BEFORE THE OREGON PUBLIC HEALTH DIVISION
OF THE OREGON HEALTH AUTHORITY
OF THE STATE OF OREGON

In the Matter of the Application)
of NEWCO Oregon, Inc., CN #675)

The public hearing was taken before Robin Reger, Registered Professional Reporter for Oregon, on Thursday, November 17th, 2016, commencing at the hour of 9:00 a.m. at Clackamas Community College, Wilsonville Campus Training Center, Wilsonville, Oregon.

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OFFICIANTS:
JANA FUSSELL
JERE HIGH
SHANE JENKINS
STEVE ROBISON

- I N D E X -

P R O C E E D I N G S

MS. FUSSELL: We'll go ahead and introduce ourselves. Obviously, I'm Jana Fussell. I'm the Certificate of Need Coordinator. And then we can start with Julie.

MS. MILLER: I'm Julie Miller. I'm assisting Jana, and I'll be the timekeeper.

MR. HIGH: Jere High. I'm the administrator for the Center for Health Protection.

MR. JENKINS: I'm Shane Jenkins, Facilities Planning and Safety.

MR. ROBISON: I'm Steve Robison. I am on loan to Jana. I'm an epidemiologist but have prior experience working in population need and will be doing the need assessment of the Certificate of Need.

MS. FUSSELL: Steve is my super numbers cruncher, and then I do the part about kind of generalized need, and alternatives, and that sort of thing. And Shane is going to help out with the architectural analysis.

So with that, we'll get going. I want to remind you, as you come forward when I call you, and you can turn off and on your mic with

the red button, the little button in front.

So now we're going to officially get going. My name is Jana Fussell, and I am the Certificate of Need Coordinator for the Oregon Health Authority, Public Health Division.

This is a public meeting convened for the purpose of discussing issues relevant to the application of NEWCO Oregon, Inc. for a 100-bed psychiatric hospital to be located in Wilsonville.

No proposed or final decision will be made as a result of this meeting.

Unlike the reconsideration proceeding which is governed by the Oregon Administrative Procedures Act, the APA, this meeting is not subject to the APA and will not, therefore, be conducted as a contested case.

I've circulated sign-up sheets, and I have checked with everyone to see if anybody wants to speak. So I'm going to call upon those people who signed their names. And only I and Public Health Division staff may ask any speaker questions to clarify or otherwise explain their testimony. I will ask that your testimony be limited to a certain amount of

time so that as many people as possible will have the opportunity to speak. We are here to listen today and will not be answering questions. If you have questions about process or procedure, I'd be happy to speak to you after the meeting to discuss those concerns.

Finally, after the oral testimony, but prior to the closing of the meeting, I will give opportunity to any person who wishes to submit written material that will be included in the application file on this matter.

The applicant and each affected party may have up to 20 minutes to speak. It is not necessary to use the entire time, and the applicant and affected parties are not required to provide comments. Once the applicant and affected parties have spoken, we will then open the meeting to comments from the general public. Members of the general public will have three minutes to speak. When you come forward to speak, please announce your name, spell it for our court reporter, and state the name of any organizations that you represent.

So with that, we're going to start with the applicant. And so we're going to ask you

to limit your comments to 20 minutes. And as I will explain at the end of the meeting, the record for receiving written materials in relation to this public meeting will remain open until December 2nd, 2016, at 5:00 p.m.

So with that, NEWCO Oregon, Inc., if you could come forward. And please remember when you speak to identify yourself. And one other thing I should mention. So Julie, the timekeeper, has the little reminders and maybe that will help you time your testimony.

MR. ESCARDA: Good morning. My name is Ron Escarda, E-S-C-A-R-D-A. I am the CEO of Fairfax Hospital and the Group Director for UHS for the Pacific Northwest.

Jana, thank you for hosting this hearing. And we are here to present our project and provide information and an overview of the project that we've proposed.

The proposed project, our Willamette Valley Behavioral Health Project, otherwise known as NEWCO, would provide voluntary and involuntary patient care to serve adolescents, adults, including older adults with -- and who require inpatient psychiatric care. NEWCO will

create and use an innovative, robust and well-coordinated treatment model involving a partnership between private, mental health and medical professionals and practitioners of inpatient psychiatric providers to deliver a seamless continuum.

Our proposed hospital is planned to begin providing services by January of 2018, and will be located in the city of Wilsonville, as part of the Clackamas, Multnomah and Washington service area. Existing inpatient psychiatric providers are operating near capacity. And our quantitative analysis of historical utilization data, as well as population data forecast inpatient psychiatric utilization statistics for the Clackamas, Multnomah and Washington County, provides us with the information that we believe that there is an estimate of a current shortage of 132 beds as of 2016, and forecasted shortages, based on population growth projections of 187 beds by 2025 in those three counties.

NEWCO is a wholly owned subsidiary of Universal Health Services. UHS is also the owner and operator of Cedar Hills Hospital, an

89-bed inpatient psychiatric facility located in Portland, Oregon. Cedar Hills has been in operation for seven years, and is committed to the same high-quality care which is consistent with UHS's high standards and expectations and commitment to the communities that we serve.

In regards to some of the market dynamics, the service area average annual population growth is expected to show growth consistent with recent historical trends averaging between 1.2 and 1.3 percent per year over the next 10 to 15 years, resulting in a projected population of approximately 2 million from the current 1.7 million residents who reside in the planning area.

In the service area there are currently eight acute care hospitals with inpatient psychiatric beds. As of 2014, these eight facilities had an average occupancy rate of 86 percent. Provided below we have submitted some tables and data and additional things which I won't cover as part of the testimony but have been submitted as part of our written documentation.

I will summarize this by saying, in

combination with the rapid growth experienced by Cedar Hills, with consistently high occupancy rates for the planned area hospitals shows that Cedar Hills' growth does not affect the other providers, which is a clear indication that additional beds are needed.

The shortage of inpatient psychiatric beds is well documented in numerous Oregon state newspaper articles. The bulk of the problem persists in the service area of interest. The result of the severe lack of inpatient psychiatric care is that many patients are boarded in emergency departments or simply released before receiving an evaluation from a licensed provider.

The review of more than 80 percent of the emergency room physicians says that "mental healthcare systems in our region are disfunctional and do not adequately serve patients." The review also pointed to data from NAMI, the National Alliance on Mental Illness, which found that 38 percent of mental health patients in EDs are waiting more than seven hours to see a mental health professional. 21 percent of those cases wait

more than 10 hours. As pointed to by the article, this is an extremely long wait time to receive care, particularly when those patients are in severe crisis.

There have been a couple of legislative occurrences over the last few years that have also had a dramatic impact on behavioral health and the need for behavioral health. The Mental Health Parity and Addiction Equity Act of 2008, which finally went into effect in July of 2014, and the Affordable Care Act, which began in January of 2014, both have and will continue to increase demand by increasing coverage for mental health services.

We propose to develop and operate a 100-bed freestanding psychiatric hospital located in Wilsonville, Oregon. The proposed hospital will serve the populations that I previously described, and would have roughly 24 beds for adolescents and 72 beds for adults and older adults.

The project offers both inpatient and complimentary outpatient care services, and where appropriate, we will collaborate with Cedar Hills, located 13 miles north of our

proposed new facility in clinical delivery, staffing, and ancillary support services.

The new psychiatric hospital will continue to optimize the collaborative relationship that has formed in recent years with Cedar Hills and other community providers and partner organizations in the region to provide a seamless continuum of care.

The confluence of factors presented above resulted in strong support from the Wilsonville officials and many others within the local community. To further this point, there was a unanimous vote in support of the project by the planning board of Wilsonville.

MR. MINOR: Thank you, Ron. My name is Rob Minor. I am Vice President of Development of the Behavioral Health Division for Universal Health Services. I have proudly worked with UHS over 13 years and have been a part of developing or acquiring over 120 behavioral health facilities in the United States.

I've had the privilege of working on the development of this project in Wilsonville from its inception. After careful analysis of the data provided by the Oregon Department of

Health, and input from Cedar Hills Hospital, we project a need to be 132 inpatient beds currently.

We see that this new operation and the opportunity to collaborate with Cedar Hills Hospital in Beaverton, just 13 miles away, as a significant step towards meeting the mental health needs of the citizens in the area.

This has been a three-and-a-half-year journey, and we would not be here today without the cooperation and support of many individuals and agencies from the region.

UHS is very excited about being a part of the Wilsonville community and helping to address the behavioral needs of the residents and surrounding communities.

We look forward to being a good citizen, a stable employer, and an advocate for the mentally ill.

Throughout the country, and here in Oregon, our facilities and employees are active in the communities in which we are privileged to serve.

Every UHS facility does more than mental healthcare. They are all integral community

partners working with neighborhoods, schools, police departments, public health clinics, hospitals, and other stakeholders.

We seek to meet the needs on a local level by identifying opportunities to support those issues important to that community, such as sponsoring programs for educators on topics like suicide awareness and prevention and supporting mental health first-aid training.

I would like to share some information about UHS. UHS is one the largest, most respected hospital management companies in the United States. During our almost 40-year history, we continue to strive to provide compassionate care that is grounded in human interaction and patient engagement.

The company owns and operates more than 245 acute care and behavioral health facilities, as well as surgical centers, from 37 states, Washington, D.C., Puerto Rico, the Virgin Islands, and we also have facilities in the United Kingdom.

The behavioral health division, with more than 220 facilities of all levels of acuity, and with upwards of 22,000 beds and

service has cared for more than 450,000 patients, representing over 5.8 million patient days in 2015.

Each day more than 70,000 dedicated employees strive to meet the needs of our patients and provide support to their families and loved ones. We never lose sight of the fact that we provide care and comfort to people at one of their most vulnerable times in their lives, and the need to do so in a respectful and dignified treatment manner.

The Joint Commission, through it's rigorous accreditation and quality assessment procedures, has established UHS as an industry leader. Over the past 40 years, 83 total UHS facilities, including 69 behavioral health facilities, were designated top performance, key quality measurements by the Joint Commission. This recognition is awarded to hospitals that attain excellence on accountability measurements, performance as a result of an evidence-based clinical process.

The percentage of UHS behavioral facilities recognized as top performers over the last four years is more than double that of

our competitors. Last year 75 of our behavioral health facilities underwent multi day, on-site Joint Commission surveys with 100 percent success rate for reaccreditation. We have never had a facility fail an assessment. All of our acute behavioral facilities are Joint Commission accredited.

In addition, we have strong performance on evidence-based industry-wide clinical quality metrics. UHS patients in our behavioral health division also constantly report high levels of satisfaction with the care that they receive at UHS facilities.

UHS is both a corporate and local supporter of the National Alliance on Mental Health Illness, NAMI. As corporate sponsor we have been instrumental in the development and rollout of NAMI's Homefront, a unique educational program designed for families, caregivers and friends of military service members and veterans, and mental health -- and veterans with mental health conditions. Originally piloted in six states, the program has expanded to 23 states, 244 teachers, including the chapter here in Oregon.

As a national partner in the National Action Alliance for Suicide Prevention, we remain committed to suicide prevention, and to changing the public conversation around this important topic.

As a part of the Zero Suicide Initiative, UHS hospitals are serving as pilot sites to address suicide safe-care and healthcare in psychiatric facilities.

Outside the healthcare industry, UHS is also recognized by Fortune magazine as one of the 500 most admired companies, and number two in the healthcare category.

Finally, UHS was ranked 290 on the 2015 Fortune 500 list of largest corporations and has been on that list for the last 13 years.

Based on the information just presented, UHS has the economic capacity to build the state-of-art facility, to properly and efficiently staff, with qualified healthcare professionals, to be a contributing member of the community and, most importantly, to provide compassionate and quality acute behavioral healthcare to the residents of Wilsonville and the region.

I respectfully request that the Board approve our application for this Certificate of Need for this hospital. Thank you.

MS. HUTTER: Good morning, my name is Elizabeth Hutter. It's H-U-T-T-E-R. And I'm the CEO of Cedar Hills Hospital, which is located in Portland, Oregon. And as was said before, Universal Health Services is our parent company, and they acquired us from 2012.

I'm here really to just give an overview of Cedar Hills Hospital, and to talk a little bit about what UHS has brought to Cedar Hills Hospital, and just talk a little bit about the way that we do business, and how we would also intend for NEWCO, Willamette Valley Behavioral Hospital will also do business.

So just to give a brief overview of Cedar Hills Hospital and outpatient services, we have 89 inpatient beds for adults, and a large outpatient center that treats folks -- or for day treatment and intensive outpatient services.

Cedar Hills opened in 2009 under the ownership of a different company and was acquired by UHS in 2012. We feel very strongly

that this was a really good transition for Cedar Hills Hospital, and UHS has brought many quality standards to the hospital, as well as provided us with more access to resources, and heavily invested in our infrastructure, in our building, and provided us with state-of-the-art hardware for patient rooms and for our units. And we also have been highly encouraged to share best practices across all facilities, and it's something that they actively do every single year at a conference where they bring all of the hospital supervisors together.

So just to talk again a little bit about Cedar Hills' experience with the shortage of inpatient psychiatric beds. We kind of use our experience as a barometer of how things are going in the community.

And so in our own data we see the trend growing of patients who are deflected and are not able to receive treatment when they need it and they are in psychiatric crisis.

Cedar Hills -- just to talk a little bit about our history -- opened with just 36 beds, and over seven years has grown to 89 beds. In 2014 we did a 10-bed expansion, and within 24

hours -- these 10 beds were on our most acute unit, our crisis stabilization unit -- within 24 hours that unit was at 100 percent capacity. So over the past years, we've run between 90 and 95 percent of our capacity at all times.

And additionally, like I said, we've been having to deflect around 40 to 50 Oregonians who are seeking mental and substance abuse treatment services on a monthly basis. And we do track and trend that data, and some of it has been submitted for the written record.

Just to talk a little bit about our model, and how we work, and how we would expect NEWCO to work as well. Cedar Hills actively works and collaborates with community mental health agencies and counties, emergency departments, medical groups, individual practitioners, residential treatment centers, veteran services, military installations, families and patients themselves, to ensure that they can receive treatment as quickly as possible if they are in crisis.

We also work with these groups and others to ensure that patients can return to

their communities with the appropriate resources and support that they need to recover. I've actually listed out 39 different agencies or groups that we work with. I'm not going to list them all for the public record, but I have submitted written record of that.

Just to name a few, we work with Lines for Life extensively, and emergency departments across the entire state of Oregon and southwest Washington. We also work with Yamhill County Mental Health, Washington County Mental Health, the Veterans Administration of Oregon, U.S. Coast Guard of Oregon, Oregon National Guard, and Western Psychological and Counseling. There's a few more, but I won't list them all.

That's one part of how we work, but another part that we see as an extremely important role and part of our mission is to play an active role in our community by participating in educational activities, community events, provider needs, county meetings, and the Oregon Association of Hospitals and Health Systems.

Cedar Hills coordinates and/or attends -- I've listed out about 11 meetings,

for the record, but I'll just mention a few. We're part of the Washington County Zero Suicide Initiative, which is an extremely important project for Washington County, and to get agencies on board in our area to adopt this initiative, which UHS had actually already, before we joined the Washington County Zero Suicide Initiative, UHS had already been involved at the national level in funding and helping this project progress. And so it's something that we're really proud of and continue to work with the county and other agencies in our area on continuing this project, which is a multiple-year project.

Okay. Just to mention a few more quick things. Cedar Hills' mission is to provide safe, effective and compassionate mental health and substance abuse treatment. We have a PI team that involves all hospital departments, and quality measures are an extremely important part of how we function as a hospital.

Just to mention one very briefly, that's extremely important to us, is our parent satisfaction survey. Cedar Hills has a patient satisfaction score of 90 percent or higher, and

they have consistently held that score since the hospital opened.

We also have our outpatient centers in the top three for UHS facilities across the entire United States running at 92 percent patient satisfaction or higher.

I know that I don't have very much time, so I'll just skip to the end. And if NEWCO is approved, this will be a much needed resource for family members, community members, people that I deal with every day. And I think this is extremely important because Cedar Hills will also actively collaborate with NEWCO in sharing resources and best practices. I think it will actually allow us, with a sister hospital in the area, to be able to create a stronger delivery system to meet the behavioral healthcare needs of individuals in our communities. Thank you.

MR. SANDBLAST: Good morning. My name is Ken Sandblast, S-A-N-D-B-L-A-S-T. I am Director of Land Use Planning at Westlake Consultants, primarily working with UHS over this last year plus to get the Willamette Valley Behavioral Health facility approved

inside the community of Wilsonville.

I'm here today to simply summarize that effort and let you know that all of the land use applications are in place and have been approved by the community.

The location of this facility was specifically selected by UHS to be located at the intersection of arterial streets within a very short distance to the interchange. It's at the north end of Wilsonville, which provides access to the growth as planned in that area of the region, as well as in the area of the city itself. So the access to the interstate and the intersection of Day Road and Boones Ferry Road, which is where this is located, was chosen to provide that kind of access, not just for vehicular access, but we've actually explored and established and confirmed that regional mass transit, both Tri-Met and the Smart system in Wilsonville will provide access right to this vicinity.

MS. FUSSELL: Time.

MR. SANDBLAST: Oh, time?

MS. FUSSELL: Yes.

MR. SANDBLAST: Okay. Well, I'll just

quickly say that I did submit some comments, and they are in the record.

MS. FUSSELL: And you can submit further, if you feel like you have more to say about that.

MR. SANDBLAST: Thank you very much.

MS. FUSSELL: So does anybody on the panel have any questions? So I did have a question, actually.

In the letter dated October 5th, 2016, from Mr. Escarda it says that "UHS has determined that inpatient care for children, persons 5 to 11 years old, will not be included at this time." So can you please discuss a little bit about your future plans for children, if you do have any?

MR. ESCARDA: Ron Escarda. Well, our future plans for children, from the beginning phases of the project, will include ambulatory care and outpatient services, and then we will gauge and determine the need for additional inpatient services, and adjust our program and structure and our bed allocation and quota, and based on that determined need. But we will be providing services for children and adolescents

from an outpatient basis, traditional outpatient IOP, partial hospitalization from the very beginning of the project.

MS. FUSSELL: Okay. Thank you very much.

Now we're doing affected parties, and first to sign up is Legacy, please.

DR. MELARAGNO: Good morning. I'm Dr. Tony Melarango. I'm the Vice President for Behavioral Health and Oncology Services at Legacy. I've been in that role for three years; prior to that I was the Chief Administrative Officer at Good Samaritan and was responsible for Behavioral Health Services for Legacy overall for probably the last eight years. I'm also the chairman of the Caremark Joint Venture, which is a joint venture between Legacy and Adventist Health. It's existed for probably the last 20 years for the care of behavioral health patients that present to our hospitals.

And I guess I'm one of the founding fathers of the Unity Center for Behavioral Health, which I'll talk more about.

I want to note that Legacy has been

working with five other providers for the past several months developing a comprehensive response to what we submitted prior to the close of public comment.

Those providers, besides Legacy Health, include Providence Health, Kaiser Permanente, Willamette Valley Medical Center, Adventist, and OHSU, will probably submit their own letter.

I'm here today to tell a little bit about the Unity Center. The Unity Center will be opening in less than two months on January 9th.

This is a unique collaboration between four competing health systems in the Portland region, and that's Legacy Health, OHSU, Adventist and Kaiser. And we are going to consolidate our inpatient beds, both adult, child and adolescent, at the old Holladay Park site.

Legacy made a commitment to the project in terms of providing building, land and raising and contributing $44 million to create a state-of-the-art facility, which will give patients access to state-of-the-art

professionals and staff at all times.

More unique about this project is we're creating a psychiatric emergency service at the Unity project, which is expected to see 45 to 55 patients a day in acute crisis.

And I think this addresses one of the points that Mr. Escarda made that patients now have to wait many hours in emergency rooms before they see psychiatric professionals. At Unity we will have a psychiatrist in the psychiatric -- at least one in the psychiatric emergency service 24 hours a day, seven days a week. In addition, we'll have psychiatric nurses, therapists, peer support specialists and social workers 24 hours a day.

We feel this is significant because currently 15 to 20 percent of the patients that are admitted to our hospitals, psychiatric units, are there for less than 24 to 48 hours, and they are admitted just so that we can get them out of our emergency rooms where we don't have an adequate environment for them, and we're not able to get them the professional help and care that they richly deserve.

At psychiatric emergency service at

Unity they will be getting assessed and begin treatment immediately. And we feel that time is necessary for us in this community to see how this progresses in terms of the actual need for beds.

Something that's really unique about the Unity project is this: We went around the country seeing other facilities like this in other psychiatric emergency services. One of the things that we found woefully lacking was that they would take care of the patients acutely, but they would discharge them, and they had very high recidivism rates. We did not want to see that. So early on, probably at least 18 months ago, we began talking to all of the community partners that provide outpatient mental health services in our community, such as Central City Concern, Cascadia, Lifeworks, et cetera, Albertina Kerr, and invited them in so that they can have a space in Unity so that we can make warm handoffs of these patients to their outpatient providers so they will get that continuum of care and not come back to the psychiatric emergency service or not need an inpatient admission.

I'd like to also note that as we've been going through this process, our analysis has confirmed no need of beds; there's a surplus of beds in the Portland region. And the applicant's ability -- the lack of applicant's ability to be paid for Medicaid patients means they will not be able to serve the majority of patients in need in our community.

We are anticipating 52 percent of our patients at Unity will be on Medicaid, and this is equal to what we see in all of our facilities currently.

We would also like to express some concern that the sister organization, Cedar Hills, is not meeting the original Certificate of Need obligations that they made. And just to remind you of what those were, one was they would have -- reasonable efforts would be made to make it widely known to the public that emergency psychiatric treatment was available regardless of the ability to pay, and also that they would accept admissions and transfers of patients without quotas, limits or other restrictions based on payor source or ability to pay. And this has not been our experience.

I'd like to conclude by saying that we feel this NEWCO proposal is oversized in its volume and financial assumptions are inaccurate, and likely unattainable.

We feel the high cost associated with NEWCO's inpatient care model to take critical resources from the broader system at a time when existing providers have committed resources to increase access and reduce the demand for inpatient beds by providing superior alternatives.

We feel without doing its fair share of adult Medicaid, NEWCO would also be placing increasing burden on the existing providers. We also worry that with the already existing scarcity of resources of psychiatrists, psychiatric nurses and therapists, would lead to fragmentation of care and higher costs. And currently it's very difficult to recruit psychiatrists and psychiatric nurses to our community.

Further, we feel that there is some recent and ongoing quality concerns related to NEWCO's parent organization, and we would encourage the Division to look further into

that. And in the end, the NEWCO project is ill timed, in our estimation, and much too early, and we would respectfully request that the Division deny this application.

Do you have any questions?

MS. FUSSELL: Anybody have any questions? No? Thank you very much. We'll receive your written comments.

So now we have SEIU, please. So here again, you can come identify who you are for the record.

MS. ISAACSON: Morning. My name is Kirsten Isaacson, it's K-I-R-S-T-E-N, I-S-A-A-C-S-O-N. I lead the research department at SEIU Local 49, although I'm here today also on behalf of our sister local, 503. Together we represent 65,000 workers, including more than 36,000 in healthcare professionals. Our members are not only healthcare providers and caregivers, but we're also consumers of healthcare and advocates.

SEIU believes in a just society, one where all workers are valued and respected and all communities and families can thrive. And part of how we seek to achieve this is by

sharing facts and evidence in public forums, help stakeholders carefully evaluate proposals, such as the one that we're discussing today.

We recognize that there are mental health challenges facing our state and support efforts to advance our goals in improving mental health services in Oregon, especially those laid out in OHA's three-year performance plan.

But we do think the proposal today fails to not only meet the state Certificate of Need criteria, but also it doesn't align with Oregon's new envisioned mental health system, and because of that we urge you to deny the application. And I'll turn our comments over to Ryan here to detail our concerns.

MR. PFEFFER: Thanks, Kirsten. Thanks all of you for being here today. My name is Ryan Pfeffer, last name is spelled P-F-E-F-F-E-R. I'm a research coordinator with SEIU. I also happen to live in Portland, Multnomah County.

I'd like to begin today by telling you guys a little bit more about UHS as a company. The applicants told you how big they are. It's

a very large company. Publicly traded for profit. They operate both acute care hospitals and behavioral hospitals. UHS is very big. They estimate that they own about 40 percent of all the free-standing facilities in the country. About one out of every five psychiatric hospital beds overall are owned by UHS. UHS made $9 billion in 2015. Half of that came from psychiatric care. They made $680 million in profit. The psychiatric business that they run is very profitable, averaging about 24 percent profit margin. That seems a little bit counterintuitive in an industry that's often seen as drastically underfunded.

UHS also has quality problems. According to the Dallas Morning News, using CMS data, about 30 percent of UHS Medicare certified facilities have had condition level violations since 2012. That indicates a serious quality problem.

Also very troubling, and somewhat unusual, this company is facing a coordinated federal investigation that now includes 23 of their facilities and the corporate parent. And

according to the company's own statements to investors, that investigation likely involves potential criminal and civil issues related to billing fraud.

Now that you know a little bit more about the company, let's turn to this application. This proposal fails to meet many of the State CON criteria, all of which we'll detail in our written comments to you guys.

Today I'm going to focus on some key failures in this application. First, UHS is unable to demonstrate need using the defined methodology. Even after adjusting their model, the company concedes in their materials that there is no need for general acute care inpatient beds.

I expect other participants today will comment on the bed need, so I'm going to move on to other areas of concern. Namely, access to care, staffing and quality of care.

The first area of concern I'd like to discuss is access to care. Ms. Lee here is handing out a copy of a few charts for you guys to take a look at.

UHS provides less charity care than

their CON application suggests. In the application, UHS points toward policies and practices at Fairfax Hospital as examples of what they are going to do in Wilsonville. UHS has claimed that Fairfax Hospital provides charity care above regional averages, but a closer examination suggests otherwise.

UHS uses Washington statewide data to support their claims, but in order to show that Fairfax provides charity care above regional averages, they removed charity care data reported by Harborview Hospital, which is a public entity.

When you look at all of the charity care provided, which is a much, much closer representation of actual care delivery in the region, the level of charity care provided by Fairfax is well below county and state averages.

As you can see in the first two handouts, Fairfax's charity care as a percentage of revenue and as a percentage of adjusted revenue, Fairfax is far below state and county averages.

And it's not just a recent issue. In

the final handout you can see that charity care has declined at Fairfax since UHS acquired them in late 2010.

The second area of concern I'd like to talk about today is staffing. UHS has a poor record of appropriate staffing as evidenced by low staffing ratios in the Pacific Northwest and nationally, repeated cuts in staffing costs, difficulties in recruiting staff, and in some instances, employing unqualified and untrained staff.

All of these factors raise significant doubts about UHS's ability and willingness to provide sufficient, qualified personnel to meet patient needs and safety.

The UHS business model is built on high occupancy and keeping staff costs low. And this model has implications for patient care. UHS CFO, Steve Filton, has told investors that high occupancy and high margins are tied together.

Further, when UHS acquired Psychiatric Solutions, one of the largest behavioral health acquisitions in history, Steve Filton told investors that the company planned to drive

improvements in profit margin by focusing on staffing.

If you take a look at the two charts that were just provided to you by Ms. Lee, you will see that both Fairfax and Cedar Hills in chart one, the FTE rate is well below the non-UHS national average. In 2015 Fairfax Hospital's FTE rate was 29 percent lower than non-UHS national average, meaning that the facility has nine fewer FTEs available for every 10 patients. Cedar Hills also has a much lower staffing rate than the non-UHS national average.

This pattern of low staffing is not isolated to Fairfax and Cedar Hills. If you look at the second chart provided, Medicare cost report data shows that the staffing ratio for UHS Behavioral Health System as a whole has been consistently below the averages -- below the non-UHS national average for nearly a decade.

In addition to having very low staffing rates compared to the non-UHS national average, UHS has at times employed unqualified and untrained staff at its facilities, with

predictably disastrous patient outcomes.

I'm going share with you a story from Massachusetts. This incident involves the tragic death of a teenage girl while seeking mental health treatment from UHS. The teen had allegedly been treated by several unlicensed and unsupervised staff, including a nurse who claimed to be a psychiatrist, and another employee who claimed to be a psychologist, despite having her license application rejected by the state.

The unlicensed and improperly supervised staff allegedly diagnosed the girl and provided her with an off-label prescription for Trileptal, which is an antiseizure medication. She experienced an adverse reaction to this medication, stopped taking it, and developed a seizure disorder, which is a known side effect of this medication. Despite never having seizures before, she died of a seizure a few months later.

The family began to look at the girl's care at UHS and discovered that many of the employees were not licensed or properly supervised. They reported this to the state.

Upon investigation of these events, the state confirmed that the care was provided by unsupervised staff, in violation of state law. And the UHS clinical director even admitted that he was, quote, "Unaware that supervision was required to be provided on a regular and ongoing basis."

Importantly, just last year Oregon strengthened staffing regulations, and the governor appointed the Nurse Staffing Advisory Board.

As you can see, the staffing record at UHS runs counter to the emphasis that Oregon has placed on safe staffing at hospitals.

Finally, I want to raise our concerns about quality of care. UHS facilities and communities across the country have a record of failing to comply with regulations and licensing requirements.

Again, according to the Dallas Morning News, based on information provided by CMS, nearly 30 percent of the Medicare certified facilities at UHS have had condition level violations since 2012. That indicates serious quality problems.

Timberlawn Mental Health Hospital in Dallas provides a useful example. Timberlawn has been owned and operated by UHS since 1996. This facility illustrates many of the concerns we raise here today and later in our formal written comments. Over a period of years Texas state regulators identified a number of serious violations of the state and federal operating regulations. These violations, along with patient death, led to a series of sanctions and penalties that include termination from the Medicare program, a move by state regulators to revoke the operating license, and the imposition of a record $1 million fine. These are extremely rare and almost unprecedented penalties.

State officials said that safety problems at Timberlawn, including suicide and violent fights among patients, left them little choice but to revoke the license. State officials went on to say, quote, "The list of serious issues kept stacking up, and we had to draw the line. It's rare that we get to that point with a hospital. Safety has to be paramount."

In fact, David Wright, CMS administrator for Region 6, which oversees Texas, stated, quote, "We have an obligation to not continue to fund a facility that fails to meet basic obligations for safety." Wright further stated, "It's very, very rare for a healthcare provider to be terminated from the Medicare program. Probably over 99 percent of the facilities that we issue a notice of termination come back into compliance. Yet Timberlawn was terminated from the Medicare program for chronically unsafe conditions that pose immediate jeopardy to patient health and safety."

The path to these extremely rare penalties is tragic and seemingly preventable. In December of 2014, a patient with a known history of suicide attempts, and while on suicide precautions, was able to hang herself from a doorknob in a trauma unit.

The facility knew about the ligature risk of these doorknobs seven months before the suicide, calling them "hospital planned anomalies" in internal documents.

Staff told CMS that no action was taken

to remove those suicide risks until after the suicide event, and that patients continued to be admitted to the rooms with those doorknobs even after the patient committed suicide.

Two months following the suicide, a CMS inspection revealed that continued presence of unsafe items accessible to psychiatric patients, which included plastic liners in trash cans, electrical cords and phone cords.

Despite the tragic death and CMS findings I just described, Timberlawn CEO told the Dallas Morning News six months after the suicide that the doorknobs in question did not violate any regulations.

Unfortunately, this is not the only tragedy to strike Timberlawn patients and workers in the past two years. Just last summer a tragic case of workplace violence occurred. The 144-bed facility was working with regulators to re-enroll in Medicare. At the time the facility did not have many patients, but one violently tackled a psychiatrist, which struck her head, lost consciousness, and died two days later.

Many more problems have been found at

Timberlawn; patient safety issues, which include failures of patient supervision, outbreaks in violence, and an incident in which the hospital lost track of six patients, all indicate problems at Timberlawn. Yet in Timberlawn's case, despite multiple chances for improvement, CMS continued to find violations.

It's clear that providing a therapeutic environment can be difficult for this patient population. However, health systems can do it without having incidents such as Timberlawn. For example, Johns Hopkins Hospital in Baltimore has admitted at least 100,000 patients in the last 40 years; not one of them has committed suicide in this facility. This is because the hospital has invested millions of dollars, over many years, to boost staffing so that it can screen and constantly monitor patients deemed at high risk for suicide. In contrast, UHS has repeatedly been the subject of news reports, lawsuits, and regulatory citations for failing to provide a safe care setting.

So how did UHS react to all of these problems? Shortly after learning that CMS

intended to terminate Timberlawn from the Medicare program, UHS filed a lawsuit in federal court. Timberlawn also filed notice under the federal WARN Act disclosing that it would close the facility and permanently lay off 160 employees.

CMS argued that it could bear the expense -- I'm sorry -- CMS argued that Timberlawn could bear the expense of keeping the facility open due to UHS's remarkable profitability. Remember, I mentioned before in 2015 UHS reported $680 million in profits? This is the same year that many of these problems were going uncorrected at Timberlawn. Timberlawn officials said that it did not matter, that the parent company can afford to fund the hospital if it will not.

The potential closure would have had a dramatic impact on the community it serves. The Dallas Morning News reported Timberlawn as one of the few psychiatric hospitals in Dallas that accepts poor and uninsured, and it's been one of the three city institutions where police routinely send people for mental health evaluations. Dallas has a significantly higher

level of uninsured and indigent people than much of Texas, and the closure of this vital facility would have harmed workers, patients and the community.

So rather than taking the numerous attempts to address these problems, rather than fixing the doorknob issue seven months before the patient suicide, or even fixing all of the ligature risks in the facility two months after that suicide, rather than using some of the company's massive profits made for treating some of the most vulnerable patients in this country, UHS chose to litigate and threaten the workers, patients and the community with the loss of a critical resource.

Oregon can do better than this company, and we should start by rejecting this proposal. Thank you.

MS. FUSSELL: Thank you very much. We'll look forward to your written comments.

So next we have Ann Kasper, please.

MS. KASPER: Good morning. I'm Ann Kasper. I am a person who, unfortunately, has been in and out at different times -- I work in TV and I'm nervous.

I'm Ann Kasper. I, unfortunately, have ended up in and out of the system here and hospital system, police, things like that for 30 years, so I have a pretty good idea of what's going on in Oregon.

I really haven't done a lot of research about this company, honestly, but I'm going to give the pros and cons as I see them from where I'm coming from. And so I'm so happy I don't have to decide yes or no, but what I can do is give you information you may not have thought about before.

And to let you know who I'm connected with, NAMI. I was there for six years volunteering. I still give speeches for them at universities; CATC, which is a subacute in Portland, Oregon, I helped start them up, and Disabilities Rights of Oregon. I've been with the police since 2004, helping to train them. I've been an ESL teacher for 20 years in the city of Portland. People just call me and say, "Hey, there's this person, we need a viewpoint from someplace else." Unity, I was volunteering 20, 40 hours a week for 11 committees for a year and a half to help build

Unity from the architecture down to the care systems; but, again, as a volunteer. I worked at Villebois up here in the housing center being a peer support specialist. So we kept the emergency people away because we were offering people what they needed; some listening and some coffee. And I teach mental health first aid. I did a TV show with SEIU, actually year ago. They do support a lot of mental health things. I do a TV show. Now it's every two weeks, Mental Health News in Oregon.

And I ask questions that perhaps system people don't ask. For example, there's something coming up in Portland where they are going to change having -- not having police drop off people, but having ambulances. And from 2015 to 2016, there's been 891 chemical restraints, and that's a lot.

So I ask the questions that no one else thinks about. And how do we keep it civil and how do we keep it safe and with human rights, how do we do the system?

So I'm going to list the positives I see from having the center here and the negatives.

And Cedar Hills actually has a monthly education forum that I go to. I learn a lot. For $20 you get breakfast as well as learning and getting CEUs. They have a Unity section for counselors, and we get to work together in that. And I have a friend who -- it was about two months ago coming to our inpatient -- excuse me -- our support groups. She was very suicidal, and there was nothing we could do. She tried her best. She ended up going to the outpatient treatment -- the intensive outpatient treatment and that saved her life.

So sometimes inpatient isn't always the answer. She was able to work, go on with her life, and Cedar Hills really helped her. We thank them for that, because we then couldn't do it, the family couldn't do it, she couldn't do it, but with that program I think her life was saved.

So the positives. Tony is not going to like this. He knows I seriously don't like the model for me as somebody who goes through whatever it's called, psychosis or not a sense of reality. I do not like the model of this PES, the Psychiatric Emergency System -- or

Services. For some people it can be really good. Some people who are feeling depressive, suicidal who need some medication, so it's really good. But for me personally to have -- to be in a room with 39 other people who are in pain, I can't handle that. And I know I've stayed in emergency rooms, been stuck there for days, I kind of like it because I get my room, and for me that works.

So, actually, this will offer another choice. They will have new architecture. We'll see how that does. I'm really excited about Unity. I love the architecture. I got focus groups in from peers and families, and I think that's going to be great.

It will keep people out of jail. As we know, 40 percent of people in jail have mental issues, not necessarily criminal. So it's another avenue to keep people out jail.

And we are losing 10 beds in Portland. As we're getting more and more -- I think you notice from traffic today -- we just have more people in Portland, and we're going to have more need. And some people just need to go to inpatient for a while. We're also going to get

more tech people who are going to have different kinds of needs, and more needs, and I hope the systems think about that.

Cedar Hills right now does work with veterans, women and substance abuse, and that is really more broad than what we see in other places. And I'm so happy, again, to have the outpatient treatment, which you can do during the day or go to work and do it at night. So that's a positive.

Negatives. The whole hospital system can also just be inhumane itself. You are watched by cameras. People are writing about you. I don't know how that makes you feel, but it's very difficult to live with. So it's just a hospital system.

For me, for example, I wake up happy everyday. And if I wake up happy in a hospital, they call me manic. So it's hard that way.

It's also hard for those of us who are very sensitive to feel energy, to have 100 people, again, in psychiatric crisis and psychiatric pain, to feel that. I personally don't like having units more than 16 beds. There must be a reason why they picked 16 beds before. More than that tips over the thing for me that I feel -- it's hard. I'm very

sensitive. It's hard to be with more than 16.

We're continuing old systems. And every hospital in Portland doesn't have enough staff on hand. I've worked with staff inside and out of the hospitals, and every hospital needs more staff on the floor. Now it has to do with financial problems. There's a lot of things going on, but that should be done everywhere.

And I always laugh at evidence-based, because we are Oregon, we're Portland, and who knows what goes on someplace doesn't necessarily work here, as we know.

Suicide -- something about suicide. So for us who say we're suicidal, I just went to a workshop in San Diego, so it doesn't necessarily mean we're going to kill ourselves. So what happens in the system is if you say that you're suicidal, they lock you up and you're in the system. Maybe it means we're not liking our life, we're very poor, things like that.

Also talking about the ligature -- I don't know how you say that. Let me start over -- of the building, so doorknobs. People may not understand this, but if you feel like you want to kill yourself, it's going to happen no matter what,

where you are going to do it. I mean, it's a horrible thing to say, but we're so strong.

So, for example, in our new hospital we're not allowed to have toilet lids, and it's going to be like prison-style toilets. It's cold. Right? Do we want that? That's coming from the State of Oregon.

So what I'm saying, in Italy -- I was in Italy last year giving a speech about mental health. They say, "You Americans, you build the worst, you expect the worst, you get the worst." So that's just something to think about. Yes, we have doorknobs, things like that. But on the other hand, it's about the care system, and it's about us as patients learning to work together. We have a subculture in the hospitals when that happens.

Let's see. So things that have happened in Portland. I'm not going to -- well, I'll give one story. So one person -- how are we doing on time?

So one person came out of the hospital. She was kind of let go a little bit early. She didn't have shoes. She didn't -- she had those hospital socks. She didn't know what to do. She couldn't take the bus. She didn't have shoes. She

had to get back to her home that was very far. And the security system -- she was just kind of confused, wandering around, and didn't know what to do. The security at the hospital arrested her, took her to jail, and that's hard because we're not offered enough. And we didn't know she was there. We couldn't pick her up. This is happening right now in Portland.

And we talk about recidivism in hospitals. I worked at CATC, the Crisis Assessment Treatment Center, and people do come back, but got skills. And sometimes maybe you have to go back for training. You know, you guys go back for training; right, CEUs, things like that? It's kind of like that. Sometimes we can't take care of things at the moment. We need to work on things. We get out, and we learn skills, and come back.

So as I was in Japan in the hospital system, they said, How did you come out of the psychosis so fast? Well, 30 years ago they had therapy in the inpatient hospital system, and I learned those skills, and used those through my life.

So we're also dealing with people's souls, which is just hard. And if we happen to

be -- those of us who kind of go in and out of the system are just more sensitive. So thinking about that as we're building systems. I'm willing to compromise because that's what I do as a person. I get in trouble with the other peers, people with mental health issues in Portland say we must oppose this and must oppose that. Well, we have to compromise. We're not at the point yet in history where -- we're not yet at the system point in history where we're ready to take away the hospitals. So now there are different ways, like music, to work with life and get healthy. We're all under a lot of stress. We're going to be under more stress in Portland, unfortunately. So just to have more options. That's okay. We're at hospitals now. But to keep in mind, keep the focus, keep the promise that we will be working towards healthier solutions for staff, as well as for us, and our families. It is so hard for everyone around us.

So what I would hope for is not these 100 big buildings of people, but small -- if we have to do hospitals, do hospitals, but small places, not more than 50 -- compromise on that one -- in different areas of town because it's so hard for family people to visit.

For example, you know, there's still hospitals around Portland. We would drop people off, as friends, we see they need hospital help, we bring them there, not that we like it, but it's the best solution sometimes. And we would put people in the hospitals closer to our house, because we can visit them a lot. And people -- my friends and peers just don't have cars, so we made it easier for us. And if you only have monopolies, and these big buildings away from everybody, not everyone has cars, transportation. So thinking about that.

What I'd like to see is more subacute, and also more support for homes, staying at home. So even like for me, I was not doing well last year, I have a support system of three people. I change from family to the three people. They are peers. Two of them believe in medication, one doesn't. It's really nice to have that kind of thing. We were talking about what am I going to do when I'm in crisis. So even texting or peer care or support from families. And we need support from families as well. But having people so we can stay home and get the treatment, make sure we're getting food, and stay at home so the hospitals can be used for people who are in really tough situations.

And they say, well, I just think there's going to be a need for more beds. Outpatient treatment, let's have that in every hospital. As we're transitioning out, do that. And they are talking about always this warm handoff. And I ask, "Warm handoff to what?" We wouldn't be having so many problems if our systems would work. And we just heard -- I can't remember which state person, they had 40 percent turnover in these public agencies. They are not paid well enough, so let's get them paid well enough.

I'm on Medicare, and I go to -- I've been at this lucky clinic. When you get disability, you have two years before you can get medical help. That clinic covered me for two years, but that was a miracle. And, again, I'm on disability, so I earn $1,200 a month. They keep us poor. I don't know why. And that's what I live off of, and I get $16 in food stamps. But one way I'm able to do all this advocacy during the day because I have my basic work is paid for, and I try to get food where I can. If I see you at meetings, I'm always taking food from people from -- the extra at meetings.

We're worried about the assisted outpatient treatment because -- for example, in the

hospital, the psychiatrist sees you maybe 5, 10 minutes. "Oh, here's the meds. This is going to work." Well, every time I've been in the hospital the last five times, I've had to come off those meds within the next two weeks because they weren't working for me.

But you learn, if you fight with the system, you don't get help. So we know our tricks. It's also hard to get in the hospital. Sometimes we know we have to say we feel suicidal or something because it's hard to get in.

Also one thing I'd like to say, systems and hospital systems, if you think about epigenetics, let us help understand, where is all this coming from; our family, from society? We need to understand that. I just learned a lot about my own grandparents, things like that, alcoholism, domestic violence, things like that that I didn't know. And no wonder I have these problems, it's gone into my body, into me. Cedar Hills has -- with trauma, studies show it's in your body. So it hits your body. So, anyway, having a gym inside, a gym is nice, fantastic.

In this society also we don't allow a lot of emotions. And I've been to 18 countries,

I've worked in two, and the American is like we have this box. You get out all these emotions, you end up in the psychiatric system. Some of us are just more sensitive than others.

I was lucky. I saved up enough airline points and went to Italy last year. Well, think about it. They allow crying, and they allow people to move their hands. And if I do that here, I get diagnosed, more medication. That's it.

So how do we fix the system? One step at a time, and make sure that whatever systems come are most humane. I think the state doesn't always know how to get the information from those of us and the families who know the system, there's no conduit for that. And if you complain in the hospitals, you can be retaliated against.

So my mother is very strong. She complained at one hospital very strongly. She's a little bit too strong. And I got worse care from that from the staffing. So I suggest we get some kind of outside way for us to give information so we can impact the system that might be better.

So I don't have a chart, but what I do have is a poem. It has to do with emotions. And I'm looking forward to continuing working with you.

I'm actually on a committee that advises Oregon Health Authority. I have hope. We are different. And hopefully we won't need more hospitals at this time, maybe we do.

So every human is a guest house, every morning a new arrival. A joy, a depression, a meanness, some momentary awareness comes as an unexpected visitor. Welcome and entertain them all, even if they are a crowd of sorrows who violently sweep your house empty of its furniture, still treat each guest honorably. He may be clearing out for some delight. The dark thought, the shame, the malice, meet them at the door laughing and invite them in. Be grateful for whoever comes, because each has been sent as a guide from above.

And we just need help understanding that in working with compassion, getting compassion, making sure there's enough staff in every hospital, and we support them, too. Thank you.

MS. FUSSELL: Thank you, Ann.

So next we have Disability Rights Oregon, please. If you will introduce yourself.

MR. JOONDEPH: Good morning. My name is Bob Joondeph. I'm the Executive Director of

Disability Rights Oregon. We are a nonprofit. We are the Governor's designated protection and advocacy system for the State of Oregon. We're funded by the federal government to provide legal advocacy services for people with disabilities across the state, and that includes people with psychiatric disabilities.

MS. FUSSELL: Is your mic on?

MR. JOONDEPH: It has a light. When you're in the capitol, they tell you to step back from the microphones. I won't do that.

I'd like to thank -- before I start my comments, I'd like to thank Elizabeth Hutter who came from Cedar Hills and came to talk with me. We had a very good conversation. I don't think that anything I have to say now will be a surprise to her, so she's duly alerted.

I've been an advocate for people with psychiatric disabilities for 30 years. I've worked in many institutions. I've worked on numerous issues. And I've been a participant in many planning processes, task forces, workgroups, and the like, trying to improve services for people with psychiatric disabilities in the state of Oregon. And that

has been a bumpy road. But it has been, usually at least, a planned-for road, so to speak.

There's been a need to have some conceptualized health services, how they can best be provided, and to implement that given always challenging funding situations.

Right now I am a member of a mental health collaborative which was brought together by the State. The supporting members -- I think about 40 members who come together in a very intensive planning process in order to decide what's the best way to move forward to provide good behavioral health services in the state, given our circumstances.

And, really, much of this is within the context of the Oregon Health Plan, Triple A with the Oregon Health Plan, which is to have quality services that are affordable as we move forward.

I've got to say at the outset that this particular facility has never been mentioned in that process, at least that I've participated in. So it's a little bit of a disjunction to have worked so intensely looking at the mental

health system, and from my perspective at least, that this particular proposal come in sort of sideways, and now we're here in the need-type process, which is a little bit off to the side.

So the comments I'm about to make are comments that I would have made had this proposal been part of an overall look at the provision of mental health services in Oregon, and I've not had an opportunity to do that because this was really -- other than the meeting that I had with Ms. Hutter, which was a great meeting, I enjoyed it, this is really the first time that I've had an opportunity to raise these issues.

So the first thing I touch upon is that when I read the proposal I was concerned about the size of the facility. I think 100 beds is a large facility. My own experience in 30 years of working is that the larger the facility is, the more difficult it is to manage, and the more opportunity there is for mischief.

I do not believe that there's any facility that's perfect. I know there's been

some concerns raised about other facilities here. I could take a long time to tell you about problems that we have confronted in a variety of facilities. And so I think the most important thing about designing the facility is making sure it's well physically designed, adequately staffed with good oversight.

I'm not sure how the oversight works for a facility of this sort. I know how it works in the public sphere. I'm not so sure how it works in this sphere.

I was also concerned about the fact that it's sited right down the street from Coffee Creek prison. I get a little ironic about this because the State of Oregon has always had a habit of siting its mental health hospitals right next to prisons. And so to have a private company come in and do the same thing seems to be replicating a disfavored model of stigmatization of the population that the discarded people go off down the road toward the prison and the mental hospital, and everyone else gets their services in the community. It is an exclusion of people of a certain identity from society rather than

inclusion of people with psychiatric disabilities into our community. At least that's the message that it sends.

In reading some of the materials I note that were presented by NEWCO, it seems to me that while they did address some of the criticisms, there was a degree of defensiveness in their materials that troubled me. And I believe that running a good behavioral health facility is very challenging, and you have to be open to criticism, and you have to be responsive to work with regulators rather than just explaining how wonderful your company is. That really doesn't solve what will be ongoing challenges for a facility. So I have that concern.

I do not have a lot of experience with private facilities. With Cedar Hills -- we did testify at this process when Cedar Hills was established. There were promises made at that time that were not followed through with. However, over in recent years we've had better relations. For us that means, as I told Elizabeth, no one calls us because they are happy with their services. They call us when

they have complaints. And so in order for us to be able to resolve complaints, we need to have a good working relationship with the management of a facility and have easy access to their residents. As I said, that has improved as of late. There were periods in which it wasn't so good.

And, again, in this proposal they presented and then brought a planning proposal, another issue I would have raised had to do with a boarding question. Boarding in emergency rooms is something that a larger plan has been grappling with and many, many of us are critical of it.

My sense of this proposal is that the way to deal with boarding is to build more patient beds. In my estimation, that doesn't address the boarding issue.

The work that's been done on the Unity Center was much more planned for open process in looking at what, in fact, is the demand in the community; how do we best address it.

I would say, just to put it simply, the thinking behind that, at least from our perspective, was that to the extent that we can

have more robust community services, more robust crisis response services in our community, but to more effectively divert people from longer term psychiatric bed stays in the hospital, that we would be better addressing the problem that way than building more patient beds, and that for better or for worse, it always starts with the dollars and cents creating a solution.

I know that the individuals -- the psychiatric disabilities that we represent, we have an advisory group in our structure in our organization that advises us, and I work with many other groups, and their desire, I would say is maybe not unanimously but predominantly, has been towards a solution of better crisis services, better support services in the community, better housing rather than building more patient psychiatric beds. So I report that to you.

I was also -- not to nitpick -- but I also represent individuals with intellectual, developmental disabilities, and their service system. One of the top issues in that community is access to psychiatric services.

The materials that I read indicated that Cedar Hills would not serve people who had cognitive limitations that did not fit with their model of treatment.

I have two concerns about that. One is that they are currently going to be serving -- or proposing to serve the geriatric population with dementia, and I wonder how that service model would differ from serving people with intellectual and developmental disabilities. And, of course, that raises a red flag for us about discrimination in terms of who they serve and who they don't serve. And perhaps if you are going to go ahead, I would be interested in seeing more of an explanation on that particular topic.

Moving to youth. You're probably aware that there have been some recent closures in terms of facilities that serve youth in Oregon, that there's a very difficult financial bind that some of the major providers are confronting right now in terms of providing inpatient residential services for youth.

Again, I don't know how this model would seek to address that in this particular

facility, because it hasn't been discussed in any other context that I've been involved with. But those are real challenges. And, again, it's a difficult population, I believe, to serve effectively because it really depends upon excellent movement of that youth in and out of that environment.

Last thing I just want to mention is about a cost savings strategy, because that's something we've talked a lot about in our planning processes. And it's one that I'm -- it always makes me very alert, because I think the cost savings across the healthcare system are something that we really have to fund publicly.

Achieving cost savings by making one resident inpatient facility less expensive troubles me. I think that the solution to cost factors is to keep people out of long term care effectively, keep them in housing, keep them with supports. When a person comes into an inpatient facility, I think it's important that it be very well funded, very well staffed, because then you avoid the suicide, you avoid the unnecessary restraints, seclusion, you

avoid injuries to staff and patients. And it's a real challenge.

30 years of doing this work has told me that's a real challenge. And solutions have been good staffing, good training, and adequate facilities, collaborative problem solving, which we need, and constant work on the culture. That doesn't come cheaply. So I would be suspicious of funding. Cost savings doesn't do that in a particular facility.

So with that, I think I've covered my points and will submit something in writing.

MS. FUSSELL: We'll look forward to receiving that. Thank you very much.

Now we have NAMI, please.

MR. BOUNEFF: Good morning. My name is Chris Bouneff. I'm the Executive Director of the Oregon State Chapter of the National Alliance of Mental Illness, NAMI. We are a membership organization, a membership-governed grassroots organization. We have 15 chapters across the state of Oregon. Our prime role is to provide education, support and advocacy services for families of individuals affected by mental illness.

We're almost entirely composed -- our membership, and our volunteers, and our leadership, and those of us who are staff -- are people with directly related experience. We live with mental illness, we have parents raising children with mental health disorders. We are siblings, and parents, and uncles, and aunts who have the love of their life living with serious mental illness.

Before I go on with my comments, I do want to clarify something that was mentioned, the program Homefront, and it being in Oregon. This is a program for veterans' families in the state of Oregon that was brought about into our state, thanks to a very significant grant from Providence Health System, not that I would reject a check from UHS to expand that program, but I did want to be on the record that, at least in the state of Oregon, it's that funding that made that program possible.

I do want to start off my comments echoing what others have said. This is a large institution. We don't favor large institutions. It's hard to be a patient in a large institution. You need family supporting

the loved one in a large institution. By and large, the clinical evidence suggests that smaller, more intimate environments -- we respond better when we are particularly in some type of acute crisis. That is our bias.

I know we're not here necessarily to discuss what the proper size is, but our comments are colored from that perspective, and that overall we would be more enthusiastic about capacity being added when we're talking about 5 to 10 to 15 beds.

We're not here either -- NAMI is not here to either support or oppose this proposal for this hospital. This is one of those circumstances where we will raise some factors that we think need to carry some considerable weight and evaluation of this application; and the approval or denial of it, we're going to kind of put our trust into the state agencies that have the expertise to evaluate this. As I am thinking about it, there is a joke in the back of my head. Any true advocacy organization, no matter what you decide, will find a way to complain about it, I'm sure.

Some of the factors that we feel as we

deliberated, read the application, there were things that came to the surface that we think are very important from our perspective as the people who will avail ourselves of these type of services, and any services in the communities in which we reside.

We think it's important that any institution, a hospital or anything, be able to accept all payors, be able to work with commercial insurance, be able to work with Medicare, be able to work with Medicaid, be able to work with whatever iteration of healthcare reform comes out of the new federal administration that may undo many of the things that we've done in the state of Oregon.

We feel that the applicant in this case should demonstrate, on some significant level, the community benefit, including working with patients who have no coverage or insufficient coverage. As an example, while it's laudable that the state of Oregon has reached about 94, 95 percent coverage of all of our citizens, we run a resource line, to which we get about 2,000 calls a year, about 20 percent of our callers still have no coverage. So our

population is particularly significantly at risk of not having coverage, despite all the efforts that have gone on to get people coverage through Medicaid and the expansion of our health insurance exchange.

We believe that an application needs to be judged also on its financial impact on the stability of our overall acute care system. Will it truly add capacity? Certainly our organization is replete with anecdotes about how difficult it is to get into an inpatient bed because none of them are available. Nevertheless, these are very expensive resources. And if you build more beds, are we going to be supplanting beds that are now operating elsewhere because we have added financial strain, so financially will we be driving people out of doing business who are currently doing business now. Truly, if we're going to add hospital-level care, it needs to be in addition to, rather than a substitution of people doing business from.

We also believe that the financial impact on the rest of our treatment and support system needs to be taken into account. We

learned through the state hospital system, and many of us warned lawmakers that it's coming, but we learned you can't build your way out of this problem. You can't have a disproportionate share of resources going to the most expensive levels of care while not having a concurrent significant investment in the rest of the treatment system, otherwise you don't prevent the crises that lead to hospitalization, and you quickly overwhelm the services you have in the hospital.

The financial -- again, the disproportion that we've seen in the public side with the hospital-level care, if we build more beds, will that take up more of our health protocol, preventing people from accessing the type of lower intensity services that we know are very effective early in the trajectory of an illness and prevent a crisis from occurring.

Certainly, the applicant in this case has a large footprint across the nation. We do believe it's valid to look at their history and quality of care. We're not casting judgment. I'm not here to present both positive or negative stories, but there is a record there,

and we believe that is a valid aspect to judge this application upon; is this an entity that can demonstrate a strong history of quality of care? If there are particular problems, are they addressable? What does that history look like?

Does the applicant in this case have and can demonstrate strong evidence of a connection to community services, yet going back to all payors, do they have strong connections to providers who provide assertive community treatment, who provide intensive outpatient, can they demonstrate partnerships with our coordinated care organizations? Can they demonstrate partnerships with our patient-centered primary care homes, which the state has made a significant investment in as putting in the kind of the center of our care; will they be able to demonstrate strong relationships as the state develops behavioral health homes? The state is making significant -- or attempting to make a significant investment in developing community centered behavioral health homes.

Can the applicant in this case clearly

demonstrate a discharge planning process that complies with House Bill 2023? In the last long legislative session a number of us worked on some legislation about discharge planning out of hospital inpatient because we were tired of horror stories of being discharged to basically nowhere, to nothing, with no plan. A lot of effort has been made, not only in passing that legislation, but working with the hospital association in putting together an implementation guide that has gone out to their members, to which NAMI is a partner on. And we want to make sure that that is implemented, and there is evidence of that.

Also, the applicant in this case, can they clearly demonstrate strong links to other community resources? Is there a NAMI that they are connected to? Are they knowledgeable of clubhouses that are available around the state? Do they know about Depression Bipolar Support Alliance? Can they demonstrate partnerships with other peer-run organizations that are located around the state?

And then one that's important to many of us who use these services or support loved ones

in these types of services, are they located within a reasonable distance of the home communities of the people being served?

I get sick and tired -- so now I'm going to get emotional. I get sick and tired because mental health, it's acceptable to ship people across the state. Everything mental health related is thought of as a statewide resource. Well, we don't live across the state. We live in our communities in our state. And I get sick and tired of seeing large institutions or residential care or things where it's acceptable, where I may live in one community, and the State of Oregon, or my healthcare provider, or just because of the way we put services around the state, you are going to pack me in some kind of transportation and ship me over a mountain, or you are going to send me down to Southern Oregon because there's an open bed even though I live in Portland. Is it reasonable? Are the people being served, is it a reasonable distance? Is there transportation available? Is it accommodating to families and networks that we rely upon, once we are discharged from care, to help keep us in

recovery, help us along our path of recuperation. And that finding is, among our considerations, one of the more important ones. And that concludes my comments. Thank you.

MS. FUSSELL: Thank you very much. Now we're going to take general public comments, and so I'm going to ask you, please, to limit your comments to three minutes.

And we will start off with Peter Hofstetter. No? Okay. So we have a decline here.

So let's move on to Candice Elliott, please.

MS. ELLIOTT: So my name is Candice Elliott, and I am general public. I represent many different fields. I'm a mental health clinician in the emergency room here in Salem -- well, in Salem, just 30 minutes down the stream. I'm also a parent of a child with mental illness, as well as a behavioral consultant in the schools, so K through 12, in the valley.

And so as a clinician, nothing is more distressing to me than to tell a loved -- whose loved one is in acute crisis, I'm sorry,

there's no beds. You have to stay in the emergency room until we can find a bed open, or there's a bed in Coos Bay, or there's a bed in Bend, just like he had said. So having another hospital that would be close by that we can say that we can send somebody to that is only 30 minutes away, versus being three hours away, or even an hour away like in Portland.

So when I heard -- I just heard that there was -- it was Certificate of Need for a bed -- well, for another hospital, I was like, please, we are so desperate. I know that there's something else happening too. Unity is going to be further away.

But in our emergency room, some times of the year we are boarding up to 14 patients a night who are in desperate need of inpatient psychiatric care, and so -- especially children. Sometimes we have kids in our ED from up to five days in a white room, and we end up having to discharge them because there is no bed on the horizon at any hospital or any subacute care.

And so also as a parent, you know, there are times when I've needed help to be able to

hear from subacute, and they say, I'm sorry, they are weeks out, or at times when friends of mine, or people that I see in the hospital need inpatient, and I say, I'm really sorry, but your son -- we have no beds on the horizon. We're going to have to make a plan, with community, with people to be able to take your child home as opposed to needing psychiatric care.

So just as somebody on the ground in the community, just down the road, and as a parent, and as a clinician, and as an advocate for mental health, I know that we need more beds. Thank you.

MS. FUSSELL: I have a question. I apologize. I was otherwise distracted. You signed in as a name of organization, Salem Health --

MS. ELLIOTT: I put that in there because I wanted -- for the record -- to know that I'm not here as a part of my hospital. I'm here as a clinician. I want you to know, too, that I'm on the board of the Oregon Housing Association. And speaking with all the clinicians that work in emergency rooms, all of

us are frustrated with not being able to have beds in our communities to be able to send people to.

And even though I work in Salem, I still feel like this is just 30 minutes away versus an hour away or three hours away in Bend or Coos Bay which have hospitals that we sometimes sadly ship people to. And it puts such intense pressure on us as the clinicians in the emergency department saying -- we've got the hospital and doctors, we need to get this person out. Logistically, we have emergency rooms, you know, and we're boarding people for days on end, and it stresses out a whole community of people that, I think, when you are looking at systems, we're on the ground, we're in the trenches, and this is what's happening for us. And it's so distressing for us, talking to families, and even our coworkers, knowing what happens too is that people get discharged early when they shouldn't be discharged, or they are clear enough no longer need to be on a hold. But if they are in a psychiatric facility, they probably would stay longer. And there's just all these things that

just keep happening.

MS. FUSSELL: I just wanted to clarify.

MS. ELLIOTT: Yes, I'm sorry. I should have just put it in "the community," but that is where I work. And, also, I see in schools we end up having to -- when children need to be in a facility, and then we have to try and make an arrangement for these kids to still come and be in school when they are very, very sick, but there's no way for them to go, it's really, really hard. Thanks. I'll just sign my name.

MS. FUSSELL: Thank you. Okay. So now we'll have Chance Wooley, please.

MR. WOOLEY: I didn't want to speak. I just signed in.

MS. FUSSELL: Okay. We have another decliner there. So now we have David Westbrook, please.

MR. WESTBROOK: Hello. My name is David Westbrook. My affiliation is with an organization called Lines for Life. We run some statewide crisis lines for Oregon, including the statewide suicide line, which we've done since 2003, a youth line, a military help line, and a number of county lines. And

across all of these lines this year we'll take between 60- and 65,000 calls. Most of these folks will be people who are in an emotional or mental health crisis.

For our suicide callers, which on the suicide line we'll take about 13,000 calls this year. In about 95 percent of those cases we're able to de-escalate the situation, find them resources, whether they are formal or informal, that don't require hospitalization.

About 5 percent of the time we're in a situation where we need to call for what we call a rescue. Basically, this is the person isn't able to stay safe and isn't going to be able to stay safe.

Frequently we know that what's going to happen with these folks is they are going to go to an emergency room, and from there they may or may not have a very short-term stay; but, in all likelihood, they are going to be put back out into a situation which is not yet safe for them.

So we experience a need for additional treatment options on a daily basis. This is even more acute when we deal with youth. As

previous speakers have mentioned, this state has a crisis, a serious shortage crisis of adolescent beds and treatment options, both in the acute and subacute scenario situations. So we see a real need for there to be an additional solution to this.

I'm down to about a minute. I want to talk briefly about our relationship as it is right now with Cedar Hills. Prior to Senate Bill 2023, Lines for Life and Cedar Hills were already making a move in this direction where Cedar Hills came to us and said, you know, you do these crisis lines, would you think about doing follow-up calls with our folks who are discharged.

So together we developed a program where we do a series of follow-up calls, no fewer than three, one 24 hours after, one 10 days after, and one 30 days after, to make sure that folks who are being discharged are safe and have the needs met that they have. We may do a bunch more calls in there, depending on that.

I just wanted to point that out as one of the places where Cedar Hills, UHS, have been really innovative and are already thinking

about what happens to our patients after they leave, after they are no longer necessarily in our care. It's a service that they do pay for, and that is helping to reduce recidivism. And with that, I'll conclude.

MS. FUSSELL: Thank you very much. And so we have Keith Breswick, please.

MR. BRESWICK: Can you hear me? I have difficulty hearing and had difficulty hearing. I just want to make sure that people can hear me.

MS. FUSSELL: Talk into the mic.

MR. BRESWICK: Is that okay?

MS. FUSSELL: Yes, that's fine.

MR. BRESWICK: I'm Keith Breswick and I'm presently employed with the Oregon Health Authority. I've worked over 40 years in Oregon in community mental health programs, acute care psychiatric hospitals, a variety of different residential programs.

But essentially what I want to comment on today in terms of my experience collectively with all of those different organizations, and some of the problems Oregon faces. When I first started off in employment, I worked at a

county facility and was never really able to achieve full-time employment. There was constant transition, loss of funding. So try as we might, we did what we could for our client in order to care for them.

I then went to work for a hospital. And at that acute care hospital that program was both owned by a for-profit, and then went back to being a public hospital basically in Oregon and serving patients. But that program, too, was very limited and changed as a result of funding and the directions that occurred.

So today I think we still are in this process of transition and trying to figure out how are we best going to serve the patients. What ends up happening today is that the emergency departments receive all patients without being able to discriminate who they serve.

So when we talk about psychiatric needs, there's numerous that we really haven't addressed here in this NEWCO corporation. Those comorbid issues, such as developmental disabilities, geriatric, psychotic disorders that are not treatable, or are more medical

than they are psychiatric, and then there's cognitive disorders. We have patients that are not getting the proper treatment either in state hospitals or in community hospitals for those types of disorders.

So, number one, the concern I have about this facility is that it has applied as a specialty hospital. It does not have to have an emergency department. What happens is, they can choose who they serve; and, as a result, I don't believe they will be serving many of the people that need to be served in the state.

Right now you need to use the specialty hospital. It's the second that Oregon has ever had. I think we need to see how Unity succeeds in meeting some of these needs before we proceed with granting another specialty hospital. Thank you.

MS. FUSSELL: Thank you very much.

So is there anybody who hasn't already spoken that was an affected part that didn't identify themselves that wishes to speak? I don't see anyone.

So if anybody wants to present written information regarding the application, they can

come up and give it to me.

And I just want to reiterate that the record for receiving written material in relation to this public meeting will remain open until December 2nd, 2016, at 5:00 p.m.

And over on the table I put some information out about how you can email information in if you wanted to.

So I thank you very much for your participation today. I think this was a very valuable meeting, and I now declare it closed. Thank you.

(Meeting adjourned at 10:45 a.m.)

CERTIFICATE

I, ROBIN REGER, Certified Shorthand Reporter, do hereby certify that the public Certificate of Need meeting In The Matter Of The Application Of NEWCO Oregon, Inc., CN #675 convened at the time and place set forth herein; that at said time and place I reported in stenotype all testimony adduced and other oral proceedings had in the foregoing matter; that thereafter my notes were transcribed using computer-aided transcription under my direction; and the foregoing transcript, Pages 1 to 88, constitutes a full, true and accurate record of such testimony adduced and oral proceedings had and of the whole thereof.

Witness my hand and stamp at Portland, Oregon, this 20th day of November, 2016.

Robin Reger

ROBIN REGER, RPR
Certified Shorthand Reporter
Certificate No. 10-0416