid addiction that must be prescribed by specially trained physicians, has not been approved for adolescents, but recent research suggests it could be effective for those as young as 16. Studies are under way to determine the safety and efficacy of this and other medications for opioid-, nicotine-, and alcohol-dependent adolescents and for adolescents with co-occurring disorders.

15. Are there specific drug addiction treatments for older adults?

With the aging of the baby boomer generation, the composition of the general population is changing dramatically with respect to the number of older adults. Such a change, coupled with a greater history of lifetime drug use (than previous older generations), different cultural norms and general attitudes about drug use, and increases in the availability of psychotherapeutic medications, is already leading to greater drug use by older adults and may increase substance use problems in this population. While substance abuse in older adults often goes unrecognized and therefore untreated, research indicates that currently available addiction treatment programs can be as effective for them as for younger adults.

16. Can a person become addicted to medications prescribed by a doctor?

Yes. People who abuse prescription drugs—that is, taking them in a manner or a dose other than prescribed, or taking medications prescribed for another person—risk addiction and other serious health consequences. Such drugs include opioid pain relievers, stimulants used to treat ADHD, and benzodiazepines to treat anxiety or sleep disorders. Indeed, in 2010, an estimated 2.4 million people 12 or older met criteria for abuse of or dependence on prescription drugs, the second most common illicit drug use after marijuana. To minimize these risks, a physician (or other prescribing health provider) should screen patients for prior or current substance abuse problems and assess their family history of substance abuse or addiction before prescribing a psychoactive medication and monitor patients who are prescribed such drugs. Physicians also need to educate patients about the potential risks so that they will follow their physician's instructions faithfully, safeguard their medications, and dispose of them appropriately.

17. Is there a difference between physical dependence and addiction?

Yes. Addiction—or compulsive drug use despite harmful consequences—is characterized by an inability to stop using a drug; failure to meet work, social, or family obligations; and, sometimes (depending on the drug), tolerance and withdrawal. The latter reflect physical dependence in which the body adapts to the drug, requiring more of it to achieve a certain effect (tolerance) and eliciting drug-specific physical or mental symptoms if drug use is abruptly ceased (withdrawal). Physical dependence can happen with the chronic use of many drugs—including many prescription drugs, even if taken as instructed. Thus, physical dependence in and of itself does not constitute addiction, but it often accompanies addiction. This distinction can be difficult to discern, particularly with prescribed pain medications, for which the need for increasing dosages can represent tolerance or a worsening underlying problem, as opposed to the beginning of abuse or addiction.

18. How do other mental disorders coexisting with drug addiction affect drug addiction treatment?

Drug addiction is a disease of the brain that frequently occurs with other mental disorders. In fact, as many as 6 in 10 people with an illicit substance use disorder also suffer from another mental illness; and rates are similar for users of licit drugs—i.e., tobacco and alcohol. For these individuals, one condition becomes more difficult to treat successfully as an additional condition is intertwined. Thus, people entering treatment either for a substance use disorder or for another mental disorder should be assessed for the co-occurrence of the other condition. Research indicates that treating both (or multiple) illnesses simultaneously in an integrated fashion is generally the best treatment approach for these patients.

19. Is the use of medications like methadone and buprenorphine simply replacing one addiction with another?

No. Buprenorphine and methadone are prescribed or administered under monitored, controlled conditions and are safe and effective for treating opioid addiction when used as directed. They are administered orally or sublingually (i.e., under the tongue) in specified doses, and their effects differ from those of heroin and other abused opioids.

Heroin, for example, is often injected, snorted, or smoked, causing an almost immediate "rush," or brief period of intense euphoria, that wears off quickly and ends in a "crash." The individual then experiences an intense craving to use the drug again to stop the crash and reinstate the euphoria.

The cycle of euphoria, crash, and craving—sometimes repeated several times a day—is a hallmark of addiction and results in severe behavioral disruption. These characteristics result from heroin's rapid onset and short duration of action in the brain.

As used in maintenance treatment, methadone and buprenorphine are not heroin/opioid substitutes.

In contrast, methadone and buprenorphine have gradual onsets of action and produce stable levels of the drug in the brain. As a result, patients maintained on these medications do not experience a rush, while they also markedly reduce their desire to use opioids.

If an individual treated with these medications tries to take an opioid such as heroin, the euphoric effects are usually dampened or suppressed. Patients undergoing maintenance treatment do not experience the physiological or behavioral abnormalities from rapid fluctuations in drug levels associated with heroin use. Maintenance treatments save lives—they help to stabilize individuals, allowing treatment of their medical, psychological, and other problems so they can contribute effectively as members of families and of society.

20. Where do 12-step or self-help programs fit into drug addiction treatment?

Self-help groups can complement and extend the effects of professional treatment. The most prominent self-help groups are those affiliated with Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA); all of which are based on the 12-step model. Most drug addiction treatment programs encourage patients to participate in self-help group therapy during and after formal treatment. These groups can be particularly helpful during recovery, offering an added layer of community-level social support to help people achieve and maintain abstinence and other healthy lifestyle behaviors over the course of a lifetime.

21. Can exercise play a role in the treatment process?

Yes. Exercise is increasingly becoming a component of many treatment programs and has proven effective, when combined with cognitive-behavioral therapy, at helping people quit smoking. Exercise may exert beneficial effects by addressing psychosocial and physiological needs that nicotine replacement alone does not, by reducing negative feelings and stress, and by helping prevent weight gain following cessation. Research to determine if and how exercise programs can play a similar role in the treatment of other forms of drug abuse is under way.

22. How does drug addiction treatment help reduce the spread of HIV/AIDS, hepatitis C (HCV), and other infectious diseases?

Drug-abusing individuals, including injecting and non-injecting drug users, are at increased risk of human immunodeficiency virus (HIV), hepatitis C virus (HCV), and other infectious diseases. These diseases are transmitted by sharing contaminated drug injection equipment and by engaging in risky sexual behavior sometimes associated with drug use. Effective drug abuse treatment is HIV/HCV prevention because it reduces activities that can spread disease, such as sharing injection equipment and engaging in unprotected sexual activity. Counseling that targets a range of HIV/HCV risk behaviors provides an added level of disease prevention.

Drug abuse treatment is HIV and HCV prevention.

Injection drug users who do not enter treatment are up to six times more likely to become infected with HIV than those who enter and remain in treatment. Participation in treatment also presents opportunities for HIV screening and referral to early HIV treatment. In fact, recent research from NIDA's National Drug Abuse Treatment Clinical Trials Network showed that providing rapid onsite HIV testing in substance abuse treatment facilities increased patients' likelihood of being tested and of receiving their test results. HIV counseling and testing are key aspects of superior drug abuse treatment programs and should be offered to all individuals entering treatment. Greater availability of inexpensive and unobtrusive rapid HIV tests should increase access to these important aspects of HIV prevention and treatment.

Treatment for drug abuse and addiction is delivered in many different settings, using a variety of behavioral and pharmacological approaches.

Drug Addiction Treatment in the United States

Drug addiction is a complex disorder that can involve virtually every aspect of an individual's functioning—in the family, at work and school, and in the community. Because of addiction's complexity and pervasive consequences, drug addiction treatment typically must involve many components. Some of those components focus directly on the individual's drug use; others, like employment training, focus on restoring the addicted individual to productive membership in the family and society (see diagram on page 8), enabling him or her to experience the rewards associated with abstinence.

Treatment for drug abuse and addiction is delivered in many different settings using a variety of behavioral and pharmacological approaches. In the United States, more than 14,500 specialized drug treatment facilities provide counseling, behavioral therapy, medication, case management, and other types of services to persons with substance use disorders.

Along with specialized drug treatment facilities, drug abuse and addiction are treated in physicians' offices and mental health clinics by a variety of providers, including counselors, physicians, psychiatrists, psychologists, nurses, and social workers. Treatment is delivered in outpatient, inpatient, and residential settings. Although specific treatment approaches often are associated with particular treatment settings, a variety of therapeutic interventions or services can be included in any given setting.

Because drug abuse and addiction are major public health problems, a large portion of drug treatment is funded by local, State, and Federal governments. Private and employer-subsidized health plans also may provide coverage for treatment of addiction and its medical consequences. Unfortunately, managed care has resulted in shorter average stays, while a historical lack of or insufficient coverage for substance abuse treatment has

curtailed the number of operational programs. The recent passage of parity for insurance coverage of mental health and substance abuse problems will hopefully improve this state of affairs. Health Care Reform (i.e., the Patient Protection and Affordable Care Act of 2010, "ACA") also stands to increase the demand for drug abuse treatment services and presents an opportunity to study how innovations in service delivery, organization, and financing can improve access to and use of them.

Types of Treatment Programs

Research studies on addiction treatment typically have classified programs into several general types or modalities. Treatment approaches and individual programs continue to evolve and diversify, and many programs today do not fit neatly into traditional drug addiction treatment classifications. Examples of specific research-based treatment components are described on pages 30–35.

Most, however, start with detoxification and medically managed withdrawal, often considered the first stage of treatment. Detoxification, the process by which the body clears itself of drugs, is designed to manage the acute and potentially dangerous physiological effects of stopping drug use. As stated previously, detoxification alone does not address the psychological, social, and behavioral problems associated with addiction and therefore does not typically produce lasting behavioral changes necessary for recovery. Detoxification should thus be followed by a formal assessment and referral to drug addiction treatment.

Because it is often accompanied by unpleasant and potentially fatal side effects stemming from withdrawal, detoxification is often managed with medications administered by a physician in an inpatient or outpatient setting; therefore, it is referred to as "medically managed withdrawal." Medications are available to assist in the withdrawal from opioids, benzodiazepines, alcohol, nicotine, barbiturates, and other sedatives.

Further Reading:

Kleber, H.D. Outpatient detoxification from opiates. *Primary Psychiatry* 1:42–52, 1996.

Long-Term Residential Treatment

Long-term residential treatment provides care 24 hours a day, generally in nonhospital settings. The best-known residential treatment model is the therapeutic community (TC), with planned lengths of stay of between 6 and 12 months. TCs focus on the "resocialization" of the individual and use the program's entire community—including other residents, staff, and the social context—as active components of treatment. Addiction is viewed in the context of an individual's social and psychological deficits, and treatment focuses on developing personal accountability and responsibility as well as socially productive lives. Treatment is highly structured and can be confrontational at times, with activities designed to help residents examine damaging beliefs, self-concepts, and destructive patterns of behavior and adopt new, more harmonious and constructive ways to interact with others. Many TCs offer comprehensive services, which can include employment training and other support services, onsite. Research shows that TCs can be modified to treat individuals with special needs, including adolescents, women, homeless individuals, people with severe mental disorders, and individuals in the criminal justice system (see page 37).

Further Reading:

Lewis, B.F.; McCusker, J.; Hindin, R.; Frost, R.; and Garfield, F. Four residential drug treatment programs: Project IMPACT. In: J.A. Inciardi, F.M. Tims, and B.W. Fletcher (eds.), *Innovative Approaches in the Treatment of Drug Abuse*, Westport, CT: Greenwood Press, pp. 45–60, 1993.

Sacks, S.; Banks, S.; McKendrick, K.; and Sacks, J.Y. Modified therapeutic community for co-occurring disorders: A summary of four studies. *Journal of Substance Abuse Treatment* 34(1):112–122, 2008.

Sacks, S.; Sacks, J.; DeLeon, G.; Bernhardt, A.; and Staines, G. Modified therapeutic community for mentally ill chemical "abusers": Background; influences; program description; preliminary findings. *Substance Use and Misuse* 32(9):1217–1259, 1997.

Stevens, S.J.; and Glider, P.J. Therapeutic communities: Substance abuse treatment for women. In: F.M. Tims, G. DeLeon, and N. Jainchill (eds.), *Therapeutic Community: Advances in Research and Application*, National Institute on Drug Abuse Research Monograph 144, NIH Pub. No. 94–3633, U.S. Government Printing Office, pp. 162–180, 1994.

Sullivan, C.J.; McKendrick, K.; Sacks, S.; and Banks, S.M. Modified therapeutic community for offenders with MICA disorders: Substance use outcomes. *American Journal of Drug and Alcohol Abuse* 33(6):823–832, 2007.

Short-Term Residential Treatment

Short-term residential programs provide intensive but relatively brief treatment based on a modified 12-step approach. These programs were originally designed to treat alcohol problems, but during the cocaine epidemic of the mid-1980s, many began to treat other types of substance use disorders. The original residential treatment model consisted of a 3- to 6-week hospital-based inpatient treatment phase followed by extended outpatient therapy and participation in a self-help group, such as AA. Following stays in residential treatment programs, it is important for individuals to remain engaged in outpatient treatment programs and/or aftercare programs. These programs help to reduce the risk of relapse once a patient leaves the residential setting.

Further Reading:

Hubbard, R.L.; Craddock, S.G.; Flynn, P.M.; Anderson, J.; and Etheridge, R.M. Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors* 11(4):291–298, 1998.

Miller, M.M. Traditional approaches to the treatment of addiction. In: A.W. Graham and T.K. Schultz (eds.), *Principles of Addiction Medicine* (2nd ed.). Washington, D.C.: American Society of Addiction Medicine, 1998.

Outpatient Treatment Programs

Outpatient treatment varies in the types and intensity of services offered. Such treatment costs less than residential or inpatient treatment and often is more suitable for people with jobs or extensive social supports. It should be noted, however, that low-intensity programs may offer little more than drug education. Other outpatient models, such as intensive day treatment, can be comparable to residential programs in services and effectiveness, depending on the individual patient's characteristics and needs. In many outpatient programs, group counseling can be a major component. Some outpatient programs are also designed to treat patients with medical or other mental health problems in addition to their drug disorders.

Further Reading:

Hubbard, R.L.; Craddock, S.G.; Flynn, P.M.; Anderson, J.; and Etheridge, R.M. Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors* 11(4):291–298, 1998.

Institute of Medicine. *Treating Drug Problems*. Washington, D.C.: National Academy Press, 1990.

McLellan, A.T.; Grisson, G.; Durell, J.; Alterman, A.I.; Brill, P.; and O'Brien, C.P. Substance abuse treatment in the private setting: Are some programs more effective than others? *Journal of Substance Abuse Treatment* 10:243–254, 1993.

Simpson, D.D.; and Brown, B.S. Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors* 11(4):294–307, 1998.

Individualized Drug Counseling

Individualized drug counseling not only focuses on reducing or stopping illicit drug or alcohol use; it also addresses related areas of impaired functioning—such as employment status, illegal activity, and family/social relations—as well as the content and structure of the patient's recovery program. Through its emphasis on short-term behavioral goals, individualized counseling helps the patient develop coping strategies and tools to abstain from drug use and maintain abstinence. The addiction counselor encourages 12-step participation (at least one or two times per week) and makes referrals for needed supplemental medical, psychiatric, employment, and other services.

Group Counseling

Many therapeutic settings use group therapy to capitalize on the social reinforcement offered by peer discussion and to help promote drug-free lifestyles. Research has shown that when group therapy either is offered in conjunction with individualized drug counseling or is formatted to reflect the principles of cognitive-behavioral therapy or contingency management, positive outcomes are achieved. Currently, researchers are testing conditions in which group therapy can be standardized and made more community-friendly.

Treating Criminal Justice–Involved Drug Abusers and Addicted Individuals

Often, drug abusers come into contact with the criminal justice system earlier than other health or social systems, presenting opportunities for intervention and treatment prior to, during, after, or in lieu of incarceration. Research has shown that combining criminal justice sanctions with drug treatment can be effective in decreasing drug abuse and related crime. Individuals under legal coercion tend to stay in treatment longer and do as well as or better than those not under legal pressure. Studies show that for incarcerated individuals with drug problems, starting drug abuse treatment in prison and continuing the same treatment upon release—in other words, a seamless continuum of services—results in better outcomes: less drug use and less criminal behavior. More information on how the criminal justice system can address the problem of drug addiction can be found in *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide* (National Institute on Drug Abuse, revised 2012).

Each approach to drug treatment is designed to address certain aspects of drug addiction and its consequences for the individual, family, and society.

Evidence-Based Approaches to Drug Addiction Treatment

This section presents examples of treatment approaches and components that have an evidence base supporting their use. Each approach is designed to address certain aspects of drug addiction and its consequences for the individual, family, and society. Some of the approaches are intended to supplement or enhance existing treatment programs, and others are fairly comprehensive in and of themselves.

The following section is broken down into Pharmacotherapies, Behavioral Therapies, and Behavioral Therapies Primarily for Adolescents. They are further subdivided according to particular substance use disorders. This list is not exhaustive, and new treatments are continually under development.

Pharmacotherapies

Opioid Addiction

Methadone

Methadone is a long-acting synthetic opioid agonist medication that can prevent withdrawal symptoms and reduce craving in opioid-addicted individuals. It can also block the effects of illicit opioids. It has a long history of use in treatment of opioid dependence in adults and is taken orally. Methadone maintenance treatment is available in all but three States through specially licensed opioid treatment programs or methadone maintenance programs.

Combined with behavioral treatment

Research has shown that methadone maintenance is more effective when it includes individual and/or group counseling, with even better outcomes when patients are provided with, or referred to, other needed medical/psychiatric, psychological, and social services (e.g., employment or family services).

Further Reading:

Dole, V.P.; Nyswander, M.; and Kreek, M.J. Narcotic blockade. *Archives of Internal Medicine* 118:304–309, 1966.

McLellan, A.T.; Arndt, I.O.; Metzger, D.; Woody, G.E.; and O'Brien, C.P. The effects of psychosocial services in substance abuse treatment. *The Journal of the American Medical Association* 269(15):1953–1959, 1993.

The Rockefeller University. The first pharmacological treatment for narcotic addiction: Methadone maintenance. The Rockefeller University Hospital Centennial, 2010. Available at *centennial.rucares.org/index.php?page=Methadone_Maintenance*.

Woody, G.E.; Luborsky, L.; McClellan, A.T.; O'Brien, C.P.; Beck, A.T.; Blaine, J.; Herman, I.; and Hole, A. Psychotherapy for opiate addicts: Does it help? *Archives of General Psychiatry* 40:639–645, 1983.

Buprenorphine

Buprenorphine is a synthetic opioid medication that acts as a partial agonist at opioid receptors—it does not produce the euphoria and sedation caused by heroin or other opioids but is able to reduce or eliminate withdrawal symptoms associated with opioid dependence and carries a low risk of overdose.

Buprenorphine is currently available in two formulations that are taken sublingually: (1) a pure form of the drug and (2) a more commonly prescribed formulation called Suboxone, which combines buprenorphine with the drug naloxone, an antagonist (or blocker) at opioid receptors. Naloxone has no effect when Suboxone is taken as prescribed, but if an addicted individual attempts to inject Suboxone, the naloxone will produce severe withdrawal symptoms. Thus, this formulation lessens the likelihood that the drug will be abused or diverted to others.

Buprenorphine treatment for detoxification and/or maintenance can be provided in office-based settings by qualified physicians who have received a waiver from the Drug Enforcement Administration (DEA), allowing them to prescribe it. The availability of office-based treatment for opioid addiction is a cost-effective approach that increases the reach of treatment and the options available to patients.

Further Reading:

Fiellin, D.A.; Pantalon, M.V.; Chawarski, M.C.; Moore, B.A.; Sullivan, L.E.; O'Connor, P.G.; and Schottenfeld, R.S. Counseling plus buprenorphine/naloxone maintenance therapy for opioid dependence. *The New England Journal of Medicine* 355(4):365–374, 2006.

Fudala P.J.; Bridge, T.P.; Herbert, S.; Williford, W.O.; Chiang, C.N.; Jones, K.; Collins, J.; Raisch, D.; Casadonte, P.; Goldsmith, R.J.; Ling, W.; Malkerneker, U.; McNicholas, L.; Renner, J.; Stine, S.; and Tusel, D. for the Buprenorphine/Naloxone Collaborative Study Group. Office-based treatment of opiate addiction with a sublingual-tablet formulation of buprenorphine and naloxone. *The New England Journal of Medicine* 349(10):949–958, 2003.

Kosten, T.R.; and Fiellin, D.A. U.S. National Buprenorphine Implementation Program: Buprenorphine for office-based practice: Consensus conference overview. *The American Journal on Addictions* 13(Suppl. 1):S1–S7, 2004.

McCance-Katz, E.F. Office-based buprenorphine treatment for opioid-dependent patients. *Harvard Review of Psychiatry* 12(6):321–338, 2004.

Treatment, not Substitution

Because methadone and buprenorphine are themselves opioids, some people view these treatments for opioid dependence as just substitutions of one addictive drug for another (see Question 19 above). But taking these medications as prescribed allows patients to hold jobs, avoid street crime and violence, and reduce their exposure to HIV by stopping or decreasing injection drug use and drug-related high-risk sexual behavior. Patients stabilized on these medications can also engage more readily in counseling and other behavioral interventions essential to recovery.

Naltrexone

Naltrexone is a synthetic opioid antagonist—it blocks opioids from binding to their receptors and thereby prevents their euphoric and other effects. It has been used for many years to reverse opioid overdose and is also approved for treating opioid addiction. The theory behind this treatment is that the repeated absence of the desired effects and the perceived futility of abusing opioids will gradually diminish craving and addiction. Naltrexone itself has no subjective effects following detoxification (that is, a person does not perceive any particular drug effect), it has no potential for abuse, and it is not addictive.

Naltrexone as a treatment for opioid addiction is usually prescribed in outpatient medical settings, although the treatment should begin *after* medical detoxification in a residential setting in order to prevent withdrawal symptoms.

Naltrexone must be taken orally—either daily or three times a week—but noncompliance with treatment is a common problem. Many experienced clinicians have found naltrexone best suited for highly motivated, recently detoxified patients who desire total abstinence because of external circumstances—for instance, professionals

or parolees. Recently, a long-acting injectable version of naltrexone, called Vivitrol, was approved to treat opioid addiction. Because it only needs to be delivered once a month, this version of the drug can facilitate compliance and offers an alternative for those who do not wish to be placed on agonist/partial agonist medications.

Further Reading:

Cornish, J.W.; Metzger, D.; Woody, G.E.; Wilson, D.; McClellan, A.T.; and Vandergrift, B. Naltrexone pharmacotherapy for opioid dependent federal probationers. *Journal of Substance Abuse Treatment* 14(6):529–534, 1997.

Gastfriend, D.R. Intramuscular extended-release naltrexone: current evidence. *Annals of the New York Academy of Sciences* 1216:144–166, 2011.

Krupitsky, E.; Illerperuma, A.; Gastfriend, D.R.; and Silverman, B.L. Efficacy and safety of extended-release injectable naltrexone (XR-NTX) for the treatment of opioid dependence. Paper presented at the 2010 annual meeting of the American Psychiatric Association, New Orleans, LA.

Tobacco Addiction

Nicotine Replacement Therapy (NRT)

A variety of formulations of nicotine replacement therapies (NRTs) now exist, including the transdermal nicotine patch, nicotine spray, nicotine gum, and nicotine lozenges. Because nicotine is the main addictive ingredient in tobacco, the rationale for NRT is that stable low levels of nicotine will prevent withdrawal symptoms—which often drive continued tobacco use—and help keep people motivated to quit. Research shows that combining the patch with another replacement therapy is more effective than a single therapy alone.

Bupropion (Zyban®)

Bupropion was originally marketed as an antidepressant (Wellbutrin). It produces mild stimulant effects by blocking the reuptake of certain neurotransmitters, especially norepinephrine and dopamine. A serendipitous observation among depressed patients was that the medication was also effective in suppressing tobacco craving, helping them quit smoking without also gaining weight. Although bupropion's exact mechanisms of action in facilitating smoking cessation are unclear, it has FDA approval as a smoking cessation treatment.

Varenicline (Chantix®)

Varenicline is the most recently FDA-approved medication for smoking cessation. It acts on a subset of nicotinic receptors in the brain thought to be involved in the rewarding effects of nicotine. Varenicline acts as a partial agonist/antagonist at these receptors—this means that it mildly stimulates the nicotine receptor but not sufficiently to trigger the release of dopamine, which is important for the rewarding effects of nicotine. As an antagonist, varenicline also blocks the ability of nicotine to activate dopamine, interfering with the reinforcing effects of smoking, thereby reducing cravings and supporting abstinence from smoking.

Combined With Behavioral Treatment

Each of the above pharmacotherapies is recommended for use in combination with behavioral interventions, including group and individual therapies, as well as telephone quitlines. Behavioral approaches complement most tobacco addiction treatment programs. They can amplify the effects of medications by teaching people how to manage stress, recognize and avoid high-risk situations for smoking relapse, and develop alternative coping strategies (e.g., cigarette refusal skills, assertiveness, and time management skills) that they can practice in

treatment, social, and work settings. Combined treatment is urged because behavioral and pharmacological treatments are thought to operate by different yet complementary mechanisms that can have additive effects.

Further Reading:

Alterman, A.I.; Gariti, P.; and Mulvaney, F. Short- and long-term smoking cessation for three levels of intensity of behavioral treatment. *Psychology of Addictive Behaviors* 15:261–264, 2001.

Hall, S.M.; Humfleet, G.L.; Muñoz, R.F.; Reus, V.I.; Prochaska, J.J.; and Robbins, J.A. Using extended cognitive behavioral treatment and medication to treat dependent smokers. *American Journal of Public Health* 101:2349–2356, 2011.

Jorenby, D.E.; Hays, J.T.; Rigotti, N.A.; Azoulay, S.; Watsky, E.J.; Williams, K.E.; Billing, C.B.; Gong, J.; and Reeves, K.R. Varenicline Phase 3 Study Group. Efficacy of varenicline, an α4β2 nicotinic acetylcholine receptor partial agonist vs. placebo or sustained-release bupropion for smoking cessation: A randomized controlled trial. *The Journal of the American Medical Association* 296(1):56–63, 2006.

King, D.P.; Paciqa, S.; Pickering, E.; Benowitz, N.L.; Bierut, L.J.; Conti, D.V.; Kaprio, J.; Lerman, C.; and Park, P.W. Smoking cessation pharmacogenetics: Analysis of varenicline and bupropion in placebo-controlled clinical trials. *Neuropsychopharmacology* 37:641–650, 2012.

Raupach, T.; and van Schayck, C.P. Pharmacotherapy for smoking cessation: Current advances and research topics. *CNS Drugs* 25:371–382, 2011.

Shah, S.D.; Wilken, L.A.; Winkler, S.R.; and Lin, S.J. Systematic review and meta-analysis of combination therapy for smoking cessation. *Journal of the American Pharmaceutical Association* 48(5):659–665, 2008.

Smith, S.S; McCarthy, D.E.; Japuntich S.J.; Christiansen, B.; Piper, M.E.; Jorenby, D.E.; Fraser, D.L.; Fiore, M.C.; Baker, T.B.; and Jackson, T.C. Comparative effectiveness of 5 smoking cessation pharmacotherapies in primary care clinics. *Archives of Internal Medicine* 169:2148–2155, 2009.

Stitzer, M. Combined behavioral and pharmacological treatments for smoking cessation. *Nicotine & Tobacco Research* 1:S181–S187, 1999.

Alcohol Addiction

Naltrexone

Naltrexone blocks opioid receptors that are involved in the rewarding effects of drinking and the craving for alcohol. It has been shown to reduce relapse to problem drinking in some patients. An extended release version, Vivitrol—administered once a month by injection—is also FDA-approved for treating alcoholism, and may offer benefits regarding compliance.

Acamprosate

Acamprosate (Campral®) acts on the gamma-aminobutyric acid (GABA) and glutamate neurotransmitter systems and is thought to reduce symptoms of protracted withdrawal, such as insomnia, anxiety, restlessness, and dysphoria. Acamprosate has been shown to help dependent drinkers maintain abstinence for several weeks to months, and it may be more effective in patients with severe dependence.

Disulfiram

Disulfiram (Antabuse®) interferes with degradation of alcohol, resulting in the accumulation of acetaldehyde, which, in turn, produces a very unpleasant reaction that includes flushing, nausea, and palpitations if a person drinks alcohol. The utility and effectiveness of disulfiram are considered limited because compliance

is generally poor. However, among patients who are highly motivated, disulfiram can be effective, and some patients use it episodically for high-risk situations, such as social occasions where alcohol is present. It can also be administered in a monitored fashion, such as in a clinic or by a spouse, improving its efficacy.

Topiramate

Topiramate is thought to work by increasing inhibitory (GABA) neurotransmission and reducing stimulatory (glutamate) neurotransmission, although its precise mechanism of action is not known. Although topiramate has not yet received FDA approval for treating alcohol addiction, it is sometimes used off-label for this purpose. Topiramate has been shown in studies to significantly improve multiple drinking outcomes, compared with a placebo.

Combined With Behavioral Treatment

While a number of behavioral treatments have been shown to be effective in the treatment of alcohol addiction, it does not appear that an additive effect exists between behavioral treatments and pharmacotherapy. Studies have shown that just getting help is one of the most important factors in treating alcohol addiction; the precise type of treatment received is not as important.

Further Reading:

Anton, R.F.; O'Malley, S.S.; Ciraulo, D.A.; Cisler, R.A.; Couper, D.; Donovan, D.M.; Gastfriend, D.R.; Hosking, J.D.; Johnson, B.A.; LoCastro, J.S.; Longabaugh, R.; Mason, B.J.; Mattson, M.E.; Miller, W.R.; Pettinati, H.M.; Randall, C.L.; Swift, R.; Weiss, R.D.; Williams, L.D.; and Zweben, A., for the COMBINE Study Research Group. Combined pharmacotherapies and behavioral interventions for alcohol dependence: The COMBINE study: A randomized controlled trial. *The Journal of the American Medical Association* 295(17):2003–2017, 2006.

National Institute on Alcohol Abuse and Alcoholism. Helping Patients Who Drink Too Much: A Clinician's Guide, Updated 2005 Edition. Bethesda, MD: NIAAA, updated 2005. Available at *pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm*

Behavioral Therapies

Behavioral approaches help engage people in drug abuse treatment, provide incentives for them to remain abstinent, modify their attitudes and behaviors related to drug abuse, and increase their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for drugs and prompt another cycle of compulsive abuse. Below are a number of behavioral therapies shown to be effective in addressing substance abuse (effectiveness with particular drugs of abuse is denoted in parentheses).

Cognitive-Behavioral Therapy *(Alcohol, Marijuana, Cocaine, Methamphetamine, Nicotine)*

Cognitive-Behavioral Therapy (CBT) was developed as a method to prevent relapse when treating problem drinking, and later it was adapted for cocaine-addicted individuals. Cognitive-behavioral strategies are based on the theory that in the development of maladaptive behavioral patterns like substance abuse, learning processes play a critical role. Individuals in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur with it.

A central element of CBT is anticipating likely problems and enhancing patients' self-control by helping them develop effective coping strategies. Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use, and developing strategies for coping with cravings and avoiding those high-risk situations.

Research indicates that the skills individuals learn through cognitive-behavioral approaches remain after the completion of treatment. Current research focuses on how to produce even more powerful effects by combining CBT with medications for drug abuse and with other types of behavioral therapies. A computer-based CBT system has also been developed and has been shown to be effective in helping reduce drug use following standard drug abuse treatment.

Further Reading:

Carroll, K.M., Easton, C.J.; Nich, C.; Hunkele, K.A.; Neavins, T.M.; Sinha, R.; Ford, H.L.; Vitolo, S.A; Doebrick, C.A.; and Rounsaville, B.J. The use of contingency management and motivational/skills-building therapy to treat young adults with marijuana dependence. *Journal of Consulting and Clinical Psychology* 74(5):955–966, 2006.

Carroll, K.M.; and Onken, L.S. Behavioral therapies for drug abuse. *The American Journal of Psychiatry* 168(8):1452–1460, 2005.

Carroll, K.M.; Sholomskas, D.; Syracuse, G.; Ball, S.A.; Nuro, K.; and Fenton, L.R. We don't train in vain: A dissemination trial of three strategies of training clinicians in cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology* 73(1):106–115, 2005.

Carroll, K.; Fenton, L.R.; Ball, S.A.; Nich, C.; Frankforter, T.L.; Shi, J.; and Rounsaville, B.J. Efficacy of disulfiram and cognitive behavior therapy in cocaine-dependent outpatients: A randomized placebo-controlled trial. *Archives of General Psychiatry* 61(3):264–272, 2004.

Carroll, K.M.; Ball, S.A.; Martino, S.; Nich, C.; Babuscio, T.A.; Nuro, K.F.; Gordon, M.A.; Portnoy, G.A.; and Rounsaville, B.J. Computer-assisted delivery of cognitive-behavioral therapy for addiction: a randomized trial of CBT4CBT. *The American Journal of Psychiatry* 165(7):881–888, 2008.

Contingency Management Interventions/ Motivational Incentives *(Alcohol, Stimulants, Opioids, Marijuana, Nicotine)*

Research has demonstrated the effectiveness of treatment approaches using contingency management (CM) principles, which involve giving patients tangible rewards to reinforce positive behaviors such as abstinence. Studies conducted in both methadone programs and psychosocial counseling treatment programs demonstrate that incentive-based interventions are highly effective in increasing treatment retention and promoting abstinence from drugs.

Voucher-Based Reinforcement (VBR) augments other community-based treatments for adults who primarily abuse opioids (especially heroin) or stimulants (especially cocaine) or both. In VBR, the patient receives a voucher for every drug-free urine sample provided. The voucher has monetary value that can be exchanged for food items, movie passes, or other goods or services that are consistent with a drug-free lifestyle. The voucher values are low at first, but increase as the number of consecutive drug-free urine samples increases; positive urine samples reset the value of the vouchers to the initial low value. VBR has been shown to be effective in promoting abstinence from opioids and cocaine in patients undergoing methadone detoxification.

Prize Incentives CM applies similar principles as VBR but uses chances to win cash prizes instead of vouchers. Over the course of the program (at least 3 months, one or more times weekly), participants supplying drug-negative urine or breath tests draw from a bowl for the chance to win a prize worth between $1 and $100. Participants may also receive draws for attending counseling sessions and completing weekly goal-related activities. The number of draws starts at one and increases with consecutive negative drug tests and/or counseling sessions attended but resets to one with any drug-positive sample or unexcused absence. The practitioner community has raised concerns that this intervention could promote gambling—as it contains an element of chance—and that pathological gambling and substance use disorders can be comorbid. However, studies examining this concern found that Prize Incentives CM did not promote gambling behavior.

Further Reading:

Budney, A.J.; Moore, B.A.; Rocha, H.L.; and Higgins, S.T. Clinical trial of abstinence-based vouchers and cognitive-behavioral therapy for cannabis dependence. *Journal of Consulting and Clinical Psychology* 74(2):307–316, 2006.

Budney, A.J.; Roffman, R.; Stephens, R.S.; and Walker, D. Marijuana dependence and its treatment. *Addiction Science & Clinical Practice* 4(1):4–16, 2007.

Elkashef, A.; Vocci, F.; Huestis, M.; Haney, M.; Budney, A.; Gruber, A.; and el-Guebaly, N. Marijuana neurobiology and treatment. *Substance Abuse* 29(3):17–29, 2008.

Peirce, J.M.; Petry, N.M.; Stitzer, M.L.; Blaine, J.; Kellogg, S.; Satterfield, F.; Schwartz, M.; Krasnansky, J.; Pencer, E.; Silva-Vazquez, L.; Kirby, K.C.; Royer-Malvestuto, C.; Cohen, A.; Copersino, M.L.; Kolodner, K.; and Li, R. Effects of lower-cost incentives on stimulant abstinence in methadone maintenance treatment: A National Drug Abuse Treatment Clinical Trials Network study. *Archives of General Psychiatry* 63(2):201–208, 2006.

Petry, N.M.; Peirce, J.M.; Stitzer, M.L.; Blaine, J.; Roll, J.M.; Cohen, A.; Obert, J.; Killeen, T.; Saladin, M.E.; Cowell, M.; Kirby, K.C.; Sterling, R.; Royer-Malvestuto, C.; Hamilton, J.; Booth, R.E.; Macdonald, M.; Liebert, M.; Rader, L.; Burns, R; DiMaria, J.; Copersino, M.; Stabile, P.Q.; Kolodner, K.; and Li, R. Effect of prize-based incentives on outcomes in stimulant abusers in outpatient psychosocial treatment programs: A National Drug Abuse Treatment Clinical Trials Network study. *Archives of General Psychiatry* 62(10):1148–1156, 2005.

Petry, N.M.; Kolodner, K.B.; Li, R.; Peirce, J.M.; Roll, J.M.; Stitzer, M.L.; and Hamilton, J.A. Prize-based contingency management does not increase gambling. *Drug and Alcohol Dependence* 83(3):269–273, 2006.

Prendergast, M.; Podus, D.; Finney, J.; Greenwell, L.; and Roll, J. Contingency management for treatment of substance use disorders: A meta-analysis. *Addiction* 101(11):1546–1560, 2006.

Roll, J.M.; Petry, N.M.; Stitzer, M.L.; Brecht, M.L.; Peirce, J.M.; McCann, M.J.; Blaine, J.; MacDonald, M.; DiMaria, J.; Lucero, L.; and Kellogg, S. Contingency management for the treatment of methamphetamine use disorders. *The American Journal of Psychiatry* 163(11):1993–1999, 2006.

Community Reinforcement Approach Plus Vouchers *(Alcohol, Cocaine, Opioids)*

Community Reinforcement Approach (CRA) Plus Vouchers is an intensive 24-week outpatient therapy for treating people addicted to cocaine and alcohol. It uses a range of recreational, familial, social, and vocational reinforcers, along with material incentives, to make a non-drug-using lifestyle more rewarding than substance use. The treatment goals are twofold:

- To maintain abstinence long enough for patients to learn new life skills to help sustain it; and

- To reduce alcohol consumption for patients whose drinking is associated with cocaine use

Patients attend one or two individual counseling sessions each week, where they focus on improving family relations, learn a variety of skills to minimize drug use, receive vocational counseling, and develop new recreational activities and social networks. Those who also abuse alcohol receive clinic-monitored disulfiram (Antabuse) therapy. Patients submit urine samples two or three times each week and receive vouchers for cocaine-negative samples. As in VBR, the value of the vouchers increases with consecutive clean samples, and the vouchers may be exchanged for retail goods that are consistent with a drug-free lifestyle. Studies in both urban and rural areas have found that this approach facilitates patients' engagement in treatment and successfully aids them in gaining substantial periods of cocaine abstinence.

A computer-based version of CRA Plus Vouchers called the Therapeutic Education System (TES) was found to be nearly as effective as treatment administered by a therapist in promoting abstinence from opioids and cocaine among opioid-dependent individuals in outpatient treatment. A version of CRA for adolescents addresses problem-solving, coping, and communication skills and encourages active participation in positive social and recreational activities.

Further Reading:

Brooks, A.C.; Ryder, D.; Carise, D.; and Kirby, K.C. Feasibility and effectiveness of computer-based therapy in community treatment. *Journal of Substance Abuse Treatment* 39(3):227–235, 2010.

Higgins, S.T.; Sigmon, S.C.; Wong, C.J.; Heil, S.H.; Badger, G.J.; Donham, R.; Dantona, R.L.; and Anthony, S. Community reinforcement therapy for cocaine-dependent outpatients. *Archives of General Psychiatry* 60(10):1043–1052, 2003.

Roozen, H.G.; Boulogne, J.J.; van Tulder, M.W.; van den Brink, W.; De Jong, C.A.J.; and Kerhof, J.F.M. A systemic review of the effectiveness of the community reinforcement approach in alcohol, cocaine and opioid addiction. *Drug and Alcohol Dependence* 74(1):1–13, 2004.

Silverman, K.; Higgins, S.T.; Brooner, R.K.; Montoya, I.D.; Cone, E.J.; Schuster, C.R.; and Preston, K.L. Sustained cocaine abstinence in methadone maintenance patients through voucher-based reinforcement therapy. *Archives of General Psychiatry* 53(5):409–415, 1996.

Smith, J.E.; Meyers, R.J.; and Delaney, H.D. The community reinforcement approach with homeless alcohol-dependent individuals. *Journal of Consulting and Clinical Psychology* 66(3):541–548, 1998.

Stahler, G.J.; Shipley, T.E.; Kirby, K.C.; Godboldte, C.; Kerwin, M.E; Shandler, I.; and Simons, L. Development and initial demonstration of a community-based intervention for homeless, cocaine-using, African-American women. *Journal of Substance Abuse Treatment* 28(2):171–179, 2005.

Motivational Enhancement Therapy
(Alcohol, Marijuana, Nicotine)

Motivational Enhancement Therapy (MET) is a counseling approach that helps individuals resolve their ambivalence about engaging in treatment and stopping their drug use. This approach aims to evoke rapid and internally motivated change, rather than guide the patient stepwise through the recovery process. This therapy consists of an initial assessment battery session, followed by two to four individual treatment sessions with a therapist. In the first treatment session, the therapist provides feedback to the initial assessment, stimulating discussion about personal substance use and eliciting self-motivational statements. Motivational interviewing principles are used to strengthen motivation and build a plan for change. Coping strategies for high-risk situations are suggested and discussed with the patient. In subsequent sessions, the therapist monitors change, reviews cessation strategies being used, and continues to encourage commitment to change or sustained abstinence. Patients sometimes are encouraged to bring a significant other to sessions.

Research on MET suggests that its effects depend on the type of drug used by participants and on the goal of the intervention. This approach has been used successfully with people addicted to alcohol to both improve their engagement in treatment and reduce their problem drinking. MET has also been used successfully with marijuana-dependent adults when combined with cognitive-behavioral therapy, constituting a more comprehensive treatment approach. The results of MET are mixed for people abusing other drugs (e.g., heroin, cocaine, nicotine) and for adolescents who tend to use multiple drugs. In general, MET seems to be more effective for engaging drug abusers in treatment than for producing changes in drug use.

Further Reading:

Baker, A.; Lewin, T.; Reichler, H.; Clancy, R.; Carr, V.; Garrett, R.; Sly, K.; Devir, H.; and Terry, M. Evaluation of a motivational interview for substance use with psychiatric in-patient services. *Addiction* 97(10):1329–1337, 2002.

Haug, N.A.; Svikis, D.S.; and Diclemente, C. Motivational enhancement therapy for nicotine dependence in methadone-maintained pregnant women. *Psychology of Addictive Behaviors* 18(3):289–292, 2004.

Marijuana Treatment Project Research Group. Brief treatments for cannabis dependence: Findings from a randomized multisite trial. *Journal of Consulting and Clinical Psychology* 72(3):455–466, 2004.

Miller, W.R.; Yahne, C.E.; and Tonigan, J.S. Motivational interviewing in drug abuse services: A randomized trial. *Journal of Consulting and Clinical Psychology* 71(4):754–763, 2003.

Stotts, A.L.; Diclemente, C.C.; and Dolan-Mullen, P. One-to-one: A motivational intervention for resistant pregnant smokers. *Addictive Behaviors* 27(2):275–292, 2002.

The Matrix Model *(Stimulants)*

The Matrix Model provides a framework for engaging stimulant (e.g., methamphetamine and cocaine) abusers in treatment and helping them achieve abstinence. Patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, and become familiar with self-help programs. Patients are monitored for drug use through urine testing.

The therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the patient and using that relationship to reinforce positive behavior change. The interaction between the therapist and the patient is authentic and direct but not confrontational or parental. Therapists are trained to conduct treatment sessions in a way that promotes the patient's self-esteem, dignity, and self-worth. A positive relationship between patient and therapist is critical to patient retention.

Treatment materials draw heavily on other tested treatment approaches and, thus, include elements of relapse prevention, family and group therapies, drug education, and self-help participation. Detailed treatment manuals contain worksheets for individual sessions; other components include family education groups, early recovery skills groups, relapse prevention groups, combined sessions, urine tests, 12-step programs, relapse analysis, and social support groups.

A number of studies have demonstrated that participants treated using the Matrix Model show statistically significant reductions in drug and alcohol use, improvements in psychological indicators, and reduced risky sexual behaviors associated with HIV transmission.

Further Reading:

Huber, A.; Ling, W.; Shoptaw, S.; Gulati, V.; Brethen, P.; and Rawson, R. Integrating treatments for methamphetamine abuse: *A psychosocial perspective*. *Journal of Addictive Diseases* 16(4):41–50, 1997.

Rawson, R.; Shoptaw, S.J.; Obert, J.L.; McCann, M.J.; Hasson, A.L.; Marinelli-Casey, P.J.; Brethen, P.R.; and Ling, W. An intensive outpatient approach for cocaine abuse: The Matrix model. *Journal of Substance Abuse Treatment* 12(2):117–127, 1995.

Rawson, R.A.; Huber, A.; McCann, M.; Shoptaw, S.; Farabee, D.; Reiber, C.; and Ling, W. A comparison of contingency management and cognitive-behavioral approaches during methadone maintenance treatment for cocaine dependence. *Archives of General Psychiatry* 59(9):817–824, 2002.

12-Step Facilitation Therapy *(Alcohol, Stimulants, Opioids)*

Twelve-step facilitation therapy is an active engagement strategy designed to increase the likelihood of a substance abuser becoming affiliated with and actively involved in 12-step self-help groups, thereby promoting abstinence. Three key ideas predominate: (1) acceptance, which includes the realization that drug addiction is a chronic, progressive disease over which one has no control, that life has become unmanageable because of drugs, that willpower alone is insufficient to overcome the problem, and that abstinence is the only alternative; (2) surrender, which involves giving oneself over to a higher power, accepting the fellowship and support structure of other

recovering addicted individuals, and following the recovery activities laid out by the 12-step program; and (3) active involvement in 12-step meetings and related activities. While the efficacy of 12-step programs (and 12-step facilitation) in treating alcohol dependence has been established, the research on its usefulness for other forms of substance abuse is more preliminary, but the treatment appears promising for helping drug abusers sustain recovery.

Further Reading:

Carroll, K.M.; Nich, C.; Ball, S.A.; McCance, E.; Frankforter, T.L.; and Rounsaville, B.J. One-year follow-up of disulfiram and psychotherapy for cocaine-alcohol users: Sustained effects of treatment. *Addiction* 95(9):1335–1349, 2000.

Donovan, D.M.; and Wells, E.A. "Tweaking 12-step": The potential role of 12-Step self-help group involvement in methamphetamine recovery. *Addiction* 102(Suppl. 1):121–129, 2007.

Project MATCH Research Group. Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol* 58(1)7–29, 1997.

Family Behavior Therapy

Family Behavior Therapy (FBT), which has demonstrated positive results in both adults and adolescents, is aimed at addressing not only substance use problems but other co-occurring problems as well, such as conduct disorders, child mistreatment, depression, family conflict, and unemployment. FBT combines behavioral contracting with contingency management.

FBT involves the patient along with at least one significant other such as a cohabiting partner or a parent (in the case of adolescents). Therapists seek to engage families in applying the behavioral strategies taught in sessions and

in acquiring new skills to improve the home environment. Patients are encouraged to develop behavioral goals for preventing substance use and HIV infection, which are anchored to a contingency management system. Substance-abusing parents are prompted to set goals related to effective parenting behaviors. During each session, the behavioral goals are reviewed, with rewards provided by significant others when goals are accomplished. Patients participate in treatment planning, choosing specific interventions from a menu of evidence-based treatment options. In a series of comparisons involving adolescents with and without conduct disorder, FBT was found to be more effective than supportive counseling.

Further Reading:

Azrin, N.H.; Donohue, B.; Besalel, V.A.; Kogan, E.S.; and Acierno, R. Youth drug abuse treatment: a controlled outcome study. *Journal of Child and Adolescent Substance Abuse* 3:1–16, 1994.

Carroll, K.M.; and Onken, L.S. Behavioral therapies for drug abuse. *American Journal of Psychiatry* 168(8):1452–1460, 2005.

Donohue, B.; Azrin, N.; Allen, D.N.; Romero, V.; Hill, H.H.; Tracy, K.; Lapota, H.; Gorney, S.; Abdel-al, R.; Caldas, D.; Herdzik, K.; Bradshaw, K.; Valdez, R.; and Van Hasselt, V.B. Family Behavior Therapy for substance abuse: A review of its intervention components and applicability. *Behavior Modification*, 33:495–519, 2009.

LaPota, H.B.; Donohue, B.; Warren, C. S.; and Allen, D.N. Integration of a Healthy Living curriculum within Family Behavior Therapy: A clinical case example in a woman with a history of domestic violence, child neglect, drug abuse, and obesity. *Journal of Family Violence* 26:227–234, 2011.

Behavioral Therapies Primarily for Adolescents

Drug-abusing and addicted adolescents have unique treatment needs. Research has shown that treatments designed for and tested in adult populations often need to be modified to be effective in adolescents. Family involvement is a particularly important component for interventions targeting youth. Below are examples of behavioral interventions that employ these principles and have shown efficacy for treating addiction in youth.

Multisystemic Therapy

Multisystemic Therapy (MST) addresses the factors associated with serious antisocial behavior in children and adolescents who abuse alcohol and other drugs. These factors include characteristics of the child or adolescent (e.g., favorable attitudes toward drug use), the family (poor discipline, family conflict, parental drug abuse), peers (positive attitudes toward drug use), school (dropout, poor performance), and neighborhood (criminal subculture). By participating in intensive treatment in natural environments (homes, schools, and neighborhood settings), most youths and families complete a full course of treatment. MST significantly reduces adolescent drug use during treatment and for at least 6 months after treatment. Fewer incarcerations and out-of-home juvenile placements offset the cost of providing this intensive service and maintaining the clinicians' low caseloads.

Further Reading:

Henggeler, S.W.; Clingempeel, W.G.; Brondino, M.J.; and Pickrel, S.G. Four-year follow-up of multisystemic therapy with substance-abusing and substance-dependent juvenile offenders. *Journal of the American Academy of Child and Adolescent Psychiatry* 41(7):868–874, 2002.

Henggeler, S.W.; Rowland, M.D.; Randall, J.; Ward, D.M.; Pickrel, S.G.; Cunningham, P.B.; Miller, S.L.; Edwards, J.; Zealberg, J.J.; Hand, L.D.; and Santos, A.B. Home-based multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis: Clinical outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry* 38(11):1331–1339, 1999.

Henggeler, S.W.; Halliday-Boykins, C.A.; Cunningham, P.B.; Randall, J.; Shapiro, S.B.; and Chapman, J.E. Juvenile drug court: Enhancing outcomes by integrating evidence-based treatments. *Journal of Consulting and Clinical Psychology* 74(1):42–54, 2006.

Henggeler, S.W.; Pickrel, S.G.; Brondino, M.J.; and Crouch, J.L. Eliminating (almost) treatment dropout of substance-abusing or dependent delinquents through home-based multisystemic therapy. *The American Journal of Psychiatry* 153(3):427–428, 1996.

Huey, S.J.; Henggeler, S.W.; Brondino, M.J.; and Pickrel, S.G. Mechanisms of change in multisystemic therapy: Reducing delinquent behavior through therapist adherence and improved family functioning. *Journal of Consulting and Clinical Psychology* 68(3):451–467, 2000.

Multidimensional Family Therapy

Multidimensional Family Therapy (MDFT) for adolescents is an outpatient, family-based treatment for teenagers who abuse alcohol or other drugs. MDFT views adolescent drug use in terms of a network of influences (individual, family, peer, community) and suggests that reducing unwanted behavior and increasing desirable behavior occur in multiple ways in different settings. Treatment includes individual and family sessions held in the clinic, in the home, or with family members at the family court, school, or other community locations.

During individual sessions, the therapist and adolescent work on important developmental tasks, such as developing decision-making, negotiation, and problem-solving skills. Teenagers acquire vocational skills and

skills in communicating their thoughts and feelings to deal better with life stressors. Parallel sessions are held with family members. Parents examine their particular parenting styles, learning to distinguish influence from control and to have a positive and developmentally appropriate influence on their children.

Further Reading:

Dennis, M.; Godley, S.H.; Diamond, G.; Tims, F.M.; Babor, T.; Donaldson, J.; Liddle, H.; Titus, J.C.; Kaminer, Y.; Webb, C.; Hamilton, N.; and Funk, R. The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized clinical trials. *Journal of Substance Abuse Treatment* 27(3):197–213, 2004.

Liddle, H.A.; Dakof, G.A.; Parker, K.; Diamond, G.S.; Barrett, K.; and Tejeda, M. Multidimensional family therapy for adolescent drug abuse: Results of a randomized clinical trial. *The American Journal of Drug and Alcohol Abuse* 27(4):651–688, 2001.

Liddle, H.A.; and Hogue, A. Multidimensional family therapy for adolescent substance abuse. In E.F. Wagner and H.B. Waldron (eds.), *Innovations in Adolescent Substance Abuse Interventions*. London: Pergamon/Elsevier Science, pp. 227–261, 2001.

Liddle, H.A.; Rowe, C.L.; Dakof, G.A.; Ungaro, R.A.; and Henderson, C.E. Early intervention for adolescent substance abuse: Pretreatment to posttreatment outcomes of a randomized clinical trial comparing multidimensional family therapy and peer group treatment. *Journal of Psychoactive Drugs* 36(1):49–63, 2004.

Schmidt, S.E.; Liddle, H.A.; and Dakof, G.A. Effects of multidimensional family therapy: Relationship of changes in parenting practices to symptom reduction in adolescent substance abuse. *Journal of Family Psychology* 10(1):1–16, 1996.

Brief Strategic Family Therapy

Brief Strategic Family Therapy (BSFT) targets family interactions that are thought to maintain or exacerbate adolescent drug abuse and other co-occurring problem behaviors. Such problem behaviors include conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior. BSFT is based on a family systems approach to treatment, in which family members' behaviors are assumed to be interdependent such that the symptoms of one member (the drug-abusing adolescent, for example) are indicative, at least in part, of what else is occurring in the family system. The role of the BSFT counselor is to identify the patterns of family interaction that are associated with the adolescent's behavior problems and to assist in changing those problem-maintaining family patterns. BSFT is meant to be a flexible approach that can be adapted to a broad range of family situations in various settings (mental health clinics, drug abuse treatment programs, other social service settings, and families' homes) and in various treatment modalities (as a primary outpatient intervention, in combination with residential or day treatment, and as an aftercare/continuing-care service following residential treatment).

Further Reading:

Coatsworth, J.D.; Santisteban, D.A.; McBride, C.K.; and Szapocznik, J. Brief Strategic Family Therapy versus community control: Engagement, retention, and an exploration of the moderating role of adolescent severity. *Family Process* 40(3):313–332, 2001.

Kurtines, W.M.; Murray, E.J.; and Laperriere, A. Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. *Journal of Family Psychology* 10(1):35–44, 1996.

Santisteban, D.A.; Coatsworth, J.D.; Perez-Vidal, A.; Mitrani, V.; Jean-Gilles, M.; and Szapocznik, J. Brief Structural/Strategic Family Therapy with African-American and Hispanic high-risk youth. *Journal of Community Psychology* 25(5):453–471, 1997.

Santisteban, D.A.; Suarez-Morales, L.; Robbins, M.S.; and Szapocznik, J. Brief strategic family therapy: Lessons learned in efficacy research and challenges to blending research and practice. *Family Process* 45(2):259–271, 2006.

Santisteban, D.A.; Szapocznik, J.; Perez-Vidal, A.; Mitrani, V.; Jean-Gilles, M.; and Szapocznik, J. Brief Structural/Strategic Family Therapy with African-American and Hispanic high-risk youth. *Journal of Community Psychology* 25(5):453–471, 1997.

Szapocznik, J.; Perez-Vidal, A.; Brickman, A.L.; Foote, F.H.; Santisteban, D.; Hervis, O.; and Kurtines, W.M. Engaging adolescent drug abusers and their families in treatment: A strategic structural systems approach. *Journal of Consulting and Clinical Psychology* 56(4):552–557, 1988.

Functional Family Therapy

Functional Family Therapy (FFT) is another treatment based on a family systems approach, in which an adolescent's behavior problems are seen as being created or maintained by a family's dysfunctional interaction patterns. FFT aims to reduce problem behaviors by improving communication, problem-solving, conflict resolution, and parenting skills. The intervention always includes the adolescent and at least one family member in each session. Principal treatment tactics include (1) engaging families in the treatment process and enhancing their motivation for change and (2) bringing about changes in family members' behavior using contingency management techniques, communication and problem-solving, behavioral contracts, and other behavioral interventions.

Further Reading:

Waldron, H.B.; Slesnick, N.; Brody, J.L.; Turner, C.W.; and Peterson, T.R. Treatment outcomes for adolescent substance abuse at 4- and 7-month assessments. *Journal of Consulting and Clinical Psychology* 69:802–813, 2001.

Waldron, H.B.; Turner, C. W.; and Ozechowski, T. J. Profiles of drug use behavior change for adolescents in treatment. *Addictive Behaviors* 30:1775–1796, 2005.

Adolescent Community Reinforcement Approach and Assertive Continuing Care

The Adolescent Community Reinforcement Approach (A-CRA) is another comprehensive substance abuse treatment intervention that involves the adolescent and his or her family. It seeks to support the individual's recovery by increasing family, social, and educational/vocational reinforcers. After assessing the adolescent's needs and levels of functioning, the therapist chooses from among 17 A-CRA procedures to address problem-solving, coping, and communication skills and to encourage active participation in positive social and recreational activities. A-CRA skills training involves role-playing and behavioral rehearsal.

Assertive Continuing Care (ACC) is a home-based continuing-care approach to preventing relapse. Weekly home visits take place over a 12- to 14-week period after an adolescent is discharged from residential, intensive outpatient, or regular outpatient treatment. Using positive and negative reinforcement to shape behaviors, along with training in problem-solving and communication skills, ACC combines A-CRA and assertive case management services (e.g., use of a multidisciplinary team of professionals, round-the-clock coverage, assertive outreach) to help adolescents and their caregivers acquire the skills to engage in positive social activities.

Further Reading:

Dennis, M.; Godley, S.H.; Diamond, G.; Tims, F.M.; Babor, T.; Donaldson, J.; Liddle, H.; Titus, J.C.; Kamier, Y.; Webb, C.; Hamilton, N.; and Funk R. The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment* 27:197–213, 2004.

Godley, S.H.; Garner, B.R.; Passetti, L.L.; Funk, R.R.; Dennis, M.L.; and Godley, M.D. Adolescent outpatient treatment and continuing care: Main findings from a randomized clinical trial. *Drug and Alcohol Dependence* Jul 1;110 (1-2):44–54, 2010.

Godley, M.D.; Godley, S.H.; Dennis, M.L.; Funk, R.; and Passetti, L.L. Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment* 23:21–32, 2002.

National Agencies

The National Institute on Drug Abuse (NIDA) leads the Nation in scientific research on the health aspects of drug abuse and addiction. It supports and conducts research across a broad range of disciplines, including genetics, functional neuroimaging, social neuroscience, prevention, medication and behavioral therapies, and health services. It then disseminates the results of that research to significantly improve prevention and treatment and to inform policy as it relates to drug abuse and addiction. Additional information is available at *drugabuse.gov* or by calling 301-443-1124.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) provides leadership in the national effort to reduce alcohol-related problems by conducting and supporting research in a wide range of scientific areas, including genetics, neuroscience, epidemiology, health risks and benefits of alcohol consumption, prevention, and treatment; coordinating and collaborating with other research institutes and Federal programs on alcohol-related issues; collaborating with international, national, State, and local institutions, organizations, agencies, and programs engaged in alcohol-related work; and translating and disseminating research findings to healthcare providers, researchers, policymakers, and the public. Additional information is available at *niaaa.nih.gov* or by calling 301-443-3860.

National Institute of Mental Health (NIMH)

The mission of the National Institute of Mental Health (NIMH) is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. In support of this mission, NIMH generates research and promotes research training to fulfill the following four objectives: (1) promote discovery in the brain and behavioral sciences to fuel research on the causes of mental disorders; (2) chart mental illness trajectories to determine when, where, and how to intervene; (3) develop new and better interventions that incorporate the diverse needs and circumstances of people with mental illnesses; and (4) strengthen the public health impact of NIMH-supported research. Additional information is available at *nimh.nih.gov* or by calling 301-443-4513.

Center for Substance Abuse Treatment (CSAT)

The Center for Substance Abuse Treatment (CSAT), a part of the Substance Abuse and Mental Health Services Administration (SAMHSA), is responsible for supporting treatment services through a block grant program, as well as disseminating findings to the field and promoting their adoption. CSAT also operates the 24-hour National Treatment Referral Hotline (1-800-662-HELP), which offers information and referral services to people seeking treatment programs and other assistance. CSAT publications are available through SAMHSA's Store (*store.samhsa.gov*). Additional information about CSAT can be found on SAMHSA's Web site at *samhsa.gov/about/csat.aspx*.

Selected Publications and Resources for Drug Addiction Treatment

The following are available from the NIDA DrugPubs Research Dissemination Center, the National Technical Information Service (NTIS), or the Government Printing Office (GPO). To order, refer to the DrugPubs (877-NIDANIH [643-2644]), NTIS (1-800-553-6847), or GPO (202-512-1800) number provided with the resource description:

Blending products. NIDA's Blending Initiative—a joint venture with SAMHSA and its nationwide network of Addiction Technology Transfer Centers (ATTCs)—uses "Blending Teams" of community practitioners, SAMHSA trainers, and NIDA researchers to create products and devise strategic dissemination plans for them. Completed products include those that address the value of buprenorphine therapy and onsite rapid HIV testing in community treatment programs; strategies for treating prescription opioid dependence; and the need to enhance healthcare workers' proficiency in using tools such as the Addiction Severity Index (ASI), motivational interviewing, and motivational incentives. For more information on Blending products, please visit NIDA's Web site at *drugabuse.gov/blending-initiative*.

Addiction Severity Index. Provides a structured clinical interview designed to collect information about substance use and functioning in life areas from adult clients seeking drug abuse treatment. For more information on using the ASI and to obtain copies of the most recent edition, please visit *triweb.tresearch.org/index.php/tools/download-asi-instruments-manuals/*.

Drugs, Brains, and Behavior: The Science of Addiction (Reprinted 2010). This publication provides an overview of the science behind the disease of addiction. NIH Publication #10–5605. Available online at *drugabuse.gov/publications/science-addiction*.

Seeking Drug Abuse Treatment: Know What To Ask (2011). This lay-friendly publication offers guidance in seeking drug abuse treatment and lists five questions to ask when searching for a treatment program. NIH Publication #12-7764. Available online at *drugabuse.gov/publications/seeking-drug-abuse-treatment*.

Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide (Revised 2012). Provides 13 essential treatment principles and includes resource information and answers to frequently asked questions. NIH Publication No.: 11-5316. Available online at *nida.nih.gov/PODAT_CJ*.

NIDA DrugFacts: Treatment Approaches for Drug Addiction (Revised 2008). This is a fact sheet covering research findings on effective treatment approaches for drug abuse and addiction. Available online at *drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction*.

Alcohol Alert (published by NIAAA). This is a quarterly bulletin that disseminates important research findings on alcohol abuse and alcoholism. Available online at *niaaa.nih.gov/publications/journals-and-reports/alcohol-alert*.

Helping Patients Who Drink Too Much: A Clinician's Guide (published by NIAAA). This booklet is written for primary care and mental health clinicians and provides guidance in screening and managing alcohol-dependent patients. Available online at *pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm*.

Research Report Series: Therapeutic Community (2002). This report provides information on the role of residential drug-free settings and their role in the treatment process. NIH Publication #02-4877. Available online at *drugabuse.gov/publications/research-reports/therapeutic-community*.

Initiatives Designed to Move Treatment Research into Practice

Clinical Trials Network

Assessing the real-world effectiveness of evidence-based treatments is a crucial step in bringing research to practice. Established in 1999, NIDA's National Drug Abuse Treatment Clinical Trials Network (CTN) uses community settings with diverse patient populations and conditions to adjust and test protocols to meet the practical needs of addiction treatment. Since its inception, the CTN has tested pharmacological and behavioral interventions for drug abuse and addiction, along with common co-occurring conditions (e.g., HIV and PTSD) among various target populations, including adolescent drug abusers, pregnant drug-abusing women, and Spanish-speaking patients. The CTN has also tested prevention strategies in drug-abusing groups at high risk for HCV and HIV and has become a key element of NIDA's multipronged approach to move promising science-based drug addiction treatments rapidly into community settings. For more information on the CTN, please visit *drugabuse.gov/CTN/Index.htm*.

Criminal Justice–Drug Abuse Treatment Studies

NIDA is taking an approach similar to the CTN to enhance treatment for drug-addicted individuals involved with the criminal justice system through Criminal Justice–Drug Abuse Treatment Studies (CJ-DATS). Whereas NIDA's CTN has as its overriding mission the improvement of the quality of drug abuse treatment by moving innovative approaches into the larger community, research supported through CJ-DATS is designed to effect change by bringing new treatment models into the criminal justice system and thereby improve outcomes for offenders with substance use disorders. It seeks to achieve better integration of drug abuse treatment with other public health and public safety forums and represents a collaboration among NIDA; SAMHSA; the Centers for Disease Control and Prevention (CDC); Department of Justice agencies; and a host of drug treatment, criminal justice, and health and social service professionals.

Blending Teams

Another way in which NIDA is seeking to actively move science into practice is through a joint venture with SAMHSA and its nationwide network of Addiction Technology Transfer Centers (ATTCs). This process involves the collaborative efforts of community treatment practitioners, SAMHSA trainers, and NIDA researchers, some of whom form "Blending Teams" to create products and devise strategic dissemination plans for them. Through the creation of products designed to foster adoption of new treatment strategies, Blending Teams are instrumental in getting the latest evidence-based tools and practices into the hands of treatment professionals. To date, a number of products have been completed. Topics have included increasing awareness of the value of buprenorphine therapy and enhancing healthcare workers' proficiency in using tools such as the ASI, motivational interviewing, and motivational incentives. For more information on Blending products, please visit NIDA's Web site at *nida.nih.gov/blending*.

Other Federal Resources

NIDA DrugPubs Research Dissemination Center. NIDA publications and treatment materials are available from this information source. Staff provide assistance in English and Spanish and have TTY/TDD capability. Phone: 877-NIDA-NIH (877-643-2644); TTY/TDD: 240-645-0228; fax: 240-645-0227; e-mail: *drugpubs@nida.nih.gov*; Web site: *drugpubs.drugabuse.gov*.

The National Registry of Evidence-Based Programs and Practices. This database of interventions for the prevention and treatment of mental and substance use disorders is maintained by SAMHSA and can be accessed at *nrepp.samhsa.gov*.

SAMHSA's Store has a wide range of products, including manuals, brochures, videos, and other publications. Phone: 800-487-4889; Web site: *store.samhsa.gov*.

The National Institute of Justice. As the research agency of the U.S. Department of Justice, the National Institute of Justice (NIJ) supports research, evaluation, and demonstration programs relating to drug abuse in the context of crime and the criminal justice system. For information, including a wealth of publications, contact the National Criminal Justice Reference Service at 800-851-3420 or 301-519-5500; or visit *nij.gov*.

Clinical Trials. For more information on federally and privately supported clinical trials, please visit *clinicaltrials.gov.*

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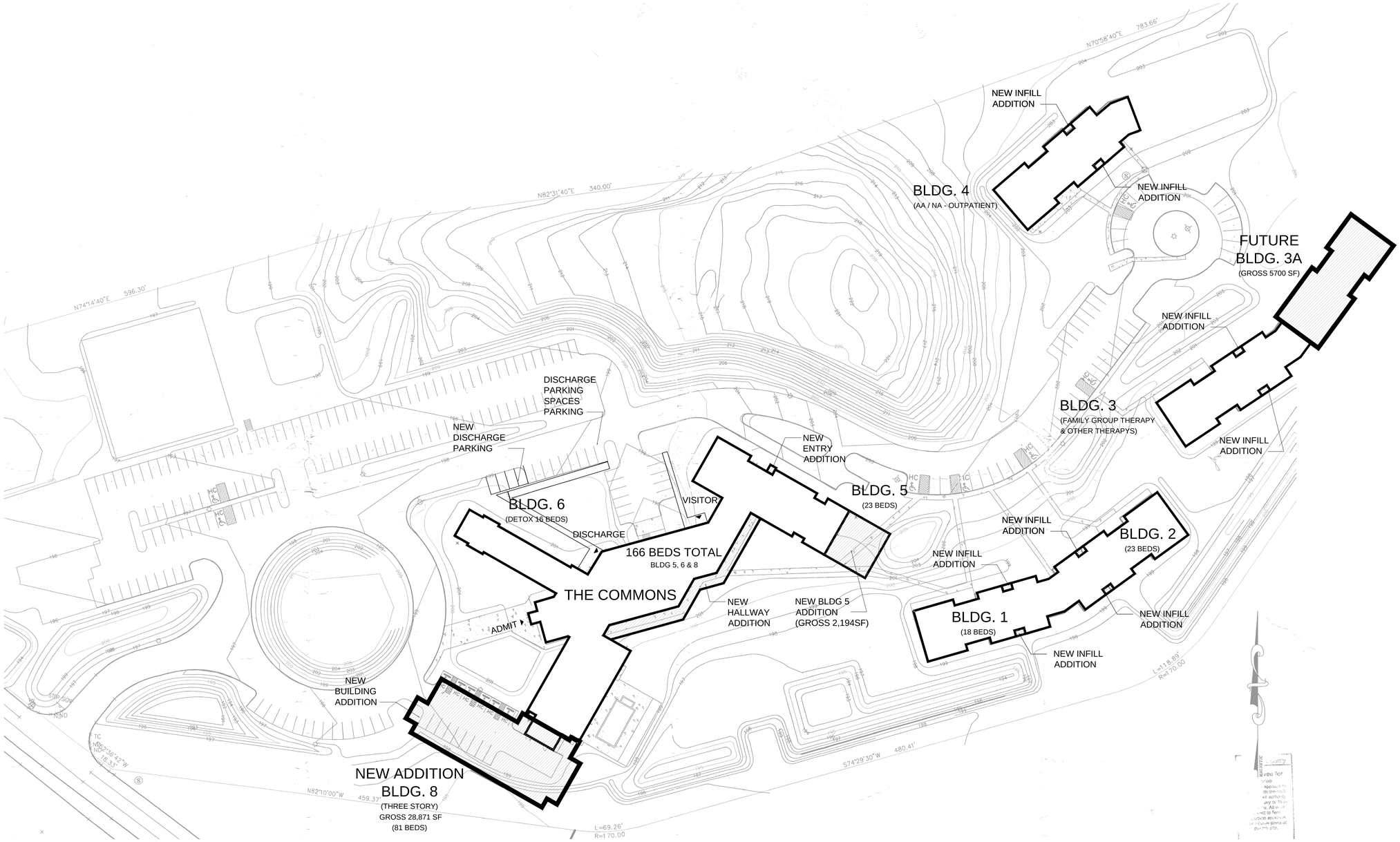
EXHIBIT 6



1 SP-1.0 SITE PLAN
SCALE: 1" = 40'

ROOM CHART - BUILDINGS 1&2					
GROSS SF: 12,341 SF		SF INCLUDES ADDITIONS		NET SF: 11,926 SF	
	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	3	0	0	3	3
DOUBLE ROOM	1	0	18	38	19
TRIPLE ROOM	0	0	0	0	0
TOTAL	4	0	18	41	22

ROOM CHART - BUILDING 3					
GROSS SF: 6,659 SF		SF INCLUDES ADDITIONS		NET SF: 6,416 SF	
	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	0	0	0	0	0
DOUBLE ROOM	0	0	0	0	0
TRIPLE ROOM	0	0	0	0	0
TOTAL	0	0	0	0	0

ROOM CHART - BUILDING 3A (FUTURE)					
GROSS SF: 5,700 SF				NET SF: 5,520 SF	
	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	0	0	0	0	0
DOUBLE ROOM	0	0	0	0	0
TRIPLE ROOM	0	0	0	0	0
TOTAL	0	0	0	0	0

ROOM CHART - BUILDING 4					
GROSS SF: 6,659 SF		SF INCLUDES ADDITIONS		NET SF: 6,416 SF	
	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	0	0	0	0	0
DOUBLE ROOM	0	0	0	0	0
TRIPLE ROOM	0	0	0	0	0
TOTAL	0	0	0	0	0

ROOM CHART - BUILDING 5					
GROSS SF: 38,025 SF		SF INCL- ADD 5,6 & COMMON		NET SF: 36,939 SF	
	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	1	5	0	6	6
DOUBLE ROOM	2	0	9	22	11
TRIPLE ROOM	0	0	0	0	0
TOTAL	3	5	9	28	17

ROOM CHART - BUILDING 6					
GROSS SF:		SF SEE BLDG 5 ABOVE		NET SF:	
	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	2	0	0	2	2
DOUBLE ROOM	0	0	7	14	7
TRIPLE ROOM	0	0	0	0	0
TOTAL	2	0	7	16	9

ROOM CHART - BUILDING 7 N/A					
GROSS SF:				NET SF:	
	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	0	0	0	0	0
DOUBLE ROOM	0	0	0	0	0
TRIPLE ROOM	0	0	0	0	0
TOTAL	0	0	0	0	0

ROOM CHART - BUILDING 8					
GROSS SF: 28,871 SF				NET SF: 27,485 SF	
	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	0	0	0	0	0
DOUBLE ROOM	3	0	24	54	27
TRIPLE ROOM	0	0	9	27	9
TOTAL	3	0	33	81	36

ROOM CHART - TOTAL PHASE 1					
GROSS SF: 69,384 SF				NET SF: 67,217 SF	
	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	6	5	0	11	11
DOUBLE ROOM	3	0	34	74	37
TRIPLE ROOM	0	0	0	0	0
TOTAL	9	5	34	85	48

ROOM CHART - TOTAL PHASE 2 - BUILDING 8					
GROSS SF: 28,871 SF				NET SF: 27,485 SF	
	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	0	0	0	0	0
DOUBLE ROOM	3	0	24	54	27
TRIPLE ROOM	0	0	9	27	9
TOTAL	3	0	33	81	36

ROOM CHART - TOTAL PHASE 1 & PHASE 2 (AND BLDG 3A)					
GROSS SF: 98,255 SF		SF LESS DEMO OF 600 GSF		NET SF: 94,702 SF	
	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	6	5	0	11	11
DOUBLE ROOM	6	0	58	128	64
TRIPLE ROOM	0	0	9	27	9
TOTAL	12	5	67	166	84

NOTE: 11 / 12 / 2014
THIS SITE PLAN DRAWING @ 11,100 BILLINGSLEY ROAD WAS PREPARED FROM DRAWINGS PROVIDED BY OWNER. NO SURVEY HAS BEEN CONDUCTED. THIS DRAWING IS FOR SCHEMATIC PURPOSES ONLY.

RCA

CLIENT APPROVAL
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RECOVERY CENTERS OF AMERICA

BILLINGSLEY FACILITY

11,100 BILLINGSLEY ROAD WALDORF MARYLAND 20602

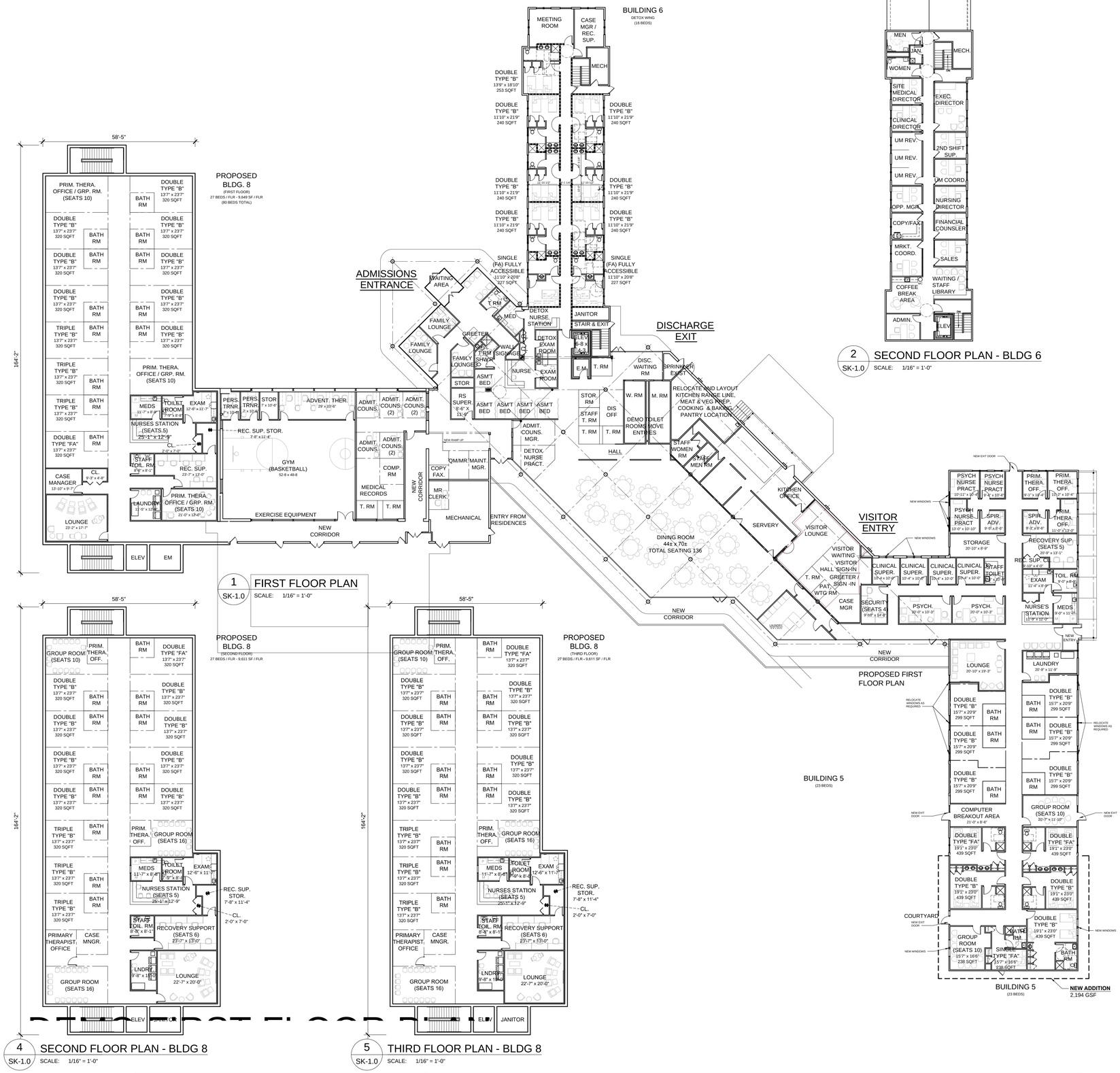
Architecture
Planning
Interiors
Thomas E. Hall & Associates, Inc.
240 Conestoga Rd.
Wayne, PA 19087
Tel. (610) 293-9900
Fax (610) 293-9901

1/16"=1'-0" 18 MAR 15

EH ARCHITECTS

SP-1.0
ISSUE 11

BILLINGSLEY



ROOM CHART - BUILDING 5

GROSS SF: 38,025 SF — SF INCL- ADD 5,6 & COMMON — NET SF: 36,939 SF

	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	1	5	0	6	6
DOUBLE ROOM	2	0	9	22	11
TRIPLE ROOM	0	0	0	0	0
TOTAL	3	5	9	28	17

ROOM CHART - BUILDING 6

GROSS SF: — SF SEE BLDG 5 ABOVE — NET SF:

	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	2	0	0	2	2
DOUBLE ROOM	0	0	7	14	7
TRIPLE ROOM	0	0	0	0	0
TOTAL	2	0	7	16	9

ROOM CHART - BUILDING 7 N/A

GROSS SF: — NET SF:

	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	0	0	0	0	0
DOUBLE ROOM	0	0	0	0	0
TRIPLE ROOM	0	0	0	0	0
TOTAL	0	0	0	0	0

ROOM CHART - BUILDING 8

GROSS SF: 28,871 SF — NET SF: 27,485 SF

	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	0	0	0	0	0
DOUBLE ROOM	3	0	24	54	27
TRIPLE ROOM	0	0	9	27	9
TOTAL	3	0	33	81	36

NOTE: 11 / 12 / 2014
THIS SITE PLAN DRAWING @ 11,100 BILLINGSLEY ROAD WAS PREPARED FROM DRAWINGS PROVIDED BY OWNER. NO SURVEY HAS BEEN CONDUCTED. THIS DRAWING IS FOR SCHEMATIC PURPOSES ONLY.

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ISSUE 11

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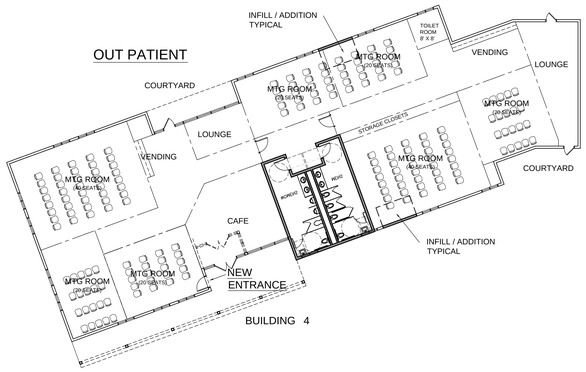
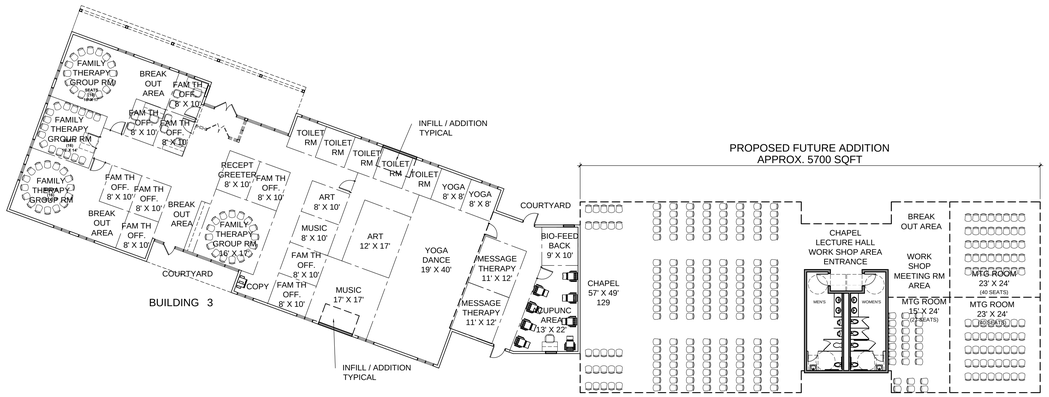


4 / SK-1.1 FLOOR PLAN DIAGRAM - BUILDING 4 - AA\NA - OUTPATIENT

SCALE: 1/16" = 1'-0"

ROOM CHART - BUILDING 4					
GROSS SF: 6,659 SF		SF INCLUDES ADDITIONS		NET SF: 6,416 SF	
	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	0	0	0	0	0
DOUBLE ROOM	0	0	0	0	0
TRIPLE ROOM	0	0	0	0	0
TOTAL	0	0	0	0	0

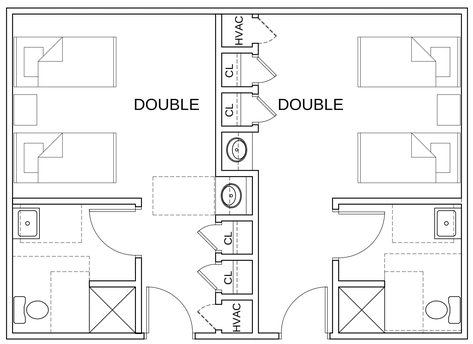


3 / SK-1.1 FLOOR PLAN DIAGRAM - BUILDINGS 3 - FAMILY GROUP THERAPY AND OTHERS

SCALE: 1/16" = 1'-0"

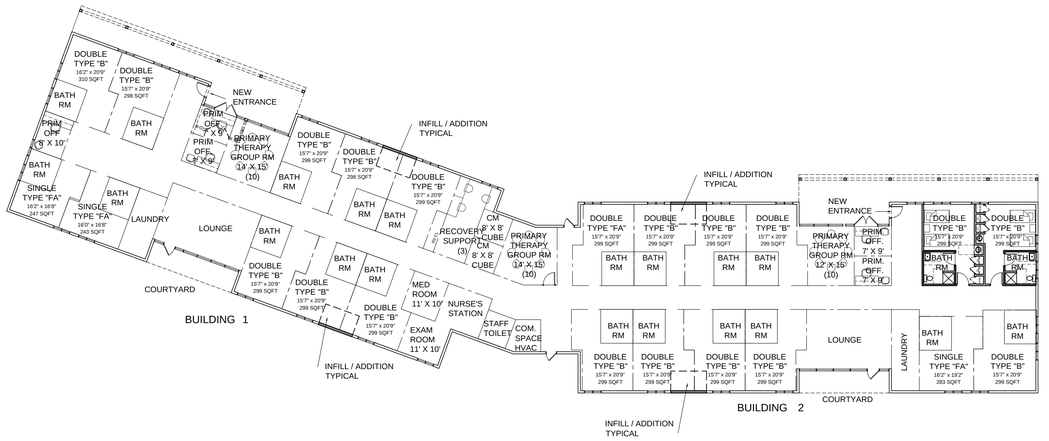
ROOM CHART - BUILDING 3					
GROSS SF: 6,659 SF		SF INCLUDES ADDITIONS		NET SF: 6,416 SF	
	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	0	0	0	0	0
DOUBLE ROOM	0	0	0	0	0
TRIPLE ROOM	0	0	0	0	0
TOTAL	0	0	0	0	0

ROOM CHART - BUILDING 3A FUTURE					
GROSS SF: 5,700 SF		SF INCLUDES ADDITIONS		NET SF: 5,520 SF	
	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	0	0	0	0	0
DOUBLE ROOM	0	0	0	0	0
TRIPLE ROOM	0	0	0	0	0
TOTAL	0	0	0	0	0



4 / SK-1.1 FLOOR PLAN DOUBLE TYPE "B"

SCALE: 1/4" = 1'-0"



1&2 / SK-1.1 FLOOR PLAN DIAGRAM - BUILDINGS 1 & 2 - INPATIENT REHAB

SCALE: 1/16" = 1'-0"

ROOM CHART - BUILDINGS 1&2					
GROSS SF: 12,341 SF		SF INCLUDES ADDITIONS		NET SF: 11,926 SF	
	FULLY ACCESSIBLE	ASSESSMENT BEDS	TYPE "B"	BEDS	ROOMS
SINGLE ROOM	3	0	0	3	3
DOUBLE ROOM	1	0	18	38	19
TRIPLE ROOM	0	0	0	0	0
TOTAL	4	0	18	41	22

NOTE: 11 / 11 / 2014
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ISSUE 11

BILLINGSLEY

EXHIBIT 7

January 2014 | Fact Sheet

How Will the Uninsured in Maryland Fare Under the Affordable Care Act?

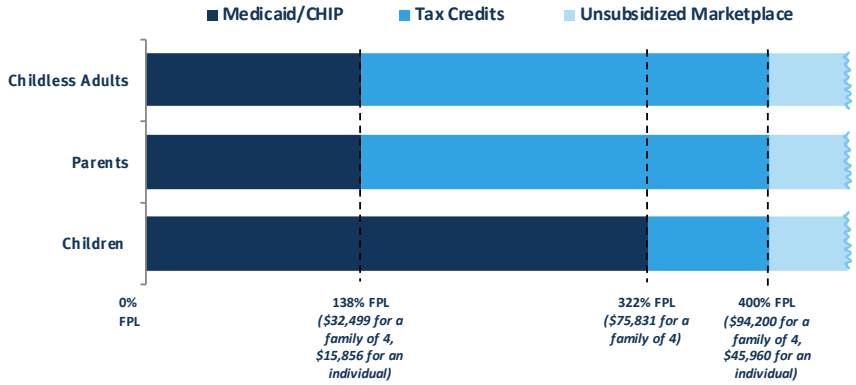
The 2010 Affordable Care Act (ACA) has the potential to extend coverage to many of the 47 million nonelderly uninsured people nationwide, including the 756,000 uninsured Marylanders. The ACA establishes coverage provisions across the income spectrum, with the expansion of Medicaid eligibility for adults serving as the vehicle for covering low-income individuals and premium tax credits to help people purchase insurance directly through new Health Insurance Marketplaces serving as the vehicle for covering people with moderate incomes. The June 2012 Supreme Court ruling made the Medicaid expansion optional for states, and as of December 2013, Maryland was planning to implement the expansion in 2014. As a result, the ACA will be fully implemented in Maryland, and almost all nonelderly uninsured, most of whom are adults, are eligible for coverage expansions. As the ACA coverage expansions are implemented and coverage changes are assessed, it is important to understand the potential scope of the law in the state.

HOW DOES THE ACA EXPAND HEALTH INSURANCE COVERAGE IN MARYLAND?

Historically, Medicaid had gaps in coverage for adults because eligibility was restricted to specific categories of low-income individuals, such as children, their parents, pregnant women, the elderly, or individuals with disabilities. In most states, adults without dependent children were ineligible for Medicaid, regardless of their income, and income limits for parents were very low—often below half the poverty level.[1] The ACA aimed to fill in these gaps by extending Medicaid to nearly all nonelderly adults with incomes at or below 138% of poverty (about $32,500 for a family of four in 2013). Thus, as of January 2014, Medicaid eligibility in Maryland covers almost all nonelderly adults up to 138% of poverty, as shown by the dark blue shading in Figure 1. All states previously expanded eligibility for children to higher levels than adults through Medicaid and the Children's Health Insurance Program (CHIP), and in Maryland, children with family incomes up to 322% of poverty (about $75,800 for a family of four) are eligible for Medicaid or CHIP. As was the case before the ACA, undocumented immigrants remain ineligible to enroll in Medicaid, and recent lawfully residing immigrants are subject to certain Medicaid eligibility restrictions.[2]

Figure 1

Income Eligibility Levels for Medicaid/CHIP and Marketplace Tax Credits in Maryland as of 2014



Notes: Medicaid eligibility is based on current Medicaid eligibility rules converted to MAGI. Applies only to MAGI populations. Medicaid eligibility levels as a share of poverty vary slightly by family size; levels shown are for a family of four. People who have an affordable offer of coverage through their employer or other source of public coverage (such as Medicare or CHAMPUS) are ineligible for tax credits. Unauthorized immigrants are ineligible for either Medicaid/CHIP or Marketplace coverage.
Source: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels.

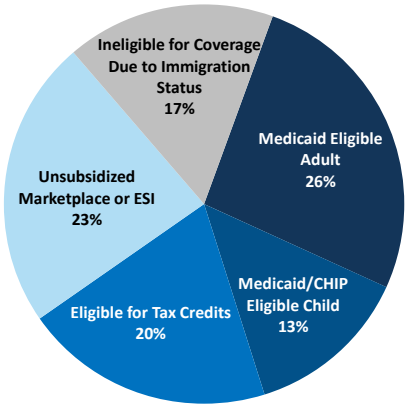
Under the ACA, people with incomes between 100% and 400% of poverty may be eligible for premium tax credits when they purchase coverage in a Marketplace. The amount of the tax credit is based on income and the cost of insurance, and tax credits are only available to people who are not eligible for other coverage, such as Medicaid/CHIP, Medicare, or employer coverage, and who are citizens or lawfully-present immigrants. Thus, the effective lower income limit for tax credits in Maryland is 322% of poverty for children and 138% of poverty for adults, as indicated by the bright blue shading in Figure 1. Citizens and lawfully-present immigrants with incomes above 400% of poverty can purchase unsubsidized coverage through the Marketplace.

HOW MANY UNINSURED MARYLANDERS ARE ELIGIBLE FOR ASSISTANCE UNDER THE ACA?

With Maryland deciding to implement the Medicaid expansion, nearly six in ten (59%) uninsured nonelderly people in the state are eligible for financial assistance to gain coverage through either Medicaid or the Marketplaces (Figure 2). Given the income distribution of the uninsured in the state, the main pathway for coverage is Medicaid, with four in ten (40%) uninsured Marylanders eligible for either Medicaid or CHIP as of 2014. While some of these people (such as eligible children) are eligible under pathways in place before the ACA, most adults are newly-eligible through the ACA expansion. One in five (20%) uninsured people in Maryland are eligible for premium tax credits to help them purchase coverage in the Marketplace.

Figure 2

Eligibility for Coverage as of 2014 Among Currently Uninsured Marylanders



Total = 756,000 Uninsured Nonelderly Marylanders

Notes: Shares may not sum to 100% due to rounding. People who have an affordable offer of coverage through their employer or other source of public coverage (such as Medicare or CHAMPUS) are ineligible for tax credits. Unauthorized immigrants are ineligible for either Medicaid/CHIP or Marketplace coverage.
SOURCE: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2012-2013 Current Population Survey.

Other uninsured Marylanders may gain coverage under the ACA but will not receive direct financial assistance. These people include the 23 percent with incomes above the limit for premium tax subsidies or who have an affordable offer of coverage through their employer. Some of these people are still be able to purchase unsubsidized coverage in the Marketplace, which may be more affordable or more comprehensive than coverage they could obtain on their own through the individual market. Lastly, the approximately 17 percent of uninsured people in Maryland who are undocumented immigrants are ineligible for financial assistance under the ACA and barred from purchasing coverage through the Marketplaces. This group is likely to remain uninsured, though they will still have a need for health care services.

***

The ACA will help many currently uninsured Marylanders gain health coverage by providing coverage options across the income spectrum for low and moderate-income people. While almost all of the uninsured in Maryland are eligible for some type of coverage under the ACA, the impact of the ACA will depend on take-up of coverage among the eligible uninsured, and outreach and enrollment efforts will be an important factor in decreasing the uninsured rate. The ACA includes a requirement that most individuals obtain health coverage, but some people (such as the lowest income or those without an affordable option) are exempt and others may still remain uninsured. There is no deadline for enrolling in Medicaid coverage under the ACA, and open enrollment in the Marketplaces continues through March 2014. Continued attention to who gains coverage as the ACA is fully implemented and who is excluded from its reach—as well as whether and how their health needs are being met—can help inform decisions about the future of health coverage in Maryland.

[1] Some states had expanded coverage to parents at higher income levels or provided coverage to adults without children. See http://www.kff.org/medicaid/fact-sheet/medicaid-eligibility-for-adults-as-of-january-1-2014/ for more detail on pre- and post-ACA Medicaid eligibility for adults.

[2] For more detail on Medicaid coverage for immigrants, see: http://www.kff.org/disparities-policy/fact-sheet/key-facts-on-health-coverage-for-low/.

EXHIBIT 8

OFFICIAL TRANSCRIPT EXCERPT

OF THE

MARYLAND HEALTH CARE COMMISSION

AGENDA ITEM 3 - CERTIFICATE OF NEED ASHLEY, INC.
d/b/a FATHER MARTIN'S ASHLEY

DOCKET NO. 13-12-2340

SEPTEMBER 19, 2013

1:00 p.m.

Maryland Health Care Commission
4160 Patterson Avenue, Room 100
Baltimore, Maryland 21215

Commissioners:
Ben Steffen, Executive Director
Craig Tanio, Chair
Garret Falcone, Vice Chair
Diane Stollenwerk
Glenn Schneider
Robert Conway
Barbara McLean
Kathryn Montgomery
Frances Phillips
John Fleig

Via Telephone:
Michael Barr
Paul Fronstin
Kenny Kan
Ligia Peralta

Also present:

Joel Riklin, Acting Chief of Certificate of Need

Father Martin's Ashley:

Father Mark Hughen,
President and Chief Executive Officer

Dr. Bernadette Solounias
Medical Director

Steven Kendrick,
Chief Operating Officer

Al Germann,
Chief Financial Officer

Daniel Berardi,
Vice-President, Support Services

Richard Koglin,
Consultant

COUNSEL FOR PETITIONER:

JACK J. ELLER, ESQ.
Ober Kaler Grimes & Shriver
100 Light Street
Baltimore, Maryland 21202
410-347-7362 (P) 443-263-7562 (F)
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Reporter:
Lisa P. Campbell
One Stop Legal
5623 Monroe Street
Hyattsville, MD 20784
(301) 379-6607

CHAIRMAN TANIO: Agenda Item Number 3 is Father Martin's Ashley has applied for a Certificate of Need to construct a new two-story building to address deficiencies in the existing physical facilities.

Joel Riklin, Acting Chief of the Certificate of Need, will present the staff recommendation. Joel.

MR. RIKLIN: Chairman Tanio and Commissioners, you have before you a proposal by Ashley, Incorporated, doing business as Father Martin's Ashley, to modernize and expand its existing facility. And I might refer to it as FMA at times during this presentation.

Father Martin's Ashley provides in-patient alcoholism and drug abuse treatment services on its campus in Havre de Grace. The applicant proposes construction of a new building, approximately 42,000 square feet. This building will increase its bed capacity by 15, from 85 beds to 100, and address a number of deficiencies in its existing physical plan, including replacing patient rooms and attic space that is currently unsuitable for occupancy and causes the facility to actually operate only 78 of its beds.

It will also eliminate patient rooms with more than two beds. It will increase the number of private rooms from 11 to 20. It will also consolidate the admission and intake process. The project costs $18,653,000. The funding, expected funding is -- at least initial funding -- is $6 million in cash,

approximately $5.7 million in fundraising, which has already been received or pledged and $7 million in debt in the form of a letter of credit or a five-year bond. The applicant expects to pay off the debt through additional fundraising.

Now, this application is relatively new to this CON program. It's only the second application from an alcoholism and drug abuse treatment facility in the last 12 years. And the way the State Health Plan regulates these facilities is actually there are two different types. There is those that have over 50 percent public funding and those are considered Track 2. And then there are those with less than 50 percent public funding, and that's Track 1.

Father Martin's Ashley is a Track 1. And it's the only private application we've received in the 12 years. The other application was from a state-run facility. Father Martin's Ashley is also unique in that half of its admissions come from outside the State of Maryland.

The applicant is also relevant and unusual because it doesn't not accept any payment from Medicaid or any other public funding. Of the 10 intermediate care, drug, and alcohol treatment facilities in Central Maryland, there is only one other facility that does not appear to accept any public funding.

Now, this application is covered by the State Health

Plan chapter for alcoholism, drug abuse, intermediate care, facility treatment services. That's a mouthful. And some of you may remember, in 2012, the applicant petitioned the Commission to amend the docketing requirements of this plan chapter that had required a minimum occupancy rate of licensed beds and a minimum number of days to be provided to indigent and near indigent patients before the Commission would consider the application.

Father Martin's Ashley didn't meet the licensed bed occupancy-docketing requirement at the time because, as I pointed out, it doesn't use all of its beds. It also didn't meet the docketing requirement with regard to service to the indigent and near indigent population and claimed that it could not meet this requirement and viably operate.

The Commission staff proposed plan amendments to address these concerns, which were adopted and became effective in February of this year. To address the concern of how bed occupancy will be considered, the amendments allow consideration of occupancy rate for operating bed capacity when some portion of a license, bed capacity is not usable.

To address the concern about -- with the minimum service to indigent and near indigent care, the docketing rule is eliminated. And consistent with the approach taken in other State Health Plan Chapters, the requirement was included in a State Health Plan check standard, which allows us to consider

what the applicant has done in the past and what they're proposing to do in the future in this regard.

The standard now requires the Commission to consider the financial feasibility of the applicant meeting the stated minimum, which was 15 percent of its patient days being provided to indigent and near indigent patients.

These amendments were considered in this review, as well as the other State Health Plan standards and the review criteria. Staff finds that the proposed project complies with the applicable State Health Plan standards and that consideration of the project, in light of the required review criteria, support approval.

Staff finds that the proposed project meets a need to modernize Father Martin's Ashley campus. Staff also finds that there is a need for more Track 1 beds to serve residents of Central Maryland, and that the addition of the 15 beds will have little or no impact in other providers, in part because of the multi-state service area of Father Martin's Ashley.

Staff also found that the applicant has demonstrated that it has the financial resources to undertake and sustain the project. While staff found the applicant to be consistent with all State Health Plan standards, Father Martin's Ashley's commitment to provide charity care to the indigent and near indigent is significantly less than the target amount. However, it is a significant increase. They are proposing an increase

currently from 3.4 percent of patient stays to 6.3 percent. And this is just for the indigent and near indigent population.

And we also feel that it's possible that the State Health Plan requirement is somewhat high. One comparison -- not strictly in apples-to-apples but somewhat -- is if you look at what Maryland hospitals do. For Fiscal Year 2012, the range of charity care for Maryland Hospitals was .44 percent, a low, to a high of 11.8 percent, with a median of about 3.5 percent.

The applicant's charity care, which also includes charity care to non-indigent, which was about 13 percent of operating expenses in FY2012, and they are projecting it to be 17 percent in Fiscal Year of 2017.

To ensure that Father Martin follows through on its commitment expressed in this application regarding the care to indigent and near indigent, staff recommends that there be a condition that Father Martin report -- provide audited data to show that they are providing this care.

Staff also found that the applicant's failure to report to the alcohol and drug abuse administration substance abuse information system was disappointing. While it, the applicant, has not been required to report because it is -- doesn't accept public funds, and the standard only requires that they agree to report, we think the Father Martin's Ashley has been dealing with this, the standards and this standard in particular, for a period of time while they develop this

application and should have had time to start reporting.

Therefore, staff recommends that the approval be conditioned on the applicant, commencing reporting within six months of the approval. Staff also found that while Father Martin has demonstrated the selection of the most cost-effective alternative to accomplish its objectives to modernize and add beds that it does not have a formal process to track and measure the effectiveness of its programs. It does not quantitatively compare its performance or success to other similar facilities.

Therefore, staff recommends a third condition that Father Martin's Ashley report back to the Commission on its efforts to systematically evaluate the effectiveness of its approach to treatment through rigorous follow-up evaluation of treatment success and collaborative efforts with similar programs in other states to institute standardized peer-reviewed study and improve program effectiveness.

Staff recommends approval of this project with these three conditions. The applicant has reviewed all the conditions and indicated acceptance to staff. At this time, I would be pleased to answer any questions.

And also available from -- representing Father Martin's Ashley is Father Mark Hushen, the President and CEO; Dr. Bernadette Solounias, Medical Director; Steven Kendrick, Chief Operating Officer; Al Germann, CFO; Daniel Berardi, Vice-President for Support Services; Richard Koglin, Consultant; and

Jack Eller, their attorney.

CHAIRMAN TANIO: Can I first get a motion to approve the Certificate of Need with the three staff conditions?

[MOTION ON THE FLOOR TO APPROVE THE CERTIFICATE OF NEED]

MR. FALCONE: Motion.

CHAIRMAN TANIO: Second?

MS. MONTGOMERY: Second.

CHAIRMAN TANIO: Okay. Discussion and questions. Reverend? Yeah.

COMMISSIONER CONWAY: Obviously, a wonderful facility. Obviously, a wonderful program, wonderful facility. What tugs at my heart right now is this some recent things that happened and they sort of keep happening in society. So my question basically is this. Directly or indirectly, will this facility have any impact on people with depression, mental problems, so forth?

MR. RIKLIN: Can I grab the microphone?

COMMISSIONER CONWAY: Yes.

MR. RIKLIN: Solounias.

MS. SOLOUNIAS: Your question is will we have any impact on people with depression and other psychiatric illnesses?

COMMISSIONER CONWAY: Yes.

DR. SOLOUNIAS: Yes. We, right now have psychiatrists on our staff, psychologists on our staff. And we treat people

with stable psychiatric illnesses which include primarily depression and anxiety disorders, but also other mood disorders and substance-induced psychiatric illnesses.

CHAIRMAN TANIO: Other questions?

COMMISSIONER BARR: Chairman Tanio, this is Michael Barr. I have a question.

CHAIRMAN TANIO: Okay.

COMMISSIONER BARR: Thank you for your excellent report. On the recommendation to demonstrate effectiveness, I'm wondering what standards will be used for that report. Are there national quality standards that staff are made to report on?

MR. RIKLIN: Well, I think, that was one of the problems. It's not only didn't -- did the applicant indicate they didn't do any comparative analysis, we were not able to find anything in the literature.

DR. SOLOUNIAS: That's correct.

CHAIRMAN TANIO: Indentify yourself, please.

DR. SOLOUNIAS: Oh, I'm sorry. Dr. Bernadette Solounias. That's correct. There aren't any standards on how to evaluate addiction treatment programs. There are studies that look at different outcomes, but they're not standardized outcomes that have been evaluated.

COMMISSIONER BARR: Thank you. So do you think this will create some creative thinking that will be potentially

interesting for the Commission to see how this evolves before the reporting occurs because it may apply another budget?

DR. SOLOUNIAS: That's correct.

CHAIRMAN TANIO: Diane?

COMMISSIONER STOLLENWERK: Sir, I appreciate the report and I appreciate the conditions. I do find the rate of care for the indigent and near indigent disappointing. I also have a question about -- and perhaps I'm focusing too much on specific words, but sometimes exactly how something is worded is very careful.

In reporting on efforts to assess program effectiveness doesn't necessarily, actually assess program effectiveness. And so I just wanted to get staff clarification that the expectation is actually assessing program effectiveness and not just reporting on we're trying, but aren't quite there yet.

There are, with the National Quality Forum and other groups, there are a number of folks who work and are coming together on reaching consensus around measures and metrics to assess chemical dependency, substance abuse, mental health service needs. So while there may not be a definitive set, there are, certainly, quite a bit of work has been done in that area. So you're not starting with a blank slate, fortunately, so I do think it's reasonable to expect that the conditions about reporting on program effectiveness, not just the effort to

try to get there.

MR. RIKLIN: Well that was certainly the hope that it would actually report on the effectiveness.

COMMISSIONER STOLLENWERK: So my request would be that to make sure that the wording and the condition is very specific -- is that it's about reporting on the effectiveness, not just the efforts to get there. Thank you.

CHAIRMAN TANIO: Diane, are you making a movement to amend any of the --

COMMISSIONER STOLLENWERK: Absolutely.

CHAIRMAN TANIO: -- conditions? Okay.

COMMISSIONER STOLLENWERK: I would prefer that the wording be very specific about the condition be the report is around the findings regarding program effectiveness.

CHAIRMAN TANIO: Okay.

COMMISSIONER SCHNEIDER: Second.

COMMISSIONER STEFFEN: Okay. Let's --

MR. STEFFEN: So let's be sure that we have -- can you restate?

CHAIRMAN TANIO: Let's get this for the record exactly right.

[MOTION TO AMEND CONDITIONS OF MOTION ON THE FLOOR]

COMMISSIONER STOLLENWERK: So I move that the condition be -- that one of the three conditions be specifically worded, and I leave that to staff to decide exactly what that

wording should be, but specifically worded so that it's clear that the expectation is around reporting on program effectiveness as opposed to reporting on efforts to assess program effectiveness.

CHAIRMAN TANIO: Yep. That's quite clear.

COMMISSIONER SCHNEIDER: Second.

CHAIRMAN TANIO: There's a second. Any discussion of this particular --

CHAIRMAN MONTGOMERY: -- I just have a question in terms, I guess, of all the conditions. The conditions are only good until first use is approved on the CON, and once CON ends, that -- the authority of the Commission sort of ends there. So I mean, I'm trying to figure out how this all works with by the time this project is completed, what -- how do you -- you just look at it that place and then you authorize or you delay the opening until all these conditions are met or how is that going to work?

CHAIRMAN TANIO: Joel, would you like to comment on that?

MR. RIKLIN: Well yeah. I think there -- at this point, the way it is, the only -- on those -- on that condition, and probably to some degree -- and to some degree certainly on the indigent care condition, it would just be that they would need to keep reporting and we would need to follow up. And the only -- the implicat -- the only kind of shtick we have is they

are coming back to us at this point.

COMMISSIONER MONTGOMERY: If they choose to come back to --

MR. RIKLIN: Yeah --

COMMISSIONER MONTGOMERY: -- The CON --

MR. RIKLIN: -- I'm thinking that on "three," maybe we can move it up too 'cause --

COMMISSIONER MONTGOMERY: I just raise it as a point --

MR. RIKLIN: Yeah.

COMMISSIONER MONTGOMERY: -- practical point 'cause it's not licensing where they come back regularly to you. This is we approve the project.

CHAIRMAN TANIO: That's correct.

COMMISSIONER MONTGOMERY: The project is approved and the project ends.

MR. RIKLIN: Well, once it's operational, yes.

COMMISSIONER MONTGOMERY: Right.

MR. RIKLIN: Yeah. So like on the first condition we probably have -- we have first-use approval as a ultimate check on that.

CHAIRMAN TANIO: Any other comments? Yeah?

COMMISSIONER STOLLENWERK: A little more clarity. So this is Diane again. I request that -- or I move that the condition be that there is a report on program effectiveness

with a standards to be approved by staff.

[MOTION TO REVISE MOTION ON FLOOR TO AMEND]

COMMISSIONER SCHNEIDER: I'll second it again.

CHAIRMAN TANIO: Yeah. Okay. So you would withdraw your other motion and that this is amended? Okay.

COMMISSIONER STOLLENWERK: Yes, I do.

CHAIRMAN TANIO: Okay.

[FIRST MOTION ON FLOOR WITHDRAWN]

COMMISSIONER STOLLENWERK: This is simply trying to be a little bit --

CHAIRMAN TANIO: Yeah.

COMMISSIONER STOLLENWERK: -- more clear --

CHAIRMAN TANIO: Yeah.

COMMISSIONER STOLLENWERK: -- I think.

CHAIRMAN TANIO: Okay. And with -- we'll take the spirit of that motion without too much of the wordsmithing because I do think that it can --

COMMISSIONER STOLLENWERK: Yeah.

CHAIRMAN TANIO: -- be -- the final order can be easily adjusted there.

Any further discussion of Commissioner Stollenwerk's --

COMMISSINER SCHNEIDER: -- Well, I have a question.

CHAIRMAN TANIO: Yes?

COMMISSIONER SCHNEIDER: I don't know if you want the

attorney to go first or --

CHAIRMAN TANIO: Sure.

MR. ELLER: You indicated there would be further discussion among staff I presume. We would have an opportunity, as the applicant, to weigh in to be sure it's feasible and acceptable from our point of view as well?

CHAIRMAN TANIO: With the wording? Yes. I think we -- yeah, we're not going to dictate standards. I think the essence is basically having a good faith. I mean, we've just talked about that the measurement of effectiveness is something that's emerging.

MR. ELLER: Right.

CHAIRMAN TANIO: I think the way that I interpret the motion is --

MR. ELLER: -- That's how we --

CHAIRMAN TANIO: -- that Commissioner Stollenwerk is basically saying that's true, but, you know, there is, you know, sort of early stages to just say you're trying to systematically evaluate it versus you actually are evaluating it and so that's the intent of this.

MR. ELLER: Okay.

CHAIRMAN TANIO: So there would be --

MR. ELLER: Thanks.

CHAIRMAN TANIO: There would be wordsmithing after this --

MR. ELLER: We are --

CHAIRMAN TANIO: -- with that part.

MR. ELLER: -- absolutely agreeable to a phase standard and intent of the standard. As long as we can work out the wording, that's fine.

CHAIRMAN TANIO: Perfect. Okay.

COMMISSIONER FALCONE: I think --

CHAIRMAN TANIO: -- Commissioner Falcone?

COMMISSIONER FALCONE: -- I think you answered my question, Mr. Chairman. I guess I was going to say, 'cause I thought I heard before there aren't really any national metrics or standards for measuring quality in these types of organizations. So I'll go back to your question. What are you saying that the staff should come up with some quality measures? That's where I was confused.

COMMISSIONER STOLLENWERK: No, I'm glad you raised it. I mean the National Quality Forum and others, through the Measure Application Partnership, they've been looking at this issue, in particular, looking at, for example, the -- within the context of the Medicare and Medicaid dual eligible population where chemical dependency and mental health substance use services are a high priority area and they're -- while there may not be the best perfect set of measures where people look at it and they say 'Yes, this is comprehensive and we -- it gives us the total picture,' we also know at the other end of the

spectrum where there is nothing available. There are measures available. So using, particularly, nationally-available measures, which would be ideal, there is at least something to start with. So that's my contention in that I just wanted to move away from being able to meet the condition by submitting a report saying we're working on it because by the way this is worded, it says it simply needs to be a report detailing their efforts to evaluate as opposed to actually evaluating. That's the distinction I'd like to submit.

CHAIRMAN TANIO: Okay. All right. Any other discussion? Then we'll just --

COMMISSIONER PHILLIPS: -- Not on this point.

CHAIRMAN TANIO: That's fine. No. Okay.

So let's vote on Commissioner Stollenwerk's amendment to the staff conditions.

All in favor?

COMMISSIONERS: Aye.

[All commissioners respond "aye".]

CHAIRMAN TANIO: Any opposed?

[None were opposed.]

CHAIRMAN TANIO: Okay. Now, general discussion around the approval of Certificate of Need. Fran.

COMMISSIONER PHILLIPS: I guess my question probably goes to the applicant and it involves the decision not to accept Medicaid, or perhaps Medicare, to be a Track 1, for example,

rather than a Track 2 facility, recognizing the overwhelming burden that substance abuse places on Marylanders, and particularly, as we're at the brink now of expanding Medicaid coverage to -- not only Medicaid coverage, but subsidized commercial coverage to hundreds of thousands of more Marylanders.

Perhaps one of you could talk about the facility's decision to stay on Track 1 as opposed to moving to Track 2, which I understand is a Track of these facilities that accept public funds.

It's a complicated question, but I think you kind of get to the --

MR. ELLER: -- Yes. There has been an awful lot of discussion over the last --

MR. STEFFEN: -- Could you come forward and identify yourself and then speak? Because we do have four commissioners on line --

MR. ELLER: Yes.

MR. STEFFEN: -- that can't hear you unless you're speak into --

MR. ELLER: I'm just going to --

MR. STEFFEN: -- the microphone.

MR. ELLER: -- I'm going to introduce Al Germann, who is the CFO and Vice-President for Finance at the facility. I just wanted to preface his remarks by saying that over the

course of the last year since the State Health Plan was changed and permitted Father Martin's Ashley to bring its application to you, the new standard in the plan permitted consideration of alternatives to the previous standard that was very rigid, and there have been lots of paper, lots of discussion with staff. And as you might imagine, and as reflected in the staff report, and I think that we have reached an understanding and Mr. Germann will further explain, directly, the answer to the Medicaid question.

MR. GERMANN: As I understand it, and open for clarification, Track 1 and Track 2 has to do with public funding of the institution. We haven't needed public funding in the past. We won't anticipate needing it in the future, but more directly to your Medicaid question, we know that there -- to participate in Medicaid, you sign contracts with medical care organizations.

As part of background, I was a CFO with Maryland Physicians Care for five years preceding this. I'm very familiar with that process. I've worked for United Healthcare as well, Aetna, Maryland Physician's Care. So as part of a contracting process, we would accept Medicaid patients. We have not been approached, at least at this point, to contract with a Medicaid care organization. Not to say that we wouldn't; we haven't ruled it out.

Our mission is certainly one where we would accept

that type of patient or clientele. It's not an issue with us at all, if it meets our needs and our mission. And I would also say, in terms of the indigent percentages, you know, we've donated charity care, we've done over $20 million in the last 10 years.

Annually, we're spending about $2.4 million, about 10 percent of revenue, under 10 percent of revenue. If you look at the projection going from 2012 to 2017, I think it's on page 12 of the recommendation, you'll see that the change in charity care is basically in the indigent gray area, percentage.

So there is -- to be clear -- there is a commitment on Father Martin's Ashley to provide care not only to the indigent and gray area, but also to those folks in the middle class that may not necessarily be able to afford it, that have jobs and have other commercial insurance coverage that really can't -- still can't afford it. And we are happy to provide charity care for those folks as well.

COMMISSIONER PHILLIPS: So just to follow-up.

CHAIRMAN TANIO: Go ahead.

COMMISSIONER PHILLIPS: The condition that was placed in connection with charity care -- what is it, 6.3 --

MR. GERMANN: 6.3 percent.

COMMISSIONER PHILLIPS: -- 6.3 percent. So maybe this question is for staff. How, going forward, how will that be monitored and Health Commission be kept aware of that?

MR. RIKLIN: Well, we're requiring Father Martin's Ashley to file audited reports for five years, starting with when this project is completed, when they are projected to meet the -- to hit that 6.3 percent figure.

COMMISSIONER PHILLIPS: So five years after the issuance -- for five years during that period.

MR. RIKLIN: For five years after the project completion.

COMMISSIONER PHILLIPS: So that's the term of the condition?

MR. RIKLIN: Right. As it's stated --

COMMISSIONER PHILLIPS: Right.

MR. RIKLIN: -- in the recommended --

COMMISSIONER PHILLIPS: The --

MR. RIKLIN: -- audit.

COMMISSIONER PHILLIPS: There is so much happening with regard to whittling away at what we call the uninsured or the indigent population so that it may be something that the commission needs to take a look at the definition of indigent population, given the fact that with the expansion of Medicaid, up to, I think 138 for childless adults, up to 138 percent of poverty, it gets that definition of indigent care, thinner and thinner slices of population.

So that might be something -- this is not relevant specifically to this application, but in general, to look at how

we regard indigent care in this changing demographic with regard to the greater insurance coverage.

MR. RIKLIN: Well, as far as this State Health Plan Chapter as it currently is -- and this was adopted -- this went into effect in 2002 -- indigent care is essentially defined as Medicaid eligible. That's as far as this Chapter goes. That's not necessarily universally throughout the regulatory scheme.

CHAIRMAN TANIO: Commissioner Phillips, I see your point. We can put that in a cue for staff to --

COMMISSIONER PHILLIPS: Yeah. I'd like to.

CHAIRMAN TANIO: -- look through it and get back to the Commission --

COMMISSIONER PHILLIPS: Thank you.

CHAIRMAN TANIO: -- on that.

MR. GERMANN: I would just add, you know, one of the things that forced us to look at, through this process, and the definition of indigent care were those folks that were not considered indigent, but really, in our minds, met the indigent criteria. That is, you know, you have someone that supported, but just barely meets, you know, the 180 percent of poverty.

You know, we found that there were instances where we felt we provided indigent care that wasn't being credited for that. So it would be a nice thing to do to look at that again.

CHAIRMAN TANIO: Other questions, comments, discussion?

[There was no response.]

CHAIRMAN TANIO: If not, let's take a vote.

All in favor, say "aye."

[All commissioners were in favor]

CHAIRMAN TANIO: Any on the phone?

MR. BARR: Aye. Michael.

CHAIRMAN TANIO: Any opposed?

[There were none opposed.]

CHAIRMAN TANIO: Motioned carries. You have your CON.

[Upon Motion by Commissioner Stollenwerk, and seconded by Commissioner Schneider, the application for CON for Father Martin's Ashley was approved.]

(Discussion and Vote on Agenda Item No. 3 was concluded at approximately 1:38 p.m.)

CERTIFICATE OF REPORTER

UNITED STATES OF AMERICA)
STATE OF MARYLAND)

I, LISA P. CAMPBELL, the reporter before whom the foregoing proceedings were taken, do hereby certify that the foregoing transcript is a true record of the proceedings.

I further certify that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and further that I am not a relative or employee of any attorney or counsel employed by the parties hereto, or financially or otherwise interested in the outcome of this action.

_____
Lisa P. Campbell
One Stop Legal

My Commission expires March 22, 2017

EXHIBIT 9

Supersedes All Previous Policy
Dated: 9/2014 **No. 2000.001**
Revised:
SUBJECT: Admission & Exclusion Criteria

DRAFT

Department Responsible: Admissions
Related Department(s): All

PURPOSE:
To establish patient admission criteria. To ensure the safety and well-being of any person entering RCA's inpatient programs. To ensure all potential patients obtain the treatment they need at the appropriate level of care.

POLICY:
Recovery Centers of America treats adult males and females who are 18 years of age or older and have an active chemical dependency problem. It is the policy of Recovery Centers of America to admit patients for treatment without regard to gender, race, religion, national origin, marital status, creed or sexual orientation. Patients may also suffer from mental health illness, which would be addressed in the treatment process. All admissions are expected to be voluntary and prospective patients must make a verbal commitment and give written consent to complete the diagnostic evaluations and be involved in treatment.

The decision to admit an individual lies solely with Recovery Centers of America. RCA is not bound by any contract or other obligation to accept for treatment a person who is inappropriate by virtue of medical or psychiatric diagnosis, motivation or demonstrated lack of responsiveness, or other factors. Prospective patients and referral sources will be informed that provisions should be made if it is determined that admission is inappropriate. Referral sources should have alternate plans in place if the person is not admitted. Per Massachusetts CMR 164.070(A), RCA shall not establish a category of automatic exclusion that is defined by a history of criminal conviction. In addition, per CMR 164.070(G), RCA shall not deny admission to an individual solely because the individual uses a medication prescribed by a physician outside RCA's service or facility.

Some patients will be excluded from admission to our inpatient programs. If a potential patient meets any of the criteria listed below, then s/he cannot be admitted to RCA inpatient programs.

- Individuals under the age of 18.
- Individuals who are registered sex offenders in the National Sex Offender Registry.
- Individuals suffering from a currently unstable psychiatric condition that requires a higher level of psychiatric care. This includes but is not limited to; person exhibiting active symptoms schizophrenia, homicidal/aggressive behavior, active suicidal ideation with a plan or active suicidal thoughts in which the patient cannot contract for safety.
- Females in their third trimester of pregnancy or pregnant women who require detoxification from opiates.
- Individuals who are bed-ridden, unable to participate in daily programing or unable to take care of their Activities of Daily Living (ADL's)
- Persons suffering from a medical condition/complication that is not able to be addressed in a non-hospital setting. This includes but is not limited to:
    - Cardiovascular
        - Unstable angina
        - Decompensated congestive heart failure
        - Severe hypertension, unresponsive to treatment – blood pressure over 200 systolic, 130 diastolic

- Undiagnosed chest pain
- o Respiratory
  - Status asthmaticus
  - Respiratory failure
- o GI
  - Active GI bleeding as evidenced by hematitus or severe melena with orthostasis
  - Acute pancreatitis with severe vomiting or severe abdominal pain
- o Central Nervous System
  - Delirium tremens
  - Comatose, obtunded or severely lethargic mental status
  - History of recent untreated head trauma
- o Endocrine
  - Diabetic ketoacidosis
  - Thyrotoxicosis
- o Infectious Diseases
  - Plague
  - Cholera
  - Measles
  - Rubella
  - Chicken Pox
  - Active tuberculosis
  - C-Diff (untreated and active)
  - Untreated MERSA
  - Scabies (untreated)
  - Shingles (untreated)
- o Persons requiring dialysis or intravenous therapy or with advanced stage liver or kidney failure
- o **Or any medical any medical complication that could pose a medical risk for treatment at a nonhospital inpatient level of care.**
- o Clarification – The severity of these medical conditions require some amount of medical judgment and a physician may need to be consulted regarding whether a particular patient is appropriate for admission.

- Individuals with an intellectual disability will be reviewed on a case-by-case basis for their ability meaningfully participate in RCA's programs.

PROCEDURES:

A. General Procedures

1. The Intake & Assessment and/or Call Center staff will collect all necessary data on a potential patient. We will utilize several assessment tools including the Addiction Severity Index (ASI).
2. If the patient is currently in another facility or Emergency Department, clinical documentation will be requested for review.
3. The admission will be approved or denied within the guidelines of the admission/exclusion criteria above.
4. A referral will be made to a more appropriate facility if the admission is denied due to exclusion criteria or the referral is inappropriate for our level of care.
5. The Intake & Assessment Center will maintain a log of referrals who were denied admission. The log will contain the name of the referral and the reasons for denial.

B. General Admission Criteria

1. Acknowledge that they have (or recently have had) problems in their lives associated with alcohol and/or drug use;
2. Have a willingness to participate in treatment;
3. Provide written consent to participate fully in diagnostic evaluations treatment;
4. Conform to guidelines established in the Patient Handbook; and
5. Be physically and mentally able to participate in necessary treatment.

C. Nonhospital Detoxification Program Admission Criteria

1. Individuals must meet the DSM 5, “Addictions & Related Disorders” or ICD-10 “Psychoactive Substance Use Disorder-Dependence”, as well as ASAM criteria for this level of care.
2. Intoxication or Withdrawal
   Individuals should also meet ONE of the following:
   a) The risk of a severe withdrawal syndrome is present but manageable in this setting, as evidenced by:
      (1) Individual is withdrawing from alcohol and CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) equals 10-19; OR

(2) Daily ingestion of sedative hypnotics or opioids for over six months, plus daily use of another mind-altering drug known to have its own withdrawal syndrome (close hourly monitoring is available, if needed), with no accompanying chronic mental/physical disorder; OR
(3) Daily ingestion of sedative hypnotics or opioids above the recommended therapeutic dosage level for at least 4 weeks (close hourly monitoring is available, if needed), with no accompanying chronic mental/physical disorder; OR
(4) The individual uses high dose/oral/nasal stimulants, or smokes or injects stimulants at least once a day in a cyclic pattern of "runs," and is currently within 7 days of such drug use; OR
(5) The individual has marked lethargy, hypersomnolence, or high levels of agitation associated with expressed high degrees of drug craving.

b) The individual is either not showing signs of intoxication with a blood alcohol of .15gm% or greater, or has a blood alcohol level of 0.2gm%.

3. Biomedical Conditions and Complications
Individuals should also meet ONE of the following:

a) Continued alcohol/drug use places the individual in imminent danger of serious damage to physical health for concomitant biomedical conditions.

b) Biomedical complications of addiction or a concurrent biomedical illness require medical monitoring, but not intensive care.

D. Nonhospital Residential Program Admission Criteria

1. Individuals must meet the DSM 5, "Addictions & Related Disorders" or ICD-10 "Psychoactive Substance Use Disorder-Dependence", as well as ASAM criteria for this level of care.

2. Intoxication or Withdrawal
Individuals should also meet ONE of the following:

a) The individual is assessed as being at minimal to no risk of severe withdrawal syndrome, as evidenced by:

(1) CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) of less than 10 following 8 hours of abstinence from alcohol without medication; OR
(2) Blood alcohol 0.0gm% and no withdrawal signs or symptoms present which require medication; OR
(3) Sub-acute symptoms of protracted withdrawal which, if present, can be managed safely without daily medically managed intervention.

b) For individuals with withdrawal symptoms no more severe than those noted in Section A, the individual has, and responds positively to, emotional support and comfort as evidenced by decreased emotional symptoms by the end of the initial interview session.

3. Biomedical Conditions and Complications
Individuals should also meet ONE of the following:

a) Continued alcohol/drug use places individual in possible danger of serious damage to physical health for any concomitant biomedical conditions (e.g. continued use of alcohol despite diagnosis and/or history of diabetes, cirrhosis of the liver, pancreatitis or seizures during withdrawal, continued cocaine use despite history of seizures associated with such use, high blood pressure or cardiovascular or cardiac problems, or continued alcohol/drug use within a self-destructive lifestyle while HIV-positive or AIDS-symptomatic);

b) Biomedical complications of addiction or concurrent biomedical illness require medical monitoring but not intensive care (e.g. AIDS-symptomatic);

c) If individual is pregnant, continued or recurring alcohol/drug use would place the fetus in imminent danger of temporary or permanent disability;

d) The individual's biomedical complications are not severe enough for Levels 3 or 4, but are sufficient to distract from recovery efforts. Such conditions, which require medical monitoring, could be treated by a concurrent arrangement with another treatment provider.

4. Emotional/Behavioral Conditions and Complications
Individuals should also meet ONE of the following:

a) Depression and/or other emotional/behavioral symptoms (e.g. compulsive behaviors) are sufficiently interfering with abstinence, recovery, and stability to the degree that a structured 24-hr environment is need to address symptoms and recovery efforts;

b) There is a moderate risk (usually manifested by highly dysfunctional behavior in the recent past) of behaviors endangering self or others (e.g. suicidal or homicidal thoughts with no active plan, but a history of suicidal gestures or homicidal threats);

c) The individual is manifesting stress behaviors related to recent or threatened losses in the work, family, or social arenas, to the extent that activities of daily living are significantly impaired. A 24-hr structured secure environment is needed to help the individual address his/her addiction;

d) Concomitant personality disorders (e.g. antisocial personality disorder with verbal

aggressive behavior requiring constant limit-setting) are of such severity that the accompanying dysfunctional behaviors require continuous boundary-setting interventions.

5. Readiness to Change

   Despite serious consequences and/or effects of the addiction on the individual's life (e.g. health, family, work, or social problems), the individual does not accept or relate to the severity of these problems. The individual is in need of intensive motivating strategies, activities, and processes only available within a 24-hr program.

6. Relapse Potential
   Individuals should meet ONE of the following:

   a) Despite a history of treatment episodes at a less intensive level of care, the individual is experiencing an acute crisis with a concomitant intensification of addiction symptoms (e.g. difficulty postponing gratification and related drug-seeking behavior);
   b) The individual is assessed to be in danger of drinking or drugging with attendant severe consequences, and is in need of 24-hr short-term professionally directed clinical interventions;
   c) The individual recognizes that alcohol and/or drug use is excessive and has attempted to reduce or control it, but has been unable to do so as long as alcohol and/or drugs are present in his/her immediate environment.

7. Recovery Environment
   Individuals should meet ONE of the following:

   a) The individual lives in an environment (e.g. social or interpersonal network) in which treatment is unlikely to succeed (e.g. family full of interpersonal conflict which undermines individual's efforts to change, family members or significant others living with the individual who manifest current substance abuse problems and are likely to undermine the individual's recovery);

   b) Logistic impediments (e.g. distance from treatment facility, mobility limitations, lack of driver's license, etc.) preclude participation in treatment services at a less intensive level;

   c) There is a danger of physical, sexual, and/or severe emotional attack or victimization in the individual's current environment which will make recovery unlikely without removing the individual from this environment;

   d) The individual is engaged in an ongoing activity (e.g. criminal activity to support habit) or occupation where continued alcohol and/or drug use on the part of the individual constitutes substantial imminent risk to public or personal safety (e.g. individual is airline pilot, bus driver, police officer, member of clergy, doctor, nurse, construction worker, etc.).

E. **Readmission Criteria**
1. Individuals must meet the general and program-specific admission criteria before being considered for readmission.
2. RCA will not deny re-admission to any person solely because that person:
   a) withdrew from treatment against clinical advice on a prior occasion;
   b) relapsed from earlier treatment; or
   c) filed a grievance regarding an action or decision of the licensee.

APPROVED: _____ **DATE:** _____

Supersedes All Previous Policy Page **1** of **3**
Dated: 10/2014 **No. 3000.007**
Revised:
SUBJECT: Discharge Procedure

DRAFT

Department Responsible: Clinical
Related Department(s): Nursing, Medical Services

PURPOSE:

To provide procedures for discharging a patient and the documentation that accompanies the discharge procedures. Also to provide quality, continuing care plans for all patients.

POLICY:

Patients shall be discharged in a uniform manner.

DEFINITIONS: N/A

PROCEDURES:

A. Discharge Order

1. A discharge order shall be obtained from a physician/physician assistant/CRNP which includes specific information regarding discharge (type, medications, etc.)

2. A nurse or clinical aide (CA) shall review the order

3. If an order for discharge has not been written, the nurse will call the physician/physician assistant/CRNP for a verbal order. A patient should not be discharged without an order.

B. Continuing Care Plan

1. The primary counselor is responsible, in cooperation with the Treatment Team, for the overall development of a comprehensive continuing care plan for each patient. This plan is formulated with patient's input and when appropriate with input from family members, significant others, guardians, employers, referral sources and judicial system.

2. All patients shall have a Continuing Care Plan in spite of discharge type. This includes AMA, AWOL (if possible), Therapeutic Discharge, etc.

3. Counselor shall make arrangements for patients based on specific needs and shall include services that will assist in recovery process. This can include but is not limited to:
    a. Intensive Outpatient Program
    b. General Outpatient Program
    c. Partial Hospitalization
    d. Individual Therapy
    e. Psychiatric Appointment

f. Recovery House
g. Halfway House
h. Shelter
i. Case Management Services
j. Inpatient services (in case of transfer)
k. Crisis Intervention
l. Specific Group – Relapse Prevention, Anger Management
m. Children Youth Services/Domestic Relation
n. Probation/Parole Officer Appointment
o. Office of Vocational Rehab

4. The physician/physician assistant/CRNP/psychiatrist will direct patients to appropriate medical and psychiatric continuing care services needed including continuing psychiatric care, medication management and follow-up with the patient's primary care physician. A current medication list will be provided to the patient with the Continuing Care Plan.

5. In order to facilitate family continuing treatment, the counselor shall encourage the family to participate in family therapy and family programs, Al-Anon and outpatient treatment.

6. Counselors are responsible for contacting the transportation department when the patient needs to be transported at discharge by facility transportation.

7. The continuing care plan will be developed as soon as possible. Aftercare shall be in planning stages within 72 hours of patient admission, regardless of length of stay to ensure as minimal a gap in between services.

8. The continuing care plan shall include:
    a. Clinical Issues to be addressed in Continuing Care
    b. A description of the services to be provided which will assist the patient in maintaining long-term sobriety
    c. A specific point of contact to facilitate the patient in obtaining the needed services
    d. Dates, times and address of continuing care appointments
    e. Re-admission information

9. It is the responsibility of the treatment team staff to be aware of discharge plans. If any changes are made during treatment, these will be documented in a progress note by the informed party and placed in the patient's chart.

10. The patient is to sign the continuing care plan indicating his/her agreement with its content and intention to follow it. Patients are given a copy of the plan upon discharge.

11. If a patient leaves Against Medical Advice (AMA) or elopes from the facility (AWOL), this must be documented in a progress note and placed in the chart. If a patient goes AMA, a continuing care plan must be offered and information must be present.

12. The continuing care plan is to be completed by the Primary Counselor with input from the nursing and medical departments. The nurse or physician/physician/CRNP will review medications that are prescribed at the time of discharge with the patient.

C. General Discharge Procedures

1. Once a counselor is aware that a patient is being discharged, the Admissions and the Nursing department should be informed.

2. The CA will give the patient a patient satisfaction survey to complete.

3. The CA must ensure that the patient is given any valuables that have been placed in the safe and file. The patient and CA must sign the bottom of the valuables form to verify all personal possessions have been returned to the patient.

4. The CA who assisted in the discharge shall document the following in the patient's chart:

    a. Time of discharge
    b. Patient's condition on discharge
    c. Valuables returned to the patient
    d. With whom the patient left the facility.

APPROVED: _____ **DATE:** _____

Supersedes All Previous Policy
Dated: 10/2014 **No. 3000.012**
Revised:
SUBJECT: *Initial Patient Care*

Department Responsible: Clinical
Related Department(s): All

DRAFT

PURPOSE:

To provide quality clinical care to all patients.

POLICY:

Staff must follow specified procedures regarding initial patient care.

DEFINITIONS: N/A

PROCEDURES:

Within 24 hours of Admission:

1. A staff member shall introduce him/herself to the patient and welcome him/her to RCA program. Staff shall ask if there are any pressing issues that need immediate attention, such as contacting an employer or family member, assisting with legal issues, etc.

2. Nursing will complete a nursing assessment upon admission.

Within 72 hours of Admission:

1. Patient will meet with his/her primary care counselor.

2. Review the face sheet and admission information for demographics, referral source protocol and check on special needs. If there are any question regarding this information, ask the Admissions Department.

3. Staff will complete biopsychosocial assessment.

4. Issue the patient an assignment – be creative and focus on the patient's individual needs. This can be a workbook that addresses the patient's primary issues, such as relapse history, co-occurring treatment or other individual treatments needs.

5. Discuss with the patient his or her living situation – find out if the patient will return home and if the home is sober, safe and supportive. Also, find out if the patient has a positive support group and which family members and friends will be involved in the patient's treatment and attend the family program.

Within 5 days of Admission:

1. Review the nursing assessment and biopsychosocial.

DRAFT

2. Develop clinical formulation utilizing the assessments completed and information obtained from initial session with patient.

3. After obtaining a release of information from the patient, contact family members and invite them to participate in the Family Program. Explain the benefits and the necessity of their participation and highly encourage their attendance. Document this phone call in a progress note.

4. Set up a family therapy session and have a firm appointment date and time or the first family therapy session. Make every effort to hold the session during working hours where there are no other schedule activities that you are involved in (group therapy, lecture, etc).

5. If the patient is using a controlled substance that is being prescribed by a medical provider, obtain release for provider. Part of treatment process is to ensure collaboration with medical provider to inform them that patient is in treatment for substance abuse. Document in progress note.

6. Contact the referral source. Thank them for the referral and ask them what is requested in terms of frequency of contact during the patient's length of stay, updates on progress and thoughts on aftercare. Document this in the progress notes headed under Referral Contact.

7. Determine an appropriate, tentative length of stay and an initial aftercare plan, including type and mode of continuing care, whether it be IOP, partial, halfway house, etc. If there are any questions regarding the length of stay, consult with the treatment team.

<u>Within 7 days of Admission:</u>

1. Develop a Treatment plan with the patient's input and ensure the treatment plan is individualized for each patient. Make sure that mental health issues are explained and documented in the treatment plan if applicable.

2. Review the treatment plan with the patient and obtain his/her signature on the treatment plan. Explain the objectives, issues, goals and how these will be accomplished. Make sure the patient is aware that there will be a continuing care plan, revised with aftercare, for him/her upon discharge.

3. Present the patient to Case Conference and identify their major issues, progress, estimated length of stay and aftercare plan. Document this in the Case Conference in the patient's chart.

APPROVED: _____ **DATE:** _____

Supersedes All Previous Policy Page **1** of **2**
Dated: 1/2015 **No. 4300.001**
Revised:
SUBJECT: Utilization Review & Continued Stay Procedure

DRAFT

Department Responsible: Utilization Review
Related Department(s): Clinical Services, Medical Services, Nursing

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PURPOSE:

To provide a review of all patient records to justify admission and continued stay to RCA programs and assure continuous financial coverage. To comply with the regulations of all commercial insurance companies that requires pre-admission authorization and continued stay review. To communicate changes in a patient's level of care to payors and assure accurate payment.

POLICY:

The Utilization Review Department is responsible for the continuous financial coverage of all patients admitted to RCA programs, by a systematic review and the abstracting of pertinent information in the medical record to justify treatment. The Utilization Review Department is responsible for communicating patient information to all insurance companies and/or their contractual agencies requiring pre-admission authorization and continued stay review.

DEFINITIONS:

Length of Stay (LOS) - the number of days a patient is expected to stay in a program based on each patient's specific medical, psychiatric, and psycho-social condition assessed at admission and during treatment.

Continued Stay Reviews - a process conducted by the Utilization Review Department at least every 7-10 days, unless otherwise indicated, to assess the need for continued treatment, based on each patient's need and progress in treatment.

PROCEDURES:

1. Information regarding patients admitted to the program is obtained from the Admission Department and the HealthCare Information System (HIS).

2. Within 72 hours from admission the Utilization Review Department will review the patient's admission record and insurance benefits.

3. The Utilization Review Department will enter the initial length of stay (LOS) into the HealthCare Information System based on the admitting diagnosis, pre-authorization information and insurance benefits.

4. The Utilization Reviewer will schedule a review for 2 to 3 days prior to the expiration of the last covered day.

5. The Utilization Review Department notifies the appropriate treatment team of the initial LOS and first scheduled review date.

6. The Utilization Review Department will review all necessary clinical, medical and nursing information in the HIS to obtain information needed to conduct a continued stay review when

necessary. Refer to *Continued Stay Review Criteria* policy for the criteria for reviews.

7. The Utilization Review Department conducts all continued stay reviews by initiating a phone call to the patient's insurance company or funding source.

8. The Utilization Review Department will provide all necessary clinical, medical and nursing information required to the patient's insurance company or funding source to justify continued stay. The Utilization Review Department will only provide information that is allowed by state and federal confidentiality laws.

9. After continued stay authorization has been obtained, the Utilization Review department updates the HealthCare Information System and notifies the treatment team of the next continued stay review date. This process continues until patient is ready for discharge.

APPROVED: _____ **DATE:** _____

Supersedes All Previous Policy
Dated: 10/2014 **No. 4300.002**
Revised:
SUBJECT: Continues Stay Criteria

Department Responsible: Utilization Review
Related Department(s): Clinical, Medical, Nursing

DRAFT

PURPOSE:

To establish a patient meets criteria before a continued stay review is conducted the inpatient program.

POLICY:

A patient is considered eligible for continued stay in an inpatient program when he/she meets the criteria in Section A (below), and also meets the conditions in at least one of the categories listed under Section B (below), for the respective levels of care.

DEFINITIONS: N/A

PROCEDURES:

Inpatient Detoxification Continued Stay

1. Section A
    a. Diagnosis of alcohol and/or drug dependence as per admission criteria . May also be accompanied by a psychiatric diagnosis.

2. Section B
    a. Patient continues to exhibit acute alcohol/drug withdrawal symptoms requiring:
        i. Skilled Observation
        ii. Aggressive Medication Management
        iii. Therapeutic Milieu
        iv. Therapeutic Supervision

Inpatient Rehabilitation Continued Stay

1. Section A
    a. Diagnosis of alcohol and/or drug dependence as per admission criteria.

2. Section B
    a. Patient recognizes the severity of the alcohol or drug problem but shows little to minimal insight and judgment on how to handle this problem.
    b. Patient does not demonstrate behaviors that s/he has developed enough problem-solving skills necessary to cope with the problem. Psychiatric or medical complications that remain unstable requiring the need for aggressive medication management and one to one psychotherapy.

3. The patient lacks the ability physically or emotionally to obtain treatment at a lower level of care.

Supersedes All Previous Policy
Dated: 10/2014
Revised:
SUBJECT: Continues Stay Criteria

DRAFT

Department Responsible: Utilization Review
Related Department(s): Clinical, Medical, Nursing

APPROVED: _____ **DATE:** _____

EXHIBIT 10

RECOVERY CENTERS OF AMERICA
610.239.6100
2701 Renaissance Boulevard, Fourth Floor
King of Prussia, Pennsylvania 19406

REFERRAL AGREEMENT

The undersigned acknowledges that a reciprocal agreement has been established between Recovery Centers of America (RCA) and CARE Consultants Treatment Center. CARE Consultants Treatment Center agrees to receive referrals from RCA for emergency, medical, addiction and/or psychiatric care 24 hours a day, 7 days a week.
This agreement is for all RCA program locations that are checked below.

- [x] ***Recovery Centers of America***
  11100 Billingsley Rd
  Waldorf, MD
- [ ] ***Recovery Centers of America***
  4620 Melwood Rd
  Upper Marlboro, MD 20772
- [ ] ***Recovery Centers of America***
  201 Wye Woods Way
  Queenstown, MD 21658
- [ ] ***Recovery Centers of America***
  314 Grove Neck Rd
  Earlville, MD 21919
- [ ] ***Recovery Centers of America***
  11000 Mattaponi Rd
  Upper Marlboro, MD 20772
- [ ] ***Recovery Centers of America***
  600 Aspen Lane
  Queenstown, MD 21658

RCA provides comprehensive addiction treatment and dual diagnosis services. RCA programs provide for inpatient detoxification, inpatient rehabilitation, partial hospitalization and outpatient services.
Both Parties agree to refer appropriate patients in accordance with program policy and procedures and to abide by federal, state and county standards dealing with the confidentiality of patient information. Any information needed for continuity of care will be furnished upon request provided that all confidentiality requirements have been met. In addition, it is understood that patients appropriate for admission shall be treated without regard to race, religion, sex, sexual preference, national origin, or physical disability.
Nothing in this agreement shall be construed as limiting the rights of either party to enter into similar agreements with any other facility. This agreement may be terminated by either party within 30 days of written notice to the other. This agreement becomes effective on the date signed below and will remain in effect for two years unless terminated in writing by either party.

RCA

SIGNATURE

Chief Clinical Officer
TITLE

DATE 3/2/15

REFERRAL AGENCY

Reginald V. Adams, CACII-LPC
SIGNATURE

President/CEO
TITLE

DATE March 2, 2015

EXHIBIT 11

RECOVERY CENTERS OF AMERICA
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DRAFT ADDICTION SEVERITY INDEX (ASI)
TRAINING AGENDA

DAY ONE

9:00 - 10:30 Purpose of Outcome/Evaluation Studies
Introduction to the ASI/Use of the ASI
1. Clinical Utility
   - Intake/Assessment/Psychosocial
   - Treatment Plan Development
2. Research Purposes
   - Descriptive Studies/Follow-up Studies
   - Norms Development
   - Severity Ratings vs. Composite Scores
3. Strengths and Limitations
   - Use with Special Populations
   - Format

10:45 - 12:00 Introduction and General Coding Instructions for ASI
ASI Introduction
ASI General Information Section
ASI Medical Status Section
ASI Coding Exercise and Vignettes for General Information & Medical

12:00 Lunch

1:00 - 4:00
ASI Employment/Support Section
ASI Coding Exercise and Vignettes for Employment/Support Section
ASI Drug & Alcohol Sections
ASI Coding Exercise and Vignettes for Drug & Alcohol Sections

DAY TWO

9:00 - 10:30 Legal Section
ASI Coding Exercise and Vignettes for Legal Section

10:45-12:00 Family History Section
Family/Social Section
ASI Coding Exercise and Vignettes for Family/Social Section

12:00 Lunch

1:00-2:00 Psychiatric Section
ASI Coding Exercise and Vignettes for Psychiatric Section

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2:15-3:30	Fifth Edition Article Role Play
3:30-4:00	Conclusion

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DRAFT MOTIVATIONAL INTERVIEWING TRAINING AGENDA

DAY ONE

8:00 – 8:30 AM	Welcome, Introductions, and Training Overview
	Pre-Test
8:30 - 10:00 AM	Introduction to Motivational Interviewing
	Definition, Spirit and Principles
10:00 – 10:15 AM	Break
10:15 – 11:30 AM	Stages of Change
11:30 - 12:30 PM	Lunch
12:30 – 2:30 PM	Fundamental Skills: Open-ended Questions, Affirmations, and Reflections
	Role-play exercises
2:30 – 2:45 PM	Break
2:45 – 4:00 PM	Reflective Listening
	Role-play exercises
4:00 – 4:30 PM	Day One Recap and Conclusion

DAY TWO

8:00 – 8:30 AM	Review from Day One
8:30 - 10:00 AM	Identifying and Eliciting Change Talk
10:00 – 10:15 AM	Break
10:15 – 12:00 AM	Change Talk – Role-play/Group Work
12:00 - 1:00 PM	Lunch
1:00 – 3:15 PM	Handling Resistance
	Role-play exercises
3:00 – 3:15 PM	Break
3:15 – 4:00 PM	Successful Implementation & Fidelity Measures
4:00 - 4:30 PM	Day Two Recap and Conclusions
	Post-Test & Training Evaluations

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DRAFT ONBOARDING TRAINING AGENDA

DAY ONE

- Mission and Philosophy
  - RCA History
  - "The Why"
- Patient Rights
- Confidentiality
- Employee Personal Safety
  - De-escalation techniques
- RCA Code of Ethics
- HIPAA
  - Notice of Health Information Practices
- Diversity/Cultural Awareness
- Incident Reporting
  - Reporting System
  - Patient or Employee Accident/Injury
- Customer Service
  - Patient Satisfaction measures
  - Referral Satisfaction measures
  - Effective Communication

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DRAFT ONBOARDING TRAINING AGENDA

DAY TWO

- Fire Safety & Prevention
  - Fire Extinguisher Types and Use
  - Fire Drills
  - Facility Health and Safety Officers
    - Fire Safety Competency Measure
- Emergency Preparedness
  - Natural Disasters (Severe Weather, Flood, Earthquakes, etc)
  - Power Outage, Workplace Violence, Bomb Threat
  - Evacuation Procedures
- Suicide Precautions
  - Suicide Risk Assessments
- Use of Hazardous Chemicals
  - Material Safety Data Sheets (MSDS)
- Infection Control, Communicable Diseases, Bloodborne Pathogens
  - Universal Precautions
    - Personal Protective Equipment (PPE)
    - Hand Washing and Sanitizing
    - HIV, Hepatitis B, C

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DRAFT Clinical Training in Evidence Based Practices

Curriculum	Topic	Training Length	Brief Description
Addiction Severity Index (ASI)	Assessment	16 Hours	Intesive training on the ASI with a focus on how to ask questions in a way that elicits the most valid data. Individual comprehensive assessment/biopsychosocial. Looks at 7 critical life areas: medical, employment/support, drug use, alcohol use, legal, family/social, and psychiatric. Includes most TEDS items. Training involves fidelity measures.
ASAM Placement Patient Criteria	Assessment	4 Hours	The American Society of Addiction Medicine Patient Placement Criteria 2R is the most widely used and comprehensive set of guidelines for placement, continued stay and discharge of patients with addiction disorders.
Cognitive Behavioral Therapy	Techniques	16 Hours	Cognitive behavioral therapy (CBT) is a form of treatment that focuses on examining the relationships between thoughts, feelings and behaviors. By exploring patterns of thinking that lead to self-destructive actions and the beliefs that direct these thoughts, people with mental illness can modify their patterns of thinking to improve coping.
Dialectical Behavior Therapy	Techniques	24 Hours	Dialectal behavior therapy (DBT) was invented by Marsha Linehan, a psychologist who modified traditional cognitive behavioral therapy (CBT) for the treatment of chronically suicidal and self-injurious individuals with borderline personality disorder (BPD). As part of the skills-based element of DBT, emphasis is often placed on the development of mindfulness practice and other relaxation techniques. Through this practice, an individual develops the ability to accept distressing thoughts without self-criticism and to tolerate self-destructive urges (e.g., the desire to cut oneself) without acting upon them. Deep breathing and progressive muscle relaxation are examples of specific mindfulness techniques.
Helping Women Recover	Women-focused	16 Hours	Helping Women Recover (HWR) is a manualized, 17-session, gender-responsive curriculum for women with substance use disorders and co-occurring trauma histories. Topics include relationships, sexuality, and family of origin. Sessions run 90 minutes each.
Motivational Interviewing	Techniques	16 Hours	Motivational Interviewing is a goal-oriented, client-centered counseling style for facilitating behavior change by helping clients to resolve ambivalence across a range of problematic behaviors. Usually delivered in individual sessions but can be applied in groups by experienced facilitator.
NIDA/TRI RoadMap (Relapse Prevention)	Relapse Prevention	4 Hours	Uses DVDs, worksheets, and other interactive materials to teach Relapse Prevention through coping with craving, making alternate plans, drug refusal skills and other activities.
Seeking Safety	Trauma-Informed	16 Hours	Seeking Safety has a minimal 3-session, basic safety oriented, manualized cognitive-behavioral therapy (CBT) curriculum for clients with a history of trauma and substance use disorders (SUDs). Each session is 60-90 minutes, delivered in group or individually or in group.
TCU Building Social Networks	Recovery Support	2 Hours	A 3-topic curricula focused on Social Networks and Support groups in recovery as well as dealing with family members who use. Has worksheets specific to 12-Step groups and others.
TCU Getting Motivated to Change	Engagement and Motivation	3 Hours	Getting Motivated to Change includes 4 topics focused on exploring the meaning of motivation and ways in which clients can develop it and put it into action. It uses a strength-based perspective and encourages participants to identify goals on which they are willing to work. Sections of the manual include Motivation 101 Introduction, Art of Self-Motivation, Staying Motivated, and Making Motivation Second Nature. They can be administered over 4-8 sessions (60-90 minutes each).
TCU Mapping Enhanced Counseling System (Mappers Dozen)	Techniques	2 Hours	The basic and introductory evidence-based TCU mapping program includes the "Mappers Dozen" - 15 maps to be used in veraious sessions when appropriate (60-90 minutes each), focusing on Road Maps (getting here to there), Decisional Maps, Strength Maps, Planning Maps, Outcomes Maps and Relationship Maps.
TCU Mapping the Treatment Journey	Engagement and Motivation	2 Hours	Evidence-based TCU mapping program includes 8 sets of maps to be used over 8-16 sessions (60-90 minutes each),designed to explore important parts and enhance involvement in the treatment journey.

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DRAFT Clinical Training in Evidence Based Practices

Curriculum	Topic	Training Length	Brief Description
TCU Mapping Your 12 Steps	Recovery Support	2 Hours	Mapping Your 12 Steps is a great introduction to the 12 Step concepts, Traditions, the Serentify Prayer and how to apply this in recovery. Sessions include 12 Steps, 12 Traditions, the Serenity Prayer, and 10 Slogans delivered in 12 to 22 in 1-hour sessions depending upon the sessions selected.
TCU Mapping Your Treatment Plan	Engagement and Motivation	2 Hours	Mapping Your Treatment Plan includes 3 topics with didactics and maps that could be spread out over 6-9 sessions, best delivered in the first month of treatment. The focus is on behaviors that led the client to treatment, the areas of life impacted, what they want to change and their goals and specific actions needed to make those changes.
TCU Partners in Parenting	Family	8 Hours	Parents in Partnering is an evidence-based 8-sessions curricula designed for delivery in 2-hour groups over the course of 8 weeks. The focus is on concepts important for parenting effectiveness such as communication skills, guidance techniques, and positive discipline strategies. The emphasis is on building skills, providing support, and helping parents understand the needs and abilities of children during different stages of development.
TCU Straight Ahead: Transition Skills for Recovery	Relapse Prevention	6 Hours	Straight Ahead is a 10-topic, closed (sequential session) program. Can be done in 10 2-hour sessions or 20 1-hour sessions, ideally with 5-7 participants. It focuses on relapse prevention, allowing the client to establish his or her own support system for recovery maintenance.
TCU Unlock Your Thinking, Open Your Mind	Recovery Support	3 Hours	Unlocking your thinking covers 3 topics areas (Feelings, Thoughts, and Mind Traps; Roadblocks to Healthy Thinking; and Thinking and Behavior Cycles) with didactics, worksheets, maps, and group discussion questions that can be divided into 3-12 sessions. Participants are introduced to how to identify the difference btween what they are feeling and thinking, how feeling-based distortions can get in the waty of productive communications, common thinking patterns that lead to frustration, distortion, and avoidance of personal responsibility, and how the use of thinking errorsa (cognitive distortions) can interfere with healthy relationships.
TCU/MATRIX Ideas for Better Communication	Recovery Support	2 Hours	Ideas for Better Communication is a solution-focused or strengths-based curricula covering four components: Communication Roadblocks, Repairing Relationships, Communication Styles, Communication Mapping. It can be delivered in 3-8 sessions ranging from 1 to 2 hours.
TCU/MATRIX Understanding and Reducing Angry Feelings	Anger Management	2 Hours	Understanding and Reducing Angry Feelings teaches clients appropriate ways to manage anger so they are more capable of coping with the reality of their situation. It includes four group topics that can be done over 8-16 sessions, each lasting 45-90 minutes. Topics include Understanding Anger, Anger & Relationships, Mapping, Emotions, Problems with People.
TRI Open Doorways (12-Step Facilitation)	Recovery Support	4 Hours	The TRI Open Doorways Toolkit addresses 12-Step groups. The manualized groups curriculum covers the history of 12-step groups, common misconceptions and concerns for clients new to recovery support. The toolkit includes posters and easy to use handouts with step-by-step instructions.

DRAFT RCA Clinical Training Plan

	Training Week 1					Training Week 2					Training Week 3					Training Week 4					
	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri	Mon	Tue	Wed	Thu	Fri	Clinical Staff
	1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	All RCA Staff
ASI on EMR (2 Days) (ALL) Contract Trainer																					Program opens for patients.
Treatment Planning, Notes, Discharge on EMR (1 day) (ALL) RCA Training Team & IT Dept Trainer																					
Motivational Interviewing (2 days) (ALL) Contract Trainer																					
Relapse Prevention, 12-Step Facilitation, TCU Intro (1 day) (ALL) RCA Training Team																					
Psychodrama for All Staff (1 day) (ALL) Contract Trainer																					
Psychodrama for Therapists (2 days) (Primary Therapists) Contract Trainer																					
TCU/TRI Toolkits (2 days) RCA Training Team																					
ASAM (8 hrs) RCA Training Team																					
Dialectical Behavioral Therapy (DBT) (3 Days) (All Clinical) Contract Trainer																					
Trauma Informed Care (Seeking Safety) (2 Days) (All Clinical) Contract Trainer																					
Cognitive Behavioral Therapy (2 days) (All Clinical) RCA Training Team																					
Clinical Boundaries, Stages of Change, Terminology, RCA Clinical Values (1 Day) (ALL Staff) RCA Training Team																					
Clinical Supervision (Clinical Director, Supervisors) RCA Training Team																					
HR Trainings (All Staff) RCA HR Dept Topics Include: RCA Mission and Philosophy, Patient Rights, Confidentiality, Patient or Employee Accident/Injury, Employee Personal Safety, Ethics, HIPAA, Diversity/Cultural Awareness, Incident Reporting, Customer Service, Medication Management, Fire Safety & Prevention, Emergency Evacuation Procedures, Suicide Precautions, Use of Hazardous Chemicals, Infection Control, Communicable Diseases, Blood-borne Pathogens.																					
Residential Campus Go Live																					

EXHIBIT 12

Supersedes All Previous Policy Page **1** of **8**
Dated: 1/2015 **No. 5200.001**
Revised:
SUBJECT: Detox Treatment Protocols

Department Responsible: Nursing, Medical
Related Department(s): n/a

DRAFT

PURPOSE:

To define the protocol for patients admitted for detoxification from drugs and alcohol.

POLICY:

All patients who have symptomatic withdrawal from drugs and alcohol are treated with a prescribed detoxification protocol related to the substance that was abused.

DEFINITIONS AND RESPONSIBILITY:

Buprenorphine – A synthetic narcotic with both antagonist and agonist properties. It will be administered in its oral form, which is currently marketed as *Subutex*.

Buprenorphine/Naloxone – This combination consists of buprenorphine as described above combined with naloxone, which is a pure opiate antagonist. This medication is marketed under the trade name of *Suboxone*. The purpose for this medication combination is to prevent unauthorized IV injection of the medication. If injected, the naloxone contained in the compound would produce an instant narcotic antagonist effect and the patient would feel significant levels of withdrawal. Taken orally, the naloxone component of this medication has no effect.

SCOPE AND RESPONSIBILITY:

The physician or physician assistant prescribes the medical detoxification protocol and the Nursing staff carries out these orders.

PROCEDURES:

1. Physician or physician assistant is to follow all protocols listed in this policy.

2. All protocols are to be ordered utilizing the Electronic Healthcare System.

3. A thorough History and Physical Examination is be completed on all patients upon admission. An attempt must be made to obtain a complete medical and addiction history from the patient, regardless of their state of intoxication or withdrawal. History from significant others should be obtained, if available. A thorough physical exam is mandatory in all cases except when a patient is combative.

4. Chemically dependent patients frequently present with known or unknown co-existing medical or psychiatric illnesses that need to be identified early in treatment. Simply assuming the patient's presenting clinical status is solely due to their current state of intoxication or withdrawal is unacceptable and may result in complications.

I. ROUTINE LAB ORDERS

1. CBC w/Differential
2. Complete Metabolic Profile
3. RPR
4. Urinalysis/Urine Drug Screen
5. ECG - if clinically indicated
6. Chest x-ray - if clinically indicated. A chest x-ray should be obtained on all HIV patients and patients with a history of positive PPD.
7. PPD - intermediate strength (Mantoux) - if negative in the past. A PPD is not necessary if a patient has written documentation of a negative PPD within one month of admission.
8. Urine pregnancy test - on any woman of child bearing age and capacity.
9. HIV testing – Will be completed if the patient agrees. A signed consent form must be completed by the nurse or the laboratory.

II. ALCOHOL DETOXIFICATION

A. In cases No significant withdrawal symptomatology present - vital signs stable, no coarse tremors, no hallucinations, no history of seizures.

   a. Monitor vital signs q shift or more frequently if indicated.

   b. When the patient presents in an intoxicated state, it is best to continue assessing until the patient has begun to demonstrate withdrawal symptomatology. During the initial phase of treatment, observe these patients closely for progressive obtundation and evolving coma.

   c. Thiamine 50-100mg p.o. or IM

   d. Diazepam 5-10mg p.o. q 4-6h if indicated. Diazepam is not usually indicated when the patient is intoxicated but should be started if and when withdrawal symptoms appear. Since it is difficult to predict the degree of withdrawal symptomatology a patient will exhibit, consider a prn order initially. Once stabilized with benzodiazepines, a tapering dosage can be initiated with a prn benzodiazepine order for breakthrough withdrawal signs and symptoms. Chlordiazepoxide may also be used in place of diazepam. Lorazepam or oxazepam should be considered in the elderly patient or those patients

with hepatic impairment. Short acting benzodiazepines should be tapered more slowly than the longer acting benzodiazepines to prevent a rebound in withdrawal symptoms and complications.

e. Most texts do not recommend the routine use of phenytoin. However, consider phenytoin if the past history of seizures are not clearly withdrawal related or have occurred several weeks after cessation of alcohol intake. If patient has a positive seizure history that requires phenytoin, and the patient has been non-compliant, it is suggested to then give loading dose of 300mg p.o. stat, and repeat q 4h x 2. Then give 100mg p.o. tid-qid starting the following day. Check phenytoin level in 3-4 days. The loading dosage must be used with caution if the patient has liver or renal disease.

f. Provide B-Complex and/or multi-vitamins if clinically indicated.

g. Folic Acid, 1mg p.o. once daily if peripheral neuropathy is suspected.

B. In cases where significant withdrawal symptomatology is present - elevated temperature, blood pressure and pulse, marked tremors of hands/tongue, confusion, agitation, hallucinations, diaphoresis, seizures, insomnia.

a. Vital signs q 1/2h until stable.

b. Stat CBC, Lytes, FBS, BUN, Creatinine, Urinalysis

c. Thiamine 100mg IM

d. ECG

e. Diazepam 10-20mg p.o. q 1h prn until stable. Use lorazepam 1-2mg q 4-8h in older patients or in presence of marked hepatic impairment. If parenteral benzodiazepines are indicated, lorazepam may be given IM, whereas diazepam IM should be avoided due to erratic absorption. Lorazepam IM is probably the drug of choice in initial treatment of significantly advanced delirium tremens.

f. If patient's in acute delirium tremens the patient should be transferred to an acute care hospital or treatment.

g. If IV's are utilized, give Thiamine prior to administration of glucose.

h. If pulse or blood pressure is persistently elevated, consider utilizing a beta-blocker if there are no pulmonary or cardiac contraindications. Atenolol 50mg once daily, a beta-1 selective blocker, appears to work well. Clonidine has also been utilized in alcohol withdrawal. However, there is no evidence indicating that these drugs will prevent seizures or DT's. In fact, use of the above such medications may mask impending

withdrawal seizures or delirium tremens. Thus, these medications should be used cautiously.

III. **SEDATIVES DETOXIICATION**

A. Withdrawal signs present (tremulousness, anxiety, insomnia, anorexia, nausea and vomiting, tendon hyper-reflexia, diaphoresis, orthostatic hypotension, seizures, delirium)

a. If symptoms are mild, quantify addiction (amount used daily); then establish Phenobarbital equivalent from data below.

i. Phenobarbital 30mg = amobarbital 100mg, pentobarbital 100mg, secobarbital 100mg, chloral hydrate 500mg, ethchlorvynal 350mg, glutenthamide 250mg, meprobamate 400-600mg, methaqualone 250-300mg, butabarbital 60mg.

ii. In no case should the daily Phenobarbital dosage exceed 600mg/day.

iii. Once patient appears stabilized x2 days, decrease dose by 30mg/day.

iv. If patient appears intoxicated, secondary to Phenobarbital, (ataxia, slurred speech, nystagmus), then you may need to recalculate daily dose.

v. Avoid daily decrease if withdrawal symptoms appear.

b. If symptoms moderate to severe, or level of addiction is unclear, may use Pentobarbital challenge technique:

i. Give 200mg Pentobarbital and examine patient in one hour.

1. If patient is asleep, then tolerance is doubtful and there is a questionable need for detox
2. If patient appears intoxicated (slurring of speech,nystagmus, ataxia), start with 125mg to 220mg of Phenobarbital/day
3. If patient is comfortable (only fine nystagmus), start with 250mg of Phenobarbital/day
4. If Pentobarbital has no effect or patient still appears to be in withdrawal, start with an increased dose. If using Phenobarbital in acute withdrawal, may want to give initial dose IM

ii. Once starting dose is determined, stabilize and then decrease daily and continue to monitor and assess.

B. If no withdrawal symptoms present, may want to use 200mg Pentobarbital challenge to establish addiction.

IV. BENZODIAZEPINES WITHDRAWAL

If patient is dependent upon benzodiazepines, he/she is easily detoxified with other benzodiazepines. Ideally, one should use a long acting benzodiazepine unless medical indications warrant a shorter acting benzodiazepine. If possible, it is best to use a different benzodiazepine than the patient's drug of choice. Phenobarbital may also be used for benzodiazepine withdrawal.

V. OPIATE DETOXIFICATION

Opiate detoxification may be accomplished by utilizing buprenorphine alone, clonidine alone, methadone alone, or a combination of medications. Below are protocols for opiate detoxification utilizing buprenorphine, clonidine alone and a methadone/clonidine combination. The protocol utilizing buprenorphine is the treatment of choice. However, there may be situations where Methadone or Clonidine alone may be best utilized or preferred by the patient.

Before initiating detox protocols, it is imperative that we establish the presence of opiate dependence. This may be accomplished through historical information, physical findings, and Urine Drug Screen. The state of intoxication or withdrawal needs to be assessed. It is also important to identify any other coexisting drug or alcohol dependencies.

A. BUPRENORPHINE PROTOCOL

1. If the physician determines the presence of an opiate dependency, the option of utilizing buprenorphine for detoxification should discussed with the patient.
2. Should the patient agree to use buprenorphine, informed consent will be obtained
3. The nurse will be responsible for observing the patient taking the sublingual tablet of buprenorphine and making sure it is dissolved.
4. Buprenorphine detoxification will proceed per the detoxification protocol.
5. Subutex will be the first choice or for opiate detoxification
6. Buprenorphine detoxification is not to be initiated until the patient is documented to have signs and symptoms of acute opiate withdrawal and/or a positive UDS.
7. Buprenorphine detoxification must not be initiated until at least 24 hours after the last dosage of methadone or 12 hours after the last dose of heroin/opiates.
8. Benzodiazepines should be avoided as an adjunctive therapy during buprenorphine treatment. However, in cases where patients are in withdrawal from both opiates and benzodiazepines, benzodiazepines should be used with caution
9. Suggested buprenorphine dosages follow:
10.

High Dose – Buprenorphine tab Protocol (given 24+hours after last reported use)		
Day 1	8 mg SL	administer Q daily, then
Day 2	6 mg SL	administer Q daily, then
Day 3	6 mg SL	administer Q daily, then
Day 4	4 mg SL	administer Q daily, then
Day 5	4 mgSL	administer Q daily, then
Day 6	2 mg SL	administer Q daily, then
Day 7	2 mgSL	administer Q daily, then
Day 8	2 mg SL	administer Q daily, then d/c

Low Dose - Buprenorphine tab Protocol - Individual (given 24+ hours after last reported use)		
Day 1	8 mg SL	administer Q daily, then
Day 2	6 mg SL	administer Q daily, then
Day 3	4 mg SL	administer Q daily, then
Day 4	2 mg SL	administer Q daily, then
Day 5	2 mg SL	administer Q daily, then d/c

B. METHADONE PROTOCOL

1. The maximum dose of methadone utilized will be 20mg. It will be tapered by 5mg per day. The methadone can be administered in a single daily dose, or the dosage can be administered in two doses.
2. The admitting physician will determine the proper dosage level for a patient. If the admitting physician determining the initial dose is not the attending physician who conducted the History and Physical examination, the attending physician shall consult with the admitting physician who performed the examination before determining the patient's initial dose and schedule.

3. Methadone shall be administered or dispensed in oral form only and shall observed.

4. For patients coming from a methadone maintenance program, they will be advised that they should be tapered down to 20mg before being admitted to our inpatient detoxification program. However, patients not tapered down to 20mg methadone may be considered on a case-by-case basis, with the knowledge that their daily dose of methadone will not exceed 20mg. .

5. The patient will be made aware of his/her dosage schedule of methadone and how it is to be tapered. The patient must also understand that we will not waiver from this protocol unless the patient refuses the methadone, or the patient is experiencing adverse affects

secondary to the methadone. The patient will be advised in the case of emesis, the dosage will not be re-administered and thus the patient should be advised to request an anti-emetic prior to his/her dose of methadone if nausea is present. Methadone should not be initiated until the patient starts to demonstrate signs and symptoms of opiate withdrawal. Do not administer methadone to an intoxicated patient.

6. Specific orders:

    a. Methadone 20mg p.o. daily in single or split dose that decreases by 5mg per day.
    b. Clonidine - As the methadone is decreased, clonidine may be added. A test dose of 0.1mg may be given, and if tolerated, 0.2mg q 4-6h may be utilized. Hold clonidine if blood pressure is less than 90mmHg systolic or 60mmHg diastolic. A Catapres-TTS 1 or 2 may be used in place of, or along with, p.o. clonidine.
    c. Tigan 250mg p.o. q 6h prn or 200 IM q 6h prn for nausea and vomiting.
    d. Bentyl 20mg q 4-6h prn for abdominal cramps
    e. Dalmane or Restoril 15-30mg hs prn
    f. Motrin 600mg q 4h prn / Acetaminophen 650 mg q 6h prn
    g. Vistaril 25-50mg q 4h p.o. or IM prn for agitation
    h. MVI daily
    i. Benzodiazepines may be utilized, but avoid using large dosages in patients nearing completion of the detoxification program.

*C. **CLONIDINE PROTOCOL***

1. Clonidine - Give test dose of 0.1mg, then watch blood pressure. If patient's blood pressure is stable in four hours, may give 0.1-0.2mg p.o. q 4-6h prn or routine. BP checks prior to each dose. Hold clonidine if systolic BP is less than 90-100mmHg, or diastolic BP is less than 60mmHg. However, these are general guidelines. In someone with an elevated blood pressure, you may want to hold the limit somewhat higher and in someone who presents with a low base line blood pressure, the cut-off points could be somewhat lower. Use clonidine with caution if other anti-hypertensive medications or medicines with potentially hypotensive side effects are used cocurrently.

2. Transdermal clonidine (Catapres-TTS) may be utilized for opiate withdrawal. It is best used after the patient has been stabilized with p.o. clonidine and the withdrawal symptoms are beginning to abate. Always advise the patient of the rationale behind the use of clonidine and the side effects, primarily orthostatic hypertension.

3. A benzodiazepine, such as diazepam or oxazepam may be utilized. The dosage will vary from patient to patient, and needs to be titrated as clinical needs indicate.

    a. Trimethobenzamide (Tigan) 250mg p.o. q 6h prn (or 200mg IM q 6h prn) for nausea and vomiting

b. Dicyclomine (Bentyl) 20mg p.o. q 4-6h prn for abdominal cramps
c. Temazepam (Restoril) 15-30mg p.o. hs prn or flurazepam (Delmane) p.o. hs prn x3-5 nights
d. Ibuprofen 400-600mg p.o. q 4-6h prn for arthralgia or myalgia
e. Vitamin supplementation
f. Hydroxyzine pamate 25-50mg p.o. q 4-6h prn for agitation; often appears to be helpful in reducing much of the subjective withdrawal symptomatology of the patient.

4. If the patient is acutely intoxicated, do not initiate treatment until specified withdrawal symptoms begin to emerge.

APPROVED: _____ **DATE:** _____

APPROVED: _____ **DATE:** _____

Supersedes All Previous Policy Page **1** of **4**
Dated: 1/2015 **No. 5200.002**
Revised:
SUBJECT: Nursing Detoxification Procedure

Department Responsible: Nursing, Medical
Related Department(s): All

DRAFT

PURPOSE:

To formalize a set of questions administered at specific intervals and assure that the nursing staff will have frequent individualized interactions with the patient. Frequent intervention with the patient provides reassurance and emotional support during the period when s/he is apprehensive and experiencing both physical and emotional discomfort. Frequent discussions also begin an early teaching process regarding primary symptoms of the disease process. Without the formalized questions, symptoms such as visual or auditory disturbances may go undetected until the progress to an advanced state. Observations relating to the patient's orientation and thought processes may give an early indication of other organic issues or psychosis.

POLICY:

Nursing will follow Detoxification Procedures for all patients to ensure quality care and patient safety and compliance with all State and Federal Regulations. The detoxification process is based on medical protocol and is monitored by Medical Staff. All medical orders are from physicians/physicians assistant and/or a CRNP. Detoxification services are provided by qualified medical and nursing staff at all times, 24 hours, 7 days a week.

DEFINITIONS:
n/a

PROCEDURES:

1. The objectives of following the detoxification procedure is:
    a. To frequently monitor the patient's status during withdrawal period at regular intervals.
    b. To assure appropriate and effective nursing intervention with the patient.
    c. To assign a numerical value to an evaluation of withdrawal, which may indicate progress or deterioration in patient status.
    d. To focus nursing attention on each area of withdrawal symptoms and to assure consistency in evaluation of patient status.
    e. To begin early patient educational regarding primary symptoms of the disease process to assist in self diagnosis.

2. Prior to detoxification protocol, patient undergoes a Nursing Assessment as part of Multi-disciplinary Assessment. This includes patient's medical history, health screening and assessment by a physician/physician assistant or CRNP for medication orders.

3. The detoxification assessment is utilized by the nurse as a tool to evaluate the patient's level of withdrawal from any chemical substance. The assessment is administered at regular intervals which correlate to the severity of the patient's physical withdrawal from chemical substances.

4. The patient is asked a set of questions relating to a variety of symptoms, which may include: gastrointestinal, tactile, visual, auditor disturbances, etc. Numbers are recorded in a column on the Assessment Sheet. The numbers are then totaled and thus provide a numerical basis for determining the status and progress of the patient.

5. The Detoxification Assessment must be completed by a RN or LPN. Assessment includes obtaining vital signs – pulse, temperature and respiration. This is face to face contact with the patient. The patient's vital signs and physiological responses are recorded at the time of the assessment.

6. Nursing Care Plan is completed by nurse and reviewed with patient. This is part of the education process of detoxification protocol with patients. The plan is reviewed continually as patients follow through with detox process.

7. The Detoxification Assessment is to be used routinely on all patients admitted for detoxification from any substance.

8. The assessment is conducted a <u>minimum</u> of every 4 hours and a maximum of every 8 hours while the patient is experiencing acute withdrawal symptoms (i.e. a D/A score >8). The nurse may increase the frequency of the assessment according to patient's needs.

9. Once the acute withdrawal symptoms have subsided, the administration of the assessment may be changed or increased to every 6 hours.

10. As part of assessment procedure, any symptoms of medical distress shall be documented addressed with the physician/physician assistant or CRNP and progress shall be noted.

11. The detoxification assessment may be discontinued when no sedative medications have been used in four consecutive assessments. Nurse must contact the physican/physican assistant or CRNP to receive an order to advance the patient to rehab. The phsycian/physician assistant or CRNP must review the patient's physical status prior writing the order to advance to rehab status.

12. Once the order is written, all detoxification medications are discontinued. Once patient is advanced from detox to rehab status, patients are considered for inpatient rehab or aftercare outside the facility where deemed appropriate for the Treatment Team. The patient's primary counselor is responsible for aftercare arrangements and for providing information regarding importance of further treatment past detoxification.

13. When the physician orders a specific frequency for detoxification assessments, a physician's/CRNP order is required to reduce or discontinue the frequency.

14. Scoring the assessment:

    a. Following the patient's response to the designated questions, the nurse will enter the appropriate score on the assessment. See scoring sheets in HER for scoring appropriately.
    b. Add the scores and enter total score on line entitled 'Total".
    c. Enter medications given to the patient for detoxification regimen on the detoxification medications section of the assessment.
    d. No schedule II, III, or IV medications may be given for a detoxification score of less than eight.
    e. The nurse must reassess the patient within one hour following administration of medication. The nurse will assess the patient's response to medication, determine the need for additional medication and document same.

15. Detoxification Protocols - Appropriate Detoxification Protocol is determined by physician/physician assistant/CRNP based on the assessment and drug and alcohol use.

    1. Patients protocols will be determined utilizing a combination of the following factors:
        a. History of prior difficult withdrawal, including: DT's, severe shakes, hallucinations, seizures
        b. History of long-term, heavy drinking or drug use
        c. Clinical presentation of patient at the time of admission – assessment of physical appearance – flushing, tremulousness, anxiety, and agitation – and vital signs
        d. History of prior AMA
        e. BAL greater the .25 on admission

    2. Medications:
        a. Buprenorphine – as prescribed per protocols
        b. Phenobarbital – as prescribed
        c. Serax - as prescribed
        d. Thiamine – as prescribed
        e. Phenergan - as prescribed
        f. Robaxin – as prescribed
        g. Motrin – as prescribed
        h. Bentyl – as prescribed
        i. Trazadone – as prescribed
        j. Catapres – as prescribed
        k. Multivitamins - as prescribed
        l. Tylenol - as prescribed
        m. Amphogel - as prescribed
        n. Vistoril - as prescribed
        o. Folate - as prescribed
        p. Pepto Bismol – as prescribed

q. Klonopin – as prescribed
r. Robitussin – as prescribed
s. Claritin – as prescribed
t. Mucinex – as prescribed
u. Milk of Mag – as prescribed
v. Fluids are encouraged

3. Detoxification will usually be completed in 3 – 5 days but may be prolonged based on the severity of the symptoms.

4. Detoxification protocol for opiate addicts is decided by Medical Staff.

5. Catapres is used to control the cramping, diarrhea, bone, aches, rhinorrhea, muscle spasms, etc or opiate withdrawal. It will not affect the restlessness, anxiety, or sleeplessness of opiate withdrawal. Phenobarbital and/or Serax are used to address these symptoms. Although the two drugs have a synergistic effect on lowering blood pressure and causing drowsiness, they are safe to administer simultaneously, the blood pressure being the limiting factor.

6. Patients may appear to be drug seeking. This is a symptom of withdrawal and should be addresses appropriately.

APPROVED: _____ **DATE:** _____

APPROVED: _____ **DATE:** _____

Supersedes All Previous Policy
Dated: 1/2015 **No. 5200.003**
Revised:
SUBJECT: Detox Assessment – Alcohol

DRAFT

Department Responsible: Nursing, Medical
Related Department(s): All

PURPOSE:
To provide quality care and safe detox protocol to all patients.

POLICY:
Nursing staff shall follow the Clinical Institute Withdrawal Assessment (CIWA) for detox assessments for patients.

DEFINITIONS: n/a

PROCEDURES:

1. The nurse will utilize the Clinical Institute Withdrawal Assessment (CIWA) to assess patients and document the results of the assessment in the patient record.

2. Nurses will obtain:
   a) Temperature No scoring
   b) Blood Pressure No scoring
   c) Respirations No scoring

3. Nurse will obtain Pulse
   a) 0-80 0
   b) 81-100 1
   c) 101-120 2
   d) Above 120 4

4. Nurses will score for Eating Disturbance
   a) Able to eat with no nausea 0
   b) Ate some and/or some nausea and vomiting 3-4
   c) Not able to eat/severe nausea and vomiting 7

5. Nurses will score for Tremor
   a) No tremor 0
   b) Tremor not visible but palpable 1
   c) Moderate degree of visible tremor with arms extended 2
   d) Severe tremor even when arms not extended 4

6. Nurses will score for Paroxysmal Sweats
   a) No sweating visible 0
   b) Mild sweating/moist palms 1
   c) Beads of sweat obvious on forehead 4

d) Drenching sweat 7

7. Nurses will score for Anxiety and Agitation
   a) No anxiety, at ease 0
   b) Moderate anxiety, fidgety or restless 4
   c) Pacing, near panic degree of anxiety 7

8. Nurses will score for Hallucinations
   a) No auditory, tactile or visual hallucinations 0
   b) Mild auditory hallucinations 1
   c) Moderately severe AH, VH or TH 4
   d) Grossly psychotic with constant hallucinations 7

9. Nurses will score for Orientation and clouding of sensory
   a) Oriented X3 and no clouding 0
   b) Uncertain of exact day or date but sensory/cognition intact 1
   c) Disoriented to date by no more than 2 calendar days 2
   d) Disoriented to date by more than 2 calendar days and/or mild confusion evident 3
   e) Moderately confused and also disoriented to place and/or person 4

** No medication shall be given for detox scores that are LESS than 10 **

APPROVED: _____ **DATE:** _____

APPROVED: _____ **DATE:** _____

Supersedes All Previous Policy
Dated: 1/2015 **No. 5200.004**
Revised:
SUBJECT: Detox Assessment – Opiates

Department Responsible: Nursing, Medical
Related Department(s): All

DRAFT

PURPOSE:
To provide quality care and safe detox protocol to all patients.

POLICY:
Nursing staff shall follow the scale listed below when making detox assessments for patients.

DEFINITIONS: n/a

PROCEDURES:

1. The nurse will utilize the Clinical Opiate Withdrawal Scale (COWS) to assess patients and document the results of the assessment in the patient record.

2. Nurses will obtain:
    a) Temperature No scoring
    b) Blood Pressure No scoring
    c) Respirations No scoring
3. Nurse will obtain pulse
    a) 80 = 0
    b) 81-100 = 1
    c) 101-120 = 2
    d) Above 120 = 4

4. Nurse will score for Tremor
    a) No tremor 0
    b) Tremor not visible but palpable 1
    c) Tremors slight 2
    d) Gross tremors 4

5. Nurse will score for Paroxysmal Sweats
    a) No sweating visible 0
    b) Subjective Sweats 1
    c) Flushing of face 3
    d) Beads of sweat on face 4

6. Nurse will score for Anxiety and Agitation
    a) No anxiety, at ease 0
    b) Moderate anxiety, fidgety or restless 1
    c) Obviously irritable 2
    d) Irritability and anxiety to the point of unable to sit still 4

DRAFT

7. Nurse will score for Hallucinations
    a) No auditory, tactile or visual hallucinations 0
    b) Mild auditory hallucinations 1
    c) Moderately severe AH, VH or TH 4

8. Nurse will score for GI Disturbance
    a) None 0
    b) Stomach cramping 1
    c) Nausea /loose stool 2
    d) Vomit /diarrhea 3
    e) Multiple episodes of N/V 5

9. Nurse will score for Muscle spasms / Bone aches
    a) None 0
    b) Mild 1
    c) Intermittent, moderate 2
    d) Severe 4

10. Nurse will score for Piloerection and Pupillary dilation
    a) None 0
    b) Mild 2
    c) Moderate 4
    d) Severe (“turkey skin” or “bug eyed” 7

** No medication shall be given for detox scores that are LESS than 8 **

APPROVED: _____ **DATE:** _____

APPROVED: _____ **DATE:** _____

Supersedes All Previous Policy
Dated: 1/2015 **No. 5200.005**
Revised:
SUBJECT: Detox Withdrawal Symptomatology

DRAFT

Department Responsible: Nursing, Medical
Related Department(s): n/a

PURPOSE:
To provide guidelines for Detox staff in describing withdrawal symptomatology in the nursing notes and progress notes.

DEFINITIONS/EQUIPMENT:
N/A

SCOPE AND RESPONSIBILITY:
The admitting physician or physician assistant will evaluate the level of withdrawal or intoxication a patient is experiencing.

POLICY:
Mild, moderate and severe may be utilized to collectively describe withdrawal signs and symptoms providing the following criteria are used:

1. Mild Withdrawal – Signs/symptoms may be utilized to describe this withdrawal state if the following criteria are met:

    a. alcohol – mild withdrawal will include no more than a fine tremor and anxiety. The vital signs are stable.

    b. opiates– mild withdrawal would include some dilation of the pupils, rhinorrea, and yawning. The patient would complain of malaise and generalized discomfort and would be irritable.

    c. sedatives – mild withdrawal should suggest no more than reported anxiety and some restlessness.

    d. stimulants – mild withdrawal would include fatigue and some irritability.

2. Moderate Withdrawal – signs/symptoms may be utilized to describe this withdrawal state if the following criteria are met:

    a. Alcohol – vital signs will indicate increase in blood pressure and/or pulse. Some nausea and vomiting, tendon hyperrefelxia and

    diaphoresis may be present. A coarse tremor will be present. However, no seizures or hallucinosis are reported or observed.

    b. opiates – positive for mydriasis, lacrimation, increased bowel sounds and piloerection. Symptomatically, the patient would report some nausea, vomiting, general myalgia, arthralgia and anxiety. Marked irritability is present.

c. sedatives – moderate withdrawal would include tremulousness, insomnia, anorexia, nausea, vomiting, tendon hyperreflexia, diaphoresis and orthostatic hypertension.

d. stimulants – positive for significant fatigue, hypersomnia, and irritability.

3. Severe Withdrawal – signs/symptoms may be utilized to describe this withdrawal state if the following criteria are met:

a. alcohol – positive for active hallucinosis and confusion. Seizures appear imminent. The vital signs will be elevated and the patient will be grossly tremulous. The temperature may be elevated as well.

b. opiates – persistent nausea and vomiting is present. The patient complains of marked myalgia, arthralgia and anxiety. The physical signs of moderate withdrawal are present as well. Tachycardia and hypertension may also be observed.

c. sedatives – the physical signs of moderate withdrawal are present. However, at this point the patient may be reporting hallucinosis and impending delirium. Seizures may be observed.

d. stimulants – marked rebound fatigue may be present. The patient reports depression and perhaps suicidal ideation.

APPROVED: _____ **DATE:** _____

APPROVED: _____ **DATE:** _____

EXHIBIT 13

Supersedes All Previous Policy
Dated: 1/2015 **No. 9000.001**
Revised:
SUBJECT: Infection Control

Department Responsible: SIC, Medical, Nursing
Related Department(s): All

DRAFT

PURPOSE:

In order to achieve an infection-free environment, RCA has established a Safety and Infection Control Committee (SIC) and the following policies.

POLICY:

RCA desires to keep the facility as free of infection as is possible.

DEFINITIONS:

Standard Precautions (formerly known as Universal precautions) - an infection control strategy designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection. Standard Precautions synthesize the major features of Universal (Blood and Body Fluid) Precautions (designed to reduce the risk of transmission of bloodborne pathogens) and Body Substance Isolation (designed to reduce the risk of transmission of pathogens from moist body substances) and applies them to all patients regardless of their diagnosis or presumed infection status. Standard Precautions apply to (1) blood, (2) all body fluids, secretions and excretions except sweat, regardless of whether they contain visible blood, (3) non-intact skin, and (4) mucous membranes.

Transmission-based Precautions - used in addition to Standard Precautions for patients known or suspected to be infected by epidemiologically important pathogens spread by airborne or droplet transmission or by contact with dry skin or contaminated surfaces. They include (1) Airborne, (2) Droplet and (3) Contact Precautions. Refer to policy 9000.008 - Isolation Precautions: Transmission Based.

PROCEDURES:

A. **Standard Precautions** – RCA follows the most current guidelines of the Centers for Disease Control and Prevention (CDC) for prevention of disease transmission, modified as needed for the unique needs of the organization. Standard Precautions are used for all patients.

   1. The procedures detailed below were developed utilizing the 2007 CDC publication Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. A link to the complete document can be found on the Intranet. (http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf.)

   2. Standard Precautions are used for the care of all patients. Standard Precautions apply to (1) blood, (2) all body fluids, secretions and excretions except sweat, regardless of whether they contain visible blood, (3) non-intact skin, and (4) mucous membranes.

   3. Handwashing

a. The Centers for Disease Control has determined that hand washing is the single most important means of preventing the spread of infection. The practice of hand washing as an effective means for preventing infection rests on its ability to remove most transient organisms acquired by contamination of the hands. Decontamination of the hands is absolutely essential for prevention and control of nosocomial infection.
b. Correct hand washing includes the following steps:
    i. Wet hands
    ii. Apply liquid soap
    iii. Apply friction for a minimum of 15 seconds following contact with body fluids
    iv. Rinse
    v. Dry with paper towel
    vi. Turn off faucets with paper towel
    vii. Discard towel in trash can
c. Personnel should wash their hands in each of the following situations:
    i. On arrival at work
    ii. Before and after patient care
    iii. After personal use of the toilet
    iv. After blowing or wiping the nose
    v. After handling contaminated materials
    vi. After removing gloves
    vii. Before eating, drinking, smoking, applying cosmetics or handling contact lenses
    viii. Before leaving work
d. Alcohol-based hand sanitizer is available at the nurses' stations and in first aid kits. When hands are visibly soiled, washing with soap and running water is the preferred method. Alcohol-based hand rinses are not effective against C-diff spores or Norovirus. To prevent ingestion, alcohol-based hand sanitizers are not to be made available to patients unless staff supervision is provided.

4. Gloves
    a. Wear clean, non-sterile gloves when touching blood, body fluids, secretions, excretions and contaminated items.
    b. Put on clean gloves just before touching mucous membranes and non-intact skin.
    c. Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms.
    d. Remove gloves promptly after use before touching non-contaminated items and environmental surfaces and before going to another patient and wash hands immediately to avoid transfer of microorganisms to other patients or environments.
    e. Latex gloves may not be washed and reused.
    f. Gloves with cuts or holes should be replaced immediately.
    g. Fingertips may not be cut from gloves for phlebotomy or other procedures. .

5. Masks, eye protection, face shields

a. Wear a mask and eye protection or a face shield to protect mucous membranes of the eyes, nose and mouth during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions.

6. Gowns
    a. Wear a gown (clean, non-sterile) to protect skin and prevent soiling of clothing during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions or cause soiling of clothing.
    b. Select a gown that is appropriate for the activity and amount of fluid likely to be encountered.
    c. Remove a soiled gown as promptly as possible and wash hands to avoid transfer of microorganisms to other patients or environments.

7. Patient-care equipment
    a. Handle used patient-care equipment soiled with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing and transfer of microorganisms to other patients and environments.
    b. Ensure that reusable equipment is not used for the care of another patient until it has been appropriately cleaned and reprocessed and single-use items are properly discarded.

8. Environmental control
    a. Follow established procedures for the routine care, cleaning and disinfection of environmental surfaces, beds, bedrails, bedside equipment and other frequently touched surfaces. See Housekeeping and other department-specific policies.

9. Linen
    a. Handle, transport and process used linen soiled with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing and avoids transfer of microorganisms to other people and environments. See Housekeeping policy.

10. Occupational health and bloodborne pathogens
    a. See Infection Control policies regarding “Occupational Exposure to Bloodborne Pathogens” and “Bloodborne Pathogens Exposure Control Plan”.
    b. Take care to prevent injuries when using needles, lancets, scalpels, and other sharp instruments or devices.
    c. Take care when handling, cleaning or disposing of used needles, lancets or other sharp instruments. Never recap used needles or otherwise manipulate them using both hands.
    d. Place used disposable syringes and needles, lancets and scalpel blades and other sharp items in appropriate puncture-resistant containers.

e. Sharps containers are kept locked in medication rooms, medical offices and the Lab to prevent client access. In medication rooms, the key to the sharps box holder can remain in the lock, provided that the room is secured at all times. The sharps disposal box is to be removed from the holder and transported to the place where the injection will be administered. The person who administers the injection, draws blood or uses the lancet (physician, nurse, lab technician or client) should directly place the item into the sharps container. Uncapped sharps are never to be placed on surfaces, wrapped in tissues or paper towels, or discarded in trash cans.
f. Use mouthpieces, resuscitation bags or other ventilation devices as an alternative to mouth-to-mouth resuscitation methods.

B. **Newly admitted persons** – in order to address the potential hazard of infection of communicable disease being introduced into the patient community by newly admitted patients, the following measures will be observed:
1. Vital signs are taken on admission and whenever deemed necessary based on a patient's presentation.
2. A physical examination is given to each patient within twenty-four hours after admission
3. Laboratory tests performed on each patient on admission may include the following:
    a. Chemzyme profile
    b. CBC
    c. Routine urinalysis
    d. Tine test
    e. Hepatitis B Surface Antigen and Anti-Hepatitis A (Total) for those patients who have abused drugs via the intravenous route and/or have been sexually promiscuous and deemed to have evidence of active disease by the physician.

4. Patient reports are reviewed by the physician/CRNP and appropriate treatment is prescribed by him/her. Reports will be forwarded to the patient's family doctor with the permission of the patient.

C. **Patients residing in the community** – during orientation, the patient is instructed to report any symptoms of illness or infection to the nurse in charge. Procedure to be followed by the symptoms are:
    a. Notification of the physician/CRNP.
    b. Symptomatic treatment with medications when appropriate.
    c. Lab Testing (i.e., CBC, liver studies, cultures, x-rays, etc) as indicated.
    d. Monitoring of vital signs.
    e. Food services chores prohibited.
    f. Documentation of test results, physical examination, treatment and medications are maintained in the patient's chart.
    g. An Infection Report Form is completed monthly and submitted to the OI Coordinator. These reports will be used to generate the monthly report to the Infection Control Committee.

D. **Employees –** new employees receive laboratory test screening and other infection control measures consisting of the following:
   1. Orientation to the importance of infection control, standard universal precautions and personal hygiene and their responsibilities in the program.
   2. Employees' results are reviewed by the physician/CRNP at the facility and copies are given to the employee to give to his/her family physician.
   3. Mantoux test is repeated annually for the duration of employment. Results are maintained in the employee's personnel file.
   4. The supervisor determines fitness for work when an employee has been absent from work due to an illness.
   5. Likewise, annually, an in-service program on infection control is presented for all employees.
   6. Immune Gamma Globulin to staff and/or patients shall be administered when deemed appropriate by the physician/CRNP as a precautionary measure, for example to Hepatitis A.
   7. Influenza vaccine will be offered to those staff who desire it. Hepatitis B vaccine is recommended for all staff but not required or offered.
   8. Follow-up care for a positive tine test is a chest x-ray.
   9. Employees must attend mandatory training regarding infection control upon hire and annually thereafter.

E. **Reporting & Surveillance** - Any suspected communicable disease that is so designated will be reported to the Health Department by the Nursing department or SIC designee.

   1. SIC is charged with developing effective measures to prevent, identify and control infections in conjunction with the Professional Staff. SIC will maintain a liaison with the Quality Improvement Committee and will have the authority to institute any control measures or studies when there is reasonably considered to be danger to any patient or employee.

   2. The committee defines nosocomial infections to provide for uniform identification and reporting of infection to determine trends.

      a. A nosocomial infection is defined as any infection that is diagnosed 48 hours or more after admission.
      b. The diagnosis will be documented in the progress notes and in the discharge diagnosis.
      c. Appropriate cultures and specimens will be taken and sent to the laboratory for diagnosis. Examples include, but not limited to:
         i. Cultures of blood
         ii. Urine
         iii. Pus
         iv. Sputum
         v. Stool
      d. It is recognized that not all nosocomial infections require culture and laboratory diagnosis. Examples include, but not limited to:
         i. Otitis Media

ii. Dermatological Infections
iii. Viral Infections
iv. Conjunctivitis

e. Adjunct laboratory data is obtained as deemed necessary and appropriate. Examples include but are not limited to:
   i. Chest X-ray
   ii. Blood Count
   iii. Urinalysis
f. At risk population is defined as the number of residents with infections divided by the ADC plus the number of admission times 100 for the month.
g. The committee reviews, evaluates and maintains records of cases of infectious disease present in the facility for both patients and staff during the past month and discusses ramifications in these cases. The committee identifies potential sources of infection within the facility and develops preventative surveillance and control procedures relating to the inanimate environment. A member, designated by the committee each month will do a walk-through of the building to look for possible sources of infection such as dirty sinks, anything stored on the floor, dirty aprons, unlabeled containers, etc.
h. The committee evaluates and implements corrective action to eliminate potential sources of infection.
i. The committee provides annual in-service program on infection control for the education of the employees.
j. All cleaning products coming into the facility will be checked by the Safety Director to determine whether they are bacterialcidal or fungicidal and will be helpful to maintain an infection controlled environment.
k. The committee shall review the policies and procedures relating to Infection Control annually.
l. Regular agenda items for the committee shall include: review of infections present, report of walk-through, dietary issues, smoking concerns, cleaning products, general storage and waste disposal.
m. The committee is consultant for various departments regarding purchase of all equipment and supplies used for disinfections, decontamination and sterile supplies. It reviews all new cleaning products to determine whether they are bacterialcidal or fungicidal and whether they will be helpful to maintain an infection controlled environment.

3. RCA's criteria for transferring to a general hospital an infection that is too hazardous for the safety of RCA's population is at the experience and judgment of the Medical Director or designee.

F. **Definitions and examles of Infection**

1. Urinary Tract Infection (UTI)
   a. Asymptomatic Bacteriuria – colony counts in urine greater than 100,000 organisms per ml without previous or current manifestations

b. Other UTI with onset of clinical signs or symptoms such as fever, dysuria, hematuria or pyuria, foul smell, change in bladder habits, new insertion of Foley catheter. Colony counts greater than 10,000 pathogens per ml or with pyuria of greater than 20 WBC's per high power field in uncentrifuged specimen.

2. Respiratory Infections
   a. Upper Respiratory Infection (URI) – this category includes clinical manifest symptoms of the nose, throat or ear (singly or in combination). Symptoms include a cold, flu, sore throat, pharyngitis and otitis media among others.
   b. Lower Respiratory Infection (LRI) – this category includes clinical signs and symptoms such as cough, pleuritic chest pain, pneumonia-positive chest x-ray and particularly purulence.
3. Gastrointestinal (GI)
   a. Viral diarrhea, increased diarrhea per resident. This could also include clinically symptomatic gastroenteritis associated with a culture which is positive for a known pathogen.
4. Skin and Subcutaneous Infections
5. Burn Infections
6. Surgical Wound Infections – any surgical wound which drains purulent material, with or without a positive culture
7. Other Cutaneous Infections – any purulent material in skin or subcutaneous tissue, whether or not a culture is positive includes non-surgical wounds as well as dermatitis and decubitus ulcers.

APPROVED: _____ **DATE:** _____

APPROVED: _____ **DATE:** _____

Supersedes All Previous Policy
Dated: 1/2015 **No. 9000.010**
Revised:
SUBJECT: HIV Testing & Counseling

Department Responsible: Nursing, Medical
Related Department(s): Counseling

DRAFT

PURPOSE:

Provide guidelines for obtaining patient consent prior to HIV testing.

POLICY:

All patients will sign the approved consent form prior to HIV testing.

DEFINITIONS / EQUIPMENT:

SCOPE AND RESPONSIBILITY:

Following receipt of the physician's order for HIV testing, the unit nurse will conduct pretest counseling and obtain the patient's written consent for testing.

PROCEDURES:

1. Patients requesting HIV testing are referred to the Medical Department for a physician's order.

2. After an order for HIV testing is obtained, the unit nurse will conduct at least one educational session with the patient to review the information contained in the education and consent form and make available to the patient information regarding the prevention of, exposure to and transmission of HIV. If the patient needs assistance with reading, the information and consent form must be read to the patient before signature of consent is obtained. All patient education is documented in the patient record, HIS.

3. The patient is to be referred again to the physician if he/she is ambivalent about testing or has questions beyond the scope of the nursing staff.

4. After the education process has been completed to the satisfaction of the nurse and the patient, the patient signs the consent form in the designated space to indicate that he/she understands the information and agrees to proceed with HIV testing. The nurse adds his/her signature, indicating required information was reviewed with the patient.

5. A copy of the form is offered to the patient and the appropriate space is checked, indicating acceptance or refusal. The original form is placed on the patient's chart.

6. The patient may revoke his/her consent for HIV testing at any time prior to processing of the specimen.

7. With the physician's approval, the nurse may discuss a normal/negative test result with the patient.

DRAFT

8. Positive confirmed test results should be referred to the physician for disposition.

9. Patients in need of additional information, counseling, and assistance with aftercare related to HIV-infection may be referred to the Nursing Supervisor.

APPROVED: _____ **DATE:** _____

APPROVED: _____ **DATE:** _____

EXHIBIT 14

Supersedes All Previous Policy Page **1** of **2**
Dated: 1/2015 **No. 7200.001**
Revised:
SUBJECT: Outpatient Services

Department Responsible: Outpatient Program, Clinical
Related Department(s): n/a

DRAFT

PURPOSE:
To describe outpatient services offered at RCA outpatient sites.

DEFINITIONS/EQUIPMENT:
N/A

POLICY:
The following outpatient services will be offered at all RCA outpatient sites:

A. Partial Hospitalization/Day Program (PHP)

1. Our Partial Hospitalization Program provides treatment to those needing daily care in an outpatient setting.
2. Intensive treatment is provided five days a week for four hours each day.
3. 20 hours of step down treatment per week prior to Intensive Outpatient Treatment which is typically nine hour per week is provided.
4. All patients receive group therapy and education seminars five days a week
5. Patients receive individual therapy sessions two times per week
6. Family therapy sessions are offered to all patients once every 2 weeks or more frequent if needed.
7. Psychiatric and medical consultation is provided to patients as needed.
8. Each patient will receive an intake assessment upon admission
9. Each patient that is admitted will participate in a psychosocial evaluation with RCA staff
10. Each patient is assigned to a primary therapist who will formulate an individual treatment plan based on the assessment information and according to patient's specific needs.
11. Each patient will be evaluated for use of anti-craving medications such as Vivitrol and Naltrexone.

B. Intensive Outpatient Treatment (IOP)

1. Provides a primary, organized treatment program to patients who establish abstinence and recovery within the context of their usual daily activities.
2. Consists of educational and group therapy sessions three days a week for three hours per day.
3. IOP groups are provided during both the day and evening hours and on weekends.
4. Family therapy sessions provided as needed
5. Psychiatric and medical consultation provided to our patients as needed.
6. Each patient will receive an intake assessment upon admission
7. Each patient that is admitted will participate in a psychosocial evaluation with RCA staff
8. Each patient is assigned to a primary therapist who will formulate an individual treatment plan based on the assessment information and according to patient's specific needs.
9. Each patient will be evaluated for use of anti-craving medications such as Vivitrol and Naltrexone.

C. Outpatient Treatment (OP)

1. Least structured option in our continuum of services.

DRAFT

2. Program consists of educational and group therapy sessions one to two times a week in an hour-and-a-half to two hour session.
3. GOP groups are provided during both the day and evening hours and on weekends.
4. Family therapy sessions are provided as needed
5. Psychiatric and medical consultation is provided to our patients as needed.
6. Each patient will receive an intake assessment upon admission
7. Each patient that is admitted will participate in a psychosocial evaluation with RCA staff
8. Each patient is assigned to a primary therapist who will formulate an individual treatment plan based on the assessment information and according to patient's specific needs.

APPROVED: _____ **DATE:** _____

APPROVED: _____ **DATE:** _____

EXHIBIT 15

Hogan unveils plan to fight heroin

By **Michael Dresser**
The Baltimore Sun

FEBRUARY 24, 2015, 9:50 PM

Gov. Larry Hogan unveiled Tuesday what he called a "holistic" strategy to deal with Maryland's growing heroin problem, but stopped short of declaring the state of emergency he vowed last year to put in place.

After weeks of buildup, Hogan announced a four-pronged approach to one of the signature issues of his campaign. It involves no dramatic breaks from the policies followed by former Gov. Martin O'Malley. Hogan put much of the substantive policy development in the hands of a task force that will report to him by Dec. 1.

The program includes a $500,000 federal grant, but no new state money for treatment.

At a State House news conference, Hogan seemed to choke up several times as he described how pervasive he found the problem as he traveled around the state last year.

"This used to be considered an urban problem, but it's not anymore," he said. All over the state, he said, local officials told him heroin had become their No. 1 problem. The governor said he felt a personal connection because a cousin died of an overdose a couple of years ago.

"I know the kind of devastation it can cause for families and communities, but still I was shocked by how widespread this problem had become," he said.

Hogan said heroin was both a law enforcement problem and a health issue. "This is a disease, and we will not be able to just arrest our way out of that crisis," he said.

Some were unimpressed by the governor's plan.

"This is the biggest joke I've ever heard in my life," said Mike Gimbel, a former drug user who served as director of Baltimore County's substance abuse office. "We need long-term, residential drug-free treatment in the state of Maryland. We've never had it. There are people out there who need it immediately."

Del. Kirill Reznik, a Montgomery County Democrat, said the task force duplicates the Alcohol and Drug Abuse Council he has served on since it was created by O'Malley in 2007. Reznik said the council has already identified what the state needs — more treatment beds and more preventive education programs starting as early as elementary school.

"I'm not seeing anything that begins to really address this problem," he said. "The idea of another task force, I'm a little skeptical of it."

Others applauded Hogan's effort. Del. Brett Wilson, a Hagerstown Republican who was named to the task force, called the plan "exactly what we need."

"I like this approach about actually learning about a problem before we address it," he said.

Del. Peter A. Hammen, a Baltimore Democrat who chairs the House health committee, also welcomed the

program . "I'm pleased the governor is focusing on the issue because it's a significant problem throughout the state."

Heroin overdoses have shot up 95 percent since 2010 as the drug's price has fallen and prescription painkillers have become more difficult to obtain. In 2013, Hogan said, Maryland had 464 overdose deaths, exceeding the state's 387 homicides. He said preliminary numbers show deaths by overdose continued to rise last year.

His four-point program includes two executive orders — one to create a coordinating council of the agencies involved in tackling the problem and the other setting up the task force. Lt. Gov. Boyd Rutherford will chair both groups.

The third point was Hogan's announcement of a donation of 5,000 EVZIO kits for the rapid treatment of heroin and other opiate overdoses by manufacturer Kaleo Pharmaceuticals. EVZIO is a delivery device similar to an epi-pen for the delivery of naloxone, a drug used to counter the effects of those substances in emergencies. Each kit has two doses, for a total of 10,000.

Hogan also announced a $500,000 federal grant to the Governor's Office of Crime Control and Prevention that will be used to increase treatment programs in the state's jails and prisons.

After the announcements, Hogan signed the executive orders and left without taking questions. He turned over the news conference to Rutherford, whom he had previously named his point man on the state's response to the heroin epidemic.

Rutherford, asked why Hogan had decided not to declare the "state of emergency" he had talked about during the campaign, said the administration found there is no statutory basis for such a declaration.

"We still consider it an emergency," Rutherford said. "It really doesn't fit from a legal standpoint."

During his campaign, Hogan criticized the administration of O'Malley and Lt. Gov. Anthony G. Brown for leaving Maryland as the only state on the East Coast that hadn't declared a heroin emergency — a claim that was later debunked. The Republican candidate repeatedly charged that the Democratic administration did little to address the heroin epidemic.

Hogan's plan so far is similar to O'Malley initiatives.

Hogan's coordinating council will consist of the departments of Health and Mental Hygiene, Public Safety and Correctional Services, Juvenile Services and Education, as well as the Maryland State Police and other agencies. The membership largely overlaps that of a group O'Malley formed last June to address the overdose treatment problem.

The new administration's work in securing the donation of naloxone doses builds on Maryland's efforts in recent years to put the drug in the hands of more first responders, to expand training on its use and to make the drug eligible for Medicaid coverage.

Like O'Malley, Hogan is facing criticism from advocates for cutting the budget for providers of drug treatment.

Dan Martin, public policy director of the Mental Health Association, said the things Hogan announced Tuesday are "important and necessary."

But Martin and his group will be part of a rally Wednesday outside the State House calling for the restoration of

$23 million cut by the O'Malley and Hogan administrations from programs that include drug treatment.

"What we really need is to restore the budget for behavioral health so that people with substance abuse and mental health issue can get the treatment they need," Martin said.

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