OPPOSITION LETTER(S)
Received after August 12, 2016

East Tennessee Health Care Holdings, LLC

CN1605-021

Dear Mr. Christoffersen,

I am FIRMLY against the Methadone clinic in Gray, and I expect you to vote NO as loyal community commissioners and be our voice!

There are available buildings that are closer to the Johnson City hospitals and would make more sense to use those buildings that are more convenient than the one in Gray.

For the safety of those participating in the clinic, if something unfortunate were to happen, if the clinic were in downtown Johnson City, then they would be closer to the hospital than in Gray. For the safety of the community, we have three schools in Gray along with Northeast State satellite site, not to mention with community people, driving on those roads. We don't need anyone impaired driving and endangering lives.

We are not in the city therefore we don't have the added police presence that is needed for this type of clinic in our community.

We would have increased traffic and the roads stay pretty busy as it is now.

The methadone clinic would decrease property values and increase crime rates. Don't you enjoy living in the beautiful county that we live in where we can leave our doors open and our kids play in our yards? We work hard for the property that we own and have chosen to live in a community that's quite and safe with nice neighborhoods. Don't bring that methadone clinic in our backyard!

WE DO NOT WANT THE METHADONE CLINIC IN GRAY!

Concerned citizen,

Alison Page, C.P.M.
Global Indirect Procurement & Supply Chain
Eastman Chemical Company
P.O. Box 1975
Kingsport, TN 37662
Phone: 423-229-3243
Fax: 423-224-0675
Email: apage@eastman.com

From: Amanda [erask33@hotmail.com]
Sent: Thursday, August 18, 2016 8:43 PM
To: Jim Christoffersen; Melanie Hill
Subject: CN 1605-021, application of East TN Healthcare Holdings, Inc

Mr Christoffersen and Ms Hill,

I am writing you as a concerned citizen of Gray, TN, regarding the certificate of need of a proposed methadone clinic in Gray.

My first concern is there is no public transportation in Gray. This is a rural/agricultural community that is lacking in this department. I feel that this will limit several people needing this treatment due to lack of transportation.

Another concern is there is no hospital close by in case there is an emergency situation regarding one of the patients who is taking Methadone. Methadone has many side effects, and there would be a 20-25 minute wait time, possibly more, for them to get to a hospital if needed.

Gray does not have a police force present in our community. There would be a significant wait for a Johnson City officer to arrive if there were any safety issues/crime with these patients.

There is great concern about the increase of traffic this clinic will bring due to the load of 600 patients per day the first year, and the possibility of that being doubled soon after that, with no patient limit known. The traffic is already very busy on this 2 lane road due to the residents, schools, businesses, farm land, etc.

There are many other issues of concern including crime increase, multiple schools within a 2 mile radius, a fossil site and children's museum within a mile, etc.

I hope that you will consider declining this need for a methadone clinic in Gray.

Thank you for your time! Amanda Gaither, 693 Shadden Road, Gray, TN, 37615

Tennessee Health Services Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CN 1605-021, application of East Tennessee Healthcare Holdings, Inc.

To Whom It May Concern:

This letter comes to you in opposition to the proposed site of the methodone clinic in Gray (Washington County). One of my concerns is the fact that there is no public transportation available in the Gray area -- no buses or taxi cabs. The proposed site has no controlled access to the 2-lane highway for those who would be driving. There is a great deal of commuter traffic on that 2-lane road as well.

Another concern, possibly the greatest in my eyes, is that there is a lack of emergency medical facilities in the immediate area. The nearest medical hospital, Johnson City Medical Center, would be a 20-25 minute drive from the proposed site. This driving distance would put the patients in danger in case of an emergency.

The proposed site in Gray is also the one that is the farthest from Johnson City. Please consider the approval of a site located much closer to the Johnson City Medical Center for the proposed methodone clinic in Washington County.

Thanks you for you consideration of my opposition to this proposal.

Sincerely,

Ardis Sue Stafford

Lowavia Eden

From: Melanie Hill
Sent: Wednesday, August 17, 2016 11:05 AM
To: Mark Ausbrooks; Lowavia Eden
Subject: FW: Methadone Clinic in Gray, TN

Melanie

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

www.tn.gov/hsda
Phone: 615-741-2364
Fax: 615-741-9884

From: Charlee Overby [mailto:charleeoverby@gmail.com]
Sent: Wednesday, August 17, 2016 6:40 AM
To: Stoutclay@aol.com; Dtomita@johnsoncitytn.org; Jbanyas@johnsoncitytn.org; Thegenuine@comcast.net; Jbrock@johnsoncitytn.org; Melanie Hill
Subject: Methadone Clinic in Gray, TN

Good Morning,

I am a resident of Gray, Tennessee. My husband and two small boys, ages 3 and 1, moved to Gray from Johnson City this past October. We decided to move to Gray because of the beautiful country, small town charm, tight knit community, etc. We thought it would be a perfect setting to raise our boys.

While raising two boys I have been a bit distracted from all the outside news until just recently when I read about a methadone clinic possibly coming to our very small, tight knit, wholesome community. This methadone clinic is within short walking distance to our schools, Natuonal Fossil Museum, etc. It's only a few miles from our precious little home where my innocent 1 and 3 year old reside.

This is disturbing. How can a methadone clinic be put so close to schools, a national fossil museum, our homes, and in our community and we not have any say. How is this justified?

If this was coming to your community just a couple of miles where your two boys played alone in their back yard, within walking distance from where they would be attending high school, where people from all over the world come to be in the presence of 100's of years old fossils, etc. Wouldn't you do everything you could to protect the safety of your community and where your babies play and learn.

I am begging you to say no to a methadone clinic in Gray. Please listen to our community and not the pockets of corporate greed. Please let the people of Gray that will be most affected have a say in this decision.

The Brackins Family
434 Buckingham Road
Johnson City, TN 37615

August 15, 2016

Via U.S. Mail
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: Opposition to Application of East Tennessee Healthcare Holdings, Inc. CN1605-021

Dear Sir or Madam:

It strains credulity to believe that anyone of average intelligence could sincerely believe that placing a non-residential substitution based treatment center for opiate addiction (hereinafter referred to as the "Methodone Clinic") at 203 Gray Commons Circle, Johnson City is rationale, safe, or appropriate for the rural community of Gray. The very fact that we are having to voice opposition to the placement of the Methodone Clinic in Gray is reminiscent of the show "Are you Smarter Than a 2nd Greater?" For example, even my 2.5 year old is able to understand the traffic limitations of the area as we sit in stand still traffic during the time frame of school dismissal at Ridgeview Elementary school just hundreds of yards from the proposed Methodone Clinic. Daniel Boone High School is approximately a 1/2 mile away on the very same road. My 2.5 year old is not old enough yet to lie as adults can (i.e. those that believe this is a fit location for a Methodone Clinic) and remarks "Mom, there is too much traffic! It's busy!"

Has East Tennessee Healthcare Holdings, Inc. (the "Applicant") provided clear and convincing evidence that the Methodone Clinic will not cause issues for the thousands of students who are forced to use the very same road as an ingress and egress to school? Has the Applicant explained that public transportation is **not available** in this area? I am not an expert on the types of folks who may need to utilize the services of the Methodone Clinic, but common sense tells me that there is a very great percentage of those individuals who could greatly benefit from public transportation availability.

Many different things go into increasing traffic accident risk, like reduced attention, slowed reaction, slowed psychomotor performance, etc. and those factors seem to weigh heavily to indicate that many people who might utilize the Methodone Clinic would be impaired or less alert than those not utilizing the clinic. This, coupled with the very high number of young children in the Gray area, is a recipe for disaster. A quick internet search reveals several reputable studies indicating that those who visit Methodone Clinics are more likely to engage in risky driving behavior and/or have a higher rate of accidents/crashes. If someone wanted to walk to other locations to shop or eat after receiving a dose of Methodone and to wait longer before they stepped behind the wheel, the Gray location does not allow for them to do so. There are no

sidewalk and simply no venues or restaurants for them to do anything other than visit the Methodone Clinic. From a common sense perspective, folks who will be utilizing the Methodone Clinic will not blend in and this could cause great shame to them---wouldn't it simply be more compassionate to place this in a location with other medical facilities for the purpose of anonymity?

The Applicant has access to dozens of other more suitable locations for the Methodone Clinic. I work in the area of Johnson City called the "Med Tech Corridor" located at the Med Tech Parkway in Johnson City. Therefore, I work in a business and medical area of town that would be suitable for the Methodone Clinic. Upon information and believe, there are vacant locations owned by Mountain States and/or ETSU in that area or in nearby areas to the Med Tech Parkway which would provide access to the medical treatment many, if not a majority, of the folks utilizing the Methodone Clinic would need. If there were truly a medical emergency at the Methodone Clinic, the nearest hospital is many, many miles away in Johnson City proper.

Have you personally visited the proposed site? If not, you should. I would welcome the Methodone Clinic to move next to where I work but I do not welcome it in a rural area in Gray, Tennessee where I reside with my husband and our daughter. I have worked hard my entire life, started work at 15 years of age, worked two jobs in law school, and still work full time now. Our move to the Gray community this past year was very intentional and well-thought. We enjoy the fact that we look out our back window and see cattle grazing and deer playing. We live less than a mile from the proposed Methodone Clinic site. Unless cattle and deer are currently needing to partake in the services of the Methodone Clinic, then the placement of the Clinic is overwhelmingly in the wrong location to reach the most addicts in the most efficient way. Has the Applicant provided you with statistics regarding how many folks within a mile radius of the Gray location would utilize the Methodone Clinic? Not many, if any, would be my educated guess.

Please understand that the interests of Johnson City proper are not aligned with the interests of Gray located in Washington County, Tennessee. In fact, the constituents of Gray are not the constituents of the city of Johnson City where the proposed site is located (although it should be noted my family spends lots of money in Johnson City each year via shopping, retail, and work pursuits). The one small section where the proposed Methodone Clinic is located was annexed years ago by Johnson City. Tennessee law greatly discourages strip annexation as evidenced by the recent developments in law regarding this issue. From a public policy standpoint, it is inconceivable that a city with very little connection to this community can single handedly make decisions for Gray. In my opinion, Johnson City may very well approve the zoning simply to keep it out of its own backyard and away from its constituents. Even Mountain States and ETSU appear ashamed to place this on their own very large campuses.

One also needs to consider the following:

- Have you spoken to the school officials of Ridgeview Elementary, Daniel Boone High School, and/or the Washington County School Board? At the meeting that was held on August 5, 2016, it is my understanding that Mr. Mabe, an educator, was also in opposition to the clinic for a variety of reasons.

- Have you spoken to the law enforcement officials in the Washington County Sheriff's Department? While the City of Johnson City Police Department may have its own opinion, the fact remains that the Washington County Sheriff's Department serves most of the area surrounding the proposed site of the Methodone Clinic. At the August 5, 2016 meeting, Sheriff Graybeal was in stringent opposition to the Gray location, citing numerous reasons why this was simply a bad, unfit, and illogical location.

Thank you in advance for your consideration of our opinion regarding the Methodone Clinic.

Very truly yours,

Christie Hayes Brackins

TJ and Christie Hayes Brackins

cc: Citizens to Maintain Gray (via e-mail only)
Mayor Clayton Stout (via U.S. Mail)
Vice Mayor David Tomita (via U.S. Mail)
Commissioner Jeff Banyas (via U.S. Mail)
Commissioner Ralph van Brocklin (via U.S. Mail)
Commissioner Jenny Brock (via U.S. Mail)

Aug. 16, 2016

Dear Mr. James Christoffersen,
If there is anyway you could help our community of Gray to stop M.S.H.A. from putting a Methodone clinic right in the middle of 2 elementary schools and 1/2 mile from Daniel Boone H.S. Plus The Fossil site with Hands On Museum. Having children coming for day trips throughout the school year!

There is not a Transit Bus to bring or take back these people for their methodone doses - esp. at 3:00 p.m. when schools are letting out! Now add these drivers to the

OVER →

121-0270

already crowded traffic backup. Most of other clinics in TN. are located closer to hospitals!!!!

There is also a lack of police force, only County services only — no city police force — This puts increase on budget for additional services with lack of funds already!

Mayor of Washington Co. offered 30 thirty alternative locations with no cosideration

This site located on map not contiguous with Johnson City property — who by the way voted down a metodone clinic

a concerned citizen of Gray Community
Debbie Killen
Brad "Rocky" Killen

Don Buxton
112 Deakins Estates
Jonesborough TN 37659
buxton4@comast.net

Subject: Methadone clinic Gray , Tennessee

Certificate of Need Hearing

Honorable Governor Bill Haslam

I am writing in regards to the proposed methadone clinic proposed for the Gray, Tennessee location. As a local resident, parent, taxpayer and customer to both MSHA and ETSU. I am opposed as many are to the location of this clinic for a number of reasons. First the clinic is in a very close proximity to several schools, businesses, fire station and rescue squad. The traffic that this will bring will have no added value for the community in the form of any revenue.
Secondly I understand the need for support and care for those who need drug addiction care. As a lifelong resident of this region I also know underlying problems this is going to create is the buying and selling of methadone on the street.This region has the pay for prescription clinics that are not non profit operations. The clinics and doctors are payed. The owning organizations are payed. This drug to remedy opioid addiction is easily obtained and spread on the street. I have many friends and even a son in law enforcement that deal with drug issues daily. Adding additional fuel to the fire does not help.
Thirdly the forcing of a clinic as well as annexation of any community that is clearly against both issues strongly suggests that the best interests are not being taken into consideration. If these entities and political leaders are acting outside of the majority of community wishes then it brings to questions the ethics and morals behind the decision ?
If the need for such an operation is still felt by MSHA and ETSU and the State of Tennessee, would it not be better served to be onsite at one of their more functional facilities such as the hospital or on campus. This will allow more security, better observation areas and more visibility?

Thank you
Don Buxton

Lowavia Eden

From: Melanie Hill
Sent: Thursday, August 18, 2016 4:32 PM
To: Lowavia Eden; Mark Ausbrooks; Jim Christoffersen; Mark Farber
Subject: FW: Gray, Tennessee Methadone Clinic

Melanie

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

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Phone: 615-741-2364
Fax: 615-741-9884

-----Original Message-----
From: Buxton4@comcast.net [mailto:Buxton4@comcast.net]
Sent: Wednesday, August 17, 2016 1:32 PM
To: Melanie Hill
Subject: Gray, Tennessee Methadone Clinic

Certificate of Need Hearing

Tennessee Health Services And Development Agency Melanie M. Hill

I am writing in regards to the proposed methadone clinic proposed for the Gray, Tennessee location. As a local resident, parent, taxpayer and customer to both MSHA and ETSU. I am opposed as many are to the location of this clinic for a number of reasons. First the clinic is in a very close proximity to several schools, businesses, fire station and rescue squad. The traffic that this will bring will have no added value for the community in the form of any revenue.
Secondly I understand the need for support and care for those who need drug addiction care. As a lifelong resident of this region I also know underlying problems this is going to create is the buying and selling of methadone on the street.This region has the pay for prescription clinics that are not non profit operations. The clinics and doctors are payed. The owning organizations are payed. This drug to remedy opioid addiction is easily obtained and spread on the street. I have many friends and even a son in law enforcement that deal with drug issues daily. Adding additional fuel to the fire does not help.
Thirdly the forcing of a clinic as well as annexation of any community that is clearly against both issues strongly suggests that the best interests are not being taken into consideration. If these entities and political leaders are acting outside of the majority of community wishes then it brings to questions the ethics and morals behind the decision ?
If the need for such an operation is still felt by MSHA and ETSU and the State of Tennessee, would it not be better served to be onsite at one of their more functional facilities such as the hospital or on campus. This will allow more security, better observation areas and more visibility?

Thank you
Don Buxton

RE: CN 1605-21 Application of East TN Healthcare Holdings

August 16, 2016

To Whom it may concern,

I am writing this to you out of concern for the proposed location that ETSU and Mountain States Health Alliance want to open a drug treatment center. As a resident that lives within a couple miles from the proposed location and has two children that attend two different schools that are within a couple miles of the clinics proposed location I hope and pray that you will consider my concerns.

The location choosen for this clinic stands out in contrast to the rest of the community as a grain silo would located in the middle of downtown Nashville. Gray is a small farming community located miles outside of Johnson City. We are about a 20-30 minute drive to the nearest hospital (10 miles to the Johnson City Medical Center). There is only one ambulance that is around Gray so its availability is hit or miss at best. My big concern is that we don't have the medical support around our community to support this clinic. If someone, God forbid, had a cardiac emergency or something else that required them to be rushed to the hospital, it will take so long to get them there that I fear they would not stand as good of a chance of survival as if they were closer to a hospital.

Mountain States Health Alliance has promised us that these powerful drugs like methadone are just going to be one of many "tools in their toolkit" and that the model for

the clinic will be a "holistic" approach but they have also admitted that they have no experience in running anything like this clinic. It seems like it puts their patients at risk to experiment with a new type of clinic out in the countryside, so far away from other medical facilities,

Please don't misunderstand me. I know that there is a problem with drug addiction and there are a lot of people that need help but our community has no access to public transportation. City busses dont run out here in the country and a lot of the patients that ETSU and MSHA want to treat have no way of actually getting out to us as opposed to city bus access if it were located in the city, many exits up the road.

There are so many other locations downtown Johnson City that would be a better site for this clinic to be put in. I ask that you reject this certificate of need for this location for the above reasons in addition to the fact that there are four schools within 1.7 miles of this clinics front doors and we have almost no police coverage in our neck of the woods.

I know that we are small voices when compared with the money and influence that ETSU and MSHA can bring to bear but the city planning commission and the City Commission have their minds already made up that they are going to force this

"experiment" on us no matter what the risk is to our children and our public safety. They wont even do the right thing and run their trial experiments for this "holistic approach" out of their pre-existing facilities to work out the bugs and find out what works and what doesnt. It is sad to see that they are even willing to put their "customers" at risk by sending them out to the countryside to be dosed up with narcotic medicines and not have emergency care or public transportation.

Please do the right thing and prevent this clinic from opening so far out in the country at least for the patients sake.

Sincerely,

From: Gaither, Jaret R [mailto:jaretgaither@eastman.com]
Sent: Friday, August 19, 2016 2:43 PM
To: Jim Christoffersen; Melanie Hill
Subject: CN 1605-021, application of East TN Healthcare Holdings, Inc.

Ms. Hill and Mr. Christoffersen,

I am writing you as a concerned citizen of Gray, regarding the certificate of need for a proposed methadone clinic in Gray. I do not think the Board should vote in favor of the clinic based on the criteria that HSDA is responsible for reviewing, as follows…

1. Public transportation does not serve Gray. This is a very rural community that does not operate a public transit service. I feel that this will limit a significant number of the people needing this treatment because they lack a method of transportation. My research suggests that there will be a lot of potential clients to this facility that rely on public transportation. Johnson City and Kingsport both have very capable public transit systems that will NOT be able to serve this location. The population served by this proposal and the reasonableness of the service area would be much better suited to a location that public transportation served. Accessibility to the consumers will be limited by this fact.
2. Secondly, the distance to the nearest hospital is quite far. From my research, I have found that there are twelve other methadone clinics in Tennessee. Below is a table of where they are located and the distance to the nearest hospital. Obviously there is a major outlier here, which is very surprising based on the fact that the tri-cities area has **THREE MAJOR TRAUMA LEVEL HOSPITALS AND CAMPUSES**. If there was an emergency situation regarding one of the patients who is taking Methadone, there would be at least a 20 minute transport time, possibly more, to get to the nearest hospital. I do not think this constitutes to the orderly development of adequate and effective health care facilities or services. The precedent has been set by other communities – these facilities should be near major medical hospitals.

Clinic Name	**Distance to nearest hospital (miles)**	Average of e
ADC Recovery & Counseling Center (Dyersburg)	0.1	
Knoxville Medical Clinic – Central	1.2	1
Knoxville Medical Clinic	1.9	

Jackson Professional Associates	2.5	
Memphis Center for Research & Addiction Treatment	0.2	
Middle Tennessee Treatment Center (Memphis)	0.9	
Midsouth Treatment Center (Memphis)	0.9	
Raleigh Professional Associates (Memphis)	2.4	
Solutions of Savannah	0.1	
Volunteer Treatment Center Inc. (Chattanooga)	2.8	
Paris Professional Associates	2.4	
Recovery of Columbia	0.1	
Proposed Gray Clinic	**10.5**	

3. My third concern is that the City of Johnson City Board of Zoning Appeals has **NOT** granted an exception to the zoning code for this location. I do not understand how it would be possible for the HSDA to approve a CON for a clinic that has not yet been approved by local officials.

I also request written notice of the decision of the agency, per TCA 68-11-1609 section f.

Respectfully,

Jaret Gaither

693 Shadden Road

Gray, TN 37663

From: Karen Ward [user204014@aol.com]
Sent: Wednesday, August 17, 2016 4:07 PM
To: Jim Christoffersen
Subject: Methadone Clinic in Gray, TN

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email. - STS-Security*****

17 August 2016

Sir,
My comments are from a medical perspective based on profession and education. Curriculum vitae not included. I am retired.

There is no feasible logic in granting a CON to a medical facility that purports they are providing treatment to drug addicts by substituting one substance of abuse with another substance of abuse. What Mountain States will attain by doing so is perpetuating a vicious cycle of addiction. By definition, Mountain States, a healthcare facility, become enablers.

Relapse rates for drug addiction is 40-60% according to the NIH, and this is in a hospital model that includes behavioral and mental health as part of their treatment protocol. There is no psychological component to a methadone clinic. Relapse is not only possible, but likely. Even drug addicts serious about kicking drugs know behavior modification and psychological components are needed for success.

There is no goal or achievable outcome with a methadone clinic. Methadone clinics simply substitute an addictive drug that is legal, for an addictive drug that is illegal. This action does not stop drug abuse or use.

Research results indicate that the number of characteristics of adolescent relapse, including rates of relapse, are comparable to that of adults, and this according to an NIH study. This shows a significant demographic, does it not? Methadone clinics do not reduce addiction numbers, nor do they reduce relapse numbers. The uneducated going to a methadone facility for help will unknowingly become further enmeshed in the addiction cycle.
How does this help the people of East Tennessee who have a substance abuse diagnoses, or the potential, and the subsequent sequelae?

Methadone clinics do not deal with drug addiction, or any substance of abuse, including alcohol addiction and abuse. Alcohol abuse is just as addictive for patients dealing with that on a daily basis, and no less important than drug abuse.

Mountain States is ignoring an entire segment of society that deal with substance abuse in the form of alcohol. Their needs go unmet. Methadone clinics have a segment of society whose clients walk out the door with unmet needs as well. This is not therapeutic. I cannot call it healthcare. It is not.

I cannot ascertain what Mountain States objective entails by this methadone clinic. Treatment is not part of the plan, because they do not treat the addiction. I see no medical plan at all.
Research proves addiction can be treated successfully. The science of addiction and the treatment of drugs or alcohol abuse disorders, led to development of evidence based interventions that actually help people stop abusing substances of abuse; drugs and alcohol.

According to the NIH, addiction cannot always be cured, but it can be managed. Successful treatment focuses on counteracting addiction's "powerful disruptive effects on the brain and behavior" to help them regain control of their lives. Methadone clinics cannot achieve this.

I reiterate, these clinics perpetuate the vicious cycle of addiction. There is no behavioral or psychological treatment in this endeavor. I see no physician/RN involvement. I have not heard of any advisory board or committee of medical professionals from Mountain States offering input, advice, comments or medical concerns into this model which is paramount in our education and daily treatment of patients. The medical professionals outside of Mountain States who I have discussed this with have major concerns as well.

As mentioned, the relapse rate for drug addiction is 40-60%.
When, and not if, methadone is not adequate, what is the next step, plan B, or alternative?
If they add Narcan, and maybe they already have, Mountain States creates an environment whereby drug addicts take their methadone orally, pocket their Narcan, and leave. Whether they make it out of the parking lot or the county remains to be seen. The fact is, they now have a drug to counteract overdose, so they keep coming back and their addiction escalates. They generally avoid hospital ER's. Law enforcement is not involved. The cycle repeats.
Instead of taxpayers footing the bill for these substances of abuse, I recommend Mountain States foot the bill, since they seem intent on keeping a segment of society addicted to their idea of treatment.

Most people suffering from substance abuse have a dual diagnosis of a behavioral and/or psychological disorder, such as depression, anxiety, OCD, and so on. These patients need professional counseling. This is a major piece of healthcare. Mental health does not exist in methadone clinics. If psychological, along with physiological treatment is not provided, this clinic is not providing medical help in any form or fashion.

The people of this area deserve better treatment options for substance abuse than what Mountain States is offering with methadone that 1) excludes alcohol addiction, and 2) provides heroin addicts a legal option of drugs to enable them to continue their addictive behaviors.
This is certainly not medical care or treatment. I question whether it is humane.

When a recovering addict relapses, that is an indication that treatment needs to be adjusted, or another treatment tried. This holds true for any medical or behavioral disease/diagnosis.

I would like Mountain States to concern themselves with the lack of satellite facilities in this rural area, such as physician offices and urgent care centers, instead of methadone handouts. When I had hives inside my throat, (highly likely they were on my internal organs), I had to drive 20 minutes into Johnson City to an after-hours facility for treatment. That is not acceptable for the only medical facility in this town. Their priorities are flawed.

Please do not issue their requested CON. Their best interests are not the people, but how to make money on the backs of drug addicts.

Best Regards,
Karen Ward, RN
1100 Keeland Lane
Gray, TN 37615

Karen Ward

"When the debate is lost, slander becomes the tool of the loser."
— Socrates

From: Kay White [1kaywhite@gmail.com]
Sent: Thursday, August 18, 2016 9:40 AM
To: Jim Christoffersen
Subject: Proposed Methadone Treatment Center in Gray TN

Tennessee Health Services Agency
502 Deadrick Street
Andrew Jackson Building 9th Floor
Nashville TN

RE: Approval of Methadone Treatment Clinic in Gray TN Community

Dear Committee,

We implore you to NOT allow the process for building a Methadone Treatment Center in Gray TN to continue. Gray is small rural farming community outside of Johnson City. We have several serious issues with having a clinic of this sort in our midst. Security is the most egregious issue facing us. Current levels of police, highway patrol and EMS services would not be able to adequately serve an enlarged health community population. Health Services to adequately compliment such a facility are 14 to 20 miles away in Johnson City and Kingsport. (Last year it was decided that a Methadone Clinic was not needed in Johnson City on Princeton Road and earlier that a Wellmont Hospital was not needed in nearby Boones Creek area.) It seems unusual to us that NOW it is needed in Gray without any supporting services for such a community. Johnson City has a large area, Med Tech Park, near both community hospitals that could easily utilize support services already existing.

Traffic in and around the I-26 and St. Route 75 intersection is congested and unsafe during business commute hours. The backup produces unsafe waiting on the access lanes.Does it make sense to increase this with additional drivers who may be unsafe to drive?

Common sense says it would be unwise to place a Methadone Treatment Center near schools. Gray has both middle and high schools located very close to the proposed site. Please do not add this additional danger to the lives of our community children.

We seldom write letters to support causes but we cannot help but join the voices that are saying "a Methadone Treatment Center in Gray is unwise for all". Please let common sense and safety factor into your decisions. Keep the Methadone Treatment Center in areas already designated for health care that already have support systems in place for all the needs of health care services!

Thank you for your consideration.

Sincerely,
J. Andrew White and Kay M. White
484 Wyndham Drive, Gray TN 37615
423.477.3204
1kaywhite@gmail.com

From: Mary Ann Stout [mastout508@gmail.com]
Sent: Friday, August 19, 2016 7:45 AM
To: Jim Christoffersen
Subject: RESENDING Letter of Opposition - CN 1605-021, application of East TN Healthcare Holdings, Inc (Gray Commons Methadone Clinic)

860 Liberty Drive

Kingsport, TN 37663

(PLEASE NOTE: the USPS assigned our address. We **vote in Gray and pay Washington County taxes**, where we live!)

August 18, 2016

James Christoffersen

Andrew Jackson State Office Building

502 Deaderick Street

9th Floor

Nashville,TN 37243

email: Jim.Christoffersen@tn.gov

Dear Sir:

Subject: CN 1605-021, application of East TN Healthcare Holdings, Inc (Gray Commons Methadone Clinic)

I am opposed to a Methadone Clinic coming to our quiet residential community (ref. CN, page 4, non-residential Methadone Clinic and see page 8 "initially methadone"*, and page 12). This is a proposed new facility (also page 4) which has a proposed spot zoning request before the Johnson City Commission to accommodate Methadone!

--Johnson City has had its problems finding an acceptable location per the Commission that would even place a Methadone Clinic near a hospital facility. The nearest hospital to Gray Commons Area: Franklin Woods – 12.4 miles. Johnson City Medical Center – 15 miles. Holston Valley Medical Center – 14.3 miles. Vs. Memphis: Clinic on Spicer Cove – 5.8 miles. Clinic on Madison – 1.0 miles. Clinic on Winchester – 6.3 miles. Vs. Knoxville Clinic on Bernard – 3 miles. The close proximity of these clinics to hospitals is probably because they are not in quiet residential communities!

--On page 9, the Gray Commons is “envisioned … as an economic development driver … for the Gray Community.” We don't want the city “spot zoning” and “driving” our community. On page 9 of the Certificate of Need, it states the “Gray Commons is otherwise surrounded by vacant land.” Gentlemen, Within 123 FEET, 250 FEET, and 460 FEET are properties with houses on them (per Property Assessors Office, Washington County) and respectable / relaxed business vs. on high alert!

--On page 9 also, “the development includes 38 acres … (MSHA owns 36.2 … Johnson City owns 2.6)”. According to the Property Assessors Office, MSHA owns 4.36. Johnson City Medical Center owns 13, 6, 4.3, 1.75, 2.03, 0.l which adds up to 27.18. Combine MSHA and JCMC that is 32.54, not 36.2.

**Does that mean Suboxone will be added and traffic increased? Can the facility and the grounds and the streets accommodate the increased number of patients?*

--Continuing on in our quiet residential community, there's traffic issues galore. A two lane highway leads across I-26 to Gray Commons and Ridgeview Elementary and Daniel Boone High School and from Gray Elementary on the other side of I-26. Student enrollment is approximately 3,000 students traveling in family cars, or school buses or vehicles operated by young drivers. Add another number of teaching / support staff of 800+ vehicles in with the normal community traffic every day, there is traffic congestion of great proportions on and off thru the day. THEN WITH 650 new patient vehicles (there is NO public transportation) plus all the staff of the Clinic, we have major problems! I know this isn't a concern to you, but on the hot days, buses are not air conditioned, and you add another 30 minutes or more of congestion, you have bus drivers in wet clothes and students with dead air before they have traveled two miles toward home. This is not acceptable!

One more point … my understanding of the need. In April, 2015, I didn't know what an opioid was. A medical issue arose that couldn't be properly identified and my husband had to drive to my doctor's office to pick up a prescription and carry it to the pharmacy. My pain was unrelenting and unbearable. I made a few trips to ER in search of relief. Had multiple tests and shots and no answers. I hated taking a hard drug and having my name in a file. I would get a few days relief in that three-month period and withdraw the pain pill only to return to unrelenting and unbearable pain. I had a community of friends praying for me. One night, with pharmacist's approval and in compliance with prescription, I took two pills. Thought my skin would separate from me. I know and understand pain and the brink of doing something stupid, not to mention being dangerous and deadly.

All thanks be to God, my pain went away as it came … only to return almost one year later. This time, the pharmacist heard me and suggested a pill for relief. Doctor prescribed it. Two weeks later, an *aggravated nerve* was quiet. Would have been helpful to have that prescription last year.

I share this to say, I understand the need for help for some needy people. I understand that doctors don't always have good “hearing”; nor answers; nor pharmacists. I also know I was being setup with Pain Management until one of my very wise doctors talked up my sleeve. He only

said “be very cautious with a pain clinic.” Then came healing. I've heard fresh testimonies: “don't do methadone.” But I understand the need. I'm believing educating doctors is a good start!

You cannot tell me that 650 patients coming to a small clinic (and the standard operating procedure is to wait 30 minutes because of the sedation probability) is not going to cause a backlog of traffic onto Suncrest Drive, the road into Gray Commons, Daniel Boone and Ridgeview Schools. Please remember, it is a two lane road through a quiet residential community. (Second year: 1000+ patients.)

New thought: you can't tell me crime will not increase. Memphis has three Methadone clinics and supposedly No problem (map on CN page 7). Yet, already in 2016, Memphis has 138 homicides … alone! Death by gun, knife, or … and often because of arguments (different from domestic) or robbery. Please protect our quiet residential community.

I am opposed to a Methadone Clinic in Gray Commons, which was spot zoned to accommodate Methadone. Methadone Clinics across the State are not in residential communities and are located within reasonable distance of a medical facility. That's my recommendation: in the CITY and near hospitals with public transportation, per standard operating procedure.

Thank you!

Mary Ann Stout

Lowavia Eden

From: Jim Christoffersen
Sent: Tuesday, August 16, 2016 2:01 PM
To: Mark Ausbrooks; Mark Farber; Melanie Hill
Subject: FW: CN-1605-021, Application of East Tennessee Healthcare Holdings, Inc.

Jim Christoffersen
General Counsel
Tennessee Health Services and Development Agency
Andrew Jackson Bldg., 9th Fl.
502 Deaderick St.
Nashville, TN 37243

(615) 741-2364

From: R. Steve Smith [ssmith377@embarqmail.com]
Sent: Tuesday, August 16, 2016 12:59 PM
To: Jim Christoffersen
Subject: CN-1605-021, Application of East Tennessee Healthcare Holdings, Inc.

Mr. Christoffersen, we appreciate your taking time to read our concerns pertaining to a proposed methadone clinic being opened in Gray, TN. We are not saying there is no need for a methadone clinic but rather have many concerns about the proposed Gray, TN location and ask that you consider a **NO** vote to the Certificate of Need as it is written and has been filed for these reasons:

1. **Farthest location from the City of Johnson City -** The proposed location is as far removed from Johnson City as it can be and still be within the City's boundary. Elected officials of both Washington County and the Town of

Jonesborough searched for and found alternative locations. One in particular which met all the criteria was suggested and immediately rejected by Mountain States' Board.

2. **Lack of public transportation -** Many of the patients are not licensed drivers and have no vehicle. There is no public transportation to this location, and it also lacks taxi service.

3. **Traffic issues -** The proposed site is in a high traffic area on a two lane street with no controlled access to the street. The hours of operation are scheduled to be 5 am to 3 pm which will fall into the peak travel time for students either driving or riding buses to and from the four schools or being driven to and from the daycare centers and preschool centers within the area. Added to this traffic is the heavy commuter travel to and from the I-26 Gray exit plus the normal off peak
traffic.

The proposed patient number is approximately 650 per day to start with a projected number of 1,050 by year two. The current population of the Gray area is estimated at 1,500. The approximate doubling of the daily population by non
residents of Gray will have many negative impacts to our rural, residential and agricultural community.

Gray is fortunate to be the home of the Fossil Museum and will soon be home to Hands On Museum when they relocate from Johnson City to a facility adjacent to the Fossil Museum. These two sites are visited by thousands each year which
only adds to the traffic count and and a methadone clinic in Gray could result in decreased visitors to these sites.

4. **Safety issues -** Traffic volume is already high in the proposed area as mentioned above. We are concerned about patients leaving the clinic impaired, sedated or high after the methadone has been administered. Another concern is increased
crime associated with this type facility - that being robberies, drug trafficking, increase in drug use
with possible selling of methadone in exchange for other drugs. This alone has added fear to our community residents, especially our
senior population. There is also the possibility of littering by waiting patients as many will arrive at the site well before the 5 am opening time and will be eating and drinking while they wait.

5. **Lack of adequate law enforcement -** The proposed location is in a strip annexed area 5 miles from the normal Johnson City boundary with a 9-10 minute response time from city police and longer response time from Washington County
sheriff deputies. In the event of an emergency situation, we are concerned which law enforcement would offer help. Currently we see little patrol from the County Sheriff Department and even less from the Johnson City Police Department
and are concerned that neither will have the manpower to monitor the increased activity as it applies to traffic, crime, and drug dealing in our community. They will also incur an increase for budgeted funds which may be difficult to obtain.

6. **Medical Services -** The closest hospital facility is a 20-25 minute drive to Johnson City and longer to Kingsport. This proposes concern should there be a patient emergency. We feel this clinic should be placed in or near a medical facility as
many clinics of this type are in larger cities, and we understand locations are available much closer to a medical facility. This would allow quicker response time in emergency situations.

7. **Decrease in property values -** We moved to Gray from Johnson City eight years ago to be near aging parents with the full intention of returning to Johnson City at a point in time when we are no longer caregivers. We had and still have the
hope of being able to market our property (which is within viewing distance of the proposed location) at a reasonable profit which would unable us to downsize and live out our senior years away from Gray and closer to our doctors,
hospitals, etc. On our street alone, nine new houses were built and occupied within the last two years. Many of the homeowners are young couples with small children and have put everything they have into being able to purchase a new
house. It is sad to think how the knowledge of this proposed clinic will change the property values in Gray.

We realize our concerns are many but feel each is important to the future of the Gray community as a whole and to us as individual property owners. While we may be small in number, we do have pride in our community and property.
We know you and the members of your group will take your time and carefully weigh the pros and cons of the Gray location as you place your vote. Again thank you for your time.

Richard S. and Jeanette Smith
Gray, Tennessee

From: Glen Abbey [glenabbeytn@gmail.com]
Sent: Wednesday, August 17, 2016 8:44 PM
To: Jim Christoffersen
Subject: CN 1605-021, Application of East Tennessee Healthcare Holdings, Inc.

Robert G. McGough

1233 Glen Abbey Way

Gray, TN 37615-5222

August 17, 2016

Mr. James Christoffersen

Tennessee Health Services Development Agency

Andrew Jackson Building 9th Floor

502 Deaderick Street

Nashville, TN 37243

RE: CN 1605-021, Application of East Tennessee Healthcare Holdings, Inc.

Dear Mr. Christoffersen:

I am writing to register my objection to East Tennessee Healthcare Holdings, Inc. application for a methadone clinic in Gray Tennessee. I am a resident of the Gray Community and will state below several reasons why believe the Certificate of Need should not be granted. I can understand the need for a methadone clinic to combat the significant opiate addiction problems we face in society. However, the location of this clinic is ill advised, does not give sufficient consideration to the needs of the local community, and will impose an undue burden on not just the community but the patients of the clinic. My deep concerns are as follows:

1. Gray is a small community of approximately 1500 people. It is rural in nature and is a considerable distance from any hospital facility. It is my understanding that all of the methadone clinics in the State of Tennessee are within close radius of a major medical facility. In checking, I find that 10 of the current clinics are within 2 miles of a major hospital. The proposed clinic in Gray would be 10 miles from the nearest hospital facility (20 to 25 minutes' travel time). When patients at the clinic and have medical emergencies, prompt response and competent medical treatment would not be readily accessible in a short period of time.

2. The proposed facility is located in an area which has 4 schools within a two-mile radius. In addition to the school properties there is a major children's Museum relocating to the area, as well as the currently situated Gray Fossil Museum which is a location visited by many schools on field trips. The proposed hours of operation of the clinic would overlap school bus and parent travel to the various schools during the day and happen during heavy commuter travel to the major highway in the area. With estimates of 600 to 1000 people a day going to the clinic, this would significantly increase traffic congestion and potentially cause additional accidents in the area which would be detrimental to the community and impact adversely the educational process and the travel time of the clients of the clinic.

3. The clients of the proposed clinic will have no public transportation available to get to the clinic's facilities. Our area, being rural, is not served by any public transportation and this would severely limit its usefulness for persons who do not or who legally cannot drive or those who do not own a personal car (such lack of transportation particularly hurts low income folks or people living in poverty). The area does not have an established taxi service, so that also is not a viable alternative for transportation to the clinic. The clinic should be located in an area where there are several transportation alternatives to service the needs of the patients being served. There are several more suitable locations in the Tri-Cities where public transportation would be readily available.

4. An additional significant concern is that the applicant has no clinical experience operating such a clinic. Without having outpatient experience in the distribution of methadone, I believe this adds additional risks to both the community and the patients of this venture.

5. Lastly, with the pending merger of MSHA and Wellmont, there will be created a large combined regional healthcare system. With a large number of facilities that this merged system will have, it would be a much better regional service if the methadone clinic was administered through some of the multiple hospital facilities that would be available. Utilization of such facilities would provide availability of law enforcement if needed in a much shorter timeframe. In addition, it would greatly reduce the travel time for many of the regions residents in need of this type of

facility. In short, it makes a great deal more sense to have such a facility affiliated with a major hospital location or in close proximity, thereto. Should medical emergencies arise, treatment and care would be much more readily available in that venue.

While this letter is rather lengthy, I believe it is a very serious concern of the residence of the area, as well as concern for the ultimate users of the new facility. Our community is a compassionate one and understands the needs of the opiate addicted to have a chance for a drug-free life. I believe there are far better solutions to the overall problem than putting a clinic in our rural community where many of the necessary auxiliary services are not readily available.

I greatly appreciate your consideration of my position and hope that the Board will reject the request for a Certificate of Need and suggest to the applicants that they find a more suitable location that would better serve not only the citizens, but the patients who would benefit from this facility.

Sincerely,

Robert G. McGough

423-676-4300

18 August 2016

Tennessee Health Services and Development Agency,

Today I am writing in opposition to the East Tennessee Health Care Holdings, Inc application CN1605-021 for a non-residential substitution-based treatment center for opioid addiction located at 203 Gray Commons Circle, Johnson City, TN 37615. I am a board certified family physician who holds a medical degree from East Tennessee State University and completed residency with the University of Tennessee College of Medicine in Chattanooga. Since completing residency, I have practiced medicine in East Tennessee for the past 6 years. After reviewing the application, I have serious concerns that this proposed clinic does not meet the current needs of the community, and its proposed location does not contribute to the orderly development and advancement of medical care in East Tennessee.

There is no question that opioid addiction is rampant in East Tennessee, and we need to find solutions to this problem. In doing so, we need a patient-centered model that treats not only opioid addiction but also the co-morbidities and social problems that accompany the opioid addiction. Since opioid problems exist in a large part of the community, access to care, social services, and primary care is extremely important and should be a consideration for approval. While the application makes mention of a "holistic approach," it fails on multiple levels to achieve this goal.

First, as per the application (page 31), "The largest socio-demographic challenges in the proposed service area relate to the significantly lower levels of income as well as education." However the proposed clinic specifically discriminates against this population. As mentioned in the review report, the clinic will focus on self-pay patients. In doing so, they are limiting access to care in a community that does not have the cash resources to afford treatment. Its proposed location also discriminates against this population.

Once a patient enters the program, per the application (page 54), the treating physician has less than 2 minutes per patient (35 patients per hour) to "perform medical history and physical exams, determining a diagnosis under current DSM criteria, determination of opioid dependence, ordering take-home privileges, discussing case with treatment team, and issuing any emergency orders." By no means could this be considered standard of care. By limiting a patient's time to less than 2 minutes with their treating physician, there is no time to adequately treat the opioid addiction, not including other co-morbidities associated the the disease. This limited physician-patient interaction, along with the cash-pay model, will promote a "pill mill" atmosphere since there is not time to adequately treat patients.

The application states (page 29) the model would "assist with housing, employment and other social needs." The current proposed location for the clinic is at the north end of the city limits where Johnson City has done "strip annexation." [Please

see the map on the last page.] The majority of city services are in the city proper and not at the proposed site. Currently there is no public transportation available at the proposed site, and there is limited access to this clinic for individuals in public housing. The Johnson City Housing Authority is 13 miles away from the proposed location. In dealing with the social aspects of opioid dependence, the need to access public resources is paramount. However many patients will not be able access these resources due to distance and lack of transportation. While the application states MSHA and ETSU will help individuals obtain these services, no one can reasonably expect they will achieve these goals by placing this facility at the opposite end of the city.

The proposed location also places the facility away from all other medical services. [Please see accompanying map on the last page.] The proposed clinic is to be a joint venture of ETSU and MSHA. Both organizations are adjacent to each other; however, the proposed clinic is approximately 14 miles from both institutions. The facility is separated from all other current medical services provided by the two institutions. In placing the facility away from all medical services, and keeping patients with opioid dependence and abuse problems away from the established medical community, it discriminates against the patient by treating them as second class citizens and prohibits them from receiving ancillary services including primary care and psychiatric services. This goes against the orderly development of health care by placing it outside the current established medical community.

Outsourcing of psychiatric services to Frontier Health is a great concern. Currently, Frontier Health is failing to meet the psychiatric needs of patients in East Tennessee. My experience as a referring provider is that most referrals take 2-3 months. Once there, Frontier Health has policies that discriminate against patients receiving care. First is their insistence that the patient see a counselor for 3 months before a patient can see a psychiatrist. Once a patient has seen a psychiatrist, is it very common for the psychiatrist to write a note to the primary care physician stating which medications are to be used for treatment but to refuse to write them and defer all prescribing and monitoring to the primary care physician. Also, Frontier Health is responsible for crisis response for Upper East Tennessee. With response time measured in days instead of hours, I have witnessed patients who were suicidal or manic being sent home from the emergency room because crisis never came. On multiple occasions I have also witnessed patients discharged from inpatient treatment with no follow-up appointments, no continuation of care after discharge, and care deferred to the primary care provider. Frontier Health is unable to provide adequate care for its current obligations, and I have serious concerns it will not be able to provide adequate services to the proposed clinic.

Infrastructure around the proposed site does not support the volume of patients proposed. The location sits on a two-lane highway between three schools, two elementary and one high school. The services times of 5 AM to 3 PM are the same times the schools will have approximately 3,000 students on the roads in front of and around the clinic. The current infrastructure is inadequate to handle current traffic, and

additional traffic will be unmanageable. The relocation of the Hands On Children's Museum to a half mile away plus this proposed clinic will stress current resources. To have orderly development of services in the area, this issue need to be addressed by both Johnson City who manages the road to the east and Washington County who manages the road to the west. Also, this issue has not been addressed in the application.

While there is a need for an opioid abuse treatment facility, the current application does not adequately meet the needs of the community. By placing this facility away from the current medical establishment and ancillary services, away from the social resources of Johnson City, and away from the psychiatric resources of Johnson City, it fails to address the fundamentals for opioid dependence treatment. The facility needs to be within the confounds of the existing medical infrastructure. Patients need to be able to access public resources, including housing and employment opportunities, which are inaccessible at the proposed location. Johnson City does have public transportation, but the current location is not close to any public transportation routes and therefore offers limited accessibility to the low income residents of Johnson City. Opioid dependence and abuse is a complex disease that needs to have a multi-faceted approach. Factors including genetics, social, and societal problems need to be addressed. Limiting physician interaction with the patient to under 2 minutes per visit significantly and fundamentally underestimates the needs of this population.

I would encourage and would love to support MSHA and ETSU in developing an addiction program that truly is "holistic" in approach. Patients need to be placed into a medical community where they can easily obtain treatment of all their diseases. Also, the clinic needs to be placed where they can easily obtain community resources. Since the medical school, ETSU Physicians & Associates, the main MSHA hospital, Niswonger Children's Hospital, and city social resources are all within walking distance of each other, placing a facility in proximity to these resources would give patient the greatest opportunity for success. Since public transportation is provided in these areas, access for low income individuals would be maintained. I would encourage the committee to decline the currently certificate of need in lieu of a more advanced, more comprehensive treatment plan that would truly meet the needs of Upper East Tennessee.

Thank you,

Samuel Plücker, M.D.
679 Walkers Bend Rd
Gray, TN 37615

18 August 2016

Lowavia Eden

From: Melanie Hill
Sent: Thursday, August 18, 2016 4:04 PM
To: Mark Ausbrooks; Lowavia Eden; Jim Christoffersen; Mark Farber
Subject: FW: Certificate of Need

Melanie

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

www.tn.gov/hsda
Phone: 615-741-2364
Fax: 615-741-9884

From: Sherry Jenkins [mailto:sherrynjenkins@gmail.com]
Sent: Thursday, August 18, 2016 2:48 PM
To: Melanie Hill
Subject: Certificate of Need

Dear Melanie,

I am writing to ask that Mountain States Health Alliance and ETSU not be granted a certificate of need for a proposed methadone clinic.

I live less than two miles from this proposed site and it worries me greatly.

I am worried about the increase of criminal activity in our area.
My husband works with someone who's sister had a methadone clinic placed 1 1/2 miles from her home and she was broken into.
The patients must come once a day in the beginning of treatment. Many who drive distances do not have jobs or the money for gas or motel rooms. They turn to crime to fund this.
I work with someone who had a family member who had to drive every day to an Asheville, NC methadone clinic. He had to borrow money off family members to pay for gas to drive back and forth every day.

I do agree that there is a huge drug addiction problem in east Tennessee and many people would benefit from it. But Not in rural Gray community.

Addiction is a disease and I feel patients would be better served in a setting closer to the hospital and ETSU since they will be operating the clinic.

Thank you for taking time to read my email and my concerns.

From: R. Steve Smith [ssmith377@embarqmail.com]
Sent: Tuesday, August 16, 2016 12:59 PM
To: Jim Christoffersen
Subject: CN-1605-021, Application of East Tennessee Healthcare Holdings, Inc.

Mr. Christoffersen, we appreciate your taking time to read our concerns pertaining to a proposed methadone clinic being opened in Gray, TN. We are not saying there is no need for a methadone clinic but rather have many concerns about the proposed Gray, TN location and ask that you consider a **NO** vote to the Certificate of Need as it is written and has been filed for these reasons:

1. **Farthest location from the City of Johnson City -** The proposed location is as far removed from Johnson City as it can be and still be within the City's boundary. Elected officials of both Washington County and the Town of

Jonesborough searched for and found alternative locations. One in particular which met all the criteria was suggested and immediately rejected by Mountain States' Board.

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traffic.

The proposed patient number is approximately 650 per day to start with a projected number of 1,050 by year two. The current population of the Gray area is estimated at 1,500. The approximate doubling of the daily population by non
residents of Gray will have many negative impacts to our rural, residential and agricultural community.

Gray is fortunate to be the home of the Fossil Museum and will soon be home to Hands On Museum when they relocate from Johnson City to a facility adjacent to the Fossil Museum. These two sites are visited by thousands each year which
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crime associated with this type facility - that being robberies, drug trafficking, increase in drug use with possible selling of methadone in exchange for other drugs. This alone has added fear to our community residents, especially our
senior population. There is also the possibility of littering by waiting patients as many will arrive at the site well before the 5 am opening time and will be eating and drinking while they wait.

5. **Lack of adequate law enforcement -** The proposed location is in a strip annexed area 5 miles from the normal Johnson City boundary with a 9-10 minute response time from city police and longer response time from Washington County
sheriff deputies. In the event of an emergency situation, we are concerned which law enforcement would offer help. Currently we see little patrol from the County Sheriff Department and even less from the Johnson City Police Department
and are concerned that neither will have the manpower to monitor the increased activity as it applies to traffic, crime, and drug dealing in our community. They will also incur an increase for budgeted funds which may be difficult to obtain.

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many clinics of this type are in larger cities, and we understand locations are available much closer to a medical facility. This would allow quicker response time in emergency situations.

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hope of being able to market our property (which is within viewing distance of the proposed location) at a reasonable profit which would unable us to downsize and live out our senior years away from Gray and closer to our doctors,
hospitals, etc. On our street alone, nine new houses were built and occupied within the last two years. Many of the homeowners are young couples with small children and have put everything they have into being able to purchase a new
house. It is sad to think how the knowledge of this proposed clinic will change the property values in Gray.

We realize our concerns are many but feel each is important to the future of the Gray community as a whole and to us as individual property owners. While we may be small in number, we do have pride in our community and property.
We know you and the members of your group will take your time and carefully weigh the pros and cons of the Gray location as you place your vote. Again thank you for your time.

Richard S. and Jeanette Smith
Gray, Tennessee

Thomas E. Schacht, Psy.D., ABPP

Diplomate, American Board of Professional Psychology
Clinical and Forensic Psychology

P.O. Box 70308, ETSU Station
Johnson City, Tennessee 37614
Phone 423-742-0305
Fax 423-434-7098

August 14, 2017

Ms. Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

RE: East Tennessee Healthcare Holdings, Inc., - Application CN1605-021

Dear Ms. Hill.

Please add this letter and attached document[1] to my previously submitted public comments in opposition to the above-styled application.

Divergences between financial projections set forth in the CON proposal and evidence-based financial benchmarks for methadone clinic operation compel a conclusion that the operation as set forth in the CON application is incompatible with quality care and therefore fails to demonstrate financial feasibility.

This conclusion holds even if all projected revenue were spent on clinic operations. The additional optimistic prospect of "excess" funds available for diversion to the proposed research mission simply does not survive objective scrutiny.

ETSU/MSHA Methadone CON Financial Projections

The CON application sets forth the following financial projections (p. 46-48) for a clinic serving 1050 patients:

- The application projects an average gross annual charge per patient of $3450 (application p. 46). At a projected census of 1050 patients, this translates into estimated annual gross revenue of $3,622,500.[2]

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[1] Copy attached of: Dunlap, L. et al. (2008) Examining variation in treatment costs: A cost function for outpatient methadone treatment prog rams. Health Services Research, 43(3), 931-950.

[2] The application proposes a daily fee of ~$13 per patient. Projected over 365 days, this extrapolates to a gross annual charge per patient of $4745, which is above the projected gross annual charge per patient. This discrepancy is not acknowledged or explained in the application, and would also reasonably factor into any estimates of the affordability of the proposed clinic services in relation to the financial resources of the region's patients for a largely self-pay service.

- The CON application projects net revenue after deduction for bad debt and charity care to be $3,405,150 (application p. 48).

- If the entire projected net revenue ($3,405,150) were spent on patient care operations, with zero dollars diverted to research, the operating expenditure for 1050 patients would equal $3243 per patient/year or *$8.88 per patient/day.*

- Subtracting the anticipated $956,425 to be diverted to research, net funds available to spend on operations are projected to equal $2,448,725 (application at p. 48). At 1050 patients, this level of program spending works out to $2332.12 per patient/year, or *$6.38 per patient/day.*

Benchmark Operating Cost-Comparisons

The foregoing ETSU/MSHA financial projections may be instructively benchmarked to study of actual methadone clinic operating costs from 159 facilities distributed across fifteen states (Dunlap et al., 2008, copy attached) and to a 2012 research-based estimate of costs to operate a methadone clinic that fully adheres to "best practices." [3]

Dunlap et al. report the average daily clinic operating cost per patient, expressed in year 2000 dollars, as $11.53, which was observed to be similar to other per-day cost estimates in the literature (p. 940-41). If the year 2000 figure of $11.53 is adjusted for normal CPI inflation it would be ~ $16.14 in current dollars. Using a larger medical inflation rate, it would be ~ $19.74 in current dollars.

The 2012 research estimate of costs to operate a "best practices" methadone clinic was $20.43 / patient / day.[4]

As noted above, the proposed expenditure on patient care in the ETSU/MSHA CON proposal is $6.38 per patient/day (considering the proposed diversion of funds to research) or $8.88 per patient/day if zero funds are diverted to research. Either of these figures are vastly below the per-patient operating expenditures reported in Dunlap et al.'s benchmark study or in the best-practices study. Even if the entirety of the ETSU/MSHA proposed $13 daily fee were spent on services, with zero dollars to research, the daily expenditure per patient would fall below inflation-corrected

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[3] The ETSU/MSHA CON promises not only to provide access to methadone, but also to embed the methadone dispensing within a comprehensive state-of-the-art multi-disciplinary package of psychological and social services. For this reason, a research projection of what it would cost to deliver methadone in a fully "best practices" manner may be a more apposite benchmark than a study of actual expenses that does not exclude facilities providing lesser levels of service.

[4] I have requested from RTI's library, but have not yet received, a copy of the 2012 methadone cost study, which was sponsored by the National Institute of Drug Abuse and conducted by RTI International. The study was cited in the context of a debate in Maine about levels of government funding for methadone treatment in that state. A separate description of the study is also available at:
http://www.methadone.us/blog/773110-the-cost-of-running-a-methadone-program/

average operating costs or research-estimated best-practice operating costs.

In Dunlap et al's study, the average clinic size was 238 patients (p. 936). This is less than one fourth the 1050 patients projected in the ETSU/MSHA CON application. While one might speculate about some economies of scale, the scalability of cost functions described in the study is not proportional to the huge differences between the ETSU/MSHA CON and the benchmark averages.

As noted in my previous communications, the therapist:patient ratio set forth in the CON proposal is clinically unrealistic. In the 2008 study, the average clinic staffing was 11.9 FTE's (for 238 patients) and it was estimated that each patient required ~ 2 hours of clinical and administrative staff time per week (p. 936). At the same staff:patient ratio and level of service intensity, the proposed ETSU/MSHA clinic would require 52.5 FTE staff, which is *triple* the staffing plan actually proposed in the CON application. (The ETSU/MSHA application at p. 53 proposes a total of 17 FTE staff).

Sincerely,

Thomas E. Schacht, Psy.D., ABPP

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RESEARCH ARTICLE

Substance Abuse Treatment

Examining Variation in Treatment Costs: A Cost Function for Outpatient Methadone Treatment Programs

Laura J. Dunlap, Gary A. Zarkin, and Alexander J. Cowell

Objectives. To estimate a hybrid cost function of the relationship between total annual cost for outpatient methadone treatment and output (annual patient days and selected services), input prices (wages and building space costs), and selected program and patient case-mix characteristics.

Data Sources. Data are from a multistate study of 159 methadone treatment programs that participated in the Center for Substance Abuse Treatment's Evaluation of the Methadone/LAAM Treatment Program Accreditation Project between 1998 and 2000.

Study Design. Using least squares regression for weighted data, we estimate the relationship between total annual costs and selected output measures, wages, building space costs, and selected program and patient case-mix characteristics.

Principal Findings. Findings indicate that total annual cost is positively associated with program's annual patient days, with a 10 percent increase in patient days associated with an 8.2 percent increase in total cost. Total annual cost also increases with counselor wages ($p<.01$), but no significant association is found for nurse wages or monthly building costs. Surprisingly, program characteristics and patient case mix variables do not appear to explain variations in methadone treatment costs. Similar results are found for a model with services as outputs.

Conclusions. This study provides important new insights into the determinants of methadone treatment costs. Our findings concur with economic theory in that total annual cost is positively related to counselor wages. However, among our factor inputs, counselor wages are the only significant driver of these costs. Furthermore, our findings suggest that methadone programs may realize economies of scale; however, other important factors, such as patient access, should be considered.

Key Words. Drug treatment costs, cost function, methadone, SASCAP

Although a substantial literature provides estimates of the total and per-patient costs for substance abuse treatment, relatively little is known about what drives these costs or why large variation in treatment costs is often observed across

programs. In this paper, we use data from a multistate sample of methadone treatment programs to examine the factors that drive the costs of providing outpatient methadone treatment. Understanding these factors has become particularly important given the limited funding for treatment and the demand for greater fiscal accountability for the services delivered. Moreover, this information is a crucial piece in understanding the delivery of treatment services as providers and policy makers continue to strive toward cost-effective treatment.

Numerous studies have examined costs for hospitals, physician practices, and other medical services (Reinhardt 1972; Grannemann, Brown, and Pauly 1986; Breyer 1987; Nyman and Dowd 1991; Goodman et al. 1992; McAvinchey and Yannopoulos 1994; Wholey et al. 1996; Carey 1997; Goodman, Nishiura, and Hankin 1998; McNamee et al. 1998; Andersen, Andersen, and Kragh-Sorensen 2000; Bilodeau, Crèmieux, and Oullette 2000). Perhaps the most relevant lesson from this literature is that, in addition to examining the influence of output and input prices on cost, the empirical specification should control for other variables that may affect costs. These variables include program characteristics such as ownership structure, urbanicity of the facility's geographic location, and severity of the program's patients. A specification that includes output, input prices, and these other program characteristics is known as a hybrid cost function (Rosko and Broyles 1988).

Using data from the 1996 Alcohol and Drug Services Study (ADSS), Duffy et al. (2004) estimated a hybrid cost function for 222 outpatient nonmethadone substance abuse treatment programs. In addition to measures of annual admissions (as a measure of output) and staff wages and rent (as measures of input prices), Duffy et al. include in their model several variables capturing facility characteristics (e.g., age, ownership, urbanicity) and patient case mix (e.g., patient race/ethnicity, percentage of criminal justice referrals). The authors found that a 10 percent increase in admissions yielded a 6.7 percent increase in total annual costs. In addition, the percentage of clients who received Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) was positively associated with total annual costs. No other explanatory variables were statistically significant.

Harwood, Kallinius, and Liu (2001) estimated the relationship between total cost per patient day and average daily client census for 60 residential

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treatment programs. Average daily census was the only explanatory variable in the regression model. Harwood and colleagues found that larger programs had lower costs per day and that a 10 percent increase in average daily census is associated with decreases in the cost per patient day ranging from 3.5 to 10.7 percent.

Studies of methadone treatment over the past 25 years have rarely provided information on how a treatment program's costs vary with its output and input prices. But, as new funding mechanisms are being adopted and patients and providers face increasing pressures to reduce services and control costs, meaningful information on the relationship between program costs, program output, and treatment inputs is needed. Understanding this relationship may help methadone treatment providers in their decisions on staffing, setting reimbursement rates, and strategic business planning.

In this study, we estimate a hybrid long-run cost function of outpatient methadone treatment programs. This study is significant because it examines the effect of key inputs and program characteristics on the costs of providing methadone treatment—the most common treatment modality for opioid abuse in the United States. To date, there are no published studies that examine how a methadone treatment program's costs vary with its output, input prices, and other relevant covariates.

Data and Methods

Data

Data in this study were collected as part of a larger study of methadone treatment programs that participated in CSAT's Evaluation of Opioid Treatment Program Accreditation Project (RTI International 2003). The evaluation study was primarily designed to study the effect on the national methadone treatment system of new opioid treatment regulations requiring accreditation from a Substance Abuse and Mental Health Services Administration (SAMHSA)-approved accreditation body. Treatment programs were chosen for the main evaluation study using a multistage, stratified-randomized control sampling design. The first stratum was states. Fifteen states were chosen to satisfy one or more of several criteria: being geographically dispersed throughout the four U.S. Census regions, having a large number of methadone programs that represent different models of treatment and/or regulation, being representative of states that participated in the National Institute on Drug Abuse's (NIDA's) Methadone Treatment Quality Assurance System (MTQAS) study,

and states currently mandating accreditation. States outside the contiguous U.S. and states having fewer than four methadone treatment programs were excluded from sampling. The 15 states selected comprised almost 70 percent of all methadone programs in the United States in 1998 and almost 75 percent of all methadone patients.

The second stage of sampling involved selecting programs within states. Selection of these treatment programs was a multistage process, ensuring the inclusion of small programs (fewer than 50 patients) as well as for-profit programs. Correctional facilities, medication dispensing units, hospital-based detoxification facilities, and programs operated by the Veterans' Administration were excluded from sampling consideration.

Under the main study, the representativeness of the full sample ($N = 172$) was analyzed based on key program characteristics (e.g., ownership, size, part of larger parent organization), and the sample was found to be very similar to the national distribution of outpatient methadone treatment programs in 1998 (RTI 2003). Statistical analysis weights were computed so that estimates could be derived for the population of outpatient methadone treatment programs in the United States (RTI 2003).

The data in this study were collected from 172 methadone treatment programs that participated in the evaluation study. Because we chose to limit our sample to outpatient facilities, we excluded two treatment programs that self-reported as residential facilities. Eleven additional programs were excluded from the analysis because they had missing program or patient characteristics data. Our final sample for this analysis included 159 outpatient methadone treatment programs.

As part of the evaluation study, methadone treatment programs were asked to complete the Substance Abuse Services Cost Analysis Program (SASCAP), a service-level cost estimation questionnaire that collects data on a treatment program's costs and the time allocation of staff across various treatment services. (See Zarkin, Dunlap, and Homsi 2004 for a detailed description of the SASCAP method.) We received strong support from the programs regarding the cost data collection yielding a 100 percent response rate for the baseline cost data.

The SASCAP questionnaire includes two components—a cost survey that collects standardized annual economic cost data that is comparable across treatment programs, and a labor allocation survey that collects data on staff time allocated across treatment services. We used data from the cost survey in our analysis. The cost survey was completed by each program's site director and/or financial officer (as appropriate) during the baseline data collection

period that occurred between 1998 and 2000. Each program was asked to report their costs for the most recently completed fiscal year for personnel and salaries, supplies and materials, contracted services, buildings and facilities, equipment, miscellaneous resources (e.g., utilities) and costs associated with services at the level of a parent organization such as human resources, billing/finance, and marketing (if applicable). In addition, the questionnaire collected information on donated or subsidized labor or building resources so that the fair market value of these resources could be estimated. The information reported in the SASCAP was reviewed by RTI economists for accuracy, and treatment programs were contacted by telephone to gain additional information or clarification as needed. With these data, we calculated the total annual economic costs for each program and those are the costs analyzed here.

Program site directors were also asked to complete a Site Director survey, which collected information on the program's organizational structure, measures of average patient census, and patient characteristics. Similar to the SASCAP questionnaire, the site director's questionnaire was reviewed by RTI staff for accuracy, and additional information was collected if needed.

Variables

The dependent variable in our estimation model is the natural logarithm of total annual costs (in year 2000 dollars). Different measures of output for health care providers have been used in the literature, such as annual number of admissions or discharges, number of patient days, and number of specific health services provided. Methadone programs produce patient care by using a variety of intermediate inputs, such as counseling sessions, methadone doses, and case management. We chose to examine separately two different aspects of methadone treatment output. Our main output variable is annual patient days.[1] We calculated annual patient days by multiplying the program's average daily census of methadone patients by 365 days. This patient-days measure represents an annualized volume of patient throughput based on average daily census. However, unlike hospital care in which a patient day means up to 24 hours of continuous care and monitoring including room and board, a patient day for methadone treatment typically does not mean that a patient receives a day's worth of treatment. Rather, it represents the annual number of days for each treatment slot for which the clinic operates and provides services to patients as needed. Patients typically receive < 1 hour of services in a given day. Programs in our sample reported that staff, on average, spent about 2 hours per patient per week performing treatment

services and administrative activities related to program operations. Although this number may seem low, in an average-sized clinic of 238 patients, this per-patient average translates into 476 total staff hours provided by the program each week, or equivalently a staff of 11.9 full-time equivalents (based on 40 hours per week).

We also examine primary services provided by methadone programs as output measures—annual hours of counseling, intake services, case management, and ongoing medical services. We chose to focus on the core direct patient services for methadone treatment; however, due to severe collinearity, we were not able to include methadone dosing in our model. We also did not include administrative activities because these are not services provided to patients, but rather are activities that support direct patient services and the ongoing operations of the clinic.

We calculated annual hours of counseling by multiplying the program's self-reported average weekly hours of individual and group counseling by 52 weeks. Annual hours of intake service, case management and ongoing medical service were calculated in the same way.

We included three measures for input prices because they represent the primary resources in producing days of patient care: the average hourly counselor wage, the average hourly nurse wage, and the program's monthly rental cost. For counselors, we used the appropriate average occupational wage reported by the Bureau of Labor Statistics (BLS) (2005) for the Metropolitan Statistical Area (MSA) in which the program is located. Specifically, for the counselor wage we used the mean wage for "Substance Abuse and Behavioral Disorder Counselor." For nurses, we used the average of the mean wages for "Registered Nurse" and "Licensed Practical or Licensed Vocational Nurse" because both nurse types may be employed by methadone treatment programs. A small number of programs were not located in a defined MSA, and in these cases we used either the county-level wage data or data from the closest MSA as appropriate. For each program, we used BLS wages for the fiscal year in which costs were reported. If wage information was not available for the relevant fiscal year, we used the nearest fiscal year and adjusted wages using the Consumer Price Index (CPI). All wages were then adjusted to year 2000 dollars using the CPI.

For monthly rent, we used as a proxy for commercial rents—the four-bedroom Section 8 Fair Market Rent (FMR) as defined by the U.S. Department of Housing and Urban Development's (HUD) Office of Policy Development and Research (2001). The FMR used was for the MSA in which the program was located for the year 2001. Historical data on four-bedroom

rates were not available before 2001. These rents were then adjusted to year 2000 dollars using the CPI. To our knowledge, no national database exists on commercial real estate rental rates. The HUD four-bedroom FMR is the same rental measure used by Duffy et al. (2004) in their estimation of a cost function for outpatient nonmethadone treatment facilities. Furthermore, as noted by them, this is the measure that is used in SAMHSA's Substance Abuse Prevention and Treatment (SAPT) block grant formula to assess the rental component of the cost of doing business in each State (U.S. Department of Health and Human Services [DHHS] 1996).

Although counselor wages, nurse wages, and rental costs are available from the SASCAP data, we did not use these data because they are endogenous and may reflect unobserved characteristics that may affect both total costs and wages or rental costs. Our use of exogenous measures for the average wages and rental rates reflects the importance of wages and building costs as a determinant of total costs but avoids potential endogeneity bias.

We also included several measures of program characteristics that may explain variation in costs across programs. These include the program's ownership status (for-profit versus not-for-profit/public), the degree of urbanicity of the program's location, whether the program is part of a larger parent organization (organizational structure), and the program's accreditation status at the time of the baseline data collection. The ownership status variable equaled 1 if the program was a private, for-profit facility and 0 otherwise. The degree of urbanicity of a program's location was represented using dichotomous variables to represent three categories—whether the program was in a large urban area (population greater than 1 million; the omitted reference category), a medium-sized urban area (population between 250,000 and 1 million), or a small-sized urban area (population between 20,000 and 250,000). Urbanicity classifications are based on the Beale urbanicity codes, which were assigned based on the facility's zip code (Butler and Beale 1994). The organizational structure variable equaled 1 if the program was not part of a larger parent organization and 0 otherwise. Programs that are part of a larger organization may be able to share administrative overheard, obtain inputs at lower prices, or take part in other efficiencies that may result in having lower operating costs (Duffy et al. 2004). On the other hand, programs that are part of a larger organization may offer a greater variety or scope of services or may have greater costs associated with administrative overhead due to a more complex management structure. Finally, the accreditation status variable equaled 1 if the facility reported being accredited before the onset of the evaluation study

and 0 otherwise. Accredited programs may have greater costs because they provide a higher level of care.

We also included several program-level variables that describe the program's patient population. These case-mix variables were designed to help control for differences in programs' patient case mix that may help explain variation in treatment costs. Because programs with a more diverse racial/ethnic patient population may incur higher costs in providing services (Duffy et al. 2004), we included a continuous measure of the program's percentage of nonwhite patients. Programs with higher levels of dually diagnosed patients (i.e., individuals with both substance use and mental health disorders) may have greater costs because they may also provide mental health services. Therefore, we created a set of indicator variables measuring the program's percentage of patients who are dually diagnosed.

Because patients who are uninsured or on Medicaid may have greater unmet needs and thus require more intensive treatment services than patients with private health insurance, we include continuous measures of both the program's percentage of uninsured patients and the percentage of patients on Medicaid. We hypothesize that programs with patients in need of more intensive services may have higher costs. However, it is also possible that programs in States with Medicaid coverage for substance abuse treatment services may have more incentive to control costs. Furthermore, programs with uninsured patients may, in fact, have some patients who are insured but who prefer to pay out-of-pocket rather than report their substance abuse treatment needs to their insurance provider.

Empirical Model

We estimated a modified translog cost function of total annual cost using the following equation:

$$\begin{aligned}\mathrm{Ln}(C_j) = &\beta_0 + \beta_1 \times \mathrm{Ln}(PDAY_j) + \beta_2 \times \mathrm{Ln}(PDAY_j)^2 + \beta_3 \times \mathrm{Ln}(IPRICE_j) \\ &+ \beta_4 \times PROG_j + \beta_5 \times CASEMIX_j + \varepsilon_j\end{aligned} \tag{1}$$

where $\mathrm{Ln}(C_j)$ is the natural logarithm of total annual cost for program j; $\mathrm{Ln}(PDAY_j)$ is the natural logarithm of number of annual patient days; $\mathrm{Ln}(IPRICE_j)$ is a vector of the natural logarithm of input prices (counselor wage, nurse wage, and monthly space cost); $PROG_j$ is a vector of program characteristics (for-profit status, urbanicity of program location, whether the program is part of a larger organization, and the accreditation status of the

program); $CASEMIX_j$ is a vector of program-level patient case-mix variables (e.g., the percentage of nonwhite patients, the percentage of dually diagnosed patients, and the insurance status of patients); the βs are coefficients to be estimated; and ε is an error term.

Next, we estimated a modified translog cost function of total annual cost with selected methadone treatment services as output variables using the following equation:

$$\begin{aligned}\mathrm{Ln}(C_j) = &\beta_0 + \beta_1 \times \mathrm{Ln}(CN_j) + \beta_2 \times \mathrm{Ln}(CN_j)^2 + \beta_3 \times Ln(INT_j) \\ &+ \beta_4 \times \mathrm{Ln}(INT_j)^2 + \beta_5 \times \mathrm{Ln}(CM_j) + \beta_6 \times \mathrm{Ln}(CM_j)^2 \\ &+ \beta_7 \times \mathrm{Ln}(OMS_j) + \beta_8 \times \mathrm{Ln}(OMS_j)^2 + \beta_9 \times \mathrm{Ln}(CN_j) \times \mathrm{Ln}(INT_j) \\ &+ \beta_{10} \times \mathrm{Ln}(CN_j) \times \mathrm{Ln}(CM_j) + \beta_{11} \times \mathrm{Ln}(CN_j) \times \mathrm{Ln}(OMS_j) \\ &+ \beta_{12} \times \mathrm{Ln}(INT_j) \times \mathrm{Ln}(CM_j) + \beta_{13} \times \mathrm{Ln}(INT_j) \times \mathrm{Ln}(OMS_j) \\ &+ \beta_{14} \times \mathrm{Ln}(CM_j) \times \mathrm{Ln}(OMS_j) + \beta_{15} \times \mathrm{Ln}(IPRICE_j) \\ &+ \beta_{16} \times PROG_j + \beta_{17} \times CASEMIX_j + \varepsilon_j \end{aligned} \tag{2}$$

where $\mathrm{Ln}(CN_j)$, $\mathrm{Ln}(INT_j)$, $\mathrm{Ln}(CM_j)$, and $\mathrm{Ln}(OMS_j)$ are the natural logarithms of annual hours of counseling, intake services, case management and ongoing medical services provided by program j.[2] We included interaction terms for these output measures so that we could evaluate the potential for local economies of scope, or weak cost complementarities (WCC), generated by producing services with similar inputs. When the multiproduct cost function is in logarithmic form, a sufficient condition for the presence of economies of scope is that the cost function exhibits WCC; that is, $\partial^2 C(\hat{y})/\partial y_i \partial y_j \leq 0$, $i \neq j$ for all $\hat{y}$ with $0 \leq \hat{y} \leq y$ (Baumol, Panzar, and Willig 1982). The remaining terms are defined as above in equation 1.

Because the dependent variable is continuous in each of the regression equations, we used ordinary least squares regression for weighted survey data to estimate the models (StataCorp 2003).

Using the estimated coefficients from the regression analyses, we estimated the marginal and average costs associated with different volumes of output. Marginal costs are derived by taking the derivative of the predicted total annual costs by the independent variable of interest (e.g., number of patients, hours of counseling). Average cost for each program for the single product specification of patient days is calculated by dividing the predicted annual total cost by the program's annual patient days, and then taking the

average across all programs. For the multiproduct specification, we used the concept of average incremental costs (Grannemann, Brown, and Pauly 1986). For each program, incremental costs for a specified output are calculated by taking the difference between the predicted annual total cost of producing all outputs (at a determined level) and the predicted annual total cost of producing all outputs except the one being examined (i.e., setting the volume of the specified output to 0). We then divide this incremental cost by the specified output's volume to obtain its associated average incremental cost. Because the average incremental cost is a function of all the regressors in our specified equation and, therefore, differs across programs, we take the average across all programs.

In estimating marginal and average costs, we retransformed the predicted total annual costs to its original scale of dollars using a smearing estimate (Duan 1983). The retransformation of the predicted annual total cost is necessary because our model is log–linear with the Ln of annual total costs as the dependent variable, and to simply exponentiate the predicted logged total costs would result in a biased predictor. Rather, we multiplied the exponent of the predicted logged total cost by a common smearing factor equal to the mean of the residual (Duan 1983).[3]

We also evaluated ray economies of scale for our multiproduct cost function. Ray economies of scale is defined as the cost saving from an increase in the aggregate output when the output mix remains constant (Panzar and Willig 1977). This measure is calculated as the reciprocal of the sum of the cost elasticities for the individual service outputs, and this measure was evaluated at mean levels. If the ray economies of scale measure is greater than, equal to, or less than 1, then returns to scale are said to be increasing, constant, or decreasing (Baumol, Panzar, and Willig 1982).

Results

Table 1 shows the weighted descriptive statistics of the dependent and explanatory variables. The mean annual total cost is $916,355 (year 2000 dollars), and the average cost per patient day is $11.53 which is similar to per-day methadone treatment cost estimates reported in the literature that typically range from about $10.50 to $13 per day (e.g., SAMHSA, 2003; Flynn, Kristiano, and Porto, 1999). Mean annual patient days is 86,734, which implies an average daily census of about 238 patients (86,734/365). The mean counseling, intake service, case management, and ongoing medical service hours

Table 1: Means of Analysis Variables (Weighted)

n = 159	*Mean*	*SE*
Total costs (2000$)	$916,355	$103,573
Cost per patient day (2000$)	$11.53	$0.74
Output		
Annual number of patient days	86,734	5,889
Average daily patient census	238	16.13
Annual hours of counseling (CN)	5,813	493
Annual hours of intake services (INT)	1,162	79
Annual hours of case management (CM)	1,949	233
Annual hours of ongoing medical services (OMS)	1,286	147
Input prices ($2000)		
Counselor wage	$14.89	$0.65
Nurse wage	$19.96	$0.46
Monthly rent for space	$1,132	$37.85
Program characteristics (% of programs)		
Private, for-profit	46.8%	7.1%
Located in large urban area	66.3%	5.6%
Located in medium-sized urban area	25.9%	4.9%
Located in small-sized urban area	7.9%	2.1%
Part of larger parent organization	70.8%	5.9%
JCAHO or CARF accredited	22.0%	4.6%
Patient case mix		
Percentage nonwhite	41.6%	3.3%
Percentage uninsured	44.9%	4.4%
Percentage on Medicaid	35.1%	5.6%
Percentage dually diagnosed (percentage of programs within each category)		
≤ 10%	19.6%	4.4%
11–40%	43.5%	5.1%
>40%	14.0%	2.4%
Unknown—not assessed	22.5%	4.2%

SE, standard error.

provided per year is 5,813; 1,162; 1,949; and 1,286. The mean counselor wage is $14.89; the mean nurse wage is $19.96; and the mean monthly rent is $1,132.

The majority of programs are nonprofit/public (53 percent) and located in either large urban (66 percent) or medium-sized urban (26 percent) areas. Most programs reported being part of a larger parent organization (71 percent), and only 22 percent of the programs were accredited. Most programs have patients with limited financial resources as indicated by the finding that the average program had 35 percent of its patients on Medicaid and 45 percent of its patients reporting being uninsured. Most programs report racial/ethnic diversity in their programs with the average program reporting that 42 percent

of their patient population was nonwhite. Patients with both substance abuse and mental health problems were also not uncommon. Fourteen percent of the programs reported that > 40 percent of their patient population was dually diagnosed with a substance abuse and mental health problem. Another 44 percent of programs reported that between 11 and 40 percent of their patient population was dually diagnosed.

Multivariate Results

Table 2 presents results from the multivariate model that includes annual patient days as the output variable (column 1). We found that average cost per patient day is negatively associated with patient days ($p<.05$) and positively associated with patient days squared ($p<.01$). These estimates suggest that average costs are initially lower for larger programs up to a certain point, and beyond that point average costs increase (a U-shaped relationship). To help interpret these estimates, we evaluated the elasticity of total cost to a change in patient days and found that the elasticity evaluated at the mean is 0.82; that is, a 10 percent increase in mean annual patient days is associated with an 8.2 percent increase in total annual cost. The estimated elasticity varies with output as indicated by the statistically significant squared term for number of patients. We conducted a statistical test to determine whether the estimated elasticity is statistically different from 1 (i.e., no economies of scale), and we found that this difference is statistically significantly different from 1 ($p<.01$).

We also find that total annual cost was positively associated with counselor wage ($p<.01$). A 10 percent increase in counselor's wage is associated with a 6 percent increase in total annual cost. The effect of monthly rent is positive but small in magnitude and statistically insignificant. Although nurse's wage is negatively associated with total annual cost (counter to our expectations), it is not statistically significant. Only one of the other covariates in the model is statistically significant. Total annual cost is less for programs that are not part of a larger parent organization ($p<.05$). Possibly, this variable is capturing more or better services being offered by programs that are part of a larger organization or reflects a more costly case mix for these programs.

Table 2 also presents results for the second specification in which we replace the aggregate output measure of patient days with selected services (column 2). We find that counseling, case management, and ongoing medical services all have a positive and significant effect on total costs ($p<.01$). We estimated mean elasticities of 0.53 for counseling, 0.09 for intake services, 0.32 for case management, and 0.20 for ongoing medical service, although, our

Table 2: Cost Function Results

	Patient Days		*Selected Services*	
Dependent Variable = Ln(Total Annual Cost)	*Coefficients*	*SE*	*Coefficients*	*SE*
Output				
Ln(annual number of patients)	−2.551**	0.961	—	—
Ln(annual patients) squared	0.148***	0.043	—	—
Ln(annual counseling hours)	—	—	0.326***	0.038
Ln(annual counseling hours) squared	—	—	0.048	0.025
Ln(annual case management hours)	—	—	0.064***	0.011
Ln(annual case management hours) squared	—	—	0.017***	0.004
Ln(annual intake hours)	—	—	0.038	0.028
Ln(annual intake hours) squared	—	—	0.009	0.005
Ln(annual ongoing medical hours) squared	—	—	0.099***	0.020
Ln(annual ongoing medical hours) squared	—	—	0.039***	0.007
Service interactions				
Ln(annual CN) × Ln(annual CM)	—	—	0.002	0.016
Ln(annual CN) × Ln(annual INT)	—	—	−0.035	0.024
Ln(annual CN) × Ln(annual OMS)	—	—	−0.058	0.038
Ln(annual CM) × Ln(annual INT)	—	—	0.013	0.014
Ln(annual CM) × Ln(annual OMS)	—	—	−0.009	0.009
Ln(annual INT) × Ln(annual OMS)	—	—	0.021	0.018
Input prices				
Ln(counselor wage)	0.612***	0.172	0.595***	0.167
Ln(nurse wage)	−0.037	0.345	0.032	0.381
Ln(monthly rent for space)	0.145	0.183	0.310	0.195
Program characteristics				
For-profit	−0.110	0.065	−0.153**	0.071
Medium urbanicity	0.042	0.086	−0.019	0.086
Small urbanicity	−0.302	0.165	−0.292	0.218
Not part of larger parent organization	−0.136**	0.059	−0.009	0.065
JCAHO or CARF accredited	0.072	0.062	0.101	0.063
Patient case mix				
Percentage nonwhite	0.001	0.001	0.001	0.001
Percentage dually diagnosed				
11–40%	0.045	0.076	−0.023	0.078
>40%	0.022	0.101	−0.011	0.081
Unknown—not assessed	−0.072	0.088	0.002	0.081
Percentage uninsured	−0.0003	0.001	−0.002	0.001
Percentage on Medicaid	0.002	0.001	−0.0004	0.002
Intercept	3.218***	1.146	5.687***	1.213

$n = 159$.
**$p < .05$, ***$p < .01$.

parameter estimates show that intake service does not have any significant effect on total costs. Thus, the effect of individual services is not great with a 10 percent increase in counseling, case management, and ongoing medical

services resulting in a 5, 3, and 2 percent increase in total annual costs. Statistical tests revealed that these elasticities were statistically significantly different from 1 ($p<.01$). We also find that the included interaction terms for the services are not statistically significantly different from 0; thereby, yielding weak cost complementarities that are not different from 0 across services. These findings suggest that methadone programs may realize local economies of scope (weakly) in producing different types of services from similar inputs.

As with the patient days results, we also find that total annual cost was positively associated with counselor wage ($p<.01$), but, again, neither monthly rent nor nurse's wage is statistically significant. However, unlike the patient days results, we do not find a significant association between total cost and whether programs are part of a larger parent organization. But we do find a negative and statistically significant association between total cost and for-profit programs. Compared with nonprofit/public programs, for-profit programs are associated with lower total costs. Possibly, this variable is capturing differences in costs for other inputs that are not included in the specification or it may be capturing differences in patient case mix.

Table 3 shows that for patient days the marginal cost is increasing with output while average cost is decreasing. Furthermore, marginal cost is below average cost at each of our output levels. For example, the estimated average and marginal cost of an additional patient day for a medium-sized methadone treatment program is $10.20 and $7.82 compared with $12.73 and $7.24 for a small program. These findings suggest that larger methadone programs benefit from economies of scale as illustrated in the decreasing average costs.

We also estimated the average incremental costs and marginal costs associated with different levels of service hours—average, low, medium, and high—for those services in which the estimated regression coefficients are statistically significant, with other services at mean values. These results (see Table 3) show that both the average and marginal costs are decreasing as output volume increases for counseling, case management, and ongoing medical service. However, the estimated measure of ray economies of scale associated with our multiproduct cost function is 0.89 indicating that returns to scale are decreasing for these selected services. We conducted a statistical test to determine whether this measure is statistically different from 1 (i.e., no economies of scale), and we found that this difference is statistically significantly different from 1 ($p<.01$).

Table 3: Estimated Average Cost and Marginal Costs for Selected Output

*Volume of Output**	*Average Cost per Patient-Day (SE†)*	*Marginal Cost per Patient-Day‡ (SE†)*	*Average Incremental Cost for Counseling Hour§ (SE†)*	*Marginal Cost Counseling Hour§ (SE†)*	*Average Incremental Cost for Case Management Hour¶ (SE†)*	*Marginal Cost Case Management Hour¶ (SE†)*	*Average Incremental Cost for Ongoing Medical Service Hour‖ (SE†)*	*Marginal Cost Ongoing Medical Service Hour‖ (SE†)*
At mean	9.80 (0.21)	8.09 (0.18)	150.54 (4.92)	89.36 (2.92)	170.61 (5.05)	153.20 (4.54)	312.82 (8.45)	157.71 (4.26)
Low	12.73 (0.28)	7.24 (0.16)	250.04 (8.18)	129.39 (4.23)	405.92 (12.02)	487.98 (14.45)	763.51 (20.62)	298.51 (8.06)
Medium	10.20 (0.22)	7.82 (0.17)	170.03 (5.56)	97.14 (3.18)	250.77 (7.43)	245.23 (7.26)	417.76 (11.28)	197.25 (5.33)
High	9.40 (0.20)	8.67 (0.19)	113.49 (3.71)	70.58 (2.31)	145.42 (4.31)	125.93 (3.73)	257.68 (6.77)	133.01 (3.44)

*Volumes for low, medium, and high output are based on the unweighted variable distribution at 25, 50, and 75 percentiles.

†SE estimated using *Stata's* bootstrap technique (StataCorp, 2003).

‡Low, medium, and high annual patient day volumes are 36,500, 71,175, and 1,20,450 representing average daily patient censuses of 100, 195, and 330 patients. Average patient-day volume is 86,870 representing an average daily census of 238 patients.

§Low, medium, and high annual hours of counseling are 2,392, 4,368, and 7,540 annual hours. Average volume is 5,721.

¶Low, medium, and high annual hours of case management are 419, 1,040, and 2,496 annual hours. Average volume is 1,921 annual hours.

‖ Low, medium, and high annual hours of ongoing medical services are 260, 832, and 1,872 annual hours. Average volume is 1,296 annual hours.

DISCUSSION

Although a number of studies examine the total and per-person costs of substance abuse treatment, few have examined how treatment costs are associated with program output and the prices of program inputs. This study is the first to examine the determinants of the costs of providing methadone treatment.

Using a multistate sample of 159 methadone treatment programs, we find that greater patient days are associated with higher total annual cost for methadone treatment programs. For a program with mean annual patient days of 238 patients, our findings indicate that a 10 percent increase in average patient daily census is associated with an 8.2 percent increase in total annual cost. Our results also indicate that the average cost per patient day decreases with increases in patient days.

This finding parallels that of Duffy et al. (2004), who found a similar relationship between annual admissions and total annual cost in a study of outpatient nonmethadone treatment programs.[4] In their study, Duffy et al. found that a 10 percent increase in output (as measured by admissions) was associated with a 6.7 percent increase in annual treatment costs.

In the broader health care costs literature, researchers have interpreted estimates of the relationship between treatment cost and size by referring to the concept of economies of scale (e.g., Grannemann, Brown, and Pauly 1986). Economies of scale are realized when long-run average costs fall as output increases, where the long-run is defined by the period of time over which programs can change all inputs (e.g., number of staff, size of facility) in providing care to patients. As noted above, in our single-product specification we find that average cost decreases with increasing output. This suggests that economies of scale may be present in the production of patient days for outpatient methadone treatment. Larger programs may be less costly on a per-person day basis than smaller ones. However, the decision for smaller programs to merge to achieve economies of scale should only be taken in light of other factors, such as the impact on patient access. For example, small programs located in rural or less densely populated areas may not be able to expand output because of their limited market size. Closing these programs or moving them to merge with larger programs may decrease patient access and increase patients' burden in getting to larger more distant-merged programs.

However, policy makers and providers may want to consider the possibility of consolidating small or medium-sized programs located in medium-sized and large urban markets to realize potential cost savings from economies of scale. Depending on the location of programs and the availability of

transportation to program clinics, such mergers may be possible without harming access. Indeed, for publicly funded patients such mergers could increase access if the merger increases the number of available subsidized slots. A smaller program may be geographically more accessible, but it may lack subsidized slots, and therefore, be financially unavailable to such patients. Consolidating programs to generate economies of scale might allow a given program budget to support more funded slots making treatment financially available, although this benefit may come with the tradeoff that the patient may face greater travel time and transportation costs. Future research should consider the implications of this tradeoff and its impact on program and patient costs.

Our findings indicate that total annual cost is positively related to counselor wages. This finding concurs with economic theory. Surprisingly, neither nurse wages nor monthly building space costs had a significant association with total costs. Furthermore, only one of the measures capturing program characteristics had a statistically significant association with total costs. Total annual cost was negatively associated with a program not being part of a larger parent organization. As noted above, programs that are part of a larger parent organization may have higher administrative overhead or they may offer a greater variety or scope of services than programs that are not part of a larger parent organization. Neither urbanicity of the program location, accreditation status, nor ownership status were significantly associated with total annual cost. This finding mirrors that of Duffy et al. (2004) who found that case-mix measures were not statistically significant in their examination of costs of nonmethadone outpatient substance abuse programs.

In our multiproduct specification, we found that proportionate increases in service outputs did not lead to cost savings as indicated by our ray economies of scale measure. This finding suggests that the mix of services produced by a methadone program may affect their overall cost efficiency.

Finally, our examination of local economies of scope indicates that methadone programs do not gain much efficiency from producing different services from similar inputs. This finding is not surprising given the nature of methadone treatment. Unlike hospitals in which different services are distinct and target different patients (e.g., cardiac care versus obstetrics), counseling, intake service, case management, and ongoing medical service are parts of an overall package of care that methadone clinics offer.

The findings in this paper face two main limitations that indicate directions for future research. First, the data contained a limited number of variables for program and patient characteristics, and these variables may not

capture important differences in programs (e.g., quality). Future research should attempt to include additional program and patient case-mix differences. Second, these data provide information only on the cost of supplying methadone treatment but not on the benefits of that treatment. To provide guidance on the optimal scale of operations for methadone treatment programs, we need to compare the benefits of treatment with its costs. Thus, like many other estimates of cost functions in the literature, our findings do not provide definitive policy conclusions on whether methadone programs should expand or merge. A natural extension of this work would be to combine treatment cost data with measures of patient outcomes to assess the cost effectiveness of alternative "doses" of treatment.

Despite these limitations, this study is important for several reasons. First, it advances our current knowledge of methadone treatment costs and associated cost factors. This information is a crucial step toward understanding what constitutes treatment costs and providing cost-effective treatment. Furthermore, these findings provide useful information to treatment providers and policy makers so that they may be better able to target limited funding resources to essential treatment areas. Finally, researchers and policy makers may find this study useful in examining the cost implications associated with changes in treatment output, inputs, and patient case mix.

ACKNOWLEDGMENTS

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NOTES

1. We attempted to include annual admissions in addition to patient days in our patient days' model. However, admissions were found to be highly collinear with patient days, and we were unable to estimate this model.
2. The problem of multicollinearity was severe between linear and squared output variables and interaction terms in our service specification. To deal with this problem and disentangle the effects of the linear and squared terms on the dependent variable, we orthogonalized the squared term to make it statistically independent of its linear counterpart. To do this, we regressed the squared term on

the linear term and used the estimated residual from this regression in our main equation in place of the original squared term. A similar procedure was followed to orthogonalize the interaction terms.

3. Manning (1998) has shown that in the presence of heteroskedasticity, use of a common smearing factor yields biased estimates of predicted costs. We tested for the presence of heteroskedasticity in our model, and the results of these tests indicated that we could not reject the null hypothesis of homoskedasticity. Therefore, our use of a common smearing factor to obtain our estimates for predicted total costs should not yield biased estimates.
4. We conducted a similar analysis for methadone treatment programs using log annual admissions instead of annual patient days. We found similar results pertaining to output, although the effect was smaller in magnitude. A 10 percent increase in annual admissions was associated with a 2.8 percent increase in total annual costs. These results are available from the corresponding author upon request.

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TO: Bill Duncan, Vice Provost for Research and Sponsored Programs

FROM: Thomas Schacht, Professor Emeritus, Psychiatry & Behavioral Sciences

RE: Request for Ethics Review - Proposed Methadone Clinic - ETSU Research Foundation

DATE: 08-09-2016

Please accept this memo as a request for independent external ethics review of the proposed methadone clinic. A basis for concern is outlined below.

[1] As set forth in the Certificate of Need application, the proposed treatment program will be an integral part of a "larger, research-based center" at ETSU. The application explains that "research and evaluation resources of ETSU will be available to do 'real-time' research on actual care practices for the opioid dependent population. This real-world research will substantiate established care practices and evaluate the efficacy of new ones." (Application p. 20).

[2] The population involved (opiate addicts) is at high risk for adverse outcomes, including significant medical and psychiatric morbidity and mortality.

[3] The population involved (opiate addicts), is "vulnerable" as that term applies to IRB analyses of research populations. Reasons to consider this population vulnerable include at least the following considerations:

- As an inherent feature of their condition, opiate addicts are subject to psychologically desperate mental states of intoxication, withdrawal, and craving that compromise their autonomy and capacity for consent and their vulnerability to coercion and exploitation.

- Intravenous opiate abuse is a risk factor for HIV infection. Accordingly, it is reasonable to expect that the center's patient population will include HIV/AIDS-affected persons. This group is generally recognized as a vulnerable population.

- Medical and psychiatric co-morbidities associated with opiate addiction increase the likelihood of cognitive impairment in the center's patient population. Some research also suggests that average education level of substance abusers tends to be lower than that of the general population. Cognitive impairment and educational disadvantage are generally

recognized as a basis for regarding a research population as "vulnerable."

- References in the Certificate of Need application to issues of neonatal abstinence syndrome suggest that proposed activities will reach populations of pregnant women and/or neonates. These groups are also categorically considered to be vulnerable populations.

- Methadone treatment commonly occurs under explicitly coercive circumstances. Coercion commonly derives from third-parties (e.g. family pressure) and/or from the criminal justice system (e.g. as a condition of probation or as part of a plea bargain or arrangement for diversion of criminal charges). Individuals seeking methadone treatment under threat of incarceration or other arrangements dictated and/or supervised by the criminal justice system bear important resemblances to prisoners, who are routinely viewed as a vulnerable population.

[4] Vulnerability is enhanced by circumstances of limited choice present because methadone treatment will be available through a single source with a virtual monopoly on providing the treatment. Choice will also be limited by the facility's decision to offer only methadone and not a Suboxone alternative for at least the first two years of its operation.

[5] As set forth in the Certificate of Need application, financial gains from the proposed methadone treatment center will be "re-invested" into the research center. At the end of the second year of operation, the application projects a positive bottom line of $956,425, which represents a roughly 28% profit margin on projected revenues of approximately $3.4 million [Application p. 32]. This money represents excess fees from patients that will not be spent on treatment services, but will instead be directed to research.

[6] The proposed allocation of profits from treatment to the research creates an objective and ethically perilous conflict of interest between patient interests in treatment and the financial benefit to the research enterprise.

This conflict of interests exists because:

- The amount of money available for research will increase if less money is spent on treatment services.

- The amount of money available for research will increase if more patients are recruited into treatment than actually need treatment.

- The amount of money available for research will increase if patients are retained in treatment for a longer period of time than is necessary.

- The amount of money available for research will increase if the program accepts and/or retains patients rather than referring them to potentially more appropriate outside alternatives.

- The amount of money available for research will increase if program structure or operation makes it more difficult for patients to exercise informed consent and choose alternative treatments.

[7] If ETSU's policy permitting extra compensation to researchers who bring in extramural funds applies to revenues from the proposed methadone treatment center, then the conflict of interest would be personal as well as institutional.

[8] Based on the program description set forth in the Certificate of Need application, the conflict of interest between clinical service and research could affect the treatment received by all patients, including those who refuse consent to participate in research. Patients who refuse consent to participate in research will still be paying for the research, since a portion of their fees that could have been used for treatment services will be involuntarily directed to the research enterprise.

[9] There are reasons to believe that the foregoing conflict of interest has already been expressed in the Certificate of Need application, which overstates the need for services, downplays ancillary risks, and proposes extreme staff to patient ratios with significant reliance on unlicensed therapists. I have attached a copy of comments submitted to the Tennessee Health Services Development Agency which spell out a detailed factual basis for these assertions.

[10] Methadone treatment is commonly paid for in cash, by patients. The absence of third-party payer scrutiny of the relationship between costs and services provided means that methadone patients will lack an independent protection against financial exploitation that is typically present for medical treatments that are covered by insurance.

[11] The University of Minnesota's unfortunate experience with conflict of interest in psychiatric research may serve as an instructive example when considering this request for independent external ethics review. See: https://en.wikipedia.org/wiki/Death_of_Dan_Markingson

corporation ■ *America's Comfort Conditioning Company*

8/19/2016

The Honorable Micah Van Huss
State Representative, 6th District
301 6th Avenue North, Suite 23
Legislative Plaza
Nashville, Tennessee 37243

RE: Certificate of Need for the Proposed Methadone Clinic in Gray, Tennessee

Dear Representative Van Huss,

As a member of the manufacturing community in the greater Tri-Cities area for over 65 years, and as a business devoted to the growth and prosperity of the entire region, TPI Corporation would like to express our concern and opposition to the proposed methadone clinic being located within the Gray, Tennessee community. While we are sympathetic to the needs of certain members of our community with regards to substance abuse, addiction, and recovery we also feel – irrespective of CEO Alan Levine's and Dr. Brian Nolan's opinions - that such a center would be better located within Mountain States Health Alliance's Med-Tech Corridor – which was developed specifically for these types of centers as well as other medical services. By doing so the facility would not only be closer in proximity to the treatment center's partner, East Tennessee State University, but would also be in better proximity to the needed medical resources that would be required in the unforeseen event of a medical complication.

Further, we believe, that by locating the facility within the Med-Tech Corridor public demands could still be met and the wishes of the residential community of Gray, Tennessee could also be satisfied. We do not feel that locating the proposed clinic within a residential community in close proximity to two schools is a proactive positive approach toward the prosperity and future growth of the Suncrest Drive/Gray/I-26 corridor.

At one-time Mountain States Health Alliance took a different approach toward growth in the Gray community before closing the Urgent Care Clinic that was once located within the building that is now being considered for use as a methadone clinic. From our perspective, seeing a non-profit entity serve isolated needs in the community, while ignoring the wishes of its neighbors, as opposed to the needs of the entire community is unfortunate.

Lastly, since all previous efforts by independent operators and separate proposals have been whole-heartedly rejected by the community up to this point, the sense that Mountain States Health Alliance in conjunction with East Tennessee State University are turning a deaf ear to the wishes of the citizens of Gray, Tennessee – and Washington County - is unmistakably noticeable.

We would appreciate your consideration of our concerns.

Respectfully submitted,

TPI Corporation

P.O. Box 4973 ■ Johnson City, Tennessee 37602-4973 ■ 423/477-4131

August 10, 2016

James Christoffersen
Andrew Jackson State Office Bldg
502 Deaderick Street
9th Floor
Nashville TN 37243

RE: Proposed Methadone Clinic in Gray, TN

Dear Sir,

Please do NOT approve the Certificate of Need for the Methadone clinic proposed by MSHA and ETSU for our community.

I and many of my neighbors believe this will be a detriment to our community. We do not believe that a clinic that simply replaces one addiction with another will be of benefit to any persons and that it will potentially cause damage to them, their families, and to our community as a whole.

With the nature of this clinic and the possible number of people that would be drawn there we are concerned about safety issues, possible crime increase, potential decrease in property values, traffic issues, the proximity to schools and our local Fossil Museum and Hands On Children's Museum, lack of emergency medical services and local police force, and the lack of public transportation.

Please consider the information here: http://novusdetox.com/methadone-clinics-maintenance.php

We do believe that if MSHA and ETSU are determined to do this kind of clinic, there are options other than our community that would be better suited to their needs.

Thank you for listening!

Jenny Christian
236 Ford Creek Road
Gray, TN 37615
423.384.9280

August 10, 2016

Melanie Hill
Tennessee Health Services and Development Agency
Andrew Jackson Bldg., 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: East Tennessee Healthcare Holdings ("ETHHI"), Inc. CN1605-021

Dear Ms. Hill,

This letter is submitted on behalf of East Tennessee Healthcare Holdings, Inc. ("ETHHI"), Mountain States Health Alliance ("MSHA") and East Tennessee State University ("ETSU") in support of the project referenced above.

It is widely known that an epidemic of opioid use disorder (OUD) exists in this country. The highest rates of OUD, overdose and neonatal abstinence syndrome are located in southern appalachia including Northest Tennessee. Medication assisted treatment (MAT) with buprenorphine (Suboxone) or methadone is a rapid and expedient method for stabalizing OUD. Only physicians with a DEA waiver can prescribe buprenorphine and there are insufficient number to meet this region's demand for treatment. This has created a shortage that has allowed many physicians to overcharge patients and refuse to accept insurance payments. This exploits patients and creates an economic barrier to access to treatment.

The opioid treatment program (OTP) proposed by ETSU and MSHA would be able to treat a large number of patients and help relieve this shortage. According to a July 31 article in the Johnson City Press (http://www.johnsoncitypress.com/Local/2016/07/31/Clinic-will-be-project-of-Mountain-States-ETSU-with-staff-from-Frontier-Health.html?ci=content&lp=10&p=1) the OTP will contract with Frontier Mental Health to provide counseling and case management. Frontier has provided quality addiction treatment in this region for several decades. The Press reports the OTP will use methadone and may include buprenorphine in year 3. Buprenorphine is medically superior (lower risk of overdose and sedation) however methadone does have a long history of effectiveness. The Press reports the OTP will charge $13/day, slightly less expensive than the $100/week charged by most local physicians. However, they do intend to file for insurance payments.

Opioid use disorder is a major problem in NE Tennessee and this opioid treatment facility will help relieve the shortage of treatment available.

Sincerely,

Jack Woodside, M.D.
Professor
Office of Academic Affairs
ETSU College of Medicine
American Soc of Addiction Med. certified
woodside@etsu.edu

1002 Hillendale Road
Gray TN 37615
August 11, 2016

James Christoffersen
Andrew Jackson State Office Building
502 Deaderick Street
9th Floor
Nashville TN 37243

Dear Mr. Chistoffersen,

I am writing this letter in GREAT opposition to the pending methadone clinic at Gray Commons in our beautiful and safe area of Washington County.

It saddens me that an area with four very close schools for our children would be exposed to this type of facility. I understand, as a pharmacist, that there are probably thousands of people in Northeast Tennessee alone who need help with rehabilitation. I see drug overdoses or serious life-threatening infections caused by IV drug abusers every single day.

Our children do not need to be exposed to this any more than they already are which is why I believe there has to be a better site that is not so close to so many of our schools. It is not fair to our children to be exposed to the patients that this clinic WILL bring to our area.

I believe also that this will increase the number of people in our area which not only exposes us to possible crime but also puts our teenagers driving to and from Daniel Boone at great risk. This doesn't even begin to consider the childcare centers or daycare centers so close which is certainly not safe for the parents with babies and small children.

I hope you will consider our children's safety, if nothing else, as you make your decisions regarding the clinic. If you doubt my intentions, please ask my old friend, Randy McNally, about who I am and my character.

Sincerely,
Vickie Adams
Vickie Adams