ANNE ARUNDEL MEDICAL CENTER

CERTIFICATE OF NEED APPLICATION

Anne Arundel Medical Center Mental Health Hospital

March 29, 2016

Anne Arundel Medical Center

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MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Anne Arundel Medical Center Mental Health Hospital**

Address:

Riva Road & Harry S. Truman Parkway	**Annapolis**	**21401**	**Anne Arundel**
Street	City	Zip	County

Name of Owner (if differs from applicant):
N/A

2. OWNER

Name of owner: **Anne Arundel Health System, Inc.**

3. APPLICANT. *If the application has co-applicants, provide the detail regarding each co-applicant in sections 3, 4, and 5 as an attachment.*

Legal Name of Project Applicant:
Anne Arundel Medical Center, Inc.

Address:

2001 Medical Parkway	**Annapolis**	**21401**	**MD**	**Anne Arundel**
Street	City	Zip	State	County

Telephone: **443-481-6436**

Name of Owner/Chief Executive: **Victoria W. Bayless**

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

N/A

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

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

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☒	
	(2) For-profit	☐	
	(3) Close	☐	State & date of incorporation 1902-Maryland
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☐	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☒	

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

A. Lead or primary contact:

Name and Title: Joshua E. Jacobs, Vice President – Strategic Planning & Marketing/Communications

Mailing Address:

2001 Medical Parkway	**Annapolis**	**21401**	**MD**
Street	City	Zip	State

Telephone: 443-481-6436

E-mail Address (required): jjacobs4@aahs.org

Fax: 443-481-6539

B. Additional or alternate contact:

Name and Title: Marta D. Harting, Esq.

Mailing Address:

750 E. Pratt Street, Suite 900	**Baltimore**	**21202**	**MD**
Street	City	Zip	State

Telephone: 410-244-7542

E-mail Address (required): mdharting@venable.com

Fax: 410-244-7742

7. TYPE OF PROJECT

The following list includes all project categories that require a CON under Maryland law. Please mark all that apply.

If approved, this CON would result in:

(1) A new health care facility built, developed, or established ☒
(2) An existing health care facility moved to another site ☐
(3) A change in the bed capacity of a health care facility ☐
(4) A change in the type or scope of any health care service offered by a health care facility ☐
(5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_march_2015.pdf ☐

8. PROJECT DESCRIPTION

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

(1) Brief description of the project – what the applicant proposes to do;
(2) Rationale for the project – the need and/or business case for the proposed project;
(3) Cost – the total cost of implementing the proposed project; and
(4) Master Facility Plans – how the proposed project fits in long term plans.

Applicant Response:

(1) Brief Description of the Project

Anne Arundel Medical Center (AAMC) proposes to establish a 16-bed mental health hospital for adults. The mental health hospital would be established in a new building that AAMC would construct on a site approximately two miles from its acute care hospital in Annapolis. The mental health hospital will also house an ambulatory outpatient mental health clinic and a psychiatric partial hospitalization program (for both adults and adolescents). The hallmark of AAMC's mental health hospital will be providing both a *comprehensive* and *community-based* mental health treatment facility. Specifically, the project will: provide improved access to services; promote high quality and safe care; strengthen community partnerships; implement a patient and family-centered recovery model; integrate information systems to improve care coordination; and promote an environment focused on support for patients, families, and the community.

(2) Rationale for the Project

AAMC is a regional health system headquartered in Annapolis, Maryland. Under the hospital's Global Budget Revenue (GBR) contract with the Health Services Cost Review Commission (HSCRC), AAMC is responsible to serve a geographic area defined by 90 zip codes encompassing a total population of 1.1 million residents. The region includes communities in Anne Arundel County and extends across seven other counties, including Calvert, Prince George's, Charles, Caroline, Talbot, Kent, and Queen Anne's counties.

AAMC's service area is one of the largest regions in Maryland without adequate inpatient psychiatric services. AAMC currently does not have an inpatient psychiatric unit, yet has witnessed a growing need for acute psychiatric services, largely through visits to its Emergency Department (ED). The ED volume at AAMC generated more than 1,100 adult and pediatric transfers in Fiscal Year (FY) 2015 to an acute psychiatric unit outside Anne Arundel County. With population growth in Anne Arundel County, and a growing need for mental health services throughout the State, these ED transfers have become increasingly difficult to arrange, causing delays in treatment. Further, long distances to the nearest hospitals with available beds impose a significant burden on patients, families, and caregivers who optimally participate and collaborate in the patient's treatment. Care transitions are more difficult to arrange across regions, and upon discharge, patients are far removed from their provider team. The overall result is a fragmented approach to behavioral health care that fails to meet any tenet of the

Institute for Healthcare Improvement's Triple Aim: Better patient experience, better population health, and lower cost per case.

Community stakeholders have identified improved mental health services to be one of the highest priority health care needs in Anne Arundel County, as described by the FY 2016 Community Health Needs Assessment conducted in Anne Arundel County (Exhibit 1). The lack of an inpatient setting for effective treatment planning, the disjointed medical and psychiatric care management, and the poor care coordination across regions contribute to high ED utilization and the number of readmissions for patients with mental health diagnoses.

Residents of Anne Arundel County and surrounding counties rely heavily on AAMC as the first point of contact. In FY 2015, AAMC served more than 2,400 adult ED patients with a mental health diagnosis as their primary diagnosis, representing an 8 percent increase over prior year volume at AAMC. This patient volume included 1,837 visits for Anne Arundel County residents, or 36 percent of all adult Anne Arundel County residents who sought mental health services in an ED. In other words, more than one third of Anne Arundel County residents who sought emergency care for mental health conditions came to AAMC. Similarly, more than 20 percent of all adult residents from Queen Anne's County who sought emergency care for mental health conditions came to AAMC. The proposed program largely aims to meet the needs of patients already coming to AAMC for care.

Through this project, AAMC will deliver a comprehensive system of care consisting of inpatient psychiatric care, psychiatric partial hospitalization, and intensive outpatient programs all located in Anne Arundel County and carefully coordinated with existing providers of care and programs of self-help and patient advocacy, aimed at reducing inpatient utilization and recidivism and to improving outcomes.

Please refer to the Comprehensive Project Description below for a more detailed discussion of the rationale for the project.

(3) Cost

The capital cost of the project is $16,998,237. Details on cost are in Appendix 1 - Table E.

(4) Master Facility Plans

A description of how the project fits in AAMC's long term plans is discussed in part (6) of the Comprehensive Project Description below.

B. Comprehensive Project Description: The description must include details, as applicable, regarding:

(1) Construction, renovation, and demolition plans;
(2) Changes in square footage of departments and units;
(3) Physical plant or location changes;
(4) Changes to affected services following completion of the project; and
(5) If the project is a multi-phase project, describe the work that will be done in each phase. If the phases will be constructed under more than one construction contract, describe the phases and work that will be done under each contract.

Applicant Response:

(1) AAMC

AAMC is an independent regional health system headquartered in Annapolis, Maryland. Founded in 1902, AAMC includes a 375-bed acute care general hospital, a medical group, imaging services, a substance use treatment center (Pathways), and a variety of other health care enterprises. In addition to its hospital campus and the property on which Pathways operates on Riva Road in Annapolis, AAMC operates several outpatient centers throughout its service area. Under the strategic vision of "Living Healthier Together" defined in 2010, AAMC reoriented what was a successful hospital into a regional health system. Creating a sustainable ambulatory care platform, delivering high quality care at low cost, and broadening the breadth and depth of clinical programs have been important parts of this effort.

Under the terms of its GBR agreement with the HSCRC, AAMC is accountable for a population of more than 1.1 million residents distributed across a region that includes communities in Anne Arundel County and seven other counties.[1] AAMC recently applied for a Transformation Grant in collaboration with University of Maryland Baltimore Washington Medical Center (UM BWMC), Healthy Anne Arundel Coalition, and other community organizations committed to quality care and health improvements across the region.

(2) The Mental Health Crisis in Anne Arundel County

Anne Arundel County—with 550,000 total residents—is the third most populous county in the State of Maryland but is currently served by only one inpatient mental health unit. This 14-bed unit is located at UM BWMC, which is constrained by its limited capacity amidst growing volume. Between FY 2014 – 2015, adult ED visits for mental health and adult discharges for mental health for Anne Arundel County residents increased by approximately 2 percent (see Chart 3, page 33). Like most general acute care hospitals with an inpatient psychiatric unit, UM BWMC admits patients largely from its ED and rarely has bed capacity to accept transfers from other hospitals. HSCRC data validates that UM BWMC's unit has consistently operated at greater than 90 percent occupancy over the course of Calendar Year (CY) 2014 and the first three quarters of CY 2015 (Chart 28, page 62).

1 This region is defined by AAMC's Global Budget Revenue Agreement with the HSCRC, and is a more broadly defined region than the service area definition for proposed for acute psychiatric program.

AAMC is experiencing comparable growth.

- According to a November 2015 report by the Maryland Hospital Association, Anne Arundel County now ranks fourth among Maryland's 24 *counties* in the number of *behavioral health* ED visits in CY 2014, reporting a total of 9,253 visits in the county.[2] And, a comparison across the 48 hospitals in Maryland shows AAMC ranks fifth across all Maryland *hospitals* with 4,144 ED visits for behavioral health visits in that same period.

- AAMC reports a growth in the number of mental health visits to the ED (Chart 1 below), and AAMC is caring for an increased share of Anne Arundel County's total ED volume (Chart 2, page 12).

Chart 1
AAMC ED Visits for Mental Health, Adults Age 18+
FY 2013 – 2015

County of Residence	Number of Adult ED Visits with Mental Health Dx FY2013	FY2014	FY2015	*% of Total FY2015*
Anne Arundel County	1,765	1,713	1,837	*75.9%*
Prince George's County	184	205	218	*9.0%*
Queen Anne's County	104	101	92	*3.8%*
All Other	230	219	273	*11.3%*
TOTAL ADULT MENTAL HEALTH ED VISITS	**2,283**	**2,238**	**2,420**	*100.0%*
% change, year over year		***-2%***	***8.1%***	

Source: HSCRC Abstract Dataset

Mental health defined by CCS codes, and do not include substance use or alcohol-related disorders

2 Maryland Hospital Association, Policy and Data Analytics. "Behavioral Health Hospital Services in MD: An Overview of Mental Health and Substance Use Related ED Visits and Admissions, 2014" (November 2015). Note: This report documents volume for "behavioral health" defined by mental health and substance use diagnoses, and includes patients of all ages.

Chart 2
Anne Arundel County Residents, Age 18+
ED Visits for Mental Health
FY 2013 – 2015

ED Visits with Mental Health Dx as Primary

Anne Arundel County Residents: Adults, only	FY2013	FY2014	FY2015	*% change, 2013-2015*
# ED visits for mental health, all hospitals	5,056	5,014	5,120	*1.3%*
# ED visits for mental health , at AAMC	1,765	1,713	1,837	*4.1%*
AAMC market share of ED mental health visits	**34.9%**	**34.2%**	**35.9%**	

Source: HSCRC Abstract Dataset

Mental health defined by CCS codes, and do not include substance use or alcohol-related disorders

- In FY 2015, AAMC had to arrange transfer for a total of 1,173 patients from AAMC's ED for admission to a psychiatric unit (this includes 949 adult patients and 224 pediatric/adolescent patients).[3] This huge volume of transfers speaks to the need for an inpatient psychiatric program at AAMC, which patients select as their choice of provider and the first point of contact.

As a result of these dynamics and UM BWMC's limited bed capacity, patients in crisis who present at AAMC's ED and require hospitalization must wait in the ED until an available bed is located and necessary transfer arrangements are made, delaying treatment. Adult patients in crisis who require admission wait an average of 28 hours in AAMC's ED from time of arrival until transfers occur. Because there rarely is an open bed at UM BWMC, patients who require inpatient care are often admitted to units located up to one hour's time or sometimes farther from home. One of the consequences is that family members—faced with one-hour drive times or limited access to public transportation—are less likely to be involved in the acute episode of care. After discharge, these patients may return to Anne Arundel County without an established local care provider to offer continuity of care post crisis, and/or often experience delays in accessing outpatient care. Therefore, while high-quality inpatient programs exist across the State of Maryland, these programs are at a geographic distance from Anne Arundel County and are less likely to be well-integrated with local, community-based resources critical to successful recovery and long-term community-based management. The volume of Anne Arundel County patients who require psychiatric admission calls for more than one locally-based inpatient unit.

In the absence of a local comprehensive program, many patients with chronic mental health conditions are heavily reliant on AAMC's ED for episodic mental health care. In CY 2015, a total of 70 patients presented at AAMCs ED three or more times in one year with a mental health condition as their primary diagnosis, a pattern that underscores the need for an improved delivery system for psychiatric services. The lack of an acute care unit may be

3 HSCRC Abstract Dataset (FY 2015)

contributing to under-treatment and return ED visits, and the lack of integration with medical management and local community resources may be contributing to relapse and episodic care. AAMC's proposed program seeks to provide a comprehensive treatment and management plan to support patients for successful community-based living, and reduce the dependence on the hospital for episodic care.

The need for mental health services in Anne Arundel County is not limited to inpatient psychiatric services. There is a serious need for partial hospitalization services in the county. The only partial hospitalization program for mental health in Anne Arundel County today is UM BWMC's program that primarily serves patients who present at UM BWMC's ED or as a stepdown unit from UM BWMC's inpatient unit. Accordingly, even when a patient who presents at AAMC's ED could be appropriately treated in a partial hospitalization program, the only option is to find an available inpatient bed for the patient (which is almost always found outside of Anne Arundel County).

A further challenge is that many of AAMC's patients have comorbidities, i.e. both medical and mental health diagnoses. The interconnectedness of mental health conditions and poor medical status is widely recognized. In FY 2015, 19 percent of AAMC's inpatients had a primary or secondary mental health diagnosis.

In an analysis of "high utilizers" at AAMC during FY 2015, a total of 1,089 high utilizers were identified. Closer analysis showed that 50 percent of these high utilizing patients had an accompanying mental health diagnosis (refer to Chart 15, page 46). Effective care management to reduce unnecessary hospital utilization requires both well-resourced medical and mental health delivery systems to improve health status and personal well-being.

To summarize:

- Anne Arundel County documents more than 3,200 mental health admissions but is dependent on distant facilities for acute psychiatric care.

- Patients residing in the AAMC service area rely heavily on AAMC as the first point of contact, but AAMC can only provide stabilization in the ED and transfer to another hospital, often located one hour or more away in travel time.

- Patients with chronic mental health conditions are relying heavily on the ED for episodic mental health care.

- Many AAMC patients who come to the ED with medical concerns also have a mental health diagnosis. Readmission rates and high utilizer patterns are strongly correlated with patients who have mental health diagnoses.

- Community residents report that their needs for mental health services are not being adequately met.

(3) The Project: AAMC's Mental Health Hospital

AAMC proposes to establish a 16-bed mental health hospital for adults (to be licensed as a Special Hospital-Psychiatric) located in a new building to be constructed on the property where AAMC currently operates Pathways (its longstanding substance use and co-occurring disorders residential and outpatient treatment facility). The new mental health hospital will also house an ambulatory outpatient mental health clinic and a psychiatric partial hospitalization program (for both adults and adolescents). A more detailed description of the proposed new building is provided in part (7) below.

This project will enable AAMC to deliver a comprehensive and integrated mental health care program that will incorporate inpatient psychiatric care, psychiatric partial hospitalization, intensive outpatient programs, and referral and care coordination to community-based support services. This comprehensive mental health care program will be well-integrated with community-based activities, including self-help and family programs to strengthen patient engagement, and patient advocacy organizations to encourage active involvement in community health. The goals will be to sustain the patient in the community and to require inpatient admissions only when absolutely necessary for the patient's health.

AAMC will offer an integrated care, population health approach for the provision of mental health services in a single setting with the collaboration of other community and health care providers to offer optimal and effective care. Integrated care entails a focus on the provision of holistic and coordinated care, liaison services, and the development of clinical pathways between and across a range of treatment providers. A prerequisite for the delivery of effective treatment is a strong collaboration, cooperation and effective working relationship between providers such as primary care physicians, psychiatrists, inpatient psychiatric services, clinical psychologists, licensed social workers, therapists, and emergency care services.

AAMC already offers several core components of this community-centered program, including the following population health initiatives:

- **Ambulatory outpatient clinic**. In 2014, AAMC opened an outpatient clinic offering services for diverse mental health needs for adults and children ages three and older. We provide comprehensive evaluation and treatment services by a team of board certified psychiatrists, nurse practitioners, and other licensed clinical professionals. Services provided through our outpatient setting include: Psychiatric evaluations, medication management, and individual and group psychotherapy. The clinic team offers services for life challenges, relationship issues, behavioral issues with a child or teen, depression, anxiety, trauma and persistent mental illness.

- **Screening and referral in the primary care setting**. In FY 2015, AAMC introduced a screening tool and early intervention model across primary care and OB/GYN practice sites to identify individuals experiencing mental health or substance use problems and to provide early intervention. A recovery navigator provides referral and follow-up to patients in eight physician offices, drawing on nine community mental health and substance use providers who collaborate with AAMC and accept referrals within 48 hours. From the program's inception to January 31, 2016, the program coordinated 509 referrals from community physician offices. The recovery navigator program is expected to expand its operations in FY 2016 to provide

services to the communities of northern Anne Arundel County in conjunction with UM BWMC.

- **Mental health clinicians embedded in the primary care setting.** In CY 2016, AAMC plans to pilot a primary care integration model in one of AAMC's primary care practice sites. This integrated model for community-based behavioral health care within the primary care setting is evidence-based with positive outcomes across the country. The pilot program at AAMC will incorporate interventions for both mental health and substance use disorders. Most recently, a bilingual therapist was hired to work at the Forest Drive Community Clinic to address the mental health and substance use needs that are seen among the patient population. This clinic provides primary care to the uninsured and underserved community, and acts as a primary care medical home for new and/or established patients who are in need of services ranging from preventative, acute and/or chronic care. The goal of the clinic is to build a provider-patient partnership with a focus on patient education and continuity of care, thereby reducing unnecessary ED visits. Patients are able to receive care regardless of their ability to pay. Adverse social determinants of health compound the complexity of these patients: low literacy, housing and nutritional challenges, lack of transportation, social isolation and poverty are common.

- **Psychiatric partial hospitalization program.** In FY 2016, AAMC will open a psychiatric partial hospitalization program with a capacity to serve up to 12 adults and 12 adolescents at any one time. This program offers a lower-cost, community-based alternative to the inpatient setting for a significant percentage of patients. Patients are expected to be referred by the ED or directly by community providers as an alternative to inpatient care, or by inpatient facilities as a step-down level of care. The projected course of treatment in the partial hospitalization program is one to three weeks. At this length of stay, the program will have a capacity to treat approximately 500 individuals on an annual basis. It is also expected to help prevent recurring hospitalization of individuals stepping down from inpatient care. This program will be relocated to the new building proposed in this Application so that it can be co-located with the new inpatient program.

Having an inpatient unit co-located with AAMC's comprehensive network of community-based services will promote continuity of care in multiple ways. Psychiatrists will work in both the inpatient unit as well as the partial hospitalization program, thus easing this transition for patients and avoiding the potential for gaps to arise in communication or appropriate follow-up care. Should an acute episode/relapse occur, physicians will be able to admit patients directly to the acute unit and eliminate the need for an ED visit/evaluation. The ability to accommodate direct admissions from sub-acute care programs when relapsing illness requires such an intervention will reduce unnecessarily overburdening acute hospital EDs and inconveniencing patients and families. The integration of self-help programs and family wellness programs into the work flows and into the very work spaces of the inpatient program will encourage incorporation of this recovery-oriented approach to mental health problems.

Continuity of these self-help programs and family programs across inpatient, partial hospital, and outpatient environments will also promote early identification of relapse and timely intervention to reduce utilization of the more intensive and costly service sites. The goal is to

support an integrated clinical program, assure continuity of care for patients, and encourage use of the most appropriate service setting. For more information on AAMC's existing behavioral health programs—including Pathways—please refer to Exhibit 2.

In summary, the project will positively impact the health care system as follows:

(a) Improve access, minimize the need for hospital-to-hospital transfer, and reduce delays in care for patients in crisis;

(b) Improve quality of care by providing continuity of care for patients who require ongoing treatment; maintain clinical relationships across acute and community-based treatment settings;

(c) Reduce length of stay in the acute care setting by providing alternative mental health settings in the same building, and by integrating closely with local community-based support services;

(d) Reduce the relapse rates, readmissions, and return visits to the ED, and improve long-term outcomes through the integration of substance use and medical services to patients and through more effective use of local community-based services;

(e) Involve family members in the recovery process by providing a more local service site and removing the hardship of travel that currently discourages family involvement;

(f) Produce operating efficiencies by leveraging the mental health workforce within the inpatient and outpatient programs and sharing well-trained, hard-to-recruit professionals;

(g) Become a community-oriented model for comprehensive mental health services, and

(h) Promote the training of clinicians at all levels, attract clinical research, and provide a setting for effective collaboration with social services.

(4) Existing Program Integration

AAMC's electronic health record (EHR) technology, Epic, plays an essential role in achieving patient-centered and seamless integrated care across the full continuum. AAMC's Epic platform successfully accommodates and connects physicians, nursing, clinicians, and the entire behavioral health team and care coordinators to help ensure that all are "on the same page" and working to develop an effective, patient-centered care plan. AAMC providers also use CRISP (Maryland's health information exchange) to access information on patients who visit multiple care locations, which allows for greater care coordination.

In addition to improved, more coordinated communication, AAMC's Epic platform includes a fully integrated behavioral health record that helps to:

- Promote solution-focused care,

- Reduce the risk of contraindicated care or conflicting medications,
- Provide more timely access to patient data,
- Offer better outcomes tracking,
- Allow more informed modifications and alterations to the plan of care, and
- Improve patient-provider relationships.

(5) Program Leadership

Raymond Hoffman, MD, is the Medical Director of the AAMC Division of Mental Health and Substance Use. He previously served as Medical Director of the Walter P. Carter Clinics in the Division of Community Psychiatry at the University of Maryland Medical Center, and as Chief Medical Officer at Mosaic Community Services. Mosaic is Maryland's largest provider of community-based outpatient, residential rehabilitation, and psychiatric rehabilitation programs. Dr. Hoffman's CV is located in Exhibit 3 (a).

Dawn Hurley, MA, CPRP, is Executive Director of Behavioral Health at AAMC. A certified psychiatric rehabilitation practitioner (CPRP), she previously served as the Division Director of Adult Psychiatric Rehabilitation at Mosaic Community Services, where she oversaw programs of psychiatric rehabilitation, supported employment, occupational therapy, and substance use. Ms. Hurley is serving as an appointee to the Governor's Task Force on Behavioral Health Initiatives. Ms. Hurley's CV is located in Exhibit 3 (b).

Barbara Jacobs, RN, is Chief Nursing Officer (CNO) at AAMC. She came to AAMC from John Hopkins Suburban Hospital in Bethesda, Maryland where she served as the chief nurse officer. She has almost 40 years of nursing experience, beginning her career in New Brunswick, New Jersey, then continued to develop her clinical skills at hospitals in Camden, New Jersey and Philadelphia, Pennsylvania and served in progressive leadership positions at George Washington University Hospital. The inpatient psychiatric unit was her responsibility at Suburban Hospital and while Interim CNO at George Washington University Hospital. She is certified in gerontological and critical care nursing. Ms. Jacobs' CV is located in Exhibit 3 (c).

(6) Consistency with AAMC's Long Term Plans

Vision 2020 – Living Healthier Together, AAMC's ten-year Strategic Plan, defines AAMC's mission to enhance the health of the people it serves. In 2014, consistent with its overall mission, AAMC developed its Strategic Plan for Behavioral Health to guide it in meeting the mental health and substance use needs in its community. Recognizing that access to quality, patient-centered behavioral healthcare services is key to having a favorable quality of life in its community, AAMC committed in this Strategic Plan to be a leader in promoting access to mental health services within a seamless, integrated medical, mental health continuum of care. One of the key elements of this Strategic Plan was the development of inpatient psychiatric services at AAMC, which the plan targets for FY 2017 – 2018.

The development of inpatient psychiatric capacity within AAMC's health system is also contemplated within its Master Facilities Plan, which shows two options for locating this program from a facilities standpoint. One potential location is shown within the acute care hospital in the North Tower, and the other location is shown in a new building that could be constructed on property on Riva Road in Annapolis where Pathways operates currently. AAMC leases the Riva Road property from Anne Arundel County on a long-term basis and the lease allows for construction of a freestanding psychiatric hospital on the property with approval from the county. AAMC began exploring the construction of a freestanding psychiatric hospital on the property conceptually in 2011, generating several conceptual drawings. AAMC participated as an interested party in the development of an adjacent site in 2011 to ensure that it would not interfere with AAMC's ability to construct a freestanding psychiatric hospital on the property. Utilities are in place (including electricity, gas, telephone and data, water and sewer), capital connection and other impact fees have been identified, and storm water management planning and additional building parking were also explored.

As will be discussed in further detail below in response to COMAR 10.24.01.08G(3)(c), Availability of More Cost-Effective Alternatives (page 79), while the Master Facilities Plan identifies two options for the location of inpatient psychiatric capacity within AAMC's health system, AAMC determined that establishing this capacity as a freestanding mental health hospital on the Riva Road property was the superior option. Among other considerations, the patient population to be served often has varied privacy needs from a standard acute-care population. This geography offers patients and family members less exposure than at a busy acute care, medical center campus. Locating the unit outside of an acute care hospital also enables the design team to prepare a pleasing, site-specific milieu while meeting the array of applicable codes and regulations as well as the therapeutic and safety needs for patients and staff. AAMC determined that this location strikes the right "balance between the safest possible healing environment and a non-institutional appearance that is correct for the unique conditions that exist in each and every facility."[4]

(7) Facility Details

(a) Construction, renovation, and demolition plans

Site Features: The proposed facility will be located adjacent to the existing Pathways building. As configured on the site, the entrance to the new building will be separate from the entrance to the existing Pathways building. The configuration of the new facility adjacent to the existing Pathways building allows for an outside courtyard area between the buildings to be secured providing an opportunity for staff and patients to utilize outdoor space while maintaining privacy and security.

Parking: Existing parking is sufficient to support both buildings and is readily accessible to the new building entrance. The secure ambulance entrance and the loading dock are accessible at the basement level with access off of Harry S. Truman Parkway providing a separate entrance away from the main entrance on the first floor.

4 Hunt, James M and David M. Sine "Design Guide for the Build Environment of Behavioral Health Facilities," Edition 7.0, May 2015.

Primary Building Features: The proposed facility will be a 66,725-square-foot, four-story structure with three stories above grade on the courtyard and main entrance sides of the building, and four stories above grade on the service entrance side of the building. Exterior façade will be similar to the existing Pathways building. Façade materials include the following: split face concrete masonry units at the building base, face brick as the predominant material, stucco in selected areas, and metal-framed windows with insulated glass and appropriate security features. Roofing materials consist of standing seam metal roofing on sloped surfaces and built-up roofing on flat surfaces. Each of the building floors includes the following functional areas:

Basement Floor: This floor of the building serves primarily to provide the various support facilities for the entire building to include the following: centralized mechanical systems, central electrical systems, loading dock, kitchen, soiled and clean laundry storage, and supply and dietary storage. In addition, the secure ambulance entrance is located on this floor with an enclosed ambulance bay leading to the appropriate intake and holding area (where patients are examined by an Intake Coordinator), and then transport via a secure elevator to the inpatient unit on the second floor.

First Floor: The main entrance to the building occurs on this floor with access available from nearby parking as well as a drop-off lane adjacent to the building entrance. Upon entering the building, appropriate security features are in place before access to the remainder of the building is granted. A multi-purpose room next to the vestibule provides space for outside group meetings without having to enter the secure portion of the building. Once passing through security, the reception, meditation, waiting, vending, and public toilet facilities are immediately available. Elevators are configured adjacent to the lobby for appropriate secure access to the inpatient unit on the second floor. Beyond the lobby, a public corridor provides access to the other functions on this floor. The corridor will be glass-enclosed on the building edge providing views and controlled access to the outdoor enclosed courtyard. Shell space is included for the future outpatient programs. Space is provided for the mental health partial hospitalization program with separate areas for adolescent patients, adult patients, and staff support functions. At the rear of the building, the service elevator is located with access to all building floors. Some storage is also available next to the service elevator.

Second Floor: This floor of the building serves as a 16-bed inpatient unit. Patients arriving by ambulance will be transported to this floor via the secure elevator discharging into a secure vestibule and subsequent intake into the unit. At the front of the building, the other elevator will provide access for families and visitors to the unit. Immediately adjacent to this elevator are a waiting room, public toilets, consult rooms, staff offices, and a staff team room. Upon entering the unit, there are two wings of patient rooms. All patient rooms are single occupancy with code compliant toilet and shower facilities. In the center of the building, the common areas for patients are located with views into the secure courtyard and views to the other portions of the site. Staff support areas are also located in the center of the building with nurse station sight lines directly down each patient wing corridor. At the rear of the building, the occupational therapy

program is provided, along with storage and the service elevator, which will provide food service to the inpatient unit from the basement floor kitchen.

Third Floor: This floor is shell space reserved for expansion for potential additional inpatient psychiatric beds or outpatient mental health programs. Please refer to page 77 below for further discussion of the proposed shell space.

(b) Changes in square footage of departments and units

Not applicable.

(c) Physical plant or location changes

When it is initiated later this year, AAMC's mental health partial hospitalization program will occupy leased space at another location. Upon completion of construction of the freestanding facility and end of existing lease, the PHP program will relocate to the new facility.

(d) Changes to affected services following completion of the project

Except for the relocation of the partial hospitalization program described in (c), there will be no change in AAMC's existing health care services following completion of the project.

(e) Multi-phase project

This is not proposed to be a multi-phased project. The project schedule is described in AAMC's response to Application Question 12.

Complete the DEPARTMENTAL GROSS SQUARE FEET WORKSHEET (Table B) in the CON TABLE PACKAGE for the departments and functional areas to be affected.

Applicant Response:

Please see Appendix 1 - Table B.

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

Complete the Bed Capacity (Table A) worksheet in the CON Table Package if the proposed project impacts any nursing units.

Applicant Response:

Please see Appendix 1 - Table A.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: Parcel 222 owned by Anne Arundel County is 13.2 acres and the leased area is 10.0 acres

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

AAMC is working with Anne Arundel County to amend the existing lease to allowing AAMC to construct the new facility on the leased property. Anne Arundel County Executive has provided a letter to AAMC affirming the project site will be under the control of AAMC by November 1, 2016. See Exhibit 4.

The property is zoned appropriately for this use.

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

(1) Owned by: _____
Please provide a copy of the deed.

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

(3) Land Lease held by: Anne Arundel County, Maryland
Please provide a copy of the land lease as an attachment.

Applicant Response: Please refer to Exhibit 5 (a), (b), (c), and (d).

(4) Option to lease held by: _____

Please provide a copy of the option to lease as an attachment.

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

11. PROJECT SCHEDULE

In completing this section, please note applicable performance requirement time frames set forth at COMAR 10.24.01.12B & C. Ensure that the information presented in the following table reflects information presented in Application Item 7 (Project Description).

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date	12	months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	4	months
Completion of project from capital obligation or purchase order, as applicable	24	months
Multi-Phase Project for an existing health care facility (Add rows as needed under this section)		
One Construction Contract		months
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.		months
Initiation of Construction within 4 months of the effective date of the binding construction contract.		months
Completion of 1st Phase of Construction within 24 months of the effective date of the binding construction contract		months
Fill out the following section for each phase. (Add rows as needed)		
Completion of each subsequent phase within 24 months of completion of each previous phase		months
Multiple Construction Contracts for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1st Phase within 12 months of the CON approval date		months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1		months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.		months
To Be Completed for each subsequent Phase of Construction		
Obligation of not less than 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase		months
Initiation of Construction on each phase within 4 months of the effective date of binding construction contract for that phase		months

	Completion of each phase within 24 months of the effective date of binding construction contract for that phase		months

12. PROJECT DRAWINGS

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

Project drawings must include the following before (existing) and after (proposed) components, as applicable:

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

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

C. For a project involving site work schematic drawings showing entrances, roads, parking, sidewalks and other significant site structures before and after the proposed project.

D. Exterior elevation drawings and stacking diagrams that show the location and relationship of functions for each floor affected.

Applicant Response:

Please see Exhibit 6, Project Drawings.

13. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction Characteristics (**Table C**) and Onsite and Offsite Costs (**Table D**) worksheets in the CON Table Package.

Applicant Response:

Please see Appendix 1 - Tables C and D.

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project, and the steps necessary to obtain utilities. Please either provide documentation that adequate utilities are available or explain the plan(s) and anticipated timeframe(s) to obtain them.

Applicant Response:

Water. The site is currently served via a 6" meter and 8" service off a 16" water main in Harry S. Truman Parkway. The site is located within the "Existing Service Area" of the Anne Arundel County Water Master Plan 2013 (Map W-7). Allocation for water will occur at Preliminary Plan approval. However, AAMC's experience with this area of the county indicates available capacity for this expansion of the facility.

Sewer. The site is currently served via an 8" service line from Public Sanitary Sewer Manhole #11428 located along Harry S. Truman Parkway. The site is located within the "Existing Service Area" of the Anne Arundel County Sewer Master Plan 2013 (Map S-7). Allocation for sewer will occur at Preliminary Plan approval. However, AAMC's experience with this area of the county indicates available capacity for this expansion of the facility.

Electric. Upgraded electric service from BGE to the existing Pathways was performed by BGE in 2014/2015 which will be utilized for the proposed expansion.

Gas. A single 2" gas service was extended to the access road for the recent Annapolis Corporate Park Office development to the west of the Pathways property. This gas service is readily available for this expansion.

Telephone/Communications. The proposed expansion will utilize the existing services for the Pathways building for any new service.

PART II - PROJECT BUDGET

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

Note: Applicant must include a list of all assumptions and specify what is included in all costs, as well the source of cost estimates and the manner in which all cost estimates are derived.

Applicant Response:

Please see Appendix 1 - Table E and Exhibit 7, Marshall Valuation Segregated Cost Form.

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

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

   Victoria W. Bayless, President/CEO
   Anne Arundel Medical Center
   2001 Medical Parkway
   Annapolis, MD 21401

   Anne Arundel Health System, Inc.
   2001 Medical Parkway
   Annapolis, MD 21401

2. Is any applicant, owner, or responsible person listed above now involved, or has any such person ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each such facility, including facility name, address, the relationship(s), and dates of involvement.

   The Applicant (Anne Arundel Health System, Inc., or "AAHSI") is the owner of Anne Arundel Medical Center (AAMC), an acute care general hospital. Neither AAHSI nor Ms. Bayless owns or operates any other health care facility, as that term is defined in Section 19-114 of the Health-General Article.

   AAHSI does own (directly or indirectly) certain other entitles that provide health care, including the following:
   Anne Arundel Health Care Services, Inc.
   Anne Arundel General Treatment Services Inc.
   Anne Arundel Health Care Enterprises, Inc.
   Anne Arundel Medical Center Foundation, Inc.
   Anne Arundel Real Estate Holding Company
   Cottage Insurance Company LTD.
   Anne Arundel Medical Center Collaborative Care Network, LLC
   Anne Arundel Health Systems Research Institute, Inc.
   Physician Enterprise, LLC

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

   None of the health care facilities listed above has had its license or certification suspended, revoked, or subjected to disciplinary action in the last 5 years.

4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) ever received inquiries from a federal or any state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

   AAMC has received the following inquiries by the entities specified above in regard to the quality of or payment for health care services where the inquiry led to (or could still lead to) penalties, admission bans, probationary status, or other sanctions (for documentation, please see Exhibit 8):

   3-Month Temporary Hold on Medicare Deemed Status – July 2015
   - Outcome: No Penalties (Action Plan accepted, restored full Deemed Status October 2015).
   - Actions/Monitoring: Documentation and monitoring of Patient Rights conditions of participation.

   3-Month Temporary Hold on Medicare Deemed Status - May 2013
   - Outcome: No Penalties (Action Plan accepted, restored full Deemed Status July 2013).
   - Actions/Monitoring: Documentation and monitoring initiative to improve language and interpretation services for patients with limited English proficiency.
   - Note: Self-Reported December 2012.

   Radiation Misadministration – February 2008
   - Outcome: Monetary Fine.[5]
   - Actions/Monitoring Completed: Developed an Emergent Radiation Oncology Protocol.
   - Note: Self-Reported.

   Joint Commission Conditional Accreditation Status - July 2003
   - Outcome: Action Plans accepted and awarded full Accreditation March 2004.
   - Actions/Monitoring Completed: Established evidence of acceptable compliance with 5 Type 1 Recommendations (Medical Record Documentation, Medication Range Orders, Data Analysis, Departmental Scope of Services, and Job Description Performance Competencies).

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5 A Maryland Department of the Environment Press release referencing this matter can be found at: http://www.mde.state.md.us/programs/PressRoom/Pages/1086.aspx.

Medicare/Tricare Billing Claims for Infusion Therapy

- Outcome: Settlement including five year corporate integrity agreement (closed 2003) plus fine.
- Actions/Monitoring Completed: Appointment of Compliance Officer/Committee, Annual Corporate Compliance Education, Implementation of a Corporate Compliance Program.[6]
- Note: Identified April 1999.

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

   No applicant, owner, or responsible individual listed in response to Question 1 above has pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2.

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

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

3-28-2016
Date

Victoria W. Bayless
Signature of Owner or Board-designated Official

PRESIDENT + CEO
Position/Title

VICTORIA W. BAYLESS
Printed Name

6 The institutional memory of relevant AAMC staff does not go further than this time period and therefore a comprehensive response to this question is not reasonably possible for time periods before 1999.

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

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

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

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

10.24.01.08G(3)(b). Need.

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

INSTRUCTIONS: Please identify the need that will be addressed by the proposed project, quantifying the need, to the extent possible, for each facility and service capacity proposed for development, relocation, or renovation in the project. The analysis of need for the project should be population-based, applying utilization rates based on historic trends and expected future changes to those trends. This need analysis should be aimed at demonstrating needs of the population served or to be served by the hospital. The existing and/or intended service area population of the applicant should be clearly defined.

Fully address the way in which the proposed project is consistent with each applicable need standard or need projection methodology in the State Health Plan.

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

Please assure that all sources of information used in the need analysis are identified. Fully explain all assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), the relevant population considered in the analysis, and the service capacity of buildings and equipment included in the project, with information that supports the validity of these assumptions.

Explain how the applicant considered the unmet needs of the population to be served in arriving

at a determination that the proposed project is needed. Detail the applicant's consideration of the provision of services in non-hospital settings and/or through population-based health activities in determining the need for the project.

Complete the Statistical Projections (**Tables F and I, as applicable**) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package.

Applicant Response:

Please see Appendix 1 – Table I for Statistical Projections.

A.

INTRODUCTION

1.

Definitions

The proposed AAMC mental health hospital will serve adult patients with a mental health diagnosis as the primary diagnosis. For purposes of this assessment, mental health services are defined based on a mental health diagnosis using the Clinical Classification Software (CCS) code as a primary diagnosis. The volume of mental health services documented in this section does *not* include patients treated for substance use/alcohol-related disorders as the *primary* diagnosis.

2.

Volume Growth in Anne Arundel County

Of all counties in Maryland, Anne Arundel County reports the fifth highest volume of mental health discharges and the fourth highest volume of ED visits in the State of Maryland for mental health.[7] Moreover, mental health volume for county residents continues to grow. Based on HSCRC data, between FY 2014 – 2015, Anne Arundel County reported a 2.1 percent increase in adult ED visits for mental health diagnoses and a 1.6 percent increase in adult discharges for mental health diagnoses (Chart 3, page 33).

7 In this section, "mental health" volume is based on a primary diagnosis of mental health as defined by CCS codes; figures do not include patients with substance use diagnoses/alcohol-related disorders as the primary diagnosis, which patients will not be treated at the mental health hospital proposed in this application. .

Chart 3
Anne Arundel County Residents, Age 18+ Years
Mental Health Volume at Maryland Hospitals

	FY2013	FY2014	FY2015
# Mental Health ED Visits	5,056	5,014	5,120
% change		*- 0.8%*	*2.1%*
# Mental Health Discharges	3,558	3,214	3,265
% change		*-9.7%*	*1.6%*

AAMC is taking care of a growing share of Anne Arundel County residents visiting the ED with mental health as a primary diagnosis. There was a 4.1 percent increase in ED visits for mental health at AAMC from FY 2013 – 2015, as shown below in Chart 2:

Chart 2
(re-presented from page 12)
Anne Arundel County Residents, Age 18+
ED Visits for Mental Health
FY 2013 – 2015

ED Visits with Mental Health Dx as Primary

Anne Arundel County Residents: Adults, only	FY2013	FY2014	FY2015	*% change, 2013-2015*
# ED visits for mental health, all hospitals	5,056	5,014	5,120	*1.3%*
# ED visits for mental health , at AAMC	1,765	1,713	1,837	*4.1%*
AAMC market share of ED mental health visits	**34.9%**	**34.2%**	**35.9%**	

Source: HSCRC Abstract Dataset

Mental health defined by CCS codes, and do not include substance use or alcohol-related disorders

At the same time, Anne Arundel County—with a total population of 550,000 residents—has only one hospital (UM BWMC) with an inpatient psychiatric unit, and this unit has consistently operated at above 90 percent occupancy through CY 2014 and through most of CY 2015. As a result, patients in crisis who present at AAMC's ED and who require hospitalization must wait in the ED until an available bed is located in another Maryland county, and necessary transfer arrangements are made. Typically, patients who require inpatient care are admitted to units as far as 40 miles from home.

The dependence on out-of-area psychiatric units has resulted in lengthy hospital stays and difficult transitions for patients post-discharge. In addition, AAMC been challenged to build an

effective care management model for patients with serious mental health problems. Under its GBR contract, AAMC is responsible for a population of more than 1.1 million residents, but must rely on out-of-area psychiatric units and out-of-area professional teams for acute psychiatric services. This delivery model results in disjointed medical and psychiatric patient management for Anne Arundel County residents, and breaks in continuity of care. The consequences are described more fully in sections following.

Accompanying these challenges, Anne Arundel County has experienced an intensified need for mental health services to combat addiction rates and overdose deaths. Anne Arundel County reports one of the most alarming increases in death rates associated with overdoses across the State of Maryland. The rising rates of drug and alcohol-related deaths are largely attributable to increases in the number of heroin and fentanyl-related deaths, and the heroin epidemic is calling on counties to respond on many levels. Mental health services are critical to effective prevention efforts in order to address root causes and to prevent mental health conditions from escalating and leading to substance use.

AAMC is committed to providing the continuum of care that extends across service settings, including partial hospitalization, outpatient office sites, home-based services, programs at community-based organizations, and residential services. While community-based care remains the preferred service site where appropriate, AAMC recognizes the critical need for an acute care setting in this region. The population is growing. ED visits for mental health care and calls to mobile crisis teams continue to increase, and for a segment of the population, the need for an inpatient setting continues to be critical for developing a treatment plan, evaluating the efficacy/tolerance of medication(s), establishing ongoing clinical relationships, and/or providing self-management training that will support treatment adherence and recovery. Finally, while clinicians at AAMC are committed to maximizing the use of the outpatient setting, a large majority of patients who present in the ED currently requiring inpatient psychiatric hospitalization do not meet the criteria for partial hospitalization, and an inpatient unit is critical to effectively manage this population if safety needs are to be met and recovery is to be promoted.

In response to the intensifying need for mental health care services, AAMC proposes to build a mental health hospital on a site located approximately three miles from the main hospital campus, to be housed in a building that will integrate acute care, partial hospitalization and outpatient services. The inpatient program will be licensed as a Special Hospital – Psychiatric, and will incorporate 16 bed for adults. The building will also include an expanded partial hospitalization program to serve up to 34 adults and adolescents per day, and a range of outpatient services including family support, self-help, and prevention programs on a campus for mental health services. The new mental health hospital will offer patient-oriented recovery programs. Patients will be encouraged to draw on community-services located on the same campus and maintain clinical relationships to support successful recovery.

The mental health hospital itself will serve adult patients only. While there is currently a significant need for mental health services for adolescents across the region, AAMC believes that its new partial hospitalization program will significantly improve access to care for the adolescent population without the addition of beds at this time. This delivery model will be closely evaluated in terms of clinical outcomes, patient satisfaction, relapse rates, and ongoing need to validate that community needs for adolescents are appropriately met through this program and through inpatient beds currently available for adolescents across the State of

Maryland.

3.

The Continued Need for Inpatient Care: Mental Health Services

Despite the growing emphasis on community-based care and despite the greater availability of communications technology to support home-based care, Maryland has not seen a dramatic decline in overall acute psychiatry volume. In fact, between CY 2014 – 2015 (based on 9 months actual), overall admissions to acute psychiatric units in Maryland were relatively stable, as shown on Chart 4 below:

Chart 4
 # Admissions to Acute Psychiatric Units in Maryland
CY 2014 – 2015, Annualized

	CY 2014	CY 2015, Annualized	*% Change*
Psychiatric Units, Acute General Hospitals	35,418	36,191	*2.2%*
Freestanding Psychiatric Hospitals	13,242	12,892	*(2.6 %)*
Total Acute Psychiatric Units	48,660	49,083	*0.9%*

Source: HSCRC Abstract Dataset, Experience Report, CY2014-2015
CY2015 figures annualized based on 9 months actual (Jan-Sept 2015)
See Chart 28, page 62 for hospital detail

This reflects a combination of factors that drive a continued need for acute care capacity, including:

- The increase in addictions rates in Maryland, accompanied by mental health conditions and family stress that have increased service need,

- The increase in rates of chronic disease, strongly correlated with higher rates of depression and other mental health conditions, and

- The increase in insurance coverage—brought about through the ACA—providing benefits to a larger percentage of Maryland's population. The State of Maryland reports more than 220,000 newly eligible adults through the ACA Medicaid expansion.

The continued need for inpatient resources also reflects a positive recognition of the improved outcomes and the sustained benefits produced by inpatient psychiatric care, particularly for those patients with both medical and psychiatric conditions. Clinicians and payors recognize the value of the inpatient setting to provide:

- The integration of medical and psychiatric treatment planning in a single service site, and the designation of a single care management team,

- An effective setting for intensive, concentrated patient education to establish healthy patterns of self-management/self-care, and

- Adequate time and treatment intensity that is more effective at preventing readmission and relapse even though the "front-end" costs may be higher relative to community-based interventions.

4.

Needs Assessment for Acute Psychiatric Beds

There is no published bed need projection in effect for child, adolescent and adult psychiatric beds, and the need projection methodology contained in the State Health Plan Chapter is recognized as obsolete. Accordingly, AAMC prepared a needs assessment and a volume projection for its proposed mental health hospital based on hospital utilization patterns and based on other indicators that identify community need. AAMC's analysis supports the need for a 16-bed mental health hospital. The mental health hospital is expected to operate at more than 90 percent occupancy beginning in Year 1 of operation. This reflects the large number of patients currently seeking care at AAMC through its ED. Indeed, the patient volume for the proposed mental health hospital largely already exists at AAMC, but cannot be served at AAMC currently.

B.

EVIDENCE OF COMMUNITY NEED

1.

In FY 2015, a total of 946 adult patients—who could be served at an AAMC mental health hospital—had to be transferred from AAMC's ED to an acute psychiatric unit in another hospital, resulting in delays and disjointed care.

Area residents in crisis rely heavily on AAMC as the first point of contact. But AAMC can only provide stabilization in the ED and must then transfer patients who require psychiatric admission to another hospital. Patients in crisis who present at AAMC must wait in the ED as calls are made to locate an available hospital bed and as the necessary transfer arrangements are made.

In FY 2015, a total of 1,173 patients initially served in AAMC's ED required transfer to an inpatient psychiatric unit at another hospital. Of these 1,173 patients, a total of 946 of these patients were adult patients and, based on clinical diagnosis, could have been served by an acute psychiatric unit at AAMC.[8] These patients are referred to as "**AAMC-eligible existing patients**." Assuming a relatively short stay of 6 days, this volume equates to approximately 14 occupied beds attributed to *existing patients* served in AAMC's ED.[9] Assuming that the

8 See Technical Notes for definition of "Clinical Exclusions," i.e. patient populations *not* expected to be served by the mental health hospital at AAMC; 946 patients represent adult patients with diagnoses expected to be served in the proposed mental health hospital.

9 Based on current transfer volume and projected LOS at an AAMC unit of 6 days, and a 90% retention rate

psychiatric partial hospitalization program would meet the needs for 15 to 20 percent of patients who are currently hospitalized (i.e. would substitute for inpatient care), this FY 2015 volume presenting in AAMC's ED (946 patients with 90 percent retention, less 15 percent in the partial hospitalization program), alone, would fill 12 occupied beds. This volume does not even include the more than 500 cases now transferred from BWMC's ED for lack of inpatient capacity, and does not account for demographic growth.

Currently, AAMC transfers this patient population to 22 different hospitals. Rarely is there an available bed at UM BWMC (the one local hospital with an acute psychiatric unit) because UM BWMC operates with a limited capacity of 14 beds and with a high-volume ED. In FY 2015, AAMC was not able to transfer any of its mental health patients to UM BWMC because of its consistently high occupancy. Instead, AAMC patients who require admission are typically transferred to a hospital 40 miles from AAMC. The distribution of AAMC transfers, by receiving hospital, is documented on Chart 5 below:

Chart 5
Transfers of Adult Patients from AAMC ED to Acute Psychiatric Units in Maryland
AAMC-Eligible, Existing Patient Base
FY 2015
(N = 946 cases)

Hospital	# Patients Transferred	% Patients Transferred
Sheppard Pratt	712	75.3%
Bon Secours	39	4.1%
UM Shore, Dorchester	33	3.5%
Calvert Memorial	24	2.5%
Washington Adventist	22	2.3%
Greater Laurel Regional	19	2.0%
Johns Hopkins Bayview	15	1.6%
MedStar Union Memorial	10	0.3%
MedStar Southern Maryland	10	1.1%
Univ of MD Medical Center	9	1.0%
MedStar Franklin Square	8	0.8%
Potomac Ridge	8	0.8%
UM St Joseph	6	0.6%
LifeBridge Sinai	6	0.6%
LifeBridge Northwest	6	0.6%
Union of Cecil	4	0.4%
All Other	15	1.6%
Total	**946**	**100.0%**

Source: HSCRC Abstract Database
"AAMC-eligible patients" defined by psychiatric diagnosis codes, with exclusions applied by AAMC based on patient cohorts whom the proposed mental health hospital is not expected to serve; see Technical Notes for diagnosis codes.

The lack of an acute care unit at AAMC results in the following:

- **Delays in care at the point of crisis** – More than 50 percent of patients waited 24 to 48 hours until a transfer could be arranged. On average, patients wait 28 hours between arrival to the ED and transfer (Chart 6 below).

Chart 6
Average ED Turnaround Time
Adult Transfers to Inpatient Psychiatric Care
CY 2014

Arrival Month	Average ED Arrival to ED Departure (Hours)
CY2014 01	24
CY2014 02	31
CY2014 03	27
CY2014 04	27
CY2014 05	28
CY2014 06	29
CY2014 07	25
CY2014 08	31
CY2014 09	34
CY2014 10	28
CY2014 11	27
CY2014 12	26
Grand Total	28

Source: AAMC Data Warehouse. Adult ED patients from 1/1/14 – 12/31/14 who were transferred to an inpatient psychiatric facility. Includes mental health patients only.

- **Hardship/Disengagement of families** – Families typically face one hour travel time to visit with loved ones, making it more difficult to stay engaged in the treatment and recovery period. Many families depend on public transportation which is expensive and oftentimes unavailable to transport them to the facilities outside of Anne Arundel County.

- **Disjointed medical and psychiatric care management** – A significant percentage of patients with psychiatric conditions are also afflicted with chronic medical conditions. Transfer to another hospital for psychiatric care means that medical management and psychiatric management is disconnected, weakening the more effective integrated care management model that AAMC provides.

- **Disruption in continuity of care** – After discharge from out-of-area hospitals, patients return to the Anne Arundel County region and often must establish new provider relationships or experience significant wait times to access ongoing care.

2.

Overall need for inpatient mental health services by Anne Arundel County residents has increased, and local hospital capacity cannot meet this need.

Anne Arundel County reports the fifth highest volume of mental health admissions[10] across all counties in Maryland,[11] and both mental health discharges and ED visits for Anne Arundel County residents increased this past year (see Chart 7 below). Between FY 2014 – 2015, adult mental health discharges for Anne Arundel County residents increased by 1.6 percent and ED visits for mental health diagnoses increased by 2.1 percent in one year.

Chart 7
Anne Arundel County Residents
Adult Mental Health Hospital Volume
FY 2013 - 2015

	FY 2013	FY 2014	FY 2015
# Mental Health Discharges	3,558	3,214	3,265
% Change, Year to Year		*(9.7%)*	*1.6%*
Average Length of Stay	6.0	6.3	6.3
# Occupied Beds for Mental Health Dx as Primary	64	61	63
# ED Visits	5,056	5,014	5,120
% Change, Year to Year		*(0.8%)*	*2.1%*

Source: HSCRC Abstract Dataset
Mental health admissions and ED visits defined by CCS codes, and do not include substance use/alcohol-related disorders

While the county saw a use rate decline from FY 2013 – 2014, the admission rate and ED visit rate for mental health services was effectively flat between FY 2014 – 2015, as shown on Chart 8 (page 40). The need for another comprehensive service program in the county, including effective inpatient management, remains high.

10 Hospital volume for "mental health" is defined in this section based on CCS codes, and does *not* include substance use diagnoses.
11 In rank order, these counties include: Baltimore City, Baltimore County, Montgomery County, Prince George's County, Anne Arundel County (Source: HSCRC Abstract Dataset, FY2015, based on CCS code for "mental health;" does not include substance use/alcohol-related disorders)

Chart 8
Anne Arundel County Residents
Adult Mental Health Hospital Volume
FY 2013 - 2015

	FY 2013	FY 2014	FY 2015
Adult Population	410,593	417,589	422,882
Mental Health Discharges			
# Adult Discharges	3,558	3,214	3,265
Discharges per 1,000	8.67	7.70	7.72
Mental Health ED Visits			
# Adult ED Visits	5,056	5,014	5,120
ED Visits per 1,000	12.31	12.01	12.11

Sources: (1) HSCRC Abstract Dataset (2) Nielsen, Inc.
Mental health discharges defined by CCS codes, and do not include substance use/and alcohol-related disorders

Currently, UM BWMC operates the only acute psychiatric unit in the county. UM BWMC's unit admits its patients largely from its own ED and rarely has the bed capacity to accept transfers. In fact, HSCRC discharge data documents that in FY 2015, UM BWMC itself transferred 530 adult cases to other hospitals for admission to a psychiatric unit, highlighting the capacity constraints of this 14-bed unit.[12] These 530 cases can be assumed to be largely patients seen in the ED at UM BWMC, but the psychiatric unit at UM BWMC could not accommodate.

Only twenty-seven percent of Anne Arundel County patients are served in-county. **Seventy-three percent of Anne Arundel County patients are admitted to out-of-area hospitals.** (See Chart 9, page 41).

12 These 530 cases only represent "AAMC-eligible cases," i.e. adult cases who would be eligible for the proposed AAMC Mental Health Hospital; total transfers are likely higher

Chart 9
Anne Arundel County Residents
Total Inpatient Adult Discharges for Mental Health, by Hospital
FY 2015

Hospital	# Discharges	% Discharges
Sheppard Pratt	1,076	33.0%
UM BWMC	729	22.3%
MedStar Franklin Square	159	4.9%
Anne Arundel Medical Center[1]	152	4.7%
Bon Secours Hospital	127	3.9%
UMMC	126	3.9%
Johns Hopkins Hospital	116	3.6%
Laurel Regional Hospital	101	3.1%
UM St. Joseph	60	1.8%
MedStar Union Memorial	59	1.8%
UMMC Midtown Campus	58	1.8%
Johns Hopkins Bayview	57	1.7%
Howard County General Hospital	56	1.7%
MedStar Montgomery General Hospital	48	1.5%
Other Specialty Psychiatric Facilities	50	1.5%
Washington Adventist Hospital	41	1.3%
UM Shore – Dorchester	38	1.2%
Calvert Memorial Hospital	36	1.1%
Northwest Hospital	24	0.7%
MedStar Southern Maryland Hospital Center	24	0.7%
MedStar Harbor Hospital Center	20	0.6%
Carroll Hospital Center	20	0.6%
Prince George's Hospital Center	17	0.5%
Harford Memorial Hospital	13	0.4%
Suburban Hospital	12	0.4%
Sinai Hospital	11	0.3%
MedStar St. Mary's Hospital	7	0.2%
Union Hospital of Cecil County	6	0.2%
St. Agnes Hospital	5	0.2%
Peninsula Regional Medical Center	4	0.1%
GBMC	4	0.1%
Meritus Medical Center	2	0.1%
Mercy Medical Center	2	0.1%
Frederick Memorial Hospital	2	0.1%
Shady Grove Adventist Hospital	1	0.0%
Fort Washington Medical Center	1	0.0%
Atlantic General Hospital	1	0.0%
Total	**3,265**	**100.0%**

Source: HSCRC Abstract Dataset.
Mental health discharges defined by CCS codes, and do not include substance use/alcohol-related disorders.
[1] Mental health discharges at AAMC in this chart are accounted for by cases admitted for OB/GYN and neurologic indications, as well as those admitted for medical or surgical indications.

While high-quality programs operate outside the county, the dependence on out-of-area facilities has serious consequences:

- Medical management and mental health management are separated across 2 services sites and 2 clinical management teams. The opportunities for integrated care management, widely recognized as important on multiple levels, are sacrificed.

- Length of stay in out-of-county facilities tends to be longer than necessary because out-of-county programs are not as well-integrated with local, community-based resources in Anne Arundel County. As a result, care planning for post-discharge supports is more time-consuming and hospital stays are unnecessarily extended. This is reflected in the comparatively longer length of stay for Anne Arundel County residents admitted for mental health conditions, as shown on Chart 10 below.

Chart 10
Average Length of Stay
Adult Mental Health Discharges at Maryland Hospitals
By County of Residence
FY 2015

	# Discharges	***ALOS***
Anne Arundel County discharges, mental health dx	3,265	7.0 days
All other discharges, mental health dx	39,677	6.3 days
Total Maryland hospital discharges mental health dx	42,932	6.3 days

Source: HSCRC Abstract Dataset.
Mental health discharges defined by CCS codes, and do not include substance use/alcohol-related disorders.

- After discharge, patients often return home to Anne Arundel County post-crisis without an established relationship with a local provider for continuity of care close to home. Patients frequently must establish new clinical relationships and often experience extended wait times until they can be seen by a provider.

- Clinicians report that it is more difficult to engage family members when they live far away, and that quality of care often suffers. Families who face long drive times or depend on public transportation are often less inclined to participate in the treatment and recovery process due to these transportation hardships. Family members are typically less involved in the treatment, and may then be less equipped to support the extended recovery at home.

3.

Area residents rely heavily on EDs for episodic mental health care services, which further intensifies the escalating need for ED services resulting from the heroin epidemic and high substance use trends in the county.

Anne Arundel County residents with chronic mental health conditions rely heavily on hospital EDs for episodic mental health care, as reflected in the comparative use rates on Chart

11 below, across counties of the Health Planning Area. The figures documented below highlight that Anne Arundel County residents demonstrate notably high ED use rates for mental health diagnoses, specifically (as distinct from ED visits for substance use diagnoses):

Chart 11
Adult ED Visits for Behavioral Health
Based on County of Residence

Six-County Health Planning Area
FY 2015

		# Adult ED Visits			Adult ED Visits per 1,000		
County	Adult Population	**Mental Health**	Substance Use Related	Total Behavioral Health	**Mental Health**	Substance Use Related	Total Behavioral Health
Baltimore City	497,492	13,018	9,667	22,685	26.2	19.4	45.6
Anne Arundel	425,048	5,120	2,717	7,837	12.0	6.4	18.4
Baltimore	655,659	7,228	4,041	11,269	11.0	6.2	17.2
Harford	189,555	1,829	1,067	2,896	9.6	5.6	15.3
Carroll	121,980	1,105	759	1,864	9.1	6.2	15.3
Howard	239,862	1,475	709	2,184	6.1	3.0	9.1

Sources: (a) HSCRC Abstract Dataset (b) Nielsen, Inc.
Note: Data includes patient volume from Maryland hospitals only. Figures do not reflect ED volume at Washington, DC hospitals.

The heavy reliance on the hospital ED for mental health care is reflected most dramatically in hospital volumes at AAMC's ED itself. Between FY 2014 – 2015, ED visits at AAMC with a mental health diagnosis as a primary diagnosis increased by 8 percent in one year, as indicated on Chart 12 (page 44). More than three quarters of this patient volume represents residents of Anne Arundel County. Thus, even though AAMC has not had an acute psychiatric unit, county demographic growth and the role of AAMC as the dominant provider has resulted in substantial growth in mental health volume in its ED.

Chart 12
ED Visits to AAMC
With Mental Health Diagnosis as Primary Diagnosis
Adults, age 18+ only

	# ED Visits		
County of Residence	FY 2013	FY 2014	FY 2015
Anne Arundel	1,765	1,701	1,837
Prince George's	184	206	218
Queen Anne's	104	102	92
Calvert	39	53	42
Baltimore City	35	28	46
Baltimore	21	22	32
Montgomery	10	9	10
Saint Mary's	8	1	4
Caroline	10	9	8
Howard	11	15	15
Dorchester	5	3	1
Frederick	2	5	2
Harford	3	0	2
Talbot	3	6	7
Worcester	5	1	4
Charles	1	4	6
Kent	4	5	9
Wicomico	1	3	6
Carroll	1	4	1
Allegany	1	0	0
Cecil	0	1	4
Washington	0	0	3
Out of State	64	53	59
Unknown	6	1	1
TOTAL	**2,283**	**2,238**	**2,420**
% Change, Year Over Year		***(2.0%)***	***8.1%***

Source: HSCRC Abstract Database

Notes:

[1] Mental health visits defined by CCS code as primary diagnosis

[2] Excludes substance use as primary diagnosis

Of particular concern is the number of repeat visits to AAMC's ED, further highlighting a pattern of "episodic management" for chronic mental health conditions. In FY 2015, **a total of 70 unique patients presented at AAMC's ED three or more times in one year with a mental health condition as the primary diagnosis** as shown on Chart 13 below, a pattern that underscores the need for an improved delivery system for psychiatric care.

Chart 13
AAMC
Adult Patients with Multiple ED Visits with Mental Health Diagnosis as Primary Diagnosis
FY 2015

	# of Unduplicated Adult Patients (Age 18+ Years)
1 visit to ED	1,769
2 visits to ED	168
3 visits to ED	**41**
4+ visits to ED	**29**
Total number of unique patients	2,007 patients

Source: HSCRC Confidential Dataset for AAMC

This utilization pattern likely reflects the lack of a local provider, lack of effective management/treatment planning early on, weak home supports, and/or poor self-management skills—each of these factors may be contributing to this pattern of episodic crisis management. In response, AAMC's proposed program aims to provide early intervention, effective evaluation and treatment planning, continuity of care and provider relationships, and a comprehensive setting for effective patient education and teaching of self-management skills to support successful, long-term community-based management. Taken together, this model is expected to reduce the dependence on the ED for episodic care.

4.

Mental health conditions that are poorly managed in the absence of an inpatient unit are contributing to medical readmissions.

In FY 2015, more than 40 percent of the readmissions to AAMC were accompanied by a mental health primary or secondary diagnosis, as indicated on Chart 14 (page 46). The interconnectedness of chronic medical conditions and chronic mental health conditions is well-recognized: Chronic mental health conditions are often correlated with poor self-care and/or deteriorating medical conditions, and chronic medical conditions are often accompanied by declining mental health. The high rate of mental health diagnoses among readmitted patients indicates the serious need for a well-resourced mental health delivery system to support self-management and personal well-being.

Chart 14
# of 30-Day Readmissions at AAMC with Mental Health Diagnosis
Including Inpatient and Observation >23 Hours
Patients Age 18+ Years
FY 2015

Total Number of Readmissions at AAMC	2,223
# of Readmissions with Mental Health Diagnosis as an Accompanying Diagnosis	906
% of Readmissions with Mental Health as Accompanying Diagnosis	41%

Source: HSCRC Confidential Dataset for AAMC

Profiles of the high utilizer population at AAMC further highlight the need to better address the behavioral health needs for AAMC's patient base in order to reduce utilization and the total costs of care. In an analysis of high utilizers at AAMC during FY 2015, a total of 1,089 high utilizers were identified. Closer analysis showed that **50 percent of these high utilizing patients had an accompanying mental health diagnosis**. An additional 20 percent had a substance use, or substance use and mental health co-occurring diagnosis, as indicated on Chart 15 below.

Chart 15
AAMC High Utilizer Patients[13] with Accompanying
Mental Health or Substance Use Diagnosis

FY 2015

High Utilizer Patients at AAMC	# Patients	% High Utilizers
Accompanied by a Mental Health Diagnosis	**547**	**50%**
Accompanied by a Substance Use Diagnosis	46	4%
Accompanied by a Substance Use and Mental Health Diagnosis	175	16%
All Other High Utilizers	321	29%
Total Number of High Utilizers at AAMC	1,089	100%

Source: FY 2015 HSCRC Confidential Dataset for AAMC
Mental health and substance use diagnoses defined by CCS codes

AAMC cannot effectively address the needs of the high utilizer population without the continuum of mental health services, including inpatient care. An acute psychiatric stay is often critical to (a) establish firm and stable clinical management relationships, (b) initiate effective medication management where appropriate, (c) integrate psychiatric management with management of chronic medical conditions, (d) provide a setting for patient education that produces lasting behavior change, and (e) establish communication systems that assure a local response from a familiar provider.

13 "High utilizers" defined as patients with ≥ 3 inpatient and/or 23 hour+ Observation stays in a 12 month period

Clinicians at AAMC expect the proposed mental health hospital will reduce readmission rates and reduce the number of high utilizers. In many cases, an inpatient stay with effective follow-up will be the most effective strategy to reduce readmissions, promote healthy behaviors, and facilitate successful community living. Taken together, this approach is expected to reduce the overall cost of care.

5.

There has been a significant growth in the number of calls to the county's Mobile Crisis Teams, another indication that many patients lack a stable provider and/or an effective treatment plan.

The Mobile Crisis Team serving Anne Arundel County reports a significant growth in the number of calls this past year, as documented by the following operating statistics on Chart 16 below:

Chart 16
Anne Arundel County Crisis Services
Number of Calls or Dispatches

	FY 2014	FY 2015
Crisis Operations, 24/7 Call Center	11,365	16,183
% increase		*42.4%*
Mobile Crisis Team: 2 Clinician Team	1,364	1,581
% increase		*15.9%*
Crisis Intervention Team w/ 1 Police Officer	N/A	1,105

Source: Anne Arundel County Mental Health Agency (Feb 2016)

The sheer volume of calls and the tremendous growth in volume in one year's time underscore the fact that Anne Arundel County's population needs another comprehensive mental health program. More specifically, Anne Arundel County needs a local area program that effectively treats, manages, and maintains continuity of care to minimize crisis episodes. For the severely ill, an inpatient stay is critical to effective treatment planning and ongoing care management, and a local area care team is invaluable to maintaining the therapeutic relationship.

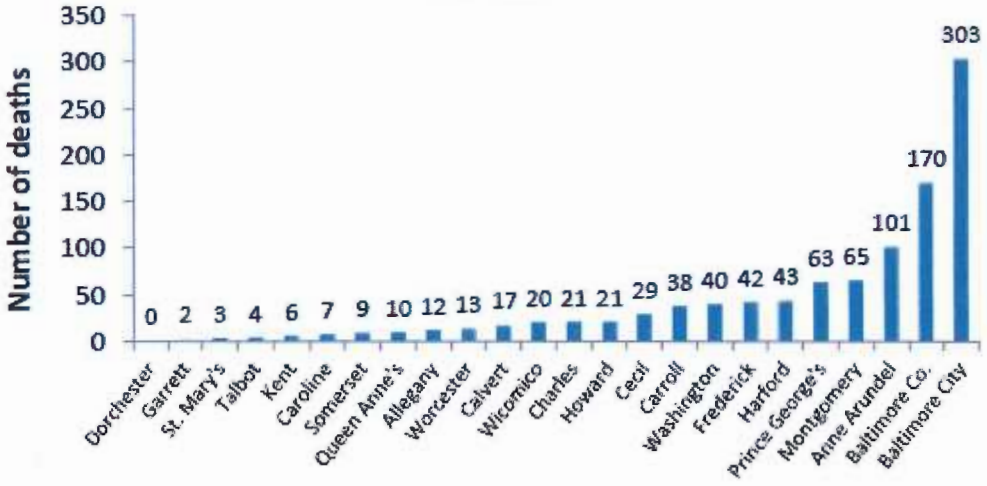
6.

The alarming rise in death rates from drug and alcohol-related deaths in Anne Arundel County calls for investment in mental health services.

In CY 2014, Anne Arundel County reported the third highest volume of drug and alcohol-related intoxication deaths in the State of Maryland, as shown on Chart 17 (page 48). Anne Arundel County saw 18 deaths per 100,000 people. This is three times the death rate of Montgomery County (6 deaths per 100,000), which has roughly twice the population of Anne

Arundel County. Health care professionals recognize that investment in mental health services is necessary to prevent those suffering from mental health problems from turning to drugs and alcohol.

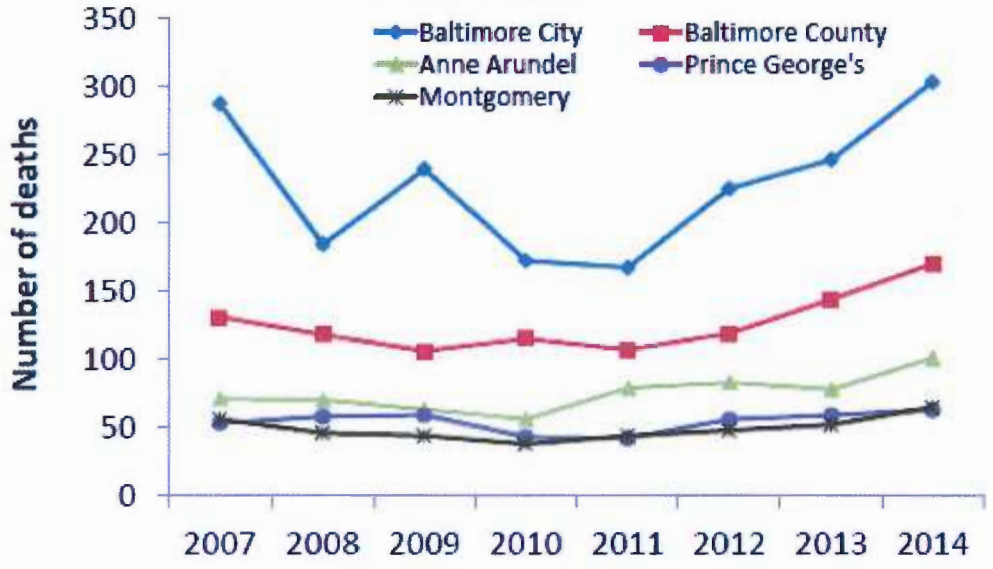
Chart 17
Drug- and Alcohol-Related Intoxication Deaths by County
CY 2014



Source: Maryland Department of Health and Mental Hygiene, May 2015

A total of 101 drug and alcohol-related deaths occurred in Anne Arundel County in just 2014, representing a 29 percent increase over the number of deaths in 2013 and an 80 percent increase since 2010. The trend line is evident on Chart 18 below.

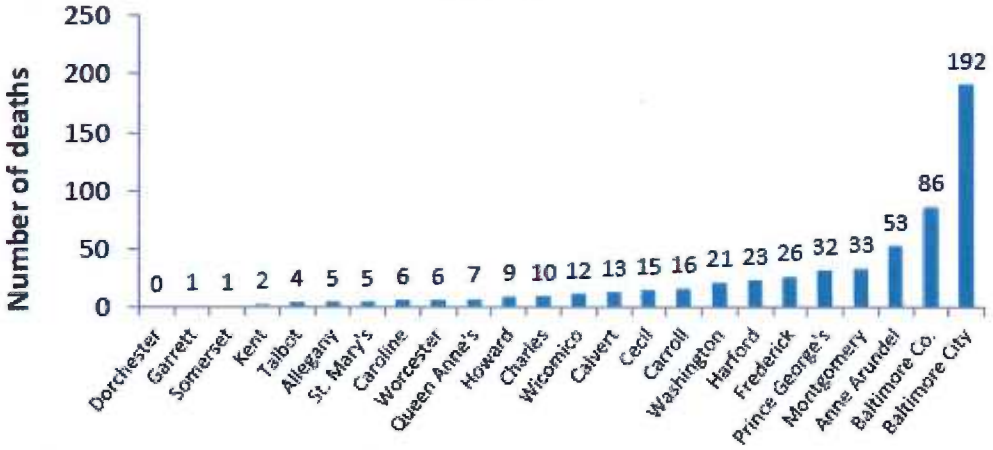
Chart 18
Drug- and Alcohol-Related Intoxication Deaths by County, Trend
CY 2007 to 2014



Source: Maryland Department of Health and Mental Hygiene, May 2015

Particularly alarming has been the increase in heroin-related intoxication deaths. In 2014, Anne Arundel County had the third highest number of heroin deaths in Maryland (after Baltimore City and Baltimore County), as shown on Chart 19 below.

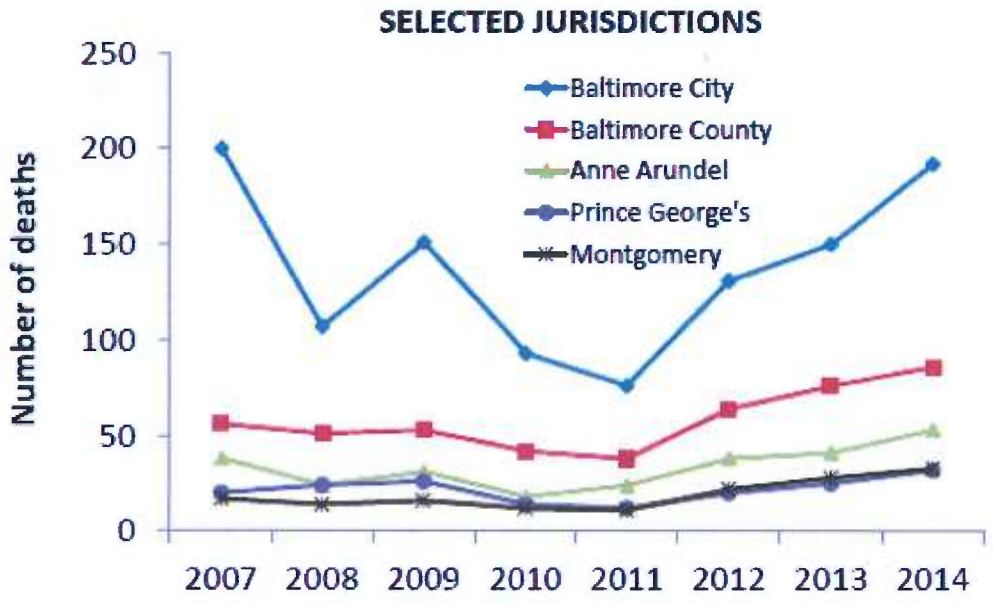
Chart 19
Heroin Deaths by County
CY 2014



Source: Maryland Department of Health and Mental Hygiene, May 2015

From 2013 to 2014, the number of heroin-related deaths increased by 29 percent in Anne Arundel County, and there was almost a three-fold increase in the number of heroin-related deaths between 2010 and 2014. The trend line is shown below on Chart 20.

Chart 20
Heroin Deaths Trend
CY 2007 to 2014



Source: Maryland Department of Health and Mental Hygiene, May 2015

7.

A person with severe mental illness in Maryland is nearly three times more likely to become incarcerated than to receive treatment.[14]

The failure to provide adequate treatment has resulted in tragic consequences on an individual level, on an institutional level, and on a cost level. Patients suffer without adequate treatment and prisons have become a default mental health facility. The annual costs of care for mentally ill inmates could be reduced by providing more appropriate and recovery-oriented treatment settings.

8.

Community health indicators demonstrate other tragic costs of mental illness left untreated/poorly addressed.

Several other indicators highlight the tragic toll of mental illness when left untreated or poorly addressed, as reflected in the tragic loss of life and the pain inflicted on others. A recent national publication cited 31 percent of adults with mental illness report being victims of violence, and 24 percent of adults with mental illness report having perpetrated at least one violent act in a six-month time period.[15] More locally, community health reports show that Anne Arundel County and Queen Anne's County document some of the highest rates in Maryland for the behaviors shown on Chart 21 below:

Chart 21[1]
Key Indicators by Select County of Residence
CY 2011 to 2013

	Maryland	Anne Arundel	Queen Anne's
Suicide rate per 100,000 population	9.0	9.4	16.7
% residents reporting excessive drinking	15%	19%	23%
% of driving deaths with alcohol involvement	34%	38%	33%
Domestic violence per 100,000 population	468.6	591.5	439.0

Sources: Maryland State Health Improvement Process (SHIP)
[1] Highlighted figures represent rates that are markedly above the State of Maryland average.

14 Treatment Advocacy Center. "More Mentally Ill Persons are in Jails and Prisons than Hospitals: A Survey of the States," May 2010.
15 Desmaris, S et al. "Community Violence Perpetration and Victimization Among Adults with Mental Illness," Amer J of Public Health, Dec 2014, 104:12, pp 2342-2349.

Clearly, these patterns reflect a number of dynamics including health, socioeconomic, and cultural factors. However, health professionals are increasingly attuned to the need to address these many factors as part of the commitment to promote healthy communities. Accessible and effective mental health services are a core component of prevention and investment in healthy communities.

9.

There is only one psychiatric partial hospitalization program that operates in Anne Arundel County and it routinely operates at full capacity.

Currently, the only psychiatric partial hospitalization program in Anne Arundel County operates at UM BWMC, and this program reportedly operates at capacity nearly always. In the past two years, BWMC has been able to accept only *one patient* from AAMC's Emergency Department to the partial hospitalization program at UM BWMC.

Visit volume at partial hospitalization programs across Maryland has grown considerably as providers increasingly rely on this setting as an alternative to the acute care setting. The figures in Chart 22 (below) document the growing need for this service, and highlight the notable pressure in Anne Arundel County: This past year, there was a 21 percent growth in volume at the only partial hospitalization program in Anne Arundel County (UM BWMC):

Chart 22
Partial Hospitalization Programs in Local Health Planning Area
Six-County Planning Region
Number of Visits

Hospital	FY2014	FY2015	*% change*
Sheppard Pratt	55,274	56,337	1.9%
Johns Hopkins Bayview	8,555	8,996	5.2%
Johns Hopkins Hospital	6,944	7,615	9.7%
Carroll Hospital Center	3,235	4,538	40.3%
MedStar Union Memorial	4,064	4,158	2.3%
UM BWMC	1,706	2,060	20.8%
UM St Joseph	1,964	2,045	4.1%
Univ of Maryland Med Cntr	1,801	2,018	12.0%
Bon Secours Hospital	1,329	1,817	36.7%
LifeBridge Sinai Hospital	2,110	1,750	(17.1%)
Harford Memorial	984	1,239	25.9%
Total	87,966	92,573	5.2%

Source: HSCRC Experience Report
Note: Does not include program at Levindale

For AAMC to effectively reduce the dependence on the hospital setting, a second partial hospitalization program in the county is essential. Integration of this partial hospitalization

program with an inpatient program will provide the continuity of care to make this continuum of care work effectively.

10.

Community residents have reported that their mental health service needs are not being met.

The most recent Community Health Needs Assessments (CHNAs) prepared by area hospitals and local health agencies provide direct input from local residents about service needs. Respondents in the service area identified mental health services as an unmet need.

- Anne Arundel County's most recent CHNA (FY 2016, Exhibit 1) cites the "rise in mental health issues" and the lack of appropriate services and service providers as a major concern for almost every participant in the needs assessment. Comments also identified the need for integration of behavioral health care at the provider level.

- Also worth noting is that Anne Arundel County's CHNA documents a significant growth in community-based mental health visits, substantiating the growth in need and demonstrating that non-hospital settings *are* being used. Chart 23 below documents the growth in the number of people served.

Chart 23
Number of People Served by a Mental Health Service in Anne Arundel County

	2012	2013	Percent of Change ('12-'13)	2014	Percent of Change ('13-'14)
Early Child (0-5)	392	394	0.5%	473	20.1%
Child (6-12)	1,821	1,880	3.2%	2,152	14.5%
Adolescent (13-17)	1,388	1,476	6.3%	1,617	9.6%
Transitional (18-21)	586	584	-0.3%	610	4.5%
Adult (22 to 64)	5,351	5,762	7.7%	6,396	11.0%
Elderly (65 and over)	59	70	18.6%	73	4.3%
TOTAL	**9,597**	**10,166**	**5.9%**	**11,321**	**11.4%**

Source: Anne Arundel County Mental Health Agency, 2015

- Shore Regional Health System prepared a Community Health Needs Assessment (2013) which similarly identified behavioral health as one of the top three areas where respondents felt that their needs were not met. This, too, provides evidence to support the need for a stronger mental health delivery system in the broader service area. The proposed program at AAMC will respond to this need, in part, by responding to the needs of Queen Anne's County residents.

11.

Parity and patient choice is threatened by IMD Exclusion.

Federal Medicaid participation is prohibited for adult (ages 21-64) admissions to freestanding psychiatric hospitals with more than 16 beds (which are defined as an "Institution for Mental Diseases" or "IMD"). This prohibition is referred to as the "IMD Exclusion." Until June 30, 2015, Maryland was not subject to the IMD Exclusion by virtue of a demonstration project under which it operated, but that demonstration project expired so Maryland is now subject to the IMD Exclusion. Maryland's application to the Centers for Medicare & Medicaid Services (CMS) for a continued waiver from the IMD Exclusion was denied earlier this year. Federal legislation recently passed that may provide relief from the IMD Exclusion in Maryland for up to three years, but that legislation is subject to certain findings by CMS as to revenue neutrality that have not yet been made. Accordingly, there is continuing uncertainty surrounding the IMD Exclusion in Maryland. As a result of the IMD Exclusion, the State Medicaid program has imposed certain diversionary requirements under which hospital emergency departments are required to exhaust available beds in non-IMD settings before an adult admission to an IMD will be approved.

AAMC is committed to serving Medicaid patients throughout its health system, and the new mental health inpatient service will be no exception to this commitment. The definition of IMD refers to a psychiatric hospital with more than 16 beds. AAMC's need analysis demonstrates that there is a need for 16 inpatient psychiatric beds in Anne Arundel County. With this number of beds (which corresponds to demonstrated need), AAMC intends its mental health hospital to be an additional non-IMD resource for the care of Medicaid patients in Maryland who require an inpatient psychiatric admission.[16]

C.

FEATURES OF THE PROPOSED MENTAL HEALTH HOSPITAL AND THE INTEGRATION WITH EXISTING AAMC RESOURCES

AAMC will deliver a comprehensive and integrated mental health care program that will incorporate inpatient psychiatric care, partial hospitalization, intensive outpatient programs, family support services, prevention programs, and referral to and care coordination with community-based support services. The program will be well-integrated with community-based activities, including family and self-help programs to strengthen patient engagement, and patient advocacy organizations to encourage active involvement in community health. The goals will be to sustain the patient in the community and to require inpatient admissions only when absolutely necessary for the patient's health.

As described in detail in the Comprehensive Project Description, Section 3 (page 13) AAMC already offers several core components of this community centered program including:

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16 Although the IMD exclusion remains in effect in Maryland at this time, proposed CMS managed care Medicaid regulations may, if adopted, provide an opportunity for the State to remove itself from the IMD exclusion, and the new Federal demonstration project described above also offers the potential for relief. As discussed further in the Shell Space analysis below (page 77), AAMC proposes third floor shell space that could accommodate additional inpatient beds in the future as additional need develops, or would also accommodate additional outpatients programs.

an outpatient clinic, screening and referral in the primary care setting, mental health clinicians embedded in the primary care setting, and a psychiatric partial hospitalization program.

D.

EXPECTED IMPACT OF THE NEW MENTAL HEALTH HOSPITAL IN RESPONSE TO COMMUNITY NEEDS

The new facility—incorporating an adult inpatient unit and a partial adult and adolescent hospitalization program—is expected to yield the following benefits:

- **Remove delays/barriers to timely care that are now associated with 946 adult patient transfers [17], and strengthen continuity of care for psychiatric patients** – The new facility is expected to:
    - Assure greater availability of inpatient care in the local community,
    - Improve quality of care by improving continuity of care and maintaining a single clinical management team for AAMC patients across a greater part of the continuum of care, and
    - Maximize the use of the partial hospitalization program at AAMC and minimize the need to admit patients if the partial hospitalization program can meet patient needs.
- **Enhance quality by improving continuity of care and by providing an integrated mental health and medical management model** - Patients will be offered integrated care management for medical and psychiatric care through a single physician network and care management team that is connected through an integrated electronic medical record. Quality initiatives conducted in concert with community-based outpatient providers in AAMC's region will reinforce continual improvement in transitions to and from outpatient care.
- **Reduce length of stay and admission rates, and encourage clinicians to leverage community-based resources to the fullest extent possible** – Volume projections assume a two-day reduction in length of stay relative to current length of stay patterns at Sheppard Pratt (Chart 36, page 75). The AAMC team will be encouraged to initiate discharge plans early on and leverage the partial hospitalization program and other outpatient services on and off campus. AAMC providers will be more familiar with available resources in the local community, and will be better-positioned to mobilize these community-based supports. In this way, acute care lengths of stay are expected to decline and some short-stay admissions are expected to be avoided altogether.
- **Reduce the number of readmissions and ED visits at AAMC, and improve long-term outcomes through effective integration of community-based mental health and medical services to patients** – AAMC expects to reduce the number of readmissions at AAMC by filling in gaps in the continuum of care, providing effective treatment planning in the

17 Of the total 1,173 transfers arranged from AAMC, a total of 946 transfers were defined to be "AAMC eligible" patients, i.e. could be served at the proposed AAMC mental health hospital.

inpatient setting for many patients, and assuring integrated medical and mental health management at AAMC for a significant number of patients.

- **Provide a lower-cost alternative for inpatient psychiatric care and reduce the per capita costs of specialty care for Maryland residents by shifting volume from higher cost facilities to AAMC** – AAMC will operate as one of the lowest-cost psychiatric providers in the State of Maryland on a case-mix adjusted basis, as shown on Chart 24 (page 56). The average payment per case at AAMC's new program is projected to be 33 percent below the statewide average and 43 percent lower relative to Sheppard Pratt, where the majority of Anne Arundel County residents are now served. Therefore, the new program at AAMC can be expected to produce more than $3.3 million of savings to the State *and* offer lower-cost options to patients who are likely to bear an increasing percentage of co-payments going forward. The combined effects of a lower-cost hospital site, a reduction in readmissions, and reduction in admissions will produce more favorable performance under the Maryland Medicare waiver.

Chart 24
Total Hospital Average Charge per Case (CPC) Comparison
Estimated FY 2016

Provider	Estimated FY 2016 Avg Chg @ CMI=1.00
Johns Hopkins Hospital	$32,169
University of Maryland Medical Center	25,482
Sheppard Pratt (Private)	23,758
Johns Hopkins Bayview Medical Center	23,583
UM Shore Medical Center at Dorchester	19,024
Adventist Behaviorial Health, Potomac Ridge, Brooklane	18,324
Calvert Memorial Hospital	18,140
Sinai Hospital	17,143
Union Hospital of Cecil County	16,727
MedStar Franklin Square Hospital Center	16,594
UM Baltimore Washington Medical Center	16,322
Harford Memorial Hospital	16,063
UM St. Joseph Medical Center	15,205
Frederick Memorial Hospital	14,684
Peninsula Regional Medical Center	14,657
Northwest Hospital Center	14,587
Carroll Hospital Center	14,578
Suburban Hospital	13,127
Prince George's Hospital Center	12,908
MedStar Union Memorial Hospital	12,834
Meritus Medical Center	12,658
UMMC Midtown Campus	12,096
Washington Adventist Hospital	12,075
MedStar St. Mary's Hospital	11,884
Bon Secours Hospital	11,747
Holy Cross Germantown	11,457
Howard County General Hospital	11,436
Laurel Regional Hospital	11,245
Western Maryland Regional Medical Center	11,101
MedStar Montgomery General Hospital	11,097
MedStar Southern Maryland Hospital Center	9,841
Total	**$20,127**
Anne Arundel Mental Health Hospital	**$13,460**

[1] MD Hospital CPC calculated as Hospital-specific total CPC @ CMI 1.00 for Adult Psychiatric APR-DRGs 750-760, 779-790, patients age 18 or greater price leveled to FY 2016 dollar (2.4% for acute general hospitals and 1.9% for Psychiatric Specialty hospitals)

[2] Due to data availability, Potomac Ridge, Brooklane and Adventist Behaviorial Health average charge is combined

- **Produce more than $3 million in savings to the State by providing this lower cost setting**

  This assessment is based on the following methodology and set of assumptions:

  - AAMC's charge per case for inpatient psychiatric services was derived from the average utilization of eligible AAMC psychiatric patients transferred to Maryland inpatient acute psychiatric providers at AAMC's FY 2016 unit rates. The length of stay for Sheppard Pratt patient was reduced by 2 days to account for efficiencies related to placement post discharge.

  - This average charge per case at FY 2022 projected volumes results in projected charges of $6,818,753 (892 cases x $7,644) at a 100 percent variable cost factor.

  - Assuming a 50 percent variable cost factor for acute general hospitals and 100 percent variable cost factor for the Psychiatric Specialty Hospitals per HSCRC policy, the proposed volume shift would reduce existing charges by $10,121,679.

  - The net reduction to Maryland hospital charges is $3,302,925 ($6,818,753 - $10,121,679), as shown on Chart 25 (following page).

Chart 25
AAMC Mental Health Hospital Reduction in the Costs of Acute Psychiatric Services
FY 2023

	Est. FY 2016 - Charges[1]				
	Cases	CPC@ CMI of 0.5679[4]	Revenue	VCF	Revenue @ VCF
AAMC Projected Psych Cases[2]	892	$7,644	$6,818,753	100%	$6,818,753
Incremental Revenue	892	7,644	$6,818,753	100%	$6,818,753
Impact on Psych Hospitals:					
University of Maryland	(9)	14,472	(131,426)	50%	(65,713)
Johns Hopkins	(3)	18,270	(55,306)	50%	(27,653)
UM Shore Medical Center at Dorchester	(31)	10,804	(337,965)	50%	(168,983)
Lifebridge Sinai Hospital	(6)	9,736	(58,947)	50%	(29,473)
Bon Secours	(36)	6,672	(242,349)	50%	(121,175)
MedStar Franklin Square	(8)	9,424	(76,076)	50%	(38,038)
Washington Adventist	(20)	6,858	(138,399)	50%	(69,200)
MedStar Montgomery General	(3)	6,302	(19,078)	50%	(9,539)
Suburban Hospital	(4)	7,455	(30,091)	50%	(15,045)
MedStar Union Memorial	(10)	7,289	(73,546)	50%	(36,773)
MedStar Saint Mary's Hospital	(1)	6,749	(6,811)	50%	(3,405)
Johns Hopkins Bayview (acute)	(15)	13,394	(202,725)	50%	(101,363)
Union of Cecil	(4)	9,500	(38,343)	50%	(19,171)
UMM Center Midtown Campus (acute)	(1)	6,869	(6,932)	50%	(3,466)
Calvert Memorial	(23)	10,303	(239,103)	50%	(119,551)
Lifebridge Northwest Hospital	(6)	8,284	(50,155)	50%	(25,077)
Howard General Hospital	(3)	6,495	(19,661)	50%	(9,830)
Greater Laurel	(14)	6,386	(90,216)	50%	(45,108)
MedStar Southern Maryland	(7)	5,589	(39,478)	50%	(19,739)
UM Saint Joseph	(5)	8,635	(43,567)	50%	(21,783)
Sheppard Pratt (Private)	(675)	13,493	(9,108,585)	100%	(9,108,585)
Potomac Ridge (Private)[3]	(6)	10,407	(63,007)	100%	(63,007)
Total Estimated Charges	(892)	$12,412	($11,071,766)	91%	($10,121,679)
Net Impact on the System			**($4,253,012)**		**($3,302,925)**

Notes:

[1] MD Hospital CPC calculated as Hospital-specific total CPC @ CMI 1.00 for Adult Psychiatric APR-DRGs 750-760, 779-790, patients age 18 or greater price leveled to FY 2016 dollar (2.4% for acute general hospitals and 1.9% for Psychiatric Specialty hospitals

[2] AAMC projected cases for FY 2023

[3] Due to data availability, Potomac Ridge average charges were based on the averge charge of Brooklane, Potomac Ridge and Adventist Behaviorial Health for APR-DRGs 750-760, 779 - 790, patients age 18 or greater price leveled FY 2016 based on a 1.9% Update Factor

[4] Reflects AAMC Projected CMI of 0.5679

- **Respond directly to patients' demonstrated choice of provider** – More than 2,400 patients came to AAMC's ED with a mental health diagnosis, *even in the absence of an acute care unit on-site*. This included more than 1,800 patients from Anne Arundel County (or 36 percent of total adult ED visits for mental health) and nearly 100 visits from Queen Anne's County (or 22 percent of total adult ED visits for mental health). AAMC's mental health hospital will respond to patients' demonstrated preference for AAMC as their provider of choice.

- **Improve access for AAMC's patient base in Queen Anne's County** – AAMC operates two family medicine practices in Queen Anne's County. Currently, residents of Queen Anne's County rely heavily on Sheppard Pratt and University of Maryland Shore Health in Dorchester for acute psychiatric services. The new mental health hospital at AAMC will be well-located to serve residents of Queen Anne's County, and drive time for acute psychiatric care will be reduced considerably for Queen Anne's County residents. More detail on distance and drive time is below on Chart 26:

Chart 26
Nearest Mental Health Facility by County

County	Closest Mental Health Facility	# Miles to Existing Mental Health Unit	# Miles to AAMC Mental Health Hospital
Anne Arundel	Baltimore Washington Hospital Center	19.5 miles	2.9 miles
Queen Anne's	UM Shore - Dorchester	36.3 miles	29.6 miles
	Sheppard Pratt	71.4 miles	29.6 miles

County	Closest Mental Health Facility	# Minutes to Existing Mental Health Unit	# Minutes to AAMC Mental Health Hospital
Anne Arundel	Baltimore Washington Hospital Center	21 minutes	8 minutes
Queen Anne's	UM Shore - Dorchester	44 minutes	32 minutes
	Sheppard Pratt	78 minutes	32 minutes

Source: Google Maps

- **Engage family members in the therapeutic process to support successful recovery and improve outcomes** - Family engagement can be very supportive to the recovery process, and proximity can make the difference between family engagement and lack of family engagement. A nearby location will be invaluable to successfully engaging family members in the recovery process by providing a more local service site and removing the hardship of travel that currently discourages family involvement.

- **Produce operating efficiencies by leveraging professional workforce across the campus and sharing well-trained, hard-to-recruit professionals** – Co-location of programs on a single campus will help eliminate travel times during a work day for staff shared across programs and will optimize staffing efficiencies.

- **Attract top talent and support recruitment of mental health clinicians to this shortage region by operating a continuum of services on the same site and provide a training environment for clinicians at all levels** –.AAMC will attract top talent and support recruitment of mental health clinicians to this shortage region by operating a continuum of mental health services in the new facility, providing a training environment for clinicians at all levels. The facility will be recognized for expertise in all areas of behavioral medicine, backed by one of the largest independent medical centers in Maryland. Amidst a shortage of psychiatrists and other mental health professionals, this campus model will provide an advantage to attract mental health providers to this Health Professionals Shortage Area.[18]

- **Serve all payors.** – As described above, AAMC is committed to serving Medicaid patients in its mental health hospital, as it does throughout its health system. With 16 beds (which corresponds to demonstrated need), AAMC intends its mental health hospital to be an additional non-IMD resource for the care of Medicaid patients in Maryland who require an inpatient psychiatric admission. As such, its projected payor mix reflects substantial Medicaid participation, as shown Chart 27 below.

Chart 27
AAMC Mental Health Hospital Payor Mix

Payor	Percent of Total Revenue
Medicare	28.2%
Medicaid	39.4%
Blue Cross	14.7%
Commercial Insurance	11.5%
Self-Pay	4.6%
Other	1.6%

- **Support the goals for population health promotion and accountability for the regional population** – Under its GBR agreement with the HSCRC, AAMC is accountable for a population base of approximately 1.1 million residents who live in a region that includes communities in Anne Arundel County and extends across seven other counties, including Calvert, Prince George's, Charles, Caroline, Talbot, Kent, and Queen Anne's counties. AAMC recognizes its responsibility to improve population health, enhance quality of care, improve health care outcomes, and lower the costs of care for this population. A comprehensive mental health services program at AAMC, managed as a continuum by the same clinical staff and committed to collaboration with local community-based providers, will reinforce AAMC's commitment to quality outcomes, continuity of care, efficient service delivery, and effective care management.

- **Establish a service site that will promote a close collaboration between clinical services and self-help and advocacy groups in the community** – The new facility will allow space for multi-purpose use by community stakeholders, such as the National Alliance on Mental Illness (NAMI), 12 Step programs, and On Our Own.

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18 Health Resources and Services Administration. http://www.hrsa.gov/shortage/.

- **Promote collaboration between clinical providers and social services to more effectively address the social determinants of health.**

- **Attract philanthropy and/or social impact bonds for expansion of this community-oriented model.**

E.

NEED ASSESSMENT AND VOLUME PROJECTIONS FOR THE NEW MENTAL HEALTH HOSPITAL[19]

In this section, AAMC presents the following:

1) Current capacity and occupancy trends: State of Maryland
2) Service area definition for the proposed mental health hospital
    a. Rationale for service area definition
    b. Population projections for the service area
3) Patient populations expected to be served at AAMC
    a. Clinical definitions
    b. Current market share patterns
4) AAMC's "current equivalent market share" for acute psychiatric care
5) Projected need for AAMC's new program, and sizing of the proposed mental health hospital
    a. Core assumptions for volume projections at AAMC
    b. Population-based use rate model

1.

Current capacity and occupancy trends: State of Maryland

While the overall occupancy level at psychiatric units in Maryland is reported to be 73 percent (see Chart 28, page 62), the occupancy rate at UM BWMC—the only hospital with an acute psychiatric unit in Anne Arundel County—has been reported to be above 90 percent for CY 2014 and the first 9 months of CY 2015.

19 Note: All need analyses are based on hospital utilization by adult patients with a mental health diagnosis as their primary diagnosis; this volume does not include patients documented with a substance use disorder as a primary diagnosis, as these patients will not be served in the new mental health hospital.

Chart 28
Maryland Acute Hospitals and Freestanding Psychiatric Facilities
CY 2014 to 2015, Annualized (January – September)

Hospital	Number of Admissions		Psychiatry Unit ALOS*		ADC in Psychiatry Unit		Number of Psychiatry Unit Beds		Occupancy %	
	CY 2014	CY 2015, Annualized	CY 2014	CY 2015, Annualized	CY 2014	CY 2015, Annualized	CY 2014	CY 2015, Annualized	CY 2014	CY 2015, Annualized
Union Hospital of Cecil County	632	615	4.5	4.6	8	8	8	8	96.7%	95.8%
Sinai Hospital	1,134	1,139	7.3	7.2	23	23	24	24	94.0%	93.8%
UM Baltimore Washington Medical Center	1,037	965	4.7	4.8	13	13	14	14	95.2%	91.0%
Northwest Hospital Center	1,099	1,069	6.8	7.1	20	21	23	23	88.5%	91.0%
MedStar Union Memorial Hospital	1,671	1,399	5.1	6.1	24	23	26	26	90.5%	90.1%
Frederick Memorial Hospital	1,085	1,036	6.5	6.6	19	19	21	21	92.2%	88.7%
Johns Hopkins Bayview Medical Center	1,283	1,081	4.8	5.9	17	18	20	20	84.5%	88.1%
Meritus Medical Center	939	995	4.4	5.1	11	14	18	16	62.4%	86.5%
Suburban Hospital	1,398	1,381	5.3	5.5	20	21	24	24	84.8%	86.1%
UM St. Joseph Medical Center	833	767	6.6	7.7	15	16	19	19	78.9%	85.5%
Johns Hopkins Hospital	2,644	4,105	12.7	8.1	92	92	108	108	84.9%	84.9%
Prince George's Hospital Center	2,100	2,213	4.3	3.8	24	23	28	28	87.4%	82.6%
Peninsula Regional Medical Center	778	697	4.9	5.2	11	10	12	12	87.9%	82.5%
MedStar Franklin Square Hospital Center	2,281	2,343	5.3	5.1	33	33	40	40	82.6%	82.3%
UMMC Midtown Campus	1,460	1,295	6.2	6.0	25	21	28	28	87.9%	76.6%
Howard County General Hospital	1,029	889	5.5	6.0	15	15	22	20	70.4%	73.1%
Calvert Memorial Hospital	677	579	4.8	5.0	9	8	11	11	80.9%	71.4%
Holy Cross Germantown Hospital	71	341	4.7	4.6	1	4	6	6	15.3%	71.2%
UM Shore Medical Center at Dorchester	591	708	6.4	5.8	10	11	16	16	65.1%	70.2%
MedStar Southern Maryland Hospital Center	1,190	1,189	4.7	5.3	15	17	25	25	61.5%	68.9%
University of Maryland Medical Center	1,663	1,576	9.3	8.9	42	38	56	56	75.5%	68.7%
Western Maryland Regional Medical Center	1,098	1,171	4.2	4.1	13	13	20	20	63.6%	65.6%
MedStar Montgomery General Hospital	1,889	1,983	2.6	2.4	13	13	25	20	53.1%	65.2%
Harford Memorial Hospital	1,341	1,125	5.4	5.6	20	17	28	27	70.3%	63.9%
Washington Adventist Hospital	1,611	1,564	5.8	5.7	25	24	40	40	63.5%	61.1%
Bon Secours Hospital	1,444	1,696	4.3	4.1	17	19	32	32	52.8%	60.2%
MedStar St. Mary's Hospital	622	581	3.9	4.3	7	7	12	12	55.2%	56.6%
Laurel Regional Hospital	733	737	3.8	3.8	8	8	14	14	54.2%	55.3%
Carroll Hospital Center	1,085	951	3.6	4.0	11	11	20	20	53.0%	52.7%
Acute Care Hospitals Subtotal	35,418	36,191	5.8	5.6	561	559	740	730	75.8%	76.6%
Sheppard Pratt	9,107	9,125	11.3	12.6	282	316	414	414	68.1%	76.3%
Brook Lane	1,641	1,749	7.8	8.9	35	43	65	65	53.6%	66.0%
Potomac Ridge	297	300	8.5	9.8	7	8	15	15	46.2%	53.8%
Adventist Behavioral Health Rockville	2,197	1,717	9.4	9.7	57	46	107	107	52.8%	42.7%
Freestanding Psych Facilities Subtotal	13,242	12,892	10.5	11.7	380	412	601	601	63.2%	68.6%
Grand Total	**48,660**	**49,083**	**7.1**	**7.2**	**941**	**971**	**1,341**	**1,331**	**70.2%**	**73.0%**
% Change, 2014-2015, Annualized		*0.9%*				*3.2%*				

Source: HSCRC Experience Data CY 2014 (full year) - CY 2015, Jan - Sept Annualized

Notes:

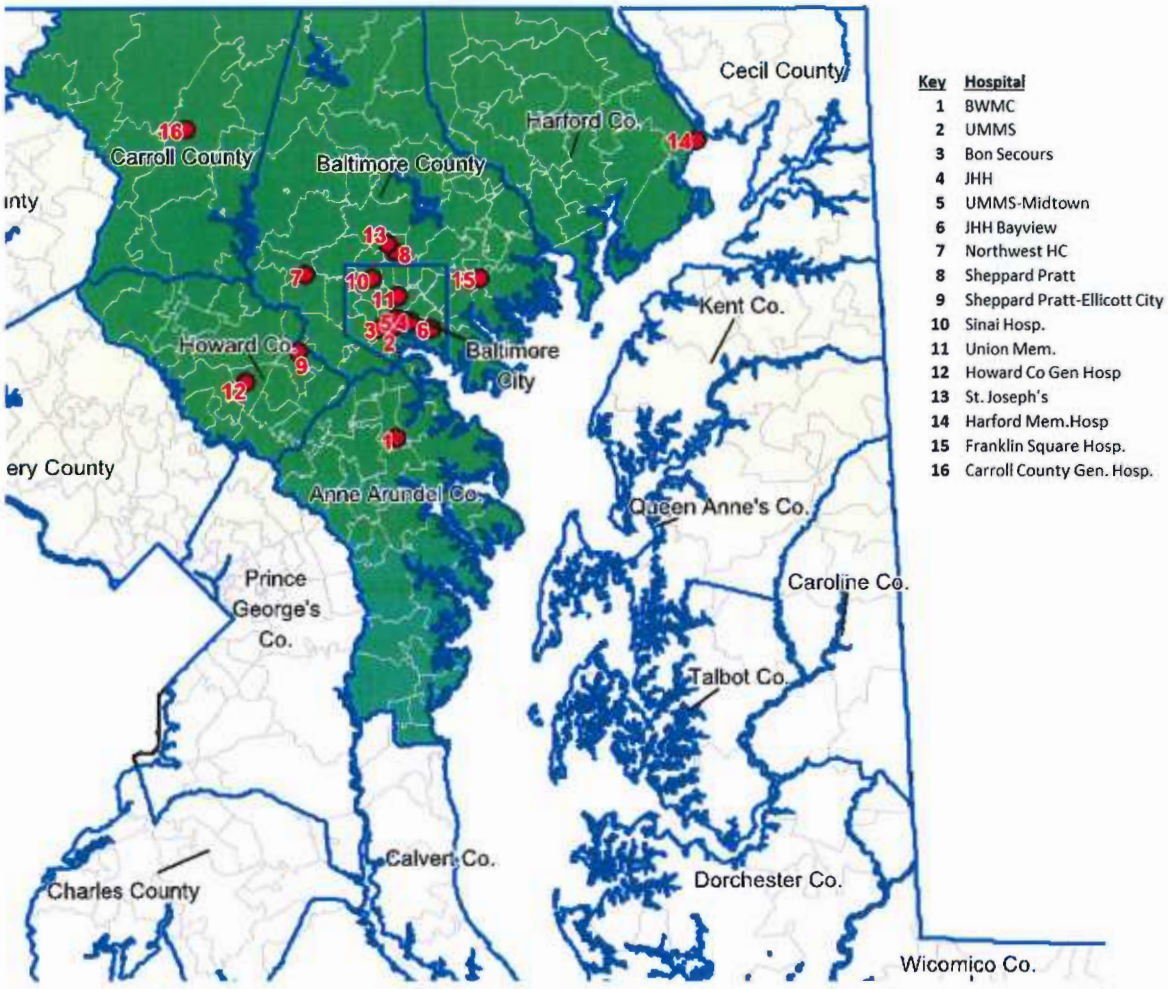
[1] Includes all volume in psychiatry units, including patients of all ages and all diagnoses

[2] Some admissions may be accompanied by additional days in Med/Surge

[3] Percentage increase in average daily census computed based on total patient days

The under-resourced Central Maryland region—including Anne Arundel County—is further highlighted by the map below (Map 1) which shows the concentration of acute psychiatric services in Baltimore City and the lack of service sites more local to the heavily populated Anne Arundel County service area.

Map 1
Acute Psychiatric Units in General Hospitals and Specialty Psychiatric Hospitals
Six-County Health Service Area



2.

Service Area Definition[20]

Data limitations: AAMC defined its service area based on whole-county definitions, reflecting the limited dataset made available. The hospital dataset provided by freestanding psychiatric facilities does not provide zip code-specific data. Therefore, AAMC's service area

20 Data from freestanding psychiatric hospitals was made available on a county basis, only; therefore, all market analyses and need forecasts have been prepared on a county basis

definition, need projection, and analysis of the impact on access is based on whole-county populations.

Service area definition: AAMC's service area for inpatient psychiatric care is defined to include two (2) counties: Anne Arundel County and Queen Anne's County. AAMC is strongly positioned—geographically, programmatically, and operationally—to serve this two-county region, produce quality improvements, and generate cost savings.

AAMC defined the service area for its proposed mental health hospital based largely on the patient origin of its transfer population, i.e. the patient population who presented in AAMC's ED in FY 2015 and who required transfer to an acute psychiatric unit. **This data represents actual experience and serves as evidence that AAMC is a provider of choice for residents of these two counties.**

AAMC defined the clinical cohorts expected to be served by the proposed mental health hospital, referred to in this application as the "AAMC-eligible population," and examined AAMC transfer data more closely based on this "AAMC-eligible population" (see Technical Notes for diagnosis code definitions).

Patients from these two counties (Anne Arundel and Queen Anne's counties) represented 75 percent of the total AAMC-eligible transfers from AAMC to acute psychiatric units in Maryland (N=946 patients). The patient origin data for AAMC-eligible transfers from AAMC is presented below on Chart 29, representing adult patients with diagnoses that will be served by the AAMC mental health hospital:

Chart 29
Number of Transfers from AAMC to Acute Psychiatric Units
AAMC – Eligible Cases, Only
FY 2015
(N = 946 cases)

	Sheppard Pratt	Acute Hospitals	Total	% Total
Anne Arundel County	514	160	674	71.2%
Prince George's County	45	17	62	6.6%
Queen Anne's County	23	13	36	3.8%
All Other	138	36	174	18.4%
Total	**720**	**226**	**946**	**100.0%**

a. **Rationale for this two-county service area definition**

AAMC defined Anne Arundel and Queen Anne's Counties as its service area for the proposed mental health hospital based on the following premises:

- Volume from these two counties represents 75 percent of total AAMC-eligible acute psychiatric cases presenting in AAMC's ED who would be candidates for admission to the mental health hospital at AAMC.

- The Queen Anne's County population represents a growing patient base for AAMC and a major focus for AAMC's population health management initiatives. AAMC currently has two affiliated family medicine practices operating in Queen Anne's County.

- The proposed mental health hospital would improve access for residents of Queen Anne's County by reducing driving time to the closest acute psychiatric unit (refer to Chart 26, page 59).

- HSCRC data indicates that AAMC is the first point of hospital contact for more than 20 percent of acute psychiatric patients who were admitted from Anne Arundel County and more than 20 percent of acute psychiatric patients who were admitted from Queen Anne's County. Therefore, AAMC is already serving more than 20 percent of psychiatric admissions from these two counties through the AAMC ED (see Section 4, Current Equivalent Market Share, page 72). While this patient volume is currently transferred to other hospitals, at a minimum, AAMC can expect to serve this share of patients requiring admission to a psychiatric unit.

AAMC's service area under GBR includes the northernmost communities of Prince George's County, and AAMC has built a substantial patient base in this region. As the ED transfer profiles indicate, patients from Prince George's County currently rely on AAMC for psychiatric services. However, AAMC anticipates that the new hospital in Prince George's County and the reconstituted Laurel Regional facility will function to serve a large percentage of county residents needing psychiatric care. Therefore, for purposes of the need analysis, AAMC has not projected Prince George's County to be a target market or a growth area. At the same time, AAMC will continue to serve a modest percentage of Prince George's County volume, as reflected in the "out of area" volume projected to be served.

Therefore, the AAMC-eligible transfer population was profiled on the basis of AAMC's transfers in FY 2015 to include:

- Patients age 18 years or more,

- Patients defined by the "eligible" diagnoses, accompanied by exclusion of defined diagnostic groups, and;

- Exclusion of the Prince George's County population.

b. **Population projections**

The total adult population in this two-county region is 457,000 adult residents (age 18 years or more), with an annual growth rate of approximately one percent per year through Year 2022 (as shown on Chart 30, page 66). This population growth rate further supports the need for a new inpatient unit in this region: Even as the partial hospitalization program comes to substitute for admission in up to 15 to 20% of cases, the population growth of this region will continue to drive the need for inpatient care. Moreover, a unit that is local to where this population lives is essential to continuity of care, patient adherence, and readmission reduction.

Chart 30
Population Projections
Defined Service Area: Anne Arundel and Queen Anne's Counties
Adults Only (18+)
Years 2014 – 2022

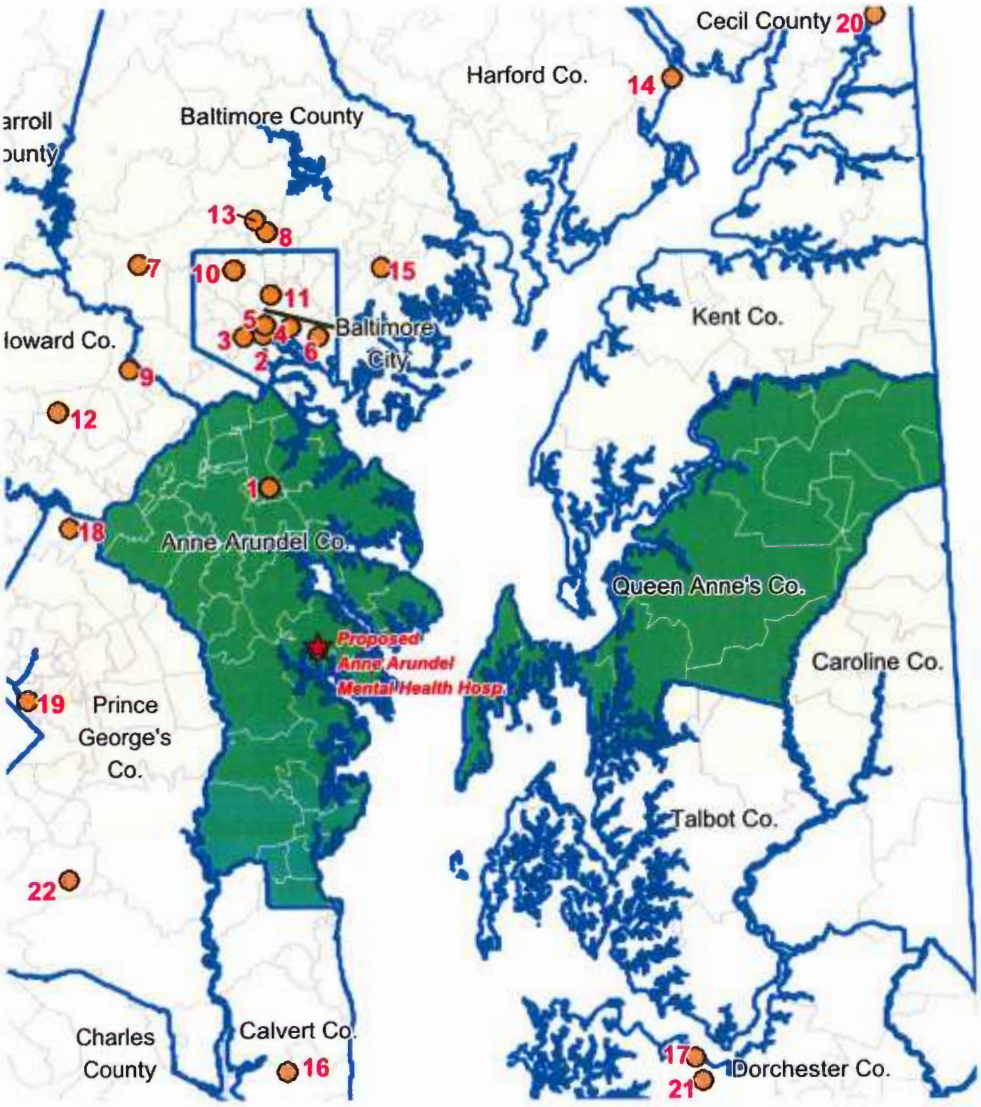
		Estimate			Projection					
		2014	2015	2016	2017	2018	2019	2020	2021	2022
Anne Arundel County	**Anne Arundel**									
	Age 18-64	345,079	347,239	347,047	347,930	348,814	349,701	350,590	351,482	352,376
	Age 65+	72,510	75,643	78,001	81,134	84,394	87,784	91,310	94,978	98,793
	Total Adult	**417,589**	**422,882**	**425,048**	**429,064**	**433,208**	**437,485**	**441,901**	**446,460**	**451,169**
	% Change		1.3%	0.5%	0.9%	1.0%	1.0%	1.0%	1.0%	1.1%
Queen Anne's County	**Queen Anne's**									
	Age 18-64	26,881	26,588	26,672	26,717	26,762	26,807	26,853	26,898	26,943
	Age 65+	7,321	7,500	7,797	8,067	8,347	8,637	8,936	9,246	9,567
	Total Adult	**34,202**	**34,088**	**34,469**	**34,784**	**35,109**	**35,444**	**35,789**	**36,144**	**36,510**
	% Change		-0.3%	1.1%	0.9%	0.9%	1.0%	1.0%	1.0%	1.0%
	Grand Total									
	Age 18-64	371,960	373,827	373,719	374,647	375,576	376,509	377,443	378,380	379,319
	Age 65+	79,831	83,143	85,798	89,202	92,741	96,420	100,246	104,224	108,360
	Total Adult	**451,791**	**456,970**	**459,517**	**463,848**	**468,317**	**472,929**	**477,689**	**482,604**	**487,679**
	% Change		1.1%	0.6%	0.9%	1.0%	1.0%	1.0%	1.0%	1.1%

Source: Nielsen, Inc.

The map (Map 2, page 67) highlights the two-county service area, as well as the hospitals that currently serve 70 percent of the acute psychiatric volume from this region. This includes the following hospitals:

- Sheppard Pratt
- UM BWMC
- UM Shore Health at Dorchester
- MedStar Franklin Square
- Bon Secours Hospital
- UMMC

Map 2
Two-County Service Area for the AAMC Mental Health Hospital
Anne Arundel County and Queen Anne's County



Key	Hospital
1	BWMC
2	UMMS
3	Bon Secours
4	JHH
5	UMMS-Midtown
6	JHH Bayview
7	Northwest HC
8	Sheppard Pratt
9	Sheppard Pratt-Ellicott City
10	Sinai Hosp.
11	Union Mem.
12	Howard Co Gen Hosp
13	St. Joseph's
14	Harford Mem. Hosp
15	Franklin Square Hosp. Center
16	Calvert Mem.Hosp.
17	Dorchester Gen Hosp
18	Laurel Reg.
19	PGRMC
20	Union Hosp of Cecil Co.
21	Adventist Behavioral Health-E. Shore
22	So.Md. Hosp.

3.

Patient populations to be served ("AAMC-eligible volume")

AAMC plans to serve adult patients, age 18 years or more, including involuntary admissions and including those patients identified as suicidal who require treatment in a psychiatric unit. The total market need was documented to reflect the specific patient population expected to be served at AAMC's proposed mental health hospital. Discharge data was compiled based on the following clinical definitions of "AAMC-eligible patients," defined by age, diagnosis code, and days in acute psychiatric care:

- All adult discharges documented with a psychiatric DRG (DRG 750-760)
- All adult discharges with an ICD-9 psychiatric diagnosis code *and* having had at least 1 or more days in an acute psychiatric unit in Maryland

This definition served to capture the current market need for acute psychiatric services which AAMC expects to serve. More specifically, this patient population included the following patient cohorts:

Core Definition:	Psychiatric DRGs	DRG 750-760 (Psychiatric DRGs) DRG 740, *and* at least 1 day in Psychiatric Unit
	Postpartum/Antepartum	DRG 561 or 566, *and* at least 1 day in Psychiatric Unit
	Other patients	Psychiatric diagnosis *and* documented to have had at least one day in acute psychiatric care

Additional volume documented to capture the full population of ED visits:

	Suicidal risk	ICD 9 diagnosis code identifying suicidal risk *and* accompanied by at least 1 day in acute psychiatric care

A number of patient cohorts will continue to be referred to other facilities and will not be admitted to AAMC's mental health hospital. These patient populations were therefore *excluded* from the market assessment and the need projection based on diagnosis codes. Patient cohorts excluded from the analyses were those patients identified by any one of the following diagnoses as a primary diagnosis:

AAMC Exclusions: Patient populations defined by the following primary diagnoses

- Substance use disorders (ICD 9 codes 290-294)
- Eating disorders (DRG 759)

- Dementia/neurologic disorders (ICD 9 290-294)

- Developmental disabilities/intellectual disorders (ICD 9 codes 317-319)

All market share analyses, use rate analyses, and need projections in this section are based on this definition of **"AAMC eligible patients"** defined above and excluding the patient populations who will not be served by AAMC.

Current market share based on definition of "AAMC-eligible patients" (see Chart 32, page 71): Utilization patterns and market share patterns were examined for the AAMC-eligible patient population, specifically. The data provides evidence of access issues and highlights the care management concerns with out-of-county care: disjointed care management, relatively long acute care length of stay, disruption in continuity of care, and travel time for patients and families. More specifically, the data document the following points:

Anne Arundel County residents

- **Inpatient care** - The one existing psychiatric unit in Anne Arundel County (at UM BWMC) consistently operates at more than 90 percent occupancy. As a result, nearly 80 percent of Anne Arundel County patients are admitted to acute care units outside of the county (see Chart 32, page 71), accompanied by the many negative consequences cited earlier. Most notably:

    - Medical management and psychiatric management, when separated, run the risk of becoming disjointed.

    - Upon discharge, Anne Arundel County patients return to services in their home area, and continuity of care often suffers. Additionally, out-of-area professional teams must mobilize continuing care resources across counties where providers have less familiarity with local community providers, and as a result, acute care lengths of stay can be extended.

- **ED care** – In FY 2015, HSCRC data documented a total of 5,120 adult ED visits from Anne Arundel County with mental health as the primary diagnosis. AAMC served 36 percent of these total ED visits for mental health (or, 1,837 adult ED visits from Anne Arundel County).

Queen Anne's County residents

- **Inpatient care** - Approximately 60 percent of Queen Anne's County patients admitted for mental health are admitted to facilities outside of the Eastern Shore (Chart 32, page 71). The majority of these psychiatric admissions are admitted to Baltimore County and Baltimore City facilities, representing approximately one hour's drive time for families. While drive time may be manageable, this imposition may result in family members being less engaged in the recovery process, a critical element to successful recovery. As noted above, provider teams at a distant hospital may be less familiar with local resources. Continuity of care is likely to be disrupted and the patient must be motivated to build a new clinical relationship.

- **ED care** – In FY 2015, HSCRC data documents a total of 380 adult ED visits from Queen Anne's County with mental health as the primary diagnosis. AAMC served 24 percent of these total ED visits for mental health (or 92 adult ED visits from Queen Anne's County) as shown below on Chart 31. This figure confirms that AAMC is the first point of contact and first choice of provider for a considerable percentage of the patient population in Queen Anne's County.

Chart 31
Adult ED Visits with Mental Health as Primary Diagnosis
By County of Residence
FY 2015

	Anne Arundel County	Queen Anne's County
Total # Adult ED Visits for Mental Health	5,120	380
# Adult ED visits for Mental Health at AAMC	1,837	92
AAMC ED Market Share for Mental Health	36%	24%

Source: HSCRC Abstract Dataset
Mental health defined by CCS code as primary, and does not include substance use or alcohol use disorders

Chart 32
AAMC Eligible Psychiatric Discharges
Market Share by Hospital
CY 2014

Hospital	Anne Arundel		Queen Anne's		Total	
	Vol	Market Share	Vol	Market Share	Vol	Market Share
Sheppard Pratt	1,043	32.1%	47	28.7%	1,090	31.9%
UM Baltimore Washington Medical Center	709	21.8%	6	3.7%	715	21.0%
University of Maryland Medical Center	182	5.6%	5	3.0%	187	5.5%
MedStar Franklin Square Hospital Center	145	4.5%	4	2.4%	149	4.4%
Bon Secours Hospital	147	4.5%	1	0.6%	148	4.3%
Laurel Regional Hospital	113	3.5%	-	0.0%	113	3.3%
UMMC Midtown Campus	112	3.4%	-	0.0%	112	3.3%
Johns Hopkins Hospital	105	3.2%	4	2.4%	109	3.2%
MedStar Union Memorial Hospital	94	2.9%	1	0.6%	95	2.8%
UM Shore Medical Center at Dorchester	25	0.8%	64	39.0%	89	2.6%
Howard County General Hospital	78	2.4%	1	0.6%	79	2.3%
UM St. Joseph Medical Center	67	2.1%	1	0.6%	68	2.0%
Johns Hopkins Bayview Medical Center	60	1.8%	3	1.8%	63	1.8%
Anne Arundel Medical Center	55	1.7%	5	3.0%	60	1.8%
MedStar Montgomery General Hospital	41	1.3%	5	3.0%	46	1.3%
Unknown - Psych Specialty	43	1.3%	1	0.6%	44	1.3%
Calvert Memorial Hospital	39	1.2%	1	0.6%	40	1.2%
Northwest Hospital	35	1.1%	-	0.0%	35	1.0%
Washington Adventist Hospital	26	0.8%	-	0.0%	26	0.8%
Carroll Hospital Center	23	0.7%	-	0.0%	23	0.7%
Suburban Hospital	17	0.5%	1	0.6%	18	0.5%
MedStar Harbor Hospital Center	17	0.5%	-	0.0%	17	0.5%
Harford Memorial Hospital	14	0.4%	1	0.6%	15	0.4%
Prince George's Hospital Center	15	0.5%	-	0.0%	15	0.4%
MedStar Southern Maryland Hospital	12	0.4%	-	0.0%	12	0.4%
Sinai Hospital	9	0.3%	1	0.6%	10	0.3%
Union Hospital of Cecil County	7	0.2%	2	1.2%	9	0.3%
UM Shore Medical Center at Easton	-	0.0%	5	3.0%	5	0.1%
MedStar St. Mary's Hospital	4	0.1%	1	0.6%	5	0.1%
Peninsula Regional Medical Center	3	0.1%	1	0.6%	4	0.1%
Greater Baltimore Medical Center	3	0.1%	-	0.0%	3	0.1%
UM Shore Medical Center at Chestertown	-	0.0%	2	1.2%	2	0.1%
St. Agnes Hospital	2	0.1%	-	0.0%	2	0.1%
Mercy Medical Center	1	0.0%	1	0.6%	2	0.1%
Frederick Memorial Hospital	1	0.0%	-	0.0%	1	0.0%
Atlantic General Hospital	1	0.0%	-	0.0%	1	0.0%
Meritus Medical Center	-	0.0%	-	0.0%	-	0.0%
Holy Cross Hospital	-	0.0%	-	0.0%	-	0.0%
Doctors Community Hospital	-	0.0%	-	0.0%	-	0.0%
Fort Washington Medical Center	-	0.0%	-	0.0%	-	0.0%
UM Charles Regional Medical Center	-	0.0%	-	0.0%	-	0.0%
Western Maryland Regional Medical Center	-	0.0%	-	0.0%	-	0.0%
Total	**3,248**	**100.0%**	**164**	**100.0%**	**3,412**	**100.0%**
% Admitted to Out of Area Hospitals	2,539	78.2%	93	56.7%	2,632	77.1%

Source: HSCRC Abstract Data

4.

AAMC's "Current Equivalent Market Share" for Acute Psychiatric Care

In FY 2015, AAMC stabilized and evaluated a total of 946 adult patients in its ED who were transferred to an acute psychiatric unit in Maryland, but who would be "AAMC-eligible," i.e., could be served in the proposed mental health hospital. In other words, these patients would be expected to be served in the new hospital rather than be transferred. Therefore, this transfer data established the basis for calculating AAMC's county-specific **"current equivalent market share"** in CY 2014 for acute psychiatric care. **Had AAMC admitted the AAMC-eligible, acute psychiatric patients who presented to AAMC's ED during FY 2015 (rather than transfer these cases for admission),** AAMC's county-specific market share for adult psychiatry would have equated to:

	FY 2015 equivalent market share	
Anne Arundel County	21%	21%
Queen Anne's County	22%	

Based on this starting point, AAMC established relatively modest market share growth targets for its proposed mental health hospital as follows:

	FY 2022 projected market share	
Anne Arundel County (growth)	25%	25%
Queen Anne's County[21]	20%	

As noted earlier, AAMC does not target Prince George's County as a growth market for the proposed mental health hospital, but will continue serving the northernmost segment of this market (representing a portion of AAMC's population health management responsibility under its GBR contract) as reflected in AAMC's "out of area" volume.

5.

Projected Need for AAMC's Mental Health Hospital

AAMC then prepared a need projection based on a population-based use rate model defined specifically by the "AAMC-eligible" adult population residing in Anne Arundel and Queen Anne's Counties. This provided the most accurate basis for projecting patient volume by excluding patient cohorts who will not be served at AAMC (i.e., patients who will continue to be referred to specialty programs across Maryland).

Core assumptions - The population-based use rate model incorporates the following assumptions:

---

21 The assumption is that a percentage of current patients coming to AAMC's ED may still opt for another hospital at the point of admission

- **Patient age**: The proposed mental health hospital will serve patients age 18 years and older.

- **Patient origin**: 85 percent of patients will be drawn from the defined service area: Anne Arundel and Queen Anne's counties.

- **Use rate decline**: Volume projections incorporate an aggressive target for use rate reduction in the service area. AAMC expects to substitute partial hospitalization and community-based services for 15 to 20 percent of its current admission base. Therefore, the projection model assumed that the admission rate for the AAMC-eligible patient population would decline by 17 percent between the Years 2014 – 2022.

- **AAMC market share**: Based on AAMC's "current equivalent market share" of 21 percent, market share is projected to grow as follows on Chart 33:

Chart 33
AAMC Market Share for Adult Psychiatric Discharges
Based on current equivalent market share of 19%

	Market Share Projection	
	FY 2015 Actual	FY 2022 Projection
Anne Arundel County	21%	25%
Queen Anne's County	18%	20%
Overall Market Share for Service Area	21%	25%

This market share target is a reasonable target based on the fact that AAMC *currently* serves 36 percent of Anne Arundel County's adult mental health visits to hospital emergency rooms and 24 percent of Queen Anne's County adult mental health visits to hospital emergency rooms. In addition, AAMC's current market share for other specialty programs in Anne Arundel County strongly supports this target as documented below on Chart 34:

Chart 34
AAMC Adult Market Share of Discharges

Anne Arundel County Adult Residents
Selected Specialties
FY 2015

	% of Adult Discharges
Orthopedics	42%
Obstetrics	74%
Medical cardiology	27%
Overall adult discharges less psych, less cardiac surgery	34%

Source: HSCRC Abstract Dataset

- **Out of area volume:** AAMC currently draws an additional (25 percent) of acute mental health patients from outside the two-county service area defined (based on its ED transfer data). However, the projection model applied a more modest assumption about out-of-area volume that would be served, applying only an additional 15 percent of volume from outside the two-county area. This percentage was reduced to acknowledge that Prince George's Regional Medical Center and Laurel Regional Medical Center are expected to serve a significant percentage of patients from Prince George's County going forward, and that Prince George's County will not be a target area for AAMC's program growth. At the same time, AAMC—under its GBR contract with the HSCRC—is accountable for population health management for segments of Prince George's County and is committed to providing more integrated medical and psychiatric care and effective care management to residents of Prince George's County.

- **DRG mix**: Based directly on its current mix of ED transfers, AAMC projects its patient mix in the proposed mental health hospital to comprise the following diagnostic mix on Chart 35:

Chart 35
Projected DRG Mix

DRG	DRG Description	% of Projected Discharges
750	Schizophrenia	12.1%
751	Major depressive disorders & other/unspecified psychoses	28.4%
753	Bipolar disorders	34.3%
754	Depression except major depressive disorder	19.3%
755	Adjustment disorders &neuroses except depressive diagnosis	2.7%
756	Acute anxiety & delirium states	3.2%

- **Average length of stay** – Projected length of stay for the mental health hospital is 6.14 days based on the following assumptions:
    - The mix of AAMC-eligible patients in the new hospital will represent the same mix of AAMC-eligible patients who are currently served in AAMC's ED and transferred for admission to an acute psychiatric unit. FY 2015 data documents the following transfer pattern and utilization data for this transfer population on Chart 36, page 75[22]:

22 For purposes of this analysis/financial modeling, a total of 14 cases were excluded from the transfer population based on DRGs that did not represent DRGs consistent with the expected clinical mix of patients, and a total of 48 cases from Prince George's County that were excluded based on the assumption that this county will not be a target market. This reduced the total volume of transfer cases from 946 cases to 884 cases.

Chart 36
Transfers from AAMC's ED for Admission
FY 2015

Admitting Hospital	# Actual Transfers	% Transfers	Current ALOS	Projected ALOS
Sheppard Pratt	669	76%	8.45 days	6.45 days
All Other Hospitals	215	24%	5.15 days	5.15 days
Total Transfers	**884**	**100%**	**7.67 days**	**6.14 days**

- Average length of stay for the patient population from Anne Arundel and Queen Anne's Counties now served at Sheppard Pratt is expected to decline from 8.45 days to 6.45 days reflecting the fact that AAMC providers will be able to make greater use of the partial hospitalization setting, maintain continuity of care with patients, and accelerate the discharge planning process through greater familiarity/working relationships with local community-based agencies.

- No further decline in length of stay is projected.
  - The aggressive use rate decline projected for the region will result from a reduction in short stay admissions (through reliance on the partial hospitalization program, improved community care integration, and peer support programs). Reducing the number of low intensity, short stay patients will leave the longer stay patients—including involuntary patients—driving length of stay patterns to some degree.
  - The basis for admission will typically require extended evaluation, medication management, and therapeutic protocols after a crisis episode. These stays will continue to require nearly one week's inpatient stay.
  - National reports/clinical studies emphasize the need to assure that length of stay is adequate to assure efficacy and tolerance of new medication(s) and adequate time to establish patient self-management skills in order to prevent readmissions.

Based on these assumptions, volume projections are presented on Chart 37 (page 76) to support a 16-bed mental health hospital, projected to operate at 91 percent occupancy in Year 1 of operation and 94 percent occupancy by Year 4 of operation.

Chart 37
Population-Based Use Rate Model
Projected Adult Psychiatric Discharges at AAMC
Based on "AAMC-eligible" Definition of Inpatient Volume

	2014	2015 Annualized	2016	2017	2018	2019	2020	2021	2022
Population									
Anne Arundel County	417,589	422,882	425,048	429,064	433,208	437,485	441,901	446,460	451,169
Queen Anne's County	34,202	34,088	34,469	34,784	35,109	35,444	35,789	36,144	36,510
Total	**451,791**	**456,970**	**459,517**	**463,848**	**468,317**	**472,929**	**477,689**	**482,604**	**487,679**
Discharges per 1,000									
Total Queen Anne's and Anne Arundel County	**7.55**	**7.73**	**7.56**	**7.32**	**7.09**	**6.94**	**6.73**	**6.58**	**6.43**
Projected AAMC Cases									
Anne Arundel County									
Market Discharges	3,249	3,360	3,302	3,226	3,152	3,110	3,041	3,002	2,963
AAMC Market Share	-	-	-	-	-	23.0%	24.0%	24.5%	25.0%
AAMC Discharges						715	730	735	741
Queen Anne's County									
Market Discharges	164	172	172	171	170	171	172	173	174
AAMC Market Share	-	-	-	-	-	20.0%	20.0%	20.0%	20.0%
AAMC Discharges						34	34	35	35
Subtotal						750	764	770	776
Out of area volume: 15% additional						112	115	116	116
Total Discharges with Year 1 @ 12 months of operation						862	879	886	892
Total Discharges with Year 1 @ 10 months of operation						**718**	**879**	**886**	**892**
Average Length of Stay						6.14	6.14	6.14	6.14
Average Daily Census						14.5	14.8	14.9	15.0
Occupancy Rate at 16 beds						90.6%	92.4%	93.1%	93.8%

Source: HSCRC Abstract Data; Nielsen, Inc.

F.

SHELL SPACE ANALYSIS

In the absence of an applicable shell space review standard in this context, AAMC applied the project review standard for shell space in an acute care general hospital project (COMAR 10.24.10.16), which provides as follows:

a) Unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective.
b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that:
   i) Considers the most likely use identified by the hospital for the unfinished space;
   ii) Considers the time frame projected for finishing the space; and
   iii) Demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.
c) Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space.
d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Service Cost Review Commission.

Applicant Response:

First Floor Shell Space

There is approximately 6,500 SF of shell space located on the First Floor. Under COMAR 10.24.10 (16)(c), using current cost estimates to fit out the shell space at $115/sf, the cost would be approximately $747,500. AAMC expects to utilize the space for outpatient mental health services. The expected timeframe to fit out the shell space is three to five years.

Third Floor Shell Space

There is approximately 16,688 SF of shell space located on the Third Floor, which will not support finished space. The most likely use will be for inpatient mental health beds and associated clinical and operational support space, as need develops and subject to the resolution of the IMD Exclusion issue, or alternatively for additional outpatient mental programs. For further discussion of the IMD Exclusion issue, please refer to Part (A)(11) under the Need standard (page 53) above. The anticipated timeframe to fit out the shell space is likely to be three to five years after building opening.

Value Analysis

The current cost to construct the shell space based upon the Marshal Swift Valuation (MSV) services is $1.30 million and time adjusted for escalation at 3.5%/year is $1.53 million. The actual anticipated cost to add a Third Floor on top of an in-use mental health facility would be substantially increased over the MSV value due to operational impacts such as infection control requirements, segregation of construction personnel and materials, utility outages and potential relocation of patients. An additional multiplier of 75 percent is justified and would result in an anticipated total cost of $2.68 million.

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

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

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

a) the alternative of the services being provided through existing facilities;

b) or through population-health initiatives that would avoid or lessen hospital admissions.

Describe the hospital's population health initiatives and explain how the projections and proposed capacities take these initiatives into account.

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

Applicant Response:

In accordance with this Standard, there is no more cost effective alternative available to achieve the goals of the project.

As described above, AAMC has recognized the need to develop inpatient psychiatric capacity for several years. Vision 2020 – Living Healthier Together, AAMC's ten-year Strategic Plan, defines AAMC's mission to enhance the health of the people it serves. In 2014, consistent with its overall mission, AAMC developed its Strategic Plan for Behavioral Health to guide it in meeting the mental health and substance use needs in the community. Recognizing that access to quality, patient-centered behavioral healthcare services is key to having a favorable quality of life in the community, AAMC committed in this Strategic Plan to be a leader in promoting access to mental health and substance use healthcare services within a seamless, integrated medical, mental health and substance abuse continuum of care. One of the key elements of this Strategic Plan was the development of inpatient psychiatric services at AAMC, which the plan targets for FY 2017 – 2018.

AAMC's primary goals associated with this project include the following:

1. Eliminate the delays and barriers to timely inpatient psychiatric care that now result from 946 patient transfers to other facilities, almost all outside of Anne Arundel County.

2. Strengthen quality and continuity of mental health care in Anne Arundel County through by establishing a comprehensive and integrated mental health care program that enables coordination with community-based support services.

3. Consistent with AAMC's mission and demonstrated need, seek to ensure that AAMC's inpatient mental health capacity is available to serve all patients regardless of payor source, including Medicaid patients, without delay.

4. Reduce length of stay and admission rates, and leverage community based resources to the fullest extent possible.

As described above, the development of inpatient psychiatric capacity within AAMC's health system is also contemplated within its Master Facilities Plan, which shows two options for locating this program from a facilities standpoint. One potential location is shown within AAMC's acute care hospital in the North Tower, and the other location is shown in a new building to be constructed on the Riva Road property that AAMC leases from the County on a long term basis. Accordingly, with the project goals in mind, over the last nine months, AAMC undertook an extensive analysis of which option would be the best alternative to achieving the goals of the project. The analysis was undertaken by representatives of a wide range of AAMC departments with subject matter expertise including clinical, financial, facilities, operational, planning, and legal. The working group developed a decision matrix to compare and "score" the location options (in the hospital, the campus where Pathways is, as well as a "greenfield" option) against various criteria related to the goals of the project. See Chart 38 (page 81). This analysis strongly supports establishing a freestanding mental health hospital on the Riva Road property as the best alternative. The analysis behind the scoring shown on Chart 38 is described further below.

Chart 38
Scoring Matrix

	Inpatient Psych CON Decision Matrix	Relative Weight	Main Hospital		Riva Road Property		Greenfield	
	Key Criteria		**Rank**	**RxW**	**Rank**	**RxW**	**Rank**	**RxW**
Quality	**Program Quality**	13	3	39	5	65	3	39
	QBR Impact	11	1	11	5	55	5	55
	Risk Management/ Patient Safety	12	1	12	5	60	5	60
Community	**Patient Care Access**	3	5	15	3	9	1	3
Workforce	**Staffing**	9	5	45	3	27	1	9
	Staff Satisfaction/Engagement	5	3	15	3	15	3	15
	Support Services	2	5	10	1	2	1	2
Growth	**Capacity for Growth**	6	1	6	3	18	5	30
	Partnering Opportunities	1	1	1	1	1	5	5
Finance	**Cost (Building Cost)**	7	5	35	5	35	1	7
	Operating Margin	10	5	50	5	50	3	30
	Life Cycle Costs	8	5	40	5	40	1	8
	Reimbursement (GBR)	4	1	4	3	12	5	20
	TOTAL		**283**		**389**		**283**	

Best outcome = 5
Average outcome, acceptable outcome = 3
Least desirable outcome = 1

AAMC explored the following four options to address the need for additional inpatient psychiatric capacity in Anne Arundel County:

1. **Option 1: Do Nothing**: As described at length in response to the Need standard (COMAR 10.24.01.08G(3)(b)), there is a demonstrated need for additional inpatient psychiatric capacity in AAMC's service area. Doing nothing to add inpatient psychiatric beds to AAMC and continuing to rely on existing facilities to meet this need was considered and rejected because it maintains the unacceptable status quo for the large volume of patients in need of inpatient psychiatric care who arrive at AAMC's ED and who must be transferred long distances to receive care. Accordingly, this option was not scored on the decision matrix (Chart 38).

2. **Option 2: Convert Existing Hospital Space**

An option to convert two existing acute-care patient units (approximately 14,326 SF) in the North Hospital Pavilion into 16 psychiatric beds was explored. The estimated total project cost range is $6.5 million to $8.5 million.

Although this is a possible option, there are several drawbacks. The only potential area that could be renovated for this program in the existing facility is on the sixth floor. Elevated floors are not ideal for a mental health locked unit for involuntary and voluntary admissions. The adjacencies, access for patients' visitors, and security for patients and visitors are inferior to those that could be achieved at a consolidated mental health and substance use campus. The ability to share staff across inpatient and partial hospital programs would be compromised. AAMC may need to add beds or multiple units to meet growing need, and the sixth floor location does not provide that option. Additionally, under GBR, as a new service in the hospital, the HSCRC has indicated that reimbursement would be subject to a 50 percent variable cost factor, which would create a negative operating margin. The operating margin in Year 3 for this option was a loss of $1.28 million or negative 38 percent. As such, the program would not be sustainable over time. This option would also have the undesired effect of increasing costs subject to the Medicare waiver. Accordingly, this option was not the preferred option as compared to option 3 which does not have these drawbacks.

3. **Option 3: Construct New Facility (*Selected option*)**

AAMC selected the option of establishing a freestanding mental health hospital on the Riva Road site over a hospital-based unit. Unlike a hospital-based option, this option enables AAMC to provide a comprehensive and integrated mental health care program at a single location that will incorporate inpatient psychiatric care, partial hospitalization, intensive outpatient programs, family support services, prevention programs, and referral to and care coordination with community-based support services. This option also supports better integration with community-based activities, including family and self-help programs to strengthen patient engagement, and patient advocacy organizations to encourage active involvement in community health.

Locating the unit outside of an acute care hospital enables the design team to prepare a pleasing, site-specific milieu while meeting the array of applicable codes and regulations as well as the therapeutic and safety needs for patients and staff. AAMC determined that this location strikes the right "balance between the safest possible healing environment and a non-institutional appearance that is correct for the unique conditions that exist in each and every facility."[23]

The land is currently leased from Anne Arundel County on a long-term basis and the lease allows for construction of a freestanding psychiatric hospital on the property with approval from the county.

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23 Hunt, James M and David M. Sine "Design Guide for the Build Environment of Behavioral Health Facilities," Edition 7.0, May 2015.

4. **Option 4: Redevelop Existing Site**

An option to build a psychiatric hospital on purchased property that would require demolition of an existing building was also explored. An advantage to the site would be that the health system would own the property as opposed to the long-term land lease with Anne Arundel County for the Riva Road property. The land acquisition, demolition and unforeseeable site conditions makes this a less favorable option. Additionally, there is substantial ongoing cost to support another satellite for the health system for couriers, materials management, technology infrastructure, personnel, etc.

A review of potential sites and conceptual estimates for this project indicate that the total capital investment would be in excess of $21.0 million. This option is not only more expensive to build, but also does not provide the numerous benefits afforded by co-locating multiple mental health and substance use services on a single site identified earlier.

As required by this Standard, AAMC also considered population health initiatives to avoid or lessen hospital admissions. AAMCs overall plan for mental health includes multiple population health initiatives (refer to page 14) and treatment collaborations to decrease the need for inpatient psychiatric care. Nevertheless, the need for additional inpatient psychiatric capacity persists.

Two programs in operation or in development will serve to facilitate earlier case detection and earlier outpatient intervention, with the ultimate impact of lessening avoidable inpatient utilization. These include use of a brief mental health and substance use questionnaire in AAMC's network of primary care clinics, and the use of a clinical navigator to field referrals for mental health intervention to a network of cooperating treatment providers. This program began in 2015 and has achieved 509 referrals as of January 31, 2016. This program will be developed further in the coming year with addition of a pilot project of primary care integration, and psychiatric consultation provided to primary care physicians managing psychotropic medications in primary care, with planned expansion to an increasing network of primary care practices in subsequent years.

AAMC will establish a psychiatric partial hospitalization program in FY 2016. It is projected that 15 to 20 percent of current ED visits historically resulting in an inpatient admission of either an adolescent or an adult will be averted through admission to psychiatric partial hospitalization, either from the ED or before presenting there at all. AAMC has taken this reduction into account in the analysis of expected ongoing need for inpatient admission from the ED. The additional impacts of psychiatric partial hospitalization on inpatient utilization are expected to be on length of stay and rates of readmission. AAMC's need analysis is based on an inpatient length of stay equal to that of Maryland acute care hospitals with inpatient psychiatric beds that also have psychiatric partial hospitalization available at their facilities as a step-down from inpatient care. The impact on readmission rates is difficult to quantify from current data, but is expected to be positive although marginal.

Crisis residential services are currently available in Anne Arundel County through Harbor House, which maintains beds in Glen Burnie and Edgewater. Diversion of avoidable

inpatient utilization through use of this service by Anne Arundel Crisis Response and mental health clinicians in the AAMC ED is already evident to some extent, and will be increased as it is employed in concert with partial hospitalization at AAMC starting this year.

In 2016, AAMC will focus on the target population by engaging behavioral health resources, skilled nursing facilities (SNFs), public and private sector care coordinators, and physicians to create a better-integrated and aligned community of practice, consistent with AAMC's Vision 2020 – Living Healthier Together. Collaborating with non-traditional partners in order to achieve its population health improvement goals, AAMC has engaged with UM BWMC in a Regional Partnership: the Bay Area Transformation Partnership (BATP). BATP addresses the community's behavioral health needs as well as social and medical needs. New collaborations will be formed and existing relationships will be expanded with community-based behavioral health resources and private and public sector providers of care management in order to improve outcomes for AAMC's target population.

Accordingly, establishing freestanding mental health hospital on the Riva Road property is the most cost-effective alternative to achieving the goals of the project. AAMC has taken into account the impact of population health initiatives that it will undertake to lessen admissions and length of stay in its need analysis demonstrating the need for 16 beds.

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

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

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

- Complete applicable Revenues & Expenses (**Tables G, H, J and K as applicable**), and the Work Force information (**Table L**) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable.

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

- Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies.

Applicant Response:

Funding Plan

The capital cost of the project will be paid for in full with cash reserves of Anne Arundel Health System, Inc., the adequacy of which is shown on its balance sheet in Exhibit 9. The Applicant reserves the right to request an allowance from the HSCRC for capital in the rates of the new mental health hospital in the future.

Tables

Please see Appendix 1 – Tables J, K, and L. Tables G and H are inapplicable because this is a new facility. These tables demonstrate that the project is sustainable and achieves a positive margin by the second year of operation.

Recruitment

AAMC will attract top talent and support recruitment of mental health clinicians to this shortage region by operating a continuum of mental health services on a single site, providing a training environment for clinicians at all levels. The facility will be recognized for expertise in all areas of behavioral medicine, backed by one of the largest independent medical centers in Maryland. Amidst a shortage of psychiatrists and other mental health professionals, this campus model will provide an advantage to attract mental health providers to this Health Professionals Shortage Area.

- **Core Principles**.
  - AAMC has a principle of open competition in its approach to recruitment; therefore all available positions are advertised both internally & externally.
  - AAMC will seek to recruit the best candidate for the position based on merit and required qualification.
  - AAMC will provide appropriate training, development, and support to those involved in the recruitment and selection activities.
  - AAMC will continuously monitor the cost effectiveness and efficacy of the selection and recruitment process.
  - AAMC will treat all documentation relating to the applicant as confidential.
- **Recruitment and Selection Procedure**. The interview process and selection will follow all guidelines as listed in Anne Arundel Health System's Policy HR 8.1.03 (please refer to Exhibit 10).

Community Support

> "Because the public mental health system no longer provides the safety net for individuals whose illnesses require containment and prompt stabilization, it has become incumbent on the private sector to provide services needed to assure personal and public safety."
>
> Steven S. Sharfstein, M.D., President and CEO
> Sheppard Pratt Health System
> From letter of support for AAMC's CON

More than a decade ago, when Crownsville State Hospital Center closed its doors, AAMC braced for a tidal wave of patients seeking mental health services. But the need for mental health services is far greater than AAMC's emergency department can fulfill. According to the National Alliance on Mental Illness, "about a third of all people experiencing mental illnesses and about half of people living with severe mental illnesses also experience substance abuse. These statistics are mirrored in the substance abuse community, where about a third of all alcohol abusers and more than half of all drug abusers report experiencing a mental illness."

That is why two years ago, AAMC expanded its mental health services to include an ambulatory outpatient clinic located across from the Riva Road property in order to treat patients locally, help them stay out of the hospital and resume their lives as normally as possible.

Still, this is not enough. More than 1,100 patients every year are transferred from AAMC's ED to inpatient units some 40 miles away. Staff, community leaders and families alike ask: why can't these patients be treated here? Pressure has mounted every year for AAMC to respond to this critical service gap.

Responding to this need, AAMC's application for a mental health hospital is drawing widespread support from a broad cross-section of the community. In the form of resolutions and letters of support, these expressions reflect a fervent desire to have inpatient psychiatric care at AAMC.

The Medical Community: Physicians, Hospitals, and Payors

First, there is strong support from AAMC's psychiatrists, primary care physicians, ED staff, and licensed clinical social workers who care for patients with mental health problems every day. As Dr. Ray Hoffman, Medical Director of the Division of Mental Health and Substance Use affirms: "the gaps and fragmentation in current systems and programs, and the lack of inpatient care in proximity to communities where our patients and their families live and work, can be addressed most effectively and efficiently with a vertically-integrated center for mental health treatment." AAMC's Director of emergency services, Dr. Michael Remoll, states that despite "a robust system of mental health consultants, substance abuse specialists, and psychiatrists who provide acute mental health evaluations and treatment," there is a critical shortage of inpatient beds.

Secondly, there also is enthusiastic endorsement from other hospitals—Johns Hopkins, Sheppard Pratt, and Calvert Memorial—as well as testimony from employees at Clifton T. Perkins. Acknowledged leader in the field, Sheppard Pratt's Steven Sharfstein, MD, notes that AAMC "has an active psychiatric emergency room and the need for general adult beds and related services in which to stabilize those needing higher levels of care is overdue." Hopkins' Ron Peterson notes that "currently AAMC provides many of the mental health and substance use services upon which the community relies…However, without an inpatient mental health unit, patients needing that higher level of care must be transferred and often experience detrimental delays in treatment as they wait for availability at another facility."

Among the strongest endorsements is this from the payor community: Chet Burrell, CEO of CareFirst BlueCross BlueShield states that, "We believe that AAMC offers a cost effective opportunity within the Central Maryland region" to address the issue of inpatient services for mental health.

The Mental Health Community: Allied partners

AAMC has fostered and enjoyed strong relationships with leading area mental health organizations, all of which are eager to see this project realized. Anne Arundel County Health Officer Dr. Jinlene Chan acknowledges that "an inpatient mental health unit would create a more seamless experience for those needing this level of care." Tracey Myers-Preston, Executive Director Maryland Addictions Directors Council, points to AAMC's reputation for high quality

programs and notes "an inpatient mental health unit…will ensure that adults and teens facing crises in mental health and substance use in Anne Arundel County have full access to appropriate levels of care." The County Mental Health Agency as well as Oasis and Arundel Lodge, two community-based service agencies, all fully support the project. Perhaps most compelling is the plea from Fred Delp, Executive Director of the National Alliance on Mental Illness for Anne Arundel County, recounting his own son's challenges: "People with mental illness in our county sit in a hospital emergency room for days until a bed can be found many miles away." They are "stung with the already existing stigma and they find out there are not enough beds in Anne Arundel County when their loved ones need immediate acute psychiatric care."

Elected officials: Representing constituents

At all levels of government, AAMC has received unwavering support for this proposal. U.S. Congressman John Sarbanes, Speaker of the Maryland House of Delegates Michael Busch, Senator John Astle, Delegate Herb McMillen, and the full Anne Arundel County delegation to the General Assembly all demonstrate their support. Anne Arundel County Executive Steve Schuh along with a resolution from the Anne Arundel County Council, as well as similar support from the Queen Anne's County Commissioners, indicate strong endorsement at the county level. Finally, Annapolis Mayor Michael Pantelides also expresses the City's solid backing for this project.

Faith-based Communities: Reflecting area residents

Several of the area's largest churches and faith-based organizations have expressed their keen interest in seeing AAMC realize its inpatient mental health unit. A few of these, like First Presbyterian Church, Heritage Baptist, and St. Mary's Catholic Church, represent huge constituencies.

Community Organizations

Organizations with whom AAMC partners on community-based projects are demonstrating their support for this project. President and CEO of United Way of Central Maryland Mark Furst notes "our research indicates that mental and behavioral health needs are growing in every jurisdiction, including Anne Arundel County" where "mental health related calls to the 2-1-1 Maryland call center increased 14% from 2013 to 2015." Melissa Curtin, Executive Director of the Community Foundation of Anne Arundel County, cites "an urgent need for increased inpatient mental health and substance use services in Anne Arundel County." Others include the Anne Arundel Community College, A.A.Co. Partnership for Children and Youth & Families. The Maryland Advocacy Policy Center, the Severna Park Community Center and the Morris H. Blum Community Center.

Boards and Volunteers

This project has the full endorsement of both AAMC's Board of Trustees and its Foundation Board of Directors. These are expressed through board resolutions and individual letters from board members. In addition, AAMC has received letters of support from many individuals who recount personal stories of poor or fragmented care due to the lack of inpatient mental health services in the county. Of particular note is the tragic story of John and Jill DePaola, whose son died after harrowing experiences trying to find care during a heart-

wrenching series of too many crises. The DePaolas now volunteer with AAMC to help realize its full vision for "a comprehensive approach to mental illness" and to help "facilitate the efforts of AAMC and the community to attack this serious medical challenge."

Through the AAMC Foundation, business and professional leaders are voicing their support as well. Many believe so strongly that AAMC should have a comprehensive mental health program that they have pledged to raise a minimum of $5 million once the CON is approved to help fund the construction and additional program development for this initiative. The Foundation and its Mental Health and Pathways Philanthropy Council, comprised of 9 dedicated and passionate community leaders, already have raised more than $500,000 to support existing mental health services.

Finally, there is a letter of support worth noting for its author. Maryland's former lieutenant governor Kathleen Kennedy Townsend is no stranger to mental health issues and substance use. Having spent time in Anne Arundel County she knows this area and its needs. When apprised of AAMC's proposed CON for an inpatient mental health unit, Ms. Townsend responded swiftly and enthusiastically with her endorsement.

In conclusion, all sectors of AAMC's community are urging the MHCC to grant the requested CON and to provide mental health patients the critical inpatient care they need.

Performance Requirements and Compliance

This project, if approved as a special hospital, is subject to the performance requirements set forth in COMAR 10.24.01.12C(3)(a). If the project is approved, AAMC must obligate 51 percent of the approved capital obligation within 24 months of the approved date of the CON, initiate construction no later than 4 months after the effective date of the capital obligation, and document, license, and complete the project within 24 months after the effective date of the binding capital obligation.

Assuming the CON is approved, AAMC intends to complete construction in the fall of 2018.

CON Application & Process Timeline

File CON	March 29, 2016
MHCC Completeness Questions	April – August 2016
CON Docketed	June 2016
CON Reviewed	September 2016
CON Decision	Nov 2016

Process for Project Design and Construction

AAMC has selected an architectural firm, CR Goodman Associates of Annapolis of Maryland, as the lead architect. AAMC has engaged a team of necessary design consultants which include a civil engineering firm, traffic engineer, mechanical and electrical design firm and a low voltage consultant. Several meetings have occurred between AAMC, the design team, and the Anne Arundel County planning and zoning and permitting staff to discuss the project, zoning, other related requirements and schedule.

A construction management firm will be engaged early on in the project to provide preconstruction services and selection will follow AAMC's procurement policies. After the pre-construction is completed and permit documents are submitted to the respective authorities, a construction management firm will be selected and contracted with to perform the site work and to construct the building. Fifty-one percent of the funds necessary to construct the project will be committed within 12 months of the approved CON date. Construction will be initiated within four months of the contract execution date.

Audited Financial Statements

Please see Exhibit 9, Anne Arundel Health System Final Financial Statements 2014 and 2015.

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

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

INSTRUCTIONS: List all of the Certificates of Need that have been issued to the applicant or related entities, affiliates, or subsidiaries since 2000, including their terms and conditions, and any changes to approved CONs that were approved. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Applicant Response:

AAMC has been issued the following CON's since 2000 and has complied with all conditions:

1. 2006 CON – for New 9-Story Addition South Tower - Docket No. 04-02-2153
2. 2008 CON Modification – Docket No. 04-2-2153
3. 2010 CON – 6th Floor South Tower 30 MSGA Bed - Docket No. 10-02-2308
4. 2012 CON – 3rd Floor South Tower 30 MSGA Bed - Docket No. 12-02-2388

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

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

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project[24];

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

c) On costs to the health care delivery system.

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

Applicant Response:

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

AAMC submits that the volume shifts associated with its proposed mental health hospital will not affect any existing inpatient psychiatric unit in such measure as to compromise the financial viability of the existing program. This is based on the following set of assumptions:

- AAMC's patient volume will largely represent the patient volume currently served in AAMC's ED and transferred to other hospitals for admission.

- The patient volume currently transferred from AAMCs ED can serve as the basis for projecting the impact of a new program on other hospitals; the distribution of cases currently transferred, by hospital, represents the distribution of total admissions expected to be retained once the new AAMC program opens. This distribution is presented on Chart 39 (page 93):

[24] Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to need for services, the relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions.

Chart 39
Current Transfers From AAMC For Psychiatric Admission
FY 2015

Admitting Hospital	Current # AAMC Transfers	% of AAMC Transfers
Sheppard Pratt	669	75.7%
Bon Secours	36	4.1%
UM Shore Dorchester	31	3.5%
Calvert Memorial	23	2.6%
Washington Adventist	20	2.3%
Laurel Regional	14	1.6%
All other hospitals	91	10.2%
Total	**884**	**100%**

Source: HSCRC Abstract Dataset
Note: Total adult transfer volume limited to "AAMC-eligible" volume and excludes Prince George's County volume as the basis for projections

- AAMC's transfer volume currently accounts for only 8 percent of the total psychiatric admissions at Sheppard Pratt and less than 5 percent of the total psychiatric admissions at UM Shore at Dorchester. AAMC's transfer volume accounts for no more than 4 percent of total psychiatric admissions at any other Maryland hospitals. Chart 40 below provides further data on transfers from AAMC.

Chart 40
Current Transfers from AAMC to Other Maryland Hospitals for Admission to Psychiatric Units
FY 2015

Hospital	# Transfers	# Total Admissions in Psych Unit	AAMC Transfers as a % of Psych Unit Admits
Sheppard Pratt	669	9,151	7.3%
Bon Secours	36	1,552	2.3%
UM Shore Dorchester	31	682	4.5%
Calvert Memorial	23	654	3.5%
Washington Adventist	20	1,597	1.3%
Laurel Regional	14	696	2.0%
All other hospitals	91	34,723	0.3%
Total	**884**	**49,055**	**1.8%**

Source: HSCRC FY2015 Experience Reports
Note: Total adult transfer volume limited to "AAMC-eligible" volume and excludes Prince George's County volume as the basis for projections

AAMC projected the number of admissions expected to shift in FY 2022 from existing programs to AAMC's mental health hospital using the following methodology:

- Total discharge volume for the new AAMC program was projected based on a defined service area and based on AAMC's market share targets. Volume assumptions are

outlined in Part IV, Section E (page 61) and form the basis for staffing models and financial projections. Annual discharge projections for the proposed mental health hospital are below on Chart 41:

Chart 41
AAMC Mental Health Hospital
Annual Discharges

	FY 2019, 10 mo	FY 2020	FY 2021	**FY 2022**
# Discharges	718	879	886	**892**

- The current transfer distribution, by hospital, was applied to the total AAMC volume projection for FY 2022 to project the number of admissions expected to shift, by hospital, based on the premise that current transfer volume would be admitted to the new AAMC mental health hospital rather than transferred to a second hospital, as depicted on Chart 42:

Chart 42
FY 2022 Projected Volume = 892 Admissions

Source of Shift	**% of AAMCs Current Transfers**	**# Admissions Expected to Shift[8]**
Sheppard Pratt	75.7%	675
Bon Secours	4.1%	36
UM Shore Dorchester	3.5%	31
Calvert Memorial	2.6%	23
Washington Adventist	2.3%	20
All other hospitals	11.8%	106
Total	**100.0%**	**892**

- Before assessing the impact of this shift on existing programs, a baseline projection was prepared for each existing unit to reflect a use rate decline. A 15 percent decline factor was applied to volume at each hospital to reflect the projected use rate decline. For purposes here, the use rate decline across hospitals is projected to be comparable to the use rate decline projected for AAMC's service area.[25] With this factor applied, projected volume for acute psychiatric care is presented *in the absence of AAMC's new program.*

- The projected volume shift to AAMC was then applied to calculate the effect of the shift

25 In fact, this factor is likely to be overstated for several of these hospitals: A very aggressive decline factor of 17% was projected for AAMC's service area based on the availability of a partial hospitalization program and a network of community-based resources to support community-based care. Therefore, FY 2022 inpatient volume at other hospitals will likely be higher than presented here, and the impact of AAMC's program likely to be even more modest.

of volume on existing programs. As stated earlier, the projected volume shift largely reflects existing patient volume at AAMC's ED that will be retained at AAMC, rather than transferred.

- This assessment is presented on Chart 43 below.

Chart 43
Impact of the AAMC Mental Health Hospital on Existing Psychiatric Units
FY 2022

			With No AAMC Program				*With AAMC Program @ 892 Discharges*		
	FY2015 AAMC Transfers: AAMC-Eligible		FY2015 Current Contribution		15% Volume Decline Attrib to Use Rate		FY2022 Projected Impact		
Hospital	# AAMC Transfers	% AAMC Transfers	Total Psych Admissions FY2015	AAMC Transfers as % of Hospital Psych	# Psych Admissions FY2015	# Psych Admissions FY2022	% AAMC Transfers	# of Disch Projected to Shift	Impact: % of Total Discharges
Sheppard Pratt	669	75.7%	9,151	7.3%	9,151	7,778	75.7%	675	8.7%
Bon Secours	36	4.1%	1,552	2.3%	1,552	1,319	4.1%	36	2.8%
UM Shore, Dorchester	31	3.5%	682	4.5%	682	580	3.5%	31	5.4%
Calvert Memorial	23	2.6%	654	3.5%	654	556	2.6%	23	4.2%
Washington Adventist	20	2.3%	1,597	1.3%	1,597	1,357	2.3%	20	1.5%
Laurel Regional	14	1.6%	696	2.0%	696	592	1.6%	14	2.4%
All Other Hospitals	91	10.3%	34,723	0.3%	34,723	29,515	10.3%	92	0.3%
Total	**884**	**100.0%**	**49,055**	1.8%	**49,055**	**41,697**	**100.0%**	**892**	**2.1%**

Source: HSCRC Abstract Dataset
Notes:
(1) Total admissions in psychiatric unit documented by HSCRC Experience Report
(2) Use rate decline factor represents percentage decline in AAMC-eligible mental health discharges projected for AAMC service area, 2015-2022
(3) AAMC transfers do not include PG County residents

Assessment

- The new facility is projected to have the largest impact on Sheppard Pratt volume, as the intent is to provide residents of Anne Arundel and Queen Anne's Counties with a closer alternative to Sheppard Pratt and a care management program that is integrated with patients' medical providers. Sheppard Pratt represents the highest volume program in the State of Maryland, reporting more than 9,100 admissions in CY 2015. Current transfers from AAMC account for only 7 percent of Sheppard Pratt's total admissions. Sheppard Pratt is supportive of the new program at AAMC, and has submitted a letter indicating their support. AAMC and Sheppard Pratt have also signed a Memorandum of Understanding in order for AAMC to consult with Sheppard Pratt in the design of the new inpatient psychiatric program (see Exhibit 11). In the coming 2 years, Sheppard Pratt plans to expand programs in specialty areas that AAMC does not expect to develop, including adolescent psychiatry and specialized areas within geriatric psychiatry.

- The new facility is expected to redirect fewer than 40 discharges currently served at UM Shore Medical Center at Dorchester and fewer than 40 discharges currently served at Bon Secours. Going forward, this volume is projected to represent only 5 percent of the total psychiatric admissions at Shore Medical Center and 3 percent of the total psychiatric

admissions at Bon Secours.[26]

- Based on CY 2014 data from the District of Columbia Hospital Association (DCHA), only 10 adult discharges from Anne Arundel County were served in acute psychiatric units at Washington, DC's general hospitals.

b) On access to health care services for the service area population

AAMC has defined its service area based on whole-county boundaries, reflecting the limited dataset made available; this hospital dataset does not provide zip code-specific data for freestanding psychiatric facilities. Therefore, AAMC's analysis of the impact on access is based on whole-county populations.

AAMC will reduce driving time for acute psychiatric care for patients and families living in Queen Anne's and areas of Anne Arundel County, and encourage more active engagement of family members in the treatment process by providing a service site closer to home. The new facility will have a considerable impact on drive time for residents of Queen Anne's County. Nearly 30 percent of residents from this county rely on Sheppard Pratt for inpatient care, entailing more than one hour's drive time. In contrast, the drive time to AAMC averages 30 minutes. More detail on distance and drive time is re-presented below from Chart 26:

Chart 26
Nearest Mental Health Facility by County
(re-presented from page 59)

County	Closest Mental Health Facility	# Miles to Existing Mental Health Unit	# Miles to AAMC Mental Health Hospital
Anne Arundel	Baltimore Washington Hospital Center	19.5 miles	2.9 miles
Queen Anne's	UM Shore - Dorchester	36.3 miles	29.6 miles
	Sheppard Pratt	71.4 miles	29.6 miles

County	Closest Mental Health Facility	# Minutes to Existing Mental Health Unit	# Minutes to AAMC Mental Health Hospital
Anne Arundel	Baltimore Washington Hospital Center	21 minutes	8 minutes
Queen Anne's	UM Shore - Dorchester	44 minutes	32 minutes
	Sheppard Pratt	78 minutes	32 minutes

Source: Google Maps

The new facility will also improve access to partial hospitalization services for residents of the two-county region by increasing the number of treatment slots and by offering direct admission from outpatient care environments and the ED. Partial hospitalization programs are currently offered at UM BWMC and at Sheppard Pratt, but the program at UM BWMC routinely

26 Based on FY2015 HSCRC Experience Report, volume for Psychiatric Unit

operates at full capacity. In fact, in the last two years, AAMC has been able to refer only one patient from the AAMC ED to the partial hospitalization program at UM BWMC. Clearly, the new partial hospitalization program will improve access to this level of care for area residents who have not been provided with adequate access to this level of care.

c) On costs to the health care delivery system

AAMC will provide a lower-cost alternative for inpatient psychiatric care and reduce the per capita costs of specialty care for Maryland residents by shifting volume from higher cost facilities to AAMC. AAMC will operate as one of the low-charge psychiatric providers in the State of Maryland on a case-mix adjusted basis. The average payment per case at AAMC's new program is projected to be 33 percent below the statewide average and 43 percent lower relative to Sheppard Pratt, where the majority of Anne Arundel County residents are now served. Therefore, the new program at AAMC can be expected to produce more than $3.3 million of savings to the state *and* offer lower-cost options to patients who are likely to bear an increasing percentage of copayments going forward. The combined effects of a lower-cost hospital site, a reduction in readmissions, and reduction in admissions will produce more favorable performance under the Maryland waiver.

Charts 24 and 25 on the following pages re-present this analysis and the projected impact on patients, payers, and the State of Maryland performance.

Chart 24
(re-presented from page 56)
Total Hospital Average Charge per Case (CPC) Comparison
Estimated FY 2016

Provider	Estimated FY 2016 Avg Chg @ CMI=1.00
Johns Hopkins Hospital	$32,169
University of Maryland Medical Center	25,482
Sheppard Pratt (Private)	23,758
Johns Hopkins Bayview Medical Center	23,583
UM Shore Medical Center at Dorchester	19,024
Adventist Behaviorial Health, Potomac Ridge, Brooklane	18,324
Calvert Memorial Hospital	18,140
Sinai Hospital	17,143
Union Hospital of Cecil County	16,727
MedStar Franklin Square Hospital Center	16,594
UM Baltimore Washington Medical Center	16,322
Harford Memorial Hospital	16,063
UM St. Joseph Medical Center	15,205
Frederick Memorial Hospital	14,684
Peninsula Regional Medical Center	14,657
Northwest Hospital Center	14,587
Carroll Hospital Center	14,578
Suburban Hospital	13,127
Prince George's Hospital Center	12,908
MedStar Union Memorial Hospital	12,834
Meritus Medical Center	12,658
UMMC Midtown Campus	12,096
Washington Adventist Hospital	12,075
MedStar St. Mary's Hospital	11,884
Bon Secours Hospital	11,747
Holy Cross Germantown	11,457
Howard County General Hospital	11,436
Laurel Regional Hospital	11,245
Western Maryland Regional Medical Center	11,101
MedStar Montgomery General Hospital	11,097
MedStar Southern Maryland Hospital Center	9,841
Total	**$20,127**
Anne Arundel Mental Health Hospital	**$13,460**

[1] MD Hospital CPC calculated as Hospital-specific total CPC @ CMI 1.00 for Adult Psychiatric APR-DRGs 750-760, 779-790, patients age 18 or greater price leveled to FY 2016 dollar (2.4% for acute general hospitals and 1.9% for Psychiatric Specialty hospitals)

[2] Due to data availability, Potomac Ridge, Brooklane and Adventist Behaviorial Health average charge is combined

Chart 25
(re-presented from page 58)
AAMC Mental Health Hospital Reduction in the Costs of Acute Psychiatric Services
FY 2023

	Est. FY 2016 - Charges[1]				
	Cases	CPC@ CMI of 0.5679[4]	Revenue	VCF	Revenue @ VCF
AAMC Projected Psych Cases[2]	892	$7,644	$6,818,753	100%	$6,818,753
Incremental Revenue	892	7,644	$6,818,753	100%	$6,818,753
Impact on Psych Hospitals:					
University of Maryland	(9)	14,472	(131,426)	50%	(65,713)
Johns Hopkins	(3)	18,270	(55,306)	50%	(27,653)
UM Shore Medical Center at Dorchester	(31)	10,804	(337,965)	50%	(168,983)
Lifebridge Sinai Hospital	(6)	9,736	(58,947)	50%	(29,473)
Bon Secours	(36)	6,672	(242,349)	50%	(121,175)
MedStar Franklin Square	(8)	9,424	(76,076)	50%	(38,038)
Washington Adventist	(20)	6,858	(138,399)	50%	(69,200)
MedStar Montgomery General	(3)	6,302	(19,078)	50%	(9,539)
Suburban Hospital	(4)	7,455	(30,091)	50%	(15,045)
MedStar Union Memorial	(10)	7,289	(73,546)	50%	(36,773)
MedStar Saint Mary's Hospital	(1)	6,749	(6,811)	50%	(3,405)
Johns Hopkins Bayview (acute)	(15)	13,394	(202,725)	50%	(101,363)
Union of Cecil	(4)	9,500	(38,343)	50%	(19,171)
UMM Center Midtown Campus (acute)	(1)	6,869	(6,932)	50%	(3,466)
Calvert Memorial	(23)	10,303	(239,103)	50%	(119,551)
Lifebridge Northwest Hospital	(6)	8,284	(50,155)	50%	(25,077)
Howard General Hospital	(3)	6,495	(19,661)	50%	(9,830)
Greater Laurel	(14)	6,386	(90,216)	50%	(45,108)
MedStar Southern Maryland	(7)	5,589	(39,478)	50%	(19,739)
UM Saint Joseph	(5)	8,635	(43,567)	50%	(21,783)
Sheppard Pratt (Private)	(675)	13,493	(9,108,585)	100%	(9,108,585)
Potomac Ridge (Private)[3]	(6)	10,407	(63,007)	100%	(63,007)
Total Estimated Charges	(892)	$12,412	($11,071,766)	91%	($10,121,679)
Net Impact on the System			**($4,253,012)**		**($3,302,925)**

Notes:

[1] MD Hospital CPC calculated as Hospital-specific total CPC @ CMI 1.00 for Adult Psychiatric APR-DRGs 750-760, 779-790, patients age 18 or greater price leveled to FY 2016 dollar (2.4% for acute general hospitals and 1.9% for Psychiatric Specialty hospitals

[2] AAMC projected cases for FY 2023

[3] Due to data availability, Potomac Ridge average charges were based on the averge charge of Brooklane, Potomac Ridge and Adventist Behaviorial Health for APR-DRGs 750-760, 779 - 790, patients age 18 or greater price leveled FY 2016 based on a 1.9% Update Factor

[4] Reflects AAMC Projected CMI of 0.5679

10.24.01.08G(3)(a). The State Health Plan.

To respond adequately to this criterion, the applicant must address each applicable standard from each chapter of the State Health Plan that governs the services being proposed or affected, and provide a direct, concise response explaining the project's consistency with each standard. In cases where demonstrating compliance with a standard requires the provision of specific documentation, documentation must be included as a part of the application.

Every acute care hospital applicant must address the standards in **COMAR 10.24.10: Acute Care Hospital Services**. A Microsoft Word version is available for the applicant's convenience on the Commission's website. Use of the *CON Project Review Checklist for Acute Care Hospitals General Standards* is encouraged. This document can be provided by staff.

Other State Health Plan chapters that may apply to a project proposed by an acute care hospital are listed in the table below. A pre-application conference will be scheduled by Commission Staff to cover this and other topics. It is highly advisable to discuss with Staff which State Health Plan chapters and standards will apply to a proposed project before application submission. Applicants are encouraged to contact Staff with any questions regarding an application.

COMAR 10.24.10 (ACUTE CARE HOSPITAL SERVICES CHAPTER)

.04 STANDARDS.

A. General Standards.

The following general standards encompass Commission expectations for the delivery of acute care services by all hospitals in Maryland. Each hospital that seeks a Certificate of Need for a project covered by this Chapter of the State Health Plan must address and document its compliance with each of the following general standards as part of its Certificate of Need application. Each hospital that seeks a Certificate of Need exemption for a project covered by this Chapter of the State Health Plan must address and demonstrate consistency with each of the following general standards as part of its exemption request.

(1) Information Regarding Charges.

Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;
(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and
(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

Applicant Response:

(a) AAMC maintains a written policy titled *Patient Financial Services – Hospital*

Financial Assistance, Charity Care, Billing & Collection Policy (Exhibit 12). That policy sets forth AAMC's procedure for providing a Representative List of Services and Charges. The list is available to the public in written form upon request or at any time by accessing http://www.aahs.org/patients-visitors/billing.php.

(b) The Patient Financial Services – Hospital Financial Assistance, Charity Care, Billing & Collection Policy sets forth the procedure for responding to individual requests for current charges for specific services and procedures. Requests are directed to the ACP Financial Coordinator (or the appropriate departmental Financial Coordinator) and the Coordinator responds to the request promptly according to the prescribed procedure.

(c) All AAMC registration staff and Financial Coordinators are educated and trained on appropriately handling inquiries regarding charges and services, including the use of the Patient Financial Services – Hospital Financial Assistance, Charity Care, Billing & Collection Policy.

(2) Charity Care Policy.

Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.

(a) The policy shall provide:
  (i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.
  (ii) Minimum Required Notice of Charity Care Policy.
    1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;
    2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and ED areas within the hospital; and
    3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

Applicant Response:

AAMC maintains a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.

(a) AAMC maintains a written policy titled *Patient Financial Services – Hospital Financial Assistance, Charity Care, Billing & Collection Policy* (Exhibit 12). That policy meets the requirements set forth in (a)(i) and (a)(ii) above. It also describes AAMC's procedure for providing appropriate notification to the public and patients regarding the charity care available at AAMC. If charity care is requested, the patient is given a determination of probable eligibility within two business days of receipt of a patient's request for charity care services or application for medical assistance.

(b) AAMC's charity care as a percentage of total operating expense is projected to be 1.5 percent, which falls within the bottom quartile for Maryland hospitals as reported in the most recent Health Services Cost Review Commission Community Benefit Report. AAMC has a very generous charity care policy, providing 100 percent charity to households at or below 200 percent of the U.S. Poverty Line and a sliding fee scale for households at or below 330 percent of the U.S. Poverty Line.

Although AAMC's charity care is lower than that provided by other hospitals in Maryland, AAMC is committed to contributing to the community and supporting vulnerable populations. This is demonstrated by the significant community services and numerous outreach programs AAMC provides to the community. AAMC's commitment to serving the community is demonstrated by the fact that AAMC's total Community Benefit for FY 2015 was $40,713,388. In FY 2014, AAMC was in the top third for all hospitals in Maryland for total benefit (see Exhibit 13).

(3) <u>Quality of Care</u>.

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:
  (i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;
  (ii) Accredited by the Joint Commission; and
  (iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90 percent level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

Applicant Response:

AAMC provides high quality care, as evidenced by the following accreditation and recognitions:

(a) (i) AAMC is in possession of Maryland Department of Health and Mental Hygiene Office of Health Care Quality License Number 02003 issued on November 23, 2013 through February 23, 2017.

(ii) AAMC is accredited by The Joint Commission and earned the Delmarva Quality Improvement Award in 2013 and 2014. The last full survey by The Joint Commission successfully concluded on November 14, 2013. AAMC is also accredited by the Joint Commission as an Advanced Primary Stroke Center awarded in October of 2014. Pathways has been accredited by the Joint Commission since its inception in 1992. The last full survey by the Joint Commission successfully concluded on July 3, 2013. Pathways is certified by the Maryland Department of Health and Mental Hygiene to provide substance use disorder treatment in eight different levels of care.

(iii) AAMC is in full compliance with the conditions of participation of CMS.

(b) Forty-five of the 46 measures on the Maryland Health Care Commission Quality Data Website were applicable to AAMC. Of the 45 applicable measures, AAMC was below average in a total of eight measures. Exhibit 14 identifies the measures, Maryland State Mean, AAMC's data, and applicable action plans in place to improve performance (MHCC data from April 1, 2014 – March 31, 2015).

COMAR 10.24.07 (Psychiatric Services Chapter)

Approval Policies

Availability

AP 1a. The projected maximum bed need for child, adolescent, and adult acute psychiatric beds is calculated using the Commission's statewide child, adolescent, and adult acute psychiatric bed need projection methodologies specified in this section of the State Health Plan. Applicants for Certificates of Need must state how many child, adolescent, and adult acute psychiatric beds they are applying for in each of the following categories: net acute psychiatric bed need, and/or state hospital conversion bed need.

Applicant Response:

There is no published bed need projection in effect for child, adolescent and adult psychiatric beds, and the need projection methodology contained in the State Health Plan Chapter is recognized as obsolete. Accordingly, AAMC prepared a needs assessment and a volume projection for its proposed mental health hospital based on hospital utilization patterns and based on other indicators that identify community need. AAMC's analysis firmly supports the need for a 16-bed mental health hospital; the new hospital is expected to operate at above 90 percent occupancy beginning in Year 1 of operation. This reflects the very large number of patients currently seeking care at AAMC through its ED; **indeed, the patient volume for the proposed unit largely exists at AAMC, waiting to be served.**

Please refer to the Applicant's response to COMAR 10.24.01.08G(3)(b) for the Applicant's complete response to AP 1a.

AP 1b. A Certificate of Need applicant must document that it has complied with any delicensing requirements in the State Health Plan or in the Hospital Capacity Plan before its application will be considered.

Applicant Response:

There are no delicensing requirements applicable to this project so this standard does not apply.

AP 1c. The Commission will not docket a Certificate of Need application for the "state hospital conversion bed need" as defined, unless the applicant documents written agreements with the Mental Hygiene Administration. The written agreements between the applicant and the Mental Hygiene Administration will specify:

(i) the applicant's agreement to screen, evaluate, diagnose and treat patients who would otherwise be admitted to state psychiatric hospitals. These patients will include: the uninsured and underinsured, involuntary, Medicaid and Medicare recipients;

(ii) that an equal or greater number of operating beds in state facilities which would have served acute psychiatric patients residing in the jurisdiction of the applicant

hospital will be closed and delicensed, when the beds for the former state patients become operational;

(iii) that all patients seeking admission to the applicant's facility will be admitted to the applicant's facility and not be transferred to the state psychiatric hospital unless the applicant documents that the patient cannot be treated in its facility; and

(iv) that the applicant and the Mental Hygiene (MHA) Administration will be responsible for assuring financial viability of the services, including the payment of bad debt by DHMH as specified in the written agreement between MHA and the applicant.

Applicant Response:

This standard is not applicable because this project does not involve hospital conversion beds.

AP 1d. Preference will be given to Certificate of Need applicants applying for the "net adjusted acute psychiatric bed need," as defined, who sign a written agreement with the Mental Hygiene Administration as described in part (i) and (iii) of Standard AP 1c.

Applicant Response:

This criterion does not apply; this application is not part of a comparative review.

AP 2a. All acute general hospitals with psychiatric units must have written procedures for providing psychiatric emergency inpatient treatment 24 hours a day, 7 days a week with no special limitation for weekends or late night shifts.*

Applicant Response:

This standard is not applicable to the proposed project. The beds will not be located in an acute general hospital.

AP 2b. Any acute general hospital containing an identifiable psychiatric unit must be an emergency facility, designated by the Department of Health and Mental Hygiene to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition.*

Applicant Response:

This standard is not applicable to the proposed project. The beds will not be located in an acute general hospital.

AP 2c. Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room.*

Applicant Response:

This standard is not applicable to the proposed project. The beds will not be located in an acute general hospital.

AP 3a. Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

Applicant Response:

AAMC's acute inpatient psychiatric program will include services required by this standard. The program will be accredited by the Joint Commission on Accreditation of Healthcare Organizations.

AP 3b. In addition to the services mandated in Standard 3a., inpatient child and adolescent acute psychiatric services must be provided by a multidisciplinary treatment team which provides services that address daily living skills, psychoeducational and/or vocational development, opportunity to develop interpersonal skills within a group setting, restoration of family functioning and any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. Applicants for a Certificate of Need for child and/or adolescent acute psychiatric beds must document that they will provide a separate physical environment consistent with the treatment needs of each age group.

Applicant Response:

This standard is not applicable because the proposed project does not include child or adolescent services.

AP 3c. All acute general hospitals must provide psychiatric consultation services either directly or through contractual arrangements.

Applicant Response:

This standard is not applicable to the proposed project. The beds will not be located in an acute general hospital.

AP 4a. A Certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.

Applicant Response:

This standard is not applicable because the proposed project does not include child or adolescent services.

AP 4b. Certificate of Need applicants proposing to provide two or more age specific acute psychiatric services must provide that physical separations and clinical/programmatic distinctions are made between the patient groups.

Applicant Response:

This standard is not applicable because the proposed project does not include two or more age-specific acute psychiatric services.

Accessibility

AP 5. Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available:

(i) intake screening and admission;
(ii) arrangements for transfer to a more appropriate facility for care if medically indicated; or
(iii) necessary evaluation to define the patient's psychiatric problem and/or
(iv) emergency treatment.

Applicant Response:

i. **Intake screening and admissions** - If a patient is being referred from an acute hospital ED (ED), the clinical information provided by the licensed evaluators in the ED will be reviewed with the psychiatrist screening the cases and a decision regarding admission will be made. Admissions to the inpatient unit from sources other than an acute hospital ED will be presented to the unit's intake coordinator by clinicians functioning in community programs, and reviewed by one of the unit's psychiatrists prior to direct (non-ED) admissions being accepted. Patients presenting for direct admission after this referral and screening will be assessed in an intake area for medical stability prior to admission.

ii. **Transfers to a more appropriate facility for care if medically indicated** - If a patient is in need of medical attention that exceeds the inpatient facility's ability to stabilize the patient, the patient will be transported to AAMC's acute general hospital for treatment. The patient will be transported either via 911 ambulance or by a private ambulance.

iii. **Necessary evaluation to define the patient's psychiatric problem** - All patients admitted for acute psychiatric care will have assessments conducted by a unit psychiatrist within 24 hours.

iv. **Emergency treatment** -The inpatient stay is designed to provide stabilization of an identified emergency psychiatric condition for a patient who presents as a danger to themselves or others. AAMC will provide emergency psychiatric intervention through continuous nursing and treatment assistant presence on the unit, and through prescriber involvement directly or on-call at all times. Emergency assessment of presenting medical problems will be provided through triage by nursing and prescribing professionals on the unit as needed through the AAMC acute care general hospital ED.

Copies of relevant written policies are attached collectively as Exhibit 15.

AP 6. All hospitals providing care in designated psychiatric units must have separate written quality assurance programs, program evaluations and treatment protocols for special

populations including: children, adolescents, patients with secondary diagnosis of substance use, and geriatric patients, either through direct treatment or referral.

Applicant Response:

AAMC will not provide care in designated units for special populations. AAMC notes, however, that its quality improvement program will assess program outcomes, determine progress toward meeting program goals, evaluate the allocation of resources, trend input from advisory groups (consumers, family members, and other stakeholders) and identify opportunities for improvement in the provision of evidence-based patient-centered care to patients and their families.

To this end, AAMC's quality improvement program will include:

1. Documentation of a plan for evaluating care;
2. Indicators for quality that are clearly identified and measured on a regular basis; and,
3. Performance data that is followed over time.

The evidence of quality improvement activities will include:

1. The program's response to the monitoring and/or evaluation data; and,
2. Performance data that is communicated back to program staff.

There will be clear lines of accountability established for quality improvement strategies including who is responsible for management of the quality improvement efforts and the response from management to the quality improvement recommendations.

The adult psychiatric inpatient program will be evaluated using the national quality measures established by CMS. These include, but are not limited to:

1. Patient and family engagement
2. Patient safety
3. Care coordination
4. Population/public health
5. Efficient use of human resources
6. Clinical protocol effectiveness

Inpatient psychiatric reporting will also include JCAHO requirements for Hospital- Based Inpatient Psychiatric Services:

1. Less than 2 hours of physical restraints
2. Less than 3 hours of seclusion use
3. Review of patient discharged on multiple antipsychotic medications
4. Review of patients discharged from inpatient care without a continuing care plan which includes referral and information that is provided to the next appropriate level of care.

AP 7. An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated psychiatric unit solely on the basis of the patient's legal status rather than clinical criteria.

Applicant Response:

AAMC's mental health hospital will routinely accept patients who are admitted as

involuntary patients on Certificates. These patients will be placed on observation status until they go to hearing before an Administrative Law Judge. If the patient is retained at hearing, they will be administratively discharged as involuntary admissions.

AAMC's policy pertaining to certified patients is attached as Exhibit 16.

AP 8. All acute general hospitals and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located, based on data available from the Health Services Cost Review Commission for the most recent 12 month period.

Applicant Response:

AAMC Mental Health Hospital's uncompensated care as a percentage of gross patient revenue is projected to be 9.7 percent, which exceeds the average level of uncompensated care (4.11 percent) of all acute hospitals in AAMC Mental Health Hospital's health service area. Please refer to Chart 44 (following page).

Chart 44

Hospital Bad Debt and Uncompensated Care

County	Hospital	Annual Filing Year	Gross Patient Revenues	Bad Debt	Charity Care	Uncompensated Care Percentage
			A	B	C	D = [B+C]/A
Baltimore City	Bon Secours Hospital	2015	$117,218	$2,681	$1,959	3.96%
Baltimore City	University of Maryland Medical Center Midtown Campus	2015	228,796	10,283	13,771	10.51%
Howard County	Laurel Regional Hospital	2015	106,468	4,651	4,726	8.81%
Harford County	Harford Memorial Hospital	2015	104,704	6,285	3,080	8.94%
Baltimore City	Johns Hopkins Bayview Medical Center	2015	618,221	23,752	16,345	6.49%
Baltimore City	Mercy Medical Center	2015	495,806	14,008	17,927	6.44%
Baltimore County	Northwest Hospital Center	2015	254,116	13,021	3,226	6.39%
Baltimore City	University of Maryland Rehab and Ortho Institute	2015	120,365	4,764	877	4.69%
Anne Arundel	University of Maryland Baltimore Washington Medical Center	2015	402,011	15,358	8,042	5.82%
Harford County	University of Maryland Upper Chesapeake Medical Center	2015	320,268	11,864	4,943	5.25%
Baltimore City	MedStar Harbor Hospital Center	2015	207,453	7,517	2,859	5.00%
Baltimore City	St. Agnes Hospital	2015	418,877	5,525	15,378	4.99%
Baltimore County	Sheppard Pratt	2015	141,516	1,430	4,679	4.32%
Howard County	Howard County Hospital	2015	286,303	8,689	3,170	4.14%
Baltimore City	Levindale	2015	59,786	2,231	225	4.11%
Baltimore County	MedStar Franklin Square Hospital Center	2015	491,173	14,130	6,028	4.10%
Baltimore County	University of Maryland St. Joseph Medical Center	2015	390,826	8,171	8,003	4.14%
Baltimore City	MedStar Good Samaritan Hospital	2015	303,789	9,142	3,057	4.02%
Baltimore City	Sinai Hospital	2015	717,312	25,940	4,173	4.20%
Baltimore City	University of Maryland Medical Center	2015	1,313,671	13,089	23,047	2.75%
Baltimore City	MedStar Union Memorial Hospital	2015	419,375	10,798	4,013	3.53%
Anne Arundel	Anne Arundel Medical Center	2015	562,953	14,405	2,704	3.04%
Baltimore County	Greater Baltimore Medical Center	2015	432,708	9,059	1,678	2.48%
Baltimore City	Johns Hopkins Hospital	2015	2,209,869	19,434	30,277	2.25%
Total for These Counties			$10,723,580	$256,225	$184,184	4.11%

Notes:
Source: 2015 Annual Filings, RE Schedule
[2] Gross patient revenues, bad debt and charity care are all stated in Thousands

AP 9. If there are no child acute psychiatric beds available within a 45 minute travel time under normal road conditions, then an acute child psychiatric patient may be admitted, if appropriate, to a general pediatric bed. These hospitals must develop appropriate treatment protocols to ensure a therapeutically safe environment for those child psychiatric patients treated in general pediatric beds.

Applicant Response:

This standard is not applicable because the proposed project does not include child or adolescent services.

Accessibility: Variant LHPA Standard

(Western Maryland) One-way travel time by car for 90 percent of the population from the jurisdiction(s) where acute psychiatric bed need is identified should be within 30 minutes for adults and 45 minutes for children and adolescents. (This standard supersedes the 1983-1988 State Health Plan Overview Standards 0 1a and 0 1b.)

Applicant Response:

This standard is not applicable because the proposed project is not in Western Maryland.

Cost

AP 10. Expansion of existing adult acute psychiatric bed capacity will not be approved in any hospital that has a psychiatric unit that does not meet the following occupancy standards for two consecutive years prior to formal submission of the application.

Psychiatric Bed Range (PBR)	Occupancy Standards
PBR <20	80%
20 ≤PBR<40	85%
PBR≥40	90%

Applicant Response:

This standard is not applicable because the proposed project is not an expansion of existing adult acute psychiatric beds.

AP 11. Private psychiatric hospitals applying for a Certificate of Need for acute psychiatric beds must document that the age-adjusted average total cost for an acute (≤ 30 days) psychiatric admission is no more than the age-adjusted average total cost per acute psychiatric admission in acute general psychiatric units in the local health planning area.

Applicant Response:

AAMC compared its projected charge per case to the age and case-mix adjusted charge per case to general acute care psychiatric units in its local health planning area (Chart 45, following page). The local health planning area was defined as Anne Arundel County, Baltimore City, Baltimore County, Carroll County, Harford County and Howard County. The definition of the age cohorts are consistent with the HSCRC's definition utilized in the annual demographic adjustment. Consistent with previous costs analyses, AAMC charges are well below (33 percent) those of acute general psychiatric providers on an age and case mix adjusted basis. This analysis further supports that AAMC is a lower-cost alternative for patients within AAMC's service area.

Chart 45
AAMC Projected Charge per Case

Age Group	Cases	Average Charge (Note 1)	CMI	Avg Charge @ CMI of 1.0000	AAMC Cases	AAMC Cases @ Health Area Average
0-4	4	$27,635	0.6853	$40,325	0	**$0**
5-14	941	12,466	0.5772	21,595	0	**0**
15-44	11,746	9,379	0.6142	15,271	549	**8,383,572**
45-54	4,449	10,118	0.6442	15,707	186	**2,921,525**
55-64	2,643	13,121	0.6891	19,040	113	**2,151,505**
65-74	914	17,456	0.7549	23,122	25	**578,047**
75-84	490	16,155	0.8053	20,062	8	**160,493**
85+	294	11,966	0.8226	14,547	3	**43,641**
Total	**21,481**	**$10,415**	**0.6412**	**$16,242**	**884**	**$14,238,784**
Overall Average Charge @ CMI of 1.0000						**$16,107**
Projected CMI						**0.5689**
Average Age Adjusted Cases at Local Health Planning Area						**$ 9,164**
AAMC Projected Charge per Case						**$ 7,644**

Source: FY 2015 HSCRC discharge abstract dataset for psychiatric APR-DRGs 750-760, 779 - 790

Note 1: Average Charge calculated from FY2015 discharge abstract data and inflated 2.4% for the FY16 Update Factor to price level it to FY16 prices

Quality

AP 12a. Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.

Applicant Response:

Inpatient psychiatric services at AAMC are under the clinical supervision of a psychiatrist who is qualified to provide the leadership required for an intensive treatment program. Raymond Hoffman, MD, a board certified psychiatrist, is the Medical Director of the Division of Mental Health and Substance Use at AAMC. All psychiatrists on staff meet the training requirements for certification by the American Board of Psychiatry and Neurology. The medical director monitors and evaluates the quality and appropriateness of services and treatment provided by the medical staff.

AP 12b. Staffing of acute psychiatric programs should include therapies for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment.

Staffing should cover a seven day per week treatment program.

Applicant Response:

The multidisciplinary team at AAMC will include psychiatrists, licensed clinical social workers, clinical psychologists and/or licensed marriage and family therapists, occupational therapists, RN's and nurse practitioners. Patients will be assigned a social worker/therapist during the course of their treatment. Upon discharge each patient will receive an individual aftercare plan that's been developed by the treatment team. The aftercare coordinator/care manager will follow-up with all patients that are discharged to confirm an appointment, assure that the referral was helpful and offer additional support.

AAMC's inpatient treatment program will be a short-term acute care service that provides programs for patients seven days per week. A psychiatrist/nurse practitioner will see patients during the week and on the weekends, and will be on-call every day. Social workers and activity therapists will provide group and individual therapy seven days per week.

AP 12c. Child and/or adolescent acute psychiatric units must include staff who have experience and training in child and/or adolescent acute psychiatric care, respectively.

Applicant Response:

This standard is not applicable because the proposed project does not include child or adolescent beds.

Continuity

AP 13. Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

Applicant Response:

The AAMC comprehensive continuum combines many programs, policies, practices, and resources to treat mental health disorders and to support affected individuals. The continuum of care will include services ranging from outpatient, partial hospital and inpatient treatment, and ongoing support services to prevention and education programs. At discharge, patients admitted to the mental health hospital will be referred to an appropriate array of clinical and support programs to ensure continuity of care and continued stabilization.

AAMC has written policies and procedures that address this standard. Please refer to Exhibit 17.

Acceptability

AP 14. Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:

(i) the local and state mental health advisory council(s);
(ii) the local community mental health center(s);
(iii) the Department of Health and Mental Hygiene; and
(iv) the city/county mental health department(s).

Letters from other consumer organizations are encouraged.

Applicant Response:

Please refer to Appendix 3 – Letters of Support and see Section 10.24.01.08G(3)(d). Viability of the Proposal, page 86.

Anne Arundel Medical Center

2001 Medical Parkway
Annapolis, Md. 21401
443-481-1000
TDD: 443-481-1235
askAAMC.org

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application filed by Anne Arundel Medical Center, Inc. are true and correct to the best of my knowledge, information and belief.

Victoria W. Bayless
President & Chief Executive Officer
Anne Arundel Medical Center

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application filed by Anne Arundel Medical Center, Inc. are true and correct to the best of my knowledge, information and belief.

Dawn K Hurley

Dawn Hurley MA, CPRP
Executive Director of Behavioral Health
Anne Arundel Medical Center

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application filed by Anne Arundel Medical Center, Inc. are true and correct to the best of my knowledge, information and belief.

Lucas Klock
Director, Capital Projects
Anne Arundel Medical Center

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application filed by Anne Arundel Medical Center, Inc. are true and correct to the best of my knowledge, information and belief.

Barbara Jacobs, RN
Chief Nursing Officer
Anne Arundel Medical Center

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application filed by Anne Arundel Medical Center, Inc. are true and correct to the best of my knowledge, information and belief.

Jeanette Cross, CPA, FHFMA, CPC
Managing Director
Berkeley Research Group, LLC

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application filed by Anne Arundel Medical Center, Inc. are true and correct to the best of my knowledge, information and belief.

3/24/16

Miriam Suldan
Senior Managing Consultant
Berkeley Research Group, LLC

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application filed by Anne Arundel Medical Center, Inc. are true and correct to the best of my knowledge, information and belief.

Bob Reilly
Chief Financial Officer
Anne Arundel Medical Center

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application filed by Anne Arundel Medical Center, Inc. are true and correct to the best of my knowledge, information and belief.

Joshua E. Jacobs, Vice President, Strategic Planning
& Marketing/Communications
Anne Arundel Medical Center

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application filed by Anne Arundel Medical Center, Inc. are true and correct to the best of my knowledge, information and belief.

Shirley Knelly
Vice President, Quality and Patient Safety
Corporate Compliance Officer
President, Pathways
Anne Arundel Medical Center

Anne Arundel County

COMMUNITY HEALTH

Needs Assessment, 2015

Anne Arundel Medical Center

University of Maryland Baltimore Washington Medical Center

Healthy Anne Arundel
Working Together To Promote Health and Wellness

Anne Arundel County Partnership for Children, Youth & Families

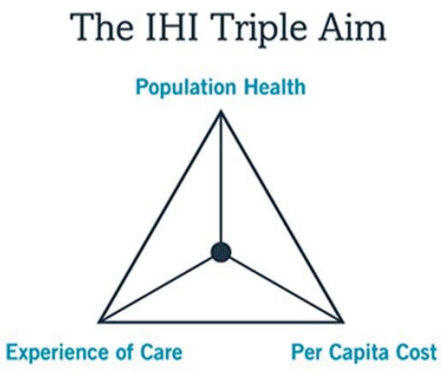
Anne Arundel County Maryland Department of Health

PREFACE

THE CONTEXT OF HEALTH CARE IN MARYLAND AND ANNE ARUNDEL COUNTY.

The health care landscape in Anne Arundel County, Maryland and the United States has been rapidly changing over the past several years and will continue to evolve. Health system reforms in public health, health care, insurance and other sectors are resulting in dramatic changes to both financing and service delivery. These changes include improving the efficiency and effectiveness of health organizations and services, as well as increasing connections and collaborations among public health, health care and other sectors (Centers for Disease Control and Prevention, 2014.)

Maryland, in particular, is a leader in health system transformation. Maryland's hospitals, guided by a five-year agreement with the Centers for Medicare & Medicaid Services, are making progress toward the Institute for Healthcare Improvement's Triple Aim of Health Care: to reduce costs, improve the health of communities and improve the experience of care for patients. Maryland is the only state in the nation that sets the rates hospitals can charge for their services. Rates are the same for all patients for the same service in the same hospital, whether they have Medicare, Medicaid, private health insurance, or pay out of their own pocket. In January 2014, the Maryland "Medicare waiver" was modernized to better reflect the current state of health care; a trend toward more outpatient care and prevention and less inpatient care. The new waiver agreement aligns with the goals of the Triple Aim of Health Care; less expensive care, better experiences for patients and healthier communities. The new agreement requires hospitals and the state to achieve specific cost and quality targets (Maryland Hospital Association, 2014).



All of Maryland's hospitals now operate under fixed annual budgets that shift incentives from volume to value. This is a model where hospitals are not rewarded based on how many patients they treat, but rather on how successful they are in keeping their patients and communities healthy. The result is that hospitals are keeping costs down by trimming unnecessary use of hospital services, improving quality and working to keep members of their communities healthier and out of the hospital. To do this, hospital leadership has moved care beyond their walls and into communities by expanding preventive care and collaborating with others to make sure care does not stop after a patient leaves the hospital (Maryland Hospital Association, 2014.) New models of care are being developed that include care coordination and navigation services, community health workers, non-traditional settings of care and unique partnerships. There is an increased awareness of the need to address the socioeconomic determinants of health through these new care models.

At the same time, due to the expansion of Medicaid and the decrease in uninsured patients, many public health departments are reducing the direct clinical services they provide. Increasingly, health departments are focusing their efforts on prevention and education, helping newly insured and others access health care services, and convening community stakeholders in coalitions to improve community health. Other governmental agencies are also being tasked with helping to keep the communities they serve healthier and able to live more productive lives. All of these changes have placed an increased emphasis on public-private partnerships, coalition building and advocacy for community health improvements. There is increased collaboration between health systems, community hospitals, insurance companies, physician practices, long-term care and other providers, as well as community-based organizations, public health departments and patients and consumers. These collaborations will only continue to grow and mature.

Foreword

The 2015 Anne Arundel County Community Health Needs Assessment (CHNA) is a compilation of summative (secondary) and formative (qualitative) data. The summative data was gathered from a variety of local, state and national sources. Population and socioeconomic statistics were compiled using data from the United States (U.S.) Census Bureau's Population Estimates Program and the American Community Survey 1-Year and 5-Year Estimates. Birth and death data files were obtained from the Maryland Department of Health and Mental Hygiene, Vital Statistics Administration. The emergency department and inpatient hospital discharge data files were obtained from the Maryland Health Services Cost Review Commission for topics like birth, mortality and hospital utilization. Other data sources used for this report were: Maryland Vital Statistics Annual Reports, Maryland Department of Health and Mental Hygiene's Annual Cancer Reports, Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention's CDC WONDER Online Database, Centers for Medicare & Medicaid Services, National Vital Statistics Reports, County Health Rankings and a variety of local databases. The specific data sources are listed throughout the report.

The 2015 CHNA draws on qualitative data gathered from **12 key informants as follows:**

CEO, University of Maryland Baltimore Washington Medical Center (UMBWMC)
CEO, Anne Arundel Medical Center (AAMC)
Executive Director, Anne Arundel County Mental Health Agency
Health Officer, Anne Arundel County Department of Health
Health Consultant, Anne Arundel County
Director, Anne Arundel County Crisis Response
Clinical Director, Anne Arundel County Mental Health Agency
Community Health Director, AAMC
Two county legislative leaders
Director, Anne Arundel County Department of Aging and Disabilities
Program Director, Domestic Violence Program, YWCA of Annapolis and Anne Arundel County
Further qualitative data was gathered from **eight focus groups as follows:**

Emergency Department and Emergency Response. Personnel from both hospitals' ERs, the EMS system, the Anne Arundel County Fire Department, and County Public School System psychologists and counselors (18)

Low-Income Youth. Job seekers, high school drop outs, Medicaid recipients, single parents. (8)

North County. Community members, substance abuse professionals, health professionals, law enforcement, council member (12)

South County. Community members, substance abuse professionals, law enforcement, health professionals (10)

Behavioral Health (1). Residential providers, crisis response, mental health professionals, behavioral health providers (9)

Behavioral Health (2). Parents, mental health providers (5)

Seniors. Three groups including professionals, care coordinators and senior citizens (20)

Hispanic Community. Consumers, attorney, non-profit leader (6)

Interviews and conversations were recorded, with the permission of participants, and transcribed verbatim. The data was read and reread until dominant themes emerged which became the subtext of the report. All participants gave permission for their words to be used in the final report, although their identities are protected.

The authors take full responsibility for the interpretations and analyses presented here.
The report has only one fundamental goal: to help frame an informed discussion about community health needs and trends in Anne Arundel County, Maryland, in order to contribute to planning and actions that address those needs.

Information Gaps in the Data

•The mental health secondary data in this report reflects the public mental health system only.

•Substance abuse numbers reflect self-reports and those abusers coming to the attention of the police departments.

•Numbers for heroin and other opiate addictions rely heavily on police reports and emergency room data. There is no accurate count for the number of heroin addicts in the county.
•Domestic violence numbers are unreliable. Many incidences of domestic violence go unreported and reflect only those victims who seek medical attention or who seek support through a domestic violence service provider.

•Homeless youth and family numbers reflect only those families or youth in a shelter or counted by the local public school system. Those families staying with a friend or another family are not captured in the secondary data.

•Opinions from youth consumers of mental health services were not captured in this report.

•Anecdotal information pointed to a growing number of undocumented residents in the county. Currently there is no method to capture an accurate number of those residents.

About The Authors

Dr. Pamela Brown is currently the Executive Director of the Anne Arundel County Partnership for Children, Youth and Families. She completed her Ph.D. in Educational Leadership at Florida Atlantic University. Her dissertation focused on the importance of community partnerships in diverse neighborhoods. She is a University Research Reviewer and Dissertation Chair for the University of Phoenix specializing in qualitative case study methods. She is certified to conduct ethical research through the Collaborative Institutional Training Initiative at the University of Miami. She has been conducting community needs assessments for over 20 years.

Bikash Singh, an epidemiologist with the Anne Arundel County Department of Health, conducted secondary data analysis. Mr. Singh has a Master's in Public Health with a specialization in epidemiology, and he has extensive experience in epidemiology, health data analysis and demography.

The Anne Arundel County Community Health Needs Assessment (CHNA) is the result of a working collaboration of the University of Maryland Baltimore Washington Medical Center, Anne Arundel Medical Center, Anne Arundel County Department of Health and the Anne Arundel County Mental Health Agency. The CHNA was developed as a planning tool for use by the Healthy Anne Arundel Coalition, both hospitals and county government agencies, and it will be used as information for each hospital's community benefit plans as well as for the strategic and operational plans of the Healthy Anne Arundel Coalition. Additionally, this plan will be used by other Healthy Anne Arundel Coalition partner organizations including the City of Annapolis, Housing Authority of the City of Annapolis, Anne Arundel County Public Schools, the Community Foundation of Anne Arundel County and MedStar Harbor Hospital. All organizations throughout Anne Arundel County, including community-based organizations, faith-based organizations and businesses are encouraged to use the CHNA findings.

With thanks to Lauren Fretz, University of Alabama, for graphics and design.

Summary of Principal Findings

Population: According to 2013 census estimates, the Anne Arundel County population is 556,348; a growth of 11.2% since 2000. While the White Caucasian population of the county continues to diminish, the Hispanic population is growing more significantly than all races/ethnicities and is now at 6.4% or 34,854 residents.

Seniors: The senior population (over 65) trend is one of rapid growth, increasing from the 2013 figure of 99,086 to 140,000 by 2030, when the trend line begins to dip. As of 2013, there were 75,607 Medicare beneficiaries in Anne Arundel County.

Leading Causes of Death: In 2013, life expectancy in the county rose to an average of 79.8 years. Cancer was the leading cause of death, followed by heart disease which accounted for nearly 47% of all deaths. There was a 6% decline in age-adjusted death rates for all cancer deaths among Blacks, an 11% decline among Whites and a 22% decline among Hispanics of any race. In 2013, 22% of all deaths in Anne Arundel County were from heart disease.

Obesity: Overweight and obesity are still significant health issues in Anne Arundel County leading to secondary issues such as diabetes. The obesity rates for those with a Body Mass Index (BMI) of 30 or more increased almost four percentage points. Approximately 69,000 (12%) of Anne Arundel County residents live in an area categorized as a food desert, which is an urban neighborhood or rural towns without ready access to fresh, healthy and affordable food.

Access to Health Care: The Affordable Care Act (ACA) has increased access and expectations for health care. The number of Anne Arundel County Medicaid enrollments increased from 68,166 in January 2013 to 84,616 in December 2014. Nonetheless, access to primary care is a growing issue in the county. Compared to Maryland, Anne Arundel County has 21.6% fewer primary care physicians and 8.5% less dentists per 100 population.

Mental Health: The demand for mental health services has increased for every age group. 11,321 residents were served by the County Mental Health Agency in 2014, an increase of 11% from FY13. There has been a 14.5% increase in mental health services for children ages 6 to 12 and a 9.6% increase for children between 13 and 17 years of age. Residential mental health beds are almost nonexistent in the county, although there are 259 residential rehabilitation beds (for the chronic and persistent mentally ill). There are only 24 crisis beds and only one in-patient psychiatric unit with 14 beds, and it is often full. There is one Spanish-speaking psychiatrist available to the Hispanic uninsured population. There are very few Spanish speaking mental health counselors.

Opioids: In 2014, the county had the third highest number of prescription opioid-related deaths in Maryland (after Baltimore City and Baltimore County). The increase in controls on prescription drugs has made the trade in prescription opioids more expensive. Partly because of this, heroin

(a derivative of opium and an illegal opiate drug) has made a profound reappearance on the streets of Anne Arundel County. Out of 101 intoxication deaths that occurred in Anne Arundel County in 2014, 53 were heroin-related. There was almost a three-fold increase in the number of heroin-related deaths (from 18 to 53) between 2010 and 2014.

Co-Occurring Issues: The relationship between substance abuse and mental illness is well documented. Patients with mental health issues may "self-medicate" by using and abusing drugs to manage their mental illness. Officials with Pathways substance abuse treatment center estimate that 80% of their population has a co-occurring disorder, yet treatment and payment options are often in traditional silos.

Access to Substance Abuse Treatment Services: Treatment options are limited in the county, especially in-patient treatment. There are currently five residential treatment providers, including Chrysalis House, Damascus House, Hope House, Samaritan House and Pathways, operated by Anne Arundel Medical Center. Pathways offers a variety of outpatient services and 40 in-patient beds, 32 for adults and eight for adolescents age 13-17. There is promise of a 120-bed facility at the Crownsville hospital site and renovations are already underway. Chrysalis House is still the only residential treatment facility that offers in-patient services to women and their children.

Emergency Departments (ED): The two hospital EDs have become the "catch-all" for somatic and behavioral health treatment. The ED is a trusted venue and one of the main "front doors" for primary care, especially among lower income residents. There were 335 visits to the ED for every 1,000 individuals in the county. The ED visit rate for Blacks was the highest among the racial and ethnic groups examined. For those residents with critical substance abuse and mental health issues, the ED is often their only choice. Domestic violence, sexual assault or abuse victims present in increasing numbers at the ED. ED providers are often involved in time consuming charting and the integration of victims' care with law enforcement, social workers and patient advocates.

Communication Among Agencies: There is a lack of communication and partnering between the various health and human services agencies, including emergency personnel. Communication between agencies is made more awkward by the regulations for patient confidentiality laid out by the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA).

Transition Points and Care Coordination: The two points of entry and discharge into EDs, hospitals and other systems were highlighted as problematic. At the point of admission, community service providers are not part of the process. The discharge process, especially from EDs, is often hurried with no means to follow up with the patient. Referrals may be made at this point; and the patient, who could have a variety of wellness and social issues, is expected to follow up. There are care coordinators in the health and human services systems, but their work is not coordinated across silos of care.

Poverty: There are 33,352 Anne Arundel County residents (6.3%) living below the poverty level, a slight dip from the 2011 level of 34,410 residents (6.4%). Census estimates suggest 14.7% of the single parent households in the county make an income that is below the federal poverty level.

North and South Polarization: The majority of negative social and health indicators are polarized in the northern and southern regions of the county. The highest percentage of poverty is in the ZIP code that contains Brooklyn at a staggering 26.5%. In South County, access to health care is very limited and there are few primary care doctors. Of the 11 medically underserved areas of the county, all but two are in South County.

Transportation: The lack of transportation continues to be a major issue for the county. There is no public transportation in South County, including taxi service, and only three bus routes serve the county. Neither city nor county bus routes operate early in the morning or later in the evening, and the wait between buses can be one to one and a half hours.

Housing: Rising home prices, high private rents and a lack of affordable and multi-family housing are continuing problems for large segments of the population. The median price for a house in Anne Arundel County is fourth highest in the state at $320,000. In 2013, Anne Arundel County homeowners spent 34.3% and renters spent a staggering 49.5% of their income on housing. There are 9,000 families on the waiting list for public housing and 10,000 families on the waiting list for Housing Choice (Section 8) vouchers.

Homelessness: Homelessness is a continuing issue for individuals and families in the county. The fastest growing homeless population is homeless families and youth who are staying with friends or living temporarily in motels. There are over 250 families living in a shelter or transitional housing. The Anne Arundel County Public School System's estimates suggest there are over 925 county students who do not sleep in their own homes on any given night.

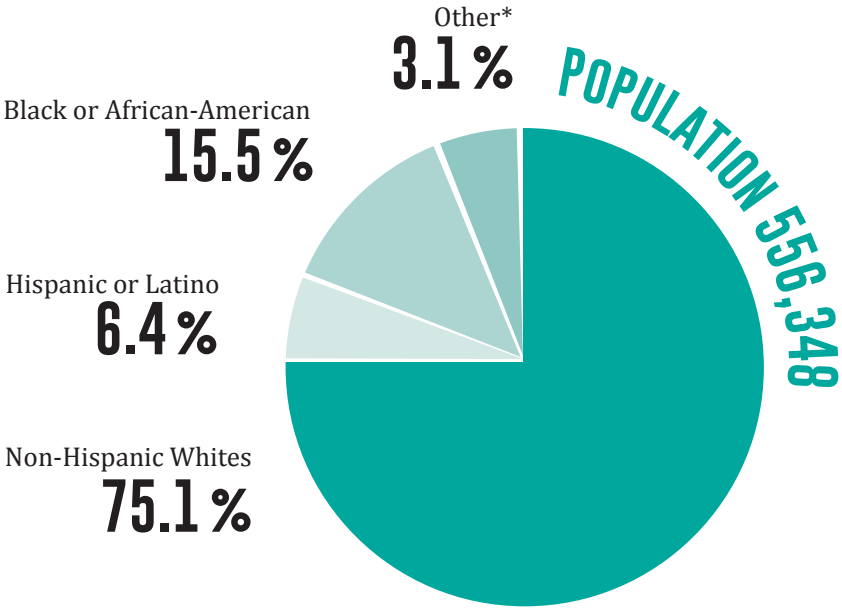
Community Health Needs Assessment

Anne Arundel County
OVERVIEW
Needs Assessment, 2015

The **SENIOR POPULATION** is growing by **2,406** per year, from 2013 to 2030

THE POPULATION HAS GROWN **11.2%** since 2000, with a **1.3%** increase between 2010 and 2013

The **HISPANIC POPULATION** is growing more significantly than all races/ethnicities and is now at **6.4%**



U.S. Census Bureau, American Community Survey, 2013. "Other" here includes "American Indian and Alaskan Native", "Asian", "Native Hawaiian or other Pacific Islander", "Some other race", or "Two or more races". Therefore, the "White" and "Black" figures are those who were counted as "White alone" or "Black alone."

POVERTY is concentrated in the **NORTH AND SOUTH OF THE COUNTY.**

33,352 residents (6.3%) **LIVE BELOW THE POVERTY LEVEL**

26.5% of residents living in the ZIP Code that contains Brooklyn **LIVE IN POVERTY**

2 MAJOR HOSPITALS
Anne Arundel Medical Center (AAMC) in Annapolis and the University of Maryland Baltimore Washington Medical Center (BWMC) in Glen Burnie

County Overview

Anne Arundel County is located in the state of Maryland and is home to more than 556,000 residents. The county is located in the heart of the nation's fourth largest marketplace, the Baltimore-Washington D.C. corridor. It is situated between the rapidly growing Washington Metropolitan Area and the redeveloping Baltimore Metropolitan Area. The county is adjacent to America's East Coast Main Street (I-95), the Northeast Corridor, which is the longest high-speed rail corridor in the United States, and to the Port of Baltimore, which has been expanded to accept greater amounts of shipborne commerce due to the widening of the Panama Canal.

The county is an appealing place to live. Its natural beauty can be enjoyed through two state and 70 county parks and through an extensive network of recreation and transportation trails. With 534 miles of linear coastline, the county ranks second for waterfront, after Frederick County, in the state and second in the nation when compared to other counties. Despite this abundance of water there are only five points of public water access for county residents.

The Chesapeake Bay is perhaps Anne Arundel County's most treasured natural resource, constituting the largest estuary in the United States. However, despite many efforts by federal, state and local governments and other interested parties, pollution in the bay does not meet existing water quality standards. Nineteen separate local water bodies are not currently meeting water quality standards. Maryland Department of Environment has established clean-up plans for seven of these segments. The good news is that since the 1983 clean-up effort was launched, nutrient pollution has been reduced by 20% (Chesapeake Bay Foundation, 2015). According to the Chesapeake Bay Foundation, all of our rivers are "impaired" under the Clean Water Act, meaning they do not meet water quality standards for their intended use. The pollutants that are largely responsible for these impairments are nutrients in the form of nitrogen and phosphorus, and sediment that come from polluted runoff. Polluted runoff also contributes 81% of the suspended sediments in the Severn River. The Patapsco (North County) has seven impairments, making it the worst in Maryland.

Air quality is another issue for the county. Anne Arundel was given an F by the American Lung Association for an average of 23 unhealthy, high ozone days every year between 2011 and 2013. The grade remained the same for the newly released 2015 figures. High ozone causes respiratory harm (e.g., worsened asthma, worsened COPD, inflammation) can cause cardiovascular harm (e.g., heart attacks, strokes, heart disease, congestive heart failure) and may cause harm to the central nervous system.

The county's four distinct geographic quadrants reflect major differences. West County, dominated by the military installation of Fort George G. Meade (Fort Meade), is growing more than any other area. That growth is fueled by job and operational additions at Fort Meade, the National Security Agency, Baltimore/Washington International Thurgood Marshall Airport (BWI Airport) and the Arundel Mills complex featuring Maryland Live! Casino. The growth is also related to Maryland's Base Realignment and Closure (BRAC). The northern part of the county (specifically Glen Burnie, Brooklyn and Pasadena) touches the edges of Baltimore City and shares issues related to urban poverty, including an upswing in drug abuse. The central part of the county is dominated by the historic City of Annapolis, situated on the Chesapeake Bay at the mouth of the Severn River. Annapolis is one of only two incorporated towns in the entire county, the other being Highland

Beach. Finally, the area referred to as South County most resembles some of the rural communities found on Maryland's Eastern Shore.

Last year the county was number one in job growth among the five largest regional counties. The county has a growing defense industry marked by the presence of the National Security Administration (NSA), the Defense Information Systems Agency (DISA) and U.S. Cyber Command, all at Fort Meade. Eight of the nation's top ten defense contractors have a presence in the county. In aggregate, the county is home to 14,500 businesses which employ an estimated 205,000 workers. Over 300 of these have 100 or more workers. Key private sector employers include Booz Allen Hamilton, Johns Hopkins HealthCare, Northrup Grumman Electronic Systems, Rockwell Collins, Southwest Airlines, Anne Arundel County Medical Center, University of Maryland Baltimore Washington Medical Center and KEYW Corporation (Maryland Department of Business and Economic Development, 2014).

POPULATION

In 2013, the estimated population of Anne Arundel County was 556,348. The population has grown 11.2% since 2000, with a 1.3% increase between 2010 and 2013 (Table 1). While the White Caucasian population of the county continues to diminish, the Hispanic population is growing more significantly than all races/ethnicities and is now at 6.4% or 34,854 residents. The county has the fourth largest Hispanic population by percentage among Maryland counties. Approximately 68% of the non-Hispanic population lives in eight ZIP codes: Glen Burnie (West), Severn, Odenton, Laurel, Brooklyn, Annapolis (ZIP code 21401), Glen Burnie (East) and Eastport. The largest sector of the Hispanic population is from Central American countries. This is significantly different from the overall U.S. Hispanic population, which is overwhelmingly Mexican (63%). In Anne Arundel County, the Hispanic population is made up of 30% Central Americans (mostly Salvadorans), 29% Mexicans, 16% Puerto Ricans, 9% South Americans and 3% Cubans (Pew Research Center, 2011).

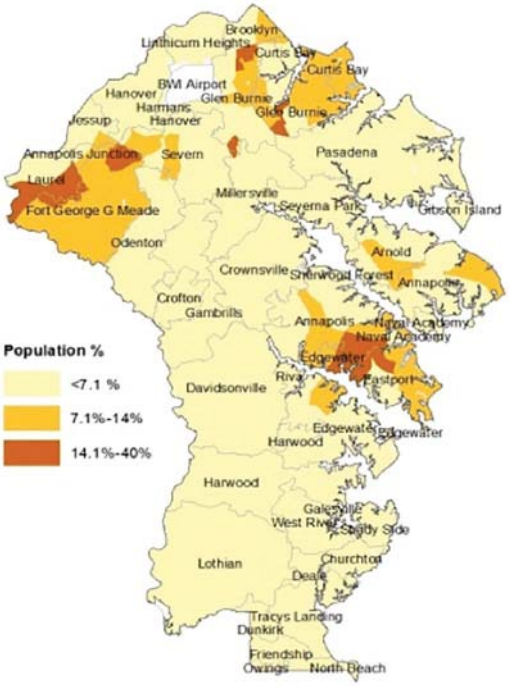
Table 1

Ethnic/Racial Composition							
	2000		2010		2013		Percent Change, 2000-2012
	Number	%	Number	%	Number	%	%
Total Population	**489,656**	**100.0**	**537,656**	**100.0**	**544,426**	**100.0**	**11.2**
Non-Hispanic Whites	390,519	79.8	405,456	75.4	408,715	75.1	4.6
Other Races	**99,137**	**20.2**	**132,200**	**24.6**	**135,711**	**24.9**	**37.0**
Hispanic or Latino	12,902	2.6	32,902	6.1	34,854	6.4	170.0
Black or African-American	65,755	13.4	83,484	15.5	84,230	15.5	28.0
Other*	20,480	4.2	15,814	3.0	16,627	3.1	18.0

Source: U.S. Census Bureau, American Community Survey, 2013. "Other" here includes "American Indian and Alaskan Native," "Asian," "Native Hawaiian or other Pacific Islander," "Some other race," or "Two or more races." Therefore, the "White" and "Black" figures are those who were counted as "White alone" or "Black alone."

Figure 1

Hispanic Population by Census Tract,
Anne Arundel County, 2013



Source: U.S. Census Bureau, 2013 American Community Survey 1-Year Estimates Hispanic Population by Census Tract, Anne Arundel County.

The **HISPANIC POPULATION** is growing more significantly than all races/ethnicities and is now at **6.4%**

The Hispanic Population has **INCREASED** by **170%** from 2000 to 2013

POPULATION BY AGE

The population distribution among Anne Arundel County residents by age is similar to that of Maryland and the U.S. Among county residents, Hispanics are the youngest with a median age of 26.7 years, while Whites are the oldest with a median age of 42.2 years.

Table 2

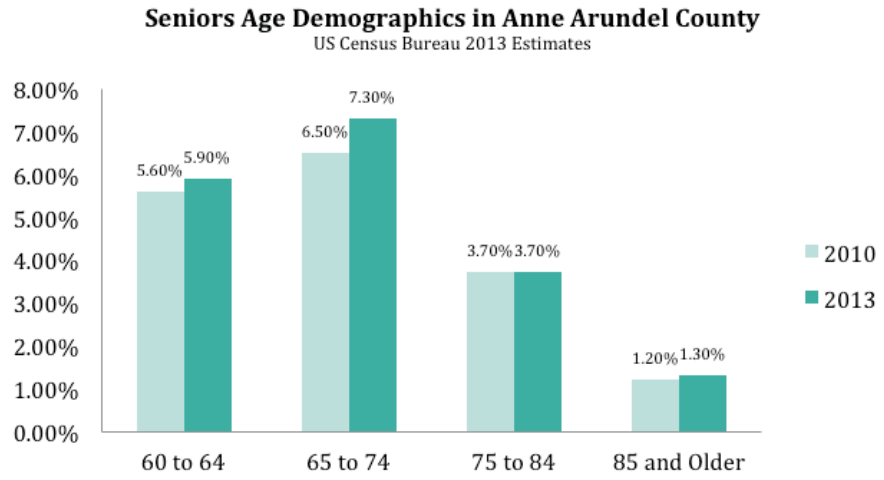
Population by Age, Anne Arundel County Compared to Maryland and U. S., 2013			
	Anne Arundel County	Maryland	United States
Under 5 Years Old	6.3%	6.2%	6.3%
18 Years and Over	77.2%	77.3%	76.7%
65 Years and Over	13.1%	13.4%	14.1%
Median Age (Years)	38.5	38.0	37.3

Source: U.S. Census Bureau, 2013 American Community Survey 1-Year Estimates

SENIORS

In Maryland, 13.4% of the population is 65 or older. Anne Arundel County has a slightly lower percentage at 13.1%. When those over 60 are included, the percentage increases to 18.2% representing 99,086 people. The 2013 estimates from the U.S. Census Bureau clearly indicates that the largest increase for our county is in the age group 65-74 (Figure 2).

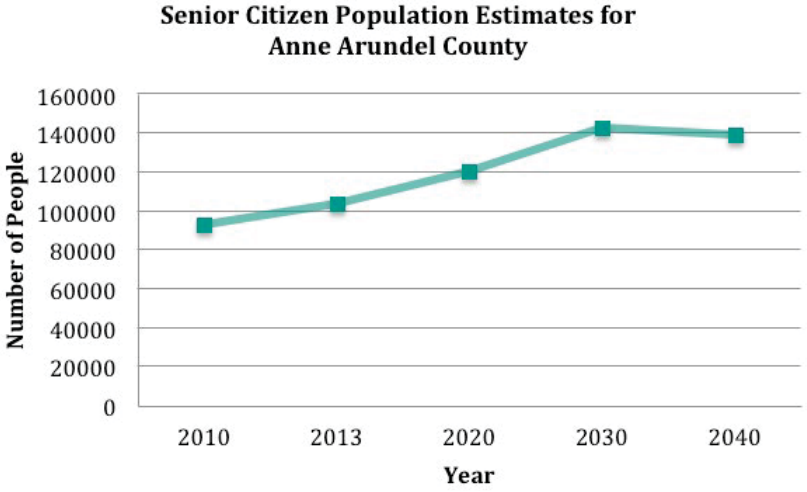
Figure 2



Source: Maryland Department of Aging, 2014

In line with the rest of the nation, the county trend for the senior population is one of rapid growth. According to the Maryland Department of Aging (2014), in Anne Arundel County that trend will continue until 2030 when the trend line begins to dip (Figure 3). By that time the population is estimated to increase from the 2013 figure of 99,086 to 140,000. In the next 15 years, seniors will have an exponentially increasing impact on county services, supports, resource allocation and health care use.

Figure 3



Source: Maryland Department of Aging, 2014

Income

Anne Arundel County is a tale of extremes. There is much wealth and natural beauty for residents but there are deep pockets of poverty to the North and South particularly. The income gap between rich and poor in the county has widened since 2010.There is an increase at both ends of the economic scale; households living below the poverty line and households with a combined income of $200,000 or more (Table 3). There has also been a significant increase in households with a combined income over $100,000. County median family income stands at $101,268 compared to $97,914 in 2010. It is higher than the state ($88,738) and the nation ($64,719).

Table 3

Estimated Annual Household Income Numbers 2010 and 2013					
Total Number of Households	2010: 195, 999		2013: 199,904		
Per household	Number	%	Number	%	Percent Change
Less than $25,000	20,819	10.62	21,890	10.95	5.14%
$25,000-34,999	12,201	6.23	11,584	5.79	-5.06%
$35,000-49,999	19,077	9.73	18,623	9.32	-2.38%
$50,000-74,999	34,853	17.78	32,962	16.49	-4.69%
$75,000-99,999	29,982	15.30	29,086	14.55	-2.99%
$100,000-199,999	61,569	31.41	64,274	32.15	4.39%
$200,000 and above	17,498	8.93	21,485	10.75	22.79%
TOTAL	195,999	100	199,904	100	

Source: U.S. Census Bureau American Community Survey, 2013 Estimates

Poverty

Poverty is defined in different ways. The federal government classifies a family of four (two adults, two children) with an annual income below $24,250 as living in poverty (2015 adjustment), although the amount is not adjusted for geographic differences in the standard of living across the nation. There are 33,352 Anne Arundel County residents (6.3%) living below the poverty level (Table 4), a slight dip from the 2011 level of 34,410 residents (6.4%). Of the 199,904 households below the poverty level in the county, families occupy 138,458. There are 31,377 households led by single parents, of which 22,565 have a female as the head of household. Economic well-being for households headed by a single parent can be fragile. Estimates suggest 14.7% of the single parent households in the county make an income that is below the federal poverty level.

Table 4

Poverty Status, Anne Arundel County, 2013		
	Number Below Poverty Level	Percent Below Poverty Level
Population Below Poverty Level	33,352	6.3%
Age		
Under 18 Years	9,966	8.0%
18 to 64 Years	19,765	5.8%
65 Years and Over	3,621	5.5%
Sex		
Male	14,860	5.8%
Female	18,492	6.8%
Race and Ethnicity		
White, not Hispanic or Latino	16,701	4.4%
Black or African American	9,997	12.7%
Asian	2,092	11.0%
Hispanic (of any race)	3,172	9.4%

Source: U.S. Census, American Community Survey, 2013 Estimates

Poverty is concentrated in the North and South of the county (Table 5). The highest percentage of poverty is in the ZIP code that contains Brooklyn (which contains a small portion of Baltimore City residents) at a staggering 26.5%. ZIP code 21077 (Harmans) has the second highest poverty level in the county at 16.5%, yet it is surrounded by an area of huge economic growth including the Maryland Live! Casino and BWI Airport. The Brooklyn poverty rate is 4.2 times higher than that of the average county's poverty rate. Curtis Bay and Harmans have a poverty rate 2.6 times higher than that of the average county's poverty rate.

Table 5

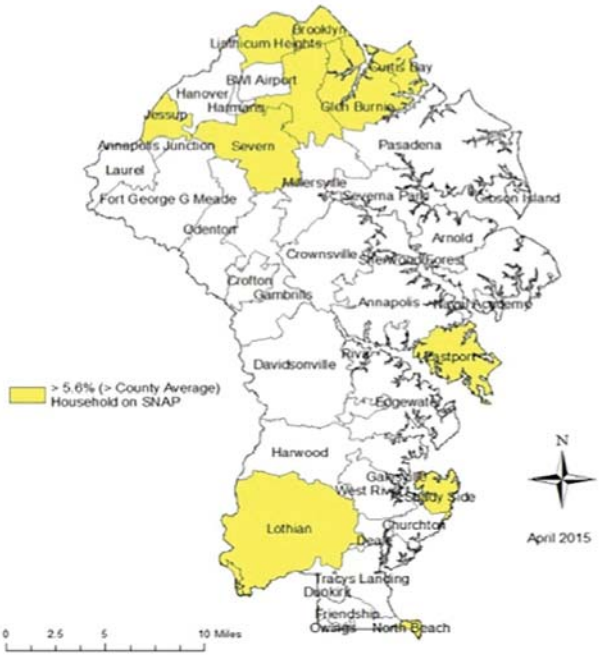
Selected Poverty Percentages by ZIP Code Anne Arundel County, 2013		
ZIP Code	Area	Poverty Percentage
21225	Brooklyn	26.5%
21077	Harmans	16.8%
21226	Curtis Bay	16.5%
21060	Glen Burnie (East)	11.2%
21061	Glen Burnie (West)	10.8%
20714	North Beach	9.9%
20751	Deale	9.2%
	Anne Arundel County	**6.3%**

Source: U.S. Census, American Community Survey, 2013 Estimates

Poverty can also be measured by the number of persons receiving what used to be called Food Stamps and is now called the Supplemental Nutrition Assistance Program (SNAP). Anne Arundel County has a lower percent of households receiving SNAP benefits (5.6%) compared to Maryland (9.5%) and the U.S. (12.4%) but the numbers have risen sharply since 2009 to a high of 22,792 adults. Brooklyn, Curtis Bay, Lothian, Glen Burnie (East and West), North Beach, Shady Side, Jessup, Severn, Linthicum Heights and Eastport have higher than average households which are on Food Stamp/SNAP benefits. Overall, 5.6% households in the county received Food Stamp/SNAP benefits in 2013. Brooklyn (30.9%) has highest percentage of households on Food Stamp/SNAP benefits followed by Curtis Bay (22%) (Figure 4).

Figure 4

Percentage of Food Stamps/SNAP Recipency Hosehold by ZIP Code, 2013



Source: U.S. Census Bureau, 2013 estimates

Figure 5

Major Hospitals in Anne Arundel County, 2015

Source: Anne Arundel County Department of Health, 2015

Health Care Services

Anne Arundel County is served by two major hospitals: Anne Arundel Medical Center (AAMC) in Annapolis and the University of Maryland Baltimore Washington Medical Center (UMBWMC) in Glen Burnie (Figure 5). Both AAMC and UMBWMC are affiliated with academic medical centers, which offer advantages to patients requiring highly-specialized tertiary care. MedStar Harbor Hospital, which is located just north of the county line in Baltimore City, also serves county residents. Additionally, there are four Federally Qualified Health Centers (FQHCs) that serve county residents: Chase Brexton Health Centers, Family Health Centers of Baltimore, Owensville Primary Care and Total Health Care. The Anne Arundel County Department of Health also offers a range of physical and behavioral health services at five clinic sites. The Anne Arundel County Mental Health Agency, Inc. provides a wide range of quality mental health services to Medicaid recipients and other
low-income and uninsured county residents who meet certain criteria. Other health care services available in the county include primary care practices, outpatient specialty care, community clinics, urgent care facilities and retail store-based health clinics.

Many providers of health care offer financial assistance. All hospitals in Maryland have financial assistance policies that provide medically necessary services to all people regardless of their ability to pay. Depending on their circumstances, patients can receive coverage for up to 100% of their medically necessary care. Payment plans are also available. FQHCs, community clinics and governmental providers offer services on a sliding scale or free basis. Assistance with enrolling in publicly funded entitlement programs and health insurance plans through the state health benefit exchange are available from the hospitals, county health departments, social service agencies and the Maryland Health Care Connection. However, it is important to note that not all health care providers, particularly behavioral health providers, accept all insurance plans or self-pay patients.

Anne Arundel County HEALTH CHAPTER 1

Needs Assessment, 2015

The number of
MEDICAID ENROLLMENTS INCREASED
from 68,166 in January 2013 to
84,616
in December 2014

Hospitalizations by Age Group
Anne Arundel County, 2013

Age Group	Number of Hospitalizations	Rate per 1,000
0 to 18 yrs.	9,371	74.1
19 to 39 yrs.	12,584	76.6
40 to 64 yrs.	18,143	94.3
Greater than 64 yrs.	19,435	267.9

Source: Inpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

The ACA does
NOT INCLUDE DENTAL BENEFITS
for adults as an essential health benefit, so dental insurance plans that are offered through Medicaid are
EXTREMELY LIMITED
in the number of benefits.

In 2013,
LIFE EXPECTANCY
in Anne Arundel County
ROSE
to an average of
79.8 YEARS

DEATH RATES
due to all causes of cancer have
DECREASED
in the county by
21%
over the last decade with deaths from colon cancershowing a
48% DECLINE

Primary Care Physicians, Dentists and Mental Health Providers
Anne Arundel County, Maryland

	Anne Arundel County Total	Anne Arundel County Ratio	Maryland Ratio	Top U.S. Counties (90th percentile)
Primary Care Physicians (2012)	385	1,430:1	1,131:1	1,045:1
Dentists (2013)	366	1,518:1	1,392:1	1,377:1
Mental Health Providers (2014)	774	718:1	502:1	386:1

Source: Anne Arundel County Health Rankings and Roadmaps, 2015

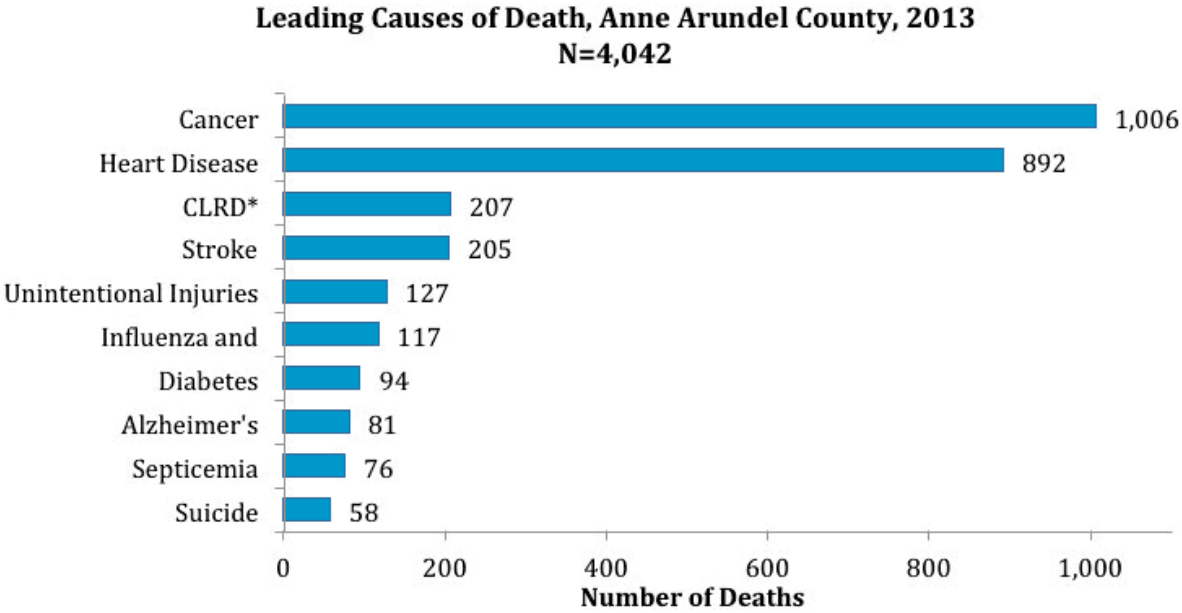
PATIENT TO DENTIST AND TO MENTAL HEALTH PROVIDER RATIOS

in Anne Arundel are worse than in Maryland and the U.S. top performing counties. Compared to Maryland, Anne Arundel County has 21.6% less primary care physicians and 8.5% less dentists per 100 population.

HEALTH
CHAPTER 1

In 2013, life expectancy in Anne Arundel County rose to an average of 79.8 years. Cancer was the leading cause of death, followed by heart disease, which accounted for nearly 47% of all deaths. From 2007 to 2013, age-adjusted death rates for cancer for all races and ethnicities decreased steadily. There was a 6% decline in age-adjusted death rates for all cancer deaths among Blacks, an 11% decline among Whites and a 22% decline among Hispanics of any race. In 2013, 22% of all deaths in Anne Arundel County were from heart disease. Overweight and obesity are still significant health issues in the county, leading to secondary issues such as diabetes. (Centers for Disease Control and Prevention, 2015)

Figure 6



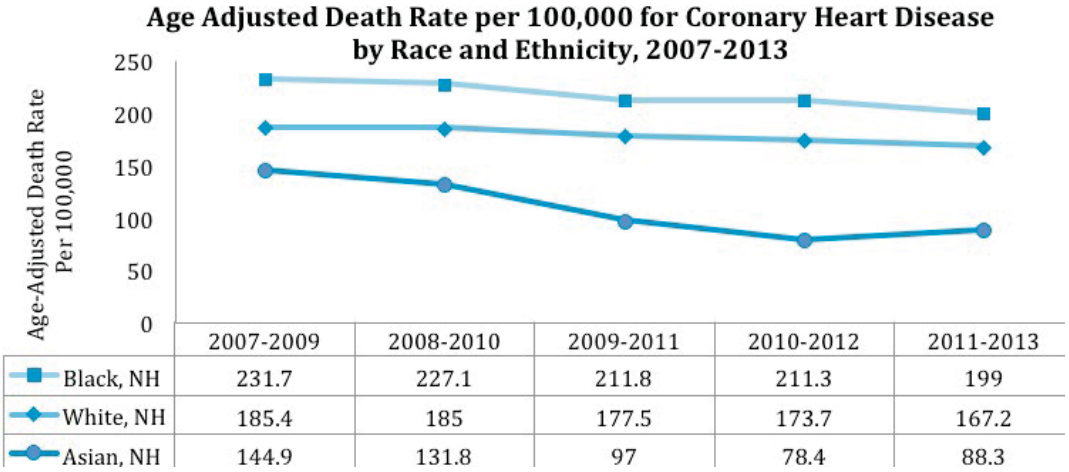
Source: Maryland Vital Statistics Annual Report 2013, Maryland Department of Health and Mental Hygiene
*Chronic lower respiratory diseases (CLRD) include both chronic obstructive pulmonary disease (COPD) and asthma.

Between 2009 and 2013, cancer and heart disease were the first and second leading causes of death among all racial/ethnic groups. They accounted for 49% of deaths among Whites, 47% of deaths among Blacks, 41% of deaths among Hispanics and 51% of deaths among Asians. Diabetes ranked as the fourth leading cause of death among Blacks and fifth leading cause of death among Hispanics.

Coronary Heart Disease

In 2013, 22% of all deaths in Anne Arundel County were from heart disease. However, since 2009, age-adjusted death rates for coronary heart disease for all races/ethnic groups have decreased steadily. Blacks still have the highest rate death from heart disease. Asians have seen the largest decrease in age-adjusted death rates at 39%.

Figure 7



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Black, NH	231.7	227.1	211.8	211.3	199
White, NH	185.4	185	177.5	173.7	167.2
Asian, NH	144.9	131.8	97	78.4	88.3

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Cancer

Anne Arundel County has a higher cancer incidence rate overall, compared to Maryland and the United States. Higher incidence rates for female breast cancer, lung and bronchus cancer, melanoma and prostate cancer are seen in the county while the incidence of colorectal cancer and cervical cancer is lower than the state and the nation. The mortality rate for melanoma has historically been an issue in the county with males having a three times higher mortality rate for the disease than females (Table 6). The good news is that death rates due to all causes of cancer have decreased in the county by 21% over the last decade with deaths from colon cancer showing a 48% decline (Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2014).

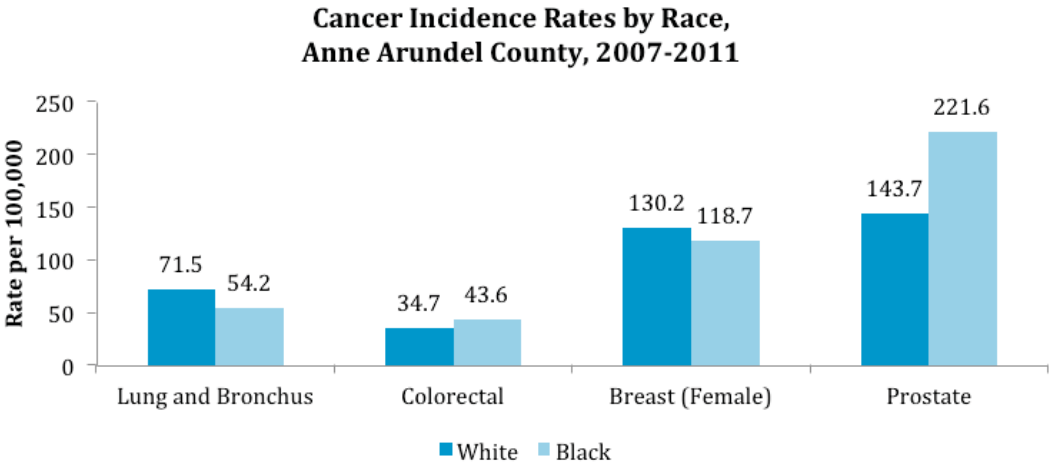
Table 6

Cancer Incidence Rates per 100,000 by Site and Gender, Anne Arundel Compared to Maryland and U.S., 2007-2011			
Site	Anne Arundel County	Maryland	United States
Breast (Female)	129.3	127.8	122.8
Colorectal	35.7	39.3	43.3
Male	39.8	45.1	50.0
Female	32.1	34.8	37.8
Lung and Bronchus	68.7	59.9	64.9
Male	76.5	69.9	78.6
Female	63.0	52.8	54.6
Melanoma	32.4	21.0	19.7
Male	43.2	27.5	25.1
Female	24.0	16.5	15.9
Prostate	151.7	148.7	142.5
Cervical	6.6	6.7	7.8
All Sites	479.2	451.8	467.7

Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2014; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Disparities exist when examining cancer incidence and mortality by race and ethnicity*(Figure 8). The rates of lung and bronchus cancer and melanoma were higher in Whites compared to Blacks while Black males were disproportionately diagnosed with and died from prostate cancer compared to White males. Although White females had a higher incidence of breast cancer, Black females had a higher mortality rate.

Figure 8



Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2014
*Individuals of Hispanic origin were included within the White or Black estimates and are not listed separately.

Infant Mortality Rate

The infant mortality rate in Anne Arundel County between 2010 and 2014 was 5.5 deaths per 1,000 live births; lower than both the United States (6.0 deaths per 1,000 live births) and Maryland (6.6 deaths per 1,000 live births) during the same period. Although the overall infant mortality rate is lower for the county than the state average, disparities exist when stratifying the data by race and ethnicity. Blacks have the highest infant mortality rate in the county (11.2 deaths per 1,000 live births) compared to 5.3 deaths and 4.0 deaths per 1,000 births for Hispanics and Whites respectively (Table 7).

Table 7

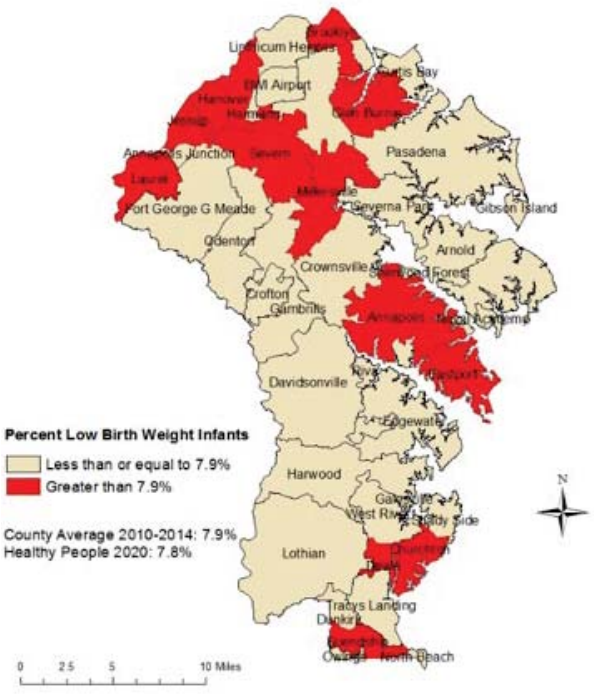
Infant Deaths and Infant Mortality Rates by Race and Ethnicity Anne Arundel County 2010-2014		
Race/Ethnicity	Number of Infant Deaths	Infant Mortality
White, NH	89	4.0
Black, NH	68	11.2
Hispanic, Any Race	22	5.3

Source: Maryland Department of Health and Mental Hygiene Vital Statistics Administration, 2013

Low Birth Weight

Low birth weight (less than 2,500 grams) is the single most important factor affecting neonatal mortality (newborn infants up to 28 days old) and a significant determinant of post neonatal mortality (newborn infant between 28 and 364 days old). Low birth weight infants run the risk of developing health issues ranging from respiratory disorders to neurodevelopmental disabilities, especially those developmental issues related to school achievement. In Anne Arundel County, the percentage of low birth weight babies is dropping slowly and is less than the state average at 8.7%. However, there are several ZIP codes concentrated in the northern part of the county where the percentage of low birth weight infants is much higher than the overall county average of 7.9%, especially in Brooklyn, Severn, Laurel, Glen Burnie (West), Hanover, Millersville, and Jessup (Figure 9).

Figure 9
Percentage of Low Birth Weight Infants by ZIP Code, Anne Arundel County, 2010-2014



Health Care Access

The Affordable Care Act (ACA) has increased access and expectations for health care. In Maryland, under the ACA, persons whose income is up to 138% of the poverty level are eligible for Medicaid. The number of Medicaid enrollments increased from 68,166 in January 2013 to 84,616 in December 2014 (Table 8). There are still many primary care doctors who do not accept Medicare/Medicaid.

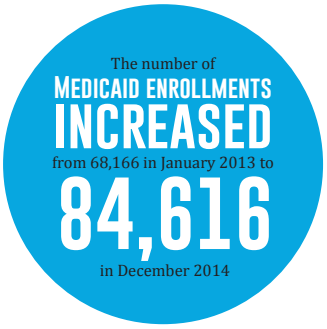
Persons whose income is above 138% but below 400% of the poverty level have the option to purchase health insurance through the Maryland Health Connection (the state's insurance marketplace/exchange). In many commercial plans, high deductibles and co-pays have burdened some individuals. To date, information is not available for how many uninsured residents gained coverage through the ACA. A small percentage of county residents such as undocumented people, those not enrolled in Medicaid despite being eligible, and people opting to pay the annual penalty instead of purchasing insurance will still remain uninsured. Overall, 6.6 % of the county population still has no health insurance. The Hispanic population has the highest rate of uninsured in the county (22%) (Office of Minority Health and Health Disparities, Maryland Department of Health and Mental Hygiene, 2013).

Of note, the ACA does not include dental benefits for adults as an essential health benefit, so dental insurance plans that are offered through Medicaid are extremely limited in the number of benefits. Those offered through the Maryland Health Connection may have high premiums with high co-pays or co-insurance costs.

Table 8

Medicaid Enrollment by Age, Sex, and Race and Ethnicity Anne Arundel County, December 2014	
	Medicaid Enrollment
Total Enrollment	**84,616**
Age	
Under 18 Years	37,843
18 to 64 Years	43,040
65 Years and Over	3,733
Sex	
Male	37,186
Female	47,430
Race and Ethnicity	
White, NH	39,793 (47%)
Black, NH	25,193 (30%)
Hispanic, Any Race	6,349 (8%)
Asian	3,829 (5%)

Source: Maryland Department of Health and Mental Hygiene, 2015



Access to Primary Care, Dentists and Mental Health Providers

Access to primary care is a growing issue in the county. Having a primary care provider reduces nonfinancial barriers to obtaining care, facilitates access to services, and increases the frequency of contacts with health care providers. Without a primary care provider, people have more difficulty obtaining prescriptions and attending necessary appointments. According to county health rankings, the patient to primary care physician ratio in Anne Arundel (1,430:1) is worse than in Maryland (1,131:1) and the U.S. top performing counties which are among the 90th percentile in ranking (1,045:1). Similarly, the patient to dentist and to mental health provider ratios in Anne Arundel are worse than in Maryland and the U.S. top performing counties. Compared to Maryland, Anne Arundel County has 21.6% less primary care physicians and 8.5% less dentists per 100 population (Table 9). According to participants in this needs assessment, the result is that the wait times for routine care are growing longer. Some primary care practices have instituted a team approach to increase the number of patients that can be seen including nurse practitioners and nurses to perform some of the health tasks. Reporting and other time consuming tasks have grown with the increase in technology and, as one primary care doctor noted:

> "We are barely keeping our noses above water and now we have five more things that we have to do and if we don't do them, eventually we will have another problem."

According to the 2014 University of Maryland Medical System, Physician Needs Assessment, primary care, psychiatry and general surgery are projected to have the most physician deficits by 2019.

Table 9

Primary Care Physicians, Dentists and Mental Health Providers
Anne Arundel County, Maryland

	Anne Arundel County Total	Anne Arundel County Ratio	Maryland Ratio	Top U.S. Counties (90th percentile)
Primary Care Physicians (2012)	385	1,430:1	1,131:1	1,045:1
Dentists (2013)	366	1,518:1	1,392:1	1,377:1
Mental Health Providers (2014)	774	718:1	502:1	386:1

Source: Anne Arundel County Health Rankings and Roadmaps, 2015

Health Professional Shortage Areas

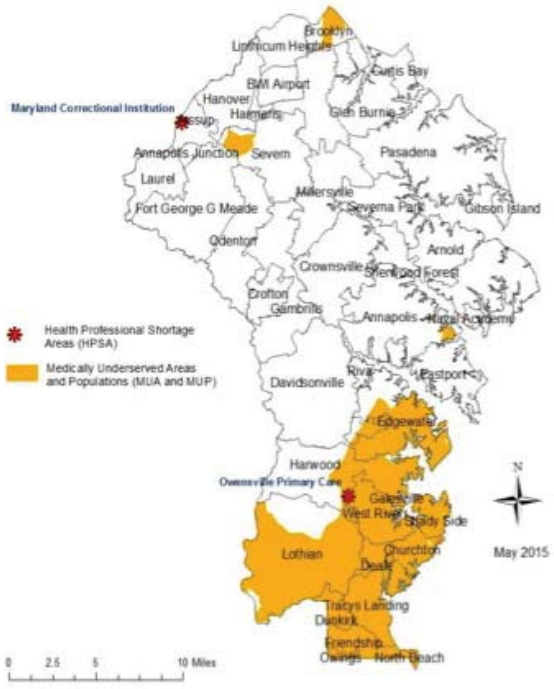
Health Professional Shortage Areas (HPSAs) are designated by the Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers and may be geographic. Currently, the county has one designated Primary Care HPSA (Owensville Primary Care), one Dental HPSA (Owensville Primary Care) and two Mental Health HPSAs (Owensville Primary Care and Maryland Correctional Institution, Jessup).

Medically Underserved Areas

Medically Underserved Areas (MUA) are designated based on four variables: ratio of primary medical care physicians per 1,000 population; infant mortality rate, percentage of the population with incomes below the poverty level; and percentage of the population age 65 or over. There are 11 census tracts in Anne Arundel County which are designated as medically underserved areas or populations. Approximately 54,700 (10%) of the county's population lives in these 11 census tracts. As illustrated in Figure 10, South County's access to health care is very limited. As one South County resident commented:

Figure 10

Health Professional Shortage Areas (HPSA) and Medically Underserved Areas and Populations (MUA/P)
Anne Arundel County, 2015



> "They're building places on the Eastern Shore but not in South County. You have to get someone to take you to AAMC. There are no taxis here. In other places they have those health clinics in Giant….that would be very helpful in South County."

Senior Health

"Seniors" is a very broad term for a group that now spans almost four decades. Participants in the needs assessment saw the aging population in three quite distinct groups: 55-70 years of age, 70-85 years of age and 85 and older. Each group has very distinct needs emotionally, physically and psychologically, yet they get lumped together when services and funding are at stake. Most of the population age 65 and older has health insurance through Medicare. As of 2103, there were 75,607 Medicare beneficiaries with Part A and Part B in Anne Arundel County. By race and ethnicity, 82.19% of Medicare beneficiaries in Anne Arundel County were White, 13.1% were Black and 1.3% were Hispanic of any race. Almost 11% of Medicare beneficiaries were also eligible for Medicaid.

Table 10

Medicare Beneficiaries in Anne Arundel County, 2013	
Beneficiary Demographic Characteristics	**Number or Percentage**
Beneficiaries with Part A and Part B	75,607
Fee-for-service Beneficiaries	69,420
Medicare Advantage (MA) Beneficiaries	6,187
Average Age	72 years
Percent Female	56.2%
Percent Male	43.8%
Percent White (Non-Hispanic)	82.2%
Percent Black	31.1%
Percent Hispanic, Any Race	1.3%
Percent Eligible for Medicaid	10.9%

Source: Centers for Medicare & Medicaid Services

Health concerns noted by those who serve seniors in our county included falls, urinary tract infections (UTIs), anxiety, dehydration, medication compliance, type 2 diabetes, obesity and lack of mobility caused by joint issues. Some of the medications prescribed to the aging population actually cause dizziness and ultimately falling. Medication compliance is another huge issue. Some seniors simply forget to take their pills; the writing is too small on the bottle; or the side effects are too unpleasant. Seniors often have more than one doctor for their different ailments. As a case manager pointed out:

> “I had a client with about 30 medications. She’s diabetic, has COPD and congestive heart failure.”

There is rarely consultation between doctors which can result in seniors taking medicines that are contraindicated.

Hospital Admissions

In 2013, there were an estimated 59,533 hospital stays in Anne Arundel County, representing a hospitalization rate of 107.1 stays per 1,000. The hospitalization rate for Blacks was the highest among the racial/ethnic groups (Maryland Health Services Cost Review Commission, 2013). The rate of hospitalization was highest in the population aged 65 years and over (Table 11).
The hospitalization rate increased with age from 74.1 hospitalizations per 1,000 population among 0-18 year olds to 267.9.3 hospitalization per 1,000 population among those aged 65 years and over. (Note: This data only includes Anne Arundel County residents admitted to hospitals in Maryland.)

Table 11

Hospitalizations by Age Group Anne Arundel County, 2013		
Age Group	**Number of Hospitalizations**	**Rate per 1,000**
0 to 18 yrs.	9,371	74.1
19 to 39 yrs.	12,584	76.6
40 to 64 yrs.	18,143	94.3
Greater than 64 yrs.	19,435	267.9

Source: Inpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Some of the leading causes of hospitalization were shared by some racial/ethnic groups but not by others. Congestive heart failure was the second leading cause of hospitalization for Blacks but only the sixth leading cause of hospitalization for Whites. Mood disorder was the fourth leading cause of hospitalization for Whites and Blacks but was not among the 10 leading causes of hospitalization for the Asian and Hispanic population (Maryland Health Services Cost Review Commission, 2013). Nonetheless, Hispanic participants in this needs assessment pointed to the trauma and increased stress that comes with immigration, especially when there are language barriers, as a contributing factor for mental health issues among that population.

NEEDS

•Health resource planning for geographic differences related to low income, poverty and health access, especially in North and South County

•Senior in-home care for non-emergency issues

•More primary care physicians and general surgeons, particularly in South County.

•Improved access to adult dental care

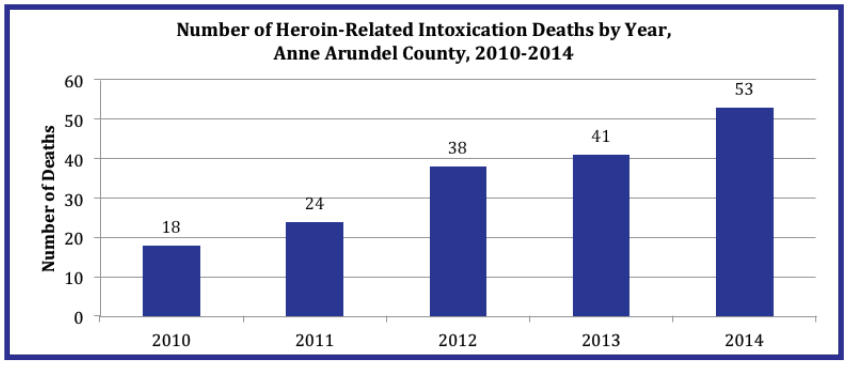
•Improved care coordination to help people manage chronic conditions such as congestive heart failure and diabetes

Anne Arundel County

BEHAVIORAL HEALTH CHAPTER 2

Needs Assessment, 2015

In 2014, Anne Arundel had the **3RD HIGHEST** number of **PRESCRIPTION OPIOID-RELATED DEATHS** in Maryland (after Baltimore City and Baltimore County).



Out of 101 intoxication deaths that occurred in Anne Arundel County in 2014, **53 WERE HEROIN-RELATED.** There was almost a three-fold increase in the number of heroin-related deaths (from 18 to 53) between 2010 and 2014.The number of heroin-related deaths increased by 29.2% between 2013 and 2014 (Behavioral Health Administration, DHMH 2014).

Anne Arundel County Mental Health Agency served **11,321 RESIDENTS** in 2014, which was an increase of **11%** from 2013. This figure compares to a 6% increase from 2013 to 2014.

There has been a **14.5% INCREASE** in the use of public mental health services for **CHILDREN AGES 6 TO 12** **&** **9.6% INCREASE FOR CHILDREN AGES 13 TO 17**

The number of residents served in 2014 **INCREASED BY ALMOST 145%** since 2002.

Behavioral Health
Chapter 2

Mental Health

The rise in mental health issues and the lack of appropriate services and service providers were the major concerns for almost every participant in this needs assessment. Those perceptions were substantiated by the rise in the numbers of county residents seeking public mental health services (Table 12). Anne Arundel County Mental Health Agency served 11,321 residents in 2014, which was an increase of 11% from FY13. This figure compares to a 6% increase from 2013 to 2014. The number of residents served in 2014 increased by almost 145% since 2002. There were several suggestions among participants as to why this increase is taking place, although most agreed that current stress levels for children and families are generally higher. According to one physician:

> "Stress plays out on the health side of things in terms of mental illness and in terms of anxiety and depression. I think it is increased because with the anxiety piece you don't have any down time, the more technologically advanced somebody's life is the less free time they have. You can work 24/7 and you never get a break so I think that is a contributor to anxiety."

Table 12

Number of People Served by a Public Mental Health Service in Anne Arundel County, 2012-2014

	2012	2013	Percent of Change ('12-'13)	2014	Percent of Change ('13-'14)
Early Child (0-5)	392	394	0.5%	473	20.%
Child (6-12)	1,821	1,880	3.2%	2,152	14.5%
Adolescent (13-17)	1,388	1,476	6.3%	1,617	9.6%
Transitional (18-21)	586	584	-0.3%	610	4.5%
Adult (22 to 64)	5,351	5,762	7.7%	6,396	11.0%
Elderly (65 and over)	59	70	18.6%	73	4.3%
TOTAL	9,597	10,166	5.9%	11,321	11.4%

Source: Anne Arundel County Mental Health Agency, 2015

Access

The ACA has increased access to mental health services, although the county still lacks sufficient mental health providers. County mental health officials report a decrease of 20% in the number of uninsured mental health service consumers and a decrease of 25% in expenditures for the uninsured between 2012 and 2014 (Table 13).

Table 13

Three Year Comparison Medicaid/Uninsured					
	Persons Served				
	FY 2012	FY 2013	% Change	FY 2014	% Change
Medicaid	8,883	9,463	6.1%	10,687	12.9%
Medicaid State Funded	1,238	1,446	14.4%	1,639	13.3%
Uninsured	768	780	1.5%	624	-20%
Total	**9,597**	**10,166**		**11,321**	**11.4%**

Source: Anne Arundel County Mental Health Agency, 2015

Residential mental health beds are almost nonexistent in the county, although there are 259 residential rehabilitation beds (for the chronic and persistent mentally ill). There are only 24 crisis beds and only one in-patient psychiatric unit with 14 beds, and it is often full. There is one Spanish-speaking psychiatrist available to the Hispanic uninsured population. There are very few Spanish speaking mental health counselors.

While access to services has increased, the county lacks psychiatrists and specialty therapists who have skill in trauma, veterans' issues and geriatric psychiatry, especially for those residents with dementia. As one participant commented:

> "Almost every Monday morning there will be 17 to 18 psychiatric patients in the emergency room waiting for placement."

There is a growing number of outpatient mental health providers in the county, but these numbers are not expected to keep up with the growing county need. The ratio of mental health providers to residents in the county is much lower than the state (Table 14). AAMC has recently opened an outpatient mental health clinic. UMBWMC is planning for an expansion of its outpatient services. Arundel Lodge has recently opened the Marcus Youth and Family Center. However, according to participants, the demand for mental health services at health access points is resulting in shortening care without proper follow-up or step down from residential care.

Table 14

Primary Care Physicians, Dentists and Mental Health Providers Anne Arundel County, Maryland				
	Anne Arundel County Total	**Anne Arundel County Ratio**	**Maryland Ratio**	**Top U.S. Counties (90th percentile)**
Mental Health Providers (2014)	774	718:1	502:1	386:1

Source: Anne Arundel County Mental Health Agency, 2015

Mental Health, 0-18 Years

There has been a 14.5% increase in the use of public mental health services for children ages 6 to 12 and a 9.6% increase for children between 13 and 17 years of age (Table 12). The most recent Maryland Youth Risk Behavior Survey (2013) found that, in the 12 months prior to the survey, 21.9% of Anne Arundel County students had been bullied on school property; 27.9% of students reported feeling so sad or hopeless almost every day for two weeks in a row that they stopped doing normal activities; 16.9% of students seriously considered attempting suicide; and 13% of students made a plan about how they would attempt suicide. Many youth are under increased stress as a result of social media, including the increasing rate of cyberbullying, described by participants in this needs assessment.

Very young children with serious mental health issues are presenting at pediatric emergency, in the Emergency Department and in primary care offices. There are no residential mental health beds for youth in the county. As one participant noted:

The ages of youth with mental health issues are decreasing. We are seeing younger and younger patients (5-7 year olds). When serious issues are identified the nearest facility is in Western Maryland. Often they are in treatment there for only two weeks without the support of their families, and they turn up again in the ER very quickly.

The need for public mental health services is growing most rapidly in the 0-5 population, yet there are only two evidence-based behavioral programs for that population in the county: BEST (Behavioral and Emotional Support and Training) offered by Anne Arundel Community College TEACH Institute and Parenting Center and CHAMPS (Children Arriving Mentally Prepared for School) offered by Arundel Child Care Connections. Some of the behavioral issues found in the early childhood population could be addressed through parenting classes, which are available at the community college, but parents must have their own transportation to get there and they must be able to find the time. One participant noted:

> “We need to educate parents but when you have two jobs and four other children, then getting to parenting class is low on the list. Transportation affects everything we do. We run a lot of parenting groups, at least one per month but if parents can’t get to them…”

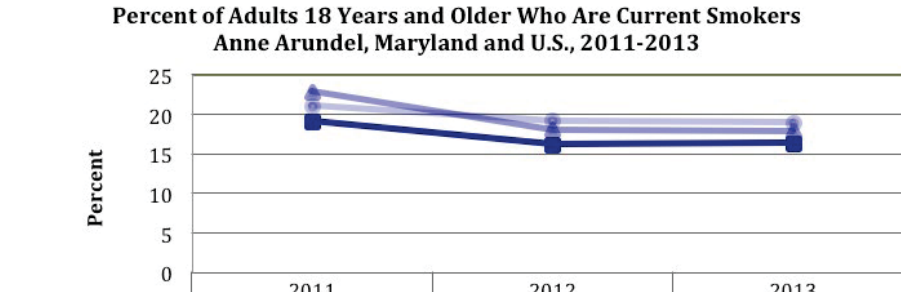
School-based clinical mental health services are available for students although there are often waiting lists. Young people in need of psychiatric care often wait in the emergency room between 12 and 24 hours. At a recent emergency nurse's roundtable one nurse expressed that her biggest fear was that one of these youths would find the means to complete suicide while waiting in the ER. According to one supervisor, "The stress on ER staff related to these issues is enormous."

Substance Abuse

Tobacco

Smoking is associated with an increased risk of heart disease, stroke, lung and other types of cancers, and chronic lung diseases (CDC). The rate of tobacco use in the county is higher than the state at 18% but lower than the nation (Figure 11).

Figure 11

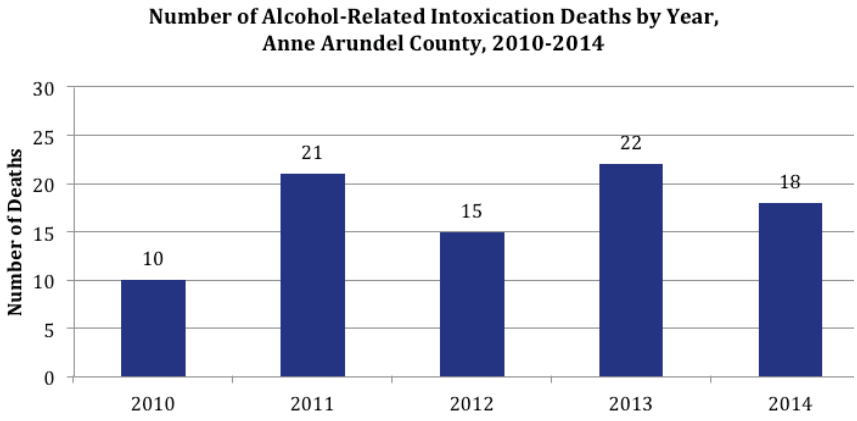


Source: Behavioral Risk Factor Surveillance Systems, Centers for Disease Control and Prevention, 2011-2013

Alcohol

Alcohol use in the county is an acceptable social norm, evidenced by the number of boating parties on weekends and the hundreds of happy hour specials in bars and restaurants. The number of alcohol-related deaths increased by 80% between 2010 and 2014 (from 10 to 18) but declined by 18% between 2013 and 2014 (Figure 12).

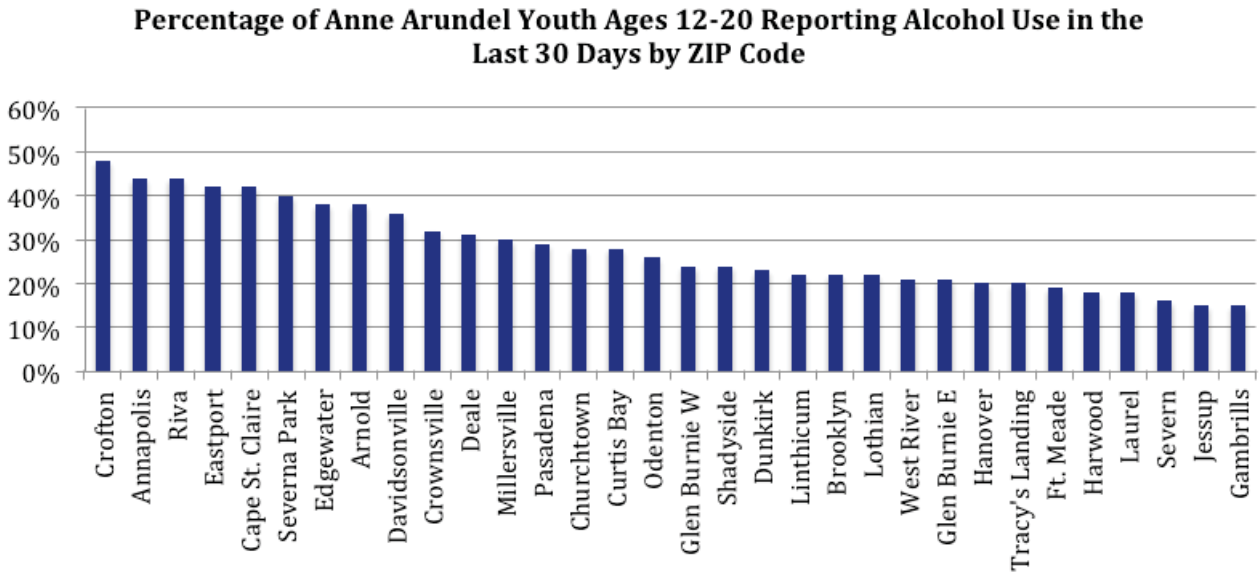
Figure 12



Source: Behavioral Health Administration, Maryland DHMH. Data is for deaths that occurred in Anne Arundel County irrespective of person's county of residence.

Alcohol is used more than tobacco and other illicit drugs among youth. According to the Maryland Youth Behavioral Risk Survey (2013), over one quarter of Anne Arundel County youth reported alcohol use. Data by ZIP code indicates underage drinking occurs in all of the county's ZIP codes with Crofton reporting the highest use and Gambrills reporting the lowest use. The majority of youth who use alcohol report that they get their alcohol from someone who gave it to them or that they gave someone money to buy it for them. Several surveys have shown that there is still a community "norm" around alcohol use in the county and that some underage youth are given alcohol by their parents.

Figure 13

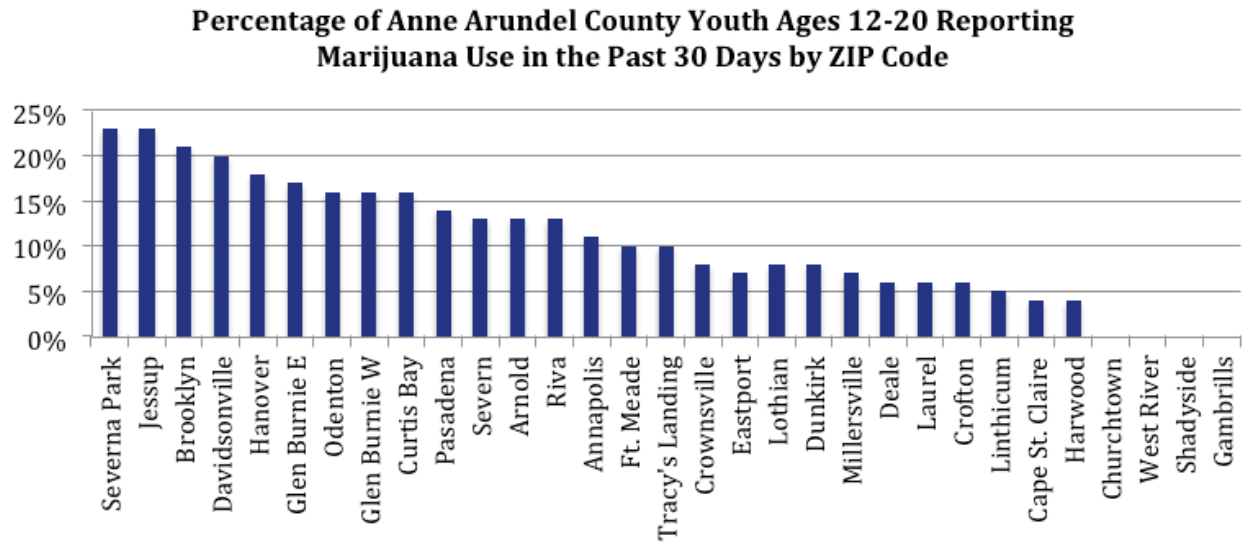


Source: Coalition for Safe Communities Behavioral Risk Survey, 2013

MARIJUANA

The impact of legalization of medical marijuana and small amounts of marijuana has contributed to youth perception that marijuana use is acceptable and even healthy. According to a risk survey completed by the Coalition for Safe Communities in 2013, marijuana is the second most popular drug for Anne Arundel County youth. An average of 14% of surveyed youth reported a past 30-day use of marijuana; 2% higher than those reporting tobacco use. The percentage varies by ZIP code (Figure 14). The county average for marijuana use is slightly higher than tobacco use, although tobacco has a slightly greater range of usage by ZIP code.

Figure 14



Source: Coalition for Safe Communities Risk Survey, 2013

Prescription Opioids and Other Prescription Drugs

While tobacco, marijuana and alcohol are the top three substances of choice among youth, participants emphasized that pills of every kind are readily available and often abused. According to one participant:

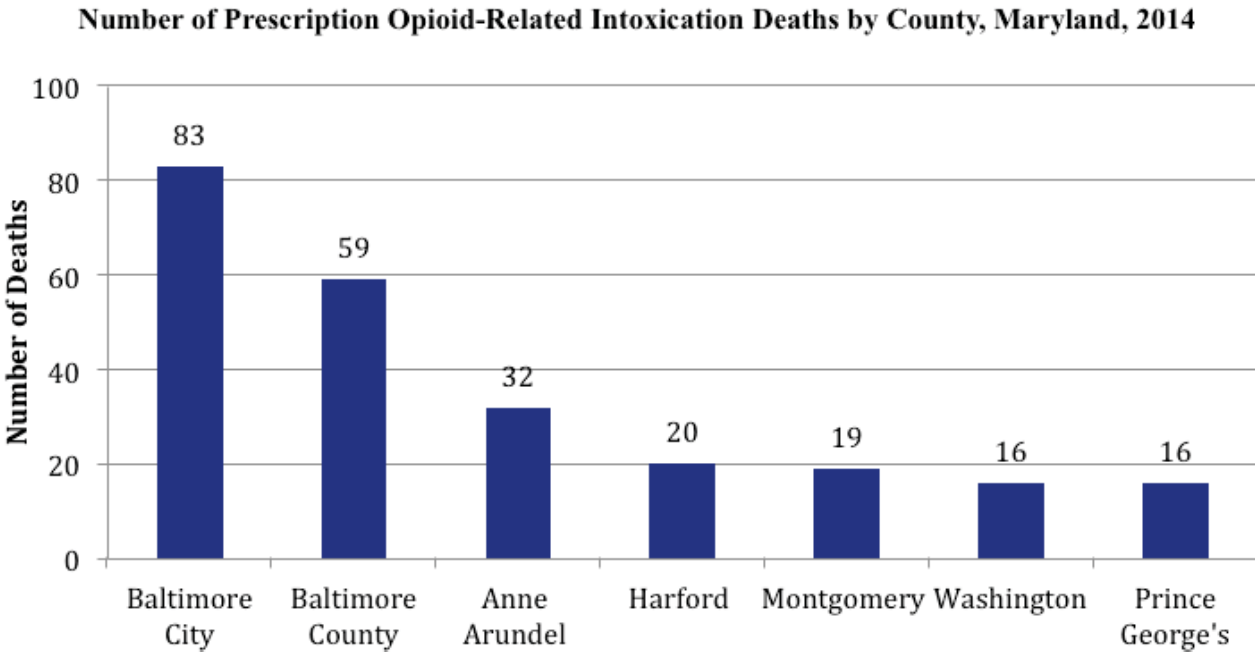
> "We have kids who come into school high at 7 in the morning. There is no learning and it's sad to watch. They are the kids that drop out and don't get a job."

Sometimes children abuse their own prescriptions for anti-anxiety or ADHD medications by taking too many or selling them to others. Some youths with a prescription pill addiction issue were prescribed painkillers after a sports injury. According to participants, there has been a large decrease in referrals for substance abuse from the school system related to the loss of the federal grant program Safe and Drug Free Schools. According to one participant:

> "All school personnel know kids are using but no-one is there to do the assessment and referrals. There's a lot more tolerance for a little weed or alcohol."

Prescription opioid addiction is now a major public health crisis. In 2014, Anne Arundel County had the third highest number of prescription opioid-related deaths in Maryland (after Baltimore City and Baltimore County). The overall number of prescription opioid-related deaths has remained relatively stable in recent years growing from 31 in 2010 to 32 in 2014 (Behavioral Health Administration, Maryland DHMH, 2014).

Figure 15



Source: Behavioral Health Administration, Maryland DHMH. Data is for deaths that occurred in Anne Arundel County irrespective of person's county of residence.

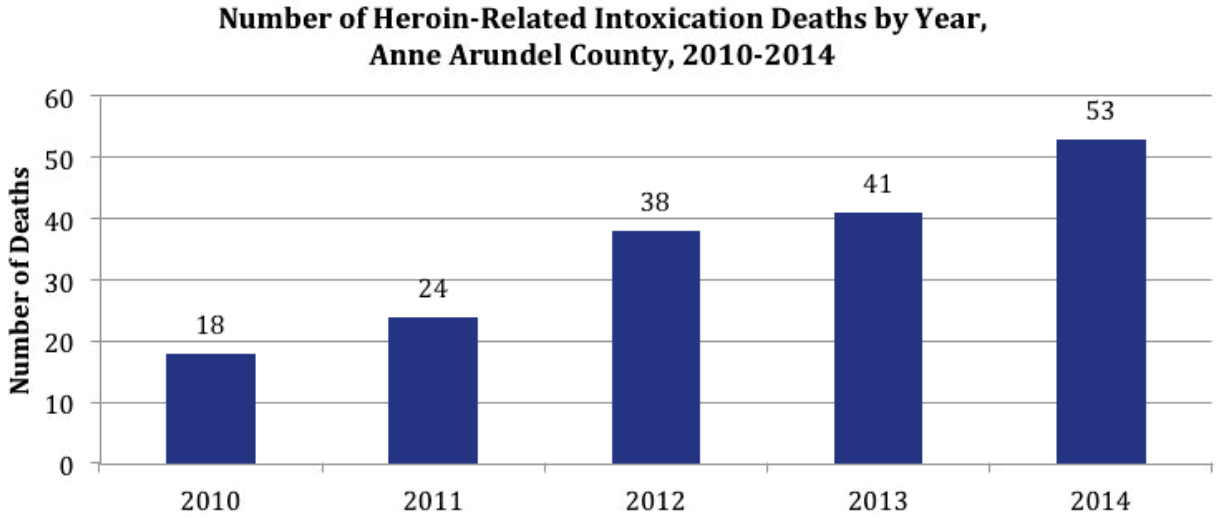
County health professionals acknowledge that while opioids are helpful to patients with pain issues, opioid addiction is a major issue. The medical community has begun tightening regulations and behaviors around opioids. As one noted:

> "If you have someone on controlled medicines for more than six weeks, then that is chronic pain management. Then you have to see them every month, you have to do specific documentation about their continued need and how they are doing."

Heroin

The increase in controls on prescription drugs has made the trade in prescription opioids more expensive. Partly because of this, heroin (a derivative of opium and an illegal opiate drug) has made a profound reappearance on the streets of Anne Arundel County. It can be as cheap as $10 per hit and can be injected, snorted or smoked. The increase in heroin use is a pressing substance abuse issue for the county presently (Figure 16). Out of 101 intoxication deaths that occurred in Anne Arundel County in 2014, 53 were heroin-related. There was almost a three-fold increase in the number of heroin-related deaths (from 18 to 53) between 2010 and 2014.The number of heroin-related deaths increased by 29.2% between 2013 and 2014 (Behavioral Health Administration, DHMH 2014).

Figure 16

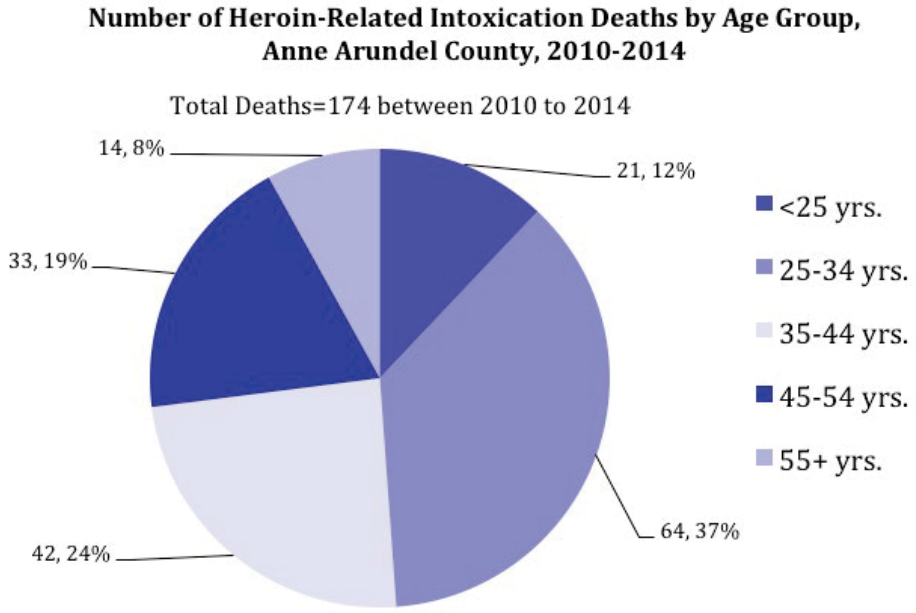


Source: Behavioral Health Administration, Maryland DHMH. Data is for deaths that occurred in Anne Arundel County irrespective of person's county of residence.

From 2010 to 2014, 80% of heroin-related deaths occurred in people ages 25 to 54. Only 12% of deaths occurred in persons less than 25 years, and 14% of deaths in persons 65 years and over (Figure 17). For most heroin addicts, the journey to heroin usually includes other drugs. As one parent noted:

> "They look for someone they know who will buy them a six pack of beer. Then it's 'try this pill it's called oxy' – then they go on to heroin. We had heroin sales on our block. It's right around the corner; it's like Starbucks now."

Figure 17



Source: Behavioral Health Administration, Maryland DHMH. Data is for deaths that occurred in Anne Arundel County irrespective of person's county of residence.

Co-Occurring Issues

The relationship between substance abuse and mental illness is well documented. Patients with mental health issues may "self-medicate" by using and abusing drugs to manage their mental illness. It is often difficult to separate the symptoms of substance abuse from the symptoms of mental illness. Mental health professionals acknowledge that they are still learning how to treat co-occurring disorders. Officials at the Pathways substance abuse treatment center estimate that 80% of their population has a co-occurring disorder, yet treatment and payment options are often in traditional silos. One mental health professional commented that there has been a huge jump in payment denials because the payers don't know how to handle co-occurring disorders:

> "The type of individual we see now, we're not just dealing with co-occurring disorders, we're seeing people who've overdosed and have co-occurring disorders at a much higher rate. The providers are making note. The providers have a huge jump in the number of denials because of co-occurring issues. They're saying they don't know how to handle them."

Substance abuse treatment services are still limited in the county. In-patient treatment is particularly lacking. Pathways, operated by AAMC, offers the only residential treatment center for adolescents in the county. They also offer a variety of outpatient services and 40 in-patient beds, 32 for adults and eight for adolescents 13-17. There is promise of a 120-bed facility for residential substance abuse treatment at the Crownsville hospital site and renovations are already underway. Private residential providers also include Damascus House, Hope House, Samaritan House and Serenity Acres. Chrysalis House is still the only residential treatment facility that offers in-patient services to women and their children.

Needs

•More providers of psychiatric, counseling and substance abuse services, especially those who are Spanish speaking

•Residential mental health and substance abuse beds, especially for the adolescent population

•Care coordination for residents coming out of residential care and returning to the community. Care coordination should extend to behavioral health providers and primary care.

•An increase in substance abuse providers across the continuum of care

•Mental health services for the early childhood population

•Integration of behavioral health care at the provider level

•Crisis beds for immediate response and to relieve the emergency departments

•School-based assessment of substance abuse

Anne Arundel County

THE SOCIAL DETERMINANTS OF HEALTH CHAPTER 3

Needs Assessment, 2015

The Anne Arundel County Public School System estimates suggest there are over

925

COUNTY STUDENTS WHO DO NOT SLEEP IN THEIR OWN HOMES ON ANY GIVEN NIGHT.

Homelessness creates huge issues for health facility discharge planners.

Approximately

69,000

(12%) of county residents live in an area categorized as a

FOOD DESERT

The YWCA, the county's **ONLY DOMESTIC VIOLENCE AND SEXUAL ASSAULT SERVICES** provider, has a waiting list of

400-500 INDIVIDUALS

at any given time.

LACK OF PUBLIC TRANSPORTATION

is a major issue for the county. Neither city nor county bus routes operate early in the morning or later in the evening and the wait between buses can be one to one and a half hours. There is only one bus from Annapolis to Glen Burnie. Residents in South County do not even have access to a taxi service.

Rising Demographic, Socioeconomic and Health Indicators by ZIP Code
Anne Arundel County, 2013

ZIP Code	Area	Poverty Percentage	Population % without High School	Percent of Households on SNAP	ED Visit Rate (per 1,000 population)	Percent of Low Birth Weight Infants (2009-2013)	Perventable Hospitalizatin Rate (per 1,000 population)	Minority Population %
20711	Lothian	^	^	^	^		^	
20714*	North Beach	^		^	^		^	
20758	Friendship	^	^		^		^	
21060	Glen Burnie (East)	^	^	^	^	^	^	^
21061	Glen Burnie (West)	^	^	^	^	^	^	^
21144	Severn	^	^	^		^		^
21225*	Brooklyn	^	^	^	^	^	^	^
21226*	Curtis Bay	^	^	^	^	^	^	
21403	Eastport	^	^	^	^			^
	Anne Arundel County	6.30%	9.30%	5.60%	334.9 (per 1,000 population)	7.9 (per 1,000 population)	14.3 (per 1,000 population	29%

Source: Maryland Department of Health and Mental Hygiene Vital Statistics Administration; American Community Survey; Maryland Health Services Cost Review Commission

* ZIP codes shared with other counties; data presented is estimate for Anne Arundel County only.

^ denotes higher than County average, preventable hospitalization category excludes low birth weight infants

The Social Determinants of Health

Chapter 3

Many factors determine the state of a person's overall wellness. Income level, especially for those who live in poverty, determines what resources are available to meet daily needs, the cleanliness and safety of the environment and access to health services. Although Anne Arundel County has a high standard of living overall, there are pockets of poverty to be found in several areas. Many participants commented that the economic recovery has not reached down into vulnerable communities as of yet and the gap between rich and poor in the county is growing. Communities that were less resourced prior to the recession continue to be less resourced and the social ills continue. As one participant asked:

> "What is the biggest cause of asthma admissions in kids in Anne Arundel County in the summer? Is it that they don't have air-conditioning, or that they didn't take their medications?"

The majority of negative social and health indicators are polarized in the North and South of the County as illustrated by Table 15, which shows the county ZIP codes where more than three socio-economic indicators of health are rising. In South County, access to health care is very limited and there are few primary care doctors. Those South County residents with transportation often travel to Glen Burnie to access primary care. Owensville Health Center, in Edgewater, is inaccessible to those residents who live in areas like Deale and have no transportation. Substance abuse rates are high in South County yet the last treatment facility based there closed this year, although Owensville Health Center is offering substance abuse treatment. Participants suggested primary care clinics based in supermarkets would be very helpful in South County but as of this writing there are none.

Table 15

Rising Demographic, Socioeconomic and Health Indicators by ZIP Code Anne Arundel County, 2013								
ZIP Code	Area	Poverty Percentage	Population % without High School	Percent of Households on SNAP	ED Visit Rate (per 1,000 population)	Percent of Low Birth Weight Infants (2009-2013)	Perventable Hospitalizatin Rate (per 1,000 population)	Minority Population %
20711	Lothian	^	^	^	^		^	
20714*	North Beach	^		^	^		^	
20758	Friendship	^	^		^		^	
21060	Glen Burnie (East)	^	^	^	^	^	^	^
21061	Glen Burnie (West)	^	^	^	^	^	^	^
21144	Severn	^	^	^		^		^
21225*	Brooklyn	^	^	^	^	^	^	^
21226*	Curtis Bay	^	^	^	^	^	^	
21403	Eastport	^	^	^	^			^
	Anne Arundel County	6.30%	9.30%	5.60%	334.9 (per 1,000 population)	7.9 (per 1,000 population)	14.3 (per 1,000 population	29%

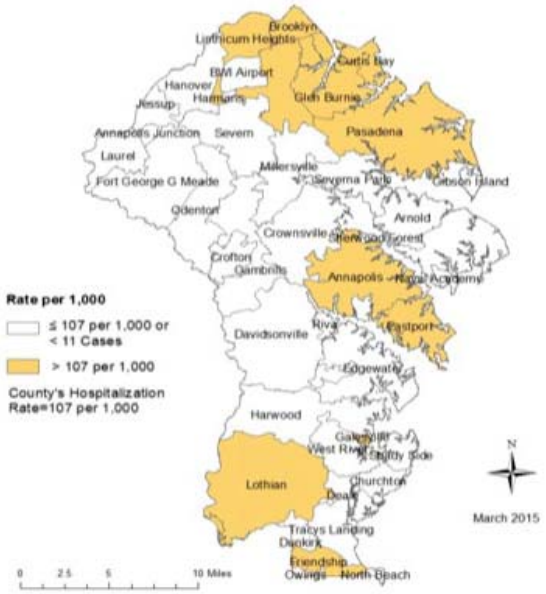
Source: Maryland Department of Health and Mental Hygiene Vital Statistics Administration; American Community Survey; Maryland Health Services Cost Review Commission
* ZIP codes shared with other counties; data presented is estimate for Anne Arundel County only.
^ denotes higher than County average, preventable hospitalization category excludes low birth weight infants

Hospitalization Patterns Related to Social Determinants

As illustrated in Figure 18, when patterns of hospitalization by ZIP code are examined, they generally reflect the social determinants illustrated in the Table 15. Eastport, Galesville, Pasadena, Lothian, Annapolis (ZIP code 21401), Linthicum Heights, Glen Burnie (West and East), Curtis Bay, Harmans, Friendship and Brooklyn have higher hospitalization rates than the county rate. Brooklyn has the highest hospitalization rate among all ZIP codes (185.2 per 1,000), which is 80% higher than the county rate (107.1).

Figure 18

Hospitalization Rate per 1,000 Population, Anne Arundel County 2013



Obesity

Many factors play a role in weight including low income, lifestyle, surrounding environment, access to healthy food, genetics and certain diseases. Overweight and obesity are determined using weight and height to determine a BMI or "body mass index" measure. Between 2011 and 2013, the percent of overweight adults (BMI of 25 to 29.9) 18 years and older in Anne Arundel County fell from 36.2 to 32.6 (Figure 19). However, the obesity rates for those with a BMI of 30 or more increased almost four percentage points (Figure 20).

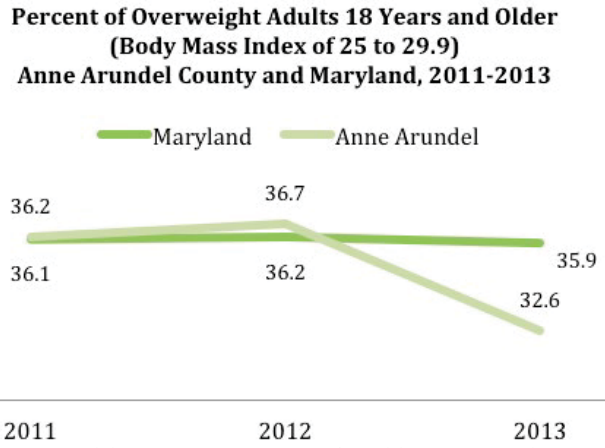
There was general acknowledgement among participants that there is no quick fix for obesity issues. Several pointed out that bad eating and exercise habits might take a generation to change. Below is a typical comment:

> "When you think about food, food quality, access to food, fitness, nutrition, education — all of the pieces that go into this — you are breaking cycles of drinking soda or lower cost unhealthy foods; that is very, very difficult to do. I would caution all of us to be patient because this stuff is not going to turn in a 3-year cycle."

Obesity is prevalent in low-income families in the county for a variety of reasons: their neighborhoods often lack full-service grocery stores and farmers' markets; healthy food can be more expensive; there is no transportation to get to a supermarket; and there is a greater availability of fast food restaurants selling cheap, filling food. As one participant commented:

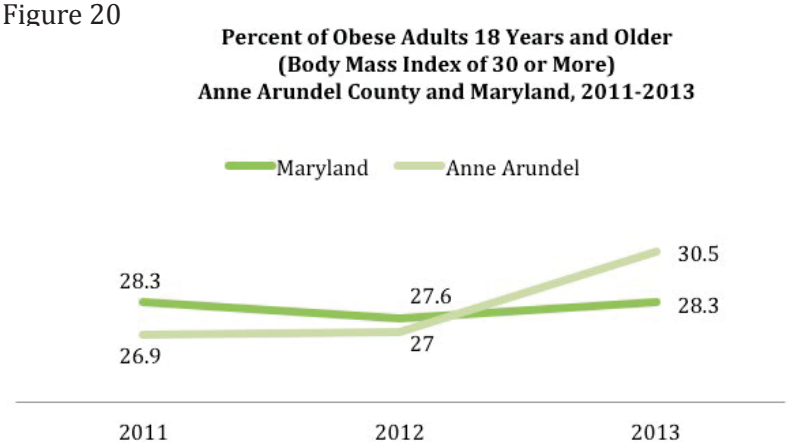
> "We have a problem with diabetes but it seems as soon as things become sugar-free they are way more expensive. You can't choose to change your lifestyle because eating healthy comes with a price….when you don't have money, you eat chicken and rice, ground beef, things that can go in the microwave, a lot of processed foods mainly - whatever is cheap and easy."

Figure 19



Source: Anne Arundel County Department of Health Report Card, 2015 (Maryland BRFSS)

Figure 20



Source: Anne Arundel County Department of Health Report Card, 2015 (Maryland BRFSS)

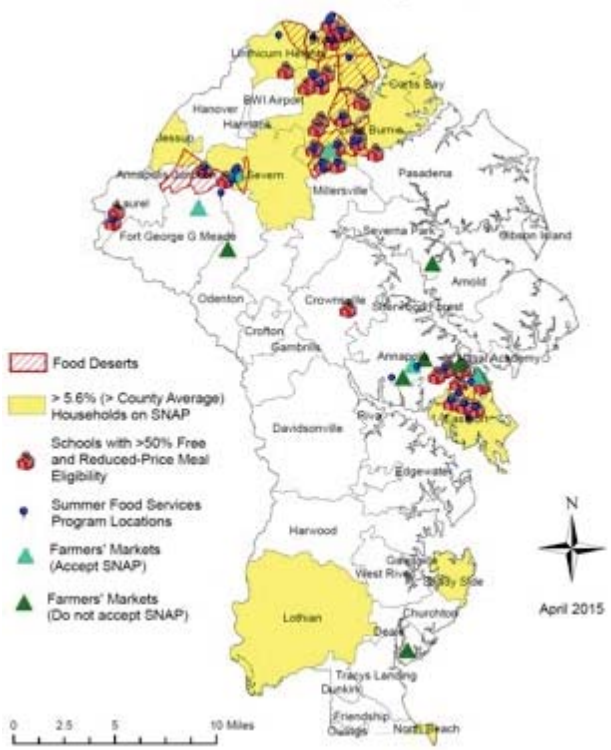
Health and Hunger

Several participants suggested that while the lack of physical activity, especially for children, is part of the picture of obesity, the real issue is the food we eat. Several low-income communities are also mapped as food deserts (Figure 21). They do not have access to healthy food and they have no transportation to get to supermarkets. Unhealthy food is cheap and filling — an important asset for large families managing with few means.

Approximately 69,000 (12%) of Anne Arundel County residents live in an area categorized as a food desert (Figure 21). Food deserts are defined as urban neighborhoods and rural towns without ready access to fresh, healthy and affordable food. Lack of access to healthy food contributes to a poor diet, which can lead to higher levels of obesity, diabetes and heart disease. Figure 21 overlays food deserts, SNAP recipients and children receiving free and reduced lunch, resulting in a grim picture of North County. Food insecurity is the most broadly-used measure of food deprivation. The United States Department of Agriculture defines food insecurity as "when consistent access to adequate food is limited by a lack of money and other resources at times during the year." According to Feeding America (2013), 50,580 of Anne Arundel County's residents are food insecure. Many of them are children. Hungry and malnourished children suffer from two to four times as many individual health problems as children who are adequately nourished. Health issues include unwanted weight loss, fatigue, headaches, irritability and frequent colds.

Figure 21

Food Environment
Anne Arundel County, 2015



Approximately
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live in an area categorized as a
FOOD DESERT

Source: Supplemental Nutrition Assistance Program (SNAP) Participation: 2009-2013 ACS, 50Year Estimates; Farmers Market: Maryland Department of Agriculture, 2014: Summer Food Service Program: Anne Arundel County Public Schools; Free and Reduced-Price Meal Eligibility: Maryland Department of Education; Food Deserts: USDA, Food Access Research Atlas. The low access and distance measure extracted from the Food Access Research Atlas, and displayed on this map, is low income and low access measured at 1/2 mile and 10 miles.

TRANSPORTATION

The lack of public transportation is a major issue for the county. Neither city nor county bus routes operate early in the morning or later in the evening and the wait between buses can be one to one and a half hours. There is only one bus from Annapolis to Glen Burnie. Residents in South County do not even have access to a taxi service. Currently the county provides subsidy support for three bus routes (B, J and K) operating on one hour to 90 minute intervals covering Maryland City, Odenton, Severn and Northwest Glen Burnie. (Anne Arundel County Transportation Commission, 2014). The City of Annapolis offers a circular route and fixed route services. According to one case manager, even those low-income residents lucky enough to live and work in Annapolis often have to walk three miles to and from the bus stop each day. Many low-income residents do not know how to drive a car and lessons are prohibitively expensive. Cheaper transportation, such as electric scooters and bikes are increasingly regulated, which requires a high initial outlay. Insurance, tag and title are other costs that have to be factored in. One North County resident commented:

> “Transportation is the real issue. We don’t have any network of transportation. Everything is still limited to the Ritchie Highway corridor. If you don’t live on that corridor it’s very difficult.”

Lack of transportation continues to impact low-income and senior residents. Many cannot get to their primary care doctor or to the pharmacy to pick up their medications. Some are discharged from the hospital or Emergency Room without a ride home and too late to ride the bus.

Housing and Homelessness

Rising home prices, high private rents and a lack of affordable and multi-family housing are continuing problems for large segments of the population. In 2013, Anne Arundel County homeowners spent 34.3% and renters spent a staggering 49.5% of their income on housing. As income levels decrease, families need to spend an increasing proportion of their income on housing. As of March 2015, there were 9,000 families on the waiting list for public housing and 10,000 families on the waiting list for Housing Choice (Section 8) vouchers (Anne Arundel County Housing Commission, 2015). More than 2,000 homeless residents received case management services in 2014 (Table 16). This number does not count those sleeping in woods or motels, or those doubled up with other families. The fastest growing homeless population is homeless families and youth who are staying with friends or living temporarily in motels. There are over 250 families living in a shelter or transitional housing (Homeless Management Information Systems, Anne Arundel County, 2014) The Anne Arundel County Public School System estimates suggest there are over 925 county students who do not sleep in their own homes on any given night. Homelessness creates huge issues for health facility discharge planners. As one succinctly commented:

> “How do you do discharge planning to people who don’t have a place to be discharged to?”

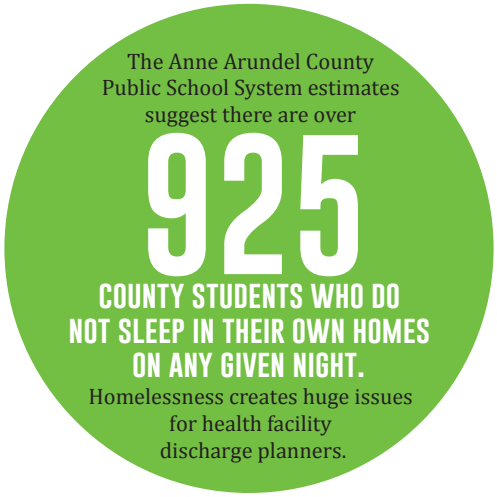

Table 16

Numbers of Homeless Served in Anne Arundel County 2013-2014		
	Total Served	New Entries in 2014
Total Homeless Served	2,078	
Total Veterans	105	
Male	1,120	
Female	958	
Emergency Shelter		
Total People	805	605
Number of Families	128	108
Transitional Housing		
Total People	152	77
Number of Families	39	20
Anne Arundel County Public Schools (Not included in numbers above)		
Active homeless students	925	
Unaccompanied Youth	350	

Source: HMIS System for Anne Arundel County, 2015

Domestic Violence/Sexual Assault or Abuse

Domestic violence/sexual assault or abuse numbers for the county are unreliable. Many victims do not report through fear and shame. Even when victims are hurt enough to warrant an emergency room visit they may deny their injuries were purposeful. Currently the YWCA (the county's only domestic violence and sexual assault services provider) has a waiting list of 400- 500 individuals at any given time. There is only one safe house for domestic violence/sexual assault or abuse victims in the county, although plans are underway to build a new shelter for victims.

Domestic violence/sexual assault or abuse victims present at local hospitals and their emergency departments. According to one participant, emergency department providers are often involved in time-consuming charting and the integration of victims' care with law enforcement, social workers and patient advocates. AAMC currently employs a staff of 13 abuse and domestic violence specialists who respond to domestic violence, sexual assault, child abuse and vulnerable adult abuse around the clock. In 2014, the team assisted 960 new victims and 196 secondary victims. Of those victims, 567 reported domestic violence and 114 reported sexual assault. Sixty-seven percent of the cases came from the emergency department. UMBWMC's Sexual Assault Forensic Exam (SAFE) program only responds to acute sexual assault or abuse. In 2015, the program served 14 adults and adolescents over 13 and seven pediatric patients less than 12 years old.

All participants familiar with domestic violence/sexual assault or abuse issues reported that they expect the numbers of victims to continue to rise, mostly due to the increased awareness and acceptance of the issue. Several suggested that a Forensic Nurse Examiner Program would help ensure the medical, safety and psycho-social needs of victims are met and forensic evidence is documented completely while helping to take pressure off emergency room personnel.

Lack of Recreational and Community Facilities

Several participants commented on the need for more recreational opportunities, especially for youth. Several noted that the rise in substance abuse among youth may be correlated with the lack of recreation and other activities outside of school. As one South County participant commented:

> "The children are bored. They have nothing to do. They go down to the pier and drink. They say 'Try this smoke.' There's a liquor store in Deale. The teenagers hang in the parking lot. They have no place to go."

Parent advocates caring for adult children with mental illnesses noted that there is a lack of social activities and employment opportunities for this population. There are no evening and very few late day programs. As one parent commented:

> "After 1:30 in the afternoon there is nothing [in the county] for the mentally ill to do but sit at home."

Technology

Social media and technology was highlighted several times as one of the root causes for increased levels of stress, anxiety and depression in our community. Examples ranged from cyberbullying to information on cutting to negative social messages. Many participants suggested that the lack of social skills prevalent in young people is directly related to technology. Children as young as two, teenagers and all the youth in between are engaged in overuse. Many are sleep deprived; it is not unusual for teens to be chatting into the early hours of the morning. Several participants suggested that everyone — young and old — turn off technology at least an hour before bedtime. Parents were urged to take responsibility for their own as well as their children's overuse. As one participant noted:

> "Kids are on the phone at 2:00 a.m. in the eighth grade. Parents need to take control. Seven year olds have headphones and tablets… Don't look at your iPads at all when your kids are around."

Needs

•Access to transportation, especially for low-income residents and seniors

•Affordable housing. The lack of affordable housing is creating stress, and worst of all homelessness, for low-income families.

•Access to recreational and social opportunities, especially for youth and the adult mentally ill

•Primary care and behavioral health providers, which are especially lacking in South County.

•Access to healthy food for low-income families

•Healthy living conditions, including air conditioning

•A Forensic Nurse Examiner Program to better serve domestic violence/sexual assault and abuse victims and to take pressure off emergency room personnel

Anne Arundel County

SERVICE DELIVERY ISSUES CHAPTER 4

Needs Assessment, 2015

HEALTH SERVICES IN THE COUNTY ARE OVERWHELMED BY REPEAT PATIENTS.

This population ranges from drug users with frequent overdoses to those with chronic conditions like diabetes and the worried elderly with ongoing somatic issues.

THERE IS A CLEAR CORRELATION BETWEEN LOW INCOME, ACCESS TO SERVICES AND MENTAL HEALTH.

Lothian, Edgewater, Annapolis (ZIP code 21401), Churchton, Deale, Glen Burnie (East and West), Curtis Bay, Friendship and Brooklyn have higher ED visits rates for behavioral health conditions than the total county rate.

BROOKLYN
has the
HIGHEST ED VISITS RATE
(42.2 per 1,000) for behavioral health conditions, which is
145% HIGHER
than the average county rate (17.2 per 1,000).

Emergency Department Visits by Race and Ethnicity
Anne Arundel County, 2013

Race/Ethnicity	Number of ED Visits	Rate per 1,000
White, NH	98,617	250.3
Black, NH	48,507	554.0
Hispanic, Any Race	8,552	223.0
Asian, NH	1,454	71.7
Total	186,124	334.9

Emergency Department Visits by Age Group
Anne Arundel County, 2013

Age Group	Number of ED Visits	Rate per 1,000
0 to 18 yrs.	39,455	312.0
19 to 39 yrs.	68,342	415.9
40 to 64 yrs.	58,087	301.9
65 years and over	20,240	279.0

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Participants suggested that
CASE MANAGEMENT AT THE POINT OF DISCHARGE
could be very helpful, especially for reducing readmission to hospitals. Rather than a hand-off, participants suggested a "warm hands on" to a paid "friend" or navigator who could follow up.

Service Delivery Issues
Chapter 4

Many of the issues and needs raised by participants in this needs assessment originate in the processes used to deliver health and behavioral health care. Care is often delivered in silos of specialization and though many agencies may be involved in the wellness of each individual, there are barriers to communication between those agencies. Because the processes used to deliver health care are not naturally fluid there are transitional points for the patient that may well need attention.

Emergency Departments

Emergency Departments (ED) provide a significant source of medical care in Anne Arundel County. In 2013, Anne Arundel County residents made approximately 186,124 ED visits to hospitals within Maryland. There were 335 visits to the ED for every 1,000 individuals in the county. The ED visit rate for Blacks was the highest among the racial and ethnic groups examined followed by Whites, Hispanics of any race and Asians. The rate of ED visits for Blacks was 121% higher compared to that of Whites and 65% higher than the county's average ED visit rate (Table 17). People over 65 years of age had the lowest rate of ED visits by age group. (Note: This data only includes Anne Arundel County residents visiting the ED of hospitals in Maryland)

Table 17

Emergency Department Visits by Race and Ethnicity Anne Arundel County, 2013		
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Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Table 18

Emergency Department Visits by Age Group Anne Arundel County, 2013		
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40 to 64 yrs.	58,087	301.9
65 years and over	20,240	279.0

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

In 2013, 85.6% of all ED visits by Anne Arundel County residents were due to acute conditions such as sprains and superficial injuries and 14.3% were due to chronic conditions. Mood disorder was the most common chronic condition (12.2%) for ED visits followed by asthma (11.6%), alcohol-related disorders (7.2%), anxiety disorders (6.0%), headaches/migraines (5.9%) and substance-related disorders (3.9%).

Table 19

Emergency Department Visits for Chronic Conditions Anne Arundel County, 2013			
	Chronic Conditions	**Frequency**	**Percent**
1	Mood Disorder	3,256	12.2%
2	Asthma	3,101	11.6%
3	Alcohol-related disorder	1,922	7.2%
4	Anxiety disorders	1,607	6.0%
5	Headache/migraine	1,576	5.9%
6	Substance-related disorder	1,042	3.9%
7	Hypertension	1,027	3.9%
8	Other nerve disorder	946	3.6%
9	Dysrhythmia	742	2.8%
10	Other upper respiratory conditions	703	2.6%
	Total ED Visits for Chronic Conditions	26,637	

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

When ED visits are disaggregated by ZIP code, there is a clear correlation between low income and numbers of visits. Eastport, North Beach, Annapolis (ZIP code 21401), Lothian, Galesville, Glen Burnie (East and West), Friendship, Harmans, Curtis Bay and Brooklyn have higher ED visits rate than the total county rate. Brooklyn has highest ED visits rate (960 per 1,000), which is 186% higher than that of the average county ED visits rate (335 per 1,000).

The two county hospital EDs at AAMC and UMBWMC have become the "catch all" for somatic and behavioral health treatment. The ED is a trusted venue and one of the main front doors for primary care, especially among lower income residents (even those with insurance and primary care doctors). Unfortunately, there are a number of diagnoses and subsequent services that Medicaid will not pay for in the ER but which could be billed in the community clinic setting. Both county ERs are on bus routes and most patients are seen within 24 hours. Patients can experience long waits and hurried entrance and discharge processes. Nonetheless, the ER remains the primary care of choice for some residents. As one participant noted:

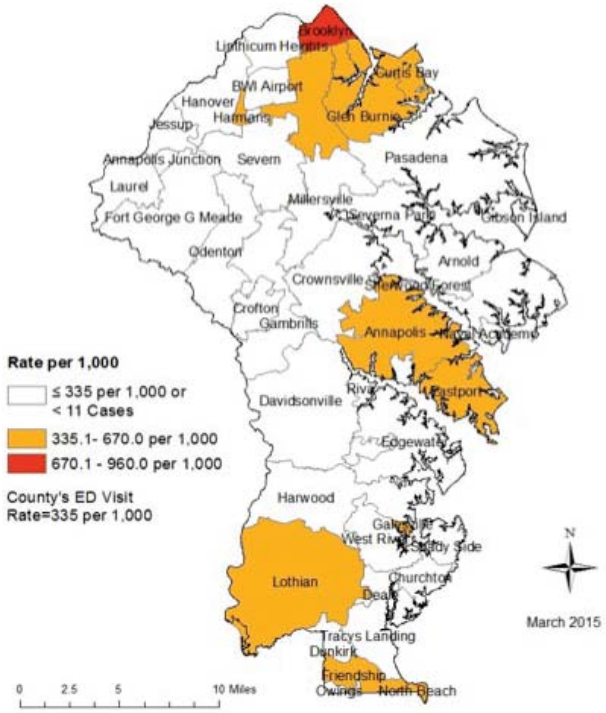
> "I would probably use the emergency room for about everything; I am not familiar with everything that goes on inside my body, so instead of waiting to see my primary care doctor I would go to the hospital. In the hospital the tests come back right then and there, so if it is something serious you will know instead of leaving and having to wait for results to come back. It could be too late; I could die."

Another participant pointed out:

> “I would rather go to the hospital and have them see me right then instead of making an appointment with primary care and waiting a couple of days. I would go there because it is a lot closer than where my primary care is and it would be a lot quicker. It is on a bus route.”

Emergency Department Visit Rate per 1,000 Population,
Anne Arundel County, 2013

Figure 22



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than the average county rate (17.2 per 1,000).

Source: Out Patient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Behavioral Health Issues and the Emergency Room

According to participants in the emergency services focus group, growing mental health issues, lack of mental health resources and denials from insurance companies are causing major issues across the emergency services spectrum. Patients with mental health issues have a ripple effect, pushing up wait times for everyone. For those residents with critical substance abuse and mental health issues, the ED is often their only choice. This can be particularly difficult for the parents of mentally ill adults. They may have to wait hours for their son or daughter to be evaluated in the ED. The fact that the patient is an adult, and therefore has confidentiality rights, means that parents cannot

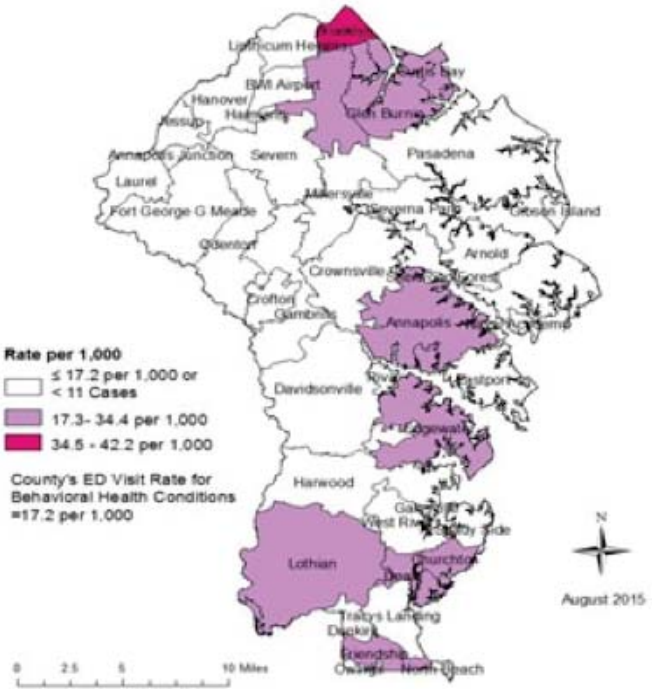
be included in the discussions about treatment without permission of their son or daughter. One parent reported that ED staff will not engage with her even when she has important and relevant information. As he noted:

> "It's the only place that my son has to go. No one talks to me even when I take a file with all the information. They will not talk to the parent. I wait out in the waiting room. None of the psychiatrists would talk to us – I couldn't even tell them what meds he was taking."

Both EDs are also seeing younger children with mental health issues. The children are being referred from daycare settings and pre-kindergarten when routine behavioral interventions have no impact on escalating behavior. Homeless residents often appear in ERs where the police are called repeatedly to assist in stabilizing the situation.

Figure 23

Emergency Department Visit Rate per 1,000 Population,
Behavioral Health Conditions as Primary Discharge Diagnosis,
Anne Arundel County, 2013



THERE IS A CLEAR CORRELATION BETWEEN LOW INCOME, ACCESS TO SERVICES AND MENTAL HEALTH.

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

When behavioral health ED visits are examined by ZIP code, there is a clear illustration of the relationship between low income, access to services and mental health. Lothian, Edgewater, Annapolis (ZIP code 21401), Churchton, Deale, Glen Burnie (East and West), Curtis Bay, Friendship and Brooklyn have higher ED visits rates for behavioral health conditions than the total county rate. Brooklyn has the highest ED visits rate (42.2 per 1,000) for behavioral health conditions, which is 145% higher than the average county rate (17.2 per 1,000).

Communication and Partnerships

The lack of communication and partnering between the various health and human services agencies, including emergency personnel, was noted by many participants. There is, at times, a disconnection between the Emergency Room, Emergency Medical Services and the Police Departments. As one participant noted, "Communication is a little bit broken." Participants did acknowledge that cross agency communication at high levels of authority has increased related to the needs in the community, but it is still lacking in those who provide the services.

Communication between agencies is made more awkward by the regulations for patient confidentiality laid out by the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA.) As an example, the school system may refer a youth to the ED, but the schools receive no report or follow-up so they don't know what transpired until they talk to the parents or the youth. Case managers and care coordinators often don't know their client has entered or been discharged from the hospital. As one coordinator noted:

> "Communication is a big issue. Sometimes we don't find out they've been to the hospital until they've already gone and come back again. What happened prior to admission? What medicine wasn't taken? Can they read their medications? Staffing with local hospitals doesn't happen and the discharge happens quickly."

Many participants suggested there should be more collaboration between county agencies, especially Health, Aging and Social Services to ensure that the services work together. Here is a typical comment:

> "There is a lot of overlap in the populations being served, but there is probably some duplication of effort and then there are still some folks slipping through the cracks."

Nonetheless, there are several partnerships related to mental health and substance abuse that have been developed between the police department, criminal justice agencies, health and mental health services and the public school system. Agencies expressed an interest in a shared general consent for information release and a centralized intake system with one number to call. There is such a release among the medical community but it does not extend to other agencies.

The crisis response system, supervised by the County Mental Health Agency, has one number for those in crisis to call, including the homeless population. Crisis teams are now assigned to AAMC and UMBWMC. A client release of information for coordination of services among agencies has been developed and works well.

The One-Stop-Shop Notion

Participants commented that services are more fragmented because they occur in several different locations. Several stressed the increased need for health and social services to be delivered at one location. The community schools model that offers primary health care, behavioral health and social services in the school building was suggested by some as a good model for low-income residents, especially those without transportation.

Telehealth

Electronic and virtual services might be the way forward for the county given the dire lack of transportation in the county. However, there was general agreement that the county is not on the cutting edge of telehealth. In the South County focus group, participants pointed out how useful telehealth could be in the areas where there are no buses or taxis. They suggested that telehealth and telemedicine, including psychiatric services, could be done through smart phones.

High Utilizers of Health Care

Health services in the county are overwhelmed by repeat patients. This population ranges from drug users with frequent overdoses to those with chronic conditions like diabetes and the worried elderly with ongoing somatic issues. These "super-utilizers" strain the system at every level, especially the crisis and emergency systems. According to an emergency services participant:

> "Some patients call Emergency Management (EMS) more than 10 times per year. Last year, there were 60,000 calls to EMS and 40,000 resulting patients."

Many of these patients could be managed more judiciously if agencies were allowed to share information and coordinate care. Home visiting and follow-up care could eliminate those who return because they didn't follow directions on their medications or didn't get their medications filled after discharge.

Transition Points, Care Coordination and Home Visiting

The two points of entry and discharge into EDs, hospitals and other systems were highlighted as problematic. Participants stressed that the hospital acts as a positive holding place where many issues can be addressed. As one participant adroitly commented:

> "When a person walks into a hospital you have them. We need some kind of staff at the front door that capture those people and do education and planning and phone calls with them sitting right there...tie them to services while they're there"

At the point of admission community service providers are not part of the process. They often don't know their clients have been admitted so they can't be helpful or supportive. The discharge process, especially from EDs, is often hurried with no means to follow up with the patient. While referrals may be made at this point, the patient is expected to follow up. As one participant noted:

> "Discharge is not handing someone a piece of paper with multiple numbers. You need to make a plan. One can't just give people a list of three clinics – they have to be coordinated by navigators."

Participants suggested that case management at the point of discharge could be very helpful, especially for reducing readmission to hospitals. Rather than a hand-off, participants suggested a "warm hands on" to a paid "friend" or navigator who could follow up with the discharge instructions, collect the medicines, read the bottles and instructions when necessary and ensure the home was ready to accept the patient. When patients return home there is currently no organized system to follow up on their immediate needs and welfare. Participants suggested home visiting programs although they acknowledged that people are not always ready to have people in their homes. As one participant noted:

> "After patients leave, there is no one to check on them, make sure their prescription is filled or that they are actually taking needed meds."

There are discussions about EMS personnel acting as home visitors who will follow up with the patient related to basic health issues such as medication management, fluid intake, follow-up appointments and so on. This new idea is being referred to as Mobile Integrated Healthcare. EMS personnel are a familiar and positive force in the community; easily identifiable by their uniform. However, the discussions related to this idea have been somewhat stalled by the Maryland Institute for Emergency Medical Services Systems, the organization that oversees and coordinates all components of the statewide EMS system in accordance with Maryland statute and regulations. The organization is concerned that someone other than nurses will administer nursing care. Several other options for "two generation" home visiting were considered by participants, including navigators to act as "friends," bachelor's level social workers, specially trained Healthy Start nurses, and Meals on Wheels personnel. There are already care coordinators in several health and human services systems but their work is not coordinated across silos of care.

Wellness, Early Screening and Personal Responsibility

Somatic health and behavioral health are interrelated. Physical illnesses can cause depression and anxiety in the same way that behavioral health issues can cause physical illness. Mental health issues and substance abuse are often co-occurring. Participants commented that somatic care, mental health and substance use are too fragmented in the current system. The health model should be holistic with an emphasis on long-term, planned wellness. As one participant noted:

> "The approach we need to be taking is that wellness is life-long. It's not just having services available but that those services are offered for every phase of the lifecycle."

The move towards wellness should include early screenings for behavioral health issues in the primary care setting and follow-up care. Patient-centered medical homes are an important part of the wellness concept. The Affordable Care Act has increased access to health care for many. With access comes responsibility for personal health and personal choices. The health system is already moving towards patient engagement and education on personal responsibility including the importance of routine health maintenance like check-ups and physicals and the management of chronic conditions. Many participants agreed that the ACA should emphasize personal responsibility. As one health care professional commented:

> "People should have access to good health care. I do think that that should be a right. I think with rights though do go some responsibilities, and I don't think the Affordable Care Act did anything related to personal responsibility."

However, in low-income communities that message may need to be louder. According to one resident living in public housing:

> "A lot of people aren't educated on finding a primary care doctor, in some communities all they know is the emergency room. In poor communities they don't understand the importance of checkups and physicals, they don't understand all that, it is just when they feel something they will go."

Needs

- Information sharing and coordination among agencies
- Comprehensive patient interviewing and case management at admission and discharge
- Home visiting and follow-up care
- Coordination and communication among care workers
- Further use and development of community health clinics
- One stop shops for health, behavioral health and social services

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Anne Arundel County, Maryland

2015 Community Health
Needs Assessment

Secondary Data Profile

Table of Contents

County Overview

Anne Arundel County is located in Maryland and is home to more than 556,000 residents. It is bounded in the north by Baltimore City; in the east by the Chesapeake Bay; in the south by Calvert County; and in the west by the Patuxent River and Prince George's and Howard counties. It lies between the two major cities of Washington, D.C. and Baltimore, MD.

Anne Arundel County has a total area of 415 square miles with approximately 1,300 people living per square mile. The northern, central and western parts of the county are urban, while the southern part of the county is rural. The county has 127 public schools, approximately 80,000 students and 5,700 teachers. There are three major institutions of higher education: Anne Arundel Community College, St. John's College and the United States Naval Academy. The county is home to the Fort George G. Meade military installation, 15 major highway routes including the Chesapeake Bay Bridge that connects Maryland's Western and Eastern Shores, and the Baltimore/Washington International Thurgood Marshall Airport. In addition, the county has two Maryland State parks, over 70 county regional and community parks, and more than 534 miles of linear coastline.

Anne Arundel County is served by two major hospitals: Anne Arundel Medical Center in Annapolis and the University of Maryland Baltimore Washington Medical Center in Glen Burnie. MedStar Harbor Hospital, located just north of the county line in Baltimore City, also serves county residents.

Additionally, four Federally Qualified Health Centers (FQHCs) and the Anne Arundel County Department of Health (six clinic sites) offer a range of physical and behavioral health services. The Anne Arundel County Mental Health Agency, Inc. (AACMHA) provides a wide range of quality mental health services to Medicaid recipients and other low-income and un-insured county residents who meet certain criteria.

Secondary Data Profile Overview

The following report is a compilation of existing health data, also known as "secondary data," for Anne Arundel County. Data presented in this CHNA report were compiled from a variety of local, state and national sources. Population and socioeconomic statistics were compiled using data from the U.S. Census Bureau's Population Estimates Program and American Community Survey 1-Year and 5-Year estimates. Trends in birth and mortality were assessed using the birth and death data files obtained from the Maryland Department of Health and Mental Hygiene's (MD DHMH) Vital Statistics Administration. Emergency department and inpatient hospital discharge data files, provided by the Maryland Health Services Cost Review Commission, were used to analyze hospital utilization. Additional data sources for this report included Maryland and U.S. Vital Statistics Annual Reports; MD DHMH Annual Cancer Reports; the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS); the CDC WONDER Online Database; Centers for Medicare and Medicaid Services; and County Health Rankings & Roadmaps. Specific data sources are referenced throughout the report.

When available, state and national comparisons are provided as benchmarks for the Anne Arundel County statistics. Demographic information, such as sex, race, ethnicity and age group, as well as geographic information, such as health outcome by ZIP code, are also presented when accessible. These data provide the context of the social determinants of health that can significantly impact health behaviors and health outcomes in an area.

The most recent data, at the time the report was prepared, were used to determine the health needs of the community; however, limitations existed. Race and ethnicity data were not available for some health indicators, such as health insurance coverage, cancer screening, obesity and tobacco use. Other data were not available at the ZIP code level. Furthermore, rates calculated for ZIP codes with small populations can be statistically unreliable estimates, so they should be interpreted with caution.

Definitions

Crude Rate - The total number of cases or deaths divided by the total population at risk. Crude rate is generally presented as rate per population of 1,000, 10,000 or 100,000. It is not adjusted for the age, race, ethnicity, sex or other characteristics of a population.

Age-Adjusted Rate - A rate that is statistically modified to eliminate the effect of different age distributions in the population over time, or between different populations. It is presented as rate per population of 1,000, 10,000 or 100,000.

Family - Defined as more than one person living together, either as relations or as a married couple.

Frequency - Often denoted by the symbol "n," frequency is the number of occurrences of an event.

Household - Defined as one or more people sharing a residence. Examples include college students sharing an apartment or a single male living alone.

Health Disparity - Differences in health outcomes or health determinants that are observed between different populations. The terms health disparities and health inequalities are often used interchangeably.

Incidence Rate - A measure of the frequency with which an event, such as a new case of illness, occurs in a population over a period of time.

Infant Mortality Rate - Defined as the number of infant deaths per 1,000 live births per year. Infant is defined as being less than one year of age.

Prevalence Rate - The proportion of persons in a population who have a particular disease or attribute at a specified point in time (point prevalence) or over a specified period of time (period prevalence).

White - A person having origins in any of the original peoples of Europe, the Middle East or North Africa.

Black or African American - A person having origins in any of the black racial groups of Africa.

Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

American Indian or Alaska Native - A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

Hispanic or Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

Demographic and Socioeconomic Statistics

Population

The 2013 estimated population of Anne Arundel County is 556,348. Non-Hispanic whites represent the largest proportion of residents (70.9%), followed by non-Hispanic blacks (15.8%), and non-Hispanic Asians (3.6%). Hispanics (all races) comprise almost seven percent of the county's population. Slightly over half (50.5%) of the population is female, similar to Maryland and the United States. However, Anne Arundel County's racial and ethnic composition is significantly different than Maryland and the United States, as non-Hispanic whites represent over two-thirds of the population versus closer to half in the state and nationwide.

Table 1: Overall Population, Anne Arundel County compared to Maryland and U.S., 2013

2013 Estimates	Anne Arundel County	Maryland	United States
Total Population	556,348	5,938,737	316,497,531
Male	49.5%	48.5%	49.2%
Female	50.5%	51.5%	50.8%

Source: U.S. Census Bureau, Population Estimates Program, 2013

Table 2: Racial Breakdown, Anne Arundel County compared to Maryland and U.S., 2013

	Anne Arundel County	Maryland	United States
White, NH*	70.9%	53.3%	62.6%
Black, NH	15.8%	29.2%	12.4%
Hispanic, Any Race	6.9%	9.0%	17.1%
Asian, NH	3.6%	6.0%	5.1%
American Indian and Alaska Native, NH	0.3%	0.2%	0.7%
Others	2.5%	2.2%	2.1%

Source: U.S. Census Bureau, Population Estimates Program, 2013
*NH = Non-Hispanic

Population Change

According to the U.S. Census, the population increased by 8% in Anne Arundel County between 2004 and 2013, similar to Maryland and the United States during the same time period.

The Hispanic population of Anne Arundel County almost doubled between 2004 and 2013 while, conversely, the non-Hispanic white population declined by 1% during this same time period.

Table 3: Percent Population Change, Anne Arundel County compared to Maryland and U.S., 2004 – 2013

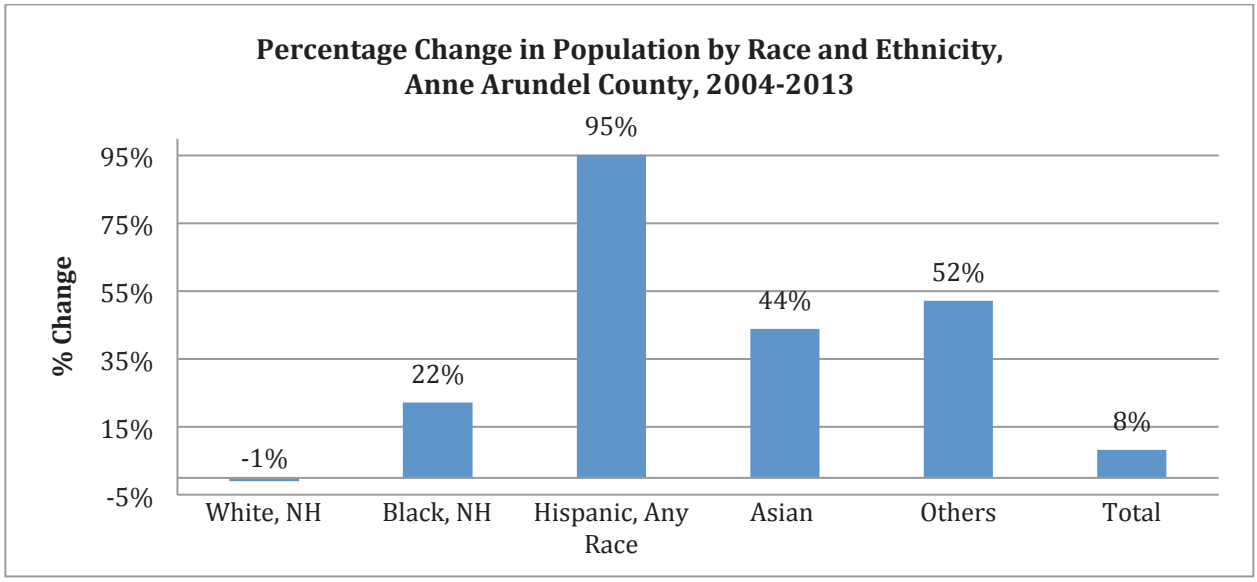
Percent Change in Population, 2004-2013	Anne Arundel County	Maryland	United States
	8%	7%	8%

Source: U.S. Census Bureau, Population Estimates Program, 2004 and 2013

Table 4: Population Change by Race/Ethnicity, Anne Arundel County, 2004-2013

	2004	2013	Difference	% Difference
White, NH	397,640	393,897	- 3,743	-1%
Black, NH	71,683	87,556	15,873	22%
Hispanic, Any Race	19,643	38,330	18,687	95%
Asian, NH	14,083	20,280	6,197	44%
Others	10,210	16,285	6,075	60%
Total	513,259	556,348	43,089	8%

Source: U.S. Census Bureau, Population Estimates Program, 2004 and 2013

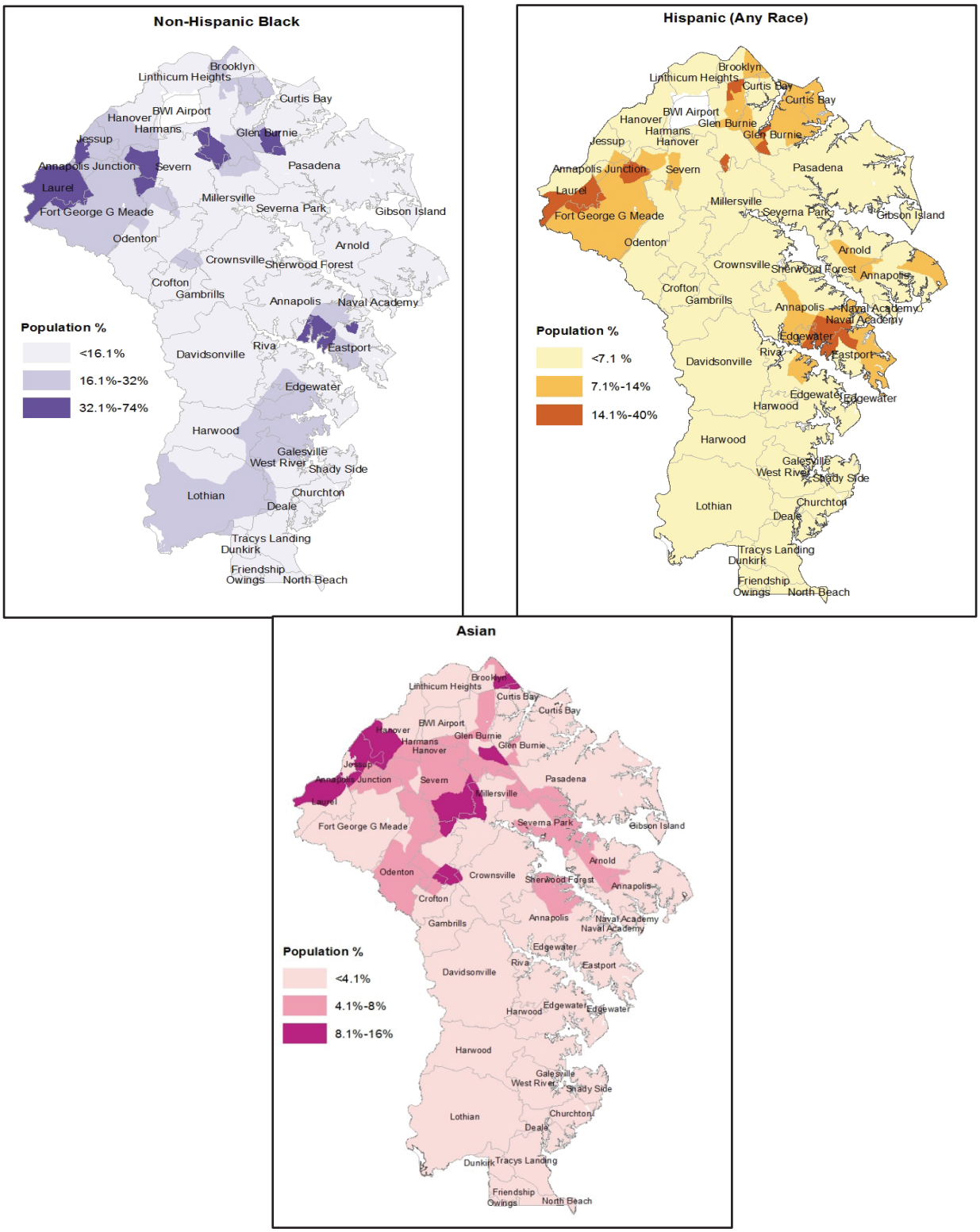


Source: U.S. Census Bureau, Population Estimates Program, 2004 and 2013

In 2004, the Hispanic population represented 3.8% of the total population in Anne Arundel County which increased to 6.9% in 2013. Among Hispanic subgroups, Mexicans ranked as the largest subgroup at 32%, followed by Puerto Ricans at 15%, and Cubans at 2.2% in 2013.

The minority populations (non-Hispanic black, Asian and Hispanic) are concentrated in the northern (Glen Burnie, Brooklyn), western (Odenton, Hanover, Laurel, Severn) and central (Pasadena, Eastport) regions of the county.

Non-Hispanic Black, Asian and Hispanic (of Any Race) Population by Census Tract, Anne Arundel County, 2013



Source: U.S. Census Bureau, 2013 American Community Survey 1-Year Estimates

Population by Age

The age distribution of Anne Arundel County is similar to Maryland and the United States. The majority of the population (61.8%) is between 20 and 64 years of age and, overall, the county has a slow and sustained growth as the birth rate exceeds the death rate.

The Hispanic population is distinctly younger than the overall population in Anne Arundel County. The median age of Hispanics is the lowest in the county at 26.7 years, compared to non-Hispanic whites with a median age of 42.2 years. Over 12 percent of Hispanics in the county are less than 5 years of age, double the county average of those less than 5 years of age (6.3%). Conversely, only three percent of the Hispanic population is over 65 years of age compared to 13.1% of the county average in the same age group.

Eighty-nine percent of Hispanics under the age of 18 were born in the U.S., while less than half of the Hispanic population over 18 years of age was born in the U.S. (45%).

Table 5: Population by Age, Anne Arundel County Compared to Maryland and U.S., 2013

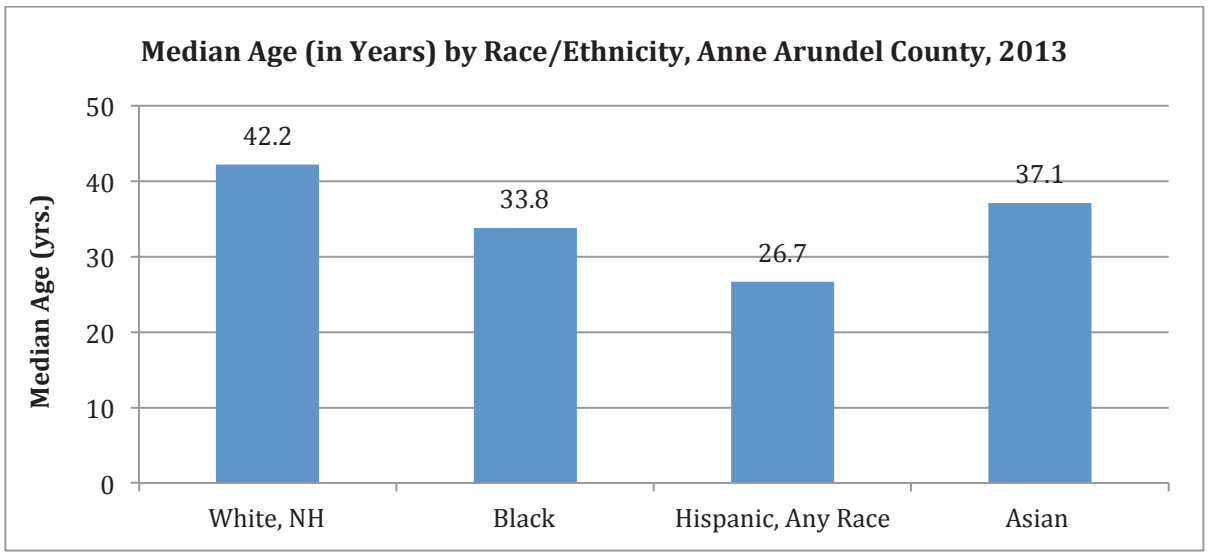
	Anne Arundel County	Maryland	United States
Under 5 Years Old	6.3%	6.2%	6.3%
18 Years and Over	77.2%	77.3%	76.7%
65 Years and Over	13.1%	13.4%	14.1%
Median Age (Years)	38.5	38.0	37.3

Source: U.S. Census Bureau, 2013 American Community Survey 1-Year Estimates

Table 6: Median Age by Race and Ethnicity, Anne Arundel County, 2013

Race and Ethnicity	Median Age (yrs.)
White, NH	42.2
Black or African American	33.8
Hispanic, Any Race	26.7
Asian	37.1

Source: U.S. Census Bureau, 2013 American Community Survey 1-Year Estimates

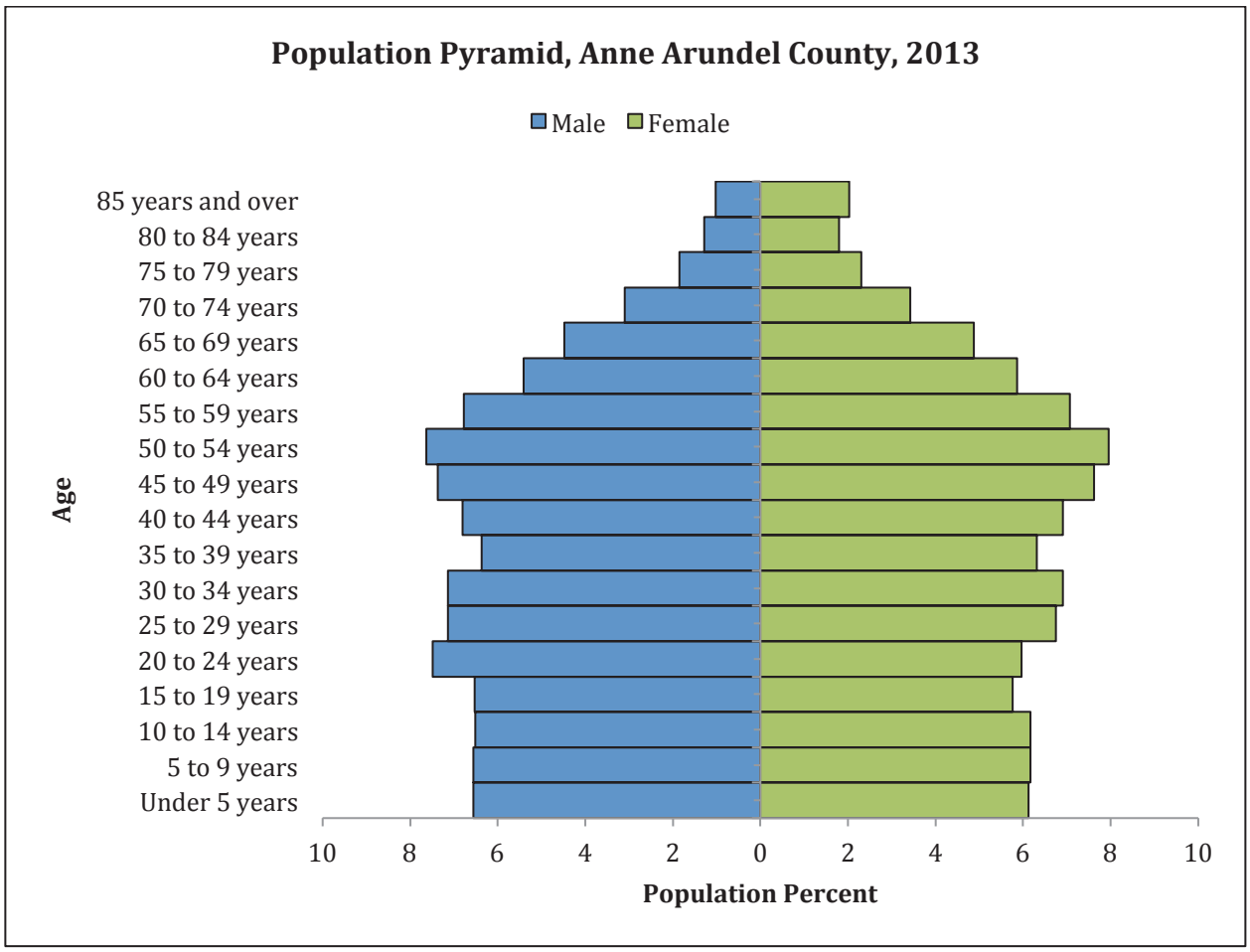


Source: U.S. Census Bureau, 2013 American Community Survey 1-Year Estimates

Table 7: Population by Age, Anne Arundel County, 2013

Age Group	Estimated Population	Percent
Under 5 years	35,372	6.3%
5 to 9 years	33,257	6.0%
10 to 14 years	37,019	6.7%
15 to 19 years	33,714	6.1%
20 to 24 years	37,770	6.8%
25 to 34 years	77,525	13.9%
35 to 44 years	73,504	13.2%
45 to 54 years	85,191	15.3%
55 to 59 years	37,648	6.8%
60 to 64 years	32,193	5.8%
65 to 74 years	43,882	7.9%
75 to 84 years	20,439	3.7%
85 years and over	8,229	1.5%

Source: U.S. Census Bureau, 2013 American Community Survey 1-Year Estimates



Source: U.S. Census Bureau, 2013 American Community Survey 1-Year Estimates

Population 65 Years and Over

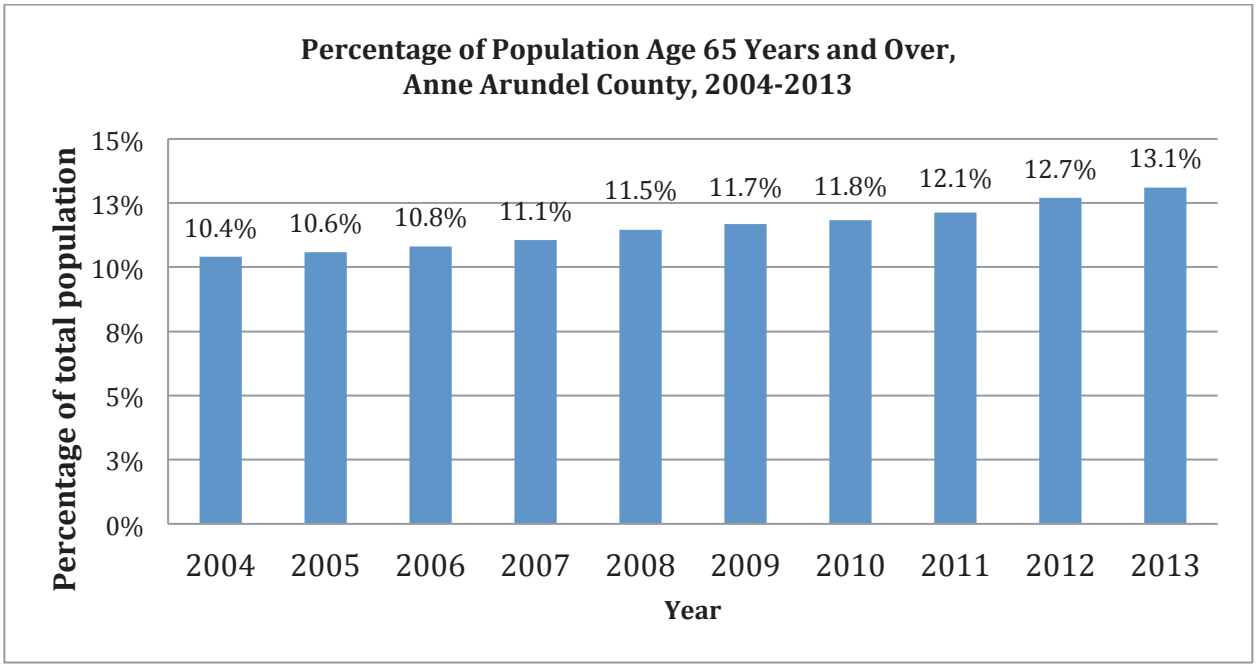
Persons age 65 years and older living in Anne Arundel County account for 13.1% of the total population, and this proportion has steadily increased since 2004. This subset of the population grew from 53,472 in 2004 to 72,850 in 2013. The "Baby Boomers" (those born between 1946 and 1964) started turning 65 in 2011. The number of older people will increase significantly between 2010 and 2030. (The Federal Interagency Forum on Aging-Related Statistics, U.S. Department of Health and Human Services)

The ratio of females to males increases as age increases, most apparent after age 75. The Hispanic population in Anne Arundel County only accounts for 1.6% of this population, again emphasizing the younger composition in this group.

Table 8: Population, 65 Years and Over, Anne Arundel County, 2013

Total Population	72,850
Sex	
Male	44.5%
Female	55.5%
Race and Ethnicity	
White, NH	83.9%
Black or African American	10.0%
Hispanic, Any Race	1.6%
Asian	2.9%
American Indian and Alaska Native	0.3%
Households By Type	
Total Households	43,150
Family households	54.7%
Householder living alone	42.3%
Disability Status	
With any disability	33.3%
No disability	66.7%
Employment Status	
Employed	20.3%
Not in labor force	78.9%
Poverty Status	
Below 100 percent of the poverty level	5.5%

Source: U.S. Census Bureau, 2013 American Community Survey 1-Year Estimates; U.S. Census Bureau, Population Estimates Program, 2013



Source: U.S. Census Bureau, Population Estimates Program, 2004-2013

Languages Spoken in the Home

Approximately 10.6 % of county residents speak a language other than English at home. Spanish speakers represent 5.1% of the population, followed by 2.6% Indo-European language speakers and 2.4% Asian or Pacific Islander language speakers. The inability to speak and read English creates barriers to health care access, provider communications and health literacy/education.

Table 9: Language Spoken at Home, 5 Years Old and Older, Anne Arundel County, 2013

Language Spoken at Home	Estimated Population	Percent
Population 5 years and over	509,623	-
English only	455,763	89.4%
Language other than English	53,860	10.6%
Speak English less than "very well"	19,094	3.7%
Spanish	25,880	5.1%
Speak English less than "very well"	11,271	2.2%
Other Indo-European languages	13,023	2.6%
Speak English less than "very well"	2,846	0.6%
Asian and Pacific Islander languages	11,984	2.4%
Speak English less than "very well"	4,516	0.9%

Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates

Income and Poverty

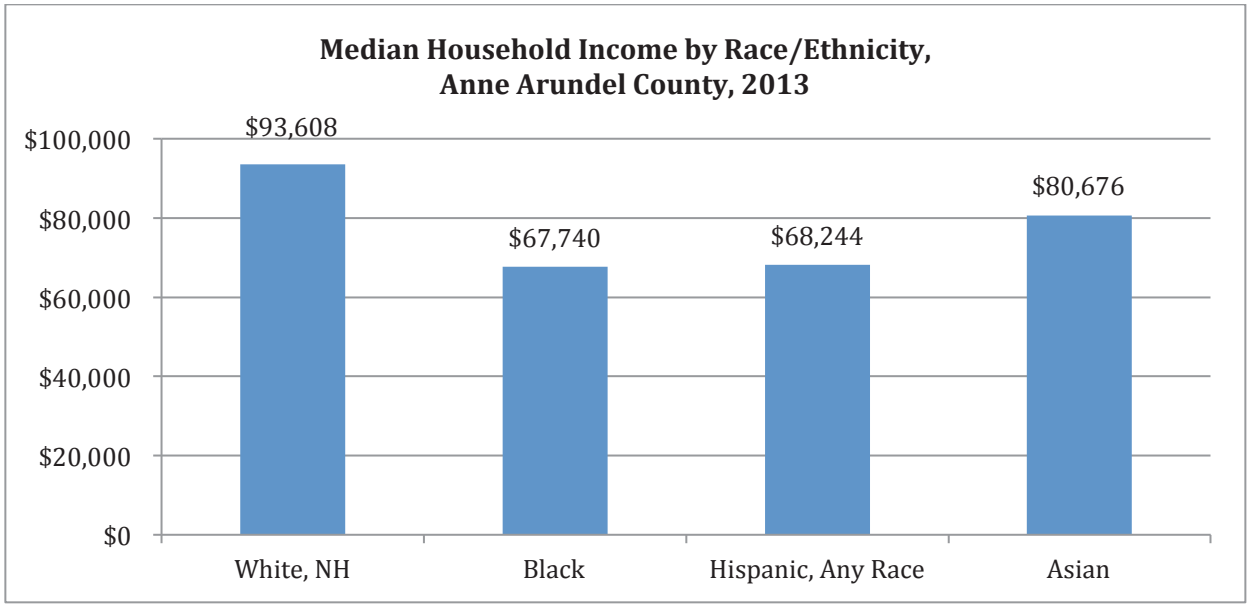
The median household income of Anne Arundel County is higher compared to that of Maryland and the U.S., a statistic driven by the large population of non-Hispanic whites with a median household income of $93,608. Income disparity, however, is evident in Anne Arundel County as the median incomes of Hispanics ($68,244) and non-Hispanic blacks ($67,740) are considerably lower than white residents.

Table 10: Household and Family Income, Anne Arundel County Compared to Maryland and U.S., 2013

Income And Benefits (In 2013 Inflation-Adjusted Dollars)	United States	Maryland	Anne Arundel County
Median household income ($)	53,046	73,538	87,430
Median family income ($)	64,719	88,738	101,268

Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates

Median Household Income by Race and Ethnicity, Anne Arundel County, 2013



Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates

The percentage of families and individuals living below the poverty level in Anne Arundel County is lower than that of Maryland and the U.S. In 2013, 4.3% of families in Anne Arundel County lived below the poverty level, compared to 6.8% of families in Maryland and 11.3% of families in the U.S. However, among families headed by single females, 14.7% lived below the poverty level. Of single-female headed families with children under age 5, almost one quarter lived below the poverty level. Among individuals, 6.3% of residents in the county lived below the poverty level in 2013, compared to 9.8% in Maryland and 15.4% in the U.S.

Similar to the income disparity, the poverty rate in 2013 is markedly higher for blacks (12.7%) and Hispanics (9.4%) than for non-Hispanic whites (4.4%).

Table 11: Families and People Below Poverty in Past 12 Months, Anne Arundel County, Maryland and U.S., 2013

	Anne Arundel County (Percent)	Maryland (Percent)	United States (Percent)
All families	4.3%	6.8%	11.3%
With related children under 18 years	6.5%	10.5%	17.8%
Married couple families	1.9%	2.7%	5.6%
With related children under 18 years	2.3%	3.4%	8.3%
Families with female householder, no husband present	14.7%	19.3%	30.6%
With related children under 18 years	20.4%	25.9%	40.0%
All people	6.3%	9.8%	15.4%
Under 18 years	8.0%	12.9%	21.6%
18 to 64 years	5.8%	9.1%	14.3%
65 years and over	5.5%	7.6%	9.4%

Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates

Table 12: Population Below Poverty by Age, Sex and Race/Ethnicity, Anne Arundel County, 2013

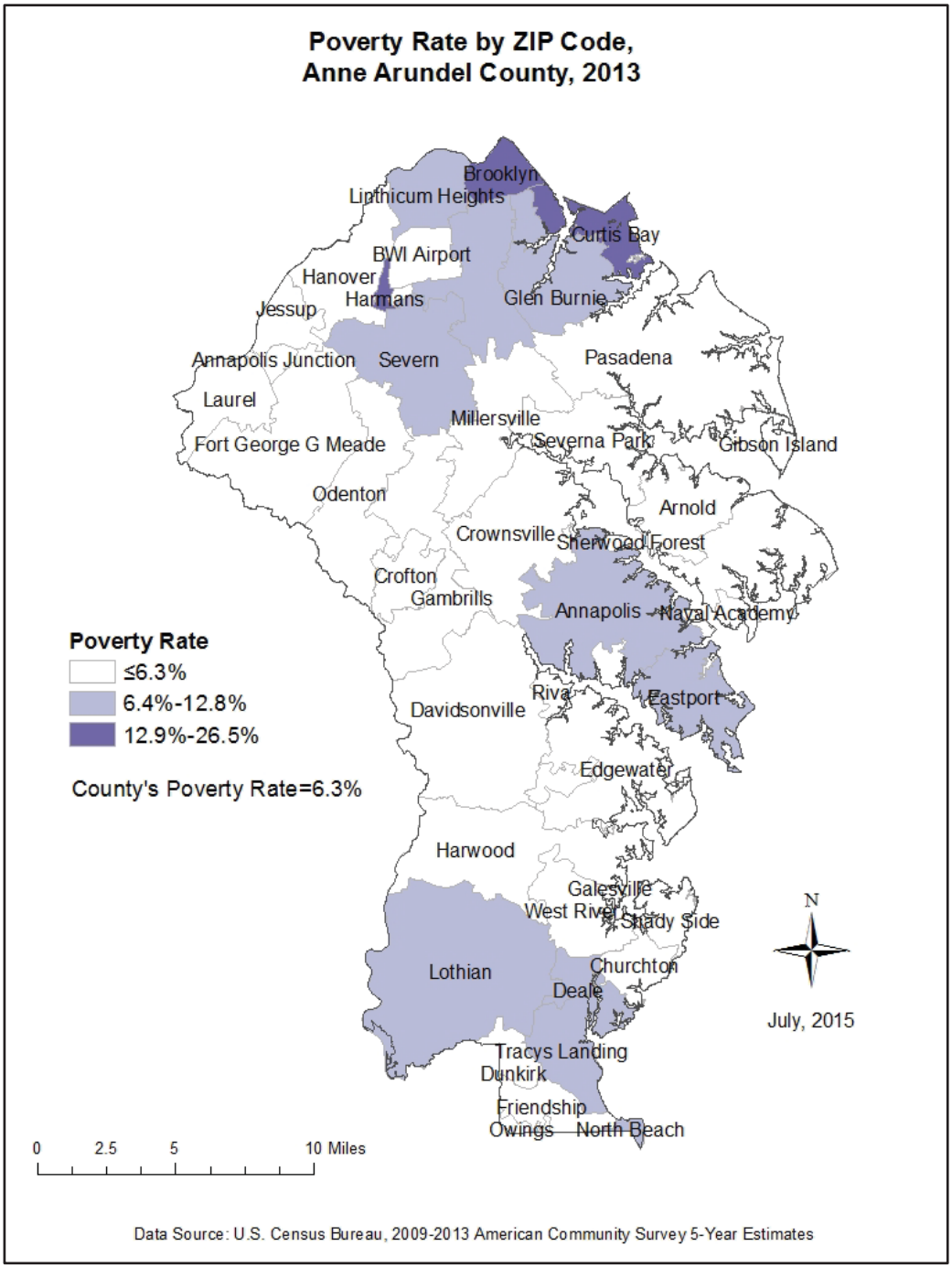
	Below Poverty Level	Percent Below Poverty Level
	33,352	6.3%
Age		
Under 18 years	9,966	8.0%
18 to 64 years	19,765	5.8%
65 years and over	3,621	5.5%
Sex		
Male	14,860	5.8%
Female	18,492	6.8%
Race and Ethnicity		
White, NH	16,701	4.4%
Black or African American	9,997	12.7%
Hispanic, Any Race	3,172	9.4%
Asian	2,092	11.0%

Source: U.S. Census Bureau, 2009- 2013 American Community Survey 5-Year Estimates

Poverty Rate by ZIP Code, Anne Arundel County, 2013

The following ZIP codes have a higher poverty rate than the average rate in the county (in descending order): Brooklyn, Harmans, Curtis Bay, Glen Burnie (21060 and 21061), North Beach, Deale, Severn, Linthicum Heights, Annapolis (21401), Eastport, Lothian and Tracy's Landing (See Table 79).

The poverty rate in Brooklyn is 4.2 times higher than that of the average poverty rate in the county. Curtis Bay and Harmans have poverty rates 2.6 times higher than that of the average poverty rate in the county. Higher poverty rates in these areas correspond with the larger minority populations in these ZIP codes.



Food Stamp/Supplemental Nutrition Assistance Program (SNAP) Benefits

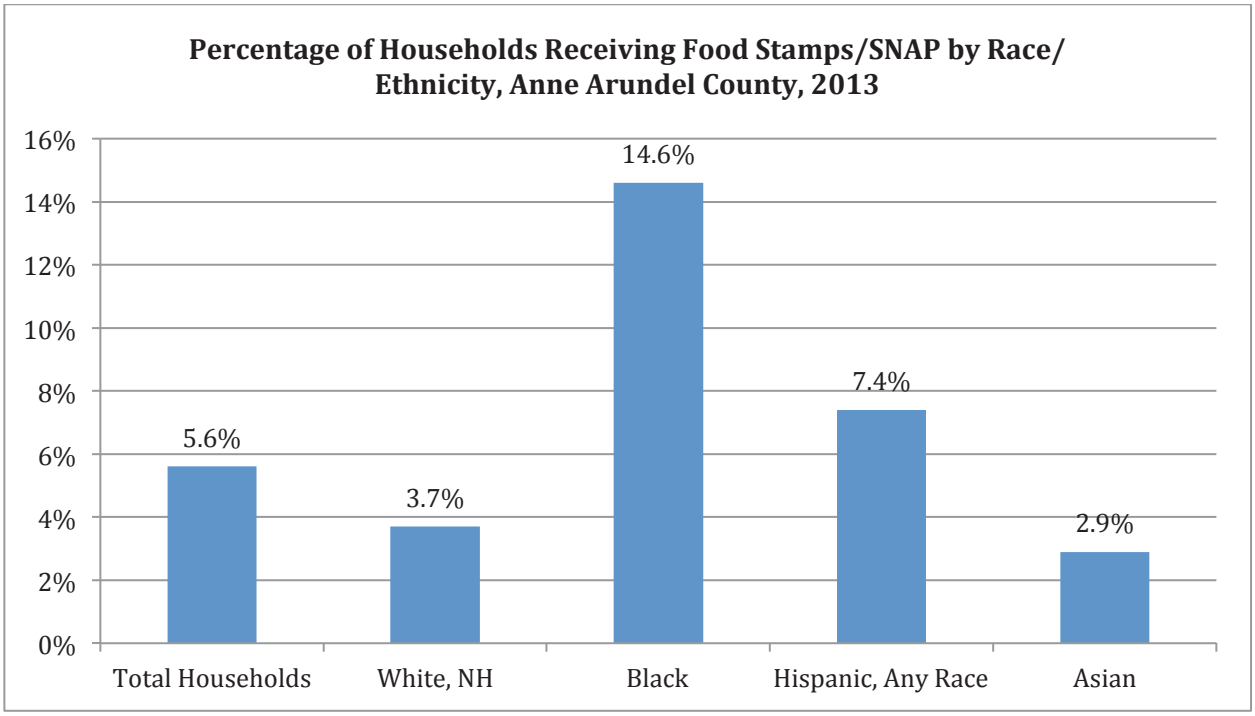
In 2013, Anne Arundel County had a significantly lower percent of households that received Food Stamp/SNAP benefits (5.6%) compared to Maryland (9.5%) and U.S. (12.4%). In Anne Arundel County, approximately 15% of non-Hispanic black households, 7.4% of Hispanic households, 3.7% of non-Hispanic white households and 2.9% of Asian households received SNAP benefits in 2013.

Table 13: Households with Food Stamp/SNAP Benefits, Anne Arundel County Compared to Maryland and U.S., 2013

	Anne Arundel County	Maryland	United States
Food Stamp/SNAP Benefits in the past 12 months	5.6%	9.5%	12.4%

Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates

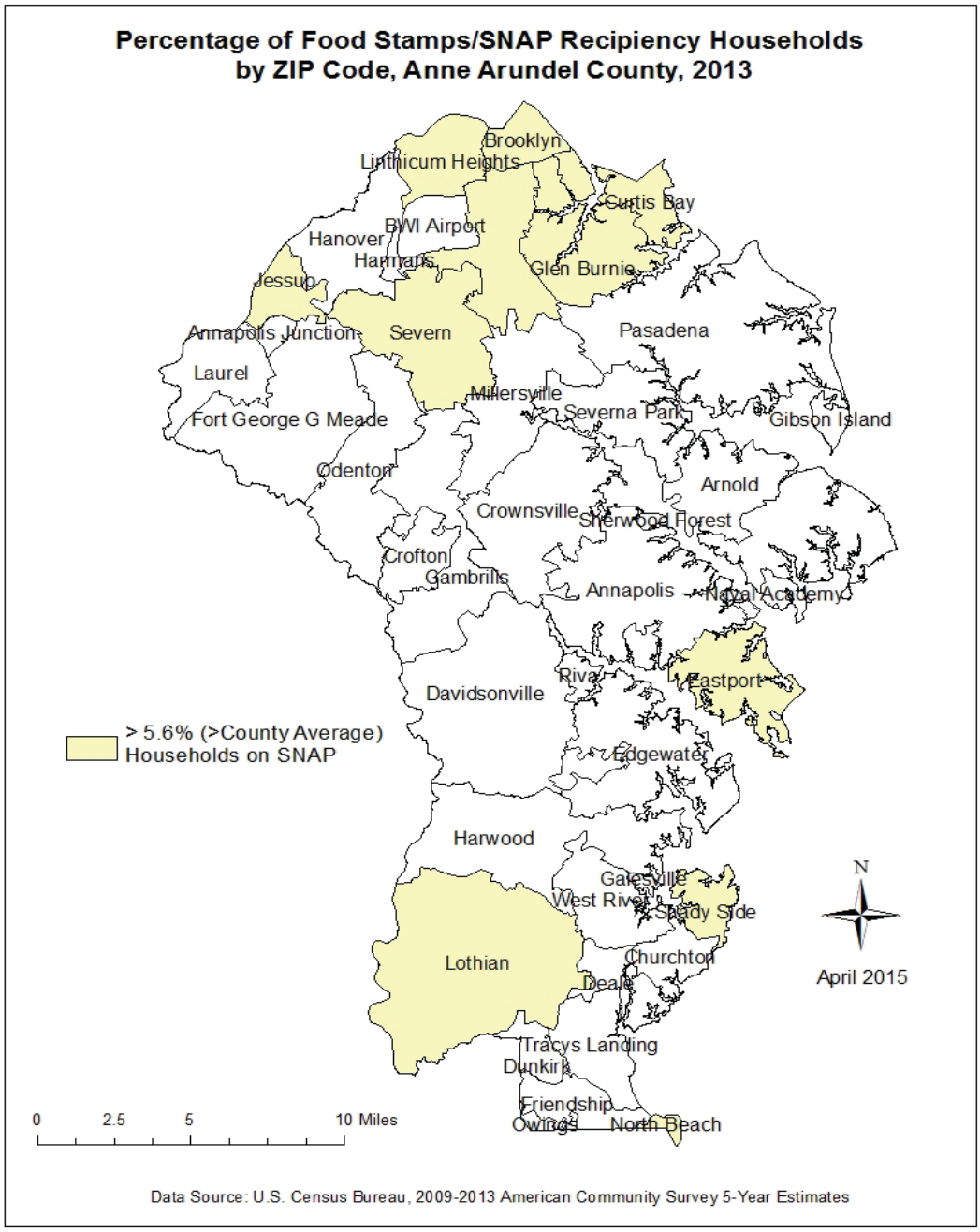
Households Receiving Food Stamps/SNAP by Race and Ethnicity, Anne Arundel County, 2013



Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates

Households with Food Stamp/SNAP Benefits by ZIP Code, Anne Arundel County, 2013

Brooklyn, Curtis Bay, Lothian, Glen Burnie (21060 and 21061), North Beach, Shady Side, Jessup, Severn, Linthicum Heights and Eastport exceed the average number of households on Food Stamp/SNAP benefits in Anne Arundel County (See Table 80). Overall, 5.6% of households in the county received Food Stamp/SNAP benefits in 2013. Brooklyn (30.9%) has the highest percentage of households on food stamp or SNAP benefits followed by Curtis Bay (22%). As previously noted, these areas also have the highest poverty rates in the county.

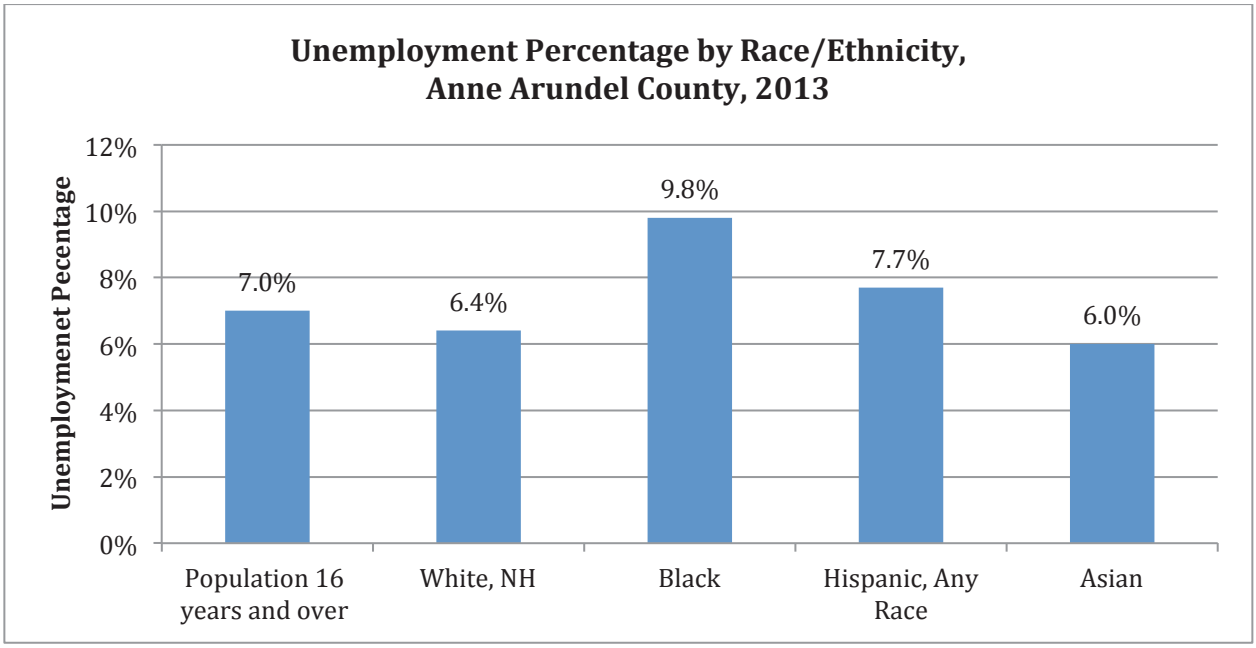


EMPLOYMENT

Unemployment limits the ability to acquire or access resources such as healthy food, safe housing, adequate clothing, reliable transportation and continuous coordinated health care. There is a well-established association between unemployment and poor physical and mental health. Unemployed persons tend to have higher annual illness rates, lack health insurance, lack access to health care and have an increased risk for death. (CDC Health Disparities and Inequalities Report, United States, 2013)

In 2013, 7% of Anne Arundel County residents were unemployed, ranging from 9.8% for the non-Hispanic black population to 6.0% for the Asian population.

Unemployment Status, Anne Arundel County, 2013



Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates

EDUCATION

Paralleling the larger median income in Anne Arundel County, education levels are also considerably higher compared to the education levels of Maryland and U.S. residents. Nearly 91% of Anne Arundel County residents aged 25 years and over have achieved at least a high school education or higher, compared to 88.7% in Maryland and 86% in the U.S. At the post-high school level, 37.1% of residents have attained at least a bachelor's degree, compared to 36.8% in Maryland and 28.8% in the U.S.

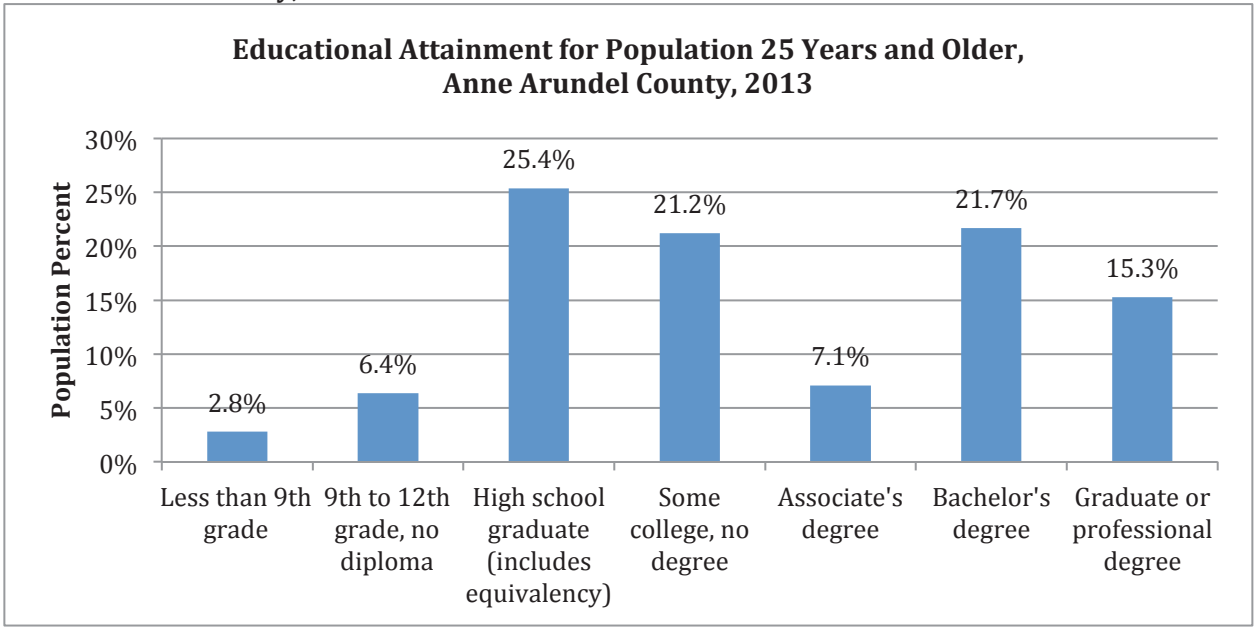
Even though educational attainment is high for most in the county, there is a disparity when stratifying by ethnicity. While about 90% of non-Hispanic whites, blacks and Asians ages 25 and older have a high school diploma (or equivalency) in 2013, only 67% of Hispanics have achieved the same degree.

Table 14: Educational Attainment Percentages for Population 25 Years and Older, Anne Arundel Compared to Maryland and U.S., 2013

Educational Attainment	Anne Arundel County	Maryland	United States
High school graduate or higher	90.7%	88.7%	86.0%
Bachelor's degree or higher	37.1%	36.8%	28.8%

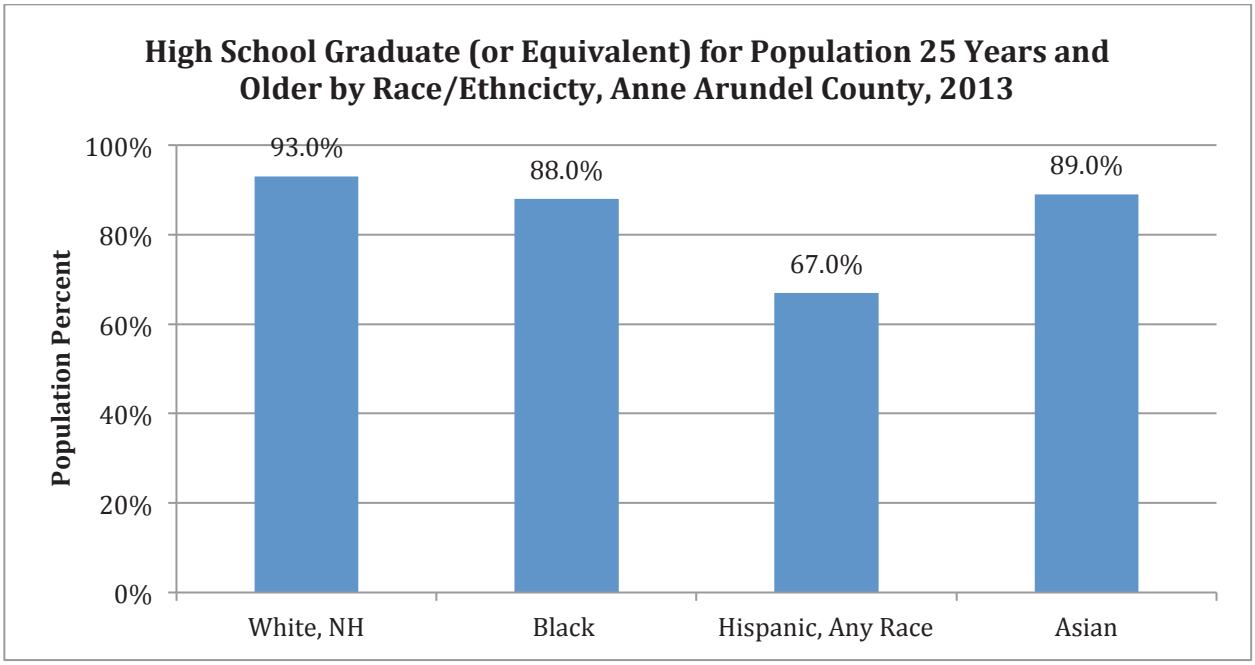
Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates

Educational Attainment Percentages for Population 25 Years and Older, Anne Arundel County, 2013



Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates

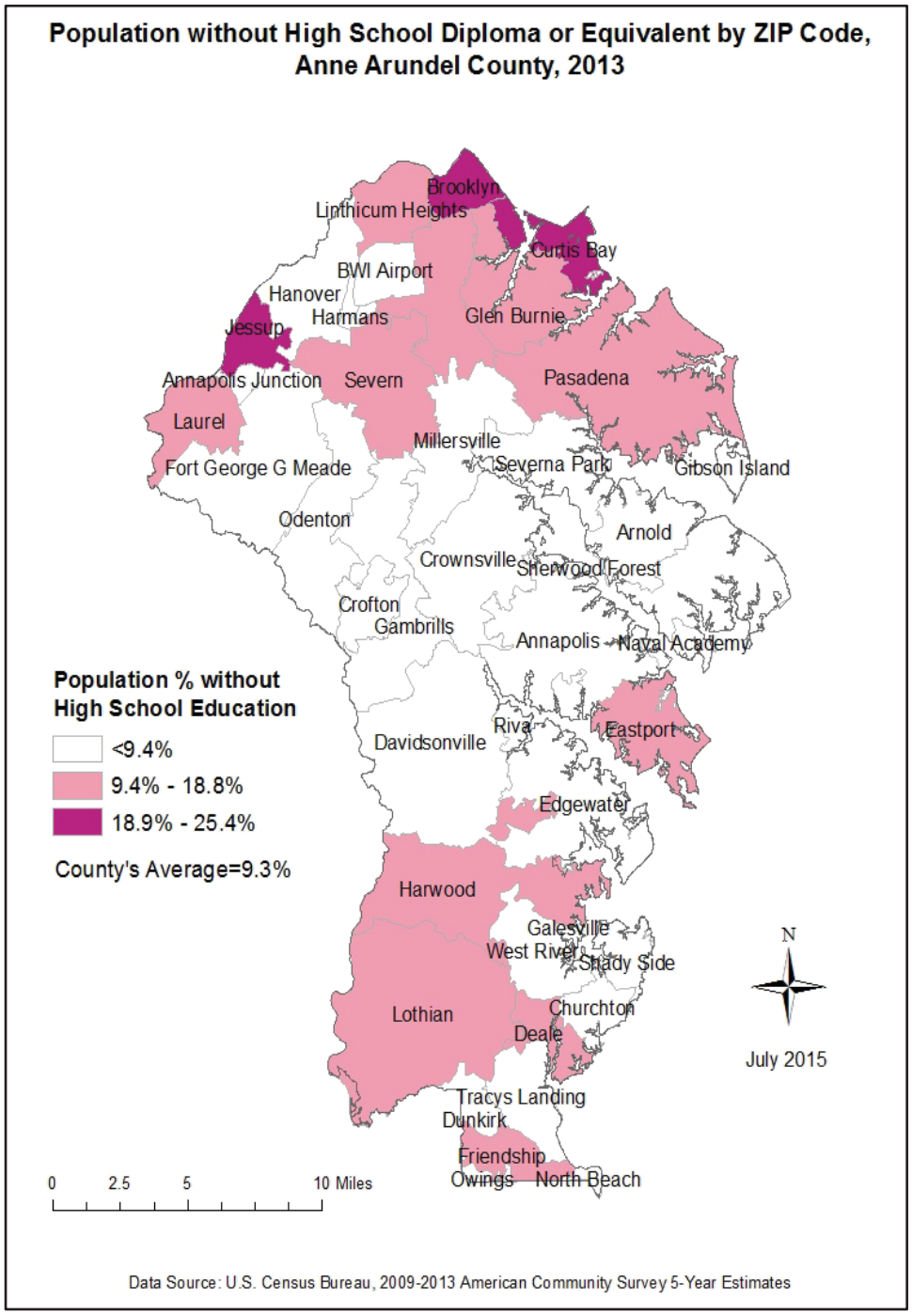
High School Graduate (Includes Equivalency) for Population 25 Years and Older by Race/Ethnicity, Anne Arundel County, 2013



Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates

Population without High School or Equivalent Education by ZIP Code, Anne Arundel County, 2013

The following ZIP codes have a higher proportion of the population without a high school or equivalent education compared to the county average (in descending order): Jessup, Brooklyn, Curtis Bay, Glen Burnie (21060 and 21061), Deale, Lothian, Friendship, Linthicum Heights, Laurel, Severn, Harwood, Pasadena and Eastport areas (See Table 81).



Health Insurance

Health insurance coverage has a significant influence on health outcomes. The proportion of residents without health insurance decreased from 8.4% in 2008-2010 to approximately 6.6% in 2013. As expected, the largest proportion of uninsured individuals are between the ages of 18 and 64 years (9.1%), as public insurance programs exist for children under age 18 and adults over the age of 65 (Medicare). Over one-fifth of the Hispanic population in Anne Arundel County is uninsured, well eclipsing the uninsured rates of other races and ethnicities, especially non-Hispanic whites (4.7%). Similarly, 23.2% of foreign-born residents were uninsured in 2013, compared to only 5.1% of native-born residents.

Table 15: Population without Health Insurance Coverage, Anne Arundel County, 2013

	Number Uninsured	Percent Uninsured (among civilian non-institutionalized population)
Uninsured Population	35,298	6.60%
Age		
Under 18 years	4,082	3.20%
18 to 64 years	30,739	9.10%
65 years and older	477	0.70%
Sex		
Male	19,272	7.40%
Female	16,026	5.80%
Race/Ethnicity		
White, NH	17,789	4.70%
Black	6,404	7.70%
Hispanic, Any Race	8,189	22.20%
Asian	1,822	9.00%
Nativity		
Native born	24,782	5.10%
Foreign born	10,516	23.20%

Source: U.S. Census Bureau, 2013 American Community Survey 1-Year Estimates

Table 16: Population without Health Insurance Coverage by Race/Ethnicity and Age Group, Anne Arundel County, 2013

	White, NH		Black		Hispanic, Any Race		Asian	
Age Group	Number	%	Number	%	Number	%	Number	%
Under 18 years	1,833	2.3%	500	2.2%	1,140	8.6%	133	3.5%
18 to 64 years	15,697	6.5%	5,686	10.6%	7,049	31.4%	1,689	11.8%
65 years and over	259	0.4%	218	3.1%	-	-	-	-

Source: U.S. Census Bureau, 2013 American Community Survey 1-Year Estimates

The Patient Protection and Affordable Care Act (ACA) began to provide health insurance through Maryland's health insurance exchange/marketplace in 2014. Under the ACA, people whose income is up to 138% of the poverty level are eligible for Medicaid. For people whose income is above 138% but below 400% of the poverty level, the ACA offers subsidies to purchase health insurance coverage. While the 2013 insurance coverage estimates presented in this report will not reflect the effect of ACA at this time, an estimate of potential gains in insurance, based off of the poverty threshold, can be extrapolated.

Out of the 35,298 uninsured Anne Arundel County residents in 2013, 8,942 individuals, whose income was up to 138% of the poverty level, were potentially eligible for Medicaid coverage in 2014 under the ACA. Approximately 15,663 uninsured individuals, whose income was between 138% and 400% of the poverty level, were potentially eligible for purchased subsidized health care insurance in 2014. The remaining 10,041 uninsured individuals, whose income was above 400% of poverty level would have the option to purchase health insurance through the exchange/marketplace. Undocumented persons will continue to be ineligible for Medicaid or other health care insurance.

Table 17: Population without Health Insurance Coverage by Poverty Threshold, Anne Arundel County, 2013

Poverty Threshold	Number Uninsured in 2013	Impact of Affordable Care Act in 2014
Under 1.38 of poverty threshold	8,942	Eligible for Medicaid coverage in 2014 under ACA
1.38 to 3.99 of poverty threshold	15,663	Eligible for subsidized health care insurance in 2014 under ACA
4.00 of poverty threshold and over	10,041	Eligible to purchase health care insurance in 2014 under ACA

Source: U.S. Census Bureau, 2013 American Community Survey 1-Year Estimates

MEDICARE

Medicare is a national social health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). Most of the population age 65 and older has health insurance through Medicare. As of 2013, there were 75,607 Medicare beneficiaries with Part A and Part B in Anne Arundel County, 82.2% non-Hispanic white, 13.1% non-Hispanic black and 1.3% Hispanic. Almost 11% of Medicare beneficiaries were also eligible for Medicaid in 2013.

Table 18: Medicare Beneficiaries in Anne Arundel County, 2013

Beneficiary Demographic Characteristics	Number or Percentage
Beneficiaries with Part A and Part B	75,607
Fee-for-service Beneficiaries	69,420
Medicare Advantage (MA) Beneficiaries	6,187
Average Age	72 yrs.
Percent Female	56.2%
Percent Male	43.8%
Percent White (Non-Hispanic)	82.2%
Percent Black	13.1%
Percent Hispanic, Any Race	1.3%
Percent Eligible for Medicaid	10.9%

Source: Centers for Medicare and Medicaid Services

Table 19: Medicaid Enrollment by Age, Sex and Race and Ethnicity Anne Arundel County, 2014 (December)

	Medicaid Enrollment
Total Enrollment	84,616
Age	
Under 18 years	37,843
18 to 64 years	43,040
65 years and over	3,733
Sex	
Male	37,186
Female	47,430
Race and Ethnicity	
White, NH	39,793 (47%)
Black, NH	25,193 (30%)
Hispanic, Any Race	6,349 (8%)
Asian	3,829 (5%)

Source: Maryland Department of Health and Mental Hygiene, 2015

Fair Market Rent

Spending a high percentage of household income on rent can create financial hardship, especially for lower-income renters. With a limited income, paying a high rent may not leave enough money for other costs, such as food, transportation and medical expenses. According to the National Low Income Housing Coalition (2014), the median renter's income in Anne Arundel ($54,137) is higher than the state-wide median ($43,254).

Table 20: Fair Market Rent, 2014

	Anne Arundel County	Maryland
Households		
Total Households (2008-2012)	198,761	2,138,806
Renter Households (2008-2012)	50,932	682,334
Percent of total households that are renters (2008-2012)	26%	32%
Fair Market Rent, 2014		
Efficiency	$847	$947
One bedroom	$1,001	$1,061
Two bedroom	$1,252	$1,297
Three bedroom	$1,599	$1,697
Four bedroom	$1,741	$1,979
Income Needed to Afford Fair Market Rent, 2014		
Income needed to afford efficiency	$33,880	$37,872
Income needed to afford 1 bedroom	$40,040	$42,432
Income needed to afford 2 bedroom	$50,080	$51,871
Income needed to afford 3 bedroom	$63,960	$67,870
Income needed to afford 4 bedroom	$69,640	$79,161
Housing Wage for efficiency	$16.29/hr.	$18.21/hr.
Housing Wage for 1 bedroom	$19.25/hr.	$20.40/hr.
Housing Wage for 2 bedroom	$24.08/hr.	$24.94/hr.
Housing Wage for 3 bedroom	$30.75/hr.	$32.63/hr.
Housing Wage for 4 bedroom	$33.48/hr.	$38.06/hr.
Income of Renter, 2014		
Estimated renter median income	$54,137	$43,254
Estimated mean renter wage	$15.89/hr.	$15.31/hr.
Rent affordable at renter median income	$1,353	$1,081

Source: National Low Income Housing Coalition, 2014

Health Status Indicators

Mortality

Overall, the age-adjusted mortality rate of Anne Arundel County residents is slightly higher than that of Maryland but lower than the national average from 2011 to 2013. Mortality is lowest for Hispanics, perhaps due to the smaller proportion of older individuals in this population. Mortality in non-Hispanic blacks is 14% higher than that of non-Hispanic whites; however, this difference is similarly observed in Maryland (15%) and U.S. (19%) during the same time period.

Table 21: Age-Adjusted Mortality Rates per 100,000 by Race and Ethnicity, 2011-2013

Race and Ethnicity	Anne Arundel County	Maryland	U.S.
White, NH	736.9	708.7	749.0
Black, NH	833.4	817.2	891.1
Hispanic, Any Race	418.1	330.1	538.3
Asian	512.0	352.6	410.0
All Races and Ethnicity	717.2	708.3	735.3

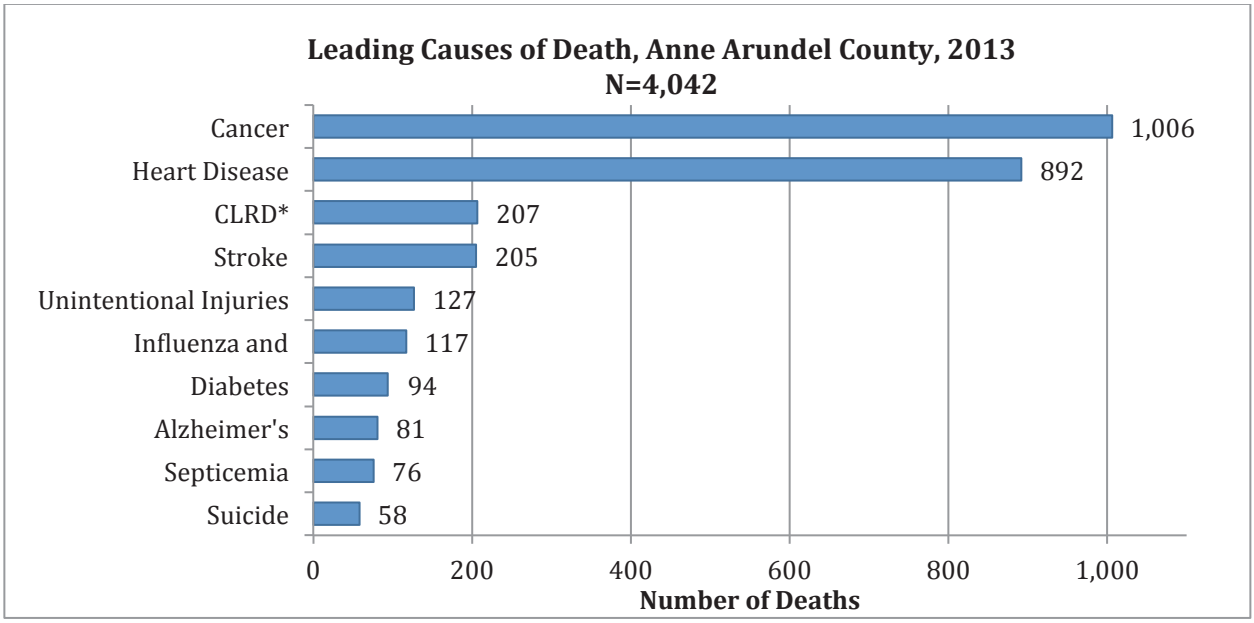
Source: Centers for Disease Control and Prevention; National Center for Health Statistics; CDC WONDER Online Database; Maryland Vital Statistics Annual Report 2013, Maryland Department of Health and Mental Hygiene

In 2013, a total of 4,042 deaths occurred in Anne Arundel County. The two leading causes of death, cancer (1,006) and heart disease (892), accounted for almost half of all deaths.

Of the top ten causes of death among residents, five were associated with preventable risk factors, such as high blood pressure, high cholesterol, obesity, tobacco use and lack of physical activity.

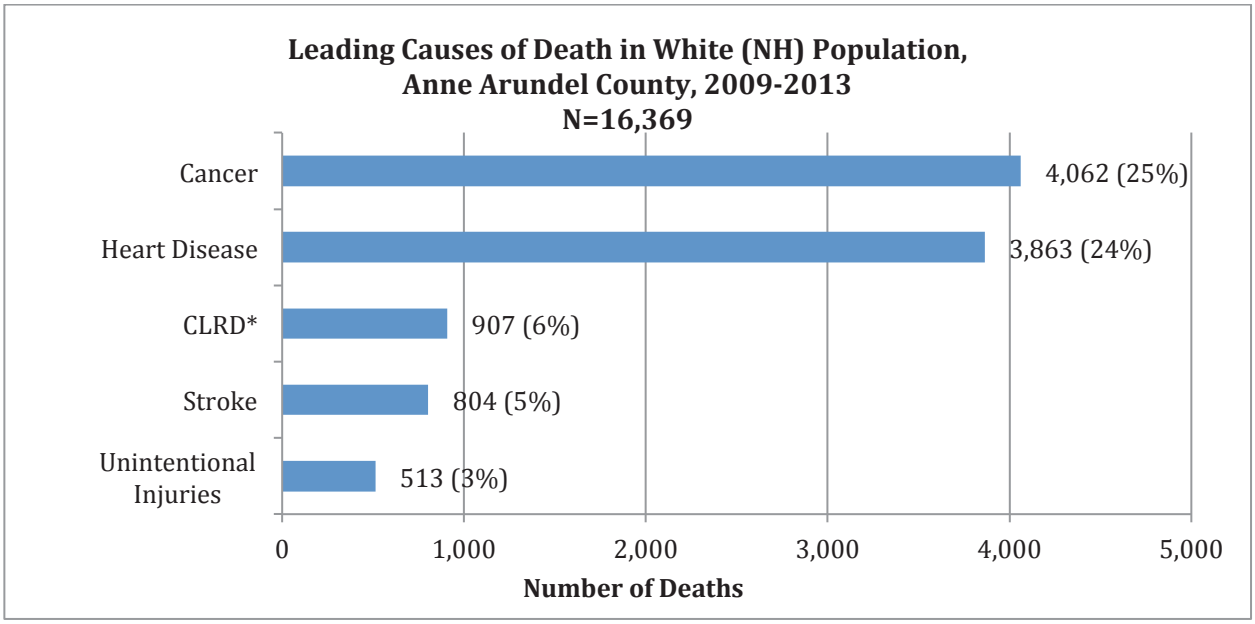
Between 2009 and 2013, cancer and heart disease were the first and second leading causes of death regardless of race and ethnicity designation. Chronic lower respiratory disease ranked third for non-Hispanic whites but was not among the five leading causes of deaths for other racial/ethnic groups examined. Conversely, diabetes ranked as the fourth leading cause of death among non-Hispanic blacks and fifth among Hispanics, but not as a leading cause of death among non-Hispanic whites. Stroke and unintentional injuries ranked among the top five causes of death for all racial/ethnic groups.

Leading Causes of Death, Anne Arundel County

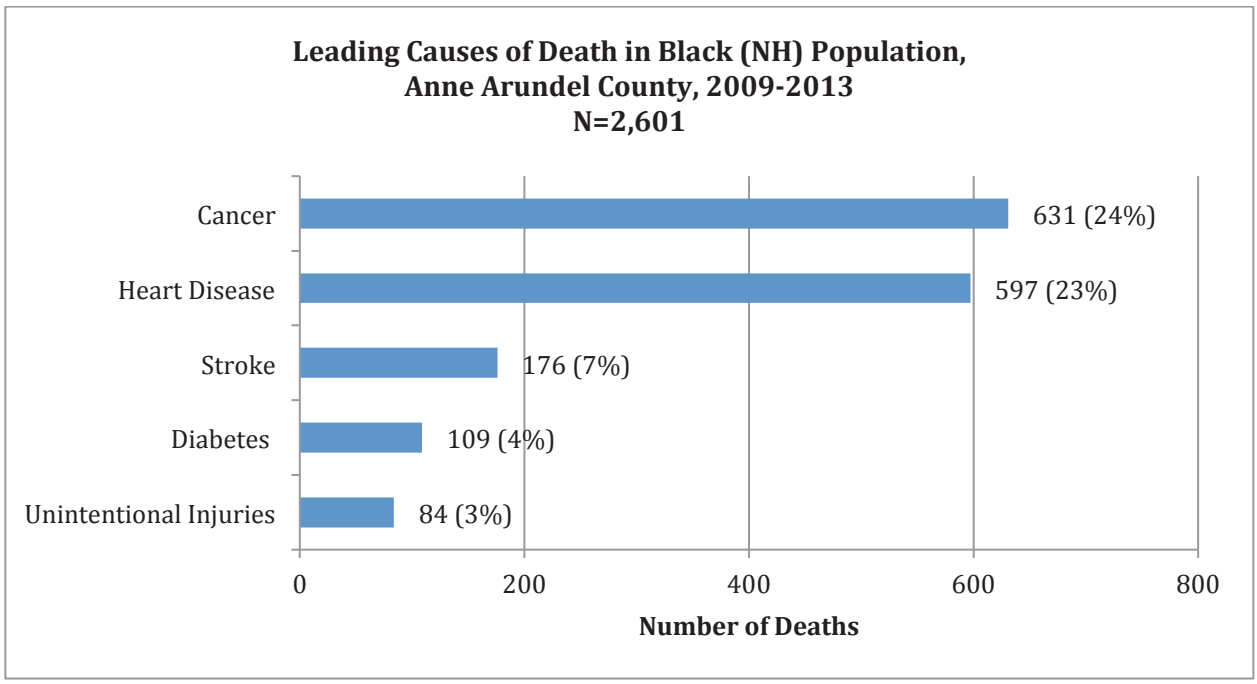


*Chronic lower respiratory diseases (CLRD) include both chronic obstructive pulmonary disease (COPD) and asthma.

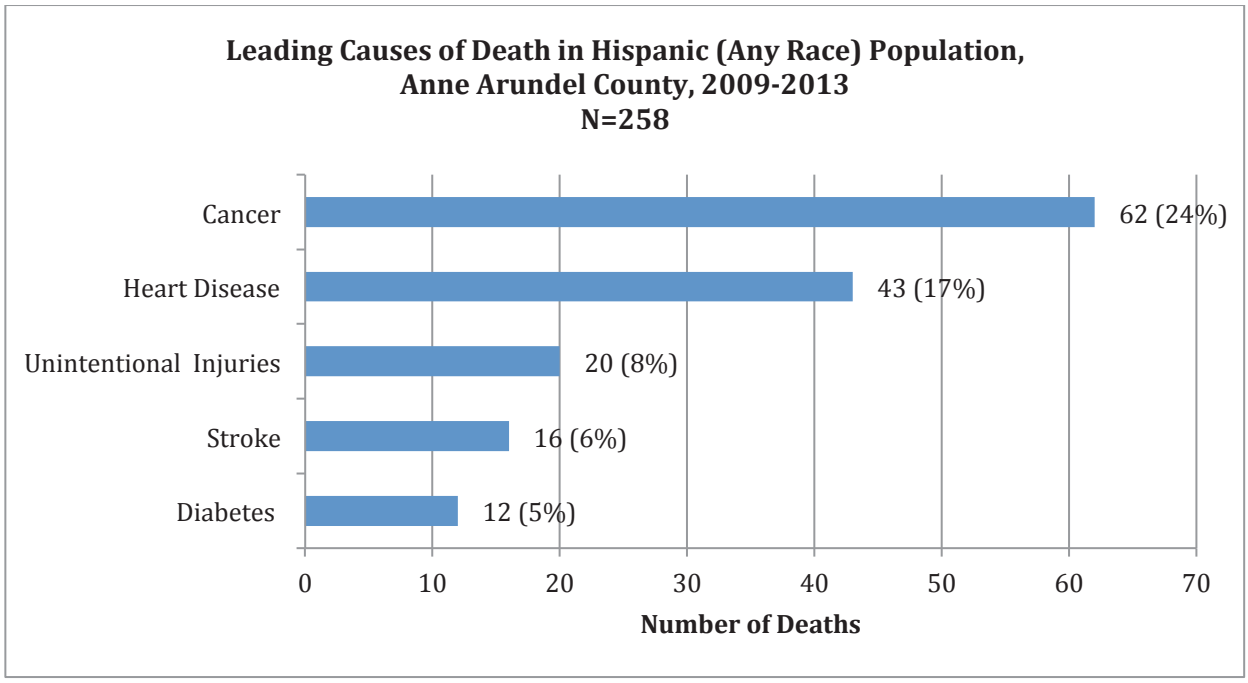
Source: Maryland Vital Statistics Annual Report 2013, Maryland Department of Health and Mental Hygiene



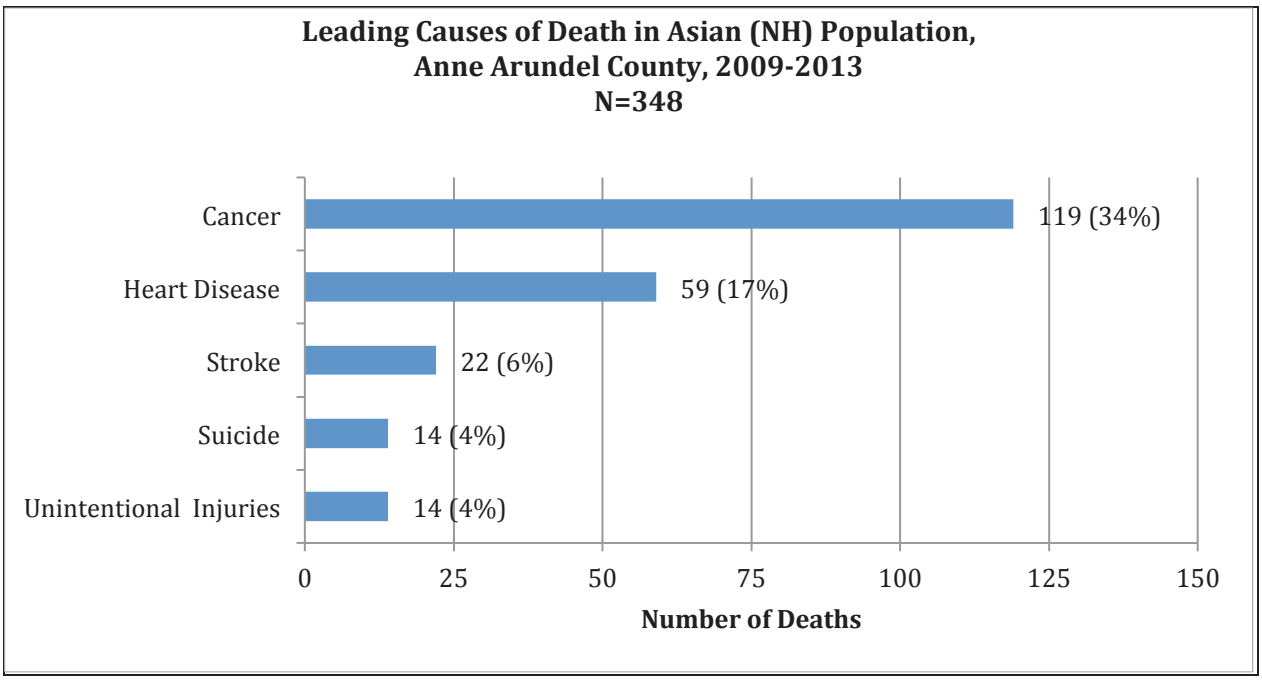
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database



Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database



Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database



Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Between 2011 and 2013, age-adjusted mortality due to cancer, chronic lower respiratory disease, stroke, diabetes and suicide were higher in Anne Arundel County than in Maryland. Age-adjusted mortality due to coronary heart disease, Alzheimer's and unintentional injuries were higher in Maryland than in the county. Most mortality rates due to the leading causes of death were significantly lower in Anne Arundel County than they were nationwide.

Table 22: Age-Adjusted Mortality Rates by Leading Causes of Deaths per 100,000 Population, 2011-2013

Cause of Death	Anne Arundel County	Maryland	U.S.
All Causes of Death	717.2	708.3	735.3
All Cancer	166.1	163.8	166.2
Coronary Heart Disease	165.0	171.7	171.3
CLRD*	37.6	32.9	42.1
Stroke	37.6	36.5	37.0
Unintentional Injuries	23.9	26.5	39.4
Diabetes	20.2	19.6	21.3
Alzheimer's	13.0	14.6	24.0
Suicide	9.4	9.0	12.6

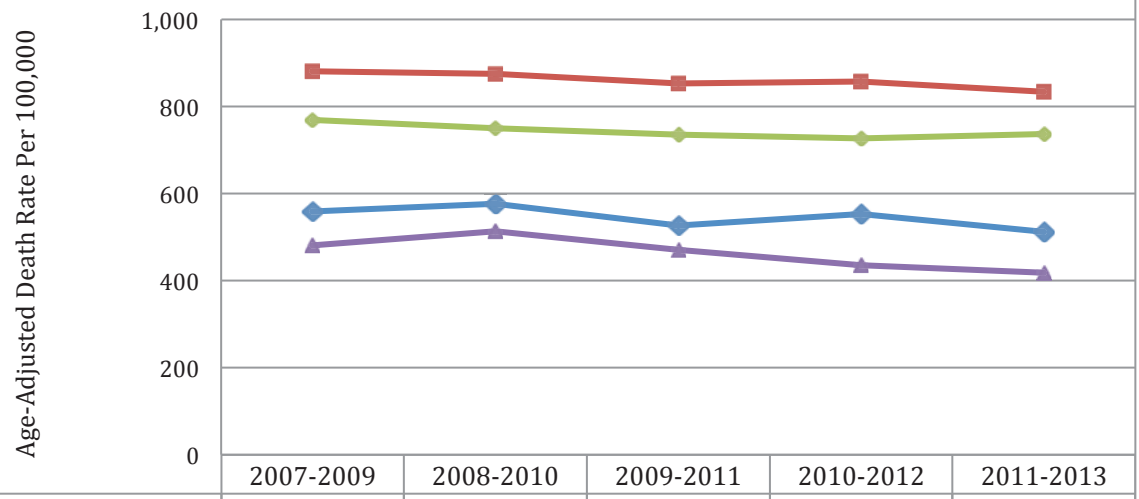
Source: Maryland Vital Statistics Annual Report 2013, Maryland Department of Health and Mental Hygiene; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

* chronic lower respiratory disease

All Causes of Deaths

In Anne Arundel County, between 2007 and 2013, the age-adjusted death rates for all causes of death among all races and ethnicities decreased steadily. Throughout the period, the rate for non-Hispanic blacks was the highest among all racial/ethnic groups followed by non-Hispanic whites, non-Hispanic Asians and Hispanics.

Age-Adjusted Death Rate per 100,000 for All Causes of Death by Race and Ethnicity, Anne Arundel County, 2007-2013

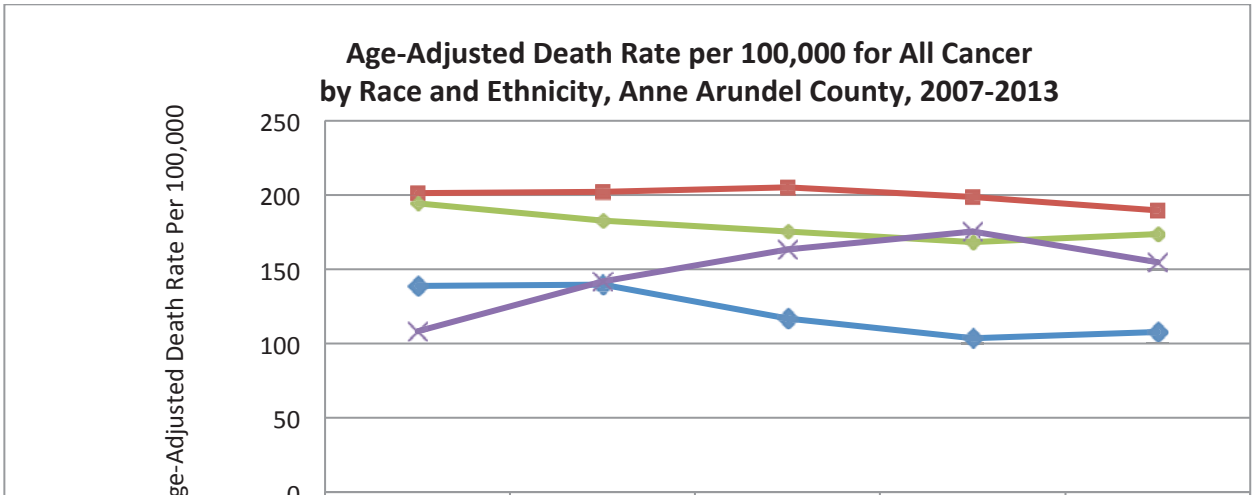


	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Black, NH	881.4	874.2	852.3	856.7	833.4
White, NH	769.2	749.4	734.7	726.6	736.9
Hispanic, Any Race	480.2	512.9	471.2	434.7	418.1
Asian, NH	558.3	575.9	526.1	552.5	512

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Cancer

In 2013, one quarter of all deaths in Anne Arundel County were from cancer. Between 2007 and 2013, cancer mortality decreased steadily for most races and ethnicities: 22% decline among Hispanics, 11% among non-Hispanic whites and 6% for non-Hispanic blacks. However, it was the opposite trend for non-Hispanic Asians which observed a 43% increase in cancer mortality during that same time period. Even though cancer mortality decreased for non-Hispanic blacks, the rate was consistently higher over time than the other racial/ethnic groups examined.

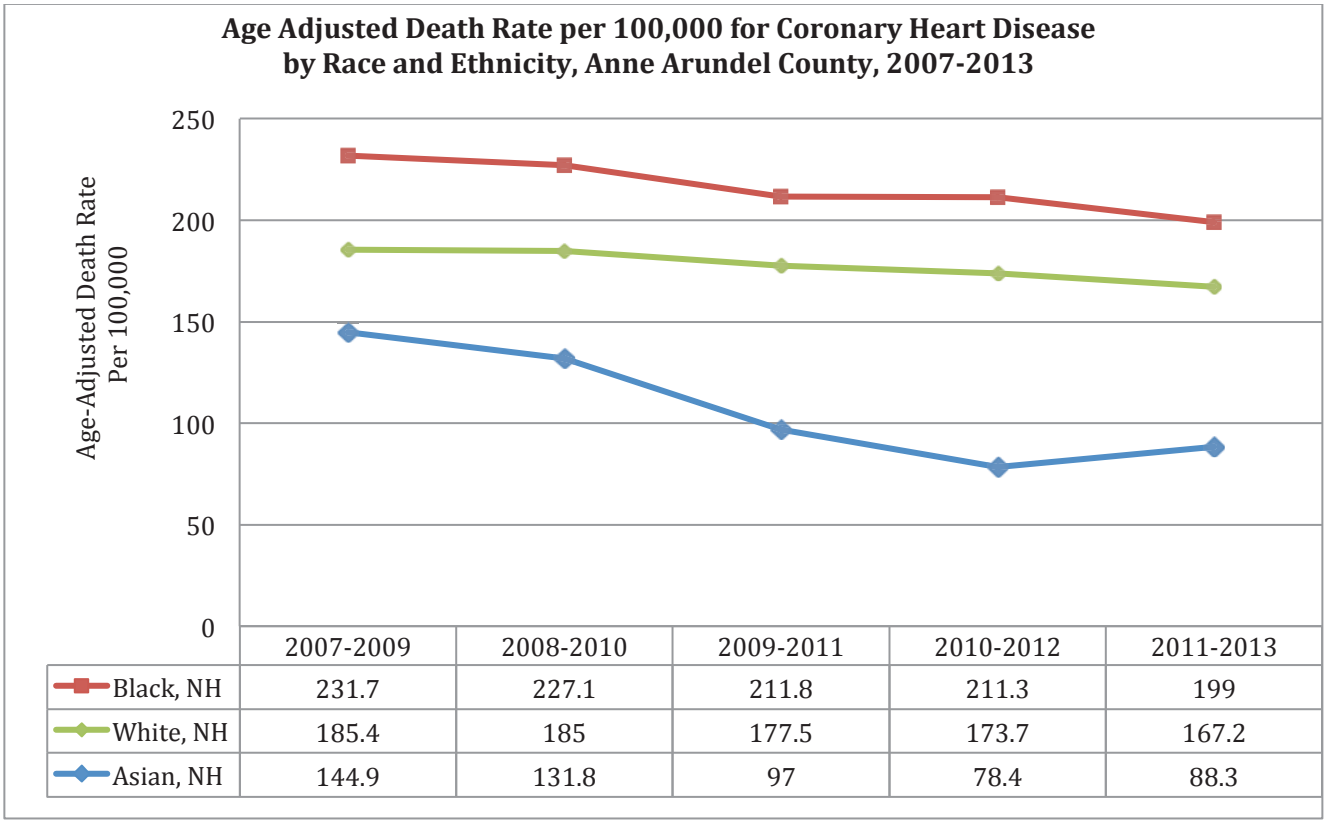


	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Black, NH	201.3	202.1	204.9	198.4	189.5
White, NH	194.3	182.6	175.4	168.2	173.4
Hispanic, Any Race	138.6	139.7	116.9	103.5	107.5
Asian, NH	108.2	141.9	163.1	175.4	154.7

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Coronary Heart Disease

In 2013, 22% of all deaths in Anne Arundel County were from heart disease. Between 2007 and 2013, mortality due to heart disease decreased for all races examined. Throughout the period, the heart disease mortality rate for non-Hispanic blacks was higher than non-Hispanic whites and non-Hispanic Asians. Non-Hispanic Asians observed a 39% decrease in heart disease mortality, followed by a 14% decline among non-Hispanic blacks and a 10% decline among non-Hispanic whites.

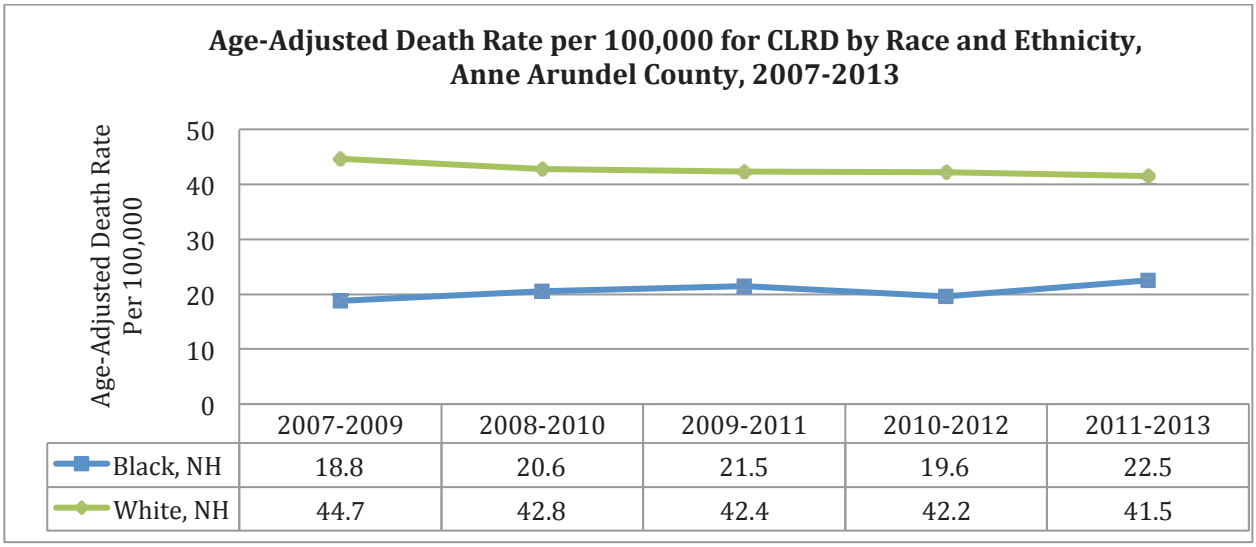


	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Black, NH	231.7	227.1	211.8	211.3	199
White, NH	185.4	185	177.5	173.7	167.2
Asian, NH	144.9	131.8	97	78.4	88.3

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Chronic Lower Respiratory Disease

Between 2007 and 2013, mortality due to chronic lower respiratory disease remained constant for non-Hispanic whites and non-Hispanic blacks; however, the rate was considerably higher for non-Hispanic whites than non-Hispanic blacks during the same time period. Furthermore, between 2011 and 2013, mortality due to chronic lower respiratory disease was 84% higher for non-Hispanic whites than that for non-Hispanic blacks.

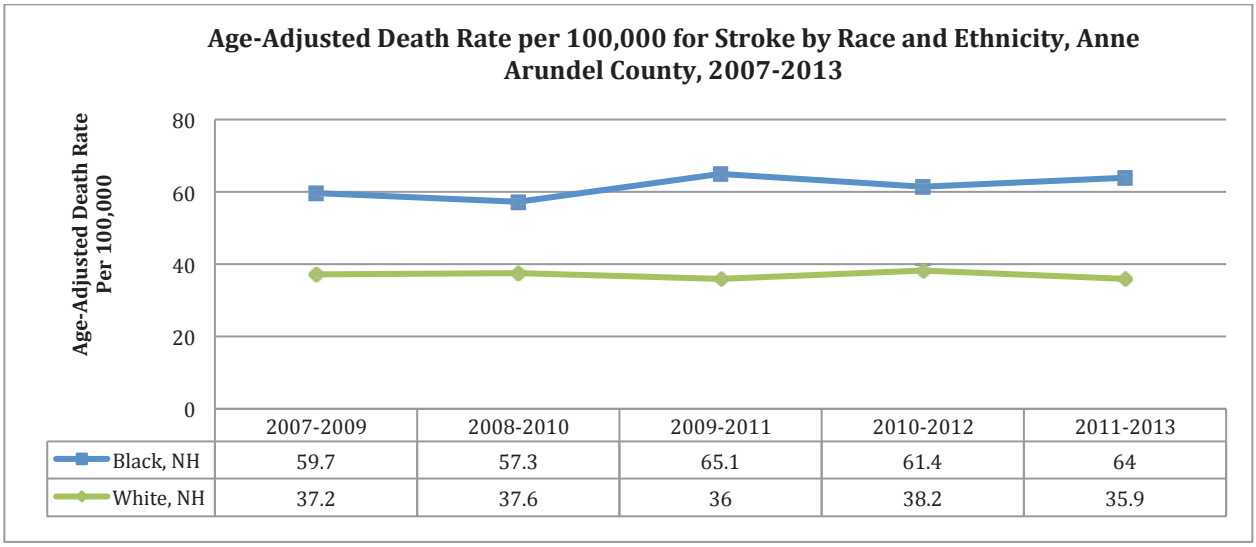


	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Black, NH	18.8	20.6	21.5	19.6	22.5
White, NH	44.7	42.8	42.4	42.2	41.5

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

STROKE

Between 2007 and 2013, mortality rates due to stroke remained consistent for both non-Hispanic whites and non-Hispanic blacks. Throughout the period, the rate for non-Hispanic blacks was higher than non-Hispanic whites; 78% higher between 2011 and 2013 alone.



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Black, NH	59.7	57.3	65.1	61.4	64
White, NH	37.2	37.6	36	38.2	35.9

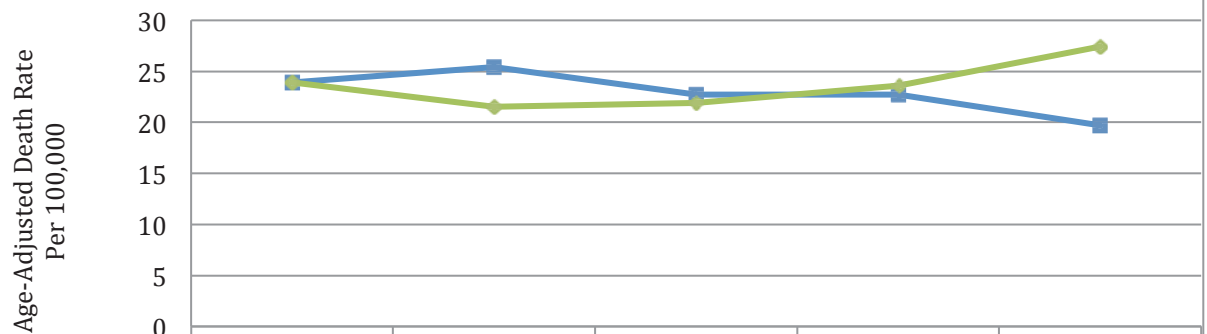
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Unintentional Injury

Unintentional injury deaths result from a variety of causes such as motor vehicle accidents, falls, firearms, drowning, suffocations, bites, stings, sports/recreational activities, natural disasters, fires/burns and poisonings. Unintentional injury risks include lack of seatbelt use, lack of motorcycle helmet use, unsafe consumer products, drug and alcohol use (including prescription drug misuse), exposure to occupational hazards, and unsafe home and community environments.

Between 2007 and 2013, mortality due to accidents decreased steadily for non-Hispanic blacks while, conversely, it generally increased during that same time period for non-Hispanic whites. During 2011-2013, mortality due to unintentional injuries for non-Hispanic whites was 39% higher than that for non-Hispanic blacks.

Age-Adjusted Death Rate per 100,000 for Unintentional Injuries by Race and Ethnicity, Anne Arundel County, 2007-2013

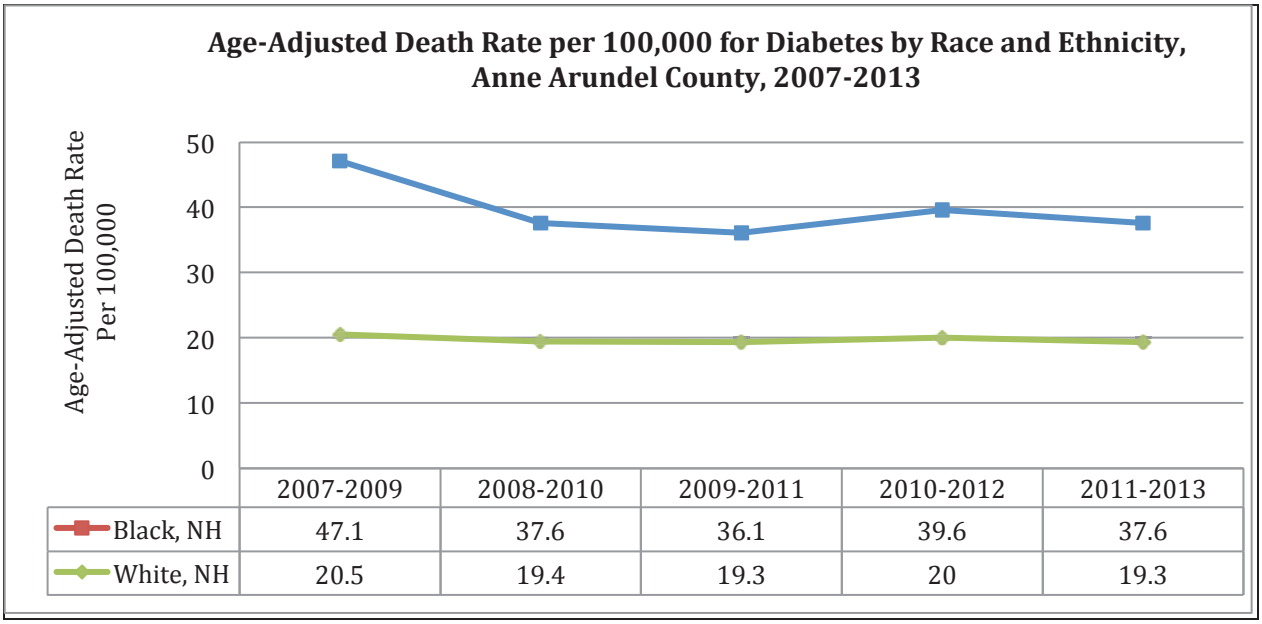


	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Black, NH	23.9	25.4	22.7	22.7	19.7
White, NH	23.9	21.5	21.9	23.6	27.4

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Diabetes

Between 2007 and 2013, mortality due to diabetes for non-Hispanic blacks decreased steadily, but remained consistently higher than for non-Hispanic whites. During 2011-2013, the mortality rate for diabetes in non-Hispanic blacks was 94% higher than that in non-Hispanic whites.



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Black, NH	47.1	37.6	36.1	39.6	37.6
White, NH	20.5	19.4	19.3	20	19.3

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Maternal and Child Health

Birth

In 2013, the live birth rate in Anne Arundel County was 12.3 births per 1,000, similar to the birth rates in both Maryland (12.1 births per 1,000) and the U.S. (12.4 births per 1,000).

Table 23: Live Birth Rate per 1,000 Population, Anne Arundel Compared to Maryland and U.S., 2013

Live Births per 1,000 population	Anne Arundel	Maryland	United States
	12.3	12.1	12.4

Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration, 2013; National Center for Health Statistics, National Vital Statistics Report, 2013

In 2013, there were a total of 6,814 births in Anne Arundel County. The highest birth rate was among the Hispanic population at 21.6 births per 1,000 population; followed by non-Hispanic Asian, non-Hispanic black and non-Hispanic white.

Table 24: Number of Births by Race and Ethnicity of the Mother, Anne Arundel County, 2013

Race/Ethnicity	Number of Live Births	Crude Birth Rate per 1,000
White, NH	4399	11.0
Black, NH	1204	13.2
Hispanic, Any Race	827	21.6
Asian, NH	356	17.6
American Indian/Alaska Native	17	1.3

Source: Maryland Department of Health and Mental Hygiene Vital Statistics Administration, 2013

In 2013, 61% of births in Anne Arundel County were to women 25-34 years old. The county had a slightly higher proportion of women giving birth over the age of 30 as compared to Maryland and the U.S.

Table 25: Number and Percent of Births by Age Group, Anne Arundel Compared to Maryland and U.S., 2013

Age Group	Anne Arundel		Maryland	United States
	Number	Percentage	Percentage	Percentage
<15 years	2	0.03%	0.07%	0.08%
15-17 years	67	1%	1.4%	1.9%
18-19 years	185	2.7%	3.7%	5.0%
20-24 years	1,077	15.8%	18.3%	22.8%
25-29 years	2,026	29.7%	27.9%	28.5%
30-34 years	2,178	31.0%	29.8%	26.4%
35-39 years	1,001	14.7%	14.9%	12.3%
40-44 years	254	3.7%	3.6%	2.8%
45-49 years	19	0.3%	0.3%	0.2%
50+ years	2	0.03%	0.04%	0.02%

Source: Maryland Department of Health and Mental Hygiene Vital Statistics Administration, 2013; National Center for Health Statistics, National Vital Statistics Report, 2013

Infant Mortality

There were 190 infant deaths between 2010 and 2014 in Anne Arundel County. Deaths are classified as infant deaths if the child dies before his or her first birthday. The infant mortality rate in Anne Arundel County was 5.5 deaths per 1,000 live births; lower than both Maryland (6.6 deaths per 1,000 live births) and the United States (6.0 deaths per 1,000 live births).

Table 26: Infant Mortality Rate, Anne Arundel County, Maryland and U.S., 2010-2014

Infant Mortality Rate per 1,000 births	Anne Arundel	Maryland	United States
	5.5	6.6	6.0

Source: Maryland Department of Health and Mental Hygiene Vital Statistics Administration, 2013; National Center for Health Statistics, National Vital Statistics Report, 2013

Although the overall infant mortality rate was lower in Anne Arundel County, disparities existed when examined by race and ethnicity. Non-Hispanic blacks had the highest infant mortality rate in the county. Between 2010 and 2014, there were over 68 infant deaths per 1,000 births for non-Hispanic blacks, compared to 5.3 deaths and 4.0 deaths per 1,000 births for Hispanic and non-Hispanic whites respectively.

Table 27: Infant Deaths and Infant Mortality Rates by Race and Ethnicity, Anne Arundel County, 2010-2014

Race/Ethnicity	Number of Infant Deaths	Infant Mortality Rate
White, NH	89	4.0
Black, NH	68	11.2
Hispanic, Any Race	22	5.3

Source: Maryland Department of Health and Mental Hygiene Vital Statistics Administration, 2013

Low Birthweight

Low birthweight (less than 2,500 grams) is the single most important factor affecting neonatal mortality and a significant determinant of post neonatal mortality. Low birthweight infants who survive are at increased risk for health problems ranging from neurodevelopmental disabilities to respiratory disorders.

The percentage of low birth weight babies born in Anne Arundel County in 2010-2014 (7.9%) was lower than both Maryland and the U.S. but still slightly exceeded the HHS Healthy People 2020 goal of 7.8%.

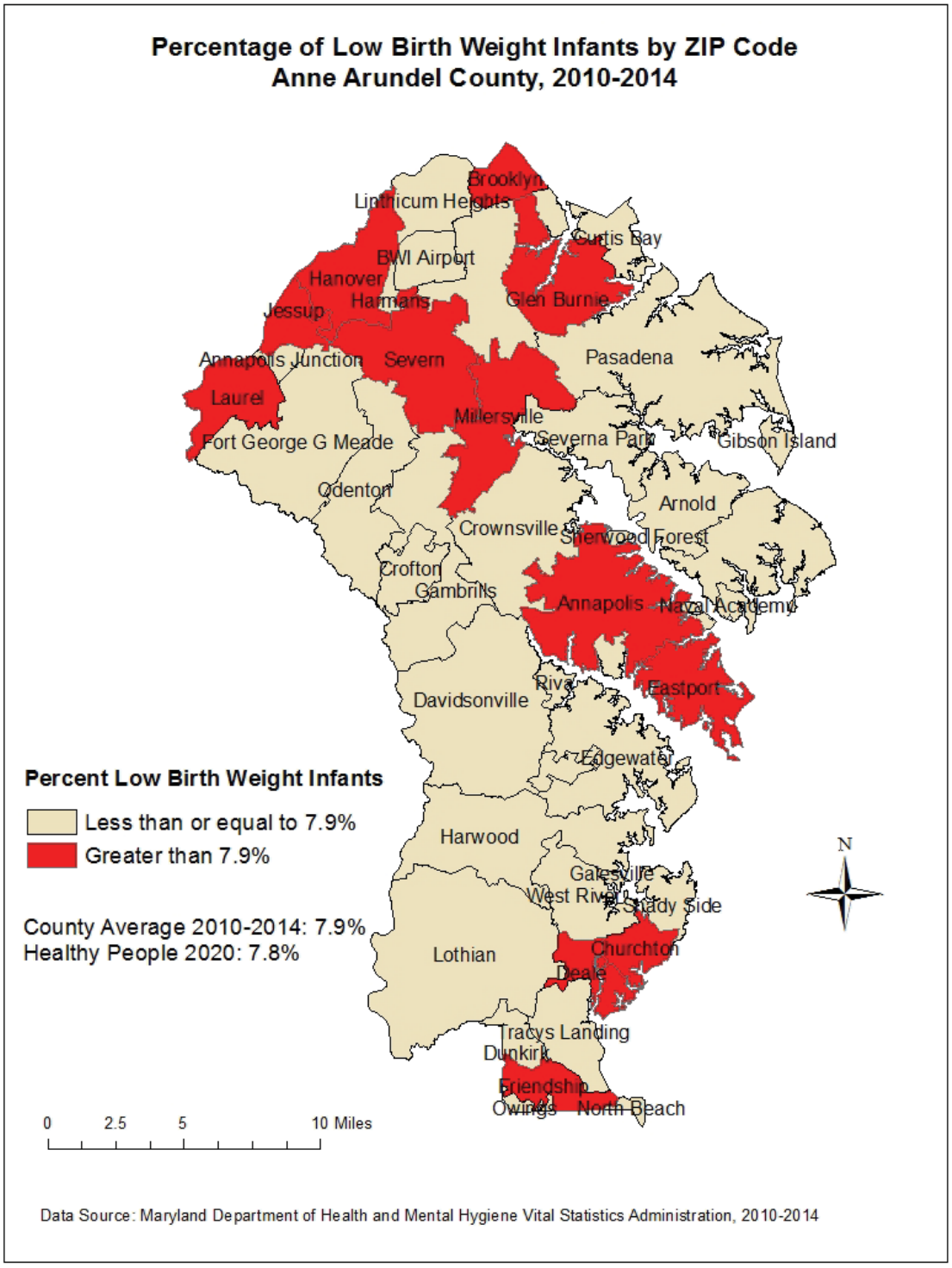
Table 28: Percentage of Low Birth Weight Babies, Anne Arundel Compared to Maryland and U.S., 2010-2014

Percentage of Low Birth Weight (<2500 g) Babies	Anne Arundel	Maryland	United States
	7.9%	8.7%	8.0%

Source: Maryland Department of Health and Mental Hygiene Vital Statistics Administration, 2010-2014; National Center for Health Statistics, National Vital Statistics Report, 2010-2014

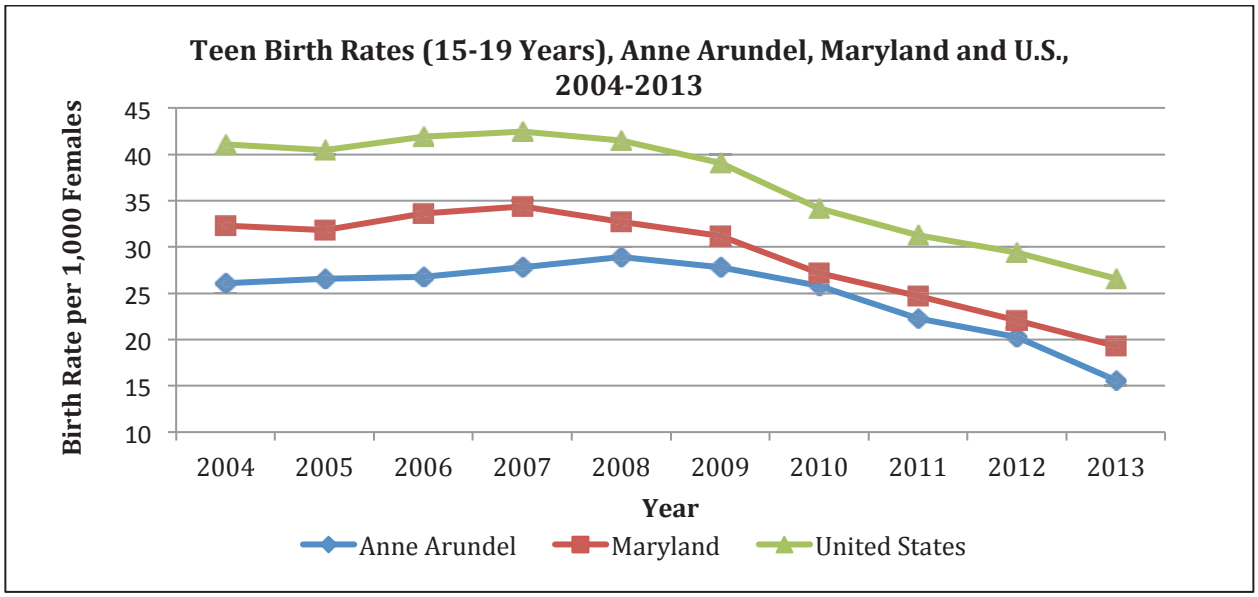
Low Birth Weight Infants by ZIP Code, Anne Arundel County, 2010-2014

Between 2010 and 2014, Brooklyn, Severn, Laurel, Jessup, Churchton, Glen Burnie (21060), Hanover, Millersville, Shady Side, Annapolis, Eastport and Friendship had higher percentages of low birth weight infants born than the county average of 7.9%. Most of these areas are located in the northern part of the county.



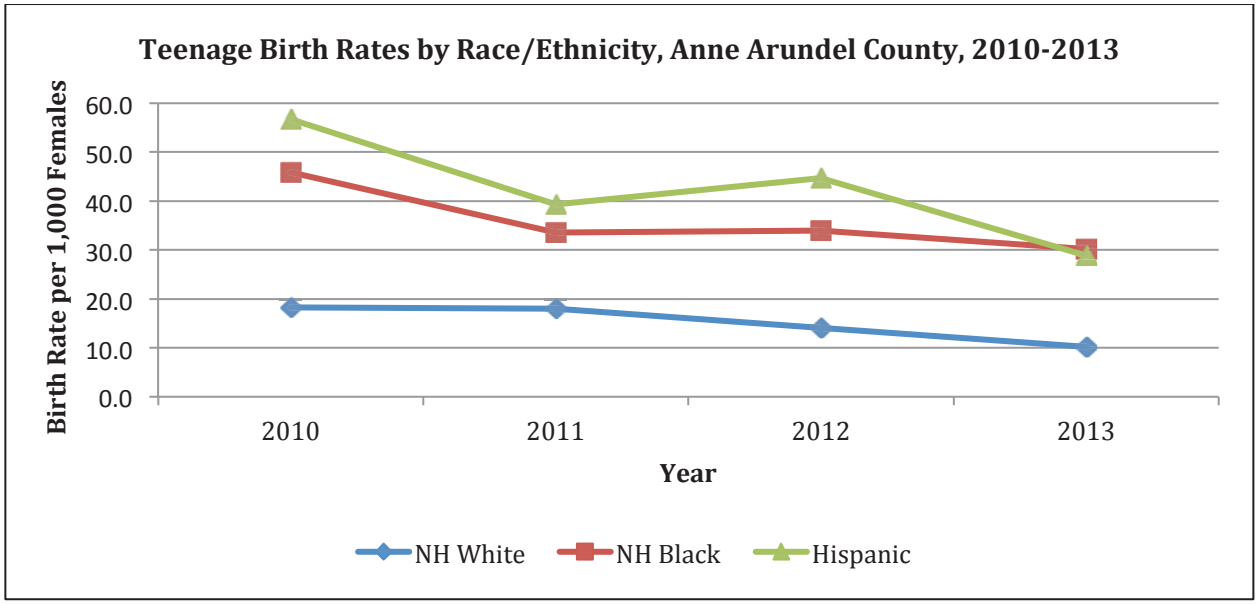
Trends in Teenage Birth Rates, Anne Arundel Compared to Maryland and U.S., 2004-2013

Anne Arundel County has lower teenage birth rates than Maryland and the U.S., however, disparities still exist. In 2013, non-Hispanic black and Hispanic teenagers had three times higher pregnancy rates compared to non-Hispanic white teens in the county. Teenage birth rates have declined steadily over the past ten years in Anne Arundel County, Maryland and the U.S.



Source: Maryland Department of Health and Mental Hygiene Vital Statistics Administration, 2004-2013; National Center for Health Statistics, National Vital Statistics Report, 2004-2013

Teenage Birth Rates by Race and Ethnicity, Anne Arundel 2010-2013



Source: Maryland Department of Health and Mental Hygiene Vital Statistics Administration, 2004-2013; National Center for Health Statistics, National Vital Statistics Report, 2004-2013

Early and adequate prenatal care and abstinence from tobacco help prevent negative health outcomes. In Anne Arundel County, the proportion of women receiving prenatal care in the first

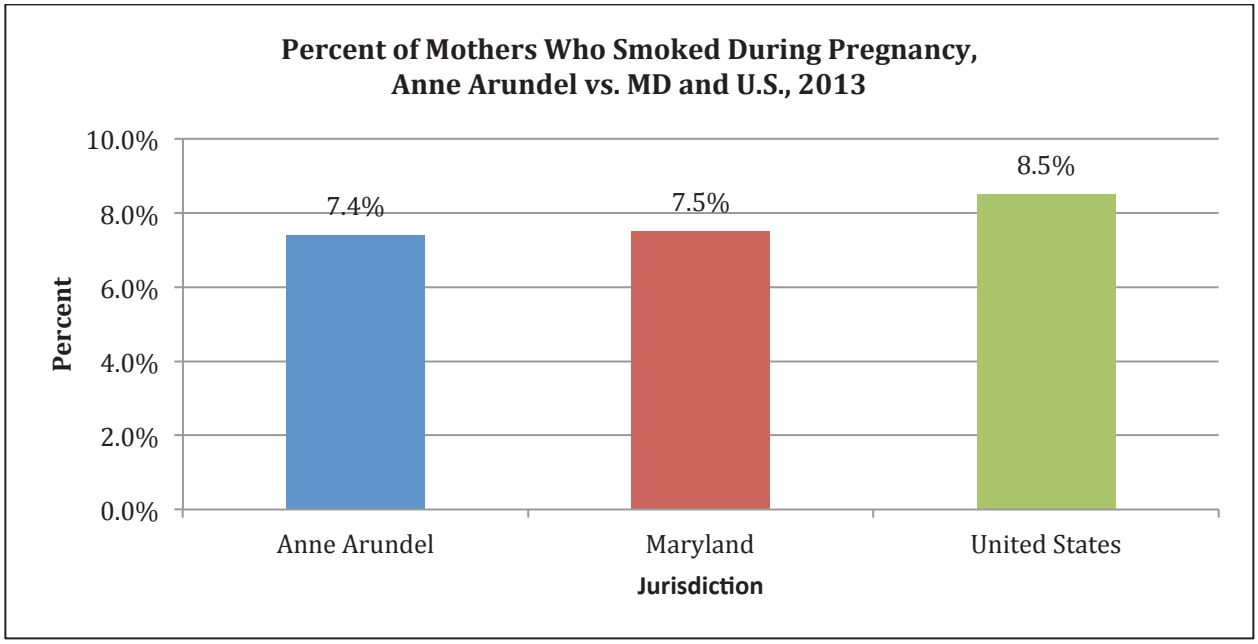
trimester remained relatively unchanged between 2011 and 2013. However, a higher percentage of non-Hispanic white mothers received first trimester prenatal care during that same time period compared to Asian, black and Hispanic mothers.

Table 29: Percent of First Trimester Prenatal Care by Race and Ethnicity, Anne Arundel, 2011-2013

Race/Ethnicity	2011	2012	2013
White, NH	79.9%	75.7%	78.6%
Black, NH	63.7%	64.7%	66.5%
Hispanic, Any Race	63.6%	57.9%	64.1%
Asian, NH	70.3%	68.6%	69.5%

Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration, 2013

In 2013, a lower percentage of Anne Arundel County mothers smoked during pregnancy than in Maryland and the U.S. The majority of mothers (92.6%) abstained from smoking during pregnancy in 2013. Anne Arundel County, Maryland and U.S. are still far from the Healthy People 2020 goal of 98.6% of expectant mothers abstaining from smoking during pregnancy.



Source: Maryland Department of Health and Mental Hygiene Vital Statistics Administration, 2013; National Center for Health Statistics, National Vital Statistics Report; 2013

Cancer Statistics

Overall, Anne Arundel County has a higher cancer incidence rate compared to Maryland and the U.S. Anne Arundel County has higher incidence rates of female breast cancer, lung and bronchus cancer, melanoma and prostate cancer compared to Maryland and the U.S.

Conversely, the incidence of colorectal cancer is lower in Anne Arundel compared to state and nationwide averages. The incidence rate of cervical cancer in Anne Arundel County is lower than the incidence rate of cervical cancer in the U.S.

Table 30: Cancer Incidence Rates per 100,000 by Site and Gender, Anne Arundel Compared to Maryland and U.S., 2007-2011

Site	Anne Arundel	Maryland	United States
Breast (Female)	129.3	127.8	122.8
Colorectal	35.7	39.3	43.3
Male	39.8	45.1	50.0
Female	32.1	34.8	37.8
Lung and Bronchus	68.7	59.9	64.9
Male	76.5	69.9	78.6
Female	63.0	52.8	54.6
Melanoma	32.4	21.0	19.7
Male	43.2	27.5	25.1
Female	24.0	16.5	15.9
Prostate	151.7	148.7	142.5
Cervical	6.6	6.7	7.8
All Sites	479.2	451.8	467.7

Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2014; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Overall, cancer mortality is higher in Anne Arundel County compared to Maryland and the U.S. Mortality due to melanoma has historically been an issue in the county. Males have three times higher mortality rate of melanoma than females in the county. The death rate due to lung and bronchus cancer is also higher in Anne Arundel County compared to Maryland and the U.S. Males have a higher mortality rate of lung and bronchus cancer than females in the county.

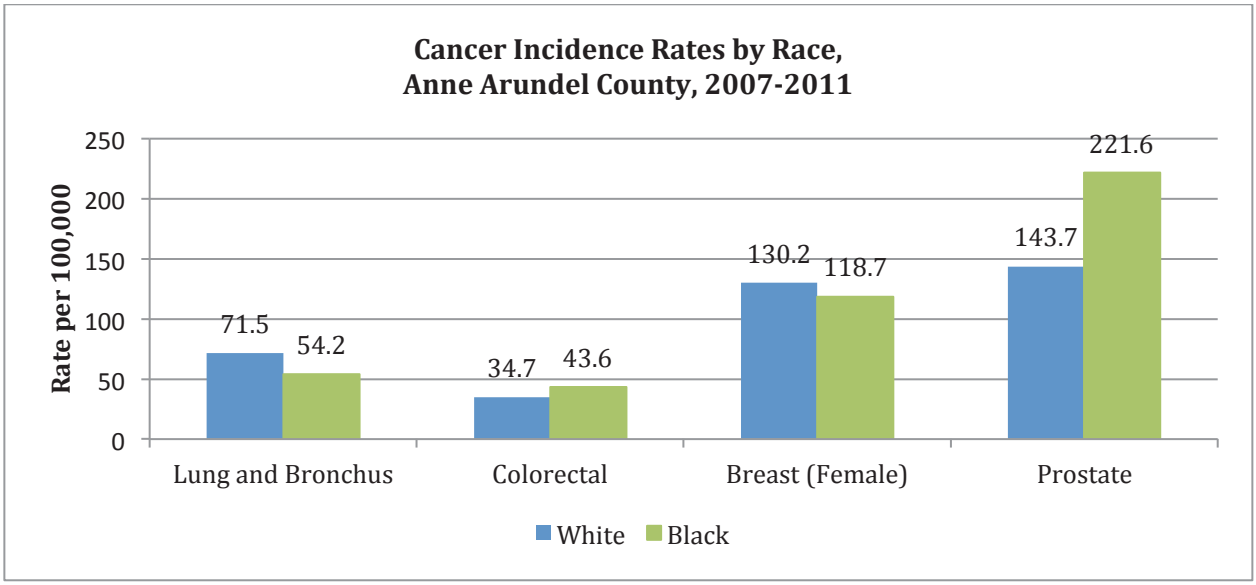
Table 31: Cancer Mortality Rates per 100,000 by Site and Gender, Anne Arundel County Compared to Maryland and U.S., 2007-2011

Site	Anne Arundel	Maryland	United States
Breast (Female)	23.0	24.0	22.2
Colorectal	14.5	16.0	15.9
Male	17.2	20.0	19.1
Female	12.3	13.2	13.5
Lung and Bronchus	55.2	47.7	48.4
Male	65.6	59.5	61.6
Female	47.6	39.4	38.5
Melanoma	3.5	2.6	2.7
Male	6.0	4.1	4.1
Female	1.8	1.6	1.7
Prostate	21.4	24.6	22.3
Cervical	2.2	2.2	2.3
All Sites	183.4	175.8	173.8

Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2014; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

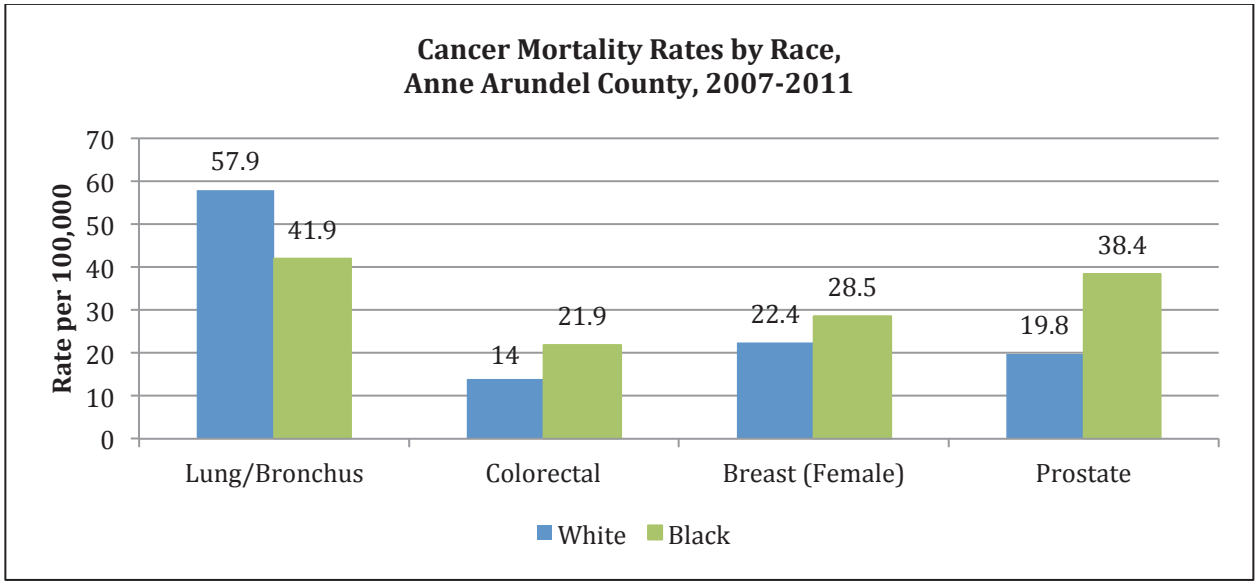
Disparities also exist when examining cancer incidence and mortality by race and ethnicity*. The incidence and mortality rates of lung and bronchus cancer and melanoma were higher in whites compared to blacks; however, black males were disproportionately diagnosed with and died from prostate cancer compared to white males. White females had a higher incidence of breast cancer; however, black females had a higher mortality rate of breast cancer in the county.

Cancer Incidence Rates by Race, Anne Arundel County, 2007-2011



Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2014
*Individuals of Hispanic origin were included within the white or black estimates and are not listed separately

Cancer Mortality Rates by Race, Anne Arundel County, 2007-2011



Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2014

Over the past decade, the incidence of all cancer types decreased significantly from 525.4 cases per 100,000 in 2002 to 455.4 per 100,000 in 2011. The biggest strides were made in the incidence of colon cancer (38% decrease since 2002) and prostate cancer (30% decrease since 2002). Conversely, the incidence of melanoma remained relatively unchanged during the same time period.

Table 32: Cancer Incidence Rates by Type, Anne Arundel County, 2002-2011

Year	Breast	Colon	Lung and Bronchus	Melanoma	Prostate	Cervical	All Sites
2002	144.9	54.9	70.7	30.1	197.7	**	525.4
2003	133.6	51.9	74.5	26.9	185	9.2	510.4
2004	135.3	46.6	69.6	24.9	150.6	**	470.3
2005	90.5	40.9	67.6	29.2	135.5	7.6	437.1
2006	116.3	43.2	72	31.7	131.8	**	442.6
2007	125.2	38.6	76.8	33.7	139.7	7.1	486.0
2008	146.8	38.6	78.9	32.1	173.4	6.7	520.4
2009	127.8	37.4	66.9	27.3	159.3	8.4	472.8
2010	122.1	30.8	58.8	34.5	151.5	**	466.7
2011	126	34.1	63.8	34	137.5	6.7	455.4

Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2014

Mortality due to all causes of cancer also decreased in the county over the last decade; from 209.1 deaths per 100,000 in 2002 to 165.5 deaths per 100,000 in 2011 (21% decrease). The decreases in incidences of lung and bronchus cancer have been slight over the past decade and the decline in mortality has been 27% since 2002. Deaths due to colon cancer also decreased from 20.4 per 100,000 in 2002 to 10.5 per 100,000 in 2011 (48% decline).

Table 33: Cancer Mortality Rates by Type, Anne Arundel County, 2002-2011

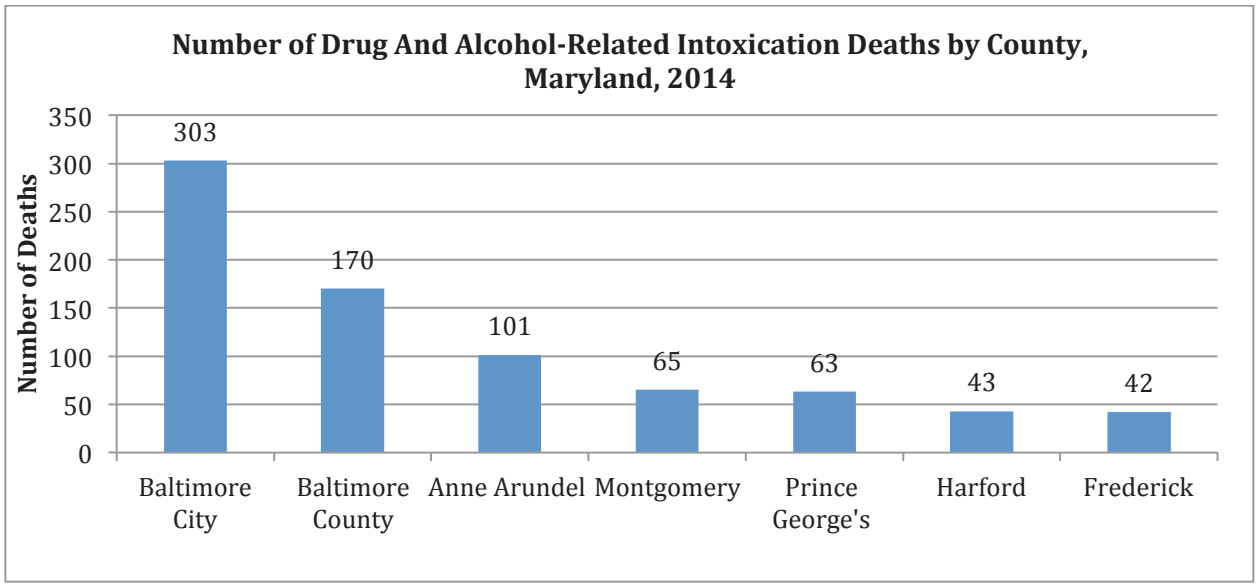
Year	Breast	Colon	Lung and Bronchus	Melanoma	Prostate	Cervical	All Sites
2002	29.7	20.4	63	4.2	23.8	3	209.1
2003	25	21.3	61.1	4.9	23.3	**	199.4
2004	28.5	22.6	59.7	**	29.1	**	202.6
2005	25.5	16	61.4	4	25.2	**	203.8
2006	23.7	17.3	65	5.4	26.2	**	202.0
2007	28.3	20.7	60.6	**	23.1	**	205.8
2008	23.7	17.2	63.9	5	25.3	**	193.7
2009	21.5	14.1	58.3	4.5	24.8	**	186.4
2010	21.8	11.7	46.4	**	16	**	165.5
2011	20.2	10.5	46.2	**	18	**	165.5

Source: Maryland Department of Health and Mental Hygiene, Annual Cancer Report, 2014

Alcohol and Drug Intoxication Deaths

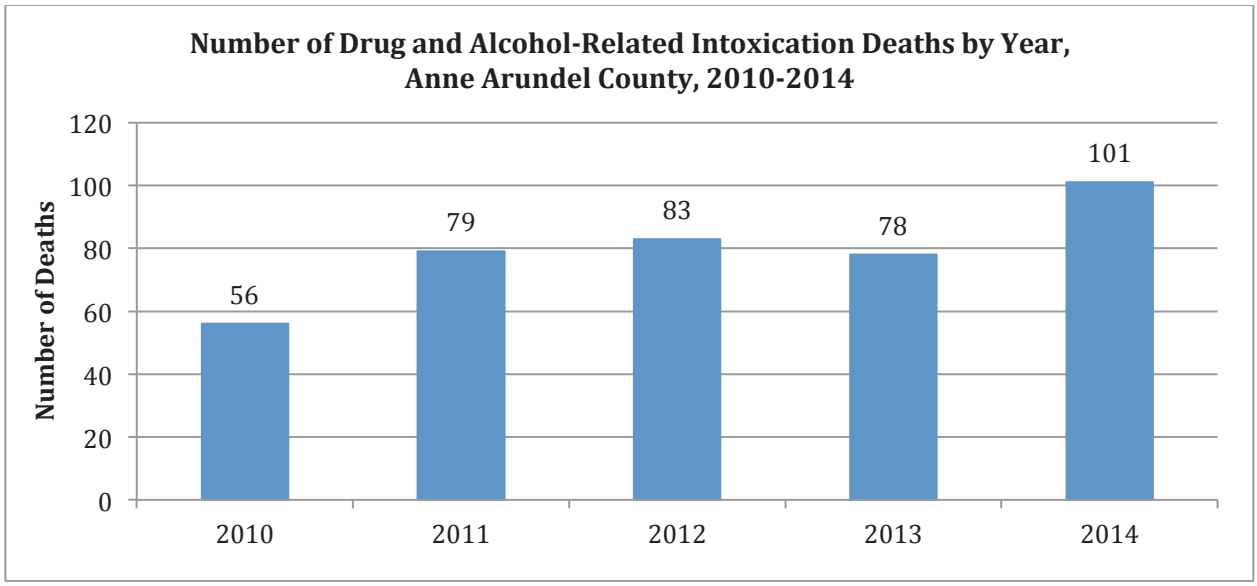
Total Alcohol and Drug Intoxication Deaths

In 2014, Anne Arundel County had the third highest number of alcohol and drug-related deaths in Maryland (after Baltimore City and Baltimore County).



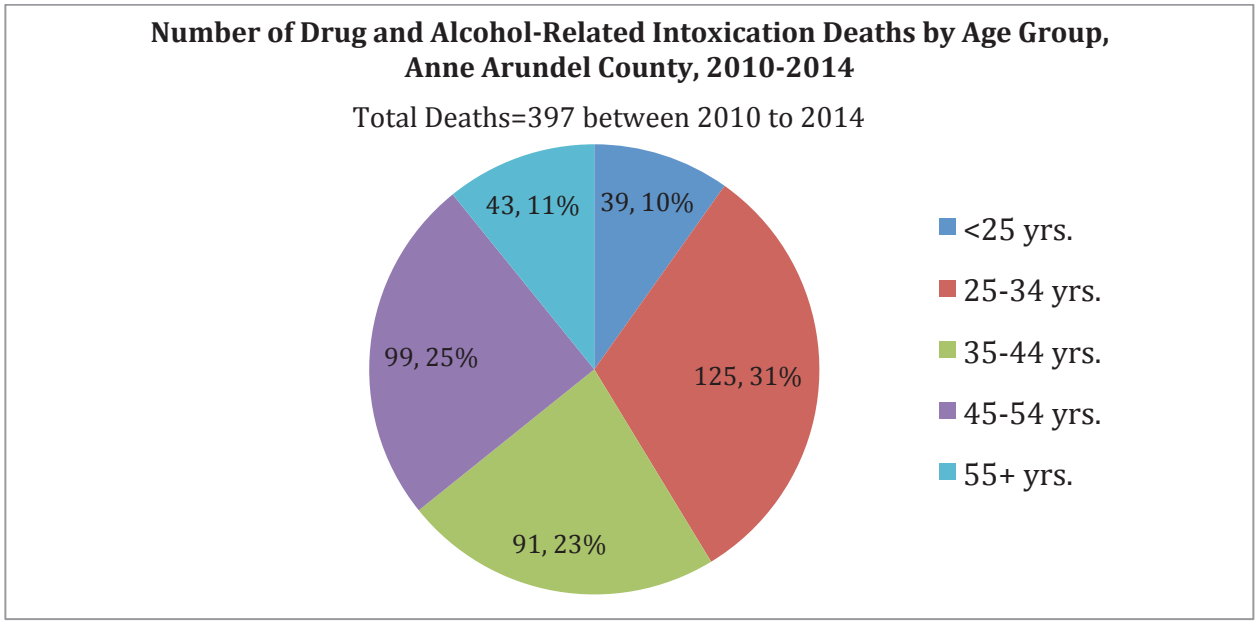
Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county.

A total of 101 drug and alcohol-related deaths occurred in 2014; a 29.4% increase over the number of deaths in 2013 and an 80.3% increase since 2010.



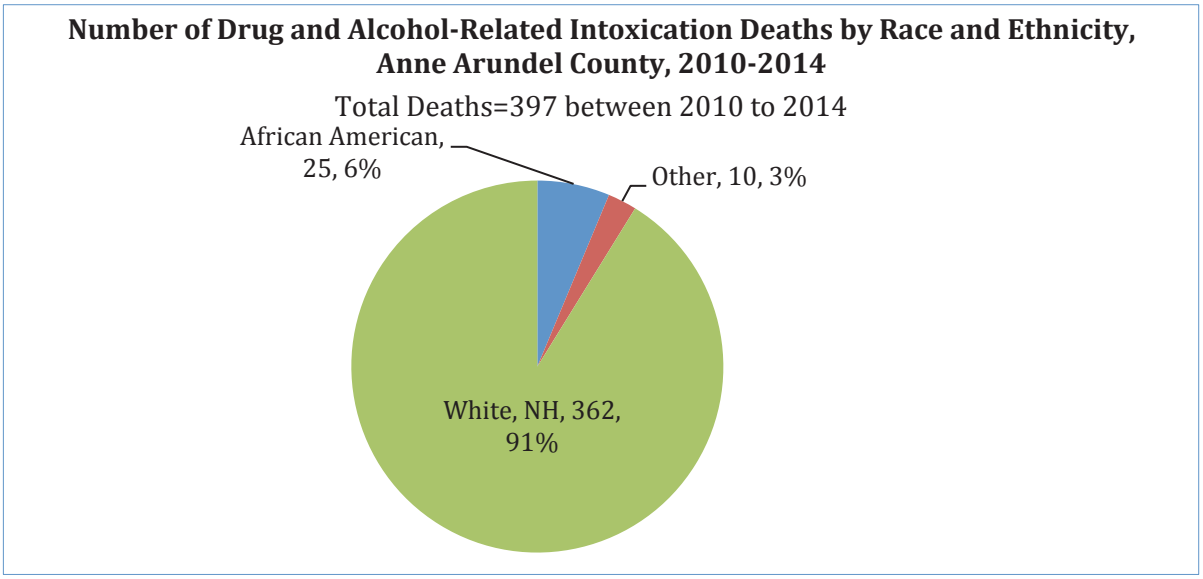
Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county.

Between 2010 and 2014, 79% of drug and alcohol-related deaths occurred in people 25 to 54 years old. Only 10% of drug and alcohol-related deaths occurred in people less than 25 years, and 11% of deaths in people 55 years and over.

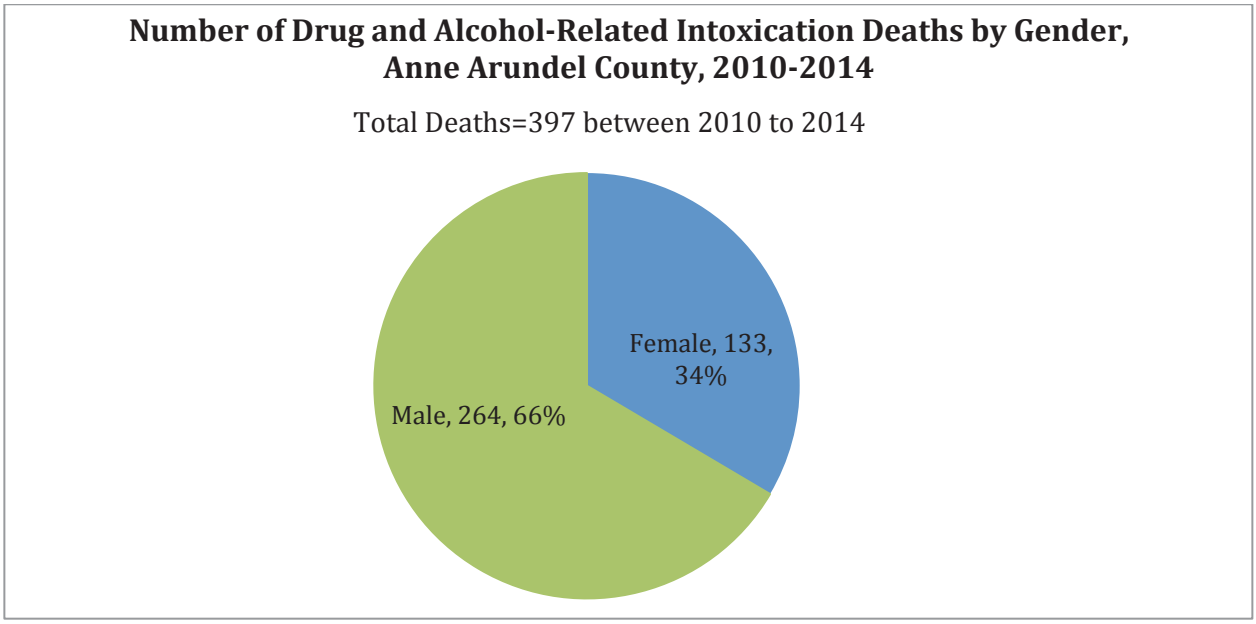


Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county.

The overwhelming majority (91%) of drug and alcohol-related deaths between 2010 and 2014 occurred among non-Hispanic whites. Two-thirds of drug and alcohol-related deaths occurred among males.



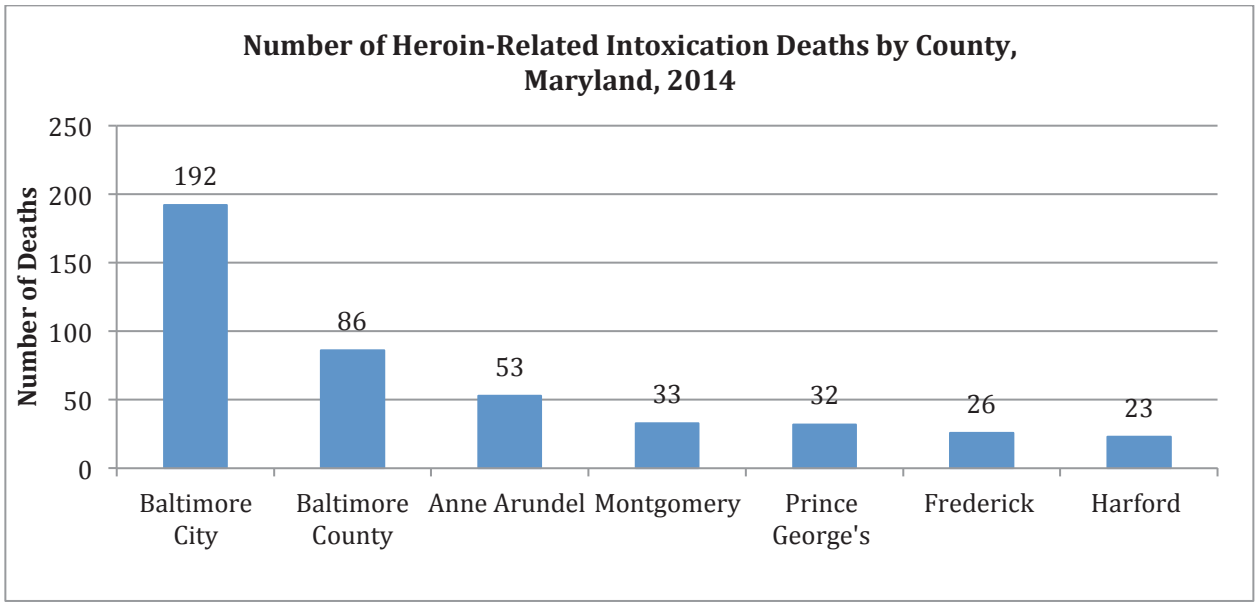
Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county.



Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county.

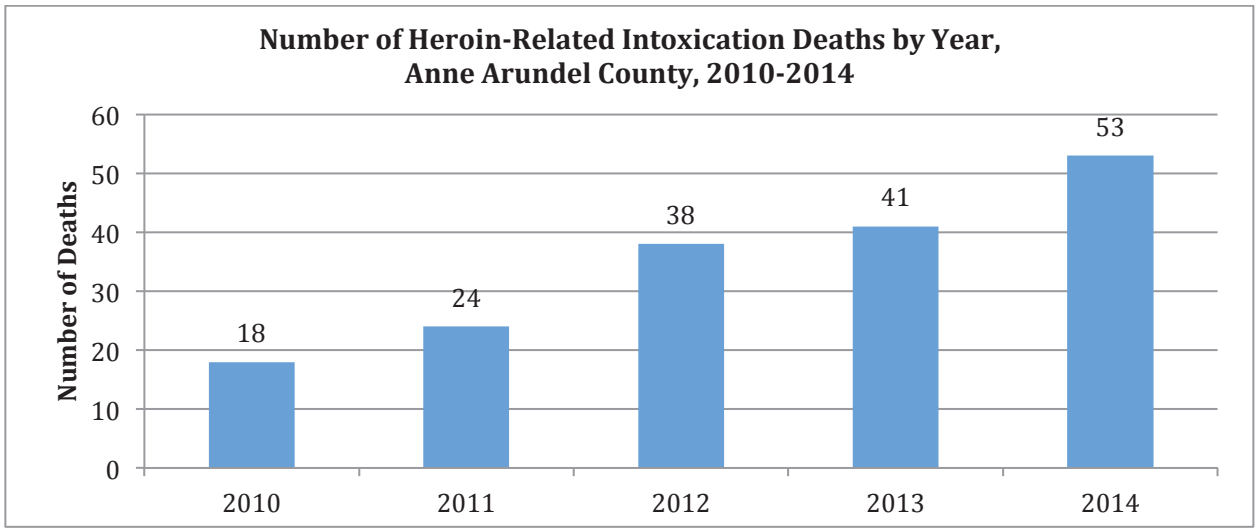
Heroin-Related Intoxication Deaths

In 2014, Anne Arundel County had the third highest number of heroin-related deaths in Maryland (after Baltimore City and Baltimore County).



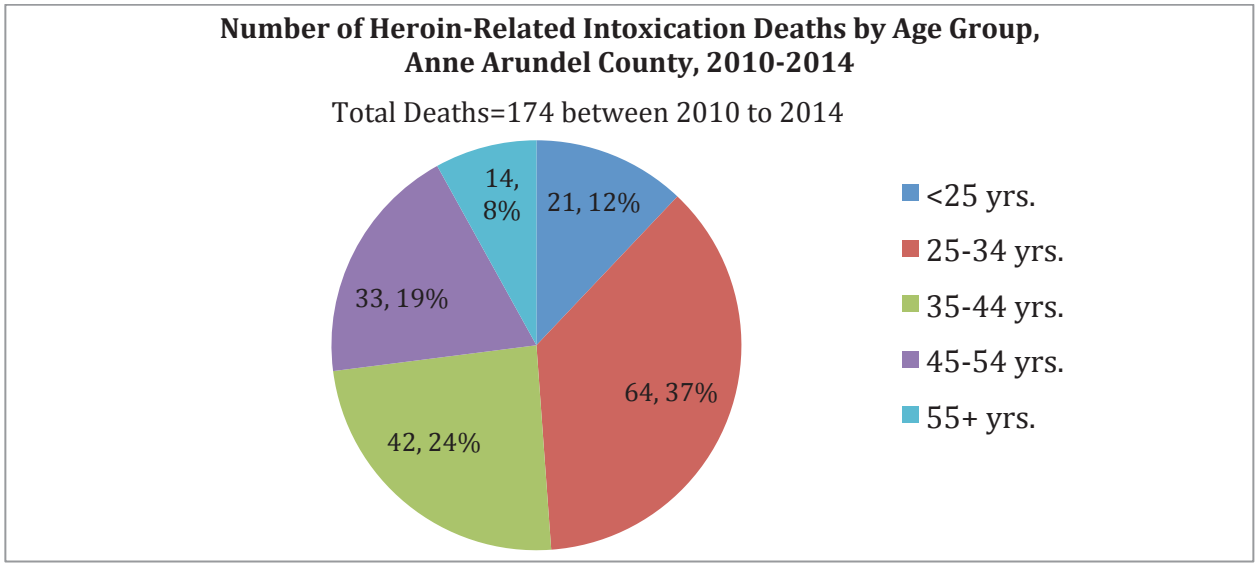
Source: Behavioral Health Administration, Maryland DHMH. Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county

Out of the 101 intoxication deaths that occurred in Anne Arundel County in 2014, 53 (52.5%) were heroin-related. The number of heroin-related deaths increased by 29.2% between 2013 and 2014, and there was almost a three-fold increase in the number of heroin-related deaths (from 18 to 53) between 2010 and 2014.



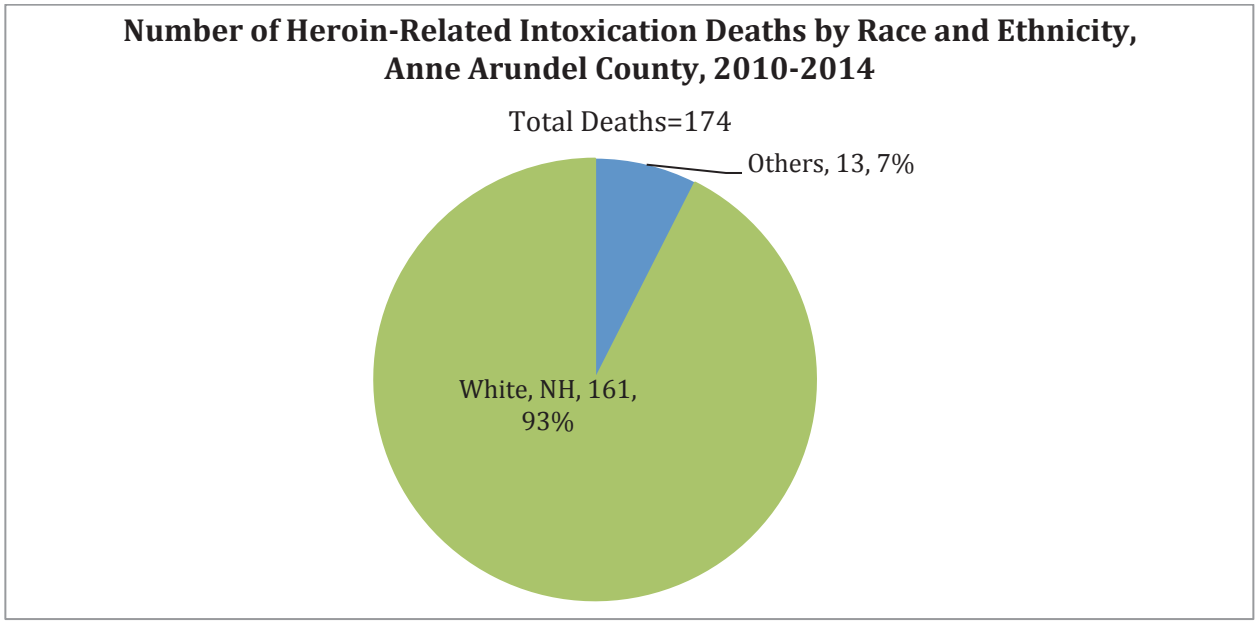
Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county

From 2010 to 2014, 80% of heroin-related deaths occurred in people between 25 to 54 years of age. Only 12% of deaths occurred in people less than 25 years, and 14% of the deaths were in people 55 years and over.

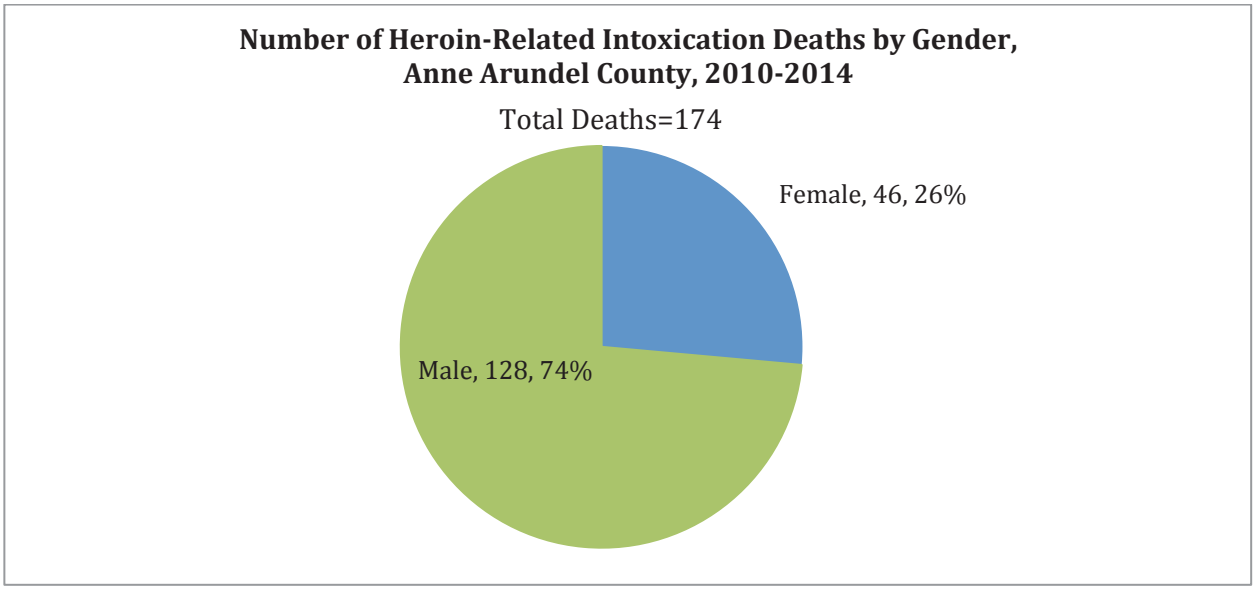


Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county.

The majority (93%) of heroin-related deaths in Anne Arundel County between 2010 and 2014 occurred among non-Hispanic whites and three-quarters of heroin-related deaths were male.



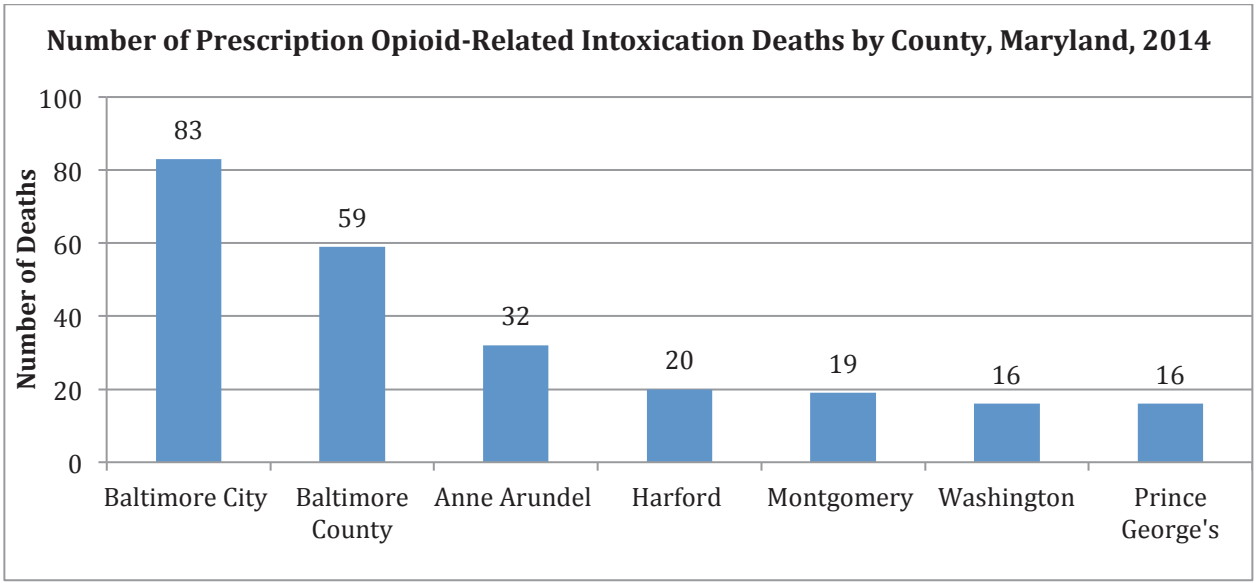
Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county.



Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county.

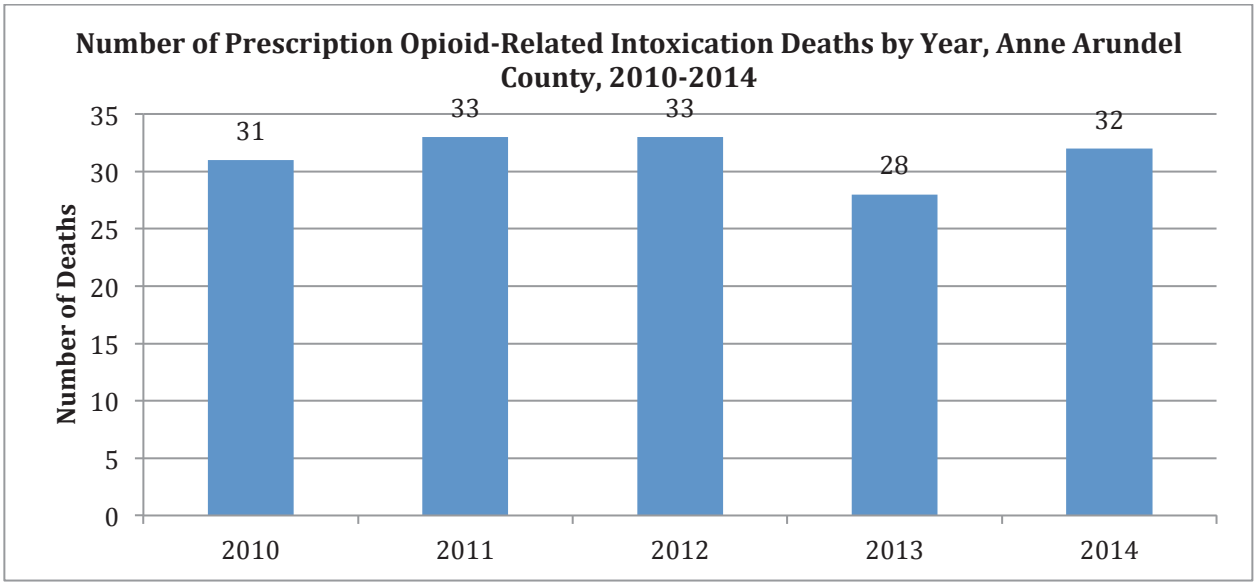
PRESCRIPTION OPIOID-RELATED INTOXICATION DEATHS

In 2014, Anne Arundel County had the third highest number of prescription opioid-related deaths in Maryland (after Baltimore City and Baltimore County).



Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county.

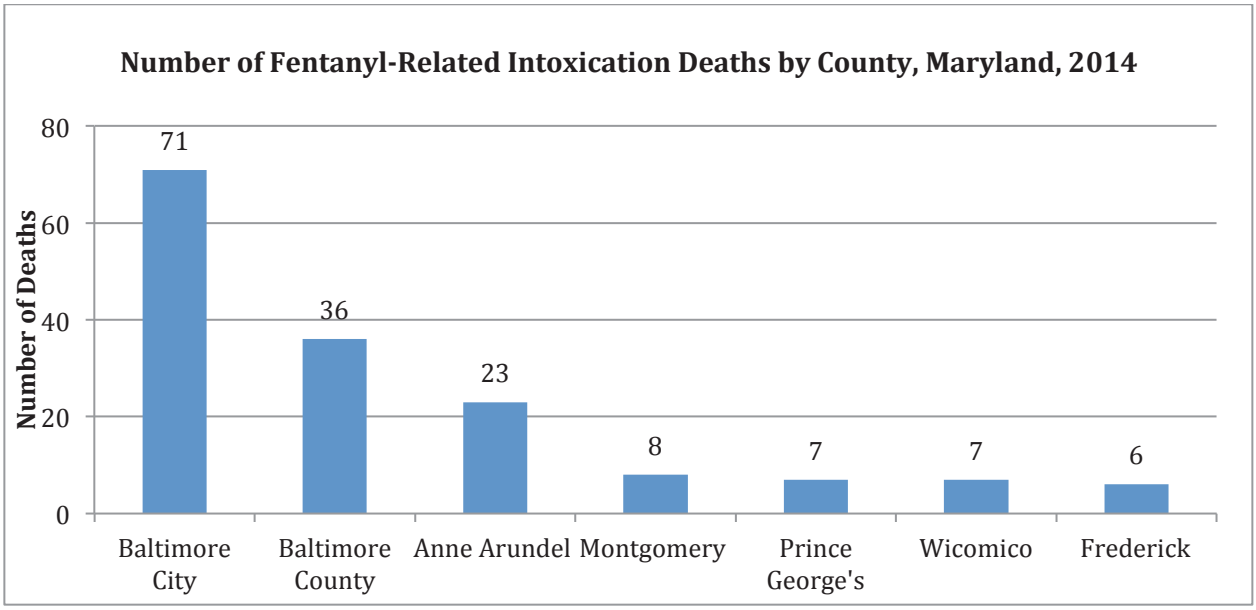
The overall number of prescription opioid-related deaths has remained relatively stable in recent years.



Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county.

Fentanyl-Related Intoxication Deaths

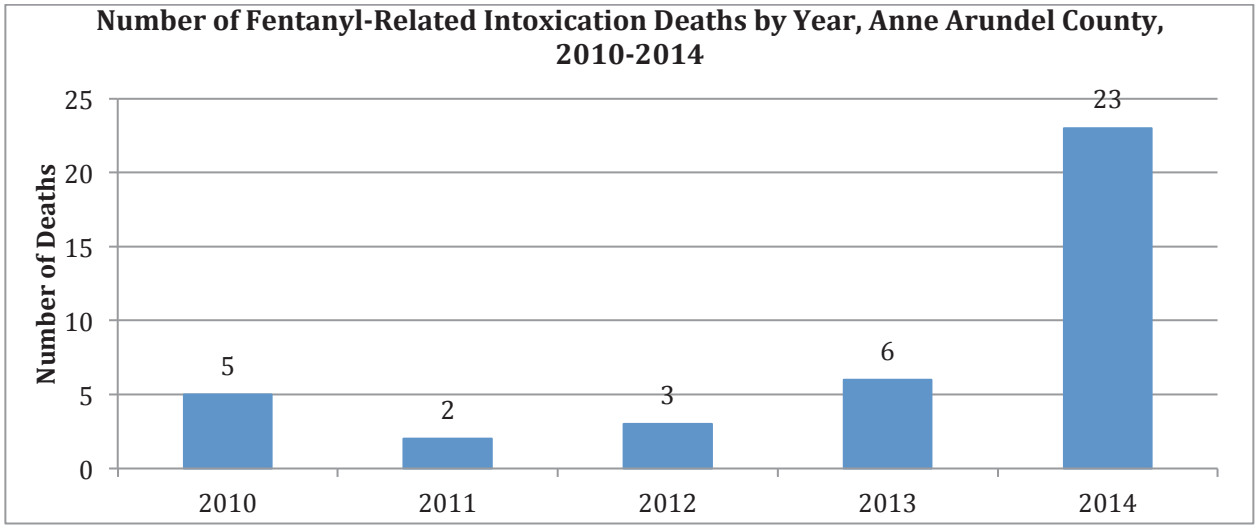
In 2014, Anne Arundel County had the third highest number of fentanyl-related deaths in Maryland (after Baltimore City and Baltimore County).



Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county.

The number of fentanyl-related deaths increased by 283% between 2013 and 2014 (from 6 to 23). In Maryland, the number of fentanyl-related deaths began increasing in late 2013 as a result of overdoses involving non-pharmaceutical fentanyl produced in clandestine laboratories and mixed

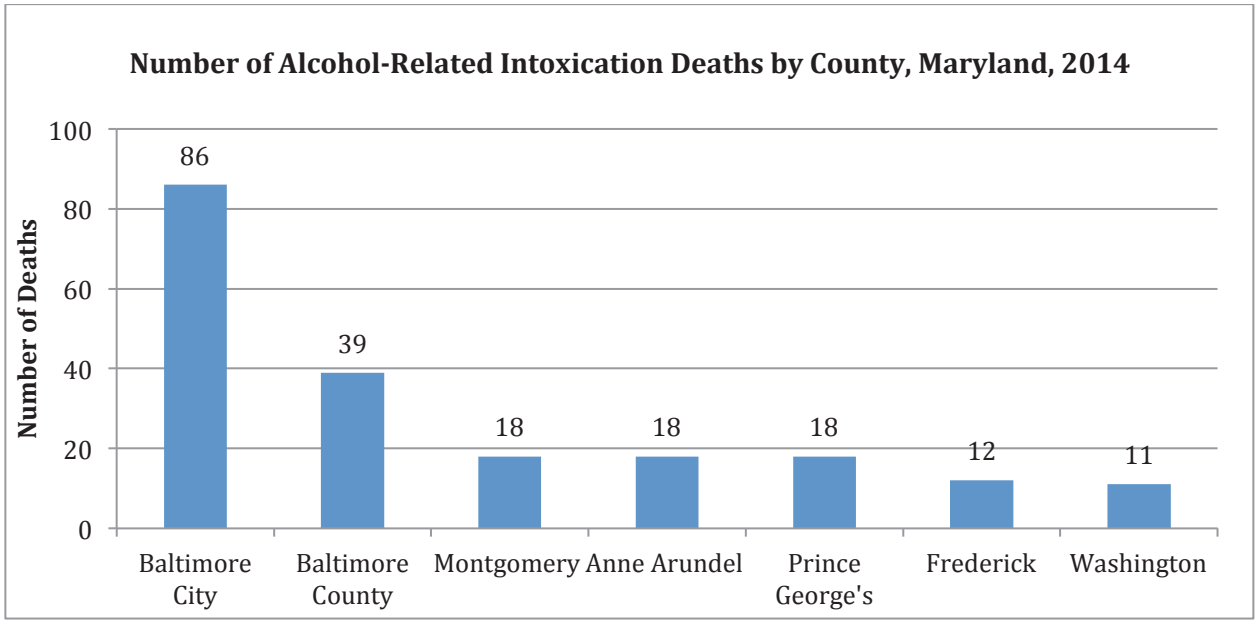
with, or substituted for, heroin or other illicit substances. Fentanyl is much more potent than heroin and greatly increases the risk of an overdose death (Behavioral Health Administration, Maryland DHMH).



Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county.

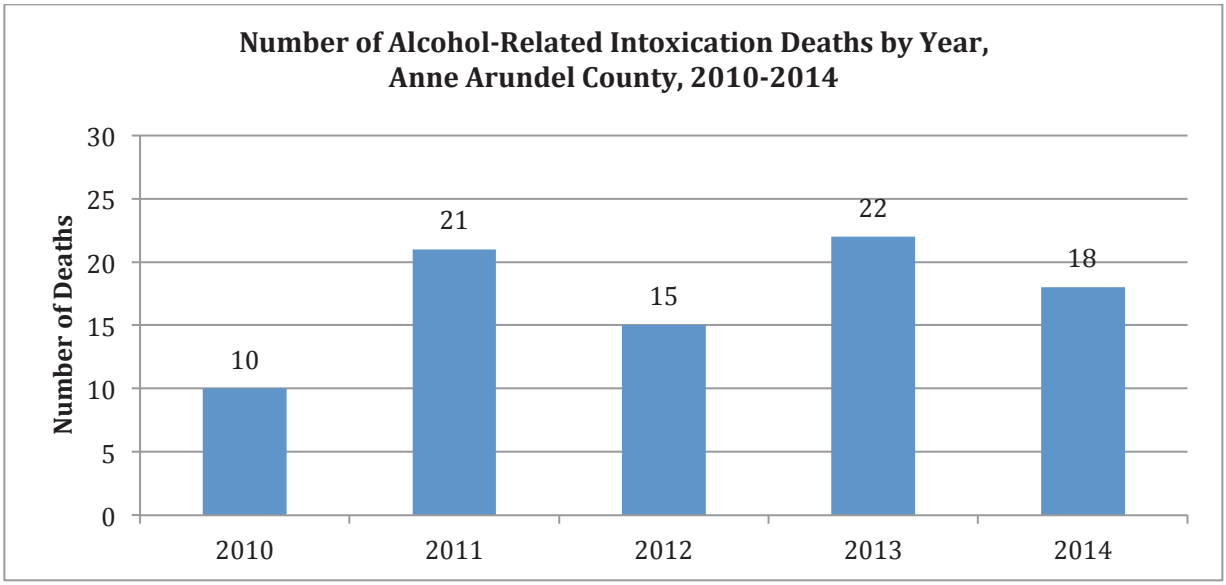
Alcohol-Related Intoxication Deaths

In 2014, Anne Arundel County had the third highest number of alcohol-related deaths in Maryland after Baltimore City and Baltimore County and tied with Montgomery County and Prince George's County.



Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county.

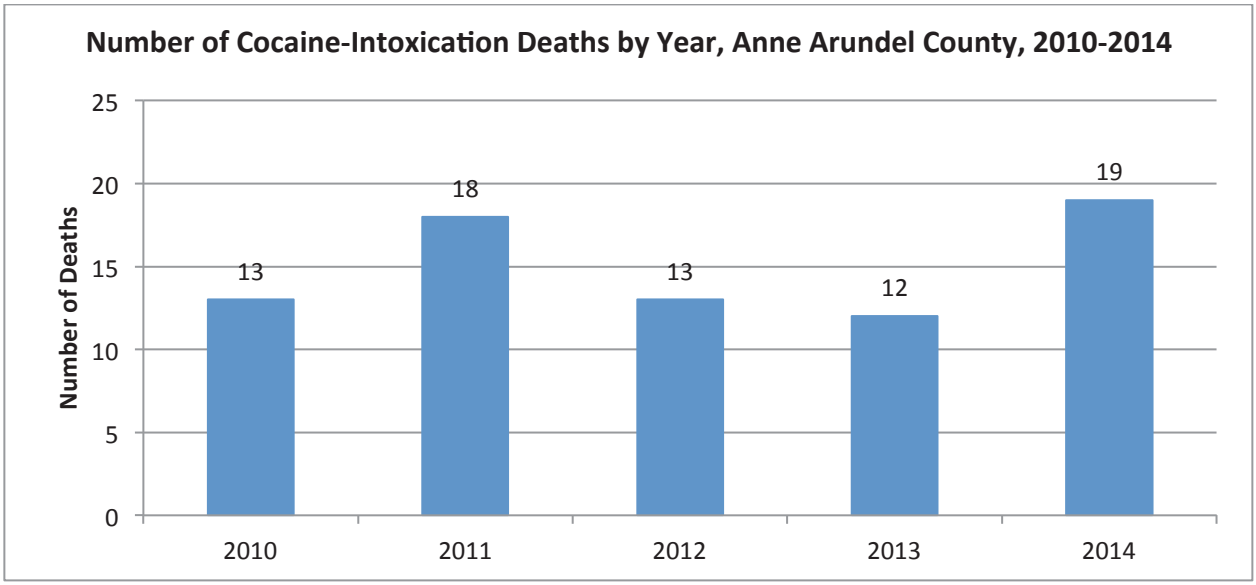
There is no consistent trend in the number of alcohol-related intoxication deaths between 2010 and 2014 in Anne Arundel County, with a low of ten deaths in 2010 and a high of 22 deaths in 2013.



Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county.

Cocaine-Related Intoxication Deaths

The 19 cocaine-related deaths in 2014 was the highest number in the past five years and a 58% increase from 2013 to 2014.



Source: Behavioral Health Administration, Maryland DHMH
Data is for deaths that occurred in Anne Arundel County irrespective of person's residence county.

Hospital Utilization

Emergency Department Visits

Emergency Departments (ED) provide a significant source of medical care in Anne Arundel County. Utilization of the ED for non-urgent health problems reflects the greater needs of the surrounding community. Access to high-quality, community-based health care can prevent a portion of unnecessary ED visits and utilization. Non-urgent use of ED leads to crowding, long wait times, high costs, as well as poor management of chronic conditions.

In 2013, 83% of UM-Baltimore Washington Medical Center's emergency department visits and inpatient admissions were comprised of the county's residents. In 2013, 75% of Anne Arundel Medical Center's ED visits and 64% of inpatient admissions were comprised of the county's residents." In 2013, Anne Arundel County residents made approximately 186,124 ED visits to hospitals within Maryland. There were 335 visits to the ED for every 1,000 individuals in the county. The ED visit rate for non-Hispanic blacks was the highest among the racial and ethnic groups examined followed by non-Hispanic whites, Hispanics and non-Hispanic Asians. The rate of ED visits for non-Hispanic blacks was 121% higher compared to that of non-Hispanic whites and 65% higher than the county's average ED visits rate.

Females had a higher overall rate of ED visits than males (372 visits per 1,000 population vs. 297 visits per 1,000). Adults aged 19-39 years had the highest ED visit rate (416 visits per 1,000) followed by children 18 years and younger (312 visits per 1,000). People over 65 years of age had the lowest ED visit rate by age group. (Note: This data only includes Anne Arundel County residents visiting EDs of hospitals in Maryland.)

Table 34: Emergency Department Visits by Race and Ethnicity, Anne Arundel County, 2013

Race/Ethnicity	Number of ED Visits	Rate per 1,000
White, NH	98,617	250.3
Black, NH	48,507	554.0
Hispanic, Any Race	8,552	223.0
Asian, NH	1,454	71.7
Total	186,124	334.9

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Table 35: Emergency Department Visits by Gender, Anne Arundel County, 2013

Gender	Number of ED Visits	Rate per 1,000
Male	81,648	296.8
Female	104,471	372.2

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Table 36: Emergency Department Visits by Age Group, Anne Arundel County, 2013

Age Group	Number of ED Visits	Rate per 1,000
0 to 18 yrs.	39,455	312.0
19 to 39 yrs.	68,342	415.9
40 to 64 yrs.	58,087	301.9
65 years and over	20,240	279.0

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

In 2013, 5.7% of ED visits were made for sprains and strains, the most frequent reason for ED visits in Anne Arundel County. The other most frequent ED visit principal diagnoses are listed in Table 37.

Table 37: Emergency Department Visits by Principal Diagnosis, Anne Arundel County, 2013

	Principal Diagnosis	Frequency	Percent
1	Sprains and strains	10,636	5.7%
2	Superficial injury; contusion	8,697	4.7%
3	Abdominal pain	8,626	4.6%
4	Nonspecific chest pain	8,604	4.6%
5	Spondylosis; intervertebral disc disorders; other back problems	7,361	4.0%
6	Upper respiratory infections	7,220	3.9%
7	Injuries and conditions due to external causes	5,433	2.9%
8	Headache; including migraine	4,967	2.7%
9	Urinary tract infections	4,339	2.3%
10	Skin and subcutaneous tissue infections	4,335	2.3%

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Emergency Department Visits for Acute and Chronic Conditions, Anne Arundel County, 2013

In 2013, 85.6% of all ED visits by Anne Arundel County residents were due to acute conditions and 14.3% were due to chronic conditions. Mood disorder was the most common chronic condition (12.2%) for ED visits followed by asthma (11.6 %), alcohol-related disorders (7.2 %), anxiety disorders (6.0 %), headaches/migraines (5.9%), and substance-related disorders (3.9%).

Table 38: Emergency Department Visits for Chronic Conditions, Anne Arundel County, 2013

	Chronic Conditions	Frequency	Percent
1	Mood disorder	3,256	12.2%
2	Asthma	3,101	11.6%
3	Alcohol-related disorder	1,922	7.2%
4	Anxiety disorder	1,607	6.0%
5	Headache/migraine	1,576	5.9%
6	Substance-related disorder	1,042	3.9%
7	Hypertension	1,027	3.9%
8	Other nerve disorder	946	3.6%
9	Dysrhythmia	742	2.8%
10	Other upper respiratory condition	703	2.6%
	Total ED Visits for Chronic Conditions	26,637	

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

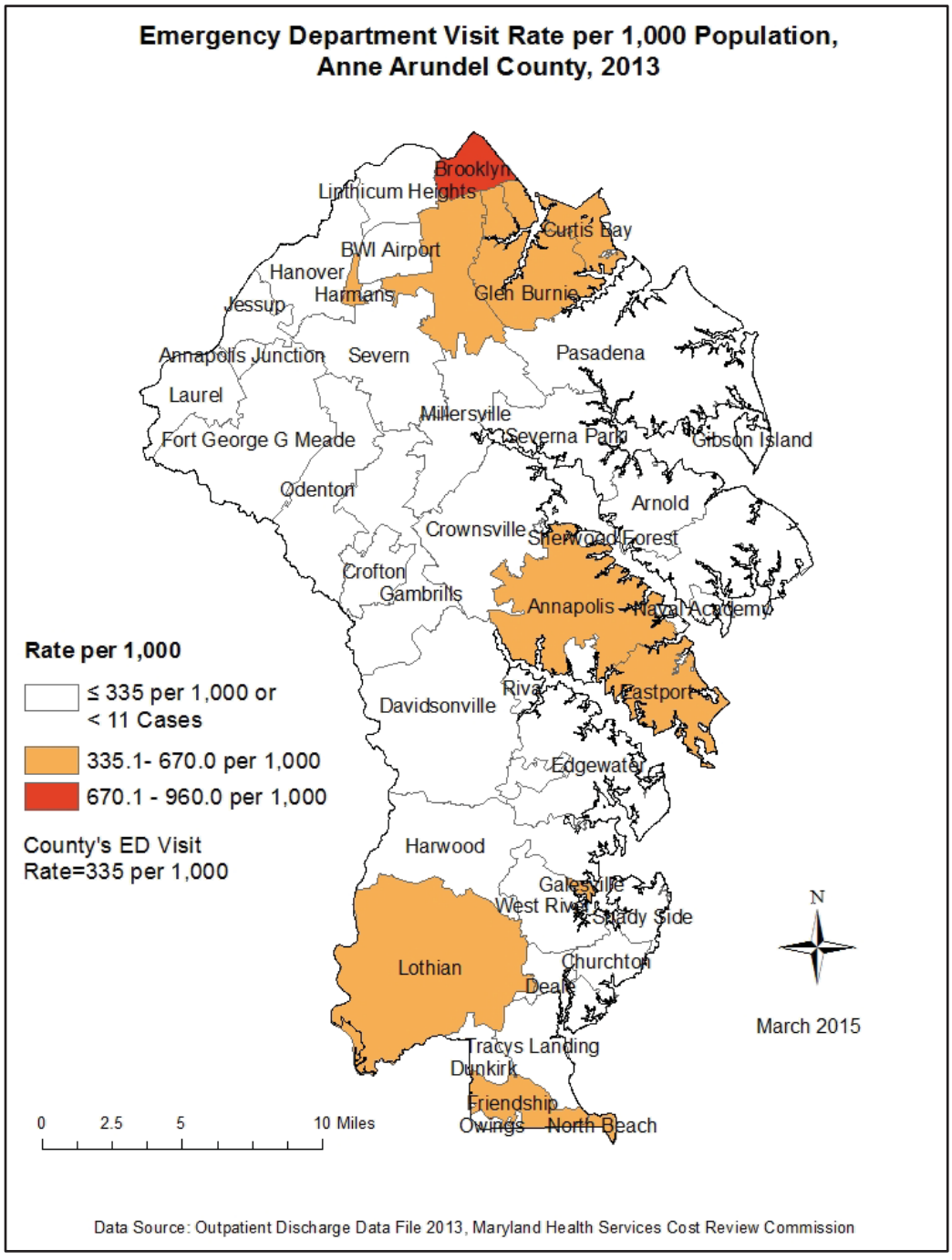
Table 39: Emergency Department Visits for Acute Conditions, Anne Arundel County, 2013

	Acute Condition	Frequency	Percent
1	Sprain	10,636	6.7%
2	Superficial injuries	8,698	5.5%
3	Abdominal pain	8,625	5.4%
4	Chest pain	8,604	5.4%
5	Back problem	7,071	4.4%
6	Other upper respiratory infection	6,517	4.1%
7	Other injuries	5,433	3.4%
8	Skin infection	4,335	2.7%
9	Urinary tract infection	4,334	2.7%
10	Teeth condition	4,239	2.7%
	Total ED Visits for Chronic Conditions	159,311	

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Crude ED Visit Rates per 1,000 Population by ZIP Code, Anne Arundel County, 2013

Eastport, North Beach, Annapolis (21401), Lothian, Galesville, Glen Burnie (21060 and 21061), Friendship, Harmans, Curtis Bay and Brooklyn have higher ED visit rates than the average county ED visit rate. Brooklyn has the highest ED visit rate (960 visits per 1,000), 186% higher than that of the average county ED visit rate (335 visits per 1,000).



Emergency Department Visits for Selected Health Conditions as Primary Discharge Diagnosis

Diabetes mellitus, hypertension, asthma and heart disease are conditions where hospitalization may have been avoided if the patient was receiving sufficient, high-quality and preventive outpatient care. These estimates represent populations where outpatient care can be improved and also target conditions for which care is needed. (Note: This data only includes Anne Arundel County residents visiting EDs of hospitals in Maryland.)

DIABETES

In 2013, the ED visit rate of non-Hispanic blacks for diabetes was 121% higher than the average county rate. The ED visit rates among males and females for diabetes were almost equal. The ED visit rate for diabetes increased exponentially with age.

Table 40: Emergency Department Visits by Race and Ethnicity, Anne Arundel County, 2013

Race/Ethnicity	Number of ED Visits	Rate per 100,000
White, NH	556	141.1
Black, NH	406	463.7
Hispanic, Any Race	46	120.0
Asian	18	88.8
Total	1166	209.6

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Table 41: Emergency Department Visits by Gender, Anne Arundel County, 2013

Gender	Number of ED Visits	Rate per 100,000
Male	570	207.2
Female	596	212.4

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

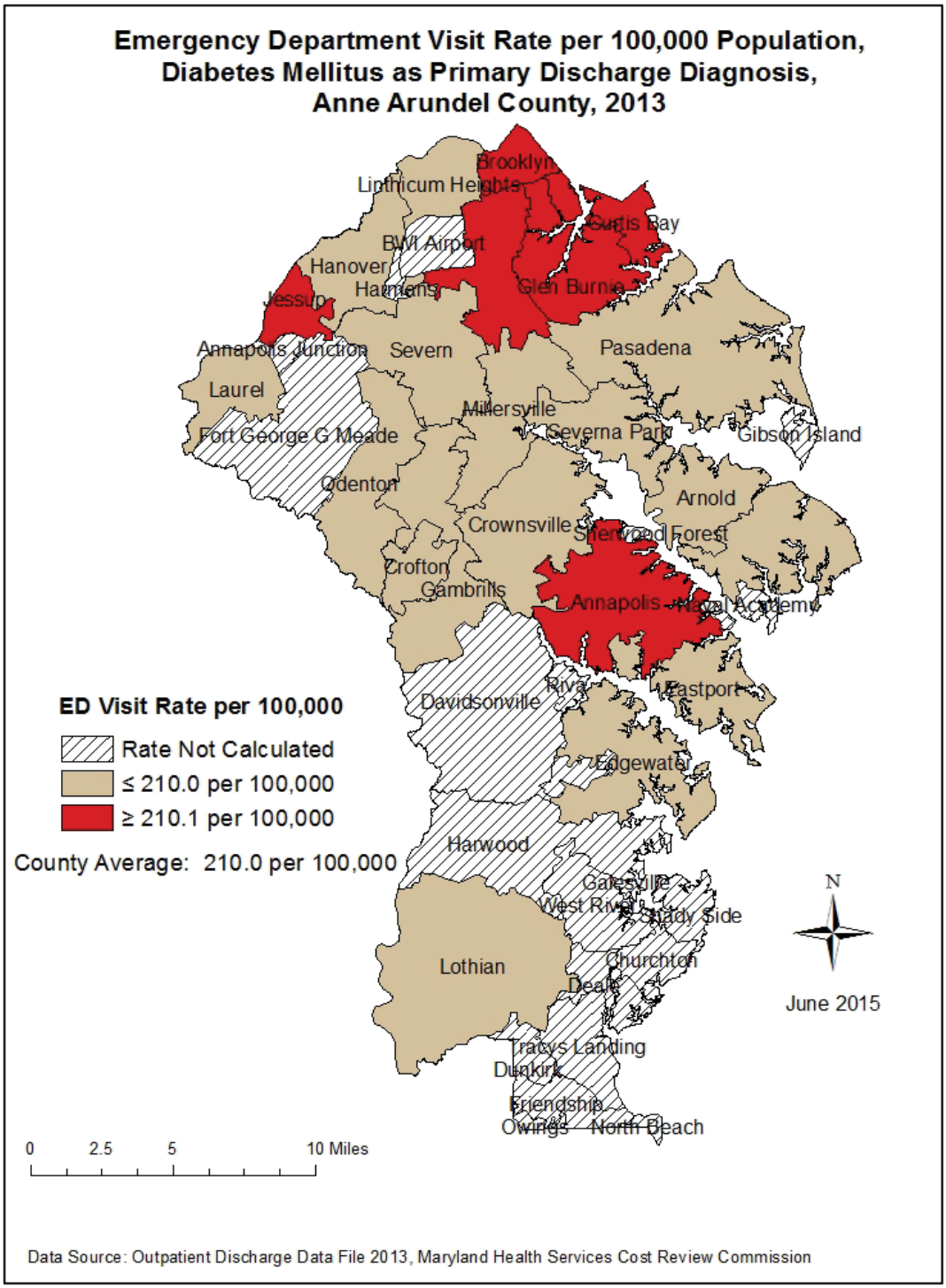
Table 42: Emergency Department Visits by Age Group, Anne Arundel County, 2013

Age Group	Number of ED Visits	Rate per 100,000
0 to 18 yrs.	59	46.7
19 to 39 yrs.	261	158.8
40 to 64 yrs.	583	303.0
65 yrs. and over	263	362.5

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Crude ED Visit Rate per 100,000 Population for Diabetes, Anne Arundel County, 2013

Brooklyn, Curtis Bay, Jessup, Glen Burnie (21060 and 21061) and Annapolis (21401) have higher ED visit rates for diabetes than the county average of 210 visits per 100,000 population. ED visit rates for diabetes were six times higher in Brooklyn and five times higher in Curtis Bay than the county average.



HYPERTENSION

Similar to diabetes, in 2013, non-Hispanic blacks had a higher ED visit rate for hypertension compared to other racial and ethnic groups examined and also higher than the county average. Non-Hispanic blacks were 2.3 times more likely to visit the ED for hypertension than the county average, while females visited the ED for hypertension 37% more than males. Also similar to diabetes, the ED visit rate for hypertension increased exponentially by age.

Table 43: Emergency Department Visits by Race and Ethnicity, Anne Arundel County, 2013

Race/Ethnicity	Number of ED Visits	Rate per 100,000
White, NH	551	139.8
Black, NH	450	514.0
Hispanic, Any Race	42	109.5
Asian, NH	-	-
Total	1233	221.6

Source: Outpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Table 44: Emergency Department Visits by Gender, Anne Arundel County, 2013

Gender	Number of ED Visits	Rate per 100,000
Male	513	186.5
Female	720	256.5

Source: Outpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

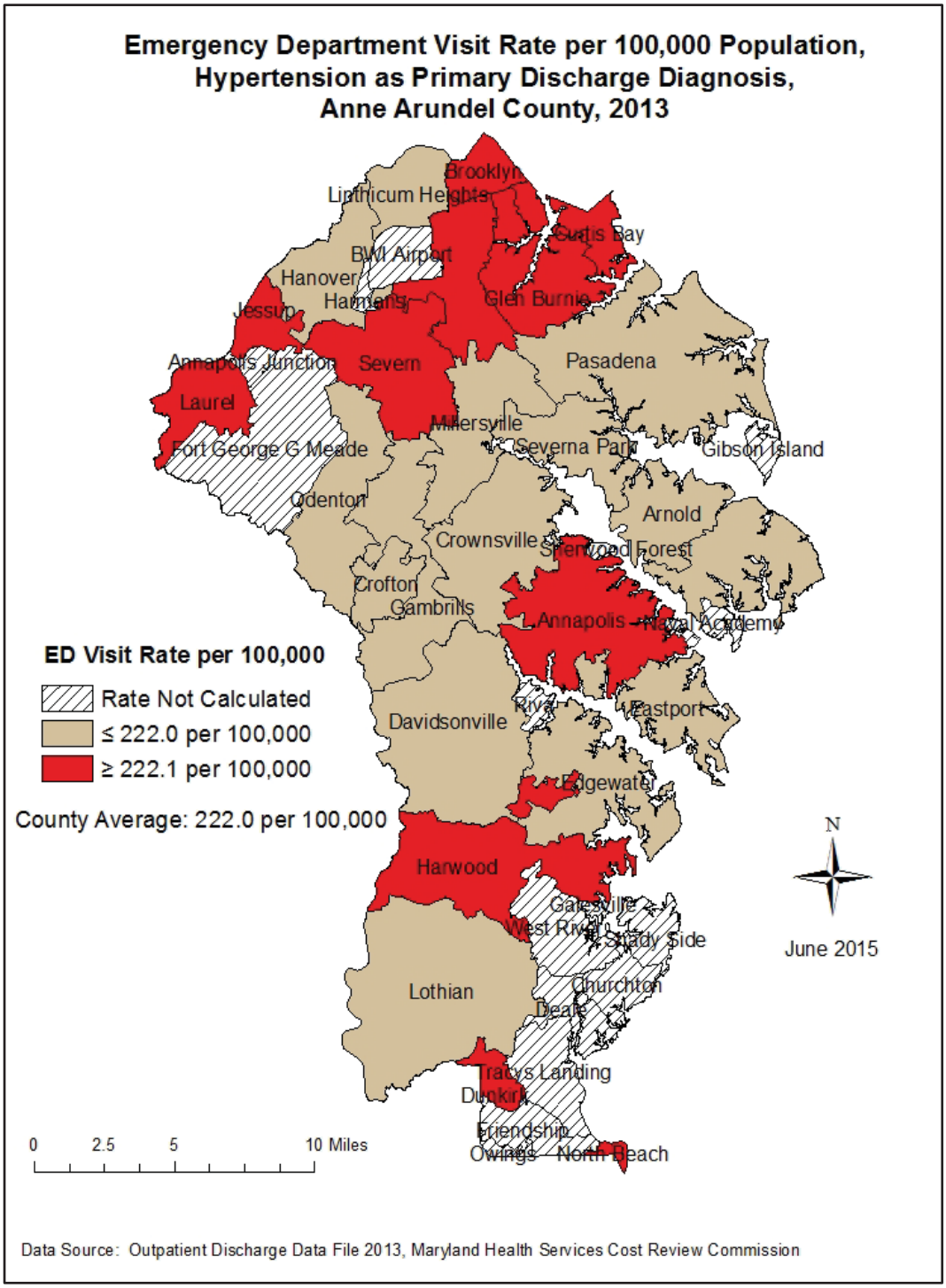
Table 45: Emergency Department Visits by Age Group, Anne Arundel County, 2013

Age Group	Number of ED Visits	Rate per 100,000
0 to 18 yrs.	-	-
19 to 39 yrs.	182	110.8
40 to 64 yrs.	668	347.2
65 yrs. and over	375	516.9

Source: Outpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Crude ED Visit Rate per 100,000 Population for Hypertension, Anne Arundel County, 2013

Residents in Dunkirk, North Beach, Brooklyn, Curtis Bay, Jessup, Annapolis (21401), Harwood, Glen Burnie (21060 and 21061), Laurel and Severn visited the ED for hypertension more than the county average of 222 visits per 100,000.



ASTHMA

Emergency Department visits for asthma revealed the biggest disparities between populations in the county. By a wide margin, non-Hispanic blacks visited the ED for asthma more than all other racial and ethnic groups examined. Non-Hispanic blacks visited the ED over six times more than non-Hispanic whites for asthma in 2013. Young people (18 and under) have disproportionately higher ED visits rate for asthma.

Table 46: Emergency Department Visits by Race and Ethnicity, Anne Arundel County, 2013

Race/Ethnicity	Number of ED Visits	Rate per 100,000
White, NH	1,051	266.7
Black, NH	1,488	1699.5
Hispanic, Any Race	165	430.3
Asian, NH	18	88.8
Total	3,356	603.2

Source: Outpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Table 47: Emergency Department Visits by Gender, Anne Arundel County, 2013

Gender	Number of ED Visits	Rate per 100,000
Male	1,726	627.4
Female	1,630	580.8

Source: Outpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

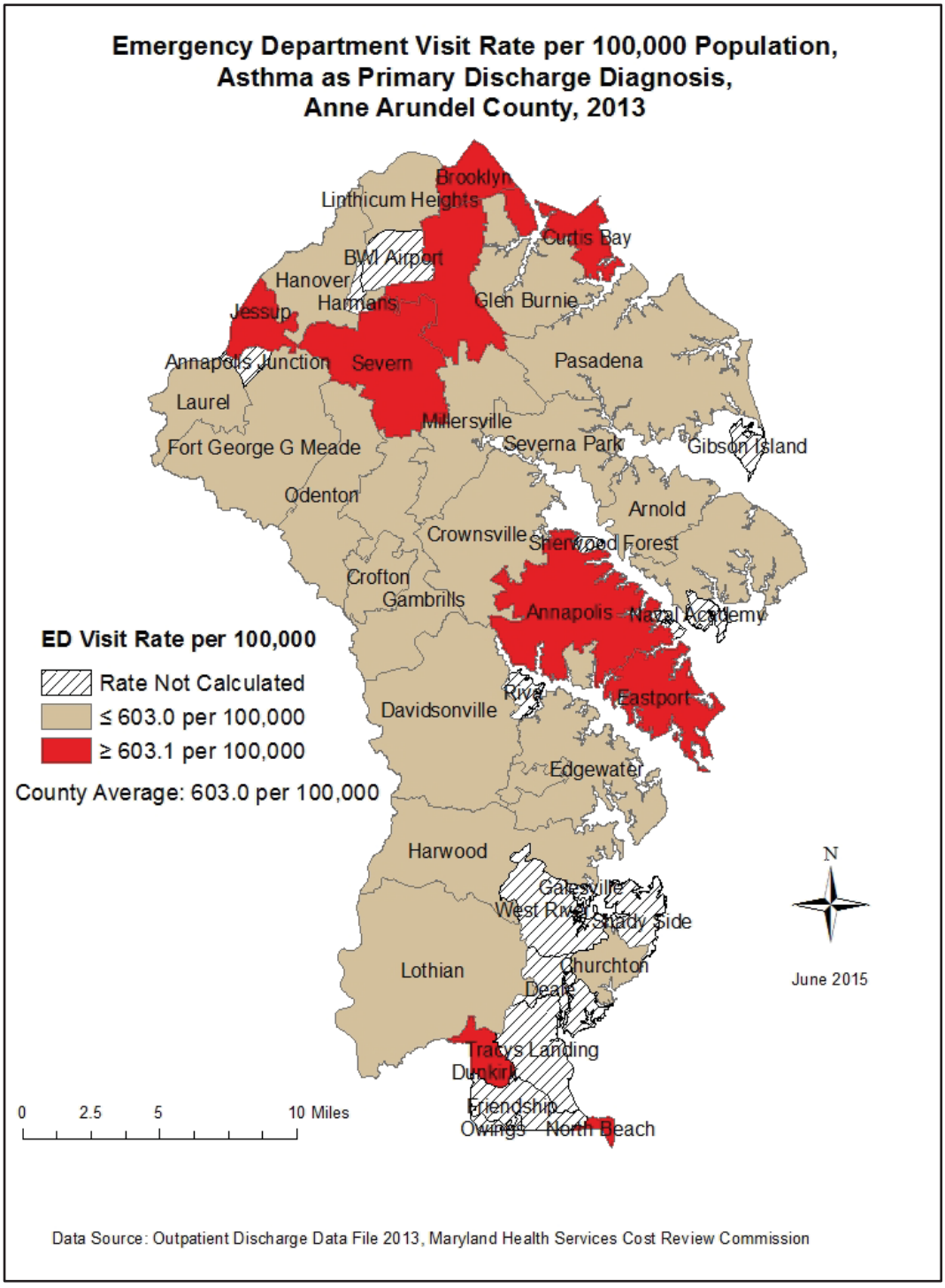
Table 48: Emergency Department Visits by Age Group, Anne Arundel County, 2013

Age Group	Number of ED Visits	Rate per 100,000
0 to 18 yrs.	1,449	1,145.8
19 to 39 yrs.	919	559.3
40 to 64 yrs.	880	457.3
65 yrs. and over	108	148.9

Source: Outpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Crude ED Visit Rate per 100,000 Population for Asthma, Anne Arundel County, 2013

Brooklyn, North Beach, Curtis Bay, Dunkirk, Glen Burnie (21060), Jessup, Severn, Annapolis (21401) and Eastport residents visited the ED for asthma more than the county average of 603 visits per 100,000. ED visits for asthma were six times higher in Brooklyn and five times higher in Curtis Bay than the county average.



Heart Disease

Visits to the ED for heart disease related conditions averaged 307 per 100,000 in 2013. Only non-Hispanic blacks had higher ED visits for heart disease (346 per 100,000). Men visited the ED for heart disease more than women (334 per 100,000 vs. 279 per 100,000). As seen previously with hypertension and diabetes, ED visits for heart disease increased with age.

Table 49: Emergency Department Visits by Race and Ethnicity, Anne Arundel County, 2013

Race/Ethnicity	Number of ED Visits	Rate per 100,000
White, NH	1,125	285.5
Black, NH	303	346.1
Hispanic, Any Race	25	65.2
Asian, NH	13	64.1
Total	1,704	306.6

Source: Outpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Table 50: Emergency Department Visits by Gender, Anne Arundel County, 2013

Gender	Number of ED Visits	Rate per 100,000
Male	920	334.4
Female	784	279.4

Source: Outpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

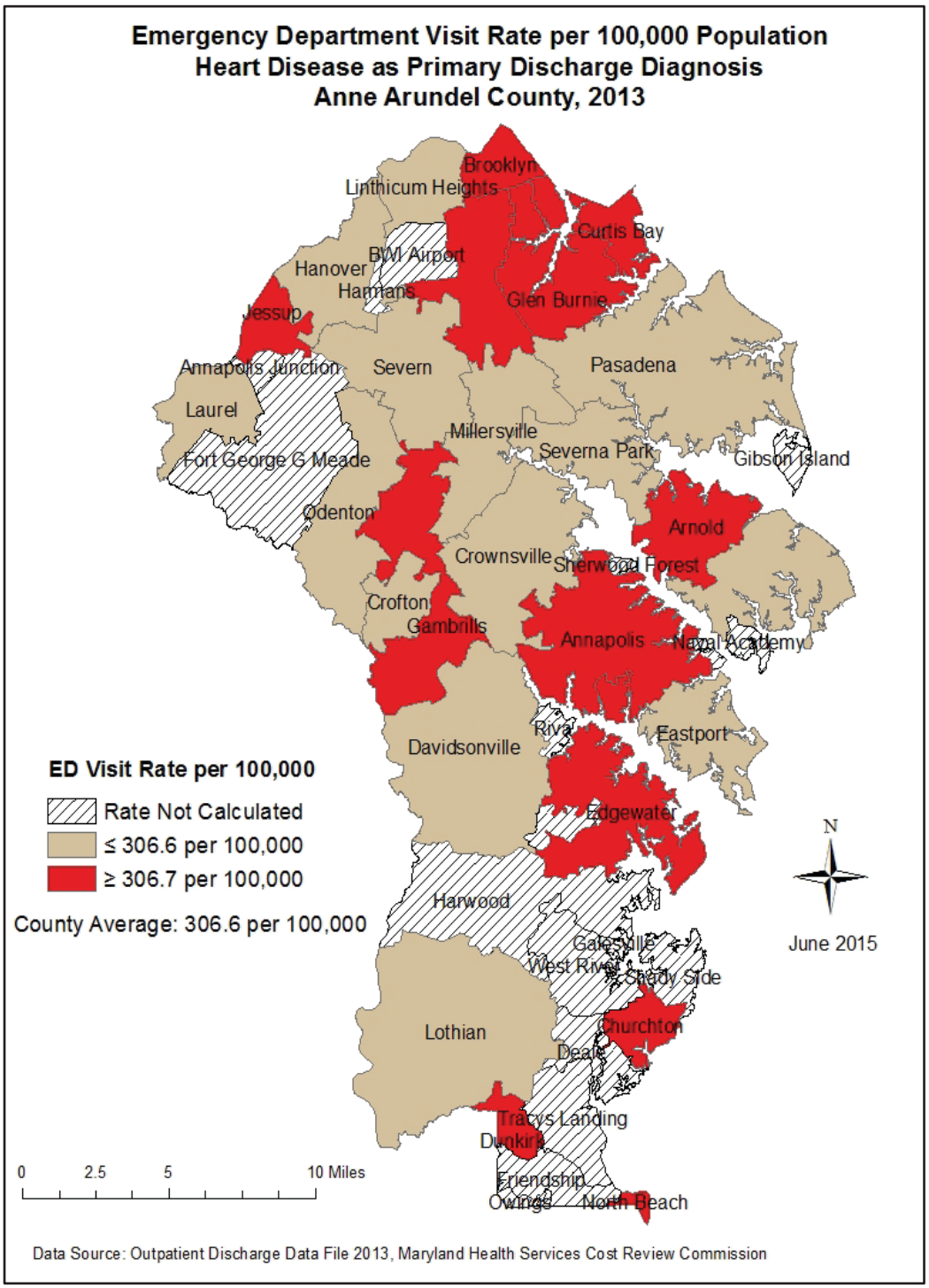
Table 51: Emergency Department Visits by Age Group, Anne Arundel County, 2013

Age Group	Number of ED Visits	Rate per 100,000
0 to 18 yrs.	55	43.5
19 to 39 yrs.	199	121.1
40 to 64 yrs.	722	375.2
65 yrs. and over	728	1003.4

Source: Outpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Crude ED Visit Rate per 100,000 Population for Heart Disease, Anne Arundel County, 2013

Dunkirk, North Beach, Brooklyn, Curtis Bay, Jessup, Lothian, Annapolis (ZIP code 21401), Churchton, Gambrills, Glen Burnie (21060 and 21061), Edgewater and Arnold have higher ED visits rate for heart disease than the county average of 307 per 100,000.



Behavioral Health

Behavioral health focuses on the overall state of mental and emotional being and encompasses both substance-related disorders as well as mental illness. Substance abuse/misuse is a prevalent behavioral health challenge in Anne Arundel County. Other behavioral health challenges include suicide and mental illness.

In 2013, 9,544 out of 186,124 (5.1%) of all ED-related visits by Anne Arundel County residents were for behavioral health related conditions. Mood disorders were the leading cause of behavioral health related ED visits (34.1%), followed by alcohol-related disorders (20.2%), anxiety disorders (16.8%) and substance-related disorders (14.1%).

Table 52: Emergency Department Visits for Behavioral Health Conditions, Anne Arundel County, 2013

Behavioral Health Condition	Frequency	Percent
Mood disorders	3,256	34.1%
Alcohol-related disorders	1,927	20.2%
Anxiety disorders	1,608	16.8%
Substance-related disorders	1,342	14.1%
Schizophrenia and other psychotic disorders	568	6.0%
Adjustment disorders	239	2.5%
Suicide and intentional self-inflicted injuries	185	1.9%
Attention-deficit, conduct and disruptive behavior disorders	176	1.8%
Miscellaneous mental disorders	159	1.7%
Disorders usually diagnosed in infancy, childhood or adolescence	44	0.5%
Personality disorders	31	0.3%
Total	9,544	

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

The ED visits rate for behavioral health conditions among non-Hispanic blacks was the highest among racial/ethnic groups, followed by non-Hispanic whites, Hispanics and non-Hispanic Asians. The rate of ED visits for non-Hispanic blacks was 16% higher compared to that of non-Hispanic whites.

Table 53: Emergency Department Visits for Behavioral Health Conditions by Race and Ethnicity, Anne Arundel County, 2013

	Frequency	Rate per 1,000
White, NH	6,386	16.2
Black, NH	1,644	18.8
Hispanic, Any Race	289	7.5
Asian	78	3.8

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Males had a higher overall rate of ED visits for behavioral health conditions than females (19.3 versus 15.1 per 1,000 populations).

Table 54: Emergency Department Visits for Behavioral Health Conditions by Sex, Anne Arundel County, 2013

	Frequency	Rate per 1,000
Male	5,321	19.3
Female	4,223	15.1
Total	9,544	17.2

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Adults aged 19-39 years have the highest ED visit rate for behavioral health conditions (26 per 1,000) followed by adults 40-64 years (17.7 per 1,000). People over 65 years of age had the lowest ED visit rate by age group.

Table 55: Emergency Department Visits for Behavioral Health Conditions by Age Group, Anne Arundel County, 2013

Age Group	Frequency	Rate per 1,000
0 to 18 yrs.	1,471	11.6
Under 5 yrs.	*13*	-
5-18 yrs.	*1,458*	*15.9*
19 to 39 yrs.	4,260	26.0
19 to 24 yrs.	*1,318*	*26.0*
25 to 39 yrs.	*2,942*	*26.0*
40 to 64 yrs.	3,422	17.7
65 yrs. and over	391	5.4

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Leading behavioral health conditions related to ED visits varied by age group. In 2013, mood disorders were leading causes of ED visits among age groups 5-39 years. Alcohol-related disorders were the leading cause of ED visits among age group 40-64 years. Anxiety disorders were the leading cause of ED visits among age group 65 years and over. Mood disorders, anxiety disorders and alcohol-related disorders were among the top five leading causes of ED visits among all ages, while substance-related disorders, schizophrenia and other psychotic disorders were among the top five leading causes of ED visits among all age groups 18 years and over.

Table 56: Emergency Department Visits for Behavioral Health Conditions by Age 5 -18 Years, Anne Arundel County, 2013

	Behavioral Health Condition	Frequency	Percent
1	Mood disorders	774	53.1%
2	Anxiety disorders	164	11.3%
3	Attention-deficit, conduct, and disruptive behavior disorders	130	8.9%
4	Alcohol-related disorders	91	6.2%
5	Adjustment disorders	89	6.1%

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Table 57: Emergency Department Visits for Behavioral Health Conditions by Age 19 -24 Years, Anne Arundel County, 2013

	Behavioral Health Condition	Frequency	Percent
1	Mood disorders	441	33.5%
2	Substance-related disorders	2,881	21.9%
3	Anxiety disorders	224	17.0%
4	Alcohol-related disorders	170	12.9%
5	Schizophrenia and other psychotic disorders	69	5.3%

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Table 58: Emergency Department Visits for Behavioral Health Conditions by Age 25-39 Years, Anne Arundel County, 2013

	Behavioral Health Condition	Frequency	Percent
1	Mood disorders	927	31.5%
2	Anxiety disorders	614	20.9%
3	Substance-related disorders	584	19.8%
4	Alcohol-related disorders	452	15.4%
5	Schizophrenia and other psychotic disorders	163	5.6%

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Table 59: Emergency Department Visits for Behavioral Health Conditions by Age 40-64 Years, Anne Arundel County, 2013

	Behavioral Health Condition	Frequency	Percent
1	Alcohol-related disorders	1,142	33.4%
2	Mood disorders	1,019	29.8%
3	Anxiety disorders	503	14.7%
4	Substance-related disorders	369	10.8%
5	Schizophrenia and other psychotic disorders	236	6.9%

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

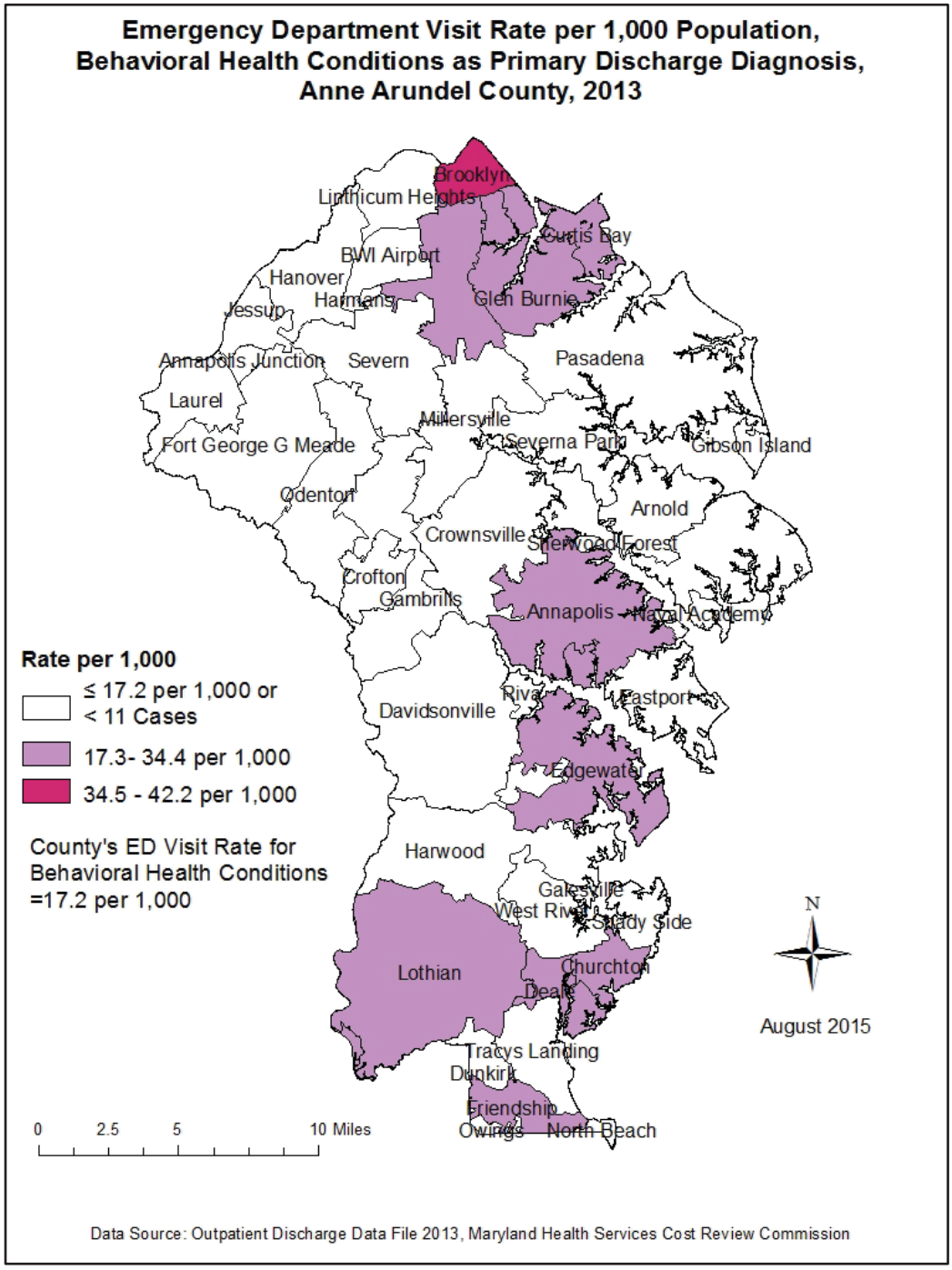
Table 60: Emergency Department Visits for Behavioral Health Conditions by Age 65 Years and Over, Anne Arundel County, 2013

	Behavioral Health Condition	Frequency	Percent
1	Anxiety disorders	103	26.2%
2	Mood disorders	94	24.1%
3	Schizophrenia and other psychotic disorders	81	20.8%
4	Alcohol-related disorders	70	18.0%
5	Substance-related disorders	17	4.5%

Source: Outpatient Discharge Data File 2013, Maryland Health Services Cost Review Commission

Crude ED Visits Rate per 100,000 Population for Behavioral Health Conditions, Anne Arundel County, 2013

Lothian, Edgewater, Annapolis (21401), Churchton, Deale, Glen Burnie (21060 and 21061), Curtis Bay, Friendship and Brooklyn have higher ED visits rates for behavioral health conditions than the county average of 17.2 per 1,000 population. Brooklyn has the highest ED visit rate (42.2 per 1,000) for behavioral health conditions, 145% higher than that of the average county rate.



Hospital Admissions

In 2013, there were an estimated 59,533 hospital stays in Anne Arundel County, representing a hospitalization rate of 107.1 stays per 1,000, lower than the hospitalization rate in Maryland of 112.6 per 1,000. The hospitalization rate for non-Hispanic blacks was the highest among the racial/ethnic groups examined. The rate of hospitalization for non-Hispanic blacks was 15% higher than that of non-Hispanic whites. (Note: This data only includes Anne Arundel County residents admitted to hospitals in Maryland.)

Table 61: Hospitalization by Race and Ethnicity, Anne Arundel County, 2013

Race/Ethnicity	Number of Hospitalizations	Rate per 1,000
White, NH	37,947	96.3
Black, NH	9,733	111.2
Hispanic, Any Race	3,006	78.4
Asian	766	37.8
Total	59,533	107.1

Source: Inpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Females had a 33% higher rate of hospitalization than males. Maternal hospitalization for females admitted for pregnancy and delivery were included in this analysis.

Table 62: Hospitalization by Gender, Anne Arundel County, 2013

Sex	Number of Hospitalizations	Rate per 1,000
Male	25,299	92.0
Female	34,231	122.0

Source: Inpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

The hospitalization rate was highest in the population aged 65 years and over. The hospitalization rate increased with age from 74.1 hospitalizations per 1,000 population among 0–18 year olds to 267.9 hospitalizations per 1,000 population among those aged 65 years and over.

Table 63: Hospitalization by Age Group, Anne Arundel County, 2013

Age Group	Number of Hospitalizations	Rate per 1,000
0 to 18 yrs.	9,371	74.1
19 to 39 yrs.	12,584	76.6
40 to 64 yrs.	18,143	94.3
Greater than 64 yrs.	19,435	267.9

Source: Inpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

In 2013, 10 leading principal diagnoses accounted for 75% of all hospitalizations among Anne Arundel County residents. Even though live births typically account for the greatest number of inpatient hospitalizations, it is the preventable conditions that are of greater importance in the analyses.

Some of the leading causes of hospitalization were shared by some groups but not by others. Congestive heart failure was the second leading cause of hospitalization for non-Hispanic blacks and sixth leading cause of hospitalization for non-Hispanic whites. Mood disorder was the fourth leading cause of hospitalization for both non-Hispanic whites and blacks, but it was not among the

10 leading causes of hospitalization for the Asian and Hispanic populations. Asthma and diabetes were the eighth and ninth leading causes of hospitalization among non-Hispanic blacks, but not among the 10 leading causes of hospitalization for any other racial or ethnic group (table not shown).

Table 64: Hospitalization by Principal Diagnosis, Anne Arundel County, 2013

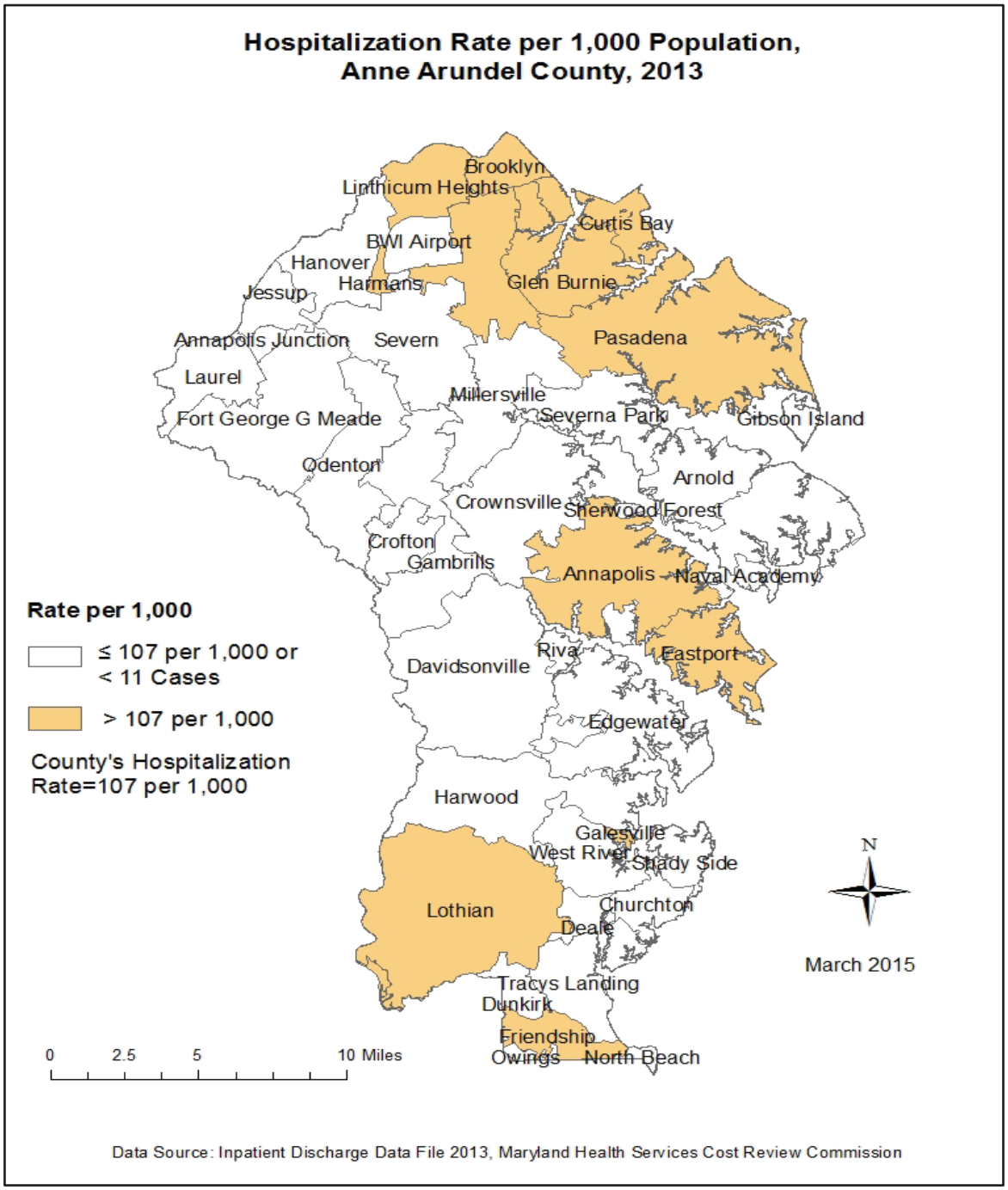
	Principal Diagnosis	Number of Hospitalization	Percent
1	Live born	6,437	10.8%
2	Septicemia (except in labor)	1,923	3.2%
3	Mood disorders	1,842	3.1%
4	Osteoarthritis	1,790	3.0%
5	Pneumonia (except cases that were caused by tuberculosis or sexually transmitted disease)	1,464	2.5%
6	Congestive heart failure; nonhypertensive	1,399	2.4%
7	OB-related trauma to perineum and vulva	1,337	2.3%
8	Complication of device; implant or graft	1,281	2.2%
9	Spondylosis; intervertebral disc disorders; other back problems	1,235	2.1%
10	Skin and subcutaneous tissue infections	1,216	2.0%

Source: Inpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Crude Hospitalization Rates per 1,000 Population by ZIP Code, Anne Arundel County, 2013

Patterns of hospitalization by ZIP code resemble that of the Emergency Department visits. Eastport, Galesville, Pasadena, Lothian, Annapolis (21401), Linthicum Heights, Glen Burnie (21060 and 21061), Curtis Bay, Harmans, Friendship and Brooklyn have higher hospitalization rates than the county average or 107 per 1,000 population. Brooklyn has the highest hospitalization rate among all ZIP codes (185.2 per 1,000), 80% higher than that of the county average.

Health Behaviors

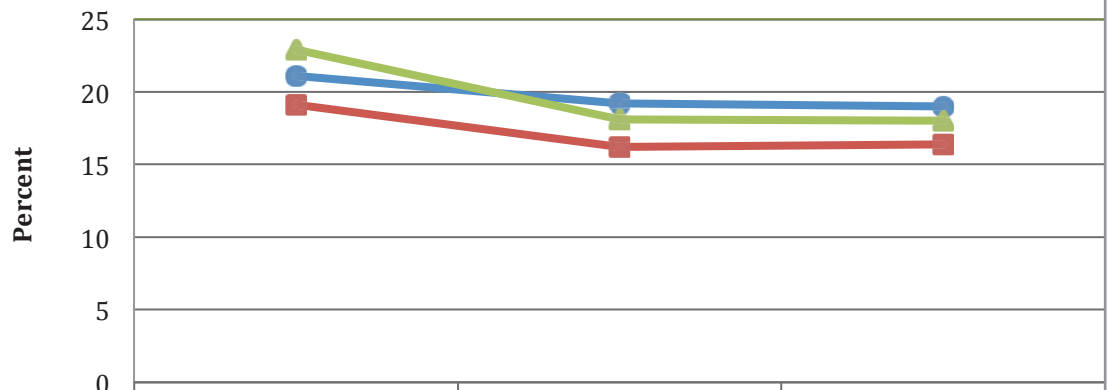


Tobacco Use

Cigarette smoking is the leading cause of preventable disease and death. Smoking is associated with an increased risk of heart disease, stroke, lung and other types of cancers, and chronic lung diseases (CDC).

In Anne Arundel County, 4.6 % of high school students smoke cigarettes regularly, higher than the state rate of 3.6%. (Youth Risk Behavior Survey Results, 2013). Among adults in the county, approximately 77,300 (18%) smoke cigarettes, higher than the 16.4 % who smoke statewide in Maryland. In the U.S., 19% of adults are current smokers.

Percent of Adults 18 Years and Older Who Are Current Smokers
Anne Arundel, Maryland and U.S., 2011-2013



	2011	2012	2013
U.S.	21.1	19.2	19
Maryland	19.1	16.2	16.4
Anne Arundel	22.9	18.1	18

Source: Behavioral Risk Factor Surveillance Systems, Centers for Disease Control and Prevention, 2011-2013

Overweight and Obesity

Overweight and obesity are major public health problems affecting adults and children in Anne Arundel County. Obesity is associated with heart disease, stroke, type 2 diabetes and certain types of cancer.

For adults, the Body Mass Index (BMI) is interpreted using standard weight status categories. These categories are the same for men and women of all body types and ages.

Table 65: Body Mass Index (BMI) Table

Body Mass Index (BMI)	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Normal or Healthy Weight
25.0 – 29.9	Overweight
30.0 and Above	Obese

Source: Centers for Disease Control and Prevention

In Anne Arundel County, approximately, 270,500 (63%) of the population over 18 years is overweight or obese. The overweight and obesity rates in Anne Arundel County are similar to overweight and obesity rates in Maryland and the U.S.

Percent of Overweight or Obese Adults, 18 Years and Older, Anne Arundel County, Maryland and U.S., 2011-2013

	2011	2012	2013
U.S.	63.5	63.9	64.3
Maryland	64.4	63.8	64.2
Anne Arundel	63.1	63.7	63.1

Source: Behavioral Risk Factor Surveillance Systems, Centers for Disease Control and Prevention, 2011-2013

Obesity results from a combination of causes including individual behaviors and genetics. Consuming a healthy diet and regular physical activity are important to maintain normal weight. In 2013, only 24.2% of Anne Arundel County adults reported meeting recommended guidelines of vigorous aerobics and muscle strengthening physical activity per week.

Approximately, 69,000 (12%) of residents live in neighborhoods categorized as food deserts. A food desert is an area where residents have low or no access to healthy foods. Limited access to healthy food often leads to poor diets and high levels of obesity and other diet-related diseases.

Table 66: Prevalence of chronic health conditions among adults (18 years and over) related to obesity and smoking, Anne Arundel County, 2013

Health Condition	Prevalence %	Estimated Population
Elevated cholesterol level	37.1%	159,344
High blood pressure	33.0%	141,735
Diabetes	9.2%	39,514
Suffered heart attack	4.7%	20,186
Suffered stroke	2.7%	11,596
Angina or coronary disease	4.1%	17,609

Source: Maryland Behavioral Risk Factor Surveillance Systems, 2013; U.S. Census Bureau

Overweight and Obesity in Children and Adolescents, Anne Arundel County

Obesity among the pediatric population is concerning because it is predictive of obesity in adulthood. Monitoring trends in obesity prevalence and identifying high risk groups will allow Anne Arundel County and the Healthy Anne Arundel Coalition to target resources and measure outcomes. The Anne Arundel County Department of Health conducted pediatric weight surveillance in 2002, 2006 and 2012.

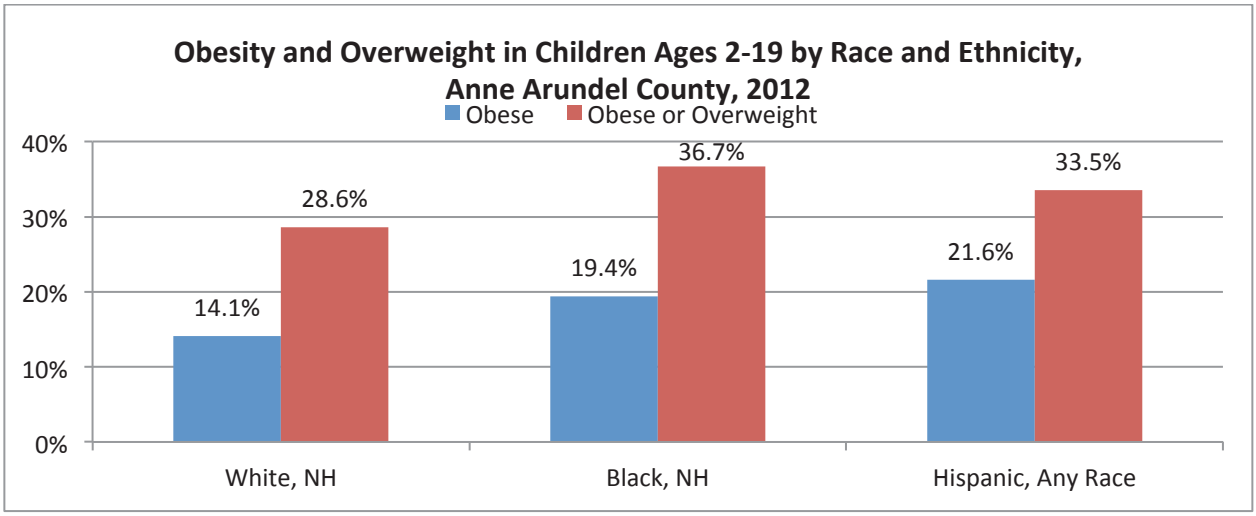
Obesity in children is defined as a Body Mass Index (BMI) greater than the 95th percentile for age and sex. Overweight is defined as a BMI between the 85th and 95th percentiles.

The prevalence of obesity among county children and adolescents is similar to that nationwide, but it did increase between 2006 and 2012.

Table 67: Obesity and Overweight in Children Ages 2-19, Anne Arundel County and U.S.

	Anne Arundel County		U.S.
Weight Status	**2006**	**2012**	**2009-2010**
Obese	15.6%	17.3%	16.9%
Overweight or obese	32.6%	32.4%	31.8%
Obesity by Age Group			
2-5 yrs.	16.5%	17.0%	12.1%
6-11 yrs.	16.1%	20.6%	18.0%
12-19 yrs.	14.0%	15.5%	18.4%
Obesity by Sex			
Male	17.6%	19.4%	18.6%
Female	13.5%	15.2%	15.0%

Source: Anne Arundel County Department of Health, Provider-based County Survey of Children and Adolescents, 2012; U.S. data from Ogden CL, Carroll MD, Kit BK, Flegal KM. "Prevalence of Obesity and Trends in Body Mass Index among US Children and Adolescents, 1999-2010." JAMA. 2012; 307(5).



Source: Anne Arundel County Department of Health, Provider-based County Survey of Children and Adolescents, 2012

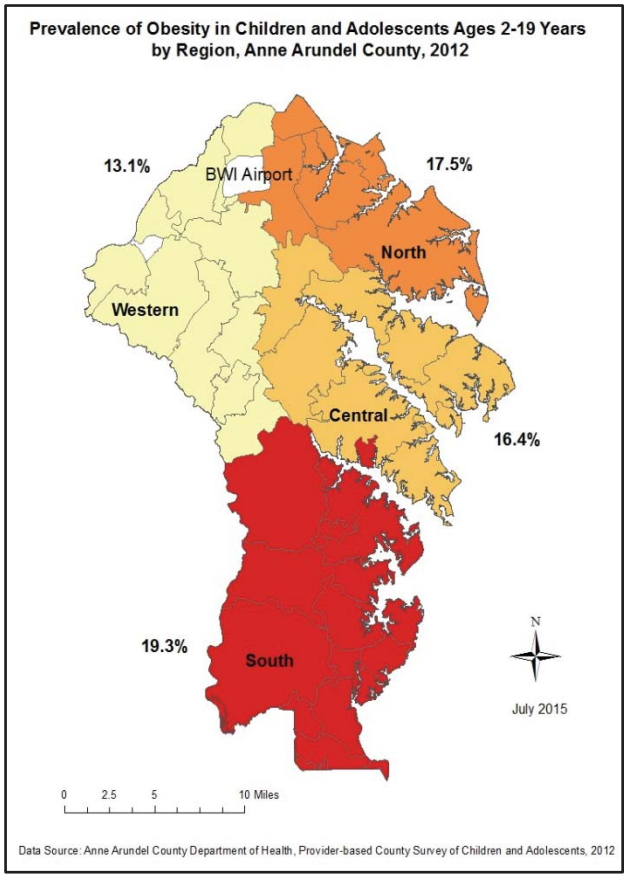
Obesity and Overweight in Children and Adolescents by Region, Anne Arundel County, 2012

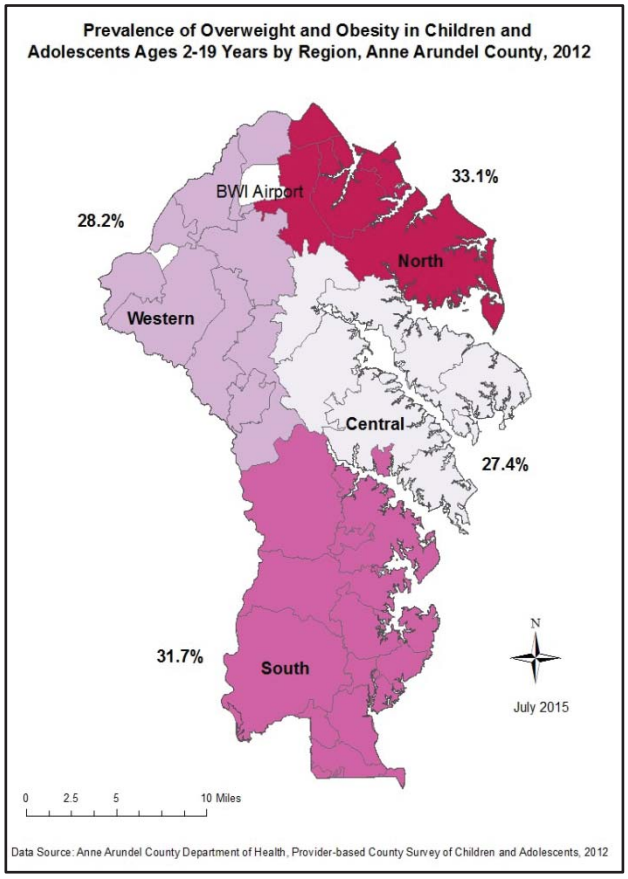
The northern region of the county has the highest percent of children who are obese or overweight (33.1%), followed by the southern (31.7%), western (28.2%) and central (27.4%) regions. Prevalence of obesity among children is highest in the southern region (19.3%), followed by northern (17.5%), central (16.4%) and western (13.1%) regions.

Table 68: Obesity and Overweight in Children Ages 2-19 by Region, Anne Arundel County, 2012

County Region	Obese	Obese or Overweight
North	17.5%	33.1%
West	13.1%	28.2%
Central	16.4%	27.4%
South	19.3%	31.7%

Source: Anne Arundel County Department of Health, Provider-based County Survey of Children and Adolescents, 2012

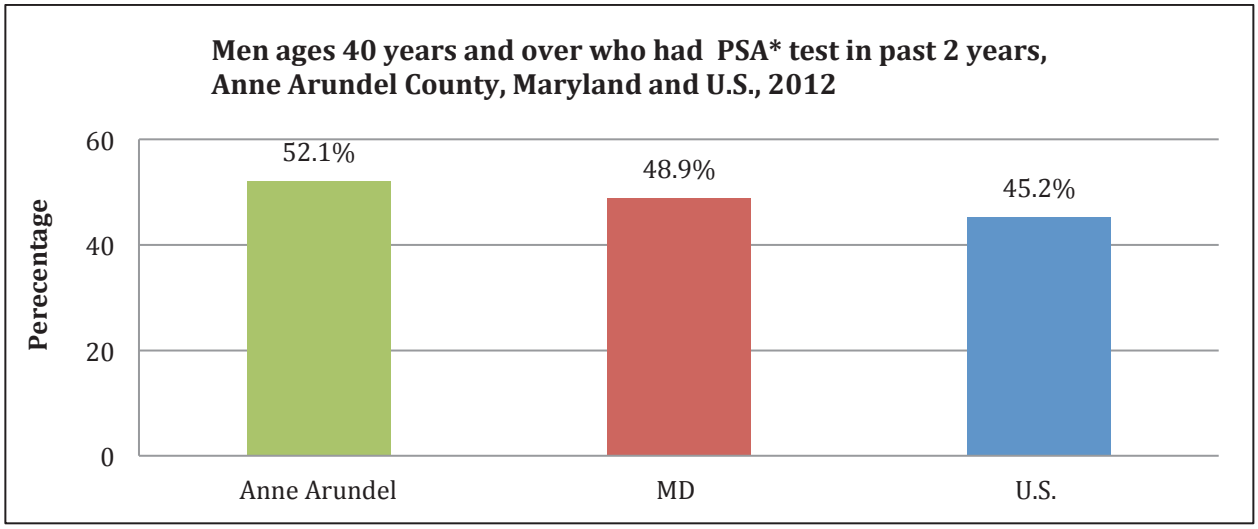




Cancer Screening

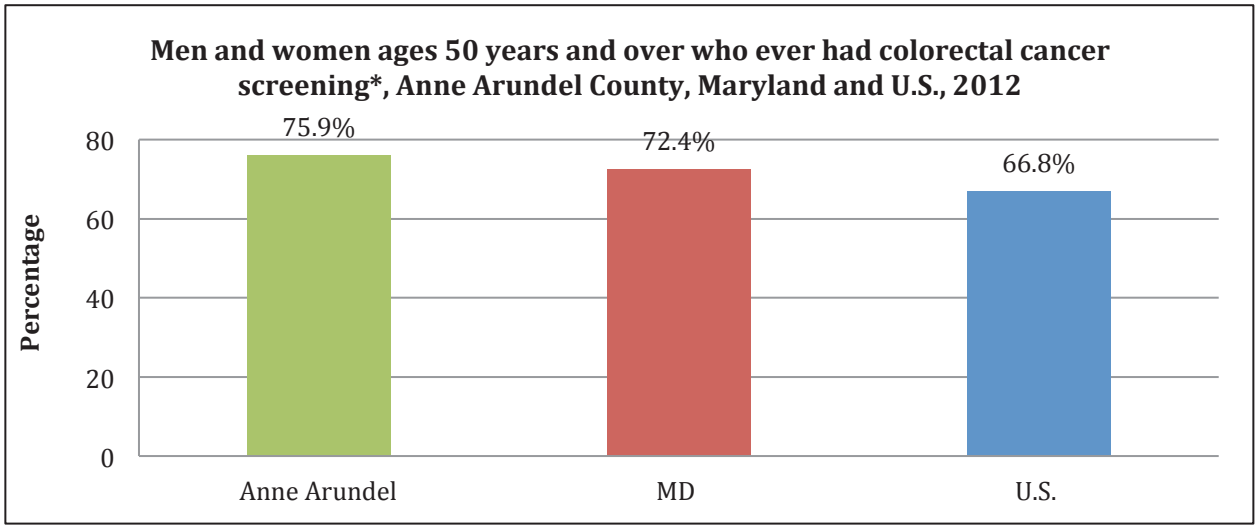
Cancer is the leading cause of death among Anne Arundel County residents. In 2013, out of the 4,042 deaths that occurred among Anne Arundel County residents, 1006 deaths (25%) were due to cancer. Early detection greatly increases the opportunity for successful cancer treatment.

In 2012, 52.1% of Anne Arundel County men aged 40 years and above had a prostate cancer screening with a prostate-specific antigen (PSA) test within the past two years. This is slightly higher than Maryland and the U.S. There were still 60,030 men (47.9%) unscreened.



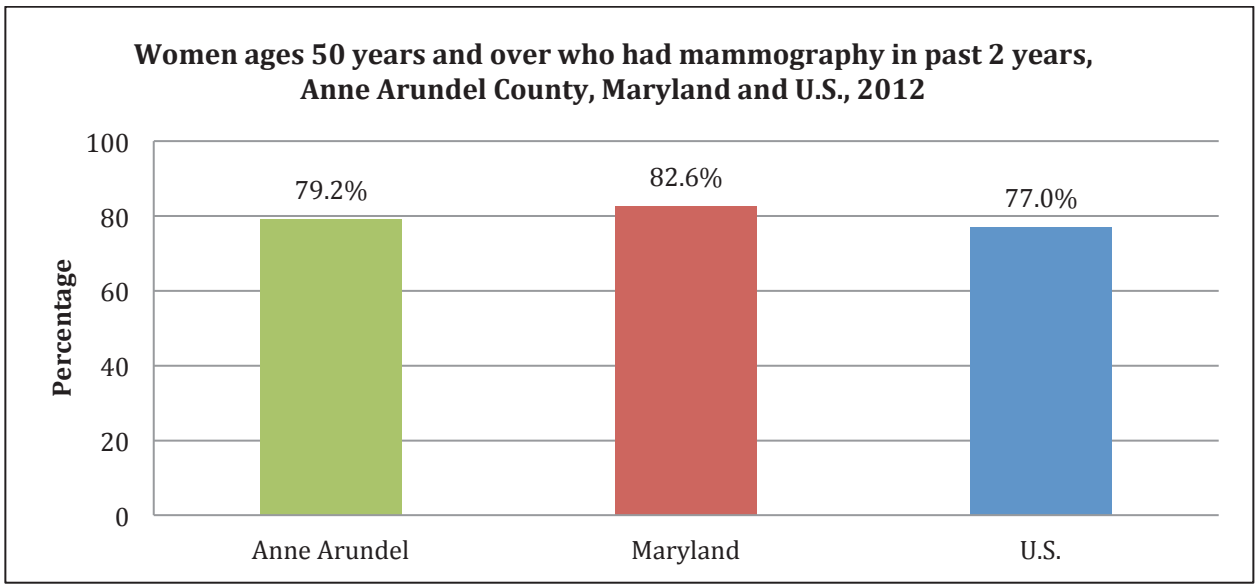
* Prostate-specific antigen
Source: The Behavioral Risk Factor Surveillance System (BRFSS)

In 2012, 75.9% of Anne Arundel County men and women aged 50 years and above had a colorectal cancer screening with sigmoidoscopy or colonoscopy, higher than Maryland and the U.S. An estimated 43,904 (24.1%) of county residents over 50 years remained unscreened.



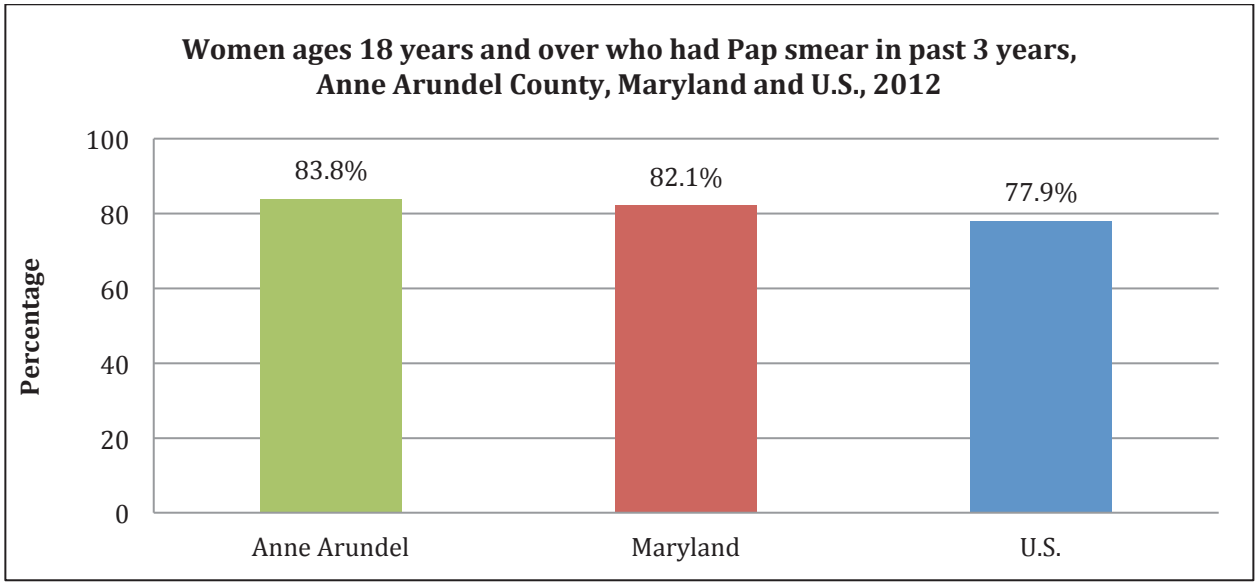
* Colorectal Cancer Screening with Sigmoidoscopy or Colonoscopy only
Source: The Behavioral Risk Factor Surveillance System (BRFSS)

In 2012, 79.2% of Anne Arundel County women aged 50 years and above had breast cancer screening with mammography within the past two years, lower than Maryland (82.9%). An estimated 20,174 (20.8%) county women over 50 years remained unscreened.



Source: The Behavioral Risk Factor Surveillance System (BRFSS)

In 2012, 83.9% of Anne Arundel County women aged 18 years and above were screened for cervical cancer with a Pap smear test within the past three years, higher than Maryland and the U.S. An estimated 35,123 (16.2%) women over 18 years remained unscreened.



Source: The Behavioral Risk Factor Surveillance System (BRFSS)

Table 69: Population not Screened for Selected Cancer, Anne Arundel County, 2012

Cancer Screening	Target Group	Total Population	Percentage not Screened	Estimated Population not Screened
Prostate Specific Antigen (PSA) in past 2 years	Men 40 years and above	125,323	47.9%	60,030
Colorectal Cancer Screening with Sigmoidoscopy or Colonoscopy	Men and women 50 years and above	182,173	24.1%	43,904
Mammography in Past 2 Years	Women 50 years and above	96,993	20.8%	20,174
Pap Smear in Past 3 Years	Women 18 years and above	216,810	16.2%	35,123

Source: The Behavioral Risk Factor Surveillance System (BRFSS); Population data from U.S. Census Bureau, Population Estimates Program, 2012

Health Care Access

Access to comprehensive, quality health care services is important to achieve health equity and increase the quality of life for county residents. Access to health services encompasses four components: insurance coverage, services, timeliness and workforce. (U.S. Department of Health and Human Services (HHS), Office of Disease Prevention and Health Promotion, Healthy People 2020)

Barriers to Access to Health Care

Lack of health insurance

Health insurance coverage is an important determinant of access to health care. Without health insurance coverage, many people find health care unaffordable and do not seek health care when they need it. In 2013, an estimated 22.2% of Hispanics, 9% of Asians, 7.7% of non-Hispanic blacks and 4.7% of non-Hispanic whites did not have health insurance. Overall, 6.6% of Anne Arundel County residents did not have health insurance coverage in 2013. The number of uninsured most likely decreased in 2014 as a result of The Patient Protection and Affordable Care Act (ACA). Under the ACA, all residents legally living in the U.S. have the option to purchase health insurance through the Maryland Health Connection (the state's insurance marketplace/exchange). To date, information is not available for how many uninsured residents gained coverage through the ACA. A small percentage of county residents, such as undocumented people, those not enrolled in Medicaid despite being eligible and people opting to pay the annual penalty instead of purchasing insurance, will still remain uninsured.

Lack of financial resources

Lack of financial resources is a barrier to health care. In Anne Arundel County, 33,352 residents (6.3%) live below the poverty level, among which 4.4 % are non-Hispanic whites, 12.7% are non-Hispanic blacks, 9.4% are Hispanics and 11% are Asian.

Irregular source of care

Having a primary care provider reduces nonfinancial barriers to obtaining care, facilitates access to services and increases the frequency of contacts with health care providers. Without a primary care provider, people have more difficulty obtaining prescriptions and attending necessary appointments.

Language barriers

Poor English language skills make it difficult for residents to understand basic health information. Language barriers can lead to decreased quality of care, safety and patient satisfaction. Language barriers can also contribute to health disparities among people with insurance. Almost 11% of residents who are age 5 and over speak a language other than English as their primary language.

Structural barriers

Examples of structural barriers include lack of transportation, inability to obtain convenient appointment times and lengthy waiting room times. These factors reduce the likelihood of an individual successfully making and keeping a health care appointment.

Anne Arundel County lacks a reliable public transportation system. There are multiple bus routes in the county, but they are concentrated in the northern region and in the Annapolis parts of the central region. Approximately 8,860 (2%) residents over 16 years of age lack personal transportation. Most hospitals and health centers are located in the northern and central regions of the county.

Inadequate public transportation is not only a barrier to health care — it is also a barrier to employment opportunities, social services, access to healthy food and other factors which impact health.

Legal obstacles

Undocumented people have legal obstacles to obtaining health care. Both the ACA and Medicaid do not cover undocumented people. For certain limited emergency care issues, undocumented people can receive Medicaid benefits. Data are not available for the number of undocumented people residing in Anne Arundel County.

Adults who are permanent residents (green card) are eligible to apply for subsidized marketplace/exchange insurance under the ACA, but are prohibited from applying for Medicaid for a five-year waiting period with limited exceptions for certain refugee groups. Medicaid services are available for lawfully present pregnant women and children prior to the five-year waiting period.

Potentially Preventable Hospitalizations

Preventable hospitalizations occur when people are hospitalized for a medical condition that could have been avoided had they received sufficient primary and preventive care earlier. By identifying the burden of preventable hospitalizations among different patient subpopulations, communities most in need can be identified.

The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for ambulatory care sensitive conditions. These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. Even though these indicators are based on hospital inpatient data, they provide insight into the community health care system or services outside the hospital setting.

Table 70: Number of Potentially Preventable Hospitalization (Excluding Low Birth Weight), Anne Arundel County, 2013

	Prevention Quality Indicators (PQIs)	**Number of Hospitalizations**
PQI #1	Diabetes Short-Term Complications Admission	274
PQI #3	Diabetes Long-Term Complications Admission	431
PQI #5	COPD or Asthma in Older Adults Admission	1,436
PQI #7	Hypertension Admission	113
PQI #8	Heart Failure Admission	1,433
PQI #13	Angina without Procedure Admission	50
PQI #14	Uncontrolled Diabetes Admission	26
PQI #15	Asthma in Younger Adults Admission	70
PQI #16	Lower-Extremity Amputation among Patients with Diabetes	66
	Prevention Quality Chronic Composite	***3,899***
PQI #10	Dehydration Admission	371
PQI #11	Bacterial Pneumonia Admission	1,048
PQI #12	Urinary Tract Infection Admission	706
	Prevention Quality Acute Composite	***2,125***
PQI #2	Perforated Appendix Admission	123
	Total: Potentially Preventable Hospitalizations	**6,147**

Source: Inpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

In 2013, 6,568 of 59,533 (11%) hospital admissions of Anne Arundel County residents were potentially preventable.

Females have a high burden of preventable hospitalizations (56%) compared to males (44%). Among the dual eligible, 68% of preventable hospitalization were among females.

Most of the preventable hospitalizations were among people aged 65 and above: 56% among all payers, 87% among Medicare, and 53% among dual eligible (except in the Medicaid population) in which 64% were age 45 to 64 years.

Overall, non-Hispanic blacks have disproportionately higher preventable hospitalizations. Approximately 20% of total preventable hospitalizations were among non-Hispanic blacks while the county's non-Hispanic black population is only around 16%. Fifty-nine percent of all preventable hospitalizations in Anne Arundel County residents were because of chronic conditions and 32% were because of acute conditions. (Note: This data only includes Anne Arundel County residents admitted to hospitals in Maryland.)

Table 71: Potentially Preventable Hospitalization by Race and Ethnicity (Excluding Low Birth Weight), Anne Arundel County, 2013

Race/Ethnicity	Potentially Preventable Hospitalizations	Rate per 1,000
Asian	307	18.3
Black NH	1,229	19.7
Hispanic Any Race	123	4.9
White NH	4,057	12.9
Total	6,147	14.3

Source: Inpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Table 72: Potentially Preventable Hospitalization by Gender (Excluding Low Birth Weight), Anne Arundel County, 2013

Gender	Potentially Preventable Hospitalizations	Rate
Male	2,705	12.8
Female	3,442	15.8

Source: Inpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

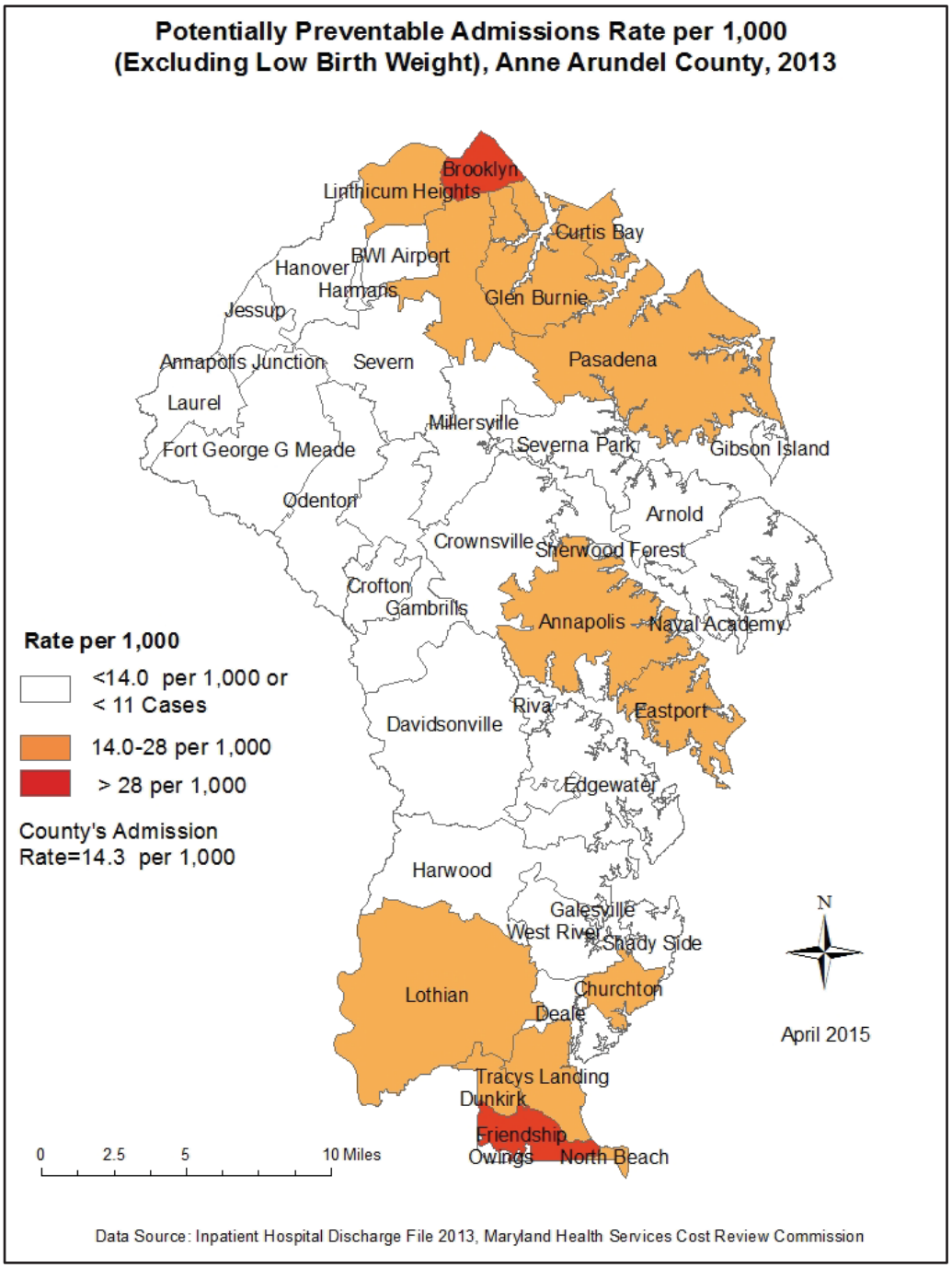
Table 73: Potentially Preventable Hospitalization by Age Group (Excluding Low Birth Weight), Anne Arundel County, 2013

Age Group	Potentially Preventable Hospitalizations	Rate per 1,000
18 to 44 yrs.	738	3.7
45 to 64 yrs.	1,967	12.7
Greater than 64 yrs.	3,442	47.4

Source: Inpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Potentially Preventable Hospitalization Crude Rate per 1,000 Population (Excluding Low Birth Weight) by ZIP Code, Anne Arundel County Residents, 2013

Friendship, Brooklyn, Glen Burnie (21060 and 21061), Curtis Bay, Lothian, Tracys Landing, North Beach, Annapolis (21401), Churchton, Pasadena and Linthicum Heights have higher potentially preventable hospitalization rates than the county average of 14.3 per 1,000 population. Friendship has a rate three times higher and Brooklyn has a rate two times higher than the county's average preventable hospitalization rate.



Health Professional Shortage Areas (HPSA)

Health Professional Shortage Areas (HPSAs) are designated by the Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers and may represent geographic areas; populations, e.g., low income or Medicaid eligible; or facilities, i.e., federally qualified health center or other state or federal prisons. There are three categories of HPSAs: primary care (shortage of primary care clinicians), dental (shortage of oral health professionals), and mental health (shortage of mental health professionals). HPSAs are designated using several criteria, including population-to-clinician ratios. This ratio is usually 3,500 to 1 for primary care, 5,000 to 1 for dental health care, and 30,000 to 1 for mental health care.

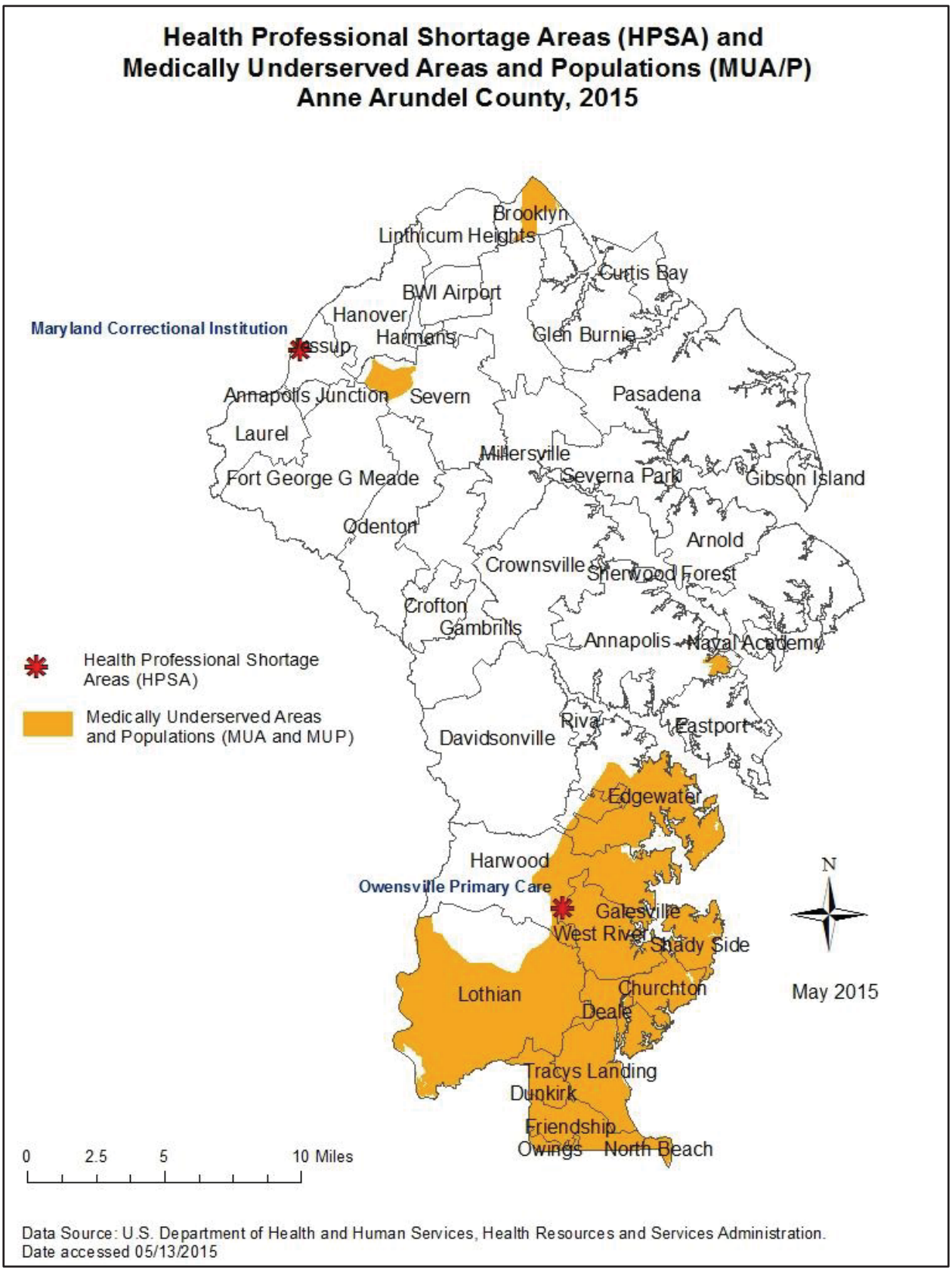
Physicians and nurses are not evenly distributed across Anne Arundel County. The county currently has one designated Primary Care HPSA (Owensville Primary Care), one Dental HPSA (Owensville Primary Care) and two Mental Health HPSAs (Owensville Primary Care and Maryland Correctional Institution, Jessup). The Maryland Correctional Institution in Jessup is a state-run institute.

Medically Underserved Areas and Population

Medically Underserved Areas (MUA) may be a whole county, group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts in which residents have a shortage of personal health services. An MUA is determined based on four variables: ratio of primary medical care physicians per 1,000 population; infant mortality rate; percentage of the population with incomes below the poverty level; and percentage of the population age 65 or over.

Medically Underserved Population (MUP) may include groups of people who face economic (low-income or Medicaid-eligible populations), cultural or linguistic barriers to primary medical care services.

There are 11 census tracts in Anne Arundel County which are designated as medically underserved areas or populations. Approximately, 54,700 (10%) of the county's population lives in these 11 census tracts, out of which 12% are age 65 and over and 23% are under 18 years of age. Seventy-four percent of the population who lives in these census tracts are non-Hispanic white, 15% are non-Hispanic black, 5% are Hispanic of any race and 2% are Asian.


Health Professional Shortage Areas (HPSA) and
Medically Underserved Areas and Populations (MUA/P)
Anne Arundel County, 2015
Brooklyn
Linthicum Heights
Curtis Bay
BWI Airport
Hanover
Maryland Correctional Institution
Harmans
Glen Burnie
Jessup
Annapolis Junction
Severn
Pasadena
Laurel
Millersville
Fort George G Meade
Severna Park
Gibson Island
Odenton
Arnold
Crownsville
Sherwood Forest
Crofton
Gambrills
Annapolis
Naval Academy
Health Professional Shortage Areas (HPSA)
Medically Underserved Areas and Populations (MUA and MUP)
Riva
Eastport
Davidsonville
Edgewater
Harwood
Owensville Primary Care
Galesville
West River
Shady Side
N
Lothian
Churchton
Deale
May 2015
Tracys Landing
Dunkirk
Friendship
Owings
North Beach
0
2.5
5
10 Miles
Data Source: U.S. Department of Health and Human Services, Health Resources and Services Administration.
Date accessed 05/13/2015

Health Care Providers in Anne Arundel County

According to the County Health Rankings, the patient to primary care physician ratio in Anne Arundel (1,430:1) is worse than in Maryland (1,131:1) and the U.S. (1,045:1 for top performing counties in the 90th percentile ranking). Similarly, the patient to dentist and mental health provider ratios in Anne Arundel are worse than in Maryland and the U.S. top performing counties. Compared to Maryland, Anne Arundel County has 21.6% less primary care physicians, 8.5 % less dentists, and 31% of the mental health providers per 100 population.

Table 74: Primary Care Physicians, Dentists and Mental Health Providers in Anne Arundel County and Maryland

	Anne Arundel County Total	Anne Arundel County Ratio	Maryland Ratio	Top U.S. Counties (90th percentile)
Primary Care Physicians (2012)	385	1,430:1	1,131:1	1,045:1
Dentists (2013)	366	1,518:1	1,392:1	1,377:1
Mental Health Providers (2014)	774	718:1	502:1	386:1

Source: U.S. County Health Rankings & Roadmaps, 2015

Projected Physician Deficits

In 2014, the Advisory Board Company conducted a Physician Needs Assessment for the University of Maryland Medical System and projected physician deficits for the year 2019. The study found that under the current scenario, there could be a 220.2 full-time equivalency physician deficit in 2019. Primary care, psychiatry and general surgery are projected to have the most physician deficits.

Table 75: Physician Deficits Projected for the Year 2019 (Using Ratio Methodology Adjusting for Expected Attrition)

Specialty	Expected Deficits (FTE*)
Primary Care	
Family Practice/UC	14.4
Internal Medicine	66.3
General Pediatrics	34.6
Medicine	
Allergy and Immunology	2.3
Infectious Disease	3.1
Occupational Medicine	6.1
Physiatry	3.0
Psychiatry	33.8
Pulmonology/Critical Care	4.4
Surgical	
Cardiothoracic Surgery	3.2
Colon and Rectal Surgery	0.3
General Surgery	20.7
Neurosurgery	1.1
Orthopedic Surgery	4.4
Otolaryngology	3.8
Obstetrics and Gynecology	
Obstetrics and Gynecology	3.5
Gynecological Oncology	2.0
Reproductive Endocrinology	0.5
Hospital Based	
Emergency Medicine	3.3
Pathology	25.8
Radiation Oncology	5.3
Radiology	38.0
Total	220.2

Note: The Anesthesiology, Emergency Medicine, Pathology, and Radiology deficits may be overstated;
*FTE= full-time equivalency
Data Source: University of Maryland Medical System, Physician Needs Assessment, 2014 (The Advisory Board Company)

Health Status of Older Adults

Older adults are often living on a fixed income. Many older adults age 65 years and over have health insurance through Medicare. Older adults are more likely to experience transportation problems and suffer from a lack of mobility. This population is at high risk for developing chronic illnesses and related disabilities. Almost 66% of Medicare beneficiaries in Anne Arundel County have at least

two chronic health conditions and 13% have more than six chronic health conditions. Older adults use many health care services and require care coordination and professional expertise that meet their needs.

Table 76: Prevalence of Chronic Conditions in Medicare Beneficiaries, Anne Arundel County, Maryland and U.S., 2013

Disease Prevalence among Medicare Beneficiaries	Anne Arundel County Percent (Count)	Maryland Percent	U.S. Percent
Heart attack	0.8% (533)	0.8%	0.8%
Atrial fibrillation	8.6% (6,004)	7.9%	7.9%
Chronic kidney disease	15.2% (10,553)	16.5%	16.0%
Chronic obstructive pulmonary disease	9.6% (6,666)	9.8%	11.2%
Depression	13.6% (9,419)	14.2%	15.8%
Diabetes	26.5% (18,411)	28.8%	26.9%
Heart failure	11.7% (8,128)	13.1%	14.1%
Ischemic heart disease	25.3% (17,565)	27.3%	27.7%
Breast cancer	3.4% (2,385)	3.3%	2.9%
Colorectal cancer	1.2% (869)	1.3%	1.2%
Lung cancer	1.3% (872)	1.1%	1.0%
Prostate cancer	3.2% (2,219)	3.3%	3.0%
Asthma	4.6% (3,176)	5.1%	5.0%
Hypertension	55.9 % (38,863)	59.5%	55.4%
High cholesterol	47.3% (32,829)	49.3%	44.9%
Arthritis	28.5% (19,806)	29.2%	29.2%
Osteoporosis	5.7 % (3,986)	6.0%	6.1%
Alzheimer's and related disorders	9.0% (6,243)	10.3%	10.3%
Stroke	4.1% (2,859)	4.3%	3.7%

Source: Centers for Medicare and Medicaid Services

Table 77: Medicare Beneficiaries, Anne Arundel County, 2012

Number of Chronic Conditions	Count of Beneficiaries in County	Prevalence (%)	Per Capita Medicare Spending ($)	30 Day Readmission Rate (%)	ED Visits per 1,000 Beneficiaries
0 to 1	66,895	34.34	1,811	8.36	163
2 to 3	66,895	31.60	5,290	9.09	399
4 to 5	66,895	20.79	10,643	14.18	788
6+	66,895	13.27	29,895	26.85	2,198

Source: Centers for Medicare and Medicaid Services

Population and Health Data by ZIP Code

Table 78: Population by ZIP Code, Anne Arundel County, 2013

ZIP	Area	White, NH	Black, NH	Hispanic, Any Race	Asian	Total
20701*	Annapolis Junction	-	-	-	-	-
20711	Lothian	4,879	1,161	371	31	6,592
20714*	North Beach	760	41	73	5	915
20724	Laurel	5,723	6,660	1,840	1,150	16,024
20733	Churchton	2,327	118	184	-	2,873
20736*	Owings	-	-	-	-	12
20751	Deale	2,105	52	85	-	2,273
20754*	Dunkirk	857	74	15	24	1,016
20755	Ft. George G Meade	5,730	2,272	1,329	419	10,369
20758	Friendship	508	51	-	-	559
20764	Shady Side	3,884	695	37	-	4,643
20765	Galesville	415	50	-	-	465
20776	Harwood	3,086	456	104	-	3,672
20778	West River	1,843	168	61	-	2,085
20779	Tracys Landing	1,334	23	-	9	1,375
20794*	Jessup	2,927	2,841	489	313	6,721
21012	Arnold	18,257	516	827	623	20,781
21032	Crownsville	7,955	382	198	102	8,743
21035	Davidsonville	7,286	229	169	140	7,899
21037	Edgewater	18,316	629	1,166	370	21,050
21054	Gambrills	7,525	677	194	811	9,589
21056	Gibson Island	222	-	-	-	222
21060	Glen Burnie (East)	19,856	4,990	2,742	798	29,233
21061	Glen Burnie (West)	30,903	12,181	5,062	2,727	53,491
21076*	Hanover	6,227	3,112	447	1,767	11,999
21077	Harmans	155	-	-	-	155
21090	Linthicum Heights	8,974	586	120	171	9,986
21108	Millersville	13,846	1,707	720	718	17,890
21113	Odenton	18,226	8,341	1,424	1,722	31,219
21114	Crofton	20,372	3,563	1,125	598	26,636
21122	Pasadena	53,440	3,411	1,880	906	60,968
21140	Riva	3,061	-	176	53	3,338
21144	Severn	16,218	10,412	2,397	1,687	32,328
21146	Severna Park	23,711	991	334	1,121	26,703
21225*	Brooklyn	6,072	6,494	913	453	14,721
21226*	Curtis Bay	3,367	717	116	38	4,378
21240	BWI Airport	-	-	-	-	-
21401	Annapolis	25,800	6,091	3,774	903	36,938
21402	Naval Academy	4,120	709	576	210	6,212
21403	Eastport	19,935	4,439	4,842	577	30,352
21405	Sherwood Forest	525	-	-	-	525
21409	Annapolis	17,019	1,306	1,250	469	20,355
	Anne Arundel County	**393,897**	**87,556**	**38,330**	**20,280**	**556,348**

*ZIP codes shared with other counties; data presented is estimates for the Anne Arundel County only.
Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates; U.S. Census Bureau, Population Estimate Program; Maryland Department of Planning

Table 79: Estimated Poverty Rate by ZIP Code, Anne Arundel County, 2013

ZIP Code	Area	Poverty Percentage
20701*	Annapolis Junction	-
20711	Lothian	7.3%
20714*	North Beach	9.9%
20724	Laurel	4.9%
20733	Churchton	3.1%
20736	Owings	-
20751	Deale	9.2%
20754*	Dunkirk	3.6%
20755	Ft. Meade	4.9%
20758	Friendship	6.3%
20764	Shady Side	4.7%
20765	Galesville	2.4%
20776	Harwood	3.8%
20778	West River	5.1%
20779	Tracys Landing	7.1%
20794*	Jessup	6.0%
21012	Arnold	3.8%
21032	Crownsville	3.4%
21035	Davidsonville	1.0%
21037	Edgewater	4.0%
21054	Gambrills	4.3%
21056	Gibson Island	0.0%
21060	Glen Burnie (East)	11.2%
21061	Glen Burnie (West)	10.8%
21076*	Hanover	3.9%
21077	Harmans	16.8%
21090	Linthicum Heights	8.0%
21108	Millersville	3.4%
21113	Odenton	4.5%
21114	Crofton	3.3%
21122	Pasadena	5.7%
21140	Riva	4.6%
21144	Severn	9.2%
21146	Severna Park	2.4%
21225*	Brooklyn	26.5%
21226*	Curtis Bay	16.5%
21240	BWI Airport	-
21401	Annapolis	8.0%
21402	Naval Academy	3.0%
21403	Eastport	7.5%
21405	Sherwood Forest	0.0%
21409	Annapolis	3.3%
	Anne Arundel County	**6.3%**

*ZIP codes shared with other counties
Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates

Table 80: Percentage of Households with Food Stamp/SNAP Benefits by ZIP Code, Anne Arundel County, 2013

ZIP Code	Area	Percent of Households on SNAP
20701*	Annapolis Junction	-
20711	Lothian	16.8%
20714*	North Beach	8.9%
20724	Laurel	2.9%
20733	Churchton	1.8%
20736*	Owings	-
20751	Deale	1.9%
20754*	Dunkirk	0.7%
20755	Ft. Meade	4.2%
20758	Friendship	0.0%
20764	Shady Side	8.1%
20765	Galesville	0.0%
20776	Harwood	1.0%
20778	West River	0.0%
20779	Tracys Landing	4.3%
20794*	Jessup	8.1%
21012	Arnold	2.9%
21032	Crownsville	3.8%
21035	Davidsonville	1.3%
21037	Edgewater	4.4%
21054	Gambrills	3.0%
21056	Gibson Island	0.0%
21060	Glen Burnie (East)	10.8%
21061	Glen Burnie (West)	11.7%
21076*	Hanover	4.1%
21077	Harmans	0.0%
21090	Linthicum Heights	5.7%
21108	Millersville	0.0%
21113	Odenton	2.7%
21114	Crofton	1.3%
21122	Pasadena	5.1%
21140	Riva	0.5%
21144	Severn	7.9%
21146	Severna Park	1.4%
21225*	Brooklyn	30.9%
21226*	Curtis Bay	22.0%
21240	BWI Airport	-
21401	Annapolis	4.3%
21402	Naval Academy	0.0%
21403	Eastport	5.7%
21405	Sherwood Forest	0.0%
21409	Annapolis	3.6%
	Anne Arundel County	**5.6%**

*ZIP codes shared with other counties
Source: Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates

Table 81: Estimated Population without High School or Equivalent Education by ZIP Code, Anne Arundel County, 2013

ZIP Code	Area	Percent without High School
20701*	Annapolis Junction	-
20711	Lothian	14.2%
20714*	North Beach	6.3%
20724	Laurel	11.8%
20733	Churchton	3.9%
20736*	Owings	6.5%
20751	Deale	16.4%
20754*	Dunkirk	3.9%
20755	Ft. George G Meade	2.2%
20758	Friendship	13.1%
20764	Shady Side	6.6%
20765	Galesville	3.2%
20776	Harwood	10.0%
20778	West River	0.7%
20779	Tracys Landing	4.6%
20794*	Jessup	25.4%
21012	Arnold	3.9%
21032	Crownsville	4.4%
21035	Davidsonville	4.1%
21037	Edgewater	8.7%
21054	Gambrills	4.1%
21056	Gibson Island	0.0%
21060	Glen Burnie (East)	16.6%
21061	Glen Burnie (West)	13.6%
21076*	Hanover	5.8%
21077	Harmans	0.0%
21090	Linthicum Heights	12.6%
21108	Millersville	7.7%
21113	Odenton	5.0%
21114	Crofton	3.1%
21122	Pasadena	10.0%
21140	Riva	4.5%
21144	Severn	10.4%
21146	Severna Park	3.5%
21225*	Brooklyn	25.4%
21226*	Curtis Bay	21.5%
21240	BWI Airport	0.0%
21401	Annapolis	8.4%
21402	Naval Academy	1.9%
21403	Eastport	9.7%
21405	Sherwood Forest	0.0%
21409	Annapolis	3.3%
	Anne Arundel County	**9.3%**

*ZIP codes shared with other counties
Source: U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates

Table 82: Number and Percent of Low Birth Weight Infants by ZIP Code, Anne Arundel County, 2009-2013

ZIP Code	Area	Number	Percent of All Births
20701*	Annapolis Junction	-	-
20711	Lothian	21	7.1%
20714*	North Beach	-	-
20724	Laurel	135	9.4%
20733	Churchton	15	8.8%
20736*	Owings	-	-
20751	Deale	-	-
20754*	Dunkirk	-	-
20755	Ft. Meade	84	6.6%
20758	Friendship	-	-
20764	Shady Side	18	8.0%
20765	Galesville	-	-
20776	Harwood	-	-
20778	West River	-	-
20779	Tracys Landing	-	-
20794*	Jessup	-	-
21012	Arnold	68	6.5%
21032	Crownsville	30	6.7%
21035	Davidsonville	16	7.3%
21037	Edgewater	83	7.1%
21054	Gambrills	32	7.0%
21056	Gibson Island	-	-
21060	Glen Burnie (East)	185	8.3%
21061	Glen Burnie (West)	341	8.4%
21076*	Hanover	81	8.4%
21077	Harmans	-	-
21090	Linthicum Heights	37	6.6%
21108	Millersville	78	8.1%
21113	Odenton	195	7.8%
21114	Crofton	128	7.0%
21122	Pasadena	262	7.5%
21140	Riva	-	-
21144	Severn	217	10.0%
21146	Severna Park	72	7.1%
21225*	Brooklyn	106	10.8%
21226*	Curtis Bay	25	8.0%
21240	BWI Airport	-	-
21401	Annapolis	185	7.6%
21402	Naval Academy	-	-
21403	Eastport	169	7.5%
21405	Sherwood Forest	-	-
21409	Annapolis	76	7.5%
	Anne Arundel County	**2,719**	**7.9%**

*ZIP codes shared with other counties; data presented is estimate for Anne Arundel County only. Rates for ZIP codes with less than 11 low birth weight births not presented.
Source: Maryland Department of Health and Mental Hygiene Vital Statistics Administration, 2009-2013.

Table 83: Number of ED Visits and Crude Rates per 1,000 Population by ZIP Code, Anne Arundel County, 2013

ZIP Code	Area	Number of ED Visits	Rate per 1,000
20701*	Annapolis Junction	-	-
20711	Lothian	2,665	404.3
20714*	North Beach	313	355.6
20724	Laurel	4,084	254.9
20733	Churchton	921	320.6
20736*	Owings	-	-
20751	Deale	674	296.5
20754*	Dunkirk	251	242.1
20755	Ft. Meade	2,858	275.6
20758	Friendship	259	463.3
20764	Shady Side	1,242	267.5
20765	Galesville	189	406.5
20776	Harwood	1,021	278.1
20778	West River	450	215.8
20779	Tracys Landing	292	212.4
20794*	Jessup	1,489	222.1
21012	Arnold	4,597	221.2
21032	Crownsville	2,146	245.5
21035	Davidsonville	1,489	188.5
21037	Edgewater	5,435	258.2
21054	Gambrills	2,191	228.5
21056	Gibson Island	26	117.1
21060	Glen Burnie (East)	13,136	449.4
21061	Glen Burnie (West)	26,780	500.6
21076*	Hanover	2,690	225.0
21077	Harmans	94	606.5
21090	Linthicum Heights	2,806	281.0
21108	Millersville	4,098	229.1
21113	Odenton	7,262	232.6
21114	Crofton	4,660	175.0
21122	Pasadena	17,638	289.3
21140	Riva	699	209.4
21144	Severn	10,763	332.9
21146	Severna Park	5,285	197.9
21225*	Brooklyn	14,167	960.1
21226*	Curtis Bay	2,808	647.2
21240	BWI Airport	-	-
21401	Annapolis	14,740	399.0
21402	Naval Academy	399	64.2
21403	Eastport	10,186	335.6
21405	Sherwood Forest	86	163.8
21409	Annapolis	4,259	209.2
	Anne Arundel County	**186,124**	**334.9**

*ZIP codes shared with other counties; data presented is estimate for the Anne Arundel County only.
Source: Outpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Table 84: Number of ED Visits and Rate per 100,000 Population for Selected Health Conditions, Anne Arundel County, 2013

ZIP Code	Area	Diabetes Mellitus		Hypertension		Asthma		Heart Disease	
		Number	Rate	Number	Rate	Number	Rate	Number	Rate
20701*	Annapolis Junction	-	-	-	-	-	-	-	-
20711	Lothian	13	197	12	182	24	364	33	501
20714*	North Beach	-	-	11	1,202	23	2,514	18	1,967
20724	Laurel	18	112	40	250	71	443	38	237
20733	Churchton	-	-	-	-	12	418	12	418
20736*	Owings	-	-	-	-	-	-	-	-
20751	Deale	-	-	-	-	-	-	-	-
20754*	Dunkirk	-	-	18	1,772	20	1,969	21	2,067
20755	Ft. George G Meade	-	-	-	-	48	463	-	-
20758	Friendship	-	-	-	-	-	-	-	-
20764	Shady Side	-	-	-	-	-	-	-	-
20765	Galesville	-	-	-	-	-	-	-	-
20776	Harwood	-	-	11	300	14	381	-	-
20778	West River	-	-	-	-	-	-	-	-
20779	Tracys Landing	-	-	-	-	-	-	-	-
20794*	Jessup	26	387	25	372	52	774	44	655
21012	Arnold	20	96	27	130	60	289	64	308
21032	Crownsville	11	126	11	126	26	297	22	252
21035	Davidsonville	-	-	11	139	17	215	16	203
21037	Edgewater	12	57	34	162	65	309	74	352
21054	Gambrills	13	136	17	177	27	282	37	386
21056	Gibson Island	-	-	-	-	-	-	-	-
21060	Glen Burnie (East)	78	267	81	277	164	561	109	373
21061	Glen Burnie (West)	187	350	159	297	436	815	177	331
21076*	Hanover	14	117	26	217	57	475	22	183
21077	Harmans	-	-	-	-	-	-	-	-
21090	Linthicum Heights	16	160	17	170	33	331	24	240
21108	Millersville	28	157	31	173	50	280	41	229
21113	Odenton	34	109	53	170	150	481	71	227
21114	Crofton	15	56	24	90	68	255	45	169
21122	Pasadena	107	176	74	121	201	330	151	248
21140	Riva	-	-	-	-	-	-	-	-
21144	Severn	62	192	77	238	229	708	62	199
21146	Severna Park	29	109	29	109	79	296	72	270
21225*	Brooklyn	188	1,277	173	1,175	785	5,333	164	1,114
21226*	Curtis Bay	46	1,051	27	617	108	2,467	33	754
21401	Annapolis	113	306	111	301	248	671	158	428
21402	Naval Academy	-	-	-	-	-	-	-	-
21403	Eastport	53	175	64	211	191	629	83	277
21405	Sherwood Forest	-	-	-	-	-	-	-	-
21409	Annapolis	25	123	25	123	50	246	49	241
	Anne Arundel County	**1,166**	**210**	**1,233**	**222**	**3,356**	**603**	**1,704**	**307**

*ZIP codes shared with other counties; data presented is estimate for the Anne Arundel County only. Rates not shown for ZIP codes with less than 11 ED visits for each primary diagnosis.

Source: Outpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Table 85: Number of ED Visits and Crude Rates per 1,000 Population for Behavioral Health Conditions by ZIP Code, Anne Arundel County, 2013

ZIP Code	Area	Number of ED Visits	Rate per 1,000
20701*	Annapolis Junction	-	-
20711	Lothian	114	17.3
20714*	North Beach	15	16.8
20724	Laurel	179	11.2
20733	Churchton	59	20.5
20736	Owings	-	-
20751	Deale	59	26
20754*	Dunkirk	-	-
20755	Ft. George G Meade	76	7.3
20758	Friendship	19	34
20764	Shady Side	70	15.1
20765	Galesville	-	-
20776	Harwood	46	12.5
20778	West River	28	13.4
20779	Tracys Landing	14	10.2
20794*	Jessup	88	13.2
21012	Arnold	358	17.2
21032	Crownsville	125	14.3
21035	Davidsonville	66	8.4
21037	Edgewater	376	17.9
21054	Gambrills	120	12.5
21056	Gibson Island	-	-
21060	Glen Burnie (East)	768	26.3
21061	Glen Burnie (West)	1573	29.4
21076*	Hanover	113	9.4
21077	Harmans	-	-
21090	Linthicum Heights	167	16.7
21108	Millersville	171	9.6
21113	Odenton	307	9.8
21114	Crofton	273	10.2
21122	Pasadena	993	16.3
21140	Riva	31	9.3
21144	Severn	445	13.8
21146	Severna Park	321	12
21225*	Brooklyn	622	42.2
21226*	Curtis Bay	141	32.3
21226	Curtis Bay	141	32.3
21240	BWI Airport	-	-
21401	Annapolis	709	19.2
21402	Naval Academy	11	1.8
21403	Eastport	434	14.3
21405	Sherwood Forest	-	-
21409	Annapolis	225	11.1
	Anne Arundel County	**9,544**	**17.2**

*ZIP codes shared with other counties; data presented is estimate for the Anne Arundel County only. Rates not shown for ZIP codes with less than 11 ED visits.

Source: Outpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Table 86: Number of Hospitalizations and Crude Rates per 1,000 Population by ZIP Code, Anne Arundel County, 2013

ZIP Code	Area	Number of Hospitalizations	Rate per 1,000
20701*	Annapolis Junction	-	-
20711	Lothian	763	115.7
20714*	North Beach	92	104.1
20724	Laurel	1,280	79.9
20733	Churchton	288	100.2
20736*	Owings	-	-
20751	Deale	243	106.9
20754*	Dunkirk	75	72.5
20755	Ft. Meade	559	53.9
20758	Friendship	96	171.7
20764	Shady Side	393	84.6
20765	Galesville	53	114.0
20776	Harwood	329	89.6
20778	West River	163	78.2
20779	Tracys Landing	137	99.6
20794*	Jessup	6,556	97.7
21012	Arnold	1,765	84.9
21032	Crownsville	920	105.2
21035	Davidsonville	614	77.7
21037	Edgewater	2,050	97.4
21054	Gambrills	989	103.1
21056	Gibson Island	22	99.1
21060	Glen Burnie (East)	4,497	153.8
21061	Glen Burnie (West)	7,819	146.2
21076*	Hanover	1,109	92.8
21077	Harmans	26	167.7
21090	Linthicum Heights	1,271	127.3
21108	Millersville	1,674	93.6
21113	Odenton	2,727	87.4
21114	Crofton	2,006	75.3
21122	Pasadena	7,006	114.9
21140	Riva	279	83.6
21144	Severn	3,052	94.4
21146	Severna Park	2,417	90.5
21225*	Brooklyn	2,733	185.2
21226*	Curtis Bay	676	155.8
21240	BWI Airport	-	-
21401	Annapolis	4,652	125.9
21402	Naval Academy	73	11.8
21403	Eastport	3,312	109.1
21405	Sherwood Forest	48	91.4
21409	Annapolis	1,572	77.2
	Anne Arundel County	**59,533**	**107.1**

*ZIP codes shared with other counties; data presented is estimate for the Anne Arundel County only. Rates not shown for ZIP codes with less than 11 ED visits

Source: Inpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Table 87: Potentially Preventable Hospitalizations (Excluding Low Birth Weight) by ZIP Code, Anne Arundel County Residents, 2013

ZIP	Area	Number of Hospitalizations	Rate per 1,000
20701*	Annapolis Junction	--	--
20711	Lothian	108	21.4
20714*	North Beach	12	17.2
20724	Laurel	91	7.5
20733	Churchton	33	15.6
20736	Owings	--	--
20751	Deale	26	14.0
20754*	Dunkirk	<11	--
20755	Ft. Meade	<11	--
20758	Friendship	22	45.8
20764	Shady Side	47	13.8
20765	Galesville	<11	--
20776	Harwood	34	11.5
20778	West River	12	7.4
20779	Tracys Landing	19	17.6
20794*	Jessup	64	11.1
21012	Arnold	134	8.7
21032	Crownsville	94	13.9
21035	Davidsonville	49	8.6
21037	Edgewater	197	12.2
21054	Gambrills	80	11.0
21056	Gibson Island	<11	--
21060	Glen Burnie (East)	572	24.3
21061	Glen Burnie (West)	920	22.0
21076*	Hanover	101	10.7
21077	Harmans	<11	--
21090	Linthicum Heights	121	15.4
21108	Millersville	167	12.2
21113	Odenton	246	10.5
21114	Crofton	119	6.2
21122	Pasadena	720	15.5
21140	Riva	19	7.3
21144	Severn	296	12.6
21146	Severna Park	222	11.3
21225*	Brooklyn	314	29.6
21226*	Curtis Bay	73	22.7
21240	BWI Airport	--	--
21401	Annapolis	521	17.2
21402	Naval Academy	<11	--
21403	Eastport	341	14.0
21405	Sherwood Forest	<11	--
21409	Annapolis	143	9.5
	Anne Arundel County	**6,147**	**14.3**

*ZIP codes shared with other counties; data presented is estimate for the Anne Arundel County only. Rates not shown for ZIP codes with less than 11 ED visits

Source: Inpatient Hospital Discharge File 2013, Maryland Health Services Cost Review Commission

Pathways Program for Adults and Teens

Pathways is guided by the philosophy that substance use and mental health disorders are treatable through professional and compassionate care, strong family involvement, education, and ongoing support.

What is Pathways?

Pathways offers clinically-proven diagnosis and treatment programs for alcohol and/or substance use disorders. In addition, mental health needs are addressed and treated as part of our comprehensive services. Programs are tailored to individual needs, with on-site family involvement an integral part of the recovery process. Admission and treatment level are determined by a professional assessment.

Inpatient Program

When clinically indicated, individuals with substance use and co-occurring mental health needs are admitted to Pathways for care.

This program is a 24-hour, seven-day-treatment program for teens (ages 13-17) and adults (age 18 and older). There are separate units for adult and teen patients.

Treatment Offered

- Medically-supervised detoxification
- 24-hour medical/nursing care
- Individual case management
- Group counseling
- Discharge planning
- Addiction and recovery education
- 12-step group meetings
- Family therapy/education
- Spirituality groups
- Adventure therapy (to increase self-awareness and behavioral changes important in the recovery process)

Additional Teen Services

- *Pathways School Program* is a highly structured educational environment designed to meet the individual needs of each student. Pathways' intent is to allow students to fulfill, with minimal interruption, basic school requirements during treatment, whether or not the individual is enrolled in school. The educational team leader for this program is a masters-level Maryland-certified special education teacher.
- Pre-GED testing
- Age appropriate social and leisure skills

Continued on back

For more information visit us online at **PathwaysProgram.org** or call **410-573-5400.**

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Pathways Programs for Adults and Teens

Partial Hospitalization Program

This is a day treatment program for patients who are medically stable and can be treated at a level of care that doesn't require inpatient detoxification or rehabilitation. When clinically appropriate, patients may live at home. However, a "boarder" component is available and allows the patient to stay overnight at Pathways for a nominal fee.

Outpatient Treatment

Pathways provides a clinically-proven diagnostic assessment and a full continuum of outpatient treatment, including drug testing for the teen or adult with substance use or co-occuring disorders.

Teen Care (ages 13 to 17)

› *Intensive Outpatient Program* is a 12-week program requiring specific individualized treatment plan objectives be met prior to discharge. Three-hour group sessions meet three days per week at night. Parents/guardians are required to attend group sessions each Monday evening for the duration of the program.

› *Continuing Care* is a variable length of stay program that provides supportive care for those who are in continuing recovery. Participation in this group requires specific individualized treatment plan objectives be met prior to discharge. Weekly one-and-a-half hour sessions are held at night.

› *At Risk Group* is a five-week education program for teens with a minimal amount of chemical use and with no identifiable pattern of use. This one-hour group meets weekly in the evenings.

Adult Care (18 and older)

› *Intensive Outpatient Program* is a variable-length-of-stay program requiring specific individualized treatment plan objectives be met prior to discharge. Sessions are three-and-a-half hours, three to four times per week, depending on clinical necessity.

› *Continuing Care* is a variable length of stay program that provides supportive care for those who are in continuing recovery. Participation in this group requires specific individualized treatment plan objectives be met prior to discharge. Weekly one-and-a-half hour sessions are held at night.

› *Traditional Outpatient Group* is typically a 12-week evening program* for adults who have experienced some negative consequences from their substance abuse. It focuses on education, self-diagnosis, defense mechanisms, development of a sober support network, and relapse prevention. Participation requires specific individualized treatment plan objectives be met prior to discharge. One-and-a-half hour sessions are held weekly.
*If clinically appropriate

› *DWI 12-hour Education Program* is a six-week state certified/MVA-approved education program that meets two hours a week. Education focuses on identifying drinking patterns, problems of drinking and driving, and alternatives to being on the highway after consuming alcohol or drugs.

› *26-week DWI Treatment Program* is a treatment model that explores the realities of substance abuse, alcoholism/drug addiction and the recovery process. Participation in this group requires specific individualized treatment plan objectives be met prior to discharge. One-and-a-half hour sessions held weekly.

For more information visit us online at **PathwaysProgram.org** or call **410-573-5400.**

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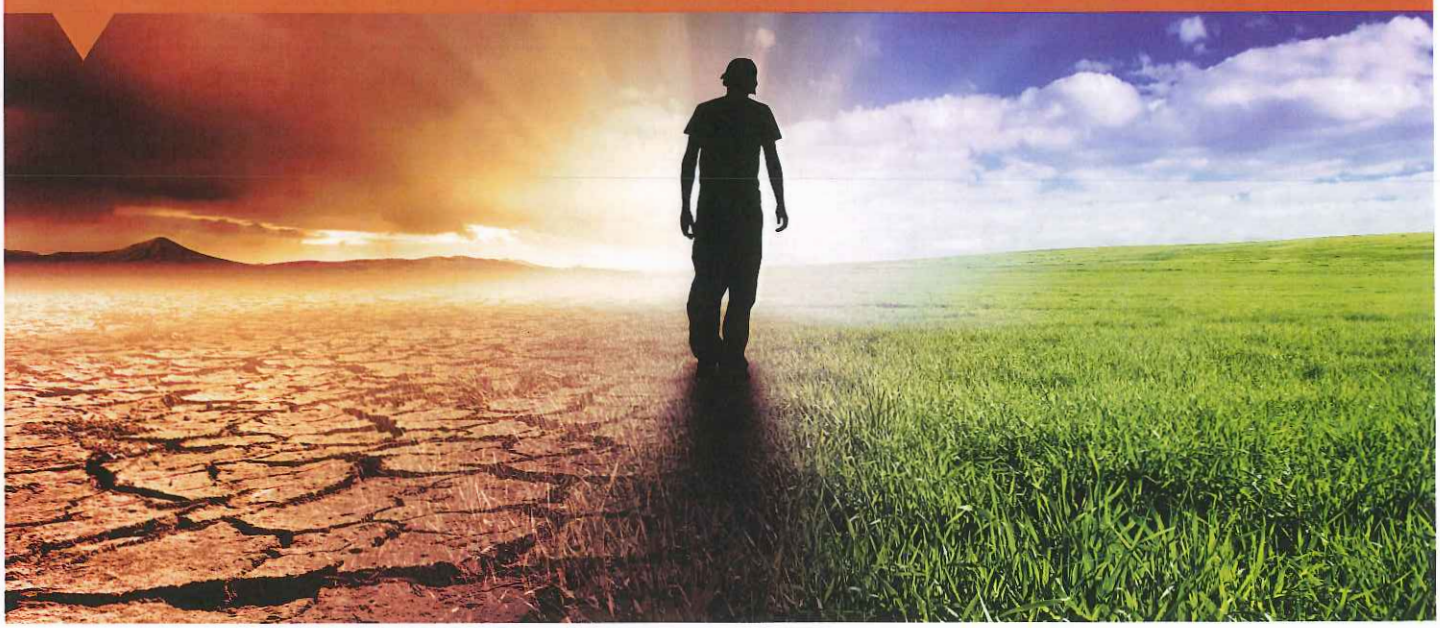
Pathways Outpatient Detoxification Program



Pathways, a substance use and mental health treatment facility in Annapolis, Md., offers outpatient detoxification (detox)—a medically managed therapeutic process to help patients withdraw safely and comfortably from opioid dependence.

About the Program

Treatment for substance use and mental health disorders requires the expertise of healthcare professionals from a number of areas. Pathways delivers coordinated outpatient detox care designed to minimize the risk of serious health problems for the patient and maximize the ease of transition through treatment. This daytime treatment program provides an opportunity for the patient to safely withdraw from opioids over a period of 3 to 6 days followed by ongoing professional support in recovery.

Treatment Overview

Patients are assessed for admission to the program by a team of professionals and are required to have a safe and sober living environment. The care of each patient is under the direction of the medical and clinical teams which includes a doctor, nurse and case manager/counselor.

The program includes:

- physician and nursing assessment
- psychosocial assessment
- medical history and physical exam
- creation of a personalized care plan
- participation in Pathways' Intensive Outpatient Program

At the end of each day in treatment, patients leave Pathways with medical instructions and return for treatment in the morning.

Aftercare

Recovery is an ongoing process that often begins with detoxification. Receiving intensive outpatient treatment during and following outpatient detox is essential for maintaining abstinence. Patients are expected to continue in one of Pathways' outpatient treatment programs, or an approved outpatient treatment program following completion of outpatient detoxification.

For more information call **410-573-5400** or visit **PathwaysProgram.org**

Pathways
Anne Arundel Medical Center

15-PATH-0082 06/15

Pathways Prevention Education Program

Pathways, a teen and adult substance use and mental health treatment center in Annapolis, Maryland, is committed to substance use prevention education. Reaching youth and the community with information that addresses key physiological and legal dangers of abusing substances is critical to reducing risk factors.

Evidence-based prevention lessons

Pathways Prevention Education Program provides evidence-based substance-use prevention lessons for students ranging from elementary school to college. Lessons are designed based on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices. We present to schools, camps, after-school programs and youth groups.

Community presentations

We provide presentations to parent groups, senior citizen groups, community health events, town hall meetings and professional development meetings. Presentations focus on current drug trends, risks of addiction, and the role of parents and communities in prevention.

Awareness campaigns

Pathways Prevention Education Program can coordinate national- and state-recognized prevention awareness events with your school, organization or group for events such as Alcohol Awareness Month in April, Red Ribbon Week in October, National Drug & Alcohol Facts Week in January, and Tobacco Free Kids Week in April. We also offer assistance to start and sustain a Students Against Destructive Decisions (SADD) group in your school or community group.

Alcohol and Drug Education Course (ADEC)

Our ADEC promotes healthy behaviors to high-risk youth by providing education about the risks and consequences of alcohol and other drugs, while helping them strengthen their decision-making, communication and coping skills.

We encourage parents and guardians to also participate to help strengthen their relationship with their teen.

Why is prevention education important?

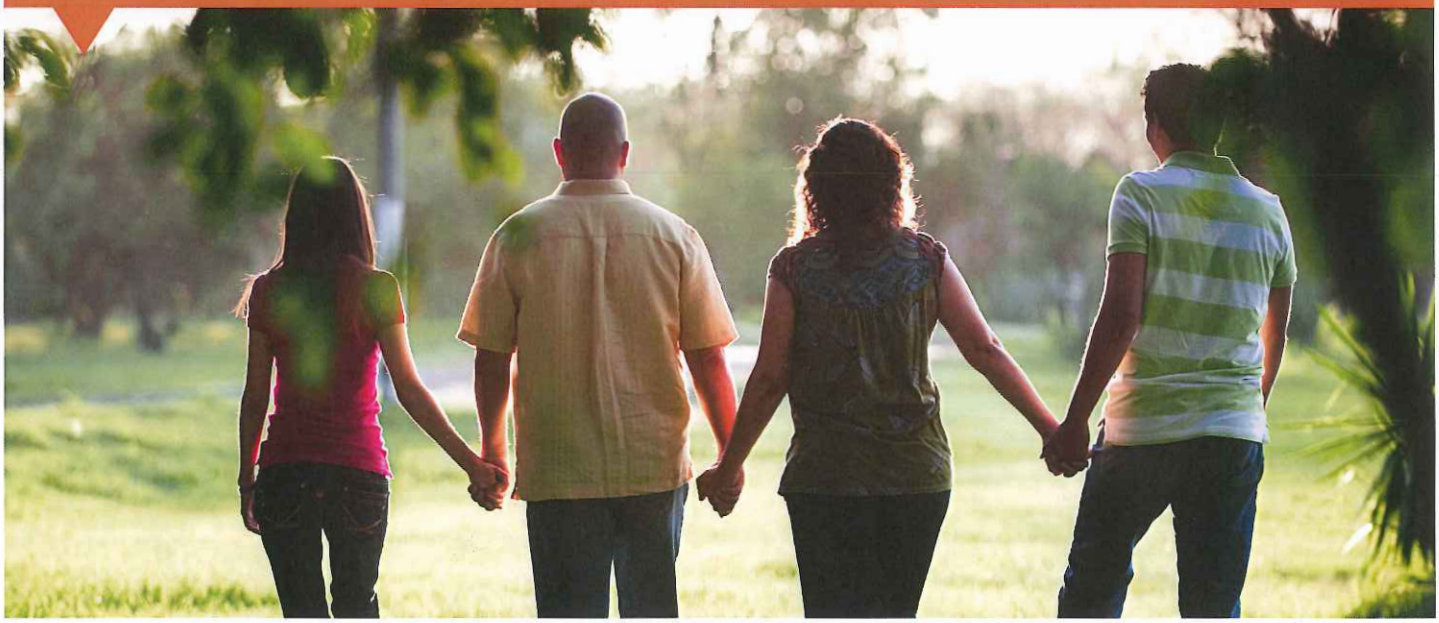
- Research shows evidence-based programs can significantly reduce early use of alcohol and drugs. National drug-use surveys indicate some children are abusing drugs by age 13.
- It provides information for parents and the community on the importance of their role in preventing substance use in teens.
- Federal funding for most school systems' drug-free programs have been cut. Pathways Prevention Education Program ensures schools have access to this critical resource in substance use and addiction prevention.
- It encourages the community to speak openly about the important topic of substance use.
- It promotes positive, healthy behaviors for our community.

To schedule a program or learn more call **410-573-5400.**

Pathways
Anne Arundel Medical Center

16-PATH-0096 02/16

Pathways Family Wellness Workshop



The misuse of alcohol and/or drugs impacts the family and other interpersonal relationships. Recovery involves the healing of ALL relationships. This workshop is open to the community.

Family Wellness Workshop

A therapeutic and educational program for family members of adults or adolescents with substance use disorders. The program brings together family members (such as parents, siblings, aunts, uncles or grandparents) for on-site group therapy, educational sessions, and personal growth.

The program equips family members with communication skills, relapse prevention strategies and coping mechanisms for ongoing recovery. This workshop is open to the community.

Participants will:

- Receive an understanding about the disease of addiction, the nature of mental health disorders and how the two interact.
- Examine stages of recovery for family members.
- Develop effective skills for communication and boundary-setting.
- Participate in adventure therapy to increase self-awareness and behavioral changes important in the recovery process.
- Develop supportive relationships with other participating families.

Program details:

- **Full day Saturday program:** 8:30am to 4pm.
  - Breakfast and lunch provided
  - Fee: $10 per person; $15 for two people (scholarships available)

2016 Workshop Dates

January 9	April 2
January 23	April 16
February 6	May 14
February 20	May 21
March 5	June 11
March 19	June 18

Lodging available at Hackerman-Patz House. Please call 410-571-3100 for rates and availability. Financial assistance may be available.

To register or for more information call 410-573 -5428 or visit AAMCevents.org.

Pathways
Anne Arundel Medical Center

13-PATH-0072 12/30

Pathways DWI/DUI Programs

Pathways' DWI/DUI programs are intended to provide education or treatment for individuals charged with driving while intoxicated (DWI) or driving while under the influence (DUI). For admission to either program, individuals must undergo a clinical assessment to determine the most appropriate level of care. This clinical assessment, conducted by certified addiction counselors is required before individuals can begin attending sessions. Participants are placed in the appropriate program based on this assessment.

12-Hour DWI Education Program

The 12-hour education program is designed to help DWI/DUI offenders increase their knowledge about how alcohol affects driving skills. It also helps participants identify their own drinking and driving patterns and develop plans to reduce the probability of future DWI/DUI behavior.

- Classes meet for six weeks, Tuesdays from 7 to 9pm
- Classes are conducted by a certified addiction counselor
- Initial drug screen and breathalyzer is required

Requirements for admission include:

- First drinking and driving charge
- Must have taken a blood alcohol level test at time of charge
- Blood alcohol level below .15
- No other illicit drug use

The program meets the requirements for education by the Maryland Vehicle Administration (MVA).

DWI 26-Week Treatment Program

The 26 week treatment program is designed for those who have a more extensive history of alcohol use and/or legal consequences related to their drinking. This program provides participants with tools to assist them in changing high-risk behaviors and identifying negative consequences associated with drinking and driving.

- Meets Tuesdays from 6:15 to 7:45pm
- Classes conducted by a licensed clinician
- Initial drug screen and breathalyzer required
- Drug screens are performed randomly throughout the program

Individuals qualify for this program when they:

- Have not taken a blood alcohol level test
- Tested above .15 at time of charge or have more than one drinking and driving charge

The program meets the requirements for treatment by the MVA.

Call **410-573-5400** for more information or visit **askAAMC.org/pathways.**

Anne Arundel Medical Center
Pathways

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Tackling the opioid epidemic

GUEST COLUMN
Elizabeth Winter

The heroin epidemic is a national problem that hits close to home in Anne Arundel County. According to the Anne Arundel County Department of Health, heroin-related deaths in the county have increased by 128 percent between 2010 and 2013. The rate of heroin use here is 5.5 percent for youths age 16 and 17 and 10.7 percent for adults age 18 and older. Both of these numbers are above the average for the state of Maryland.

The danger of opioids

Fueling the epidemic are opioids. Opioids come in two main forms: prescription painkillers like OxyContin and Percocet and illegal drugs like heroin. The Centers for Disease Control and Prevention (CDC) is writing new guidelines for physicians to explore other options before prescribing opioids. Still, many people already have a prescription for opioids.

In 2012, doctors wrote 259 million opioid prescriptions. That's enough for every adult in the United States to have a bottle of pills, according to the CDC.

Not everyone who takes opioids gets addicted. However, everyone develops tolerance and some may start to crave these drugs. Opioid use can lead to risk of falls, respiratory problems, sleep apnea, interaction with other medications and potentially fatal overdoses.

Suboxone: A safe solution

Quitting opioids "cold turkey" is painful and dangerous. Withdrawal symptoms start around 12 hours after someone stops using opioids. Symptoms can include stomach pain, anxiety, body pain, chills, diarrhea, nausea, sweating, insomnia, weakness and more.

For people dependent on opioids, Suboxone can help. Suboxone is a medication that helps people safely stop opioid use by reducing withdrawal symptoms and opioid cravings. The medication also blocks the effects of other opioids.

Suboxone treatment not only allows people to safely withdraw from opioids with little discomfort, it helps manage other health issues related to opioid use. Suboxone treatment also links people with professional counselors. Counselors can help people develop coping skills and behaviors to prevent setbacks. Only qualified, licensed doctors can prescribe Suboxone.

Pathways, Anne Arundel Medical Center's substance use and mental health treatment center, offers both inpatient and outpatient Suboxone treatment. Both programs begin with a phone call to understand the patient's needs. Based on the phone call, we recommend either inpatient or outpatient care.

See **OPIOID,** *page D4*

The opioid epidemic is complex, and the solution is not simple. At Pathways, we believe we can begin to turn this public health crisis around by working together with other healthcare professionals, our community partners and our patients.

Elizabeth Winter, MD, is the medical director at Pathways, AAMC's substance use and mental health treatment center. She can be reached at 410-573-5400. For more information on Suboxone treatment and other options available through Pathways, visit PathwaysProgram.org.


Health&Fitness
Nonsmokers avoid, immune

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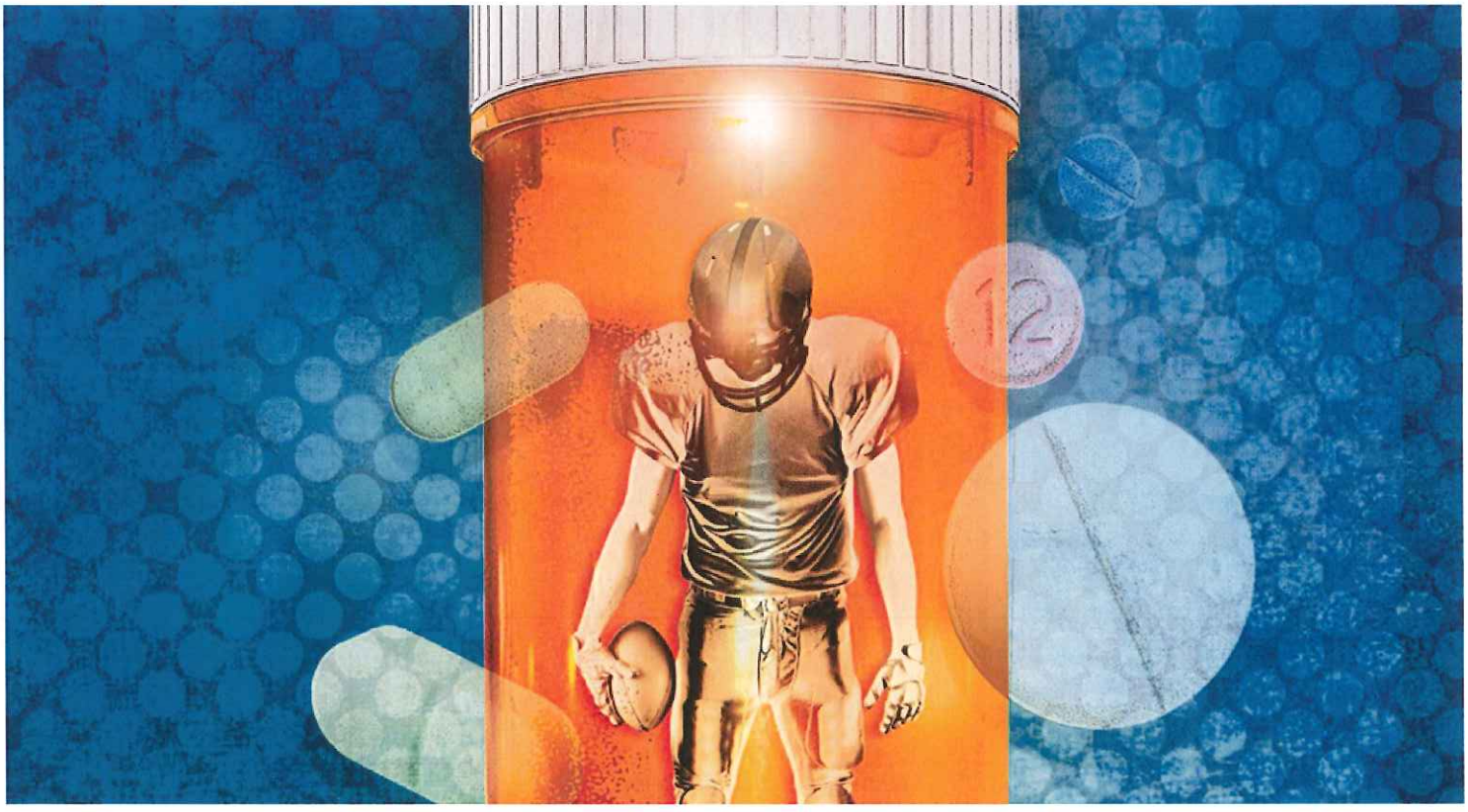
(http://www.aahs.org/living/)
NOV 17, 2015

PREVENTING OPIOID ADDICTION IN YOUNG ATHLETES



More than 38 million girls and boys under age 19 participate in organized sports each year in the United States. Among these kids, injury—from minor sprains to broken bones—is

common. In fact, one in three young athletes will miss practice or games due to an injury.

When athletes are injured, they want to get back in the game as soon as possible. The doctors treating them will determine the best way to repair their injuries and may prescribe pain medications. This is where some young people can fall into the trap of opioid addiction.

A National Crisis

Over the past two decades, addiction to opioids, which includes narcotic painkillers like Vicodin, OxyContin and Percocet—as well as heroin—has soared across the nation. In Anne Arundel County, 308 overdoses of heroin and other opioids were reported last year. This year, Anne Arundel County Executive Steve Schuh declared a public health emergency related to heroin abuse and Maryland Governor Larry Hogan called it a statewide crisis, creating the Heroin and Opioid Emergency Task Force.

Prescription narcotic abuse is often a first step to heroin addiction. Narcotic painkillers are easy to get hooked on, and when people can't get enough pain medication from doctors to satisfy their need, they may turn to street sources. A shocking 80 percent of all heroin users made the switch to heroin after abusing narcotic painkillers, according to the U.S. Substance Abuse and Mental Health Services Administration.

"Once you start buying those narcotics on the street, you realize how expensive they are," says Edward McDevitt, MD(http://findadoc.aahs.org/Details/10574?index=1&lastName=McDevitt), an orthopedic surgeon with Bay Area Orthopaedics & Sports Medicine. "Then it's very easy to switch to heroin, because it's 10 times more euphoria-producing and 10 times cheaper than oxycodone."

The Danger for Athletes

A recent study in the Journal of Adolescent Health found that boys who participate in organized sports have a higher chance of being prescribed narcotics and a higher chance of abusing them than boys who do not play sports. However, girls are more likely to be prescribed narcotics and to abuse them than boys, whether or not they play sports.

Mandy Larkins, prevention education coordinator at Pathways(http://www.pathwaysprogram.org/), Anne Arundel Medical Center's substance use and mental health treatment center, has seen first-hand that narcotic abuse often starts unintentionally. "People are in pain and they don't read the directions on their prescriptions," says Mandy. "So if it says take two every six hours and they're in pain in two hours, they're taking it again."

"A sports injury can be very painful, so we might give strong narcotics," says Dr. McDevitt. "But if you take too many or for too long, you're stuck, because your body says, 'I need more of them.'"

Programs at Pathways

Outpatient Opioid Detox Program

This new Pathways program allows patients to safely withdraw from opioids over a period of three to six days, followed by ongoing professional support in recovery. For more details, visit **PathwaysProgram.org**(http://www.PathwaysProgram.org) or call **443-481-5400.**

Family Wellness Workshop

A therapeutic and educational program for family members of adults or teens with substance use disorders brings together family members for on-site group therapy, educational sessions and personal growth. The program equips family members with

communication skills, relapse prevention strategies and coping mechanisms for ongoing recovery. Full-day and weekend sessions are available. Call **410-573-5449** or visit PathwaysProgram.org(http://www.PathwaysProgram.org). The next session is **December 4–6**.

Be Cautious About Narcotics

"I recommend that parents ask about non-narcotic options when their child has a sports injury," says Mandy. "Especially if they know that there is a family history of addiction, then I would say to try other options for pain relief first."

Dr. McDevitt often prescribes anti-inflammatory medications and directs his patients to apply an analgesic rub or spray for pain relief. He also encourages athletes to consider physical therapy or chiropractic care to help them recover from an injury.

When narcotic painkillers are necessary, ask to start with a small prescription. "Doctors don't know how much pain a patient is going to be in, so they might just go ahead and prescribe 30 pills," says Mandy. But most people don't finish a 30-pill prescription, and leftover narcotics in a medicine cabinet can tempt a family member or acquaintance. Mandy recommends asking the doctor, "Can I start out with five pills, and if I need more, can I contact you?"

If you do have leftover pills, ask your pharmacy if they accept unused pills, or take them to a police department medication disposal box.

Medication Disposal

The Anne Arundel County Police Department has drop boxes at four locations for the safe disposal of unused, expired or unwanted medications(http://www.aahealth.org/programs/env-

hlth/housing/med-disposal). Residents can drop off medications at anytime daily at the following four district stations:

- Northern District located at 939 Hammonds Lane in Baltimore, Maryland.
- Southern District located at 35 Stepneys Lane in Edgewater, Maryland.
- Eastern District located at 204 Pasadena Road in Pasadena, Maryland.
- Western District located at 8273 Telegraph Road in Odenton, Maryland.

Communication Is Key

Don't wait for your child to have a sports injury to talk about taking medicines responsibly. "Talk to your teens about this before it even becomes a problem," advises Mandy. Kids need to understand that they should take only the medications that are prescribed to them, and they should only use them for the purpose the doctor prescribed them. Anything else is narcotics misuse or abuse.

Mandy believes it is important to talk openly and honestly not just with our kids, but with
each other, so we understand that addiction can happen to anybody. "Unfortunately, a lot of really good people start taking these pain medicines, and they can't help but get addicted to them," says Dr. McDevitt.

Once addicted to opioids, "most people cannot just stop," says Mandy. "It's an evil, sickening withdrawal, so they're going to need help."

"Sports injuries are just one of many paths young people can follow to

addiction, but we have to fight this crisis on all fronts, and we don't want parents left saying, 'I wish I knew,'" says AAMC Chief Medical Officer Mitchell Schwartz, MD(http://www.aahs.org/aboutus/bios/Schwartz_Mitchell.php). "Beyond educating parents, we're encouraging area primary care providers, who are often on the front lines of treating sports-related and other injuries, to know the best practices for prescribing narcotics."

"And one of the most important roles the hospital can play in the community is to talk openly about this, removing the stigma associated with addiction so people aren't ashamed to get help for themselves or their loved ones," adds Dr. Schwartz. Removing the stigma is a big step toward ending the crisis.

AAMC's **Pathways Treatment Center**(http://pathwaysprogram.org/) offers individualized substance abuse and mental health treatment. Call **443-481-5400** for more information.

Contributors

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***Mandy Larkins** is a prevention education coordinator at Pathways and can be reached at **410-573-5428**.*

Mitchell Schwartz, *MD, is AAMC's Chief Medical Officer.*

Living Healthier together
Anne Arundel Medical Center

(http://www.aahs.org/living/)

JAN 15, 2016

THE POWER OF PARENTS IN PREVENTING SUBSTANCE ABUSE

→ Register for a Family Wellness Workshop

(http://www.pathwaysprogram.org/classes.php)

The heroin epidemic in Maryland continues to make headlines. Heroin deaths in Anne Arundel County are on pace to double since 2013, and recently Maryland Governor Larry Hogan and Anne Arundel County officials declared it a "public health emergency."

But as any parent would tell you, it's not just heroin they worry about but a whole host of temptations that seem to be impacting kids at even younger ages.

"The decision-making center of the brain is not fully developed in adolescents; therefore, teens have a difficult time making decisions when presented with a risky situation," says Amanda Larkins , prevention education coordinator for Pathways(http://www.pathwaysprogram.org/classes.php). "We need to focus on training teens to stop and think about decisions. Parents should consider practicing with their teens."

Parents are still the #1 influence on their teens. According to research done by the Substance Abuse and Mental Health Services Administration, approximately 93 percent of teens reported their parents would be disappointed if they used alcohol, cigarettes or other drugs.

So what power do parents have in preventing substance use disorders?

"Parents can make all the difference with family bonding or increased face-time. "The more engaged parents are with their children, the less likely kids are to act out inappropriately," says Debra Ament, family program supervisor for Pathways(http://www.pathwaysprogram.org/).

The Academy of Pediatrics calls it Purposeful Parenting(https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/EBCD/Documents/PurposefulParentingInitial.pdf). The National

Institute on Drug Abuse(http://www.nih.gov/about/almanac/organization/NIDA.htm) cites the importance of family bonding saying it is the bedrock of the relationship between parents and children.

"Bonding can be strengthened through parent supportiveness of their kids, effective communication, and parental involvement," adds Ament. "This can be as simple as sitting down at the dinner table each night and discussing our day's events. This face-time is so important!"

Some tips to keep in mind:

- Be a parent to your child, not a friend.
- Educate yourself(http://preventsubstanceabuse.org) about what's happening in your child's school, in the community and about resources available to help.
- Be a positive role-model and promote positive behaviors.
- Communicate effectively.

Effective communication helps reassure family members that they care about each other and appreciate each other's efforts. Good everyday communication can also make it easier to bring up issues, make requests when needed, and resolve conflict when it arises.

Every family needs ongoing communication about shared interests and concerns—running the household, recreational activities, and solving problems—to name just a few. Family members also need to be able to express feelings to each other, emotions such as happiness, anger, sadness, concern, and anxiety.

The Hazelden Betty Ford Foundation(http://www.hazelden.org/) offers these tips on things to remember for effective communication with your child:

Expressing Positive Feelings

We all feel good when our efforts are acknowledged. When we give people positive feedback about what they've done, however small, we let them know they are appreciated. And that sense of being noticed and cared about can help foster further change and growth. Try deliberately expressing positive feelings using these steps:

1. Look at the person.
2. Tell the person what he or she did that pleased you.
3. Tell him or her how it made you feel. For example: *"I'm proud of you for talking to your teacher about that, even though I know you didn't feel like it."*

Expressing Negative Feelings

We all have negative feelings at times. Learning to express them constructively is crucial to resolving conflicts and getting along with others. To air negative feelings in a way that will help resolve them, try these steps:

1. Look at the person and talk with a serious tone of voice.
2. Tell the person what he or she did that displeased you.
3. Tell him or her how you feel as a result—be specific
4. Make a request for change, if possible. For example: *"I was worried when you didn't come home from school at your usual time. In the future, if you think you're going to be late, please call me."*

Express Feelings Clearly with "I" Statements

Describe your own feelings and avoid putting others on the defensive. By using words such as "angry," "happy," "upset," or "worried," you can

tell your own truth and help prevent the misunderstandings that can occur when people have to guess each other's feelings. "I" statements, such as "I feel anxious when . . . ," are direct, and they make an impression. When upset feelings are involved, "I" statements work better than blaming "you" statements.

For example, instead of saying "You really ticked me off when you were late for dinner last night" (a blaming statement), try this: "I was angry when you came home late for dinner last night. I'd appreciate it if you'd be on time or call if you're going to be late."

✚ Do you have a family member struggling with drug use, alcohol use, or a combination of substance use and mental health problems?

Pathways(http://www.pathwaysprogram.org/) hosts one-day and weekend "Family Wellness Workshops" to help families gain facts and understanding about addiction, substance use and co-occurring mental health issues, as well as relapse prevention strategies. At Pathways, we believe that family involvement is an integral part of the recovery process. For more information on upcoming workshops click **here**(http://www.pathwaysprogram.org/classes.php) or call **410-573-5449**. If you're traveling in from out of town, you may want to check into staying at our **Hackerman-Patz House**(http://bit.ly/1KZdupK).

Living Healthier together
Anne Arundel Medical Center

(http://www.aahs.org/living/)

DEC 15, 2015

PREVENTING PRESCRIPTION ADDICTION IN SENIORS

As a prevention education coordinator at Pathways(http://www.pathwaysprogram.org/), Anne Arundel Medical Center's substance use and mental health treatment center, Mandy Larkins is in the community daily. She works to prevent anyone from having to deal with the devastating disease of addiction. "It can affect anyone, any age, any socioeconomic group, any gender and any race," she says. Senior citizens are at greater risk for addiction if they take multiple medications and take prescription pain medications.

According to the National Clearinghouse for Alcohol and Drug Information, up to 17 percent of adults age 60 and over abuse prescription drugs. Common medications of abuse include narcotic pain killers, sleeping pills and tranquilizers.

To help prevent prescription addiction, Mandy reminds seniors to ask questions when talking to their doctors about certain medications. Questions to ask include:

- Does this medication have an addictive tendency?
- What are the side effects and will it interact with my current medications?
- What is the least amount of time I will need to take this medicine?
- Are there other options for this medication?

Social drinking while taking medications can also cause a negative reaction, especially if someone is taking several prescriptions. "Social drinking could mean one glass of wine a night or it could mean five beers on a weekend, and these can certainly interact differently with medications," says Mandy. "Have a conversation with your doctor about social drinking and what the problems would be with drinking and taking new medication."

The warning signs of addiction are sometimes hard to separate from the side effects experienced from the medications. Mandy notes that a drug side effect will show up soon after the patient starts taking the new medication. In contrast, addiction might take some time to display its symptoms. You might not see symptoms until the patient stops taking the drug. Signs of addiction include:

- Differences in sleep
- Changes in appetite
- Fluctuations in mood or unusual behavior
- Taking more than the prescribed dose of medication
- Taking medication for reasons other than what it is prescribed

"It's important to talk to your doctor if you have been treated for any addiction earlier in life," says Mandy. "Certain medications could be trigger points for some people."

If you believe an elderly loved one may have an addiction problem, alert his or her physician. The right type of treatment will vary depending on the individual and the situation.

AAMC's Pathways Treatment Center(http://www.pathwaysprogram.org/) offers individualized substance abuse and mental health treatment. Call **410-573-5449** for more information.

Contributor

*(http://www.aahs.org/living/wp-content/uploads/Amanda-Larkins_fmt.jpeg)**Mandy Larkins** is a prevention education*

*coordinator at Pathways and can be reached at **410-573-5428**.*

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Anne Arundel Medical Center

(http://www.aahs.org/living/)

DEC 21, 2015

FEELING THE WINTER BLUES? SEASONAL AFFECTIVE DISORDER MAY BE TO BLAME

Seasonal affective disorder (SAD)

The holiday season is often referred to as the 'most wonderful time of the year' but sometimes keeping your spirits up can be hard work. In fact, for some, it feels impossible. Many people may have difficulty with the feelings holidays bring up from past experiences, or feelings of isolation. But in some cases, the holiday blues are caused by seasonal affective disorder (SAD) (http://aahs.netreturns.biz/HealthInfo/Story.aspx?StoryID=bcd8f993-dbab-4581-95fc-91c711436b82).

SAD affects millions of Americans each year, particularly in northern states. So what's the science behind this? The shorter days of winter—when people are exposed to less and less sunlight—seems to be the source of SAD. Lack of light may upset your biological clock, which controls your sleep-wake pattern and other important physical and mental rhythms. It can also cause problems with serotonin, which is your brain chemical that affects mood.

Symptoms of SAD may include feeling depressed, irritable, moody or anxious. SAD may also lead to a loss of interest in your favorite activities, a change in appetite (especially a craving for sweet or starchy foods), lack of energy, irritability and difficulty concentrating.

Light therapy 101

Some people with mild winter blues may find relief by taking long walks outside or spending time in front of a window during the day. Seasonal affective disorder can also be treated with light therapy. Light therapy brings complete remission of symptoms for 50 to 80 percent of people who use it. This involves exposure to full-spectrum lights bright enough to make a difference in brain chemistry.

During light therapy, you sit in front of a special fluorescent lamp that is encased in a box or mounted on a visor worn like a cap. The lamp gives off a bright white light, filters out ultraviolet radiation and

diffuses the light to limit glare. Light therapy takes about 30 to 90 minutes a day, and its best done in the morning. The therapy should be done every day until natural sunlight returns in the spring. If you stop too early, your symptoms may come back. When needed, SAD also can be treated with antidepressant medications.

How to cope

Don't let stress or depression ruin your holidays. The pressures of shopping, entertaining, family gatherings and overnight visitors can add even more stress. The American Psychological Association(http://www.psychiatry.org/) and other experts offer these tips for coping with holiday stress and depression:

- Avoid alcohol. It can make depression worse.
- Organize and prioritize your holiday activities. Be realistic about what you can do.
- Accept that feelings of sadness and loneliness may be present during the holidays.
- Do something for someone else, such as volunteering.
- Try activities that are fun and free. Take a drive to look at holiday decorations, play in the snow or go window-shopping.
- Spend time with people who are supportive and caring. Make new friends or contact someone you haven't seen for a while.
- Take time for yourself. Don't try to be responsible for everything—let others help out.
- Talk to your doctor. SAD can determine whether we enjoy—or simply endure—the holiday season. If you think you're experiencing SAD, your doctor can help.

AAMG Mental Health Specialists(http://www.aamgmentalhealthspecialists.com/) offers care for a full range of mental health needs including anxiety and depression. To schedule an appointment call **410-573-9000**.

Author

*(http://www.aahs.org/living/wp-content/uploads/Hoffman_Ray_MD.jpg)By **Ray Hoffman, MD**(http://bit.ly/1EUKw2D), a psychiatrist and psychoanalyst, and medical director of **AAMG Mental Health Specialists**(http://bit.ly/1KiU51g). You can reach his office at **410-573-9000.***

To listen to this article, click here(http://www.aahs.org/aamctv/radio/wp-content/uploads/WYPR-14-Dec-Dr.-Hoffman-Mental-Health-SAD-w-intro-as-MP3.mp3).

Published 11/28/2014. WYPR Medical Commentary for Dec. 2014.

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NOV 13, 2015

SAFEGUARD YOUR CHILD AGAINST CYBERBULLYING

As access to electronics continues to grow among teens and preteens, there's a disturbing trend that some have dubbed the "hate virus": cyberbullying. "The mental health consequences of this growing problem can be quite serious," says Melissa Wellner, MD(http://findadoc.aahs.org/Details/11803?

lastName=Wellner&Index=1), child and adolescent psychiatrist at AAMC. "Studies show higher rates of depression, suicidal thoughts and suicide attempts can be the result, and those of us in the mental health community are seeing this firsthand."

"This is an epidemic," concurs Doyle Batten, supervisor of school security for Anne Arundel County Schools(http://aacps.org/). Doyle says that around-the-clock online access means victims can't escape their tormentors after school, and that nearly all of the physical confrontations he sees at school can be traced to online interactions. "From a mental health standpoint and from a violence-prevention standpoint this is the most urgent thing I've seen."

Parents and guardians are the most important safeguards against cyberbullying fallout, says Dr. Wellner. That means being equipped to step in well before teasing, taunts or intimidation create a life-threatening problem. Here are some ways to keep on top of potential problems:

How to help your child avoid cyberbullying

• **Awareness and access**: As adolescents have near-universal online access, it may be more realistic to monitor their online use rather than to deny access. Be aware of the social media sites your child uses, and make sure you have passwords to accounts and devices.
• **Communicate**: Have regular, open-ended conversations about online activities with your child, and discuss responsible online behavior, such as never sharing personal information and that what you post may stick around forever.
• **Encourage reporting**: Young people should feel safe talking about cyberbullying, whether they are being victimized or someone they know is. Explain to younger children that reporting cyberbullying isn't tattling.
• **Know the signs**: A sudden drop in grades, frequent illness, withdrawing from friends or school activities, sleep and appetite

changes, and extreme irritability are all warning signs that something is wrong. It could be cyberbullying.

What to do if your child is a victim of cyberbullying

• **Listen**: Some mean or hurtful attacks may not seem serious to an adult, but they can be very serious to a young person. Victims need to feel heard.
• **Question**: Without judging, ask open-ended questions to understand the underlying cause.
• **Report**: Contact a teacher, school counselor and/or administrator. If the bullying involves physical threats or is sexual in nature, it should be reported to the police.
• **Understand the law**: Cyberbullying doesn't always rise to the level of a crime. If you think it may, talk to the police or a school safety officer for guidance. In cases of sexually suggestive or explicit materials, kids and parents need to understand that both the bully and the victim may be implicated in a crime if the victim is a minor and willingly took or distributed explicit photos of himself or herself.
• **Seek help**: Bullying can pose a serious threat to physical and mental health. Your child may need professional help developing coping mechanisms, social skills, assertiveness, or friendship skills to prevent and guard against cyberbullying.

What to do if your child is the cyberbully

• **Teach empathy**: Some bullies think it's funny to tease or hurt someone online. In some cases they simply don't realize the impact of their activity and need to be taught to empathy.
• **Seek help**: Sometimes children bully because of low self-esteem or because they are being bullied. If your child is bullying as a way to cope with his or her own emotions, seek the help of a mental health professional.
• **Teach consequences**: Parents need to stress that bullies may lose their phones or online accounts. They may face legal charges. If their

bullying behavior is sexual in nature it can lead to the bully being registered as a sex offender.

RESOURCES

AAMG Mental Health Specialists
AAMC's outpatient mental health clinic(http://www.aamgmentalhealthspecialists.com/) on Riva Road offers mental health services, including a counseling group for kids from 12 to 17 to discuss issues such as bullying self-esteem, body image, family dynamics, school stress and more.
410-573-9000

Anne Arundel County Mental Health Agency Warmline
24/7 information, assistance and referrals
410-768-5522

Anne Arundel County Public Schools Student Safety Hotline
877-676-9854

AACo PD Speak Out App
Allows anyone to discretely contact Anne Arundel County school police officers
http://aacopdspeakout.myapp.name(http://aacopdspeakout.myapp.name)

Maryland Youth Crisis Hotline
800-422-0009

Contributors

(http://www.aahs.org/living/wp-content/uploads/Melissa-Wellner-1-lighter-back.jpg)

Melissa Wellner, MD, is a child and adolescent psychiatrist at

AAMC. Call **410-573-9000** to make an appointment with Dr. Wellner or another professional at AAMG Mental Health Specialists(http://www.aamgmentalhealthspecialists.com/).

(http://www.aahs.org/living/wp-content/uploads/Doyle_Batten.jpg)

Doyle Batten is supervisor of school security for Anne Arundel County Schools(http://aacps.org/).

Living Healthier together
Anne Arundel Medical Center

(http://www.aahs.org/living/)

NOV 12, 2015

WHEN WORDS HURT: ANOTHER KIND OF DOMESTIC VIOLENCE

When discussing domestic violence, I often hear comments like, "I'm lucky not to know anyone affected by domestic violence," or "I have never been exposed to anything like

that." Most people are not only surprised to learn domestic violence is not always as obvious as a black eye—a lot of people, in fact, have been exposed in some capacity.

While domestic violence can include physical and sexual violence, the most elusive kind of abuse is emotional abuse. Unlike physical abuse, the people doing it and receiving it may not even be aware it is happening.

Emotional abuse can be more harmful than physical abuse. Even in the most violent families, the incidents tend to be cyclical—a violent outburst, followed by a honeymoon period with remorse and attention that eventually ends, and then the violence starts over again. But with emotional abuse, it happens every day. The effects are more harmful because they're so frequent. This emotional abuse can happen between a parent and child, husband and wife, among relatives, and between friends.

The other factor that makes emotional abuse so devastating is victims are more likely to blame themselves. When the words directed at you seem subtle—if the abuser says you're unattractive, fat, dumb or unlovable—it's easier to assume this is your own doing. But if someone hits you, it's easier to see that he or she is the problem. It can undercut what we think about ourselves and impair our ability to be our true selves and escape the abuse.

> "With emotional abuse, the abuser projects their words, attitudes or actions onto an unsuspecting victim. One person controls the other by undermining his or her trust, value, development, or emotional stability, or causes fear or shame by manipulating or exploiting that person."

And it's not so much about the words used, rather the threatening effects of the behavior by the abuser. The body language, tone and actions by an abuser oftentimes contradict the words. And this is very destructive to the victims.

Warnings signs of abuse can include: decreased interaction with friends and family, constantly receiving phone calls or text messages inquiring about location and activity, seemingly anxious to please the partner, making excuses for partner's behavior, going along with everything the partner says and does, decreased productivity at work or school, personality changes, lowered self-esteem, and limited access to transportation and money. These signs of abuse are more common and often overlooked.

The support of family and friends can be helpful. But professional counseling will provide the victim with tools to prevent, cope and move on from an abusive situation.

Anne Arundel Medical Center's Abuse and Domestic Violence Program(http://www.aahs.org/domesticviolence/) has professionally trained staff available to help patients, employees and community members.

✚ For information about abuse, visit our domestic violence website(http://www.aahs.org/domesticviolence/), call 443-481-1209 or email(mailto:abusedv@aahs.org) us. For a 24-hour Domestic Violence Hotline, call 410-222-6800.

Author

Rae Leonard, Anne Arundel Medical Center's abuse and domestic violence program coordinator, can be reached at 443-481-1209.

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(http://www.aahs.org/living/)
AUG 25, 2015

HOVERING PARENTS CAN LEAD TO ANXIOUS KIDS

The term "helicopter parent" may have been recently coined, but it's certainly not a new phenomenon. The term is applied to parents who "hover over" their children, like a helicopter, paying extremely close attention to their experiences and problems, both in everyday life and academic settings.

Parents may feel as if they're looking out for their children's welfare and helping their children excel, but there's a downside to being overly involved and concerned. Studies are finding significantly higher levels of anxiety and depression in college students and young adults with helicopter parents.

Why might that be? For one, helicopter parents may not allow their children to experience adversity and establish a sense of their own competence at managing things in the world around them. They can also convey a sense that perfection is what is required and demanded.

Studies on the mental health of our youth confirm the harm done by expecting little when it comes to independence, yet much when it comes to achievements in school, sports or other extracurricular activities.

Kids who are used to having their parents make every decision for them may face quite a shock when they enter a stage of life where more independence is expected, such as college or work. Inevitable small setbacks can feel like big failures, and a lack of feelings of self-sufficiency can lead to anxiety and depression.

One of the primary developmental tasks of adolescence is to create a growing sense of autonomy. Healthy functioning depends on learning to navigate between demands that are too extreme—creating too much anxiety—and a realistic sense of what is actually required in the world for success. Part of normal development has to involve processes of trial and error.

What can parents do to help?

- **Get comfortable with failure.** The feeling of disappointment can be actually beneficial and children need to know you accept them as imperfect. Talk openly about dealing with setbacks or failures to help your child develop coping skills and emotional resilience.

- **Be mindful of praise.** We all know lack of approval can be devastating to children. At the same time, confidence grows from overcoming challenges, not being told how great you are all the time. Strike a balance, and keep in mind that sometimes "good" truly ought to be good enough.

- **Remember, you're the role model.** It's important to handle your own disappointments with grace—your kids are watching you. Help them see that adults make mistakes and experience setbacks. Own your decisions, and let them take ownership of theirs.

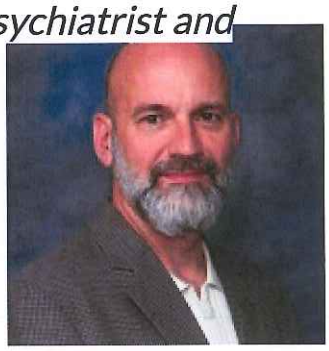
It can be difficult for parents to experience the world as complicated and demanding and not be highly anxious about their children going out into it. Parents should support their children when they fail, but they shouldn't prevent their child from ever experiencing failure.

It's the ability to go out into the world, experience some degree of failure, and pick oneself up to try again that gives an individual a healthy sense of the resources they have inside themselves to successfully navigate a path through life—a path that is truly theirs, not someone else's.

AAMG Mental Health Specialists(http://bit.ly/1KiU51q) is currently enrolling adults and teens into its Cognitive Behavioral Therapy Group to help with anxiety and depression, its Anger Management Group, and its Tween/Teen Girls Talking Group. If you're interested in learning more or enrolling in a group therapy session, please call **410-573-9000**.

Author

*By **Ray Hoffman, MD**(http://bit.ly/1EUKw2D), a psychiatrist and psychoanalyst, and medical director of **AAMG Mental Health Specialists**(http://bit.ly/1KiU51q). You can reach his office at **410-573-9000**.*



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(http://www.aahs.org/living/)

OCT 23, 2015

4 WAYS PARENTS CAN PREVENT UNDERAGE DRINKING

In Anne Arundel County, one in four youth ages 12-20 reported alcohol use in the past 30 days, according to the 2013 Youth Risk

Behavior Survey(http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx) conducted by the Maryland Department of Health and Mental Hygiene. That's higher than both the state and national averages. Even more troubling is parents' role in underage drinking.

"Parents are giving alcohol to their child and their child's friends because they think it's safer for kids to drink under parental supervision," says Sandy Smolnicky, prevention specialist for the Anne Arundel County Health Department. "In reality, it's illegal and dangerous for everyone involved."

A recipe for disaster

Regardless of intention, providing alcohol to your child's friends is prohibited by law. Parents can be prosecuted, fined and sued. Alcohol also puts kids at risk for sexual assault, violence, alcohol poisoning, drunk driving, addiction, and delayed brain development. But the outcomes don't have to be extreme to warrant parents' attention.

"Your child might just wake up the next morning feeling sick or embarrassed, but you still don't want that for them," says Mandy Larkins, prevention education coordinator for Pathways(http://www.pathwaysprogram.org/), Anne Arundel Medical Center's (AAMC) substance use and mental health treatment center. "With social media, kids are posting embarrassing pictures and videos online for everyone to see. These pictures don't disappear, and they can really affect kids' future plans."

Parents and prevention

Preventing the consequences of underage drinking begins by changing the attitudes that justify it, and the perceptions that perpetuate it. That's the idea behind the county-wide campaign, "Parents Who Host, Lose the Most(http://preventsubstanceabuse.org/parents-who-host-lose-the-most/)," funded by a grant from the Maryland Highway Safety Office.

Aimed at addressing parents' roles(http://www.aahs.org/living/?p=4371) in preventing underage drinking, the campaign is promoted especially during times when parents are more likely to host parties, such as homecoming and prom seasons.

"We need to change the way kids think about drinking, and that starts with parents," says Mandy. "There's no prescription for parenting, but there are things parents can do to create a positive, healthy culture for their kids that doesn't involve alcohol."

Tips for parents

1. **Communication is key.** Take initiative to talk to your child about the risks of drinking.
    1. Know where your child is and establish times for them to call (not text) you.
    2. Set up a contract with your child to form clear guidelines and expectations.
    3. If your child gets into trouble, maintain an open line of communication, avoid accusatory language and establish a consequence together.
2. **Offer alternatives.** Engage your child in activities that don't involve alcohol.
    1. Host alcohol-free parties and encourage other parents to do the same. To anonymously report a party, call the Anne Arundel County Police Department tip line at 443-390-8477.
    2. Encourage your child to get involved in extracurricular activities.
    3. Celebrate your child's achievements.

3. **Be involved. Stay informed.** Play an active role in your child's life.
    1. Know your child. Choose strategies that work for their personality.
    2. Get to know your child's friends. Get to know their parents.
    3. Educate yourself on current trends and lingo related to teen partying so you can identify warning signs when you see them.
4. **Set an example.** Be aware of how you use alcohol in front of your child.
    1. If you depend on alcohol to cope with stress or have fun at social events, your child may learn to imitate those habits.
    2. If you keep alcohol in your home, ensure your child cannot access it.

For more information on AAMC's Pathways, visit PathwaysProgram.org(http://www.pathwaysprogram.org/).

Mandy Larkins is a prevention education coordinator for Pathways and can be reached at 410-573-5428.

Sandy Smolnicky is a prevention specialist for the Anne Arundel County Health Department and can be reached at 410-222-7095.

Sources:

Anne Arundel County Health Department(http://preventsubstanceabuse.org/parents-who-host-lose-the-most/)

Drug Free Action Alliance(https://www.drugfreeactionalliance.org/parents-

who-host)

Maryland Department of Health and Mental Hygiene(http://dhmh.maryland.gov/SitePages/Home.aspx), 2013 Youth Risk Behavior Survey(http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx)

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(http://www.aahs.org/living/)
OCT 23, 2014

WHY MEN SHOULDN'T IGNORE DEPRESSION

Even a tough guy goes to the hospital if a tree falls on his head. So why won't men seek medical help when their world comes crashing down on them, as it can with depression? Nearly 6 million American men experience depression each year, yet few seek treatment.

Perhaps men don't realize that depression is a disease—not a weakness. Or maybe they're not aware that successful treatments exist. No matter the reason, depression is a disease that shouldn't be ignored by anyone—including men.

Recognizing depression

"The vast majority of people who seek treatment for depression end up feeling better," says Raymond Hoffman, MD(http://findadoc.aahs.org/Details/11565?lastName=hoffman&Index=1), a psychiatrist and the medical director of mental health and substance abuse at AAMC. It's a good idea to visit your doctor if you're experiencing these signs and symptoms of depression:

- loss of energy or increased fatigue
- restlessness, anger or irritability
- a lack of interest in favorite activities
- sleep problems
- changes in appetite
- excessive feelings of sadness, worthlessness or guilt
- trouble concentrating, remembering or making decisions
- thoughts of, or attempts at, suicide

Your doctor can check to see if physical problems are affecting your emotional health. Plus, he or she can refer you to a therapist or counselor who will work with you to relieve your symptoms.

It's OK to ask for help

"It may not be easy to talk about how you're feeling," Dr. Hoffman says. "But depression can seriously interfere with your work and personal

life. Acknowledging it and getting treatment can help you get your life back to normal."

Additional sources: American Psychiatric Association; American Psychological Association; National Institute of Mental Health

FOR IMMEDIATE RELEASE
Contact: Kelly Swan, cell: 443-690-0682

EXPANDED SUPPORT FOR FAMILY MEMBERS OF PEOPLE WITH SUBSTANCE USE DISORDERS
—Pathways Grant-Funded Workshop Now Able to Educate More Families—

ANNAPOLIS, Md. (date) – Pathways, Anne Arundel Medical Center's (AAMC) alcohol and drug treatment center has expanded its Family Wellness Workshop program to now include both one day and full weekend sessions. The expansion was made possible through a generous grant from the William J. and Dorothy K. O'Neill Foundation.

The program offers education and therapeutic support for family members of adults or teens struggling with substance use and mental health concerns. "This program gives families a chance to gain a deeper understanding of what their loved ones are going through," says Debra Ament, family program supervisor. "We know that more than 65 percent of people suffering from substance use disorders also suffer from mental health issues. This workshop helps families understand this and prepares them to support their loved one on the road to recovery." Workshop participants will:

- Learn about addiction, substance use and co-occurring mental health issues.
- Review relapse prevention strategies.
- Examine stages of recovery for family members.
- Develop effective skills for communication, coping and boundary-setting.
- Participate in adventure therapy to increase self-awareness and behavioral changes that are important to the recovery process.
- Develop supportive relationships with other families.

Go to **PathwaysProgram.org** for more information. The next three workshops will be held on March 7, April 17 through 19, and May 2. Additional dates are planned through December. Cost is $10 per person or $15 for two people for full day Saturday programs and $20 per person or $30 for two people for full weekend programs with breakfast and lunch provided. To register, please call **410-573-5449**.

About Anne Arundel Medical Center
Anne Arundel Medical Center (AAMC), a regional health system headquartered in Annapolis, Md., serves an area of more than one million people. Founded in 1902, AAMC includes a 425-bed not-for-profit hospital, a medical group, imaging services, a substance use treatment center, and health enterprises. In addition to a 57-acre Annapolis campus, AAMC has outpatient pavilions in Bowie, Kent Island, Odenton, and Waugh Chapel. AAMC is nationally recognized for its joint replacement center, emergency heart attack response and cancer care. A leader in women's services, AAMC delivers the state's second highest number of births annually and has a Level 3 NICU. With more than 1,000 medical staff members, 3,900 employees and 750

volunteers, AAMC consistently receives awards for quality, patient satisfaction and innovation. To learn more, visit askAAMC.org.

FOR IMMEDIATE RELEASE

Pathways Receives Substance Abuse Care Award

(ANNAPOLIS, Md., June 16, 2014)—Pathways, an affiliate of Anne Arundel Medical Center, earned national recognition for delivering highly effective, cost-effective inpatient substance abuse care.

The Platinum award designation by Optum, formerly known as United Behavioral Health, bases its honor on clinical data such as such as readmission rates and the average length of inpatient stays collected throughout the year. The data is compared to that of other regionally-based facilities and Pathways exceeds nearly all areas.

Pathways offers diagnosis and treatment programs for adolescents and adults with inpatient and outpatient alcohol and/or drug addiction treatment. Comprehensive inpatient and outpatient programs are tailored to the individual patient's needs, with on-site family involvement as an integral part of the recovery process. Extensive continuing care and relapse prevention programs offer patients the important support they need to make the transition to a substance free lifestyle and successful return to the family, school, work and the community.

For more information about Pathways, call (410) 573-5400 or visit askAAMC.org/PathwaysProgram.

About Anne Arundel Medical Center

Anne Arundel Medical Center (AAMC), a regional health system headquartered in Annapolis, Md., serves an area of more than one million people. Founded in 1902, AAMC includes a 425-bed not-for-profit hospital, a medical group, imaging services, a substance use treatment center, and health enterprises. In addition to a 57-acre Annapolis campus, AAMC has outpatient pavilions in Bowie, Kent Island, Odenton, and Waugh Chapel. AAMC is nationally recognized for its joint replacement center, emergency heart attack response and cancer care. A leader in women's services, AAMC delivers the state's second highest number of births annually and has a Level 3 NICU. With more than 1,000 medical staff members, 3,900 employees and 750 volunteers, AAMC consistently receives awards for quality, patient satisfaction and innovation. To learn more, visit askAAMC.org.

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Raymond Stephen Hoffman, M.D.

EDUCATION

Doctor of Medicine, Creighton University School of Medicine, Omaha, NE, 1987
Bachelor of Arts, summa cum laude, Saint Mary's University of Minnesota, Winona, MN, 1983
University of North Dakota, Grand Forks, ND – 1979-1980

MEDICAL TRAINING

New York Freudian Society Psychoanalytic Training Institute, Graduate, March 2000
Mercy Center for Eating Disorders, Baltimore, MD, Fellow, 1991-1992
University of Maryland, Department of Psychiatry, Resident in psychiatry, 1987-1991

LICENSURE AND CERTIFICATION

American Board of Neurology and Psychiatry, Board Certification in Psychiatry, since 1993
Maryland Board of Physician Quality Assurance, licensed since 1988

PROFESSIONAL EXPERIENCE

Anne Arundel Medical Center, Division Director, Mental Health and Substance Abuse, (2013—present)

- current role encompasses leadership of a regional medical center psychiatric and substance abuse services division with inpatient, emergency department, partial hospital, and outpatient services across the mental health and substance abuse spectrum.

Mosaic Community Services, Inc., Chief Medical Officer (2004-2013)

- role involved overseeing 19 prescribers who worked clinically in outpatient, crisis residential, and mobile treatment teams, and oversight of clinical processes, documentation, peer review, and clinical quality improvement in a CARF-accredited mental health service agency providing clinical, residential, and rehabilitative services to ~6000 children, adolescents, and adults in Baltimore City, Baltimore County, and Carroll County, Maryland.

Contemporary Freudian Society, (Formerly New York Freudian Society)

- Training and Supervising Analyst, (2009—present)
- Chair, Progressions Committee (2013-present)
- Chair, Subcommittee on Evaluations (2009-2013)

Family Service Foundation, Consulting Psychiatrist (2002-2004)
University of Maryland Department of Psychiatry, Division of Community Psychiatry, Walter P. Carter Clinics, 1993-2002

- Medical Director, 1998-2002
- Senior Staff Psychiatrist, Fayette Street Clinic, 1995-1998
- Staff Psychiatrist, 1993-1995

University of Maryland Department of Psychiatry, Division of Education (1998-2002)

- Grand Rounds Coordinator, 1998-2002

Chase Brexton Clinic, Consulting Psychiatrist (1992-1995)
Whitman-Walker Clinic, Washington, D.C., Consulting Psychiatrist (1993-1994)
Baltimore County Eastern Regional Mental Health Center, Consulting Psychiatrist (1992-1993)
Private Practice of Psychiatry, 1991-present

UNIVERSITY EXPERIENCE

Division of Community Psychiatry

Community Division Best Practices Committee (chair), 2001-2002
Community Division Quality Improvement Committee, 2000-2002

Division of Education

Psychotherapy Competencies Committee, 2000-2001
PGY III Site Coordinator, Walter P. Carter Clinics, 1998-2002
Course Master, Supportive Psychotherapy (PGY II and III), 1998-2002
Course Lecturer, Clinical Interviewing (PGY I), Dissociative Disorders, 2000-2002
Course Lecturer, Combining Psychotherapy and Psychopharm (PCY IV), 2000-2002
Course Lecturer, Topics in Human Sexuality (PGY IV), 2001-2002
Supervisor, Individual Psychotherapy (PGY III and IV), 1993-2002
Supervisor, Combined Accelerated Program in Psychiatry (MS II, III, IV), 1995-2002

Presentations:

Hoffman, Raymond S. (March 2013) Psychoanalytic Diagnosis Through the Lens of the Expected Evolution of the Transference, presented at Baltimore Society for Psychoanalytic Studies, Towson, MD.

Hoffman, Raymond S. (May 2011) The Male-Gendered Preoedipal Good Object, presented at George Washington University Conference on Diversity, "Breaking the Glass Ceiling: Multiple Diverisities in the New Millenium," Washington, DC.

Publications:

Hoffman, Raymond S. (2002). Working with a Patient's Defenses in Supportive Psychotherapy. Psychiatric Services, Vol.53:141-142

Dawn K. Hurley

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(240) 444-1037

Accomplished progressive administrator with over 26 years of extensive experience leading people, developing and expanding healthcare programs and providing consultative services for healthcare systems. Expertise in increasing operating revenues, and enhancing service utilization. Proven track record in the successful planning and direction of activities that improve clinical outcomes.

Career Progression:

Anne Arundel Medical Center 2001 Medical Parkway Annapolis, MD. 21046	08/2014- present	Executive Director of Behavioral Health
Mosaic Community Services 1925 Greenspring Drive Timonium, Maryland 21093	01/1990-08/2014	Division Director of Adult Psychiatric Rehabilitation and Addiction Services

Professional experience:

- Responsible for the business development, marketing, supervision and oversight for Anne Arundel Medical Center's Emergency Department's psychiatric services, ambulatory outpatient mental health clinic and psychiatric partial hospitalization program. Additional roles include community outreach and working collaboratively with AAMC's leadership to provide the fullest continuum of services for mental health and substance use.
- Works collaboratively with the leadership to facilitate the development, communication, and implementation of the behavioral health strategic plan that is consistent with the health system's vision, mission and goals.
- Evaluates, monitors and reports on the impact of annual strategic planning, introduction of new programs, services and strategies and regulatory interaction.
- Develops implements and evaluates clinical performance against quality indicators. Assures programs are compliant with all AAMC, Joint Commission, local, state, federal and governing body policies and procedures.
- Oversaw the operations of two large outpatient clinics within the Baltimore Metropolitan area serving 19,000 adults with co-occurring disorders. This included developing and implementing a tele-behavioral

health program that enhanced coordination of care between physicians and consumers.

- Assisted in the development of a Behavioral Health Home for individuals with chronic mental health and substance use disorders.
- Regularly reviewed and recommend changes in program services to CEO, with particular emphasis on services for underserved populations.
- Provided oversight of multiple program evaluations and quality assurance functions, including assessment of applicable legal and professional requirements.
- Developed and implemented integrated case management services within a psychiatric rehabilitation program providing crisis, day, outpatient mental health services, community employment, and residential services.
- Managed utilization review department, which was responsible for concurrent and retrospective consumer chart audits to measure clinical performance, as well as issues that may have affected MA reimbursement.

Additional Professional Activity:

- Appointed to serve on the Governor's Task Force for Behavioral Health Initiatives.
- Served and held office on numerous advisory and advocacy organizations within the industry, such as the Professional Development Committee and the Community Behavioral Health Organization (CBH), and MADC (Maryland Addiction Directors Council).
- Presented at various conferences on topics affecting consumers with disabilities, such as the National Council for Behavioral Health.
- Served as a Board member for the YMCA of Central Maryland

EDUCATION:

2008-2012 Loyola College of Maryland, Baltimore, Maryland-
12 credits post-graduate towards LCPC certification

M.A., 1996 Bowie State University, Bowie, Maryland
Towson State University, Towson Maryland
Major: Counseling Psychology

B.A., 1988 University of Maryland Baltimore County, Catonsville, Maryland
Major: Psychology/ Social Work
Minor: Women's Studies

PROFESSIONAL AFFILIATIONS

Psychiatric Rehabilitation Association (PRA, formerly USPRA)
Certified Psychiatric Rehabilitation Practitioner

Barbara S. Jacobs, MSN, RN-BC, CCRN
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bjacobsrn@gmail.com

PROFESSIONAL EXPERIENCE

Suburban Hospital/Johns Hopkins Medicine Bethesda, MD
Sr. Director, Nursing /Chief Nurse Officer
September 20, 2010 to July 2015

Responsible for all aspects of nursing operations including financial, human resource, compliance and patient care for 230 bed, level II trauma, community not for profit hospital. Suburban Hospital is a member of Johns Hopkins Medicine and is affiliated with NIH on several major programs including the NIH Stroke Center and NIH Heart Center/Cardiothoracic Surgery.

Accomplishments include:

- Supported four hospital based shared governance nursing councils to engage front line nursing staff in decision making. Some of these councils' major accomplishments :
    - Development of peer reviewed falls prevention program which has brought falls rate below national benchmarks with very limited sitters and no restraints on med-surg units
    - ABNS (American Board of Nursing Specialty) 2014 Award for Nursing Certification Advocacy
    - New RN Clinical Ladder Model
    - New Peer Review Nursing evaluation process
    - New Nursing Practice Model calling attention to Patient Centered Care http://www.hopkinsmedicine.org/news/publications/dome/may_2011/visualizing_exemplary_practice
    - New dress code developed and implemented
    - First nursing led research projects undertaken
- Established unit based nursing councils on all units
- Led hospital through NICHE certification and establishing geriatric care as a priority for hospital
    - Recipient of 2013 Niche Conference Video Award https://www.youtube.com/watch?v=wQqmRnhnR5w
- Led the development of a Patient Family Advisory Council as co-chair with Family Advisor. This has truly transformed the relationship between staff and patient/families. Accomplishments include:
    - PFAC members on most hospital committees and on Medical Quality Board
    - PFAC members present at all new employee orientation and are embedded in nursing unit quality improvement activities including CUSP teams
    - PFAC, nursing councils, and hospital education committee partnered to develop a new Patient Interactive Handbook which received the 2015 Grand Prize Clear Mark Award from Institute of Plain Language http://centerforplainlanguage.org/clearmark/2015-clearmark-winners/#mg_ld_9336
- Established a nurse residency program to augment new graduate training already in place
- Revised new nursing orientation, including specialty areas (ICU, ED, Cardiothoracic Critical Care), to insure competency, improve quality and reduce length of orientation.
- Facilitated and supported extremely smooth transition from legacy software to Epic July 2015
- Improved HCAHPS scores through multiple tactics including:
    - Established daily interactive unit huddles with established format
    - Revised patient communication boards
    - Established bedside shift report on all units
    - Post discharge calls made to all discharged patients
    - Partnering with physician colleagues to invite patient/family on daily rounds
- Assisted in smooth transition of hospital to Kaiser Preferred status with Kaiser surgery and medical admissions
- Developed nursing staffing and tracking plan to insure efficient management of flexible staffing 24/7.
- Facilitated multi-disciplinary Standards of Behavior Committee which re wrote our Standards of Behavior and policy on enforcement.
- Led hospital wide initiative to develop slogan for patient engagement – Your Care Our Passion
- Led revision of unit secretary role to one centered more on the patient experience
- Partnered with team to develop No One Dies Alone program http://www.bethesdamagazine.com/Bethesda-Magazine/July-August-2015/At-Suburban-Hospital-No-One-Dies-Alone/

- Acted as executive lead on multiple quality and patient safety initiatives including CUSP team and state and national programs in critical care, open heart, med-surg
- Board Member: Potomac Home Health, Potomac Home Support and Suburban Surgical Center

George Washington University Hospital Washington, DC

Director of Critical Care

November 1997 – September 16, 2010

Responsibilities included continuous administrative and clinical responsibility for a 48 bed adult critical care and respiratory therapy department. George Washington University Hospital (GWUH) is 371 bed academic medical center operated in a limited partnership between Universal Health Services, Inc (a for profit healthcare management company) and the George Washington University. Critical care beds include cardiothoracic, neurosurgical, general surgical, trauma, general medical and cardiac medicine.

In addition responsibilities included:

- Inpatient wound care June 2009 – 2010
- Emergency Department (64,000 visits) August 2007- October 2009
- Cardiac Catheterization Laboratory, Interventional Laboratory and Heart Station December 2008 – January 2009
- Cardiac telemetry unit (45 beds) January 2006 – January 2009

- Participated in re-design team for ED staffing which developed role of ED greet technician and improved triage nursing that allowed for consistent LWBS of less than 3%
- Eliminated Emergency Department daily agency nurse use ($200,000/yr to zero)
- Co-chair of Value Analysis Committee from 2000 - 2009
- Directed development of IV standardization and drug library protocols for all nursing and anesthesia
- Championed development of hypothermia, skin care, glycemic control and VAP prevention protocols
- Participated in multiple six sigma teams to improve hospital performance
  - ED Team: Time to triage reduced from 19.7 to 10.3 minutes. Left Without Being Seen decreased to 1.6%
  - MRI Team: Inpatient MRI performed less than 24 hours from the time of order improved from 69% to 90%
  - ED Throughput: Improved and made more efficient communication between med-surg nursing and ED
  - CLABSI: Active multidisciplinary committee to reduce CLABSI and improve compliance with bundles
- Collaborated with Cardiac Surgeons on a multi-disciplinary Cardiac Surgery Task force which developed protocols for care that have resulted in exceptional STS verified patient outcomes. (This committee was the recipient of the 2007 DCHA Patient Safety Award.)
- Active participant on the hospital Pharmacy and Therapeutics Committee which presides over drug selection, protocols and cost effective management of pharmaceuticals. Significant cost savings relating to critical care protocols and practice have been done through my collaboration with intensivists.
- Developed staffing grids that allowed for efficient management of employees while providing safe and effective clinical care
- Acted as leader for city wide collaborative (DCFEMS and 7 hospitals) in developing STEMI protocols that were initiated in Jan 2009. Wrote application which resulted in this group receiving DCHA 2009 Patient Safety Award.
- Chair of Critical Care Committee comprised of multidisciplinary representatives from ICU, ED, Cath Lab, NICU, and Anesthesia (*First nursing chair to this normally physician led committee)*
- Standardized care through all critical care units to improve patient safety while ensuring nursing competency
- Established critical care daily management model that allows for extremely flexible movement of patients and staff resulting in a more efficient patient flow
- Worked with manager of operations to develop position control product for nursing
- Created extremely successful nurse internship program that allows new graduates to transition to critical care in 12 week program
- Led hospital team in major purchasing decisions for cardiac monitoring, IV pump purchases, and bed purchases
- Initiated Tandem Heart ECMO program in ICU and Impella program in cardiac catheterization lab and ICU
- Participated as nursing leader on the planning for the design and opening of new GWUH in August 2002
- Coordinated the movement of critical care patients and all patients requiring respiratory support during the move to GWUH new hospital August 2002
- Led the development, and continued participant in the hospital Transplant Committee. The hospital is a multi-year recipient of awards from Department of HHS for excellence.
- Led development and education of hospital wide Rapid Response Team

- Regularly taught in many hospital educational offerings to employees including nursing internship, charge nurse classes, rapid response training, and perceptions of care training

George Washington University Hospital Washington, DC
Interim Chief Nurse Officer
June 2006 - May 2007 & November 2009 - May 2010

- Directed all financial, budgeting, operating, compliance, purchasing, human resource, and administrative functions for the Department of Patient Care Services through these transitional periods
- Successfully guided hospital through Joint Commission surveys during April 2007 and April 2010
- Led hospital through multiple Washington DC Department of Health surveys
- Re-organized nursing Practice Committee to allow for more efficient flow of practice policies, and developed model which allows all department practice policies to be reviewed by one committee
- Implemented aggressive re-direction of hospital managers to ensure compliance regarding employee competency
- Significantly reduced agency use by guiding nursing focus to a more efficient use of current resources
- Developed nursing Retention and Recruitment Plan with Director of Human Resources and CFO
- Improved HCAHPS scores in test units through joint undertaking with Director of Quality
- Utilized outstanding relationships with nursing staff, physicians, and other unit department directors to develop short/long term organizational goals and objectives (Quality Improvement, HCAHPS, employee engagement, etc.)
- Re-designed classes to better prepare new charge nurses for employee management, critical thinking and chain of command
- Provided stability, expert management and leadership during transitional periods while occupying dual roles (Interim CNO & Director of Critical Care)

George Washington University Hospital Washington, DC
ICU Charge Nurse and Nursing Supervisor
March 1992 – November 1997

- Developed multiple policies in ICU as a part time staff nurse/charge nurse that allowed for standardization of care, such as development of "ICU Standards of Care"
- Recipient of first Zimmerman Award which recognizes one exceptional bedside critical care nurse per year

Cooper University Hospital Camden, NJ
Hahnemann University Hospital Philadelphia, PA
Thomas Jefferson University Hospital Philadelphia, PA
January 1982 – March 1992 (exact dates can be provided for each institution if needed)

- Worked in a variety of Intensive Care/Coronary Care/Cardiothoracic Surgery/Trauma units as a part time staff nurse developing clinical expertise in a variety of areas

Middlesex General Hospital (now known as Robert Wood Johnson Hospital) New Brunswick, NJ
Staff nurse, Head Nurse and Assistant Director of Nursing for Medicine
June 1977 - December 1981

- Progressed from staff nurse (new graduate) to head nurse and then Assistant Director of Nursing within 4 years of graduation
- Responsible for all aspects of management for 110 medical beds
- Cultivated exceptional relationships with physicians that allowed for standardization of care and development of patient protocols

EDUCATION

George Washington University, MSN - Leadership & Management — Washington, DC
University of Rochester, BSN — Rochester, NY

PROFESSIONAL ACTIVITIES AND MEMBERSHIPS

Maryland Organization of Nurse Executives, Current President (2014-2016)
Member, Greater Washington Area Chapter, AACN, 2004 - current
George Washington University Nursing Honor Society, Founding Member at Large, 2008
American Association of Critical Care Nurses
Sigma Theta Tau
Emergency Nurses Association
American Association of Nurse Executives
Society of Critical Care Medicine
American College of Chest Physicians

BOARD OF ADVISORS

Cardiothoracic Critical Care (FACTS-CARE) Advisory Board, 2005 - current
Marymount University Nursing Board, 2010
Masimo Corporation Advisory Board, 2010

AWARDS

Zimmerman Award for Nursing Excellence, ICU, 1994
Presidential Scholarship, Rutgers University, 1981

CERTIFICATIONS

CCRN by AACN since 1986
RN-BC in Gerontological Nursing by ANCC September 2011

SELECTED PRESENTATIONS

Jacobs, B. (2003, May). How signal extraction technology has improved patient care. For Masimo Technology. National Teaching Institute, American Association of Critical Care Nurses, San Antonio, TX.
Jacobs, B. (2004, April.) Critical care nursing. Presented at the Cardiothoracic Surgery Critical Care Conference, Washington, DC.
Jacobs, B. (2004, November). DVT/PE silent killers. Presented at the Spotlight on Critical Care, Maryland: Greater Washington Area Chapter, American Association of Critical Care Nurses.
Jacobs, B. (2004, May). How signal extraction technology has improved patient care. Presented at the National Teaching Institute Masimo Technology (Ed.), Orlando, FL: American Association of Critical Care Nurses.
Jacobs, B. (2005, June). Creation and maintenance of the critical care environment: Taking care of the care providers. Panel member presented at the Cardiothoracic Surgery Critical Care Conference, Washington, DC.
Jacobs, B. (2005, March). DVT/PE silent killers. Takoma Park, MD: Washington Adventist Hospital.
Jacobs, B. (2005, June). Increasing safety in the ICU. Panel member presented at the Cardiothoracic Surgery Critical Care Conference, Washington, DC.
Jacobs, B. (2005, November). Non invasive ventilation. Presented at the Spotlight on Critical Care, Maryland: Greater Washington Area Chapter, American Association of Critical Care Nurses.
Jacobs, B. (2006, March). DVT/PE., Maryland: Suburban Hospital.
Jacobs, B. (2006, March). DVT/PE., Washington, DC: Providence Hospital.
Jacobs, B. (2006, March). DVT/PE., Maryland: Holy Cross Hospital.

Jacobs, B. (2007, March). Glycemic control. Panel member presented at the Cardiothoracic Surgery Critical Care Conference, Washington, DC.
Jacobs, B. (2007, 2008, 2009, April and November). Anticoagulants, antithrombolytics and antiplatelets for GWUH nursing. Washington, DC: George Washington University Hospital.
Jacobs, B. (2009, May). Organ donation. Panel member presented at the Washington Regional Transplant Consortium, Fairfax, VA.
Jacobs, B., & Rickman, H. (2009, March). Death in the ICU. Presented at the Cardiology Grand Rounds, Washington, DC: George Washington University.
Jacobs, B., & Welch, S. (2008, November). Continuous renal replacement therapy. Presented at the Spotlight on Critical Care, Springfield, VA: Greater Washington Area Chapter, American Association of Critical Care Nurses.
Jacobs, B. (2009, October) Panel member, Cardiovascular-Thoracic Critical Care Conference, Washington, DC.
Jacobs, B. (2010, October) Panel member, Cardiovascular-Thoracic Critical Care Conference, Washington, DC
Jacobs, B. (2011, October) Panel member, Cardiovascular-Thoracic Critical Care Conference, Washington, DC
Jacobs, B. (2011, December) Feedback, essential skill of leadership, MONE Nurse Manager Conference, Hagerstown, MD
Jacobs, B. (2012, April) Transition in Care at Community Hospital, Transitions in care: perspectives for clinicians and caregivers (symposium), Rockville, MD
Jacobs, B. (2012, October 14) For Our Patients: Maintain the Gain Maryland Hospital Association Conference. Presented with Jennifer Anderson, Kimberley Kelly on CLABSI initiatives at Suburban Hospital.
Jacobs, B. (2012, October) Panel member, Cardiovascular-Thoracic Critical Care Conference, Washington, DC
Jacobs, B. (2013, October) Panel member, Cardiovascular-Thoracic Critical Care Conference, Washington, DC
Jacobs, B (2014, October) Panel member, Cardiovascular-Thoracic Critical Care Conference, Washington, DC
Jacobs, B (2015, March) Anticoagulants and Antiplatelet Medication, Presented at Mended Hearts Association, Takoma Park, MD

PUBLICATIONS/EXHIBITIONS

Jacobs, B. (2003, July). Smart choices lead to substantial savings in pulse oximetry. Healthcare Purchasing News.
Jacobs, B. (2005, January). Pump away high-risk infusion errors. Nursing Management, 36(2), 40-44.
Jacobs, B. (2005, January). Raise your smart pump IQ: Gain further perspectives on this key medication safety tool. Nursing Management, 36(2), 40-44.
Jacobs, B. (2006, May). Averting high risk dosing errors with infusion pump programming. Poster presented at the National Teaching Institute, Anaheim, CA: American Association of Critical Care Nurses.
Jacobs, B. (2006, April). Pump away high-risk infusion errors. Men in Nursing, 1(2), 6-9.
Jacobs, B. (2006, October). Using an infusion pump safely. Nursing, 37(18), 24.
Sattarian, M., Shesser, R., Sikka, N., Salazar, L., Jacobs, B., & Howard, R. (2008, October 1). Variability among emergency department charge nurses in the efficiency of patient bed assignment. Annals of Emergency Medicine, 52(4), S132.
Sattarian, M., Shesser, R., Sikka, N., Salazar, L., Jacobs, B., & Howard, R. (2009, May 1). Variability among emergency department charge nurses in the efficiency of patient bed assignment. Powerpoint presentation at the Virtual Exhibition of Nursing Honor Society, Washington, DC: George Washington University.
Chawla, LS, Akst, S., Junker, C., Jacobs, B., Seneff, MG. (2009, October 5). Surges of electroencephalogram activity at the time of death: a case series. Journal of Palliative Medicine.
Jacobs, B. (2014) Cited Reviewer for book: S. Burns. AACN Essentials for Critical Care Nursing. McGraw Hill Publishing
Jacobs, B (2014) Cited Reviewer for book: S. Burns. AACN Essentials for Progressive Care Nursing. McGraw Hill Publishing

STEVEN R. SCHUH
County Executive

ANNE ARUNDEL COUNTY
MARYLAND

P.O. Box 2700 | Annapolis, Maryland 21404
(410) 222-1821 | countyexecutive@aacounty.org | www.aacounty.org

March 1, 2016

Victoria W. Bayless, President and Chief Executive Officer
Anne Arundel Medical Center
2001 Medical Parkway
Annapolis, Maryland 21401

RE: New Special Psychiatric Hospital Building

Dear Ms. Bayless:

Anne Arundel Medical Center has requested that Anne Arundel County grant approval for a 66,000 square-foot building that AAMC seeks to construct on the Riva Road campus where AAMC currently operates Pathways (a substance-abuse and co-occurring mental health disorders treatment facility). The property is owned by Anne Arundel County and is leased to AAMC. In this new building, AAMC intends to establish a new, special psychiatric hospital with 16 patient beds, and a partial-hospitalization, mental-health day program.

On January 6, 2016, representatives of AAMC made an informative presentation about the proposed facility to the County's Chief Administrative Officer, Director of the Department of Public Works, Planning and Zoning Officer, County Health Officer, County Attorney, and to me.

Based on the information provided to us during the presentation, it is evident that this project will create a comprehensive, integrated campus providing a continuum of inpatient and outpatient mental-health and substance-abuse services. Given the enormous need for such services in our County, I would like to express my strong support for this project. My expectation is that, subject to review and acceptance of AAMC's final plans, all applicable approvals will be issued by Anne Arundel County.

In order to facilitate the issuance of the various approvals required for development and construction of the new building, I have appointed Chief Administrative Officer Mark Hartzell to serve as a coordinator for all relevant County agencies. I have also instructed all County agencies to give this matter the highest priority so as to facilitate the process of development and construction. The County approvals required for this project are routine in nature, and I foresee no impediments to AAMC obtaining all necessary approvals in a timely manner.

Additionally, I have asked the County Attorney to make appropriate revisions to the Ground Lease dated November 30, 1990, to facilitate the development process and to authorize the new facility as an allowable use. I expect these revisions to be completed so that AAMC will have control of the site no later than November 1, 2016.

On behalf of all citizens of Anne Arundel County, I want to thank the leadership of AAMC for taking the initiative to expand the network of substance-abuse and mental-health services in our County.

Sincerely,

Steven R. Schuh

SLH

Received 1-10-91
Woodward

ANNE ARUNDEL COUNTY
MARYLAND

OFFICE OF LAW
HERITAGE OFFICE COMPLEX
2662 RIVA ROAD
ANNAPOLIS, MARYLAND 21401 - 7374
Annapolis (301) 222 - 7827
Baltimore (301) 222 - 7827
Washington (301) 970 - 8250 x 7827
FAX (301) 222 - 7589

January 7, 1991

COUNTY ATTORNEY
Stephen R. Beard

DEPUTY COUNTY ATTORNEY
Stephen M. LeGendre

SENIOR ASSISTANT COUNTY ATTORNEY
Robert M. Pollock

ASSISTANT COUNTY ATTORNEYS
Cheryl P. Boudreau
Mary Blakemore Gentner
Sarah M. Iliff

M. Lucinda Motsko, Esquire
Venable, Baetjer & Howard
Suite 1800
2 Hopkins Plaza
Baltimore, MD 21201

Re: Pathways Ground Lease

Dear Cindy:

Enclosed please find a fully executed original of the Ground Lease. Thank you for your cooperation in finalizing this portion of the documentation for this important project.

Very truly yours,

Stephen M. LeGendre
Deputy County Attorney

SML/llw

Enclosure

cc: Adrian G. Teel, Chief Administrative Officer
David E. Woodward, Director, Pathways Treatment Center (with copy)

GROUND LEASE

by and between

ANNE ARUNDEL COUNTY, MARYLAND

and

ANNE ARUNDEL GENERAL TREATMENT SERVICES, INC.

Table of contents

TEMP EASEMENT

Exhibits

GROUND LEASE

THIS GROUND LEASE (hereinafter referred to as "this Lease"), made as of the 30th day of November, 1990, by and between ANNE ARUNDEL COUNTY, a body corporate and politic organized and existing under the law of Maryland having an address at 44 Calvert Street, Annapolis, Maryland 21401 (hereinafter referred to as "the Named Landlord"), and ANNE ARUNDEL GENERAL TREATMENT SERVICES, INC., a Maryland corporation having an address at Franklin and Cathedral Streets, Annapolis, Maryland 21401 (hereinafter referred to as "the Named Tenant"),

WITNESSETH, THAT FOR AND IN CONSIDERATION of the mutual covenants and agreements of the parties hereto, as are hereinafter set forth, and for other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged by each party hereto, the Named Landlord hereby leases to the Named Tenant and the Named Tenant hereby leases from the Named Landlord all of that tract of land (hereinafter referred to as "the Land") on Harry S. Truman Parkway in Anne Arundel County, Maryland, consisting of 9.079 acres more or less and which is described in Exhibit A,

TOGETHER WITH any and all rights, alleys, ways, waters, privileges, appurtenances and advantages, to the same belonging or in any way appertaining (all of which, together with the Land, are hereinafter referred to collectively as "the Premises").

SUBJECT TO THE OPERATION AND EFFECT of the Permitted Encumbrances,

TO HAVE AND TO HOLD the Premises unto the Named Tenant, its successors and assigns, for the term of years set forth herein,

UPON THE TERMS AND SUBJECT TO THE CONDITIONS which are hereinafter set forth:

Section 1. Definitions.

1.1. As used herein, the following terms have the following meanings

1.1.1. "Additional Rent" has the meaning given it by the provisions of subsection 3.1.

1.1.2. "Annual Rent" has the meaning given it by the provisions of subsection 3.1.

1.1.3. "Bankruptcy" shall be deemed, for any person, to have occurred either

(a) if and when such person (i) applies for or consents to the appointment of a receiver, trustee or liquidator of such person or of all or a substantial part of its assets, (ii) files a voluntary petition in bankruptcy or admits in writing its inability to pay its debts as they come due, (iii) makes an assignment for the benefit of its creditors, (iv) files a petition or an answer seeking a reorganization or an arrangement with its creditors or seeks to take advantage of any insolvency law, (v) performs any other act of bankruptcy, or (vi) files an answer admitting the material allegations of a petition filed against such person in any bankruptcy, reorganization or insolvency proceeding; or

(b) if (i) an order, judgment or decree is entered by any court of competent jurisdiction adjudicating such person a bankrupt or an insolvent, approving a petition seeking such a reorganization, or appointing a receiver, trustee or liquidator of such person or of all or a substantial part of its assets, or (ii) there otherwise commences with respect to such person or any of its assets any proceeding under any bankruptcy, reorganization, arrangement, insolvency, readjustment, receivership or similar law, and if such order, judgment, decree or proceeding continues unstayed for any period of sixty (60) consecutive days after the expiration of any stay thereof.

1.1.4. "the Building" means the building to be constructed in accordance with the provisions of Section 8.1, and any and all alterations and additions thereto and replacements thereof hereafter existing on the Premises.

1.1.5. "Building Service Equipment" means all apparatus, machinery, devices, fixtures, appurtenances, equipment and attached personal property now or hereafter located within the Building and necessary for the proper operation and maintenance of the Building including, by way of example rather than of limitation, any and all awnings, shades, screens and blinds; asphalt, vinyl, composition and other floor, wall and ceiling coverings; partitions, doors and hardware; elevators, escalators and hoists; heating, plumbing and ventilating apparatus; gas, electric and steam fixtures; chutes, ducts and tanks; oil burners, furnaces, heaters, incinerators and boilers; air cooling and air conditioning equipment; washroom, toilet and lavatory fixtures and equipment; engines, pumps, dynamos, motors, generators, electrical wiring and equipment; window washing hoists and equipment; refrigerators, dishwashers, disposals, ranges and other installed kitchen appliances and all additions thereto and replacements thereof but not including any furnishings or health care equipment or other personal property of Tenant considered to be trade fixtures.

1.1.6. "the Commencement Date" has the meaning given it by the provisions of subsection 2.1.

1.1.7. "Condemnation" has the meaning given it by the provisions of Section 12.

1.1.8. "Default" has the meaning given it by the provisions of subsection 16.1.

1.1.9. "Event of Default" has the meaning given it by the provisions of subsection 16.2.2.

1.1.10. "the Fee Estate" means the fee simple estate in the Premises, subject to the operation and effect of this Lease.

1.1.11. "Force Majeure" means any (a) strike, lock-out or other labor troubles, (b) governmental restrictions or limitations, (c) failure or shortage of electrical power, gas, water, fuel oil, or other utility or service, (d) riot, war, insurrection or other national or local emergency, (e) accident, flood, fire or other casualty, (f) adverse weather condition, (g) other act of God, (h) inability to obtain a building permit or a certificate of occupancy, or (i) other cause similar or dissimilar to any of the foregoing and beyond the reasonable control of the person in question.

1.1.12. "the Improvements" means the Building and any and all other buildings, structures or other improvements (including, by way of example rather than of limitation, any and all parking facilities, roads, walk-ways, terraces, truck-loading and dockage facilities and, to the extent of the Tenant's interest therein, fencing and utility lines) existing on the Premises on the date hereof or hereafter constructed during the Term, and any and all alterations and additions thereto and replacements thereof hereafter existing on the Premises.

1.1.13. "Institutional Lender" means any commercial bank or trust company (whether acting indirectly or in a fiduciary capacity), savings bank, savings and loan institution, pension, profit or retirement fund or trust, insurance company authorized to do business in Maryland, governmental agency, fund, revenue or development authority or other financial or lending institution whose loans on real estate or with respect thereto are regulated by state or federal law or any other governmental entity or any combination of Institutional Lenders.

1.1.14. "Insurance Requirements" has the meaning given it by the provisions of Subsection 4.2.1.

1.1.15. "the Landlord" means the Named Landlord and its heirs, personal representatives, successors and assigns as holder of the Fee Estate.

1.1.16. "the Land Records" means the Land Records of Anne Arundel County, Maryland.

1.1.17. "Lease Year" means (a) the period commencing on the Commencement Date and terminating on the first (1st) anniversary of the last day of the calendar month containing the Commencement Date, and (b) each successive period of twelve (12) calendar months thereafter during the Term.

1.1.18. "the Leasehold Estate" means the leasehold estate in the Premises held by the Tenant under this Lease.

1.1.19. "the Leasehold Mortgage" has the meaning given it by the provisions of subsection 13.1.

1.1.20. "the Leasehold Mortgagee" means the person secured by a Leasehold Mortgage.

1.1.21. "Legal Requirements" has the meaning given it by the provisions of Subsection 4.2.1.

1.1.22. "Mortgage" means any mortgage or deed of trust at any time encumbering any or all of the Property or any interest therein, and any other security interest therein existing at any time under any other form of security instrument or arrangement used from time to time in the locality of the Property (including, by way of example rather than of limitation, any such other form of security arrangement arising under any deed of trust, sale-and-leaseback documents, lease-and-leaseback documents, security deed or conditional deed, or any financing statement, security agreement or other documentation used pursuant to the provisions of the Uniform Commercial Code or any successor or similar statute), provided that such mortgage, deed of trust or other form of security instrument, and an instrument evidencing any such other form of security arrangement, has been recorded among the Land Records or in such other place as is, under applicable law, required for such instrument to give constructive notice of the matters set forth therein.

1.1.23. "Mortgagee" means the person secured by a Mortgage.

1.1.24. "the Named Landlord" means the person hereinabove named as such.

1.1.25. "the Named Tenant" means the person hereinabove named as such.

1.1.26. "the Net Condemnation Proceeds" has the meaning given it by the provisions of Section 12.

1.1.27. "the Original Term" has the meaning given it by the provisions of subsection 2.1.

1.1.28. "the Permitted Encumbrances" means any and all instruments and matters of record on the date hereof, (which matters are listed in a Schedule attached hereto as Exhibit B), and anything that a physical inspection or survey of the Land would disclose.

1.1.29. "person" means a natural person, a trustee, a corporation, a partnership and any other form of legal entity.

1.1.30. "Plans and Specifications" has the meaning given it by the provisions of subsection 8.1.

1.1.31. "the Premises" has the meaning given it hereinabove; provided, that if at any time hereafter any portion of the Premises becomes no longer subject to this Lease, "the Premises" shall thereafter mean so much thereof as remains subject to this Lease.

1.1.32. the "Project" has the meaning given it in Section 4.1.

1.1.33. "the Property" means the Premises, the Improvements and the Building Service Equipment.

1.1.34. "Rent" means all Annual Rent and all Additional Rent.

1.1.35. "Renewal Term" has the meaning given it by the provisions of subsection 2.1.2.

1.1.36. "Restoration" means the repair, restoration or rebuilding of any or all of the Property after any damage thereto or destruction thereof, with such alterations or additions thereto as are made by the Tenant in accordance with the provisions of this Lease, together with any temporary repairs or improvements made to protect the Property pending the completion of such work.

1.1.37. "Taxes" has the meaning given it by the provisions of subsection 5.1.

1.1.38. "the Tenant" means the Named Tenant and its heirs, personal representatives, successors and permitted assigns as holder of the Leasehold Estate.

1.1.39. "the Term" means the Original Term and any Renewal Term.

1.1.40. "the Termination Date" has the meaning given it by the provisions of subsection 2.1.

1.1.41. "Vesting Date" has the meaning given it by the provisions of Subsection 12.2.2.

1.2. Any other term to which meaning is expressly given by the provisions of this Lease shall have such meaning.

Section 2. Term.

2.1. Length.

2.1.1. Original Term. This Lease shall be for a term (hereinafter referred to as "the Original Term") commencing on that date specified in writing by Tenant in accordance with the provisions of Section 22 (hereinafter referred to as "the Commencement Date"), and (b) terminating at 11:59 o'clock P.M. on the day immediately preceding the thirtieth (30th) anniversary of the first (1st) day of the first (1st) full calendar month during the Original Term (which date is hereinafter referred to as "the Termination Date," except that if the date of such termination is hereafter advanced to an earlier date or extended pursuant to the provisions of Subsection 2.1.2. or any other provision of this Lease, or by express, written agreement of the parties hereto, or by operation of law, the date to which it is advanced, extended or postponed shall thereafter be "the Termination Date" for all purposes of the provisions of this Lease).

2.1.2. Renewal Term. The Tenant shall have the right to renew this Lease for three separate and consecutive renewal terms of ten (10) years each (individually, or collectively, the "Renewal Term"), commencing on the expiration date of the Original Term, or the expiration date of the then current Renewal Term, as the case may be, upon all of the same terms, conditions and covenants as are applicable to the Original Term. Tenant may exercise this right of renewal, if at all, by issuing written notice to Landlord of its election to renew this Lease at least six months prior to the expiration

date of the Original Term or the then current Renewal Term, as the case may be.

2.1.3. Confirmation of commencement and termination. The Landlord and the Tenant shall at the Landlord's request after (a) the commencement of the Original Term, or (b) the expiration of the Term or any earlier termination of this Lease by action of law or in any other manner, confirm in writing by instrument in recordable form that, respectively, such commencement or such termination has occurred, setting forth therein the Commencement Date and the Termination Date.

2.2. Surrender. The Tenant shall, at its expense, at the expiration of the Term or any earlier termination of this Lease, (a) promptly yield up to the Landlord the Premises, the Building and the rest of Improvements (but only to the extent Tenant is responsible for the maintenance attendant to such Improvements), and the Building Service Equipment, in good order and repair (ordinary wear and tear excepted) and broom clean, (b) remove therefrom the Tenant's signs, goods and effects and any machinery, trade fixtures and equipment which are used in conducting the Tenant's trade or business and are not part of the Building or the Building Service Equipment or not otherwise already owned by the Landlord, and (c) repair any damage to the Property caused by such removal. Upon such expiration or termination (whether by reason of an Event of Default or otherwise), (a) neither the Tenant nor its creditors and representatives shall thereafter have any right at law or in equity in or to any or all of the Property (including the Building and the rest of the Improvements) or to repossess any of same, or in, to or under this Lease, and the Landlord shall automatically be deemed immediately thereupon to have succeeded to all of the same, free and clear of the right, title or interest therein of any creditor of the Tenant or any other person whatsoever (but subject to the rights of any person then holding any lien, right, title or interest in or to the Fee Estate), and (b) the Tenant hereby waives any and all rights of redemption which it may otherwise hold under any applicable law.

2.3. Holding over.

2.3.1. Nothing in the provisions of this Lease shall be deemed in any way to permit the Tenant to use or occupy the Premises after the expiration of the Term or any earlier termination of this Lease.

2.3.2. If the Tenant continues to occupy the Premises after the expiration of the Term or any earlier termination of this Lease without having obtained the Landlord's express, written consent thereto, then without

altering or impairing any of the Landlord's rights under this Lease or applicable law, (a) the Tenant hereby agrees to pay to the Landlord immediately on demand by the Landlord as Annual Rent for the Premises, for each calendar month or portion thereof after such expiration of the Term or such earlier termination of this Lease, as aforesaid, until the Tenant surrenders possession of the Premises to the Landlord, a sum equaling two hundred percent (200%) of the amount of the Annual Rent which would have been due and payable under the provisions of subsection 3.1.1, had the Landlord given its express, written consent to the Tenant's occupation of the Premises after the expiration of the Term or earlier termination of this Lease, as aforesaid, and (b) the Tenant shall surrender possession of the Premises to the Landlord immediately on the Landlord's having demanded the same. Nothing in the provisions of this Lease shall be deemed in any way to give the Tenant any right to remain in possession of the Premises after such expiration or termination, regardless of whether the Tenant has paid any such Rent to the Landlord.

Section 3. Rent.

3.1. Amount. As rent for the Premises, the Tenant shall pay to the Landlord

3.1.1. Annual Rent. Annual rent (hereinafter referred to as "Annual Rent") which for each Lease Year during the Original Term and any Renewal Term, is in the sum of One Dollar ($1.00); and

3.1.2. Additional Rent. Additional rent (hereinafter referred to as "Additional Rent") in the amount of any payment referred to as such in any provision of this Lease which accrues while this Lease is in effect (which Additional Rent shall include any and all charges or other amounts which the Tenant is obligated to pay to the Landlord under any of the provisions of this Lease, other than the Annual Rent).

3.2. When due and payable.

3.2.1. The Annual Rent for any Lease Year shall be due and payable in advance, on the Commencement Date, and thereafter, on the anniversary of the Commencement Date for the duration of the Term.

3.2.2. Any Additional Rent accruing to the Landlord under any provision of this Lease shall, except as is otherwise set forth herein, be due and payable when the installment of Annual Rent next falling due after such Additional Rent accrues becomes due and payable, unless the Landlord makes written demand upon the Tenant for payment

thereof at any earlier time, in which event such Additional Rent shall be due and payable at such time.

3.2.3. Each such payment shall be made promptly when due, without any deduction or setoff whatsoever, and without demand. Any payment made by the Tenant to the Landlord on account of Rent may be credited by the Landlord to the payment of any Rent then past due before being credited to Rent currently falling due. Any such payment which is less than the amount of Rent then due shall constitute a payment made on account thereof, the parties hereto hereby agreeing that the Landlord's acceptance of such payment (whether or not with or accompanied by an endorsement or statement that such lesser amount or the Landlord's acceptance thereof constitutes payment in full of the amount of Rent then due) shall not alter or impair the Landlord's rights hereunder to be paid all of such amount then due, or in any other respect.

3.3. Where payable. The Tenant shall pay the Rent, in lawful currency of the United States of America, to the Landlord by delivering or mailing it to the Landlord's address which is set forth hereinabove, or to such other address or in such other manner as the Landlord from time to time specifies by written notice to the Tenant.

3.4. Tax on Lease. If federal, state or local law now or hereafter imposes any tax, assessment, levy or other charge (other than any income tax) directly or indirectly upon (a) the Landlord with respect to this Lease or the value thereof, (b) the Tenant's use or occupancy of the Premises, (c) the Annual Rent, Additional Rent or any other sum payable under this Lease, or (d) this transaction, the Tenant shall pay the amount thereof as Additional Rent to the Landlord upon demand unless the Tenant is prohibited by law from doing so, in which event the Landlord may, at its election, terminate this Lease by giving written notice thereof to the Tenant.

Section 4. Use of Property.

4.1. Nature of use. The Tenant shall, throughout the Term, continuously use and operate the Premises and the Improvements for an adolescent and young adult substance abuse treatment facility (the "Project") and such other uses as are reasonably and customarily attendant to such use, provided however, that such use of the Premises may be changed to an alternative related use with the Landlord's prior written consent, which consent shall not be unreasonably withheld. If this Lease is assigned pursuant to a foreclosure of a Leasehold Mortgage or an assignment in lieu of foreclosure to any party that is unaffiliated with the Named Tenant thereafter, Landlord may not withhold consent to a change in use which is compatible

with the uses found on the surrounding properties if such change will not violate applicable zoning laws or impair the value of the Building or the rest of the Improvements.

4.2. Compliance with law and covenants. The Tenant, throughout the Term and at its sole expense, in its construction, possession and use of the Premises, the Building or the rest of the Improvements, and the Building Service Equipment,

4.2.1. shall comply promptly and fully with (a) all laws, ordinances, notices, orders, rules, regulations and requirements of all federal, state and municipal governments and all departments, commissions, boards and officers thereof (all of which are hereinafter referred to collectively as "Legal Requirements"); and (b) all requirements (i) of the National Board of Fire Underwriters (or any other body now or hereafter constituted exercising similar functions) which are applicable to any or all of the Property, or (ii) imposed by the provisions of any policy of insurance covering any or all of the Property and required by the provisions of Section 6 to be maintained by the Tenant (all of which are hereinafter referred to collectively as "Insurance Requirements"); each instrument or matter listed in Exhibit B, as aforesaid, all if and to the extent that any of the Legal Requirements, the Insurance Requirements or the said provisions relate to any or all of the Premises, the Improvements, the Building Service Equipment, the fixtures and equipment upon the Premises, or the use or manner of use thereof, whether any of the foregoing are foreseen or unforeseen, or are ordinary or extraordinary;

4.2.2. (without limiting the generality of the foregoing provisions of this subsection) shall keep in force throughout the Term all licenses, consents and permits required from time to time by applicable law to permit the Property to be used in accordance with the provisions of this Lease;

4.2.3. shall pay or cause to be paid when due all personal property taxes, income taxes, license fees and other taxes assessed, levied or imposed upon the Tenant in connection with the operation of any business upon the Property or its use thereof in any other manner;

4.2.4. shall not take or fail to take any action, as the result of which action or failure to act the Landlord's estate, right, title or interest in and to any or all of the Premises or the rest of the Property might be impaired; and

4.2.5. shall not in violation of applicable law (either with or without negligence) (a) cause or permit the escape, disposal or release of any biologically or chemically active or other hazardous substances or materials, or (b) allow the storage or use of such substances, or (c) allow any such substances to be brought onto the Property. For purposes of this Lease, "hazardous substances" shall include, without limitation, those described in the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended (42 U.S.C. sections 9601 et seq.), the Resource Conservation and Recovery Act, as Amended (42 U.S.C. sections 6901 et seq.), any applicable state or local laws, and the regulations adopted under these acts. If any lender or governmental agency ever requires Landlord to test to ascertain whether or not there has been any release of hazardous substances on the Premises occurring after the Commencement Date and while this Lease is in effect and provided further such testing occurs after the Commencement Date, then the reasonable costs thereof shall be reimbursed by the Tenant to the Landlord upon demand as additional charges if such requirement applies to the Premises. The Tenant shall execute affidavits, representations and the like from time to time at the Landlord's request concerning the Tenant's best knowledge and belief regarding the presence of hazardous substances on the Premises. The Tenant shall defend, indemnify and hold harmless the Landlord against and from any liability, claim of liability or expense arising out of any release of hazardous substances on the Premises occurring after the Commencement Date and while the Tenant is in possession thereof, or elsewhere if caused solely by the Tenant or solely by any person acting under the Tenant. The Landlord shall defend, indemnify and hold harmless the Tenant against and from any liability, claim of liability or expense arising out of the presence on the Premises of any hazardous substances deposited there before the Commencement Date, and any deposited there after the Commencement Date if deposited by Landlord or by Landlord's agents or contractors. The foregoing covenants shall survive the expiration or earlier termination of this Lease.

Section 5. Taxes.

5.1. The Tenant (a) shall bear the full expense of any and all real property or other taxes (or payments in lieu of real property taxes), metropolitan district charges or other assessments or charges which are levied against any or all of the Premises, the Building, the other Improvements and the Building Service Equipment, and are payable with respect to any calendar or tax year or other period falling wholly or partly within the Term (all of which are hereinafter referred to collectively as "Taxes"), except that if any such tax, charge or assessment is levied with respect to a period beginning

before the Commencement Date or ending after the Termination Date, the Tenant shall bear the full expense of only that percentage thereof equaling the percentage of such period falling within the Term; (b) shall pay the same when due and payable and before any penalty is incurred for late payment thereof; and (c) shall deliver to the Landlord the receipted bill for such Taxes paid within ten (10) days after the Landlord requests it from the Tenant in writing.

5.2. Each party hereto shall deliver to the other, promptly after such party's receipt thereof, the originals of any and all bills for Taxes and notices of assessments or reassessments made or to be made for the purpose of levying any Taxes. Landlord agrees to attempt to have the real property tax bills for the Premises delivered directly to Tenant.

5.3. Proceedings to contest. The Tenant may, subject to the provisions of any Leasehold Mortgage, and without postponing payment thereof, as aforesaid, bring proceedings to contest the validity or the amount of any Taxes, or to recover any amount thereof paid by the Tenant, provided that prior thereto the Tenant notifies the Landlord in writing that the Tenant intends to take such action. The Tenant shall indemnify and hold harmless the Landlord against and from any expense arising out of any such action. The Landlord shall, upon written request by the Tenant, cooperate with the Tenant in taking any such action, provided that the Tenant indemnifies and holds harmless the Landlord against and from any expense or liability arising out of such cooperation.

5.4 Tax Exemption. Tenant, as a non-profit corporation, has notified Landlord that Tenant intends to seek to continue the current property tax exemption for the Land. Landlord agrees to cooperate fully with Tenant, at Tenant's expense, in connection with any application for property tax exemption or appeal of any denial thereof. Landlord and Tenant agree that Tenant's operation of the Premises for a substance abuse treatment facility is for the general welfare of the people and thus is a "governmental use or purpose."

Section 6. Insurance and indemnification.

6.1. Insurance to be maintained by Tenant. Tenant will at all times during the term of this Lease maintain, at its expense, all liability and casualty insurance required by any Leasehold Mortgage, but in no event shall such insurance maintained by Tenant be less than the following:

6.1.1. insurance against loss or liability in connection with bodily injury, death or property damage or destruction, occurring in or upon the Property or arising out

of the use thereof by the Tenant or its agents, employees, officers, tenants, subtenants, invitees, visitors and guests, under one or more policies of public liability insurance having such limits as to each as are agreed upon by the Landlord and the Tenant in writing from time to time (but in any event of not less than Two Million Dollars ($2,000,000) combined single limit. All of such insurance shall, by its terms, be primary and noncontributory with respect to any other insurance carried by Landlord.

6.1.2. all-risk or fire and extended coverage insurance covering the Property (and any other casualty insurance covering the Property as may be agreed upon by the parties hereto), issued under a non-reporting policy and having such limits as are agreed upon by the Landlord and the Tenant in writing from time to time (provided, that such limits shall in any event be not less than the full insurable replacement cost of (i) the then-existing Improvements above their foundation walls and (ii) the Building Service Equipment, as determined without deduction for depreciation). If there is then a Leasehold Mortgage covering the Leasehold Estate in the Premises, the proceeds of any such all-risk, fire, extended coverage or other casualty policy shall be payable to the Leasehold Mortgagee thereunder as a named insured, as its interest may appear, provided that it has agreed in writing with the Landlord and the Tenant that such proceeds will be applied to the cost of rebuilding the Improvements and replacing the Building Service Equipment subject to the limits set forth in Section 9.

6.1.3. workmen's compensation insurance having such limits, and under such terms and conditions, as are required by applicable law.

6.2. Insureds. Each such policy shall name as insureds thereunder (a) the Tenant, (b) the Landlord, and (c) any Leasehold Mortgagee.

6.3. Cancellation. Each such policy shall, by its terms, not be cancelable unless at least thirty (30) days prior thereto written notice thereof is given to the Landlord and any Leasehold Mortgagee.

6.4. Insurer. Each such policy shall be issued by an insurer of recognized responsibility licensed to issue such policy in Maryland, which insurer shall have been approved in writing by the Landlord before policy issuance (which approval shall not unreasonably be withheld).

6.5. Evidence.

6.5.1. (a) At least ten (10) days before the Commencement Date, or simultaneously with Tenant's written notice to Landlord of the Commencement Date, the Tenant shall deliver to the Landlord an original or a signed duplicate copy of each such policy or a certificate evidencing such insurance in form satisfactory to Landlord, and (b) before any such policy expires, the Tenant shall deliver to the Landlord an original or a signed duplicate copy of a replacement policy therefor or a certificate thereof; provided, that

6.5.2. So long as such insurance is otherwise in accordance with the provisions of this Section, the Tenant may carry any such insurance under a blanket policy covering the Property for the risks and in the minimum amounts specified in subsection 6.1, in which event the Tenant shall deliver to the Landlord two (2) insurer's certificates therefor in lieu of an original or a copy thereof, as aforesaid.

6.6. Waiver of subrogation. If either party hereto is paid any proceeds under any policy of insurance naming such party as an insured, on account of any loss, damage or liability, then such party hereby releases the other party hereto, to and only to the extent of the amount of such proceeds, from any and all liability for such loss, damage or liability, notwithstanding that such loss, damage or liability may arise out of the negligent or intentionally tortious act or omission of the other party, its agents or employees; provided, that such release shall be effective only with respect to loss, damage or liability occurring during such time as the appropriate policy of insurance of the releasing party provides that such release shall not impair the effectiveness of such policy or the insured's ability to recover thereunder. Each party hereto shall use reasonable efforts to have a clause to such effect included in its said policies without any increase in the premium therefor, and shall promptly notify the other in writing if such clause cannot be included in any such policy without such increase (in which event such other party shall be entitled, at its election, to pay any such increase in the amount of such premium, whereupon the first such party shall have such clause included in its said policy).

6.7. Indemnification of Landlord. Except if and to the extent that the Tenant is released from liability to the Landlord pursuant to the provisions of subsection 6.6, the Tenant shall defend, indemnify and hold harmless the Landlord against and from any and all liability, claim of liability or expense arising out of (a) the use, occupancy, conduct, operation or management of the Property during the Term, or (b) any work or thing whatsoever done or not done on the

Property during the Term, or (c) any breach or default by the Tenant in performing any of its obligations under the provisions of this Lease or applicable law, or (d) any negligent, intentionally tortious or other act or omission of the Tenant or any of its agents, contractors, servants, employees, subtenants, licensees or invitees during the Term, or (e) any injury to or death of any person, or damage to any property, occurring on the Property during the Term (whether or not such event results from a condition existing before the execution of this Lease or resulting in the termination of this Lease), and from and against all expenses and liabilities incurred in connection with any such claim or any action or proceeding brought thereon (including, by way of example rather than of limitation, the fees of attorneys, investigators and experts), all regardless of whether such claim is asserted before or after the expiration of the Term or any earlier termination of this Lease.

6.8. Increase in risk.

6.8.1. The Tenant shall not do or permit to be done any act or thing as a result of which either (a) any policy of insurance of any kind covering any or all of the Property or any liability of the Landlord in connection therewith may become void or suspended; and

6.8.2. if insurance in regard to the Property is maintained by the Landlord, Tenant shall not do or permit any act or thing as a result of which the insurance risk would be made greater unless Tenant pays as Additional Rent the amount of any such greater risk within ten (10) days after the Landlord notifies the Tenant in writing of such increase.

Section 7. Public Utility Charges. The Tenant shall pay or cause to be paid all charges for all gas, electricity, light, heat, steam, power, water and sewerage, telephone or other communication services used, and other services rendered or supplied, upon or in connection with the Property during the Term, and shall indemnify and hold harmless the Landlord against and from any liability therefor. The Landlord shall not be liable to the Tenant for any failure, modification or interruption of any such service whatsoever, including, by way of example rather than of limitation, any such failure, modification or interruption which either (a) arises out of a Force Majeure, or (b) is required by any federal or other law or regulation relating to the furnishing or consumption of energy or the temperature of buildings, or any other applicable law unless such failure or interruption is caused by the negligent or intentional wrongful acts of Landlord or its agents or contractors.

Section 8. Improvements to Premises.

8.1. Construction of Improvements.

8.1.1. Plans and Specifications. The Tenant shall prepare the following documents (all of which are hereinafter referred to as "Plans and Specifications"):

(a) schematic and final architectural plans of the exterior of the Building;

(b) a grading and landscaping plan for the Premises;

(c) a schedule of the exterior colors and building materials to be used by the Tenant for such Improvements;

(d) a signing program for the Property; and

(e) a lighting plan for the Property.

8.1.2. The Tenant shall submit such Plans and Specifications and any material change thereto to the Chief Administrative Officer for the Landlord for Landlord's review, and shall take no action to effectuate any of them unless the Landlord has approved them, which approval shall not be unreasonably withheld. In the event Landlord has not delivered to Tenant its written approval or rejection (with specific reasons therefor) of the Plans and Specifications within fifteen (15) business days of submission of the Plans and Specifications by Tenant to Landlord, Landlord shall be deemed to have given its approval to said Plans and Specifications.

8.1.3. Tenant's obligation to submit to Landlord the Plans and Specifications set forth in Section 8.1.1 is in addition to, and not in substitution for Tenant's obligation to comply with any and all zoning requirements, building codes and other governmental codes, requirements, statutes, and the like imposed upon Tenant in connection with its development of the Property, which may include, among other things, submission of the Plans and Specifications for the review and approval of various County agencies and departments in connection with Tenant's application for and acquisition of building permits, or otherwise, as may be required.

8.1.4. Landlord's Contribution. Landlord agrees to contribute a total sum of Two Million Dollars ($2,000,000) (the "Landlord's Contribution") to Tenant for alterations and improvements to the Premises ("Tenant's Work") to be made in accordance with the Plans and Specifications, which Landlord's

Contribution shall be paid to Tenant in accordance with the terms of a separate Memorandum of Understanding to be negotiated in good faith, executed by the parties and thereafter attached hereto.

8.1.5. Alterations. After the completion of the Improvements to the Premises described above, the Tenant shall not thereafter make any alteration, improvement or addition to the Premises, the Building or the rest of the Improvements, or demolish any portion thereof, without first presenting to the Landlord Plans and Specifications therefor and obtaining the Landlord's written consent thereto (which consent shall not be withheld so long as, in the Landlord's reasonable judgment, such alteration, improvement, addition or demolition will not violate applicable law or the provisions of this Lease, or impair the value of the Building or the rest of the Improvements); provided, that the Tenant may, without having to obtain the Landlord's consent, make minor alterations and improvements to the interior of the Building, provided that they do not affect the exterior or the structure of the Building or the strength of such structure, or reduce the value of the Building or the rest of the Improvements. In the event Landlord has not delivered to Tenant its written consent or written refusal to consent within fifteen (15) business days of Tenant's written request for such consent, Landlord shall be deemed to have consented to the requested alteration, improvement or addition to the Premises. The Plans and Specifications to be provided Landlord pursuant to this section are those listed in subsection 8.1.1 as appropriate.

8.2. Mechanics' or other liens.

8.2.1. The Tenant shall (a) as set forth in Subsection 8.2.3 release (by bonding or otherwise) any mechanics', materialman's or other lien filed or claimed against any or all of the Property, by reason of labor or materials provided for or about any or all of the Property during the Term or otherwise resulting from work ordered by the Tenant or anyone claiming under the Tenant and (b) defend, indemnify and hold harmless the Landlord against and from any and all liability, claim of liability or expense (including, by way of example rather than of limitation, that of reasonable attorneys' fees) incurred by the Landlord on account of any such lien or claim.

8.2.2. The Landlord shall release (by bonding or otherwise) any mechanics', materialman's or other lien filed or claimed against any or all of the Property, by reason of labor or materials provided for or about any or all of the Property during the Term or otherwise resulting from work ordered by the Landlord or anyone claiming under the Landlord and (b) defend,

indemnify and hold harmless the Tenant against and from any and all liability, claim of liability or expense (including, by way of example rather than of limitation, that of reasonable attorneys' fees) incurred by the Tenant on account of any such lien or claim.

8.2.3. Subject to the requirements of any Leasehold Mortgage, if the Tenant fails to discharge any such mechanics', materialman's or other lien within thirty (30) days after it first becomes effective against any of the Property, then, in addition to any other right or remedy held by the Landlord on account thereof, the Landlord may (a) discharge it by paying the amount claimed to be due or by deposit or bonding proceedings. The Tenant shall reimburse the Landlord for any amount paid by the Landlord to discharge any such lien and all expenses incurred by the Landlord in connection therewith, together with interest thereon at the Penalty Rate defined in subsection 16.3.4 from the respective dates of the Landlord's making such payments or incurring such expenses (all of which shall constitute Additional Rent).

8.2.4. Nothing in the provisions of this Lease shall be deemed in any way (a) to constitute either the Tenant's or the Landlord's consent or request, express or implied, that any contractor, subcontractor, laborer or materialman retained by such other party to this Lease provide any labor or materials for any alteration, addition, improvement or repair to any or all of the Property, or (b) to evidence either the Tenant's or the Landlord's consent that the Property or Landlord's Fee Estate therein be subjected to any such lien.

8.3. Improvements and Fixtures. Any and all improvements, repairs, or alterations, and all other property attached to or otherwise installed as a fixture within the Premises by the Tenant shall, immediately on the completion of their construction or installation, be the property of Tenant during the entire term of this Lease, provided that at the expiration or earlier termination of this Lease title to such Improvements and Fixtures shall automatically vest in Landlord without the need for any deed or other documentation, except that any machinery, equipment or fixtures installed by the Tenant at no expense to the Landlord and used in the conduct of the Tenant's trade or business (rather than to service the Premises, the Building or the Property generally) and not part of the Building Service Equipment shall remain the Tenant's property, and shall be removed from the Premises by the Tenant at the end of the Term (and any damage to the Property caused by such removal shall be repaired at the Tenant's expense).

8.4. Signs. The Tenant shall have the right to erect from time to time within the Building, in accordance with applicable law, such signs as it desires, except that the Tenant shall not erect any sign either (a) on the Premises outside of the Building, or (b) on the exterior of the Building, or (c) within the Building in any place where such sign is visible primarily from the exterior of the Building, unless the Landlord has given its express, written consent thereto, such consent not to be unreasonably withheld or delayed. In the event Landlord has not delivered to Tenant its written consent or refusal to consent to the proposed sign within fifteen (15) days of submission of Tenant's request to post such sign, Landlord shall be deemed to have given its consent to the posting of such sign.

Section 9. Repairs and maintenance.

9.1. Building and Building Service Equipment.

9.1.1. Repairs. The Tenant shall, throughout the Term and at its expense,

(a) keep the Building, and the Building Service Equipment in good order and condition; and

(b) promptly make any and all repairs, ordinary or extraordinary, foreseen or unforeseen, to the Building, and the Building Service Equipment as are necessary to maintain them in good order and condition (including, by way of example, rather than of limitation, any and all such repairs to the plumbing, heating, ventilation, air-conditioning, electrical and other systems for the furnishing of utilities or services to the Property), and replace or renew the same where necessary (using replacements at least equal in quality and usefulness to the original improvements, equipment or things so replaced), and the Landlord shall have no obligation hereunder as to the same.

9.1.2. Maintenance. The Tenant shall keep and maintain the Building and the Building Service Equipment in a clean and orderly condition, free of accumulation of dirt and rubbish.

9.2. Improvements other than the Building and Utility Lines.

9.2.1. Repairs. The Landlord shall, throughout the Term and at its expense,

(a) take good care of the Improvements other than the Building and the utility lines and keep them in good order and condition; and

(b) promptly make any and all repairs, ordinary or extraordinary, foreseen or unforeseen, to the Improvements other than the Building and the utility lines as are necessary to maintain them in a first-class condition (including, by way of example, rather than of limitation, any and all such repairs to the parking facilities, roads, sidewalks, landscaping or other improvements) and replace or renew the same where necessary (using replacements at least equal in quality and usefulness to the original improvements, equipment or things so replaced), and the Tenant shall have no obligation hereunder as to the same.

9.2.2. Maintenance. The Landlord shall, at its expense, keep and maintain the Improvements other than the Building and the utility lines in good order and repair and in a clean and orderly condition, free of accumulation of dirt, rubbish, snow and ice and shall maintain the lawns and landscaping on the Premises in a good condition including periodic mowing, weeding, watering, mulching and trimming and shall promptly replace any dead or dying vegetation with similar plantings, and reseed grass lawns as necessary. Landlord shall defend, indemnify and hold harmless the Tenant against and from any liability, claim of liability or expense arising out of the performance of Landlord's maintenance obligations set forth under this subsection 9.2.2. The foregoing indemnification shall survive the expiration or earlier termination of this Lease. The parties hereto acknowledge that Tenant, at its expense, shall install the initial lawn and landscaping on the Premises in accordance with the landscaping plan submitted to Landlord pursuant to Section 8.1.1(b).

Section 10. Landlord's right of entry.

10.1. Inspection and repair. The Landlord and its authorized representatives shall be entitled to enter the Building and the rest of the Property at any time during the Tenant's business hours and at any other reasonable time to (a) inspect the Property and (b) make any repairs thereto and/or take any other action therein which is required by applicable law, or which the Landlord is permitted to make by any provision of this Lease, after giving the Tenant at least forty-eight (48) hours' notice of the Landlord's intention to take such action (provided, that in any situation in which, due to an emergency or otherwise, the physical condition of the Building or any other part of the Property would be unreasonably jeopardized unless the Landlord were to take such action immediately, the Landlord shall give only such notice, if any, to the Tenant as is reasonable under the circumstances, and may enter the same at any time and provided further that

Landlord's contractors or agents may enter on the Land, but not the Building, without prior notice to perform routine maintenance and landscaping services). Nothing in the foregoing provisions of this Section shall be deemed to impose any duty upon the Landlord to make any such repair or take any such action other than as required by the terms of this Lease, and the Landlord's performance thereof shall not constitute a waiver of the Landlord's right hereunder to have the Tenant perform such work. The Landlord may, while taking any such action upon the Property, store therein any and all necessary materials, tools and equipment, provided the storage of such materials, tools and equipment does not interfere with Tenant's operation of the Premises, and the Tenant shall have no liability to the Landlord for any damage to or destruction of any such materials, tools and equipment except if and to the extent that such damage or destruction is proximately caused by the negligence of the Tenant or its agents and employees. Provided Landlord takes reasonable care to avoid any inconvenience, annoyance, disturbance, loss of business, or other damage to Tenant as a result of Landlord's entries, the Landlord shall not be liable to the Tenant for any inconvenience, annoyance, disturbance, loss of business or other damage sustained by the Tenant by reason of the making of such repairs or the taking of such action, or on account of the bringing of materials, supplies and equipment onto the Property during the course thereof, and the Tenant's obligations under the provisions of this Lease shall not be affected thereby.

10.2. Exhibiting the Premises. During the last eighteen months of the Term, or at any time after Landlord or Tenant has exercised a right to terminate this Lease, the Landlord and its business invitees may from time to time, after giving notice thereof to the Tenant at least forty-eight (48) hours in advance, enter the Building and the rest of the Property during the Tenant's normal business hours to exhibit the Premises for purposes of (a) sale or mortgage, or (b) leasing the Premises to any prospective tenant thereof, provided that in doing so the Landlord and each such invitee observes all reasonable safety standards and procedures which the Tenant may require.

Section 11. Fire and other casualties.

11.1. Where cost of Restoration exceeds specified sum.

11.1.1. If any or all of the Property is damaged or destroyed, the Tenant shall (a) immediately notify the Landlord thereof if the cost of Restoration on account thereof equals or exceeds $30,000, and (b) (unless this Lease is terminated pursuant to the provisions of subsection 11.2), to

the extent insurance proceeds are available and adequate for such purposes and regardless of the dollar amount of such damage or loss (and regardless of whether the cost of Restoration is less than or greater than $30,000), commence and complete Restoration with reasonable diligence at the Tenant's expense but subject to the limits of any insurance proceeds received for such purpose, as nearly as possible to the Property's value, condition and character immediately before such damage or destruction.

11.1.2. All insurance proceeds (other than any proceeds which are separately paid on account of any damage to or destruction of the Tenant's personal property, inventory or work-in-process, all of which shall be paid to the Tenant) payable as a result of such casualty under policies of insurance against such casualty shall be held and disbursed by the Leasehold Mortgagee, if any, provided the Leasehold Mortgage is an Institutional Lender or, if there is then no Leasehold Mortgage or if such Mortgage is not an Institutional Lender, then the insurance proceeds shall be held and disbursed by a trustee designated by both Tenant and Landlord.

(a) If the cost of repairing and/or replacing damaged property is Thirty Thousand Dollars ($30,000) or less, the insurance proceeds shall be paid to Tenant by the trustee or Leasehold Mortgagee, as the case may be, when the repairs and replacements are completed and such work has been approved by an architect or other inspector ("inspector") appointed by the Landlord and the Leashold Mortgagee. If the cost of repairing the damage and/or replacing the damaged property exceeds Thirty Thousand Dollars ($30,000.00), then the insurance proceeds shall be paid to Tenant by the trustee, as the Tenant may direct, from time to time as such Restoration progresses, to pay or reimburse the Tenant for the cost of such Restoration, upon the Tenant's written request accompanied by evidence satisfactory to the Landlord and any Leasehold Mortgagee that an amount equalling the amount requested is then due and payable or has been paid, and is properly a part of such cost, and that such Restoration Work has been approved by the inspector. Upon receipt by the Landlord and the Leasehold Mortgagee of evidence satisfactory to them that such Restoration has been completed and the cost thereof paid in full, and that no mechanics', materialmens' or similar lien for labor or materials supplied in connection therewith may attach to the Property, the balance, if any, of such proceeds shall be paid to the Tenant or as it may direct.

11.1.3. Anything contained in the provisions of this Lease to the contrary notwithstanding, upon the expiration or earlier termination of this Lease before such Restoration is completed free and clear of any such liens, any insurance

proceeds not theretofore applied to the cost of such Restoration shall be paid to the Leasehold Mortgagee to satisfy any outstanding mortgage debt, next to the Landlord up to a total of $2,000,000 and the balance, if any, to the Tenant; provided, that if such termination occurs pursuant to the provisions of Section 12, any such insurance proceeds not theretofore so applied shall be deemed to be part of the Condemnation award and shall be disposed of in the manner set forth in such provisions.

11.2. No total or partial damage to or destruction of any or all of the Property other than a total or partial damage to or destruction of any or all of the Property in the last five years of the Initial Term, or during any Renewal Term, shall entitle the Tenant to surrender or terminate this Lease, or shall relieve the Tenant from its liability hereunder to pay in full the Annual Rent, any Additional Rent and all other sums and charges which are otherwise payable by the Tenant hereunder, or from any of its other obligations hereunder. If a total or partial damage to or destruction of any or all of the Property occurs in the last five years of the Initial Term or during any Renewal Term, Tenant shall be entitled to terminate this Lease, at its option, provided, that if such termination occurs, any insurance proceeds shall first be paid to satisfy the debt under any Leasehold Mortgage, next to the Landlord up to a total of $2,000,000, and the balance, if any, to the Tenant.

Section 12. Condemnation.

12.1. As used in the provisions of this Lease, the term "Net Condemnation Proceeds" means the amount by which

12.1.1. the full and entire award made by the condemning authority on account of a condemnation under the exercise of any power of eminent domain or a conveyance to or at the direction of any governmental entity under a threat of such taking (a "Condemnation") (excluding any portion thereof made on account of a taking of any real or personal property which is not located on or part of the Property) exceeds

12.1.2. the aggregate of all reasonable attorneys', experts' and other fees, and all other expenses, incurred by the Landlord, the Tenant and/or the Leasehold Mortgagee in connection with such Condemnation or in collecting such award (excluding any portion thereof incurred in connection with a taking of any real or personal property which is not part of the Property or in collecting any award made for such taking).

12.2. Substantial Condemnation. In the event of a taking of all or substantially all of the Property by Condemnation,

12.2.1. the Tenant shall promptly give written notice thereof to the Landlord;

12.2.2. this Lease shall terminate on the date (hereinafter referred to as "the Vesting Date") on which the title to so much of the Property as is the subject of such Condemnation vests in the condemning authority, and any Additional Rent and all other sums and charges required to be paid by the Tenant hereunder shall be apportioned and paid to the date of such termination; and

12.2.3. the Landlord and the Tenant (and/or any Leasehold Mortgagee) shall together make one claim for an award for their combined interests in the Property, and the Net Condemnation Proceeds shall be paid as follows and in the following order of priority:

(a) First, the Landlord shall be paid so much, if any, of the Net Condemnation Proceeds as is necessary to cure any monetary Event of Default.

(b) Second, the Landlord shall receive that portion of the Net Condemnation Proceeds specifically allocated by the condemning authority to the Land (without the Improvements) or if no such separate award is made then an amount equal to the fair market value of the Land taken excluding therefrom the value of the Improvements.

(c) Third, any Leasehold Mortgagee shall be paid an amount equalling the outstanding balance of Leasehold Mortgage,

(d) Fourth, the Landlord shall receive up to the sum of $2,000,000, and

(e) Fifth, the Tenant shall receive the entire balance, if any, of the Net Condemnation Proceeds.

12.2.4. For purposes of the provisions of this Section, all or substantially all of the Property shall be deemed to have been taken in a Condemnation if and only if such Condemnation renders the Premises or the Improvements not reasonably usable for the Tenant's continued conduct of its business thereon, in substantially the same manner and to substantially the same extent as such business was conducted immediately before such Condemnation (whether due to the area so taken or the location of the part so taken in relation to

the part not so taken or under applicable zoning laws, building regulations or Tenant's economic considerations or otherwise).

12.3. Non-substantial Condemnation. If not all or substantially all of the Property is taken, as aforesaid,

12.3.1. this Lease shall continue in full force and effect;

12.3.2. the Tenant shall promptly give written notice thereof to the Landlord;

12.3.3. to the extent the Net Condemnation Proceeds are available or adequate for such purposes based upon the cost of such Restoration, the Tenant shall, promptly after the Vesting Date, commence and complete Restoration of the Property with reasonable diligence at the Tenant's expense, as nearly as possible to its value, condition and character immediately before such Condemnation but subject to the limits of any Net Condemnation Proceeds received by Tenant, all in accordance with Plans and Specifications therefor which shall have been approved in writing by the Landlord, such approval not to be unreasonably withheld or delayed; and

12.3.4. to the extent the Net Condemnation Proceeds are not applied to the cost of Restoration, the Net Condemnation Proceeds shall be paid in the following order of priority:

(a) First, the Landlord shall receive so much, if any, of the Net Condemnation Proceeds as is necessary to cure any monetary Event of Default;

(b) Second, the Landlord shall receive that portion of the Net Condemnation Proceeds specifically allocated by the condemning authority to the Land (without the Improvements) or if no such separate award is made then an amount equal to the fair market value of the Land so taken excluding therefrom the value of the Improvements.

(c) Third, the Leasehold Mortgagee shall receive that portion or all of the balance of the Net Condemnation Proceeds, if any, to which the Leasehold Mortgagee is entitled on account of such Condemnation under the provisions of the Leasehold Mortgage; and

(d) Fourth, the Landlord shall receive up to the sum of $2,000,000, and

(e) Fifth, the Tenant shall receive the balance of the Net Condemnation Proceeds.

12.3.5. Anything contained in the provisions of this subsection 12.3 to the contrary notwithstanding, upon the expiration or earlier termination of this Lease before such Restoration is completed free and clear of any liens, any of the Net Condemnation Proceeds not theretofore applied to the cost of such Restoration shall be paid first to pay the outstanding debt under any Leasehold Mortgage and the balance to the Landlord.

12.4. If this Lease is terminated under the foregoing provisions of this Section 12, any Additional Rent and all other sums and charges required to be paid by the Tenant hereunder shall be apportioned and paid to the date of such termination.

12.5. Valuation. For purposes of the provisions of this Section 12 the fair market value referred to in such provisions shall be those, if any, which are formally found to exist in the Condemnation proceeding or, if not so found, shall be determined by a written agreement by the parties hereto or, in the absence of such agreement, by an appraisal made by a competent professional real estate appraiser (which appraiser shall be selected by the parties hereto within sixty (60) days after the Vesting Date). Such appraiser shall determine and report to the parties hereto as to such fair market value within ninety (90) days after the Vesting Date. If the parties hereto can not agree upon an appraiser within the said period of sixty (60) days, then each party hereto shall select a competent professional real estate appraiser within seventy-five (75) days after the Vesting Date, and the two appraisers so selected shall by mutual agreement select a third appraiser within ninety (90) days after the Vesting Date. Each such appraiser shall then determine and report to the parties hereto as to the said fair market value within one hundred twenty (120) days after the Vesting Date, and the fair market value shall be the average of the fair market values determined by the three (3) appraisers but no more than the highest fair market value of any appraisal presented by Landlord and Tenant in the Condemnation Proceeding.

12.6. Except as otherwise expressly provided in this Section, no partial Condemnation shall entitle either party hereto to surrender or terminate this Lease, or shall relieve the Tenant from its liability hereunder to pay in full the Annual Rent, any Additional Rent and all other sums and charges which are otherwise payable by the Tenant hereunder, or from any of its other obligations hereunder, and the Tenant hereby waives any right now or hereafter conferred upon it by statute or otherwise, on account of any such Condemnation, to surrender this Lease, to quit or surrender any or all of the Premises, or

to receive any suspension, diminution, abatement or reduction of the Annual Rent or any Additional Rent or other sum payable by the Tenant hereunder.

13. Leasehold Mortgages.

13.1. Tenant may encumber the Leasehold Estate hereby created in the Premises or any part thereof by way of a mortgage or deed of trust or mortgages or deeds of trust (a "Leasehold Mortgage") provided the outstanding principal due under such Leasehold Mortgage or Leasehold Mortgages does not in the aggregate exceed the fair market value of the Improvements less Two Million Dollars ($2,000,000). The fair market value shall be determined by a written agreement of the parties hereto, or in the absence of such agreement, by an appraisal conducted as set forth in Section 12.5 hereof.

13.2. Landlord shall, if requested by the Leasehold Mortgagee, deliver to the Leasehold Mortgagee (the name and address of which shall be furnished to Landlord by Tenant or by the Leasehold Mortgagee) copies of all notices sent to Tenant under and with respect to this Lease at the same time and in the same form and manner as sent to Tenant.

13.3. In the event Tenant shall be in default under this Lease, Landlord shall notify in writing the Leasehold Mortgagee and, within thirty (30) days after the giving of the notice, the Leasehold Mortgagee shall have the right to cure the default for the account of Tenant and, if more than thirty (30) days shall be required to cure the default with reasonable diligence, the Leasehold Mortgagee shall have such additional time (beyond the thirty (30) days) as may be reasonably necessary to cure the default. Landlord shall not be liable for failure to give the notice, but if Landlord shall fail to notify the Leasehold Mortgagee of the existence of a default hereunder, the time within which the Leasehold Mortgagee shall have the right to cure the default shall not commence to run until the Leasehold Mortgagee shall have been given written notice of the default by Landlord.

13.4. There shall be no cancellation, surrender or modification of this Lease by the joint action of Landlord and Tenant without the prior written consent of any Leasehold Mortgagee.

13.5. If the Landlord shall elect to terminate this Lease by reason of an Event of Default (hereinafter defined), a Leasehold Mortgagee shall have the right to postpone and extend the dates of the termination of this Lease for a period of not more than six months provided that the Leasehold Mortgagee shall cure or cause to be cured any then

existing default (other than defaults which are beyond the reasonable ability of the Leasehold Mortgagee to cure) and meanwhile pay the Annual Rent and any Additional Rent, and comply with and perform all of the other terms, conditions and provisions of this Lease on Tenant's part to be complied with and performed (other than those which are beyond the reasonable ability of the Leasehold Mortgagee) and shall forthwith take steps to acquire or sell Tenant's interest in this Lease by foreclosure of the Leasehold Mortgage or otherwise, and shall prosecute the same to completion with all due diligence. If, at the end of the six month period, the Leasehold Mortgagee shall be actively engaged in steps to acquire or sell Tenant's interest herein the time shall be extended for such period as may be reasonably necessary to complete such steps with reasonable diligence and continuity. Notwithstanding the foregoing, Landlord may at any time during the first ninety (90) days of such six month period, elect to purchase the Leasehold Mortgage pursuant to the terms of Section 13.15 by giving written notice of such election to the Leasehold Mortgagee. If for any reason Landlord fails to complete the purchase of the Leasehold Mortgage within ninety (90) days of delivery of notice to the Leasehold Mortgagee, the right of Leasehold Mortgagee to extend or postpone termination of the Lease shall continue in force for another ninety (90) days following the termination of Landlord's right to purchase the Leasehold Mortgage, which period may be extended as set forth above, during which time the Leasehold Mortgagee may proceed with its efforts to acquire or sell Tenant's interest in this Lease.

13.6. Landlord agrees promptly after submission to it to execute, acknowledge and deliver any agreements modifying this Lease as may be reasonably requested by any Leasehold Mortgagee provided that such modification does not decrease the Tenant's obligations or decrease the Landlord's rights pursuant to this Lease.

13.7. Provided the Leasehold Mortgagee is an Institutional Lender, the proceeds arising from a casualty or condemnation may be held by any Leasehold Mortgagee provided they are distributed pursuant to the provisions of this Lease.

13.8. In the event this Lease shall be terminated at any time during the term hereof by reason of a default by Tenant, then Landlord, if requested by a Leasehold Mortgagee within thirty (30) days of the receipt by the Leasehold Mortgagee from the Landlord of written notice that the termination has occurred, agrees to enter into a new lease for the Property with the Leasehold Mortgagee or with any nominee of the Leasehold Mortgagee, upon all the same terms and conditions as shall then be contained in this Lease, provided

however that Landlord shall not be required to warrant possession of the Premises to the Leasehold Mortgagee or its nominee under the new lease. Any new lease shall not relieve Tenant from liability for any costs, expenses, damages and liabilities resulting therefrom. Notwithstanding the foregoing, Landlord shall have no obligation to enter into such new lease with the Leasehold Mortgagee provided Landlord, within fifteen (15) days of receipt of Leasehold Mortgagee's request that Landlord execute a new lease notifies Leasehold Mortgagee that Landlord has elected to purchase the Leasehold Mortgage pursuant to the terms of Section 13.15 hereof and Landlord does in fact, so purchase the Leasehold Mortgage.

13.9. Except as provided in subsection 13.4 above, the Leasehold Mortgagee shall not be liable for any of Tenant's obligations hereunder, unless, until and from the date the Leasehold Mortgagee shall acquire Tenant's interest in this Lease.

13.10. In the event any Leasehold Mortgagee shall acquire Tenant's interest in this Lease as a result of a sale under its mortgage pursuant to a foreclosure and sale, or through any transfer or assignment in lieu of foreclosure, or through settlement of or arising out of any pending or contemplated foreclosure action, or otherwise, the Leasehold Mortgagee shall have the privilege of transferring its interest in the Lease to any other person, firm or corporation, including but not limited to its nominee, all without the prior consent of Landlord and free and clear of any control of Tenant, and the Leasehold Mortgagee shall be relieved of any further liability under this Lease from and after such transfer and thereafter the transferee shall be liable for Tenant's obligations under this Lease.

13.11. In no event shall Tenant be relieved of its obligations under this Lease upon the exercise by a Leasehold Mortgagee of the rights given it above, or the entering into by Landlord of a new lease with the Leasehold Mortgagee (or its nominee).

13.12. Nothing contained in this Section shall release or be deemed to release Tenant from the full and faithful observance and performance of any covenants and conditions in this Lease contained and on its part to be observed and performed (except that Landlord acknowledges that a cure by a Leasehold Mortgagee of a default by the Tenant shall be deemed to have been accepted by the Landlord as if the same had been done by the Tenant) or from any liability for the non-observance or non-performance thereof or to be deemed to constitute a waiver of any rights of Landlord hereunder as against Tenant.

13.13. Tenant shall obtain the agreement of any Leasehold Mortgagee to (a) provide Landlord with a copy of any notice sent to Tenant in accordance with the terms of any Leasehold Mortgage and (b) allow Landlord, at its option, to cure any monetary default of Tenant under such Leasehold Mortgage and accept such cure by Landlord as if such cure had been performed by Tenant.

13.14 Tenant shall obtain the agreement of any Leasehold Mortgagee that in the event Tenant is in default under the terms of such Leasehold Mortgage and the Leasehold Mortgagee notifies Tenant in writing that it has accelerated the loan and intends to foreclose under the Leasehold Mortgage or pursue any transfer or assignment in lieu of foreclosure, then the Leasehold Mortgagee must give the same notice to Landlord and Landlord shall have the privilege of purchasing the Leasehold Mortgage from the Leasehold Mortgagee pursuant to the provisions of Section 13.15 hereof. Landlord shall notify the Leasehold Mortgagee of its intent to purchase the Leasehold Mortgage within fifteen (15) days of Landlord's receipt of written notice from the Leasehold Mortgagee of its acceleration and intent to foreclose under the Leasehold Mortgage. If the settlement of the Landlord's purchase of the loan documents does not occur within 90 days of Landlord's notice to the Leasehold Mortgagee of its election to purchase the loan, then the Leasehold Mortgagee shall be free to pursue all remedies available to it under the Leasehold Mortgage documents.

13.15. Tenant shall obtain the agreement of any Leasehold Mortgagee that Landlord shall have the privilege of purchasing the Leasehold Mortgage from the Leasehold Mortgagee, exercisable upon the occurence of the following events:

a) Landlord elects to terminate this Lease pursuant to the provisions of Section 13.5 hereof;

b) Landlord terminates this Lease pursuant to the provisions of Section 13.8 hereof; or

c) Leasehold Mortgagee elects to foreclose the Leasehold Mortgage or pursue any transfer or assignment in lieu of foreclosure pursuant to the provisions of Section 13.14.

Landlord shall have the right to purchase the Leasehold Mortgage for a sum equal to all amounts due under the Leasehold Mortgage documents (including accrued principal, interest and late charges), calculated as of the date of the assignment of the Leasehold Mortgage documents to Landlord. Landlord shall have ninety (90) days to close on the purchase of the Leasehold

Mortgage following the Leasehold Mortgagee's receipt of Landlord's written notice that it has elected to purchase the Leasehold Mortgage. If the Landlord fails to purchase the loan documents within such ninety (90) day period as a result of Landlord's actions or inactions, then the Landlord's right to purchase the Leasehold Mortgage shall terminate and the Leasehold Mortgagee may exercise any and all rights available to it under the terms of this lease or under any of the Leasehold Mortgage documents.

Section 14. Assignment and subletting.

14.1. Tenant shall not assign this Lease or sublet all of the Premises (other than pursuant to space leases which comply with the use restrictions set forth in subsection 4.1), without the prior written consent of Landlord, provided however, that the Landlord's consent shall not be required in connection with (a) the creation of a Leasehold Mortgage or with a conveyance of the Tenant's leasehold estate in connection with the foreclosure of a Leasehold Mortgage or a deed of assignment in lieu thereof or (b) the assignment by the Named Tenant to any parent, sister, or subsidiary corporation of Tenant to any other person or entity controlled by or under common control with the Named Tenant. In the event of any such assignment or sublease (other than a space lease), Tenant shall nevertheless remain primarily liable for the performance of all of Tenant's covenants contained in this Lease unless otherwise agreed in writing by Landlord. Any assignee of this Lease or sublessee (other than a space lessee) shall be and become jointly and severally, primarily and personally liable with Tenant for the performance of all of Tenant's covenants contained in this Lease unless otherwise agreed in writing by Landlord.

14.2. All space leases shall contain an agreement by the space lessee to attorn to Landlord if Landlord ter- minates this Lease and to any person, firm or corporation which purchases the Premises at a foreclosure sale. Landlord shall not unreasonably refuse to give non-disturbance agreements to tenants under Space Leases if the same is requested.

Section 15. Net lease. This Lease shall be deemed and construed to be a "net lease" and, accordingly, anything contained in the provisions of this Lease to the contrary notwithstanding, the Landlord shall receive the Annual Rent, the Additional Rent and all other payments to be made by the Tenant hereunder free from any charges, assessments, impositions, expenses or deductions of any and every kind or nature whatsoever. Other than as provided elsewhere in this Lease and in a Memorandum of Understanding between the parties

to be executed in connection with this Lease, the Landlord shall not be required by any provision of this Lease to render any service or make any payment of any kind to the Tenant or any other person whatsoever.

Section 16. Default.

16.1. Definition. As used in the provisions of this Lease, each of the following events shall constitute, and is hereinafter referred to as, a "Default":

16.1.1. If the Tenant fails (a) to pay any Annual Rent, Additional Rent or other sum which it is obligated to pay by any provision of this Lease, when and as it is due and payable hereunder, or (b) to perform any of its obligations under the provisions of this Lease; or

16.1.2. if the Tenant's Bankruptcy occurs; or

16.1.3. if the Certificate of Need issued Tenant in connection with its construction and operation of the Pathways Treatment Center is revoked by the Maryland Health Resources Planning Commission following any adverse administrative action, judicial review of any such administrative action and either all time for appeal of such revocation has passed or, if appeals are taken, all such appeals are exhausted without overturning the revocation.

16.2. Notice to Tenant; grace period. Anything contained in the provisions of this Section to the contrary notwithstanding, on the occurrence of a Default the Landlord shall not exercise any right or remedy on account thereof which it holds under any provision of this Lease or applicable law unless and until

16.2.1. the Landlord has given written notice thereof to the Tenant, and

16.2.2. the Tenant has failed, (a) if such Default consists of a failure to pay money, within ten (10) days after Tenant receives written notice from Landlord to pay all of such money, or (b) if such Default consists of something other than a failure to pay money, within thirty (30) days after Tenant receives written notice from Landlord to cure such Default (or, if and only if such Default is not reasonably curable within such thirty (30) day period, to proceed within such period actively, diligently and in good faith to begin to cure such Default and to continue thereafter to do so until it is fully cured provided such cure period shall not exceed ninety (90) days). If Tenant fails to cure the Default after notice and within the cure period or fails to diligently pursue

the cure of the Default and complete the cure within ninety (90) days if such cure cannot reasonably be completed within thirty (30) days then an event of default shall have occurred ("Event of Default").

16.2.3. no such notice shall be required to be given, and (even if the Landlord gives such notice) the Tenant shall be entitled to no such grace period, (i) in any emergency situation in which, in the Landlord's reasonable judgment, it is necessary for the Landlord to act to cure such Default without giving such notice, (but in such cases, the Landlord's remedy shall be limited to collecting any amounts expended by Landlord for such cure plus interest as provided in subsection 16.3.4),(ii) if the Tenant has substantially terminated or is in the process of substantially terminating its continuous occupancy and use of the Premises for the purpose set forth in the provisions of Section 4; or (iii) in the case of any Default listed in the provisions of Sections 16.1.2 or 16.1.3.

16.3. Landlord's rights on Event of Default.

16.3.1. On the occurrence of any Event of Default, the Landlord may (subject to the operation and effect of the provisions of subsection 16.2) take any or all of the following actions:

(a) reenter and repossess any or all of the Premises and any or all improvements thereon and additions thereto; and/or

(b) declare the entire balance of the Rent for the remainder of the Term, to be due and payable immediately, and collect such balance in any manner not inconsistent with applicable law; provided that if the Landlord elects to relet any or all of the Premises following such acceleration of Rent, the provisions of subsection 16.3.1(d) shall be applicable with respect to the rights of the Landlord and the Tenant. Accelerated payments payable hereunder shall not constitute a penalty or forfeiture or liquidated damages, but shall merely constitute payment of Rent in advance; and/or

(c) terminate this Lease by giving written notice of such termination to the Tenant, which termination shall be effective as of the date of such notice or any later date therefor specified by the Landlord therein (provided, that without limiting the generality of the foregoing provisions of this subsection 16.3.1(c), and prior to any such termination by Landlord the Landlord shall not be deemed to have accepted any abandonment or surrender by the Tenant of any or all of the Premises or the Tenant's leasehold estate under this Lease unless the Landlord has so advised the Tenant expressly and in

writing, regardless of whether the Landlord has reentered or relet any or all of the Premises or exercised any or all of the Landlord's other rights under the provisions of this Section or applicable law); and/or

(d) in the Landlord's own name (but either as agent for the Tenant, if this Lease has not then been terminated, or for the benefit of the Tenant, if this Lease has then been terminated), relet any or all of the Premises with or without any additional premises, for any or all of the remainder of the Term (or, if this Lease has then been terminated, for any or all of the period which would, but for such termination, have constituted the remainder of the Term) or for a period exceeding such remainder, on such terms and subject to such conditions as are acceptable to the Landlord in its sole and absolute discretion (including, by way of example rather than of limitation, the reasonable alteration of any or all of the Premises in any manner which, in the Landlord's judgment, is necessary or desirable as a condition to or otherwise in connection with such reletting (provided Tenant shall not be liable to pay any cost of alteration made to change the use of the Premises from that stated in Section 4.1), and the allowance of one or more reasonable concessions or "free-rent" or reduced-rent periods), and collect and receive the rents therefor. Anything contained in the provisions of this Lease or applicable law to the contrary notwithstanding,

(i) the Landlord shall use commercially reasonable efforts to mitigate its damages caused by the Tenant's default,

(ii) the Tenant shall have no right in or to any surplus which may be derived by the Landlord from any such reletting, in the event that the proceeds of such reletting exceed any Rent, installment thereof or other sum owed by the Tenant to the Landlord hereunder; and

(iii) except as provided below the Tenant's liability hereunder shall not be diminished or affected by any such failure to relet or the giving of any such initial or other commercially reasonable concessions or "free-rent" or reduced rent periods in the event of any such reletting.

In the event of any such reletting, the Tenant shall pay to the Landlord, at the times and in the manner specified by the provisions of Section 3 (unless the Landlord has elected to accelerate Rent as provided in subsection 16.3.1(b), in which event the Tenant shall be obligated to pay such accelerated amount as provided in subsection 16.3.1(b)), both

(x) the installments of the Annual Rent and any Additional Rent accruing during such remainder (or, if this Lease has then been terminated, damages equalling the respective amounts of such installments of the Annual Rent and any Additional Rent which would have accrued during such remainder, had this Lease not been terminated), less any monies received by the Landlord with respect to such remainder from such reletting of any or all of the Premises, plus

(y) the cost to the Landlord of any such reletting (including, by way of example rather than of limitation, any attorneys' fees, leasing or brokerage commissions, repair or improvement expenses (subject to the limitations expressed above) and the expense of any other commercially reasonable and justified actions taken in connection with such reletting), plus

(z) any other sums for which the Tenant is liable under the provisions of Subsection 16.3.4 (and the Tenant hereby waives any and all rights which it may have under applicable law, the exercise of which would be inconsistent with the foregoing provisions of this subsection 16.3.1(d)).

Notwithstanding the foregoing, Landlord may, upon delivery of written notice to Tenant, elect not to relet the Premises upon an Event of Default, in which event, Tenant shall be released from any further liability and obligations hereunder (including, but not limited to the payment of the installments of the Annual Rent and any Additional Rent accruing during the remainder of the term of this Lease; and/or

(e) cure such Event of Default in any other manner; and/or

(f) pursue any combination of such remedies and/or any other right or remedy available to the Landlord on account of such Event of Default under this Lease and/or at law or in equity.

16.3.2. Except as provided in Section 16.3.1(d), No such expiration or termination of this Lease, or summary dispossession proceedings, abandonment, reletting, bankruptcy, re-entry by the Landlord or vacancy, shall relieve the Tenant of any of its liabilities and obligations under this Lease (whether or not any or all of the Premises are relet), and the Tenant shall remain liable to the Landlord for all damages

resulting from any Event of Default, including but not limited to, any damage resulting from the breach by the Tenant of any of its obligations under this Lease to pay Rent and any other sums which the Tenant is obligated to pay hereunder.

16.3.3. If any or all of the Premises are relet by the Landlord for any or all of the unexpired Term of this Lease, the amount of rent reserved upon such reletting shall be deemed to be the fair and reasonable rental value for the part or the whole of the Premises so relet during the term of the reletting.

16.3.4. On the occurrence of an Event of Default, the Tenant shall, immediately on its receipt of a written demand therefor from the Landlord, reimburse the Landlord for (a) all expenses (including, by way of example rather than of limitation, any and all repossession costs, management expenses, operating expenses, legal expenses and attorneys' fees) incurred by the Landlord (i) in curing or seeking to cure any Event of Default and/or (ii) in exercising or seeking to exercise any of the Landlord's rights and remedies under the provisions of this Lease and/or at law or in equity on account of any Event of Default, and/or (iii) otherwise arising out of any Event of Default, and/or (iv) (regardless of whether it constitutes an Event of Default) in connection with any action, proceeding or matter of the types referred to in the provisions of Subsections 16.1.2 and 16.1.3, plus (b) interest on all such expenses, at the lesser of the rate of four percent (4%) per annum above the prime rate of interest charged by Maryland National Bank or any successor banking institution from time to time or the highest rate then permitted on account thereof by applicable law ("Penalty Rate"), all of which expenses and interest shall be Additional Rent and shall be payable by the Tenant immediately on demand therefor by the Landlord.

16.3.5. The Tenant hereby expressly waives, so far as permitted by law, the service of any notice of intention to re-enter provided for in any statute, and except as is herein otherwise provided, the Tenant, for itself and all persons claiming through or under the Tenant (including any leasehold mortgagee or other creditors), also waives any and all right of redemption or re-entry or repossession in case the Tenant is dispossessed by a judgment or warrant of any court or judge or in case of re-entry or repossession by the Landlord or in case of any expiration or termination of this Lease. The terms "enter," "re-enter," "entry" or "re-entry" as used in this Lease are not restricted to their technical legal meanings.

16.3.6. Each party hereto hereby waives any right which it may otherwise have at law or in equity to a

trial by jury in connection with any suit or proceeding at law or in equity brought by the other against the waiving party or which otherwise relates to this Lease, as a result of an Event of Default or otherwise.

16.4. Landlord's security interest. In addition to any lien for rent available to the Landlord, subject to the lien of any Leasehold Mortgage, the Landlord shall have, subject to the lien of any Leasehold Mortgage and the Tenant hereby grants to the Landlord, subject to the lien of any Leasehold Mortgage, a continuing security interest for all Rent and other sums of money becoming due hereunder from the Tenant, upon all of the Tenant's accounts receivable, inventory, equipment and all other personal property located on the Premises, none of which may be removed from the Premises without the Landlord's express, written consent so long as any Rent or other such sum from time to time owed to the Landlord hereunder remains unpaid or another uncured Event of Default has occurred. On the occurrence of an Event of Default, the Landlord shall have subject to the lien of any Leasehold Mortgage, in addition to any other remedies provided herein or by law, all of the rights and remedies afforded to secured parties under the provisions of the Uniform Commercial Code, as codified in Maryland (hereinafter referred to as "the Code"), including by way of example rather than of limitation (a) the right to sell the Tenant's said property at public or private sale upon ten (10) days' notice to the Tenant, and (b) the right to take possession of such property without resort to judicial process in accordance with the provisions of Section 9-503 of the Code. The Tenant shall, on its receipt of a written request therefor from the Landlord, execute such financing statements and other instruments as are necessary or desirable, in the Landlord's judgment, to perfect such security interest.

Section 17. Estoppel certificate; short form.

17.1. Estoppel certificate. Each party hereto shall, at any time and from time to time within thirty (30) days after being requested to do so by the other party in writing, execute, enseal, acknowledge, and address and deliver to the requesting party (or, at the latter's request, to any existing or prospective Mortgagee, transferee or other assignee of the requesting party's interest in the Property or under this Lease which acquires such interest in accordance with the provisions of this Lease) a certificate in recordable form,

17.1.1. certifying (a) that this Lease is unmodified and in full force and effect (or, if there has been any modification thereof, that it is in full force and effect as so modified, stating therein the nature of such

modification); (b) that the Tenant has accepted possession of the Premises, and the date on which the Term commenced; (c) as to the dates to which Annual Rent and any Additional Rent and other charges arising hereunder have been paid; (d) as to the amount of any prepaid Rent or any credit due to the Tenant hereunder; (e) as to whether, to the best of such party's knowledge, information and belief, the requesting party is then in default in performing any of its obligations hereunder (and, if so, specifying the nature of each such default); and (f) as to any other fact or condition reasonably requested by the requesting party; and

17.1.2. acknowledging and agreeing that any statement contained in such certificate may be relied upon by the requesting party and any such other addressee.

17.2. Short form. The parties hereto shall, at the request of the Landlord, the Tenant or any Leasehold Mortgagee, execute, enseal, acknowledge and deliver at any time after the Commencement Date, in recordable form, a short form thereof (in form and substance satisfactory to each party hereto in its reasonable judgment) for recordation among the said Land Records. Any and all recordation fees and taxes and transfer taxes payable upon recordation of this Lease or short form lease shall be paid by Tenant.

Section 18. Condition of Title and Premises.

18.1. For so long as this Lease is in effect, Landlord shall not encumber, by way of a fee Mortgage or other encumbrance, its reversionary interest in the fee simple estate in and to the Premises.

18.2. The Landlord hereby warrants and represents that

18.2.1. at the time of the execution and delivery of this Lease by the parties hereto and as of the Commencement Date, it (a) is the owner of a fee simple estate in and to the Premises, subject to the operation and effect of only the Permitted Encumbrances, and (b) has the full right, power and authority to enter into this Lease and thereby to lease the Premises; and

18.2.2. the Tenant will have quiet and peaceful possession of the Premises during the Term so long as all of the Tenant's obligations hereunder are timely performed, except if and to the extent that such possession is terminated pursuant to the provisions of Sections 11 or 12 or any other provision of this Lease permitting such termination.

18.2.3. the studies, surveys, plans, reports, title work, and similar work product itemized and designated on Exhibit C hereto (collectively the "Studies"), and which have been delivered to Tenant simultaneous with or prior to the execution of this Lease, constitute all of the Studies concerning the Property of which Landlord has knowledge or possession.

18.2.4. the Landlord has removed from the Premises all underground storage tanks found on the Premises in accordance with applicable law, and no hazardous substances or materials or oil or petroleum products were released in connection with such removal.

18.2.5. to the best of Landlord's knowledge, except for the previous presence of the underground storage tanks on the Land, the Land (and any part thereof) has not been used for the production, deposit, generation, transportation, storage, treatment, or disposal of any toxic, dangerous, or hazardous substances, waste, debris, or pollutants (collectively, "hazardous substances"), including, but not limited to, (i) nuclear fuel or waste; (ii) "oil" or "oil, petroleum products, and their products" as defined by the Maryland Natural Resources Code Ann. §8-1411(a)(3), as amended, and the regulations promulgated thereunder; (iii) any "hazardous substance" or "hazardous material" as defined in the Comprehensive Environmental Response, Compensation and Liability Act, 42 U.S.C.A. §9601 et seq., as amended, and the regulations promulgated thereunder; and (iv) any "hazardous waste" or "controlled hazardous substance" as defined by the Resource Conservation and Recovery Act, 42 U.S.C.A. §6901 et seq., as amended, and the regulations promulgated thereunder, and no such hazardous substances were disposed of on, in or at the Land.

18.3. Nothing in the provisions of this Lease shall be deemed to impose upon the Landlord any liability on account of any act or failure to act by any person other than the Landlord its agents, employees and contractors.

18.4. Landlord hereby agrees to indemnify, defend, and hold Tenant harmless from and against any and all costs, expenses, losses, actions, suits, claims, judgments, and other liabilities whatsoever (including, but not limited to, reasonable attorneys' fees) arising out of or relating to a breach of the representations and warranties set forth in Subsection 18.2. The foregoing indemnification shall survive the expiration or earlier termination of this Lease.

Section 19. Notices. Any notice, demand, consent, approval, request or other communication or document to be

provided hereunder to the Landlord or the Tenant (a) shall be in writing; (b) shall be deemed to have been provided on the earlier of (i) forty-eight (48) hours after having been sent as certified or registered mail in the United States mails, postage prepaid, return receipt requested, or (2) the next business day after having been deposited (in time for delivery by such service on such business day) with Federal Express or another national courier service, or (3) (if such party's receipt thereof is acknowledged in writing) upon having been sent by telefax or another means of immediate electronic communication, in each case to the address of such party set forth hereinabove or to such other address in the United States of America as such party may designate from time to time to each other party hereto, or (ii) (if such party's receipt thereof is acknowledged in writing) its having been given by hand or other actual delivery to such party; and (c) (i) if provided to the Landlord, shall also be provided to County Attorney, Anne Arundel County Office of Law, Arundel Center, 44 Calvert St., P.O. Box 2700, Annapolis, MD 21404, or (ii) if provided to the Tenant, shall also be provided to its attorney, M. Lucinda Motsko Esquire (whose address is 1800 Mercantile Bank & Trust Building, 2 Hopkins Plaza, Baltimore, Maryland 21201).

Section 20. Subdivision.

20.1 Landlord to Subdivide. Landlord agrees to subdivide the Land from the remainders of those tracts of real property to be retained by Landlord as shown on Exhibit A ("Landlord's Remainder"), by recording in the Land Records of Anne Arundel County a subdivision plat creating lines of division substantially as shown on Exhibit A. In connection therewith, the Landlord shall arrange to have the Land designated as a separate parcel for purposes of real property taxation.

20.2 Easements. The Landlord shall grant to Tenant for the benefit of the Land such easements over Landlord's Remainder as may reasonably be necessary for the development and use of the Land and Premises as described herein.

Section 21. General.

21.1. Effectiveness. This Lease shall become effective on and only on its execution and delivery by each party hereto.

21.2. Complete understanding. This Lease represents the complete understanding between the parties hereto as to the subject matter hereof, the Premises, the Building, the rest of the Improvements, the Building Service Equipment, or the rest

of the Property, and the rights and obligations of the parties hereto as to the same, and supersedes all prior negotiations, representations, guaranties, warranties, promises, statements or agreements, either written or oral, between the parties hereto as to the same. No inducements, representations, understandings or agreements have been made or relied upon in the making of this Lease, except those specifically set forth in the provisions of this Lease. Neither party hereto has any right to rely on any other prior or contemporaneous representation made by anyone concerning this Lease which is not set forth herein.

21.3. Amendment. This Lease may be amended by and only by an instrument executed and delivered by each party hereto.

21.4. Waiver. No party hereto shall be deemed to have waived the exercise of any right which it holds hereunder unless such waiver is made expressly and in writing (and, without limiting the generality of the foregoing, no delay or omission by any party hereto in exercising any such right shall be deemed a waiver of its future exercise). No such waiver made in any instance involving the exercise of any such right shall be deemed a waiver as to any other such instance, or any other such right. Without limiting the generality of the foregoing, no action taken or not taken by the Landlord under the provisions of this Section or any other provision of this Lease (including, by way of example rather than of limitation, the Landlord's acceptance of the payment of Rent after the occurrence of any Event of Default) shall operate as a waiver of any right to be paid a late charge or of any other right or remedy which the Landlord would otherwise have against the Tenant on account of such Event of Default under the provisions of this Lease or applicable law (the Tenant hereby acknowledging that, in the interest of maintenance of good relations between the Landlord and the Tenant, there may be instances in which the Landlord chooses not immediately to exercise some or all of its rights on the occurrence of an Event of Default).

21.5. Applicable law. This Lease shall be given effect and construed by application of the law of Maryland, and any action or proceeding arising hereunder shall be brought in the courts of Maryland; provided, that if any such action or proceeding arises under the Constitution, laws or treaties of the United States of America, or if there is a diversity of citizenship between the parties thereto, so that it is to be brought in a United States District Court, it shall be brought in the United States District Court for the District of Maryland or any successor federal court having original jurisdiction.

21.6. Time of essence. Time shall be of the essence of this Lease.

21.7. Headings. The headings of the Sections, subsections, paragraphs and subparagraphs hereof are provided herein for and only for convenience of reference, and shall not be considered in construing their contents.

21.8. Construction. As used herein, all references made (a) in the neuter, masculine or feminine gender shall be deemed to have been made in all such genders, (b) in the singular or plural number shall be deemed to have been made, respectively, in the plural or singular number as well, and (c) to any Section, subsection, paragraph or subparagraph shall be deemed, unless otherwise expressly indicated, to have been made to such Section, subsection, paragraph or subparagraph of this Lease.

21.9. Exhibits. Each writing or plat referred to herein as being attached hereto as an exhibit or otherwise designated herein as an exhibit hereto is hereby made a part hereof.

21.10. Severability. No determination by any court, governmental or administration body or agency or otherwise that any provision of this Lease or any amendment hereof is invalid or unenforceable in any instance shall affect the validity or enforceability of (a) any other such provision, or (b) such provision in any circumstance not controlled by such determination. Each such provision shall remain valid and enforceable to the fullest extent allowed by, and shall be construed wherever possible as being consistent with, applicable law.

21.11. Disclaimer of partnership status. Nothing in the provisions of this Lease shall be deemed in any way to create between the parties hereto any relationship of partnership, joint venture or association, and the parties hereto hereby disclaim the existence of any such relationship.

21.12. Commissions. Each party hereto hereby represents and warrants to the other that, in connection with the leasing of the Premises hereunder, the party so representing and warranting has not dealt with any real estate broker, agent or finder, and there is no commission, charge or other compensation due on account thereof. Each party hereto shall defend, indemnify and hold harmless the other against and from any liability, claim of liability or expense arising out of any inaccuracy in such party's representation.

21.13. Temporary Easement Benefitting the Premises.

21.13.1 Landlord hereby grants and conveys to Tenant and Tenant's successors and assigns, for the benefit of the Premises, a non-exclusive, temporary, 25 foot wide construction easement for pedestrian and vehicular access, ingress and egress to and from the Premises. The easement shall be located in approximately the area of the existing roadway on the Landlord's Remainder shown on Exhibit A, as a "20 foot wide right-of-way" extending from the Premises in a southerly direction to Riva Road, plus sufficient additional area along the existing road to make a 25 foot wide easement on Landlord's Remainder (herein the "Easement Area"). Tenant shall be entitled to enter on the Easement Area to improve it with a temporary roadway, at the discretion of Tenant, and to maintain, repair, or replace the same from time to time as Tenant deems necessary. Tenant may permit use of the road by Tenant's employees, agents, contractors, visitors, and other invitees. This easement shall terminate without any further act of the parties upon the final completion of the improvements to the Premises to be made pursuant to Section 8 hereof.

21.13.2 Landlord covenants that any conveyance by Landlord of the Landlord's Remainder or any lien granted or established thereon before this easement terminates shall expressly be made subject to the foregoing temporary construction easement, and that prior to any such conveyance or grant, Landlord shall execute, acknowledge, and record in the Land Records of Anne Arundel County an easement in form and substance reasonably acceptable to Tenant and incorporating the provisions of this Section.

Section 22. Contingencies.

22.1. The Commencement Date of this Lease and Tenant's obligations hereunder are contingent upon the following (collectively, the "Contingencies"):

22.1.1. Tenant obtaining a Certificate of Need or exemption therefrom issued by the Maryland Health Resources Planning Commission.

22.1.2. The execution of one or more Memoranda of Understanding between the parties hereto that define, among other things, all services to be provided Tenant by Landlord for the development and/or operation of the Project and the release of Landlord's Contribution described in subsection 8.1.4.

22.1.3. Tenant's receipt and evaluation of all soils reports, wetlands reports, environment assessment reports, title reports and the like, deemed reasonably necessary by Tenant to evaluate the feasibility of development of the Property, and which indicate to Tenant's reasonable satisfaction, that the Land may be developed in accordance with normal construction methods and without extraordinary expense so that the final cost of development as contemplated by the parties will not exceed $4,500,000 and will permit the Tenant to construct and operate the Project in a financially viable manner.

22.1.4. Tenant's acquisition of all private or governmental licenses, permits, waivers, consents, approvals, easements and the like, which are necessary for the development and operation of the Project, including, but not limited to, waivers of certain on-site parking requirements and a parking and ingress/egress easement from the adjoining property owner(s).

22.1.5. Landlord's subdivision of the Land as described in Section 20 hereof.

22.2. If any one or all of the Contingencies set forth in Subsection 22.1 are not satisfied on or before April 1, 1991, then Tenant may, by written notice to Landlord given on or before April 1, 1991, either opt to extend the April 1, 1991 deadline to December 31, 1991, terminate this Lease or waive any unfulfilled contingency. If Tenant extends the contingency period and the contingencies are not fulfilled by December 31, 1991, this Lease shall automatically terminate unless Tenant gives written notice to Landlord on or before December 31, 1991 that Tenant is waiving the unfulfilled Contingencies.

22.3. Upon satisfaction of all of the Contingencies, Tenant shall notify Landlord in writing of the date on which the Contingencies have been fulfilled and shall specify the first day of the first month commencing after the satisfaction of the Contingencies as the Commencement Date.

Section 23. Termination. Tenant shall have the right to terminate this Lease with six (6) months prior written notice to Landlord, and with the prior written consent of the Leasehold Mortgagee, if any, if notwithstanding the exercise of Tenant's reasonable and diligent efforts:

23.1. Tenant is unable to obtain, if needed, financing for the construction of the Project on terms reasonably acceptable to Tenant, which financing (when added to the Landlord's Contribution and any government grant) is sufficient in amount to fund the construction of the building and Tenant-owned improvements, fixtures and equipment related thereto;

23.2. at any time after the third anniversary of the Commencement Date, the operation of the Project generates net operating losses in excess of $100,000 in any year. The County shall be entitled to cause an audit of the Project's account in the event that Tenant intends to terminate this Lease on the basis of net operating losses.

provided, however that Tenant may not exercise a right to terminate under Section 23.1 once Tenant has commenced excavation of the Land for construction of the improvements.

IN WITNESS WHEREOF, each party hereto has executed and ensealed this Lease or caused it to be executed and ensealed on its behalf by its duly authorized representatives, the day and year first above written.

WITNESS or ATTEST:

ANNE ARUNDEL COUNTY

by _____ (SEAL)

Landlord

6581U

WITNESS or ATTEST:

ANNE ARUNDEL GENERAL TREATMENT SERVICES, INC., a corporation organized and existing under the law of Maryland,

by _____ (SEAL)

Tenant

STATE OF MARYLAND: COUNTY OF : TO WIT:

I HEREBY CERTIFY that on this 30th day of November 1990, before me, a Notary Public for the state and county aforesaid, personally appeared _____, known to me or satisfactorily proven to be the person whose name is subscribed to the foregoing Ground Lease, who acknowledged that he is the CAO of Anne Arundel County, a County organized and existing under the law of Md., that he has been duly authorized to execute, and has executed, such instrument on its behalf for the purposes therein set forth, and that the same is its act and deed.

IN WITNESS WHEREOF, I have set may hand and Notarial Seal, the day and year first above written.

_____
Notary Public

My commission expires on 9-1-92.

_____ 11-30-90
Deputy DATE

6581U

STATE OF MARYLAND: COUNTY OF Anne Arundel : TO WIT:

I HEREBY CERTIFY that on this 30th day of December, 1990, before me, a Notary Public for the state and county aforesaid, personally appeared Carl G. Beaudette, known to me or satisfactorily proven to be the person whose name is subscribed to the foregoing Ground Lease, who acknowledged that he is the President of Anne Arundel General Treatment Services, Inc., a corporation organized and existing under the law of Maryland, that he has been duly authorized to execute, and has executed, such instrument on its behalf for the purposes therein set forth, and that the same is its act and deed.

IN WITNESS WHEREOF, I have set may hand and Notarial Seal, the day and year first above written.

Carol A. Davis
Notary Public

My commission expires on 7/1/94.

GROUND LEASE

by and between

ANNE ARUNDEL COUNTY, MARYLAND

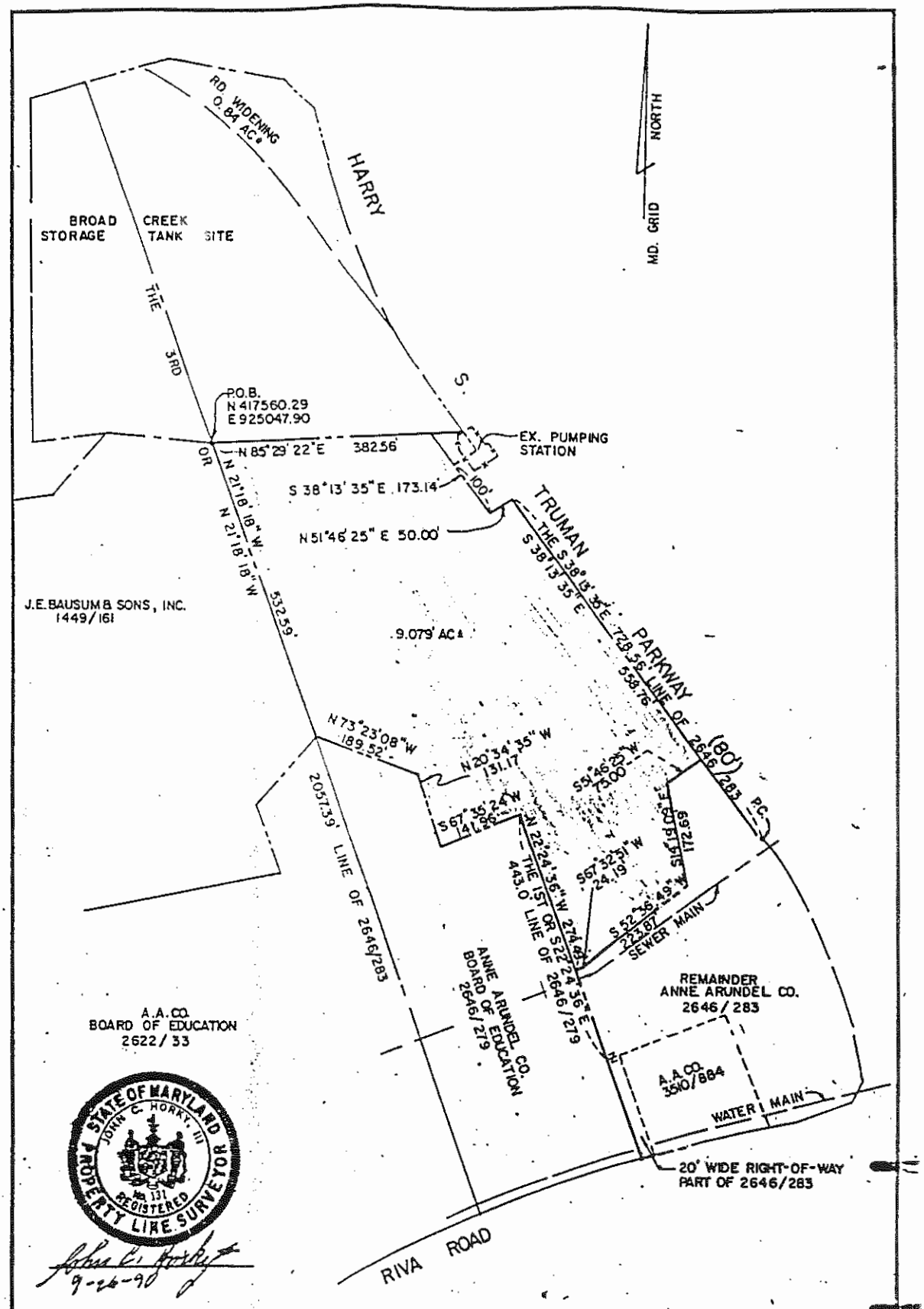
and

ANNE ARUNDEL GENERAL TREATMENT SERVICES, INC.

EXHIBIT A

Description of the Land

ALL OF THAT LAND in Anne Arundel County, Maryland, which is shaded on the attached plat and described on the attached description.



DRAWN BY EH. & D.B.	COUNTY OF ANNE ARUNDEL	SCALE 1" = 200'	REVISIONS
TRACED BY K.G.	DEPARTMENT OF PUBLIC WORKS	DATE SEPT. 1990	DATE / BY
CHECKED BY	PATHWAYS — ALTERNATE DRUG	PROJECT NO.	12-6-90 / K.G.
DRAWING NO. 1 OF 1	TREATMENT CENTER	APPROVED Richard M. Hall 9/26/90	
	2 ND ASSESSMENT DISTRICT A.A.CO., MD.	CHIEF RIGHT-OF-WAY SERVICES	

EXHIBIT A

ANNE ARUNDEL COUNTY

LIBER 2646 FOLIO 283

Beginning for the same at a point where the third or North 21 degrees 18 minutes 18 seconds West 2057.39 foot line of that parcel of land which by deed dated December 20, 1973 was granted and conveyed by James H. Moshovitis to Anne Arundel County, and recorded among the Land Records of Anne Arundel County, Maryland, in Liber 2646 Folio 283, intersects the Southernmost boundary of Broad Creek Storage Tank Site, thence leaving said third line and binding on a part of said Southernmost boundary North 85 degrees 29 minutes 22 seconds East 382.56 feet to a point, thence leaving said Southernmost boundary of said tank site South 38 degrees 13 minutes 35 seconds East 173.14 feet, passing over the beginning of the eleventh line of the parcel of land described in the deed mentioned above, to a point marking the end of said eleventh line, thence running with and binding on the twelfth line of the deed mentioned above North 51 degrees 46 minutes 25 seconds East 50.00 feet to a point on the Southeast side of Harry S. Truman Parkway, 80 foot wide Right-of-Way, said point also being the beginning of the thirteenth or South 38 degrees 13 minutes 35 seconds East 728.56 foot line of that parcel of land described in the deed mentioned above, thence binding on said side of said parkway and binding on a part of said thirteenth line South 38 degrees 13 minutes 35 seconds East 558.76 feet to a point, thence leaving said side of said parkway and running through said parcel of land described in the deed mentioned above the following four courses and distances Viz: South 51 degrees 46 minutes 25 seconds West 75.00 feet, South 14 degrees 19 minutes 09 seconds East 172.69 feet, South 52 degrees 36 minutes 49 seconds West 223.87 feet and South 67 degrees 32 minutes 51 seconds West 24.19 feet to intersect the first or South 22 degrees 24 minutes 36 seconds

East 443.00 foot line of that parcel of land which by deed dated December 20, 1973 was granted and conveyed by James H. Moshovitis to the Board of Education of Anne Arundel County and recorded among the Land Records of Anne Arundel County, Maryland, in Liber 2646 Folio 279, thence binding on a part of said first line reversely North 22 degrees 24 minutes 36 seconds West 274.49 feet to a point marking the beginning thereof, said point being marked P.O.B. and shown on plat No. 16030-D dated March 1974 entitled "Boundary Survey Broad Creek Park" and kept on file at the Department of Public Works of Anne Arundel County, Maryland, thence binding on the fifth, sixth and seventh lines of said parcel of land described in the deed secondly mentioned above, reversely, South 67 degrees 35 minutes 24 seconds West 141.96 feet, North 20 degrees 34 minutes 35 seconds West 131.17 feet and North 73 degrees 23 minutes 08 seconds West 189.52 feet to a point in the said third line of that parcel of land described in the deed firstly mentioned above, thence running with and binding on a part of said third line North 21 degrees 18 minutes 18 seconds West 532.59 feet to the point of beginning.

Containing in all 9.079 acres of land more or less. All as shown on a plat prepared by The Department of Public Works of Anne Arundel County, Maryland, dated September 1990 entitled "Pathways - Alternate Drug Treatment Center" attached hereto and recorded herewith.

Being a part of the property conveyed to Anne Arundel County, Maryland, by deed dated December 20, 1973 and recorded among the Land Records of Anne Arundel County, Maryland, in Liber 2646 Folio 283.

6581U

GROUND LEASE

by and between

ANNE ARUNDEL COUNTY

and

ANNE ARUNDEL GENERAL TREATMENT SERVICES, INC.

EXHIBIT B

Schedule of certain Permitted Encumbrances

NONE

GROUND LEASE

by and between

ANNE ARUNDEL COUNTY, MARYLAND

and

ANNE ARUNDEL GENERAL TREATMENT SERVICES, INC.

EXHIBIT C

Landlord's Studies

Wetlands determination
Forested Areas determination
Floodplain analysis

MASTER MEMORANDUM OF UNDERSTANDING

WHEREAS, Anne Arundel Treatment Services, Inc. (hereinafter referred to as the "Hospital") and Anne Arundel County, Maryland (hereinafter referred to as the "County") have expended significant energy to establish a residential adolescent and young adult substance abuse treatment facility in Anne Arundel County (hereinafter referred to as the "facility"); and

WHEREAS, in furtherance of this effort County departments and the Hospital have executed various memoranda of understanding; and

WHEREAS, the County and the Hospital wish to execute a Master Memorandum of Understanding to provide affirmation regarding the interrelation of existing memoranda of understanding and the direction of future accommodations necessary to secure the success of the facility.

NOW THEREFORE, it is hereby affirmed as follows:

1. The County agrees to contribute to the project the $2,000,000 appropriated in the FY91 budget in accordance with the Financial Memorandum of Understanding. That Memorandum delineates a procedure to expedite the distribution of these funds.

2. Provisions for support services by the County Health Department are delineated in the Memorandum of Understanding executed by the Health Department and the Hospital.

3. A Land Lease with a 30 year term and rent of One Dollar

($1.00) per year will be executed by the parties for land titled to the County which is located near the junction of Riva Road and Harry Truman Parkway. The Land Lease will provide for three 10-year renewals. A conservative appraisal of the property establishes a Two Hundred Thousand Dollar ($200,000) per acre value which should provide a sufficient base for meeting the matching fund requirements delineated at Chapter 242 of the Acts of 1990 which is known as the Anne Arundel Treatment Services, Inc. Loan of 1990.

4. The Hospital agrees to commit the personnel necessary to plan, design, and operate a state of the art program consisting of residential assessment and rehabilitation, and outpatient support for adolescents and young adults. The Hospital will admit Anne Arundel County residents to the facility regardless of their ability to pay and will make special accommodations for gray area/indigent patients.

5. The Board of Education will be responsible for providing adequate educational services to eligible patients consistent with the demands of therapy. The Hospital and the Board of Education are engaged in efforts to finalize a memorandum of understanding that describes the particulars of this program. The Memorandum will also describe the easement through the Board's property to the facility and the manner by which patients will access Board recreational or camping facilities.

6. The County Department of Recreation and Parks will make available to patients of the facility recreational facilities and will coordinate with the facility recreational programs for patients.

7. The County and the Hospital are committed to providing egress for the facility, the Heritage Office Plaza, and the Board of Education through the Connector Road project. The design phase of this project is being completed and efforts to secure continued funding will be pursued.

ANNE ARUNDEL COUNTY, MARYLAND

By: _____
James Lighthizer,
County Executive

ANNE ARUNDEL GENERAL
TREATMENT SERVICES, INC.

By: _____
Carl A. Brunetto, 11-30-90
President

MEMORANDUM OF UNDERSTANDING

==========

The Health Department of Anne Arundel County and Anne Arundel General Treatment Services, Inc. (hereinafter referred to as "Pathways") agree that:

1 - Two and a half full time equivalent Open Door Addiction Counselors will be housed at Pathways.

2 - The services rendered by these Open Door counselors will be consistent with the current services provided by Open Door.

3 - Supervision of these personnel rendering services at Pathways will be under the auspices of the Health Department.

4 - Assigned Open Door personnel will be part of a multidisciplinary outpatient team at Pathways and actively involved in collaborative working relationships with regard to case management/assignment, enforcing patient rules and guidelines, and overall program direction.

5 - Further consultation and collaborative meetings between Open Door and Pathways will take place in regularly scheduled meetings to further elaborate these aspects of the interaction.

6 - These consultative and collaborative meetings will evolve more detailed working descriptions of the relationship between the parties.

DEPARTMENT OF HEALTH
ANNE ARUNDEL COUNTY,
MARYLAND

By _____
Thomas C. Andrews,
Health Officer

Date 11/30/90

ANNE ARUNDEL GENERAL
TREATMENT SERVICES, INC.
(Pathways Treatment Center)

By _____
Carl A. Brunetto,
President

Date 11-30-90

DEED OF EASEMENT

This DEED OF EASEMENT made this ___ day of _____, 1991 by Anne Arundel County Maryland ("Grantor") to and for the benefit of Anne Arundel General Treatment Services, Inc., ("Grantee").

WHEREAS, Grantor has, prior hereto, recorded the Plat attached hereto as Exhibit A in the Plat Records of Anne Arundel County; and

WHEREAS, Grantor is the owner of the parcel of land designated on Exhibit A as "Remainder" (hereinafter the "Remainder Property"); and

WHEREAS, Anne Arundel General Treatment Services, Inc. desires to develop a treatment facility on the property designated on Exhibit A as the "Leased Parcel" (hereinafter, the "Leased Parcel") and requires an easement for access, ingress and egress to and from the Leased Parcel in connection with the development and use of the facility, and Grantor supports the development of the facility and is willing to grant the access easement reserving the right, described herein, to relocate the access easement under the terms stated herein.

NOW, THEREFORE, in consideration of the foregoing, and $10 paid in hand, the receipt and sufficiency of which are hereby acknowledged, the Grantor hereby grants, conveys, and assigns to Grantee, it successors and assigns, an easement for pedestrian and vehicular access, ingress and egress over the Remainder Property in the location designated on Exhibit A as "95' Temporary Ingress and Egress & Parking Easement," ("herein the Easement").

SUBJECT, however, to the reservation by Grantor of the right to relocate the Easement if required by Grantor in its use and development of the Remainder Parcel so long as the replacement location (herein "relocation area") does not unreasonably interfere with Grantee's operations on the

Leased Parcel. Before exercising the foregoing right of relocation, Grantor agrees to (i) promptly inform Grantee of any plans of Grantor to relocate the Easement, and of any material change in such plans; (ii) provide Grantee and its agents and engineers with information and drawings for any proposed relocation before the same are finalized; (iii) allow Grantee the opportunity to comment on the plans for the revised location, (which comments must be submitted to Grantor within 15 days of submission of plans to Grantee); and (iv) take Grantee's comments into consideration when formulating the final plan. The relocation area and any road to be constructed therein shall be designed in compliance with good traffic engineering standards. The Grantor shall be entitled to construct a new road in the relocation area at its cost and expense and Grantee shall be entitled to continue to use the original Easement for access, ingress and egress until construction of the replacement access in the relocation area is complete.

This Easement shall be binding on Grantor and its heirs and assigns and shall benefit Grantee its successors and assigns, and any future owner of the Leased Parcel, and their heirs, successors and assigns.

IN WITNESS whereof, the Grantor has executed this Deed of Easement, under seal, the day and year first above written.

Approved for form and legal sufficiency

_____

Witness:

_____

Approved and Accepted this ____day of _____, 1991

Anne Arundel County, Maryland

By: _____
Robert Neall,
County Executive

5216/BLURE

STATE OF MARYLAND
COUNTY OF ANNE ARUNDEL

On this ___ day of _____, 1991, before me, the undersigned officer, personally appeared _____, of the State and County aforesaid, known to me (or satisfactorily proven) to be the person described in the foregoing instrument, and acknowledged that he executed the same in the capacity therein stated and for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

_____
Notary Public

My Commission Expires:

I HEREBY CERTIFY, that I am an attorney admitted to practice before the Court of Appeals of Maryland and that the within instrument was prepared by me or under my supervision.

M. Lucinda Motsko

M. Lucinda Motsko

December 3, 1991

Date

5216/BLURE

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding (hereinafter referred to as "Memorandum") is made and entered into this 29th day of November, 1990, by and between Anne Arundel County, Maryland (hereinafter referred to as "County") and Anne Arundel General Treatment Services, Inc. (hereinafter referred to as "Pathways").

WHEREAS, Pathways is a private, not-for-profit corporation organized under the laws of the State of Maryland for purposes of providing substance abuse treatment and related services with its principal place of business at Harry S. Truman Parkway and Riva Road, Annapolis, Maryland 21401.

WHEREAS, funds in the aggregate amount of $2,000,000.00 have been appropriated in the budget of Anne Arundel County for FY 1991 for the construction of a substance abuse treatment center for the citizens of the County and other regions;

WHEREAS, Pathways proposes to construct and operate the substance abuse treatment center desired by the County; and

WHEREAS, the County requires Pathways to provide certain information as a condition of disbursing these funds on behalf of Pathways;

NOW, THEREFORE, the following procedure shall control the disbursement of the appropriated funds:

1. Commencing July 1, 1990, Pathways may submit to the County requests for disbursement of the allocated $2,000,000.00.

2. Disbursements may only be made for expenditures incurred after July 1, 1990 and for expenditures which are subject to contracts that have been approved by the Board of Public Works.

3. Requests for disbursement shall not be submitted more than once in any two-week period.

4. Pathways shall present to the County the authorized signature and title of the person(s) authorized to request the aforedescribed disbursements.

5. Requests for disbursement shall include the following supporting documentation:

a. where the request is for direct payment to a vendor, copies of invoices required to be paid by Pathways; or

b. where the request is for payment to Pathways or an affiliated corporate entity as reimbursement for payments made to a vendor on behalf of Pathways, copies of paid invoices.

6. Requests for disbursement shall be made by personal delivery to the Office of Finance or by certified mail, return receipt to the Assistant Comptroller, Office of Finance, Room 302, Arundel Center, 44 Calvert Street, Annapolis, Maryland 21404.

7. Upon receipt of the supporting documentation described in paragraph 5, the County shall promptly determine the propriety of the expenditures and, if appropriate, shall disburse the funds either directly to a vendor, to Pathways, or to an affiliated corporate entity, as requested by Pathways.

8. Disbursements shall be made within three working days of approval by the County.

9. The parties understand and acknowledge that Pathways is neither an agency nor instrument of the County and that this Memorandum does not make the County the guarantor, indemnitor, or insurer of any debt or other obligation now existing or which may arise in the future.

Anne Arundel General Treatment Services, Inc.

Witness

By: _____
DeLany Fawkes
Secretary-Treasurer

Anne Arundel County
Office of Finance

Witness

By: _____
Joseph Burrows
Comptroller

CR**Goodman**ASSOCIATES
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STATE OF MARYLAND LICENSE NUMBER: 14696

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CONSULTANTS

ISSUE	DATE	NUMBER

CLIENT

Anne Arundel Medical Center

PROJECT TITLE

MENTAL HEALTH HOSPITAL

DATE	03.22.16
CRGA PROJECT NUMBER	15.129.A

DRAWING TITLE

EXTERIOR RENDERING

DRAWING NUMBER

A101

J:\2015\15.129.A\BI Drawings\1 Schematic Design\03 Working Files\Current_AAMMC Pathways Model.rvt

3/3/2016 1:47:03 PM

PROPOSED STEP POOL STORM CONVEYANCE SYSTEM

PROPOSED FREESTANDING MENTAL HEALTH FACILITY - 3 STORIES (16 BEDS)

PROPOSED MICRO-BIORETENTION FACILITIES

PROPOSED COUNTY PRODUCTION WELL

NAMED PERENNIAL TRIBUTARY TO ROAD CREEK

EASTERN TRIBUTARY

EXISTING 2 STORY OFFICE BUILDING "A" 181 HARRY S. TRUMAN PKWY 63,318 SQ. FT. ± F.F. ELEV.= 77±0

LOT 1

PROP. BLDG. BSMT. EL. 60.0

EXISTING BUILDING "PATHWAYS"

EXISTING BUILDING "BOARD OF EDUCATION"

HARRY S TRUMAN PARKWAY

EX. PUBLIC RIGHT-OF-WAY RIVA ROAD

C2

C4

W1

PROJECT SUMMARY

C2 ZONING (COMMERCIAL OFFICE DISTRICT - ARTICLE 18-5-301) - PERIPHERY CLASSIFICATION, RIVA NORTH / GOVERNMENT PARK SUB-AREA OF THE PGMA

DESCRIPTION	REQUIRED
MINIMUM LOT SIZE	20,000 SQ. FT.
MAX. BUILDING HEIGHT	4 STORY MAX. (6 STORY W/ INCENTIVES)
FLOOR AREA RATIO	0.4 MAX. / 0.5 W/ INCENTIVES
SETBACKS:	
- SIDE	10'
- REAR	10'
MINIMUM LOT DEPTH	100'
MAX. LOT COVERAGE (STRUCTURES & PARKING)	80% OF GROSS AREA - C2 ZONE 75% MAX. / 81.25% W/ INCENTIVES - PGMA
OPEN AREA	25% MIN. OF GROSS AREA

SITE LEGEND

- PROPERTY LINE
- EXISTING CONTOUR
- EXISTING WOODS
- EXISTING FENCE
- EXISTING SOILS BOUNDARY
- EXISTING SOILS DESIGNATION
- EXISTING UTILITY POLE W/ OVERHEAD WIRE
- EXISTING WATER
- EXISTING SEWER
- EXISTING STORM DRAIN
- EXISTING GAS
- EXISTING ZONING BOUNDARY
- EXISTING ZONING DESIGNATION
- EXISTING GUARDRAIL
- EXISTING NON-TIDAL WETLANDS & 25' BUFFER
- EXISTING RIPRAP
- EXISTING EASEMENT
- EXISTING SPECIMEN TREE W/ CRITICAL ROOT ZONE
- EXISTING SPECIMEN TREE TO BE REMOVED
- EXISTING STREAM AND STREAM BUFFER
- EXISTING STEEP SLOPES 15% TO 25%
- EXISTING STEEP SLOPES GREATER THAN 25%
- EXISTING STEEP SLOPES BUFFER

Revisions

Rev. #	By	Date	Description

I hereby certify that these documents were prepared or approved by me, and that I am a duly licensed professional engineer under the laws of the State of Maryland.

Terry Schuman — Date 3/31/16
License No. 19933 — Expiration Date

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Warning: This document is an instrument of professional service prepared by Bay Engineering Inc. Alteration of this document by any party other than Bay Engineering Inc. is a violation of law that will be prosecuted to its fullest extent.

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Engineers, Planners and Surveyors
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Annapolis, Maryland 21401
410.897.9290
410.897.9295 fax
mail@bayengineering.com
www.bayengineering.com

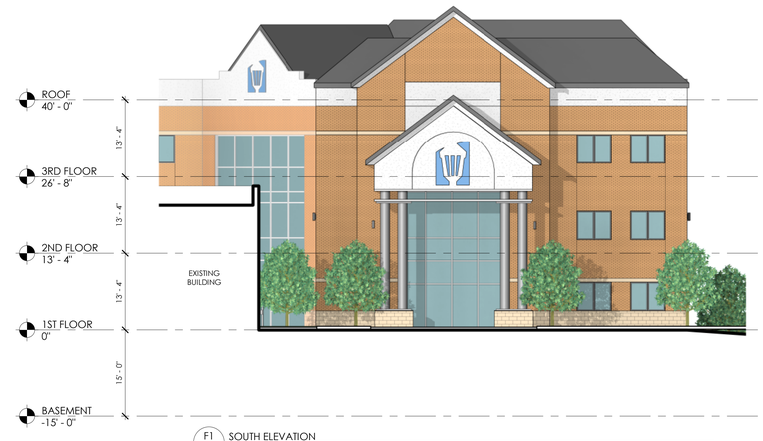
Date: FEBRUARY, 2016
Job Number: 15-5446
Scale: 1"=50'
Drawn By: LS
Approved By: TS
Folder Reference: GOODMAN ARCHITECTS PATHWAYS, ANNAPOLIS

PROPOSED SITE PLAN
FEASIBILITY PLAN
FOR
FREESTANDING MENTAL HEALTH HOSPITAL
ANNE ARUNDEL MEDICAL CENTER
TAX MAP 50, GRID 6, PARCEL 222
2605 RIVA ROAD
ANNAPOLIS, MARYLAND 21401
SECOND DISTRICT ANNE ARUNDEL COUNTY ZONED C2

Sheet No. 1 OF 1

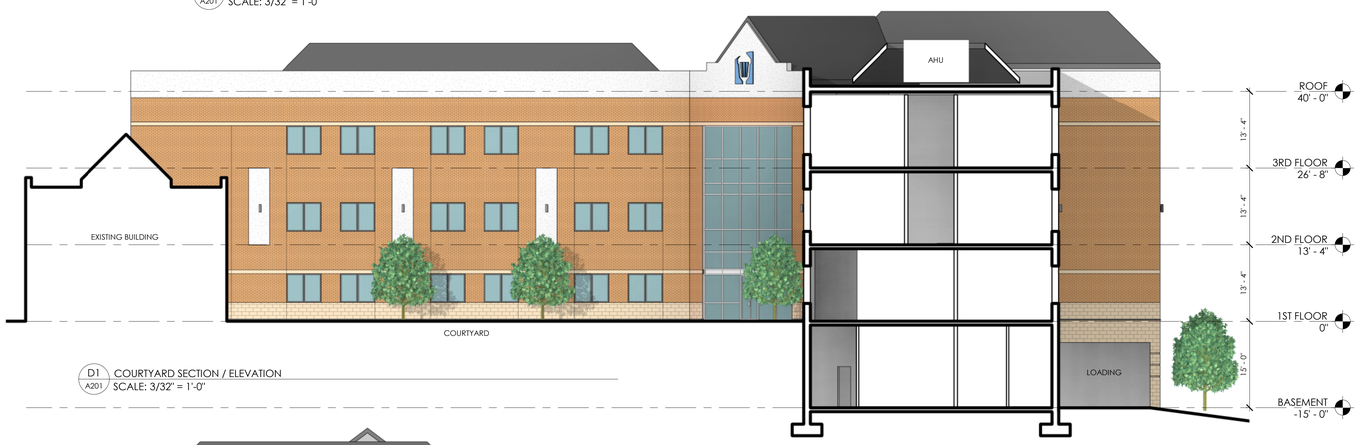
PLOTTED: Feb 19, 2016 - 9:31am
INCLUDED XREFS & IMAGES: 15-5446 PATHWAYS-ANNAPOLIS-BASE.dwg 30x42.dwg 20151221092943_00001.jpg

F:\15-5446 Goodman Architects Pathways Annapolis\Drawing Files\Feasibilities\15-5446 PATHWAYS-ANNAPOLIS-FEASIBILITY PLAN 01.dwg

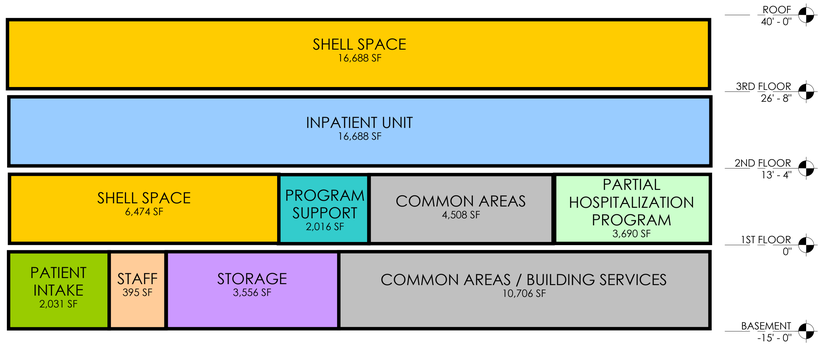


F1 A201 SOUTH ELEVATION
SCALE: 3/32" = 1'-0"

F6 A201 WEST ELEVATION
SCALE: 3/32" = 1'-0"



D1 A201 COURTYARD SECTION / ELEVATION
SCALE: 3/32" = 1'-0"



STACKING DIAGRAM

B1 A201 NORTH ELEVATION
SCALE: 3/32" = 1'-0"

A4 A201 EAST ELEVATION
SCALE: 3/32" = 1'-0"

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STATE OF MARYLAND LICENSE NUMBER: 14496

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ISSUE	DATE	NUMBER
CON SUBMISSION	02.19.16	

CLIENT
Anne Arundel Medical Center

PROJECT TITLE
MENTAL HEALTH SPECIALTY HOSPITAL

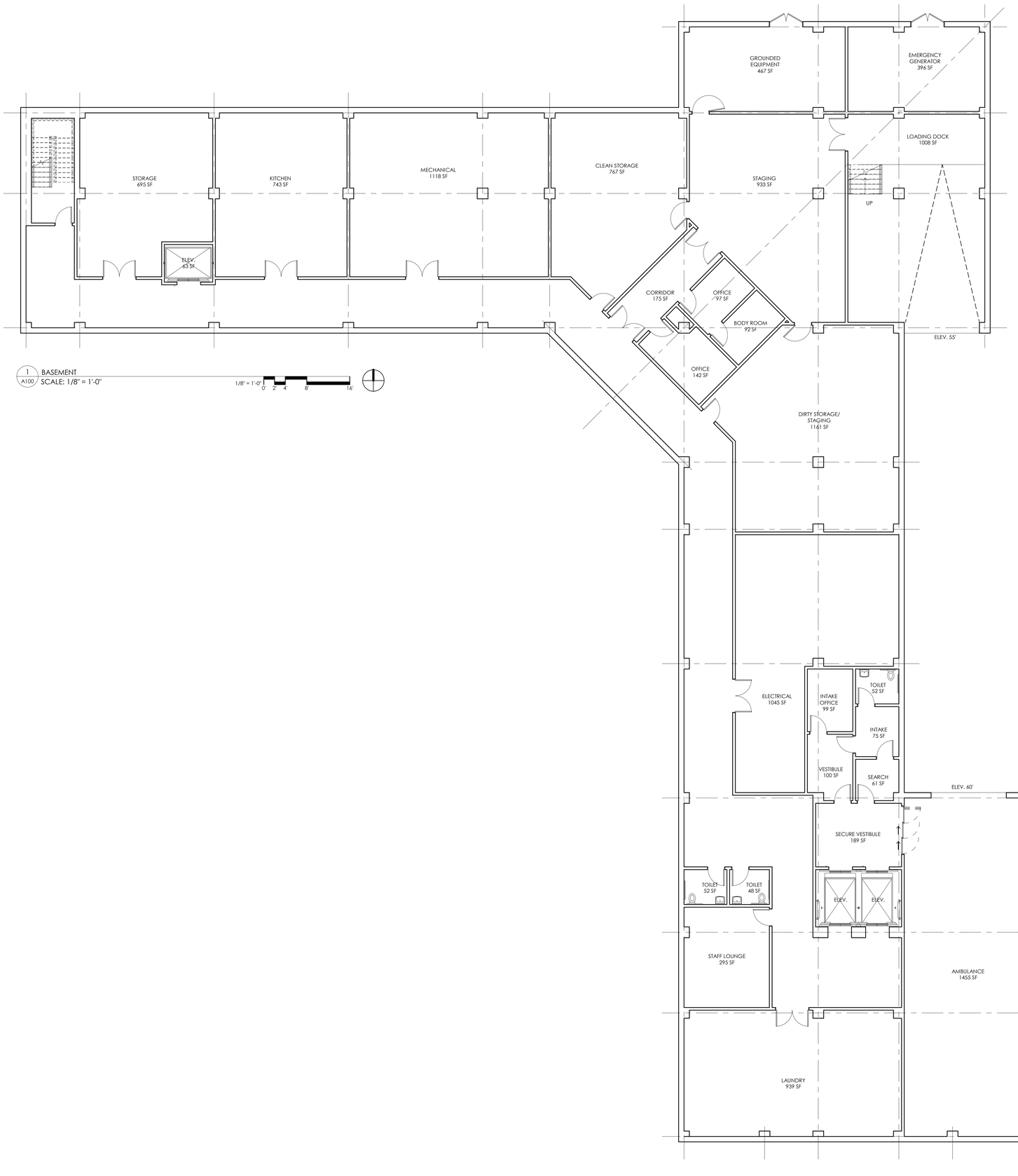
DATE 02.19.16

CRGA PROJECT NUMBER 15.129.A

DRAWING TITLE
BUILDING ELEVATIONS

DRAWING NUMBER
A201

J:\2015\15.129.A\O) Renderings\02.15.16 - Exterior Elevations\02.15.16 - Exterior Elevations.rvt
2/15/2016 5:00:40 PM



1 A100 BASEMENT
SCALE: 1/8" = 1'-0"

1/8" = 1'-0"
0 2 4 8 16

2/18/2016 2:22:58 PM J:\2015\15.129 A\B) Drawings\1 Schematic Design\03 Working Files\Current_ AMMC Pathways Model2.rvt

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CONSULTANTS

ISSUE	DATE	NUMBER
CON SUBMISSION	02.19.16	

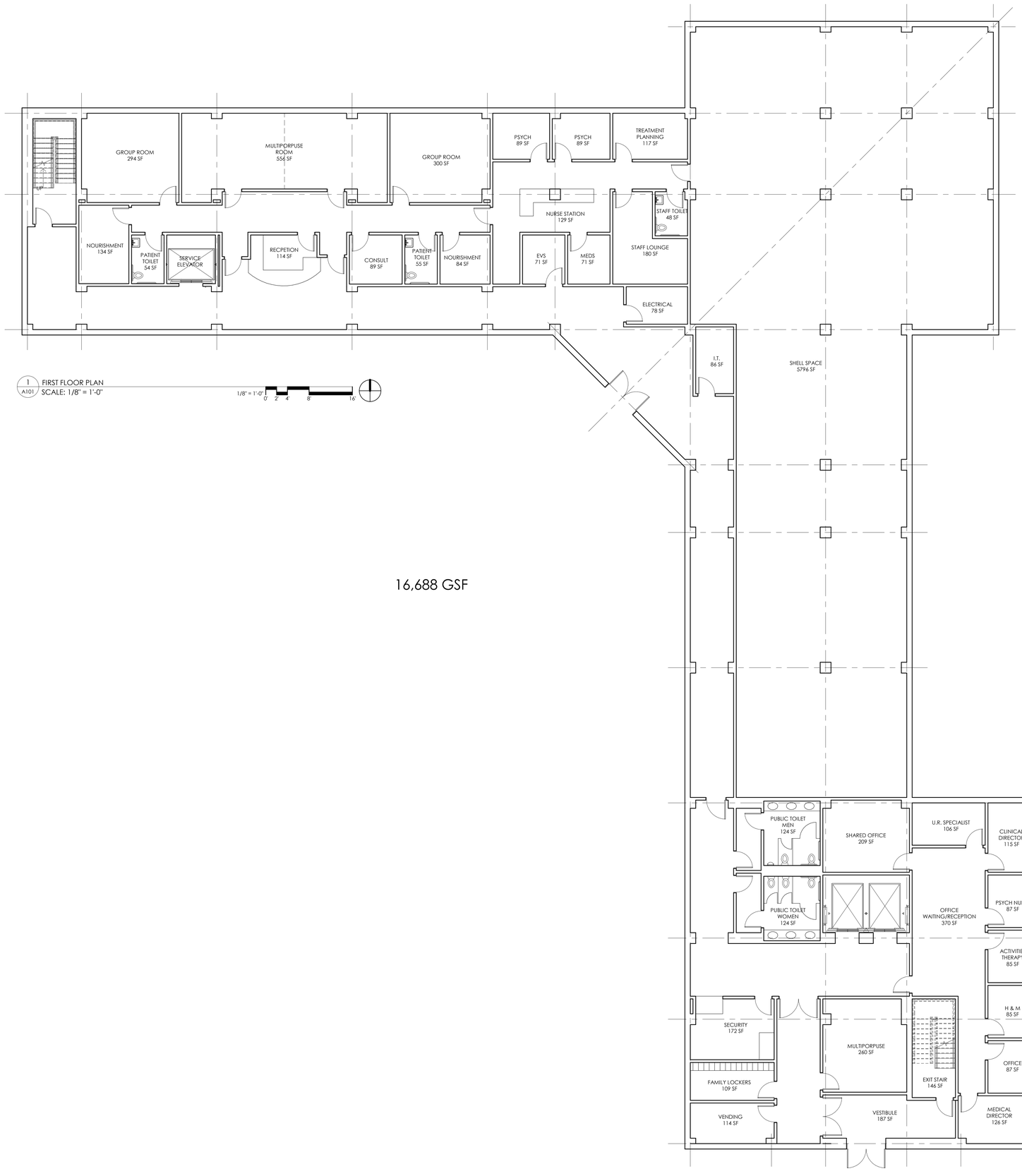
CLIENT
Anne Arundel Medical Center

PROJECT TITLE
MENTAL HEALTH SPECIALTY HOSPITAL

DATE	02.19.16
CRGA PROJECT NUMBER	15.129.A

DRAWING TITLE
BASEMENT FLOOR PLAN

DRAWING NUMBER
A100



1 A101 FIRST FLOOR PLAN
SCALE: 1/8" = 1'-0"

1/8" = 1'-0" 0' 2' 4' 8' 16'

16,688 GSF

2/23/2016 11:28:08 AM J:\2015\15.129 A\B (Drawings)\1 Schematic Design\03 Working Files\Current_AAMC Pathways Model.rvt

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STATE OF MARYLAND LICENSE NUMBER: 14696

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CONSULTANTS

ISSUE	DATE	NUMBER
CON SUBMISSION	02.23.16	

CLIENT
Anne Arundel Medical Center

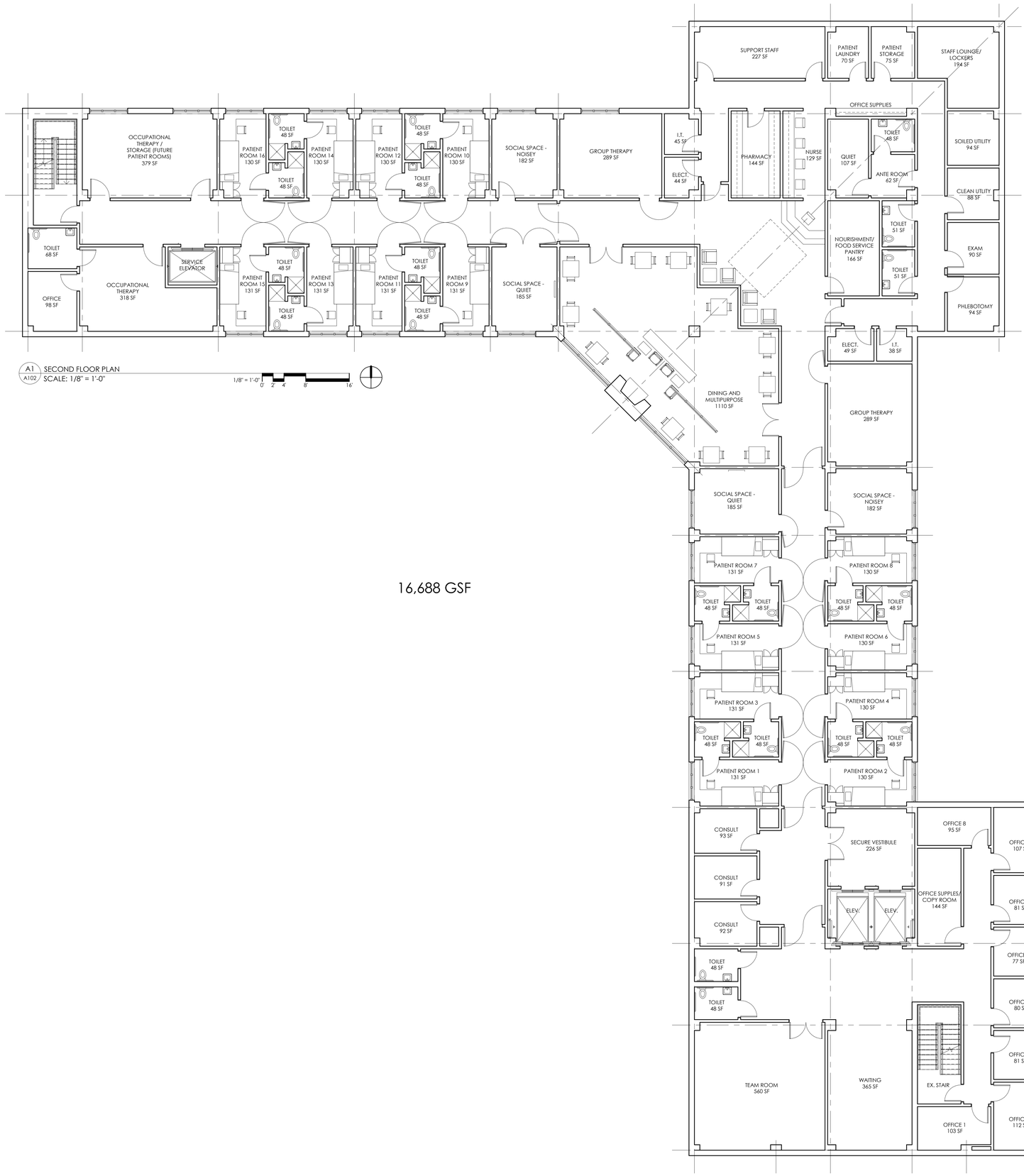
PROJECT TITLE
MENTAL HEALTH SPECIALTY HOSPITAL

DATE 02.23.16

CRGA PROJECT NUMBER 15.129.A

DRAWING TITLE
FIRST FLOOR PLAN

DRAWING NUMBER
A101



A1 SECOND FLOOR PLAN
A102 SCALE: 1/8" = 1'-0"

1/8" = 1'-0" 0 2 4 8 16'

16,688 GSF

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CONSULTANTS

ISSUE	DATE	NUMBER
CON SUBMISSION	02.19.16	

CLIENT

Anne Arundel Medical Center

PROJECT TITLE

MENTAL HEALTH SPECIALTY HOSPITAL

DATE	02.19.16
CRGA PROJECT NUMBER	15.129.A

DRAWING TITLE

SECOND FLOOR PLAN

DRAWING NUMBER

A102

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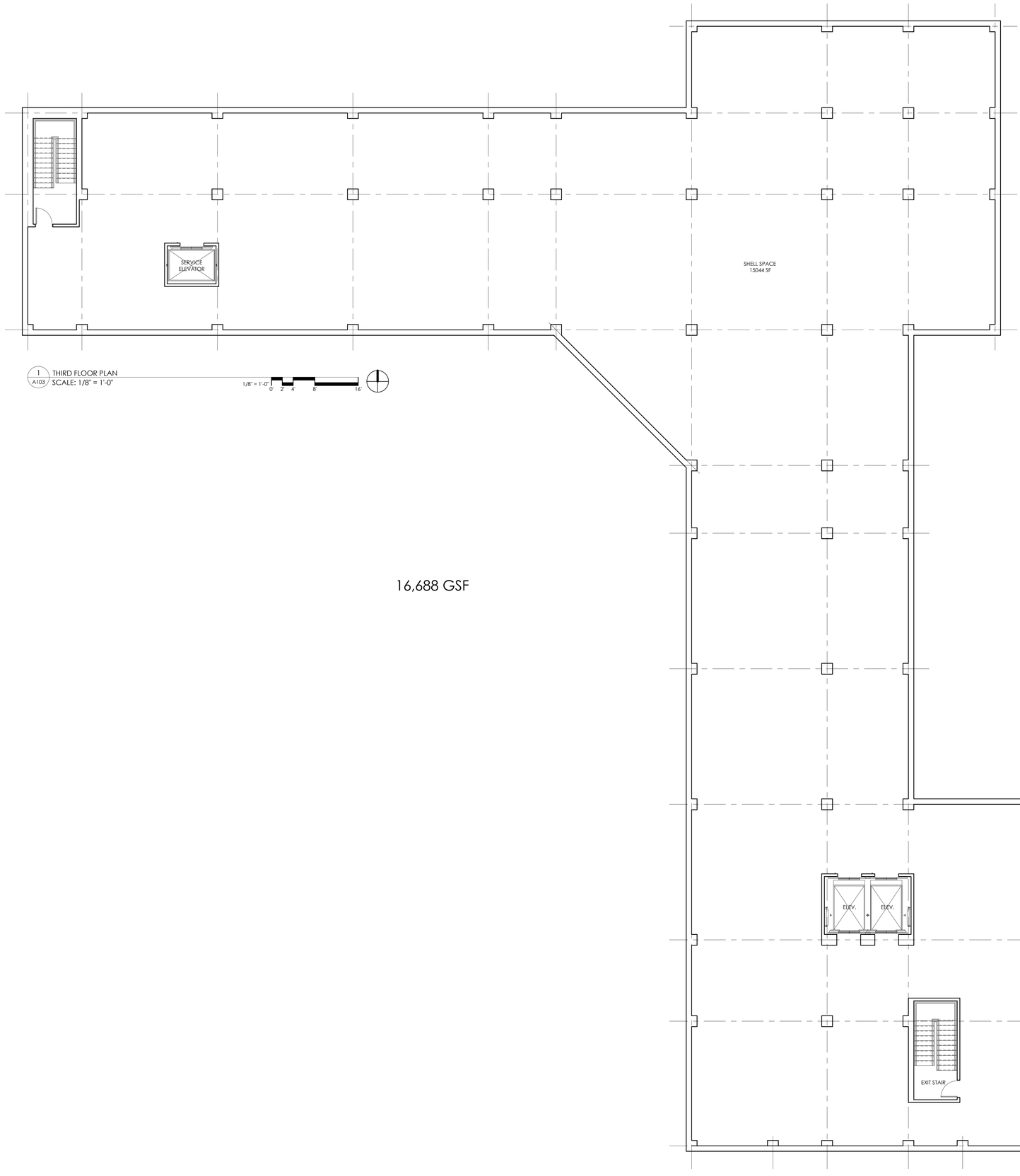

1 A103 THIRD FLOOR PLAN
SCALE: 1/8" = 1'-0"

1/8" = 1'-0" 0' 2' 4' 8' 16'

16,688 GSF

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STATE OF MARYLAND LICENSE NUMBER: 14696

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CONSULTANTS

ISSUE	DATE	NUMBER
CON SUBMISSION	02.19.16	

CLIENT

Anne Arundel Medical Center

PROJECT TITLE

MENTAL HEALTH SPECIALTY HOSPITAL

DATE	02.19.16
CRGA PROJECT NUMBER	15.129.A

DRAWING TITLE

THIRD FLOOR PLAN

DRAWING NUMBER

A103

2/18/2016 2:55:06 PM J:\2015\15.129 A\B) Drawings\1 Schematic Design\03 Working Files\Current_AAMC Pathways Model2.rvt

SEGREGATED COST FORM

For subscribers using the MARSHALL VALUATION SERVICE *Segregated Cost Method*

1. Subscriber making survey GUILBANK BUILDING Date 3·3·16 Name of Building AAMC - MARYLAND HEART
2. Located at RIVA ROAD, ANNAPOLIS, MD. Owner/AAMC SPECIALTY HOSPITAL

	Section I OUTPATIENT B.H.	Section II	Section III
3. Occupancy			
4. Building class and quality	Cls. A Qual. GOOD	Cls. Qual.	Cls. Qual.
5. No. of stories & height per story	No. 4 Ht. 14'-0"	No. Ht.	No. Ht.
6. Age and condition	Age Cond.	Age Cond.	Age Cond.

7. Region: Western Central Eastern X
8. Climate: Mild Moderate X Extreme

COST RANGE RATING NUMBERS			
Low No. 1	Average No. 2	Above Average No. 3	High No. 4

FLOOR AREA COSTS / UNIT COSTS

		NO.	SECTION I	NO.	SECTION II	NO.	SECTION III
9.	Excavation:						
10.	Foundation: SEE CALC	2	3.58				
11.	Frame: SEE CALC	2	20.24				
12.	Floor Structure: SEE CALC	2	12.08				
13.	Floor Cover: SEE CALC	2	7.54				
14.	Ceiling: SEE CALC	2	3.67				
15.	Interior Construction: SEE CALC	2	50.77				
16.	Plumbing: SEE CALC	2	8.14				
17.	Sprinklers:	2	2.59				
18.	Heating, Cooling, Ventilating: SEE CALC	2	13.21				
19.	Electrical: SEE CALC	2	17.38				
20.	*Total floor area unit costs; move to line 27*		139.20				
	WALL COSTS						
21.	Exterior Walls: *Move to line 28*	2	27.50				
22.	Wall Ornamentation: *Move to line 29*						
	ROOF COSTS						
23.	Roof Structure:	2	14.65				
24.	Roof Cover:	2	10.75				
25.	Trusses:	2	3.24				
26.	*Total roof unit costs; move to line 30*		28.64				

FINAL CALCULATIONS

		from line	SECTION I UNIT COST x AREA = TOTAL COST	SECTION II UNIT COST x AREA = TOTAL COST	SECTION III UNIT COST x AREA = TOTAL COST
27.	Floor Area Costs	20	66,752 x 139.20 = 9,291,878	x =	x =
28.	Exterior Walls	21	33,392 x 27.50 = 890,780	x =	x =
29.	Wall Ornamentation	22	x =	x =	x =
30.	Roof	26	16,688 x 28.64 = 477,944	x =	x =
31.	Section Subtotals		10,660,602		
32.	Number of Stories Multiplier		X	X	X
33.	Section Totals		10,660,602		
34.	Architects' Fees (Sec. 99, p. 2)				
35.	Current Cost Multiplier (Sec. 99, p. 3)		1.05		
36.	Local Multiplier (Sec. 99, pp. 5 – 10)		1.04		
37.	Final Multiplier (Ln. 34 x Ln. 35 x Ln. 36)		1.09		
38.	Line 37 x Line 33		11,620,057		
39.	LUMP SUMS (Line 45)		1,170,000		
40.	REPLACEMENT COST (Ln. 38 + Ln. 39)		12,790,057		
41.	Depreciation % (Section 97)				
42.	Depreciation Amount (Ln. 41 x Ln. 40)				
43.	DEPRECIATED COST (Ln. 40 – Ln. 42)				

TOTAL OF ALL SECTIONS

44. Replacement Cost: $ 12,790,057 Depreciated Cost: Insurable Value:

Calculations:

FOUNDATION : 3.36 + (3.36)(.04 + .008 + .008 + .008) = 3.58

FRAME: 18.40 + (18.40)(.03 + .03 + .02 + .02) = 20.24

FLOOR STRUCTURE: SOG = 4.74 + .97 = 5.71 ; ELEVATED DECK = 14.2 USE A BLENDED RATE

5.71 + 14.2 + 14.2 + 14.2 = 48.31 / 4 = 12.08

FLOOR COVERING: (1.17)(.35) + [(5.93 + 16)/2](.65) = .41 + 7.13 = 7.54

CEILING: 2.28 + 1.88 + .90 = 5.06 ; (5.06)(.65) = 3.67

INTERIOR CONSTRUCTION: 71 + 10% = 78.10 ; (78.10)(.65) = 50.77

PLUMBING: (10.85)(.75) = 8.14

HEATING COOLING : 13.85 + 6% = 14.68 ; (14.68)(.90) = 13.21

ELECTRICAL: (20.75)(.85) = 17.38

* CALCS TAKE INTO ACCOUNT 65% FIT OUT AND 35% SHELL SPACE ; FOR MEP WE USED SLIGHTLY HIGHER FACTORS B/C THE INFRASTRUCTURE STILL HAS TO BE INSTALLED

Lump Sum (Elevators, Storefronts, etc.):

ELEVATORS (3)	315,000
STAIRS (2)	80,000
ENTRANCE	300,000
INTEGRATED TECHNOLOGY	350,000
COMMISSIONING	125,000
	1,170,000

45. *Total lump sum cost; move to Line 39*

Insurance Exclusions (Section 96)	SECTION I	SECTION II	SECTION III
46. Replacement or Depreciated Cost (Line 40 or 43)			
47. Demolition, Debris Removal %			
48. Added Amount (Line 47 x Line 46)			
49. Basement Excavation			
50. Foundation Below Ground			
51. Piping Below Ground			
52. Architects' Plans and Specifications			
53. Total % of Exclusions (Lines 49 through 52)			
54. Excluded Amount (Line 53 x Line 46)			
55. Insurable Value (Line 46 + Line 48 – Line 54)			

Notes:

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Suite 216, The Public Ledger Building
150 S. Independence Mall, West
Philadelphia, PA 19106-3413

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Northeast Consortium/ Division of Survey & Certification

October 2, 2015

Ms. Victoria Bayless, Administrator
Anne Arundel Medical Center
2001 Medical Parkway
Annapolis, MD 21401

Dear Ms. Bayless:

Re: CMS Certification Number: **210023**

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Based on the results of the Maryland Office Of Health Care Quality survey that ended on June 1, 2015, we find that **Anne Arundel Medical Center** is now in compliance with all of the Medicare conditions of participation.

Anne Arundel Medical Center can again be recognized as meeting Medicare requirements by virtue of its accreditation by the Joint Commission (JC). The hospital's "deemed status" has been restored as of the date of this letter.

We appreciate your efforts and the steps taken to correct the Medicare deficiencies cited by the Maryland Office Of Health Care Quality. We thank you for your cooperation, and look forward to working with you on a continuing basis in the administration of the Medicare program.

Sincerely,

Pat McNeal
Principal State Representative
Certification and Enforcement Branch

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Philadelphia Regional Office
Suite 216, The Public Ledger Building
150 S. Independence Mall, West
Philadelphia, PA 19106-3413

Northeast Division of Survey & Certification

July 9, 2013

Ms. Victoria Bayless, Administrator
Anne Arundel Medical Center
2001 Medical Parkway
Annapolis, MD 21401

Dear Ms Bayless:

Re: CMS Certification Number: 210023

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Based on the results of the Maryland Office of Health Care Quality survey that ended on July 2, 2013 , we find that Anne Arundel Medical Center is now in compliance with all of the Medicare Conditions of Participation.

Anne Arundel Medical Center can again be recognized as meeting Medicare requirements by virtue of its accreditation by the Joint Commission (JC). The hospital's "deemed status" has been restored as of the date of this letter.

We appreciate your efforts and the steps taken to correct the Medicare deficiencies cited by the Maryland Office of Health Care Quality. We thank you for your cooperation, and look forward to working with you on a continuing basis in the administration of the Medicare program.

Sincerely,

Pat McNeal
Principal State Representative
Certification and Enforcement Branch

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

June 25, 2004

Caroline Rader
Corporate Compliance Officer
Anne Arundel Medical Center
2001 Medical Parkway
Annapolis, Maryland 21401

Re: Corporate Integrity Agreement – Close Out Letter

Dear Ms. Rader:

Anne Arundel Medical Center, (Medical Center) entered into a Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the Department of Health and Human Services on April 29, 1999. The CIA required the establishment of a Corporate Integrity Program (compliance program) to be in effect for five years from the date of the execution of the CIA and obligated the Medical Center to implement certain corporate integrity provisions (e.g., training, writing policies, audits, etc.) during that time period. Pursuant to the terms of this CIA, the five years have expired and the corporate integrity provisions have been fulfilled.

During the term of its corporate integrity requirements, the Medical Center submitted annual reports to the OIG summarizing the status of their compliance program that appeared to meet the basic requirements of the CIA. The OIG has completed its review of your most recently submitted annual report and found that it satisfied all the basic requirements of the CIA. The OIG recognizes that once our monitoring obligations cease, the Medical Center is under no obligation to maintain its compliance program in its current structure. However, the OIG encourages the Medical Center to continue its current compliance efforts as structured and if possible, expand the resources and presence of its compliance program as the Medical Center continues to develop and mature into a major regional health institution. Although the Medical Center appears to have implemented an efficient compliance program over the last five years, your organization is in the best position to validate the legitimacy, integrity and suitability of its effectiveness.

The OIG cannot equivocally confirm that such reports demonstrated that the Medical Center implemented an effective compliance program. It is a health care provider's responsibility to formulate policies, procedures and practices that are tailored to its own operations and demands, and that are comprehensive enough to ensure compliance with all Federal and State health care program requirements.

Although the terms for the Medical Center's corporate integrity obligations have concluded, you should be aware that the OIG may find it necessary to make further inquiries into your claim submissions and if necessary, take corrective action should it discover at a subsequent time that (1) there were potential material violations with regard to the Medical Center's compliance with the terms of its corporate integrity program during the life of the CIA, or (2) the information provided to the OIG in the Medical Center's annual reports was material inaccurate.

At the next monthly update, the Medical Center will be removed from the OIG's List of Settlement Agreements with Integrity provisions on the OIG's website. The OIG makes no representations in this letter as to the Medical Center's compliance practice that may be subject to ongoing investigations. Furthermore, our comments do not reflect our assessments of any legal claims made against the Medical Center.

Please feel free to contact me at 202-619-2580 if you have any questions.

Respectfully,

Stephen H. Davis

Stephen H. Davis
Office of Counsel to the Inspector General

Joint Commission
on Accreditation of Healthcare Organizations
Setting the Standard for Quality in Health Care

file
JCAHO
accreditation

March 11, 2004

Martin L. Doordan
President and CEO
Anne Arundel Medical Center
2001 Medical Parkway
Annapolis, Maryland 21401

Dear Mr. Doordan:

The Joint Commission is pleased to inform you that your organization's Conditional Accreditation status will be updated to Accredited based on the results of your recently completed follow-up survey. This accreditation status applies to all services offered by your organization that have been surveyed by the Joint Commission.

Your accreditation remains effective from the day after the last day of your original survey and will be continued for the balance of your current accreditation cycle.

We direct your attention to several Joint Commission policies relating to accreditation. Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or the health care services you provide. Any other reports or focused survey visits concerning other type I recommendations related to your accreditation award must also be satisfied in order to maintain your accreditation.

We wish to advise you that a copy of this correspondence, including the integral enclosures, is being provided to the Centers for Medicare and Medicaid Services. This information-sharing arrangement was created by Section 6019[a] of the Omnibus Budget Reconciliation Act of 1989, (PL 101-239) which requires hospitals using their Joint Commission accreditation for Medicare certification purposes to authorize Joint Commission release of a copy of their most recent accreditation survey, and any other information related to the survey, to the Department (upon the request of the Department). The Department's request to us for this information was issued by CMS letter of August 27, 1990.

Congratulations on the improvements, which have been made in your organization's compliance status with the standards of the Joint Commission.

Sincerely,

Russell P. Massaro

Russell P. Massaro, MD, FACPE
Executive Vice President
Division of Accreditation Operations

cc: James McEneaney, Chairman, Board of Directors
Michael Lapenta, MD, President of Medical Staff

One Renaissance Boulevard
Oakbrook Terrace, IL 60181
(630) 792-5000
http://www.jcaho.org

Member Organizations
American College of Physicians
American College of Surgeons
American Dental Association
American Hospital Association
American Medical Association

JCAHO
Hospital Accreditation Services
Accreditation Decision Grid

Organization:	Anne Arundel Medical Center 6241 2001 Medical Parkway	**Survey Date:**	March 2, 2004
Location:	Annapolis, Maryland 21401	**Survey Type:**	Conditional Follow-up Survey

PATIENT-FOCUSED FUNCTIONS

Patient Rights and Organizational Ethics

Patient Rights	
Organizational Ethics	

Assessment of Patients

Initial Assessment	1
Pathology and Clinical Laboratory Services - Waived Testing	
Reassessment	
Care Decisions	
Structures Supporting the Assessment of Patients	
Additional Requirements for Specific Patient Populations	

Care of Patients

Planning and Providing Care	
Anesthesia Care	
Medication Use	1
Nutrition Care	
Operative and Other Procedures	
Rehabilitation Care and Services	
Special Procedures	1

Education

Patient and Family Education and Responsibilities	

Continuum of Care

Continuum of Care	

ORGANIZATIONAL FUNCTIONS

Improving Organization Performance

Design	
Data Collection	
Aggregation and Analysis	1
Performance Improvement	

Leadership

Planning	1
Directing Departments	
Integrating and Coordinating Services	
Role in Improving Performance	1

Management of Environment of Care

Planning	1
Implementation	
Other Environmental Considerations	
Measuring Outcomes Of Implementation	

Management of Human Resources

Human Resources Planning	
Orientation, Training, and Education of Staff	1
Assessing Competence	1
Managing Staff Requests	

ORGANIZATIONAL FUNCTIONS CONTINUED

Management of Information

Information Management Planning	
Patient-Specific Data and Information	
Aggregate Data and Information	
Knowledge-Based Information	
Comparative Data and Information	

Surveillance, Prevention and Control of Infection

Surveillance, Prevention, and Control of Infection	

STRUCTURES WITH FUNCTIONS

Governance

Governance	

Management

Management	

Medical Staff

Organization, Bylaws, Rules, and Regulations	
Credentialing	

Nursing

Nursing	

Special Type 1 Recommendations

Accreditation Participation Requirements	1

Rating Scale

1=Evidence of good compliance
2=Evidence of acceptable compliance
3=Insufficient evidence of acceptable compliance (least deficient)
4=Insufficient evidence of acceptable compliance (more deficient)
5= Insufficient evidence of acceptable compliance (most deficient)
N=Not Applicable

Joint Commission
on Accreditation of Healthcare Organizations

Setting the Standard for Quality in Health Care

Official Accreditation Decision Report

One Renaissance Boulevard
Oakbrook Terrace, IL 60181
(630) 792-5000
http://www.jcaho.org

Member Organizations
American College of Physicians
American College of Surgeons
American Dental Association
American Hospital Association
American Medical Association

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS
OFFICIAL ACCREDITATION DECISION REPORT

Anne Arundel Medical Center
2001 Medical Parkway
Annapolis, Maryland 21401

ORGANIZATION IDENTIFICATION NUMBER 6241

DATE OF SURVEY
March 2, 2004

SURVEYOR
Laurence C. Wegienka, MD

PROGRAM
Hospital Accreditation Program

Prepared By:
Nikkiba T. Jones

ACCREDITATION DECISION

The type I recommendations which required a follow-up survey visit on the above date have been removed. The findings of this survey indicate that your organization satisfied the requirements of these type I recommendations and is no longer in Conditional Accreditation.

The results of this conditional follow up survey do not affect any other type I recommendation requirements that may exist on your current accreditation status.

STATEMENT OF CONDITIONS

This accreditation decision is based, in part, on your organization's acceptable use of the Statement of Conditions relating to compliance with the Life Safety Code. Continued accreditation is, in part, contingent upon your maintenance of a current and accurate Statement of Conditions and implementation of any corrective actions outlined in Part 4 of the Statement of Conditions (including compliance with the identified time frames for achievement). The Statement of Conditions procedure also requires you to notify the Joint Commission in writing of any significant inability to implement the Plan for Improvement as identified in Part 4 of the Statement of Conditions and/or any substantial changes to the Statement of Conditions that was submitted to the Joint Commission at the time of survey.

CLEARED TYPE I RECOMMENDATION TOPICS

The following topics, reviewed as a part of this Type I recommendation response, have been found in compliance.

Hospital Accreditation Program

1. Special Procedures
2. Initial Assessment
3. Aggregation and Analysis
4. Role in Improving Performance
5. Orientation, Training, and Education of Staff
6. Medication Use
7. Planning
8. Assessing Competence
9. Accreditation Participation Requirements

*** No Recommendations ***

Consolidated Financial Statements and Supplementary Information

Anne Arundel Health System, Inc. and Subsidiaries
Years Ended June 30, 2015 and 2014
With Report of Independent Auditors

Ernst & Young LLP

Building a better working world

Anne Arundel Health System, Inc. and Subsidiaries

Consolidated Financial Statements and Supplementary Information

Years Ended June 30, 2015 and 2014

Contents

Ernst & Young LLP
621 East Pratt Street
Baltimore, MD 21202

Tel: +1 410 539 7940
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ey.com

Report of Independent Auditors

The Board of Trustees
Anne Arundel Health System, Inc.

We have audited the accompanying consolidated financial statements of Anne Arundel Health System, Inc. (a Maryland not-for-profit corporation) and subsidiaries, which comprise the consolidated balance sheets as of June 30, 2015 and 2014, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We did not audit the financial statements of Cottage Insurance Company, Ltd., a wholly-owned subsidiary, which statements reflect total assets of $34,229,000 and $34,970,000 as of June 30, 2015 and 2014, respectively, and net loss after elimination of intercompany revenues of $1,098,000 and $1,396,000, respectively, for the years then ended. Those statements were audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Cottage Insurance Company, Ltd., is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers

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internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audits and the report of other auditors, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Anne Arundel Health System, Inc. and subsidiaries as of June 30, 2015 and 2014, and the consolidated results of their operations, changes in their net assets, and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary consolidating information is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Ernst & Young LLP

September 25, 2015

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Anne Arundel Health System, Inc. and Subsidiaries

Consolidated Balance Sheets

	June 30	
	2015	**2014**
Assets		
Current assets:		
Cash and cash equivalents	**$ 99,625,000**	$ 76,168,000
Short-term investments	**2,484,000**	6,627,000
Current portion of assets whose use is limited	**17,721,000**	14,885,000
Patient receivables, less allowance for uncollectible accounts of $18,639,000 and $19,186,000, respectively	**61,854,000**	68,622,000
Current portion of pledges receivable, net	**3,015,000**	3,525,000
Inventories	**8,130,000**	8,122,000
Prepaid expenses and other current assets	**6,257,000**	6,972,000
Total current assets	**199,086,000**	184,921,000
Property and equipment	**809,488,000**	796,494,000
Less accumulated depreciation and amortization	**(356,402,000)**	(322,727,000)
Net property and equipment	**453,086,000**	473,767,000
Other assets:		
Investments	**253,285,000**	248,988,000
Investments in joint ventures	**8,310,000**	8,123,000
Pledges receivable, net of current portion and net of allowance for uncollectible pledges of $497,000 and $548,000, respectively	**4,404,000**	6,273,000
Assets whose use is limited	**51,566,000**	62,234,000
Deferred debt issue costs, net of accumulated amortization of $1,194,900 and $1,592,000, respectively	**4,645,000**	6,100,000
Restricted collateral for interest rate swap contract	**62,939,000**	51,616,000
Other assets	**16,800,000**	12,485,000
Total assets	**$ 1,054,121,000**	$ 1,054,507,000

Anne Arundel Health System, Inc. and Subsidiaries

Consolidated Balance Sheets

	June 30	
	2015	**2014**
Liabilities and net assets		
Current liabilities:		
Accounts payable	**$ 19,485,000**	$ 20,372,000
Accrued salaries, wages, and benefits	**39,465,000**	32,446,000
Other accrued expenses	**23,034,000**	20,626,000
Current portion of long-term debt and capital lease obligations	**12,222,000**	8,613,000
Advances from third-party payors	**22,465,000**	25,244,000
Total current liabilities	**116,671,000**	107,301,000
Long-term debt and capital lease obligations, less current portion and unamortized original issue premium	**413,310,000**	403,749,000
Interest rate swap contracts	**65,852,000**	55,626,000
Accrued pension liability	**22,702,000**	19,270,000
Other long-term liabilities	**20,511,000**	22,614,000
Total liabilities	**639,046,000**	608,560,000
Net assets:		
Unrestricted	**389,579,000**	418,016,000
Temporarily restricted	**14,364,000**	16,634,000
Permanently restricted	**11,132,000**	11,297,000
Total net assets	**415,075,000**	445,947,000
Total liabilities and net assets	**$ 1,054,121,000**	$ 1,054,507,000

See accompanying notes.

Anne Arundel Health System, Inc. and Subsidiaries

Consolidated Statements of Operations and Changes in Net Assets

	Year Ended June 30	
	2015	**2014**
Operating revenue:		
Net patient service revenue	**$ 624,656,000**	$ 592,232,000
Provision for bad debts	**(19,431,000)**	(29,295,000)
Net patient service revenue less provision for bad debts	**605,225,000**	562,937,000
Other operating revenue	**28,480,000**	28,180,000
Total operating revenue	**633,705,000**	591,117,000
Operating expenses:		
Salaries and wages	**272,891,000**	250,936,000
Employee benefits	**42,925,000**	41,838,000
Medical supplies and drugs	**129,398,000**	122,275,000
Purchased services	**95,542,000**	92,594,000
Professional fees	**16,806,000**	15,655,000
Depreciation and amortization	**36,267,000**	37,032,000
Interest	**14,427,000**	16,349,000
Total operating expenses	**608,256,000**	576,679,000
Operating income	**25,449,000**	14,438,000
Other income (loss):		
Investment income, net	**16,584,000**	8,264,000
Income (loss) from joint ventures and other, net	**1,895,000**	(335,000)
Loss on advanced refunding of debt	**(32,230,000)**	–
Change in unrealized (losses) gains on trading securities, net	**(16,031,000)**	23,604,000
Realized and unrealized (losses) gains on interest rate swap contracts, net	**(16,637,000)**	(9,088,000)
Total other (loss) income, net	**(46,419,000)**	22,445,000
Revenues and gains in excess of (less than) expenses	**$ (20,970,000)**	$ 36,883,000

Anne Arundel Health System, Inc. and Subsidiaries

Consolidated Statements of Operations and Changes in Net Assets (continued)

	Year Ended June 30	
	2015	**2014**
Unrestricted net assets		
Revenues and gains in excess of (less than) expenses	**$ (20,970,000)**	$ 36,883,000
Pension liability adjustment	**(11,683,000)**	3,050,000
Net assets released from restrictions used for purchase of property and equipment	**3,177,000**	5,290,000
Transfers and other, net	**1,039,000**	250,000
(Decrease) increase in unrestricted net assets	**(28,437,000)**	45,473,000
Temporarily restricted net assets		
Contributions and pledges	**4,669,000**	3,954,000
Change in net unrealized gains and losses on investments	**(1,333,000)**	2,090,000
Temporarily restricted investment income	**387,000**	314,000
Net assets released from restrictions	**(7,763,000)**	(11,099,000)
Transfers and other, net	**1,770,000**	1,508,000
Decrease in temporarily restricted net assets	**(2,270,000)**	(3,233,000)
Permanently restricted net assets		
Contributions for endowment funds	**57,000**	76,000
Transfers of interest income and other, net	**(222,000)**	(208,000)
Decrease in permanently restricted net assets	**(165,000)**	(132,000)
(Decrease) increase in net assets	**(30,872,000)**	42,108,000
Net assets at beginning of year	**445,947,000**	403,839,000
Net assets at end of year	**$ 415,075,000**	$ 445,947,000

See accompanying notes.

Anne Arundel Health System, Inc. and Subsidiaries

Consolidated Statements of Cash Flows

	Year Ended June 30	
	2015	**2014**
Operating activities		
(Decrease) increase in net assets	**$ (30,872,000)**	$ 42,108,000
Adjustments to reconcile (decrease) increase in net assets to net cash from operating activities:		
Change in net unrealized (losses) gains on investments	**17,364,000**	(25,694,000)
Realized and unrealized losses on interest rate swap contracts, net	**16,637,000**	9,088,000
Pension liability adjustment	**11,683,000**	(3,050,000)
Equity in earnings of joint ventures and other	**(332,000)**	92,000
Distributions received from joint ventures	**145,000**	–
Restricted contributions and pledges, net	**(4,726,000)**	(4,030,000)
Loss on extinguishment of debt	**32,230,000**	–
Depreciation and amortization	**36,267,000**	37,032,000
Restricted investment income	**(387,000)**	(314,000)
Increase in investments – trading	**(17,518,000)**	(3,549,000)
Decrease (increase) in assets whose use is limited, net – trading	**3,565,000**	(3,423,000)
Net change in operating assets and liabilities	**(1,009,000)**	7,733,000
Net cash from operating activities	**63,047,000**	55,993,000
Investing activities		
Purchases of property and equipment	**(14,645,000)**	(15,547,000)
Decrease in assets whose use is limited – other-than-trading	**4,267,000**	3,720,000
Change in collateralization and payments on interest rate swaps	**(17,734,000)**	(9,372,000)
Net cash used in investing activities	**(28,112,000)**	(21,199,000)
Financing and fundraising activities		
Net proceeds from issuance of Series 2014 Revenue Bonds	**134,825,000**	–
Repayments of long-term debt and capital lease obligations	**(35,456,000)**	(8,529,000)
Advance refunding of Series 2009A Revenue Bonds	**(116,440,000)**	–
Payments for deferred financing costs	**(1,899,000)**	(23,000)
Restricted contributions received and other	**7,105,000**	7,384,000
Restricted income received	**387,000**	314,000
Net cash used in financing and fundraising activities	**(11,478,000)**	(854,000)
Net increase in cash and cash equivalents	**23,457,000**	33,940,000
Cash and cash equivalents at beginning of year	**76,168,000**	42,228,000
Cash and cash equivalents at end of year	**$ 99,625,000**	$ 76,168,000

Anne Arundel Health System, Inc. and Subsidiaries

Consolidated Statements of Cash Flows (continued)

	Year Ended June 30	
	2015	**2014**
Changes in operating assets and liabilities		
Increase (decrease) in operating assets:		
Patient receivables, net	**$ 6,768,000**	$ 9,190,000
Inventories	**(8,000)**	194,000
Prepaid expenses and other	**715,000**	2,859,000
Other assets	**(3,891,000)**	(591,000)
	3,584,000	11,652,000
(Decrease) increase in operating liabilities:		
Accounts payable	**(887,000)**	(1,879,000)
Accrued salaries, wages, and benefits	**7,019,000**	1,918,000
Other accrued expenses	**2,408,000**	(843,000)
Advances from third-party payors	**(2,779,000)**	3,791,000
Other long-term liabilities	**(10,354,000)**	(6,906,000)
	(4,593,000)	(3,919,000)
Net change in operating assets and liabilities	**$ (1,009,000)**	$ 7,733,000
Supplemental disclosures		
Cash paid for interest	**$ 15,258,000**	$ 12,163,000

Anne Arundel Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements

June 30, 2015

1. Organization and Basis of Presentation

Anne Arundel Health System, Inc. (the Parent or the System) is a Maryland not-for-profit corporation. The Parent has the following wholly owned subsidiaries: Anne Arundel Medical Center, Inc. (the Hospital) and its subsidiaries, Anne Arundel Health Care Services, Inc. (HCS), and Anne Arundel General Treatment Services, Inc. (GTS); Anne Arundel Medical Center Foundation, Inc. (the Foundation); Anne Arundel Health Care Enterprises, Inc. (HCE); Physician Enterprise, LLC (PE) and its subsidiaries, Anne Arundel Physician Group, LLC (AAPG) and Orthopedic Physicians of Annapolis (OPA); Anne Arundel Real Estate Holding Company, Inc. (the Real Estate Company) and its subsidiaries, Pavilion Park, Inc. (PPI), Annapolis Exchange, LLC, and Blue Building, LLC; Anne Arundel Health System Research Institute, Inc. (RI); and Cottage Insurance Company, Ltd. (Cottage). The accompanying consolidated financial statements include the accounts of the Parent and its wholly owned subsidiaries (collectively, the Group). All significant intercompany accounts and transactions have been eliminated in consolidation.

The Real Estate Company and PPI own a 42.84% interest in Kent Island Medical Arts, LLC (KIMA), a limited liability company that owns and operates a medical office building. PPI is the managing member of KIMA and has substantive participation rights in KIMA. The financial statements of KIMA are consolidated in the accompanying consolidated financial statements. The non-controlling interest in KIMA was 57.16% as of June 30, 2015 and 2014. This interest was $981,000 and $994,000 at June 30, 2015 and 2014, respectively, and is included within unrestricted net assets in the accompanying consolidated balance sheets.

2. Summary of Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents include cash held in checking and savings accounts, money market accounts, and short-term certificates of deposit with original maturities of 90 days or less. Cash balances and collateral held by a counterparty are principally uninsured and are subject to normal credit risks. At June 30, 2015 and 2014, and at various times during the year, the System maintained cash-in-bank balances in excess of the $250,000 federally insured limits.

2. Summary of Significant Accounting Policies (continued)

Derivative Instruments

On May 10, 2006, the Hospital entered into a forward variable-to-fixed interest rate swap agreement with an effective date of November 1, 2008. This contract was also entered into in an effort to reduce the risk of variable interest rate debt and has a term through July 1, 2048. Under Accounting Standards Codification (ASC) 815, *Derivatives and Hedging*, the Hospital has recognized its derivative instruments as either assets or liabilities in the accompanying consolidated balance sheets at fair value. As these derivative instruments are not designated as hedges, the unrealized gain or loss on these contracts has been recognized in the accompanying consolidated statements of operations and changes in net assets as realized and unrealized gains (losses) on interest rate swap contracts, net. The fair market values of the derivative instruments include a credit valuation adjustment (CVA) as required by ASC 820, *Fair Value Measurements and Disclosures* (ASC 820). When applying the CVA, the valuation of the variable-to-fixed interest rate swap contract was decreased by $761,000 and $698,000 as of June 30, 2015 and 2014, respectively.

A summary of the Hospital's derivative instruments and related activity at June 30, 2015 and 2014, and for the years then ended is as follows:

	2015	
Description of Derivative Instrument	**Fair Value Liability**	**Change in Unrealized Gain (Loss)**
Variable-to-fixed interest rate swap contract	**$ (65,852,000)**	**$ (10,226,000)**

	2014	
Description of Derivative Instrument	**Fair Value Liability**	**Change in Unrealized Gain (Loss)**
Variable-to-fixed interest rate swap contract	$ (55,626,000)	$ (2,624,000)

2. Summary of Significant Accounting Policies (continued)

At June 30, 2015 and 2014, the net termination value (i.e., mark-to-market value) of the derivative instruments totaled $68,455,000 and $57,969,000, respectively. The Hospital may be exposed to credit loss in the event of nonperformance by the other party to the interest rate swap agreements, the risk of which is reflected in the fair value of the instruments under ASC 820. However, the Hospital does not anticipate nonperformance by the counterparty.

During fiscal 2015, the Hospital paid net payments under its interest rate swap program of $6,411,000. In fiscal 2014, the Hospital paid net payments under its interest rate swap program of $6,464,000. These amounts are included within realized and unrealized gains (losses) on interest rate swap contracts, net in the accompanying consolidated statements of operations and changes in net assets and investing activities in the accompanying consolidated statements of cash flows.

Under the derivative contract, the Hospital must transfer collateral for the benefit of the counterparty to the extent that the termination values exceed certain limits. The Hospital's collateral requirement for the benefit of the counterparty was approximately $62,939,000 and $51,616,000 at June 30, 2015 and 2014, respectively. The ongoing mark-to-market values and resulting collateral requirements of the Hospital's interest rate swap contract are subject to variability based on market factors (primarily changes in interest rates). Collateral requirements under this interest rate swap contract are excluded from unrestricted cash and investments for purposes of determining the System's compliance with its liquidity covenants under its Maryland Health and Higher Educational Facilities Authority (MHHEFA or the Authority) revenue bond agreements and its derivative agreements. Collateral amounts are included in noncurrent assets in the accompanying consolidated balance sheets. As of June 30, 2015, approximately $3,657,000 was due to the financial institution, whereas as of June 30, 2014 the settlement date with the financial institution correlated with the reporting period end date, and therefore no additional collateral was due.

2. Summary of Significant Accounting Policies (continued)

The amount due is included in other accrued expenses in the accompanying consolidated balance sheet as of June 30, 2015, and is reflected within investing activities in the accompanying consolidated statements of cash flows. The collateral requirement as of September 21, 2015, was $69,974,000.

Assets Whose Use is Limited and Investments

Assets whose use is limited are principally comprised of certain funds established to be held and invested by a trustee. These funds are related to the issuance of the Hospital's Revenue Bonds, investments held at Cottage, and certain permanently restricted endowment assets.

The fair values of publicly traded securities and mutual funds are based on quoted market prices of individual securities or investments or estimated amounts using quoted market prices of similar investments. Hedge fund investments, some of which are structured that the System holds limited partnership interests, are stated at fair value as estimated in an unquoted market. Valuations of these investments, and therefore the System's holdings, may be determined by the investment manager or general partner and for fund of funds investments are primarily based on financial data supplied by the underlying investee funds. Values may be based on historical cost, appraisals or other estimates that require varying degrees of judgment. Investment income or loss from all unrestricted investments is included in the accompanying consolidated statements of operations and changes in net assets as part of other income (loss).

Investment income or loss on investments of temporarily and permanently restricted assets is added to or deducted from the appropriate restricted fund balance if the income is restricted. The cost of securities sold is based on the specific-identification method.

All investment balances are principally uninsured and subject to normal credit risk. Investments are classified as either current or noncurrent based on maturity dates and availability for current operations. Investments included in noncurrent assets consist of board-designated investment funds of $251,672,000 and $247,287,000 as of June 30, 2015 and 2014, respectively. Based on the System's investment policy, such amounts could be liquidated, at the discretion of the Board, to satisfy short-term requirements.

2. Summary of Significant Accounting Policies (continued)

Substantially all investments, other than borrowed funds required to be expended on capital projects, are classified as trading securities, with unrealized gains and losses included in revenues and gains in excess of (less than) expenses.

Borrowed funds required to be expended on capital projects are classified as other-than-trading and are included in assets whose use is limited.

Patient Receivables and Allowances

The Group's policy is to write off all patient accounts that have been identified as uncollectible. An allowance for doubtful accounts is recorded for accounts not yet written off that are anticipated to be uncollectible in future periods. When determining the allowance, the Group's policy considers the probability of recoverability of accounts based on past experience, taking into account current collection trends. Credit risks are assessed based on historical write-offs, net of recoveries, as well as an analysis of aged accounts receivable balances with allowances generally increasing as the receivable ages. The analysis of receivables is performed monthly, and the allowances are adjusted accordingly.

Insurance coverage and credit information are obtained from patients when available. No collateral is obtained for accounts receivable.

Accounts receivable from third-party payors have been adjusted to reflect the difference between charges and the estimated reimbursable amounts.

Inventories

Inventories, which primarily consist of medical supplies and drugs, are carried at the lower of cost or market. Cost is determined using the first-in, first-out method.

Property and Equipment

Property and equipment are stated at cost. Included in computers and software are capitalized labor costs of $10,696,000 and $10,482,000 as of June 30, 2015 and 2014, respectively. Depreciation and amortization, including amortization of assets recorded under capital leases, are recorded on the straight-line method over the estimated useful lives of the assets.

2. Summary of Significant Accounting Policies (continued)

The following is a summary of property and equipment, stated at cost:

	Estimated Useful Lives	June 30 2015	2014
Land		**$ 13,151,000**	$ 13,151,000
Land improvements	20 years	**22,016,000**	22,016,000
Buildings and improvements	20–40 years	**471,322,000**	470,229,000
Fixed equipment	5–20 years	**9,720,000**	8,947,000
Leasehold improvements	5–10 years	**50,184,000**	48,091,000
Movable equipment	7–10 years	**177,387,000**	175,016,000
Computers and software	3–5 years	**62,351,000**	58,234,000
Construction-in-progress	–	**3,357,000**	810,000
		$ 809,488,000	$ 796,494,000

Construction-in-progress consists of direct costs associated with hospital department renovations, certain leasehold improvements, and smaller capital projects. As these projects are completed, the related assets are transferred out of construction-in-progress and into the appropriate asset category and are depreciated over the applicable useful lives.

Investments in Joint Ventures

The System accounts for its investments in joint ventures using the equity method of accounting. During 2011, the Real Estate Company and another party formed West County, LLC, a joint venture that owns and operates a medical office building that opened in December 2012. The Real Estate Company has a 50% interest in this joint venture, with each owner's investment being $7,933,000 and $7,600,000 as of June 30, 2015 and 2014, respectively.

2. Summary of Significant Accounting Policies (continued)

Deferred Debt Issuance Costs

Administrative, legal, financing, underwriting discount, and other miscellaneous expenses that were incurred in connection with debt financings were deferred and are being amortized over the lives of the bond issues using the straight line method which approximates the effective interest method in all material respects. The amortization expense of deferred debt issue costs was $310,000 and $351,000 for the years ended June 30, 2015 and 2014, respectively.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Group has been limited by donors to a specific time period or purpose. Substantially all temporarily restricted net assets in the accompanying consolidated financial statements are restricted to fund certain Hospital capital additions and operating programs. Permanently restricted net assets have been restricted by donors to be maintained in perpetuity. The income from these funds is expendable to support health care services.

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered. This includes regulatory discounts allowed to Blue Cross, Medicare, Medicaid, and other third-party payors and charity care.

During 2015 and 2014, approximately 36% of net patient service revenue was received under the Medicare program, 29% and 24% from Blue Cross, 30% and 35% from contracts with other third parties, and 5% from other sources, respectively.

2. Summary of Significant Accounting Policies (continued)

The following table sets forth the detail of net patient service revenue:

	Year Ended June 30	
	2015	**2014**
Gross patient service revenue	**$ 772,094,000**	$ 756,051,000
Revenue deductions:		
Charity care	**3,202,000**	5,933,000
Contractual and other allowances	**144,236,000**	157,886,000
Net patient service revenue	**624,656,000**	592,232,000
Less provision for bad debts	**19,431,000**	29,295,000
Net patient service revenue less provision for bad debts	**$ 605,225,000**	$ 562,937,000

Patient accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Hospital analyzes its past history and identifies trends to estimate the appropriate allowance for doubtful accounts and provision for bad debts. For receivables associated with services provided to patients who have third-party coverage, the Hospital analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary. For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Hospital records a provision for bad debts in the period of service on the basis of its past experience. The difference between the approved rates and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. The Hospital has not changed its charity care or uninsured discount policies during fiscal years 2015 or 2014.

A substantial amount of the Group's revenues are received from health maintenance organizations and other managed care payors. Managed care payors generally use case management activities to control hospital utilization. These payors also have the ability to select health care providers offering the most cost-effective care. Management does not believe that the Group has undue exposure to any one managed care payor.

2. Summary of Significant Accounting Policies (continued)

The Hospital's revenues may be subject to adjustment as a result of examination by government agencies or contractors, and as a result of differing interpretation of government regulations, medical diagnosis, charge coding, medical necessity, or other contract terms. The resolution of these matters, if any, often is not finalized until subsequent to the period during which the services were rendered.

The Group employs physicians in several hospital-based specialties (including, but not limited to, obstetrics, intensive care, and hospitalists). Net physician revenue is recognized when the services are provided and recorded at the estimated net realizable amount based on the contractual arrangements with third-party payors and the expected payments from the third-party payors and the patients. The difference between the billed charges and the estimated net realizable amounts are recorded as a reduction in physician revenue when the services are provided. The System recognized net physician revenue of $84,436,000 and $74,328,000 for the years ended June 30, 2015 and 2014, respectively. At June 30, 2015 and 2014, $7,058,000 and $6,042,000, respectively, of net physician accounts receivable are included in patient receivables in the accompanying consolidated balance sheets.

Charity Care

The Group provides charity care to patients who meet certain criteria established under its charity care guidelines. Because members of the Group do not pursue the collection of amounts determined to qualify as charity care, they are not reported as revenue in the accompanying consolidated statements of operations and changes in net assets. The direct and indirect costs associated with providing this care are $2,338,000 and $4,458,000 for the years ended June 30, 2015 and 2014, respectively. These costs are calculated by applying a ratio of operating expenses over gross patient charges to the charity care provided at established rates. The state of Maryland rate system includes components within the rates to partially compensate hospitals for uncompensated care.

2. Summary of Significant Accounting Policies (continued)

Other Operating Revenue

Other operating revenue is comprised of grant revenue, incentive payments related to the implementation and meaningful use of certified electronic health records, cafeteria revenue, net assets released from restrictions for operating purposes, and other miscellaneous items.

The American Recovery and Reinvestment Act of 2009 provides for Medicare and Medicaid incentive payments beginning in 2011 for eligible hospitals and professionals that implement and achieve meaningful use of certified electronic health record (EHR) technology that demonstrate improved quality and effectiveness of care. Eligibility for annual Medicare incentive payments depends on providers demonstrating meaningful use of EHR technology in each period over a four-year period. An additional Medicaid incentive payment is available to providers that adopt, implement, or upgrade certified EHR technology. However, in order to receive additional Medicaid incentive payments in subsequent years, providers must demonstrate continued meaningful use of EHR technology.

For Medicare and Medicaid EHR incentive payments, the Hospital utilizes a grant accounting model to recognize these revenues. Under this accounting policy, EHR incentive payments were recognized as revenues when attestation that the EHR meaningful use criteria for the required period of time was demonstrated. The System recognized $2,081,000 and $708,000 of EHR revenue for the years ended June 30, 2015 and 2014, respectively.

The System’s attestation of compliance with the meaningful use criteria is subject to audit by the federal government or its designee. The recognition of grant income is based on management’s best estimate and the amounts recognized are subject to change. Any subsequent changes in the recognition of the grant income will impact the results of operations in the period in which they occur.

2. Summary of Significant Accounting Policies (continued)

Donations and Bequests

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional promises to give, and indications of intentions to give, are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets in the accompanying consolidated statements of operations and changes in net assets. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated financial statements. Contributions that are unrestricted are reflected as other operating revenue in the accompanying consolidated statements of operations and changes in net assets.

Scheduled payments on pledges receivable for the years ending June 30 are as follows:

2016	$ 3,194,000
2017–2020	3,502,000
2021 and thereafter	1,553,000
Less:	
Impact of discounting pledges receivable to net present value	(333,000)
Allowance for uncollectible pledges	(497,000)
Net pledges receivable	$ 7,419,000

Pledges receivable are discounted using rates between 0.3% and 2.9%.

2. Summary of Significant Accounting Policies (continued)

Revenues and Gains in Excess of (Less Than) Expenses

The accompanying consolidated statements of operations and changes in net assets include revenues and gains in excess of (less than) expenses. Changes in unrestricted net assets that are excluded from revenues and gains in excess of (less than) expenses, consistent with industry practice, include contributions received and used for additions of long-lived assets and certain changes in pension liabilities.

Group Purchasing Organization Initial Public Offering

The Hospital has participated and owned equity in the Premier Limited Partnership (Premier) which has served as a group purchasing organization for many years. This participation provides purchasing contract rates and rebates the System would not be able to obtain on its own. The Hospital accounts for its investment in Premier using the equity method of accounting.

During the year ended June 30, 2014, Premier restructured from a privately held company to a public company in an initial public offering (IPO) and several financial transactions have occurred with those holding equity in Premier before the IPO, including the System. As a result, the System received a cash payment of approximately $1,500,000 in exchange for 16% of its previous ownership in Premier. In addition, in exchange for the extension of the group purchasing contract, the System received partial ownership of the new public Company (the Class B units).

The Hospital recognized a gain of approximately $1,385,000 for the sale of its 16% interest, which is included in other operating revenue in the consolidated statement of operations and changes in net assets. The System received 309,580 Class B units that are earned in 7 separate tranches over an 85-month period ending October 31, 2020. This investment is reflected in other assets in the consolidated balance sheet. The opportunity will exist in the future for these Class B units to be converted to the Premier public company stock. Prior to vesting, the Class B units may be transferred or sold with the approval of Premier. During the years ended June 30, 2015, and 2014 the System recognized approximately $1,891,000 and $1,100,000, respectively of income related to Tranches 1 and 2 of the Class B which is included as a reduction of supplies expense in the consolidated statement of operations and changes in net assets. The value of the Class B units is tied to the group purchasing contract and is considered a vendor incentive.

2. Summary of Significant Accounting Policies (continued)

Income Tax Status

The Parent, the Hospital, the Foundation, HCS, GTS, PE, and RI have received determination letters from the Internal Revenue Service (IRS) stating that they are exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. The Real Estate Company has received a determination letter from the IRS stating that it is exempt from federal income taxes under Section 501(c)(2) of the Internal Revenue Code.

HCE and PPI are subject to federal and state income taxes. A provision for income taxes has been recorded for fiscal 2015. Deferred tax assets are deemed realizable, and are attributable to the exhaustion of NOL's and remaining timing differences of book and tax depreciation for long-lived assets, such as buildings.

Certain limited liability companies within the consolidated group are not subject to income taxes. Taxable income or loss is passed through to and reportable by the members individually.

Under the Cayman Islands Tax Concessions Law (Revised), the Governor-in-Cabinet issued an undertaking to Cottage on November 29, 2005, exempting it from all local income, profit, or capital gains taxes. The undertaking has been issued for a period of 20 years and at the present time, no such taxes are levied in the Cayman Islands. Accordingly, no provision for taxes is made in these consolidated financial statements.

Under the requirements of ASC 740, *Income Taxes*, tax-exempt organizations could be required to record an obligation as the result of a tax position they have historically taken on various tax exposure items. The Group has determined that it does not have any uncertain tax positions through June 30, 2015.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

2. Summary of Significant Accounting Policies (continued)

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. 2014-09 *Revenue from Contracts with Customers (Topic 606)*. This guidance is intended to improve and converge with international standards the financial reporting requirements for revenue from contracts with customers. In August 2015, the FASB issued ASU No. 2015-14 *Revenue from Contracts with Customers (Topic 606)* which extends the effective date originally contemplated by ASU 2014-09. The revised standards will be effective for fiscal year 2020 and early adoption is permitted beginning in fiscal year 2018. We have not yet determined the impact from adoption of this new accounting pronouncement on our financial statements.

In August 2014, the FASB issued ASU No. 2014-15, *Presentation of Financial Statements—Going Concern (Subtopic 205-40)*, which provides guidance in GAAP about management's responsibility to evaluate whether there is substantial doubt about an entity's ability to continue as a going concern and to provide related footnote disclosures. This amendment should reduce diversity in the timing and content of footnote disclosures. This ASU is effective for fiscal year 2017. The guidance is not expected to materially impact the System's consolidated results of operations, net assets, or cash flows.

In April 2015, the FASB issued ASU No. 2015-03, *Interest—Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs*. The amendments in this ASU require that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. This guidance is effective for fiscal year 2017. The guidance is not expected to materially impact the System's consolidated results of operations, net assets, or cash flows.

3. Regulatory Environment

Medicare and Medicaid

The Medicare and Medicaid reimbursement programs represent a substantial portion of the Group's revenues. The Group's operations are subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, and government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Over the past several years, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs, together with the imposition of fines and penalties, as well as repayments for patient services previously billed. Compliance with fraud and abuse standards and other government regulations can be subject to future government review and interpretation. Also, future changes in federal and state reimbursement funding mechanisms and related government budgeting constraints could have an adverse effect on the Group.

In 1983, Congress approved a Medicare prospective payment plan for most inpatient services as part of the Social Security Amendment Act of 1983. Hospitals in Maryland were granted a waiver from the Medicare prospective payment system under Section 1814(b) of the Social Security Act. The waiver would remain in effect as long as the Maryland rate of increase in payments per admission remained below the national average rate of increase.

In January 2014, the Centers for Medicare and Medicaid Services approved a modernized waiver that includes both inpatient and outpatient revenue. The new waiver will be in place as long as Maryland hospitals achieve significant quality improvements and limit the per capita growth for all payers for Maryland residents. The Medicare per capita spending target is expected to produce cumulative Medicare savings of $330 million over the five-year period through 2018.

3. Regulatory Environment (continued)

HSCRC

The Hospital's rate structure for all hospital-based services is subject to review and approval by the Maryland Health Services Cost Review Commission (HSCRC or the Commission). Under the HSCRC rate-setting system, the Hospital's inpatient and outpatient charges are the same for all patients regardless of payer, including Medicare and Medicaid.

Beginning in fiscal year 2014, the Hospital entered into an agreement with the HSCRC to participate in the Global Budget Revenue (GBR) program. The GBR model is a revenue constraint and quality improvement system to provide hospitals with strong financial incentives to manage their resources efficiently and effectively in order to slow the rate of increase in health care costs and improve health care delivery processes and outcomes. Under GBR, total revenue is capped at a pre-determined fixed amount. The annual approved revenue is calculated using a permanent base revenue with positive or negative adjustments for inflation, assessments, performance in quality-based programs, infrastructure requirements, and population. Revenue may also be adjusted annually for market share levels and shifts of regulated services to unregulated settings.

The Commission's rate setting methodology compares the approved rate to the actual average rate charged. Any overcharges or undercharges are settled in future revenue determinations on an annual basis. For the current fiscal year, the Hospital was within the allowed corridors for charging.

The Hospital's policy is to recognize revenue based on actual charges for services to patients in the year in which the services are performed. The Hospital's revenues may be subject to adjustment as a result of examination by government agencies or contractors, and as a result of differing interpretation of government regulations, medical diagnosis, charge coding, medical necessity, or other contract terms. The resolution of these matters, if any, often is not finalized until a subsequent period than which the services were rendered.

4. Investments

Investments, including assets whose use is limited, are stated at fair value. Borrowed funds that are required to be expended on specified capital projects under MHHEFA revenue bond agreements are classified as available for sale. All other investments and assets whose use is limited are classified as trading securities.

	June 30	
	2015	**2014**
Assets whose use is limited:		
Endowment assets:		
Cash and cash equivalents	**$ 916,000**	$ 768,000
Equity mutual funds	**10,628,000**	11,764,000
Fixed income mutual funds	**4,367,000**	4,596,000
	15,911,000	17,128,000
Amounts held by trustee:		
Cash and cash equivalents	**14,346,000**	12,097,000
U.S. government obligations	**13,456,000**	21,656,000
	27,802,000	33,753,000
Amounts held by Cottage:		
Cash and cash equivalents	**2,647,000**	2,312,000
Equity mutual funds	**8,915,000**	9,322,000
Fixed income mutual funds	**12,413,000**	13,081,000
Hedge funds	**1,599,000**	1,523,000
	25,574,000	26,238,000
Total assets whose use is limited	**69,287,000**	77,119,000
Less current portion	**17,721,000**	14,885,000
	$ 51,566,000	$ 62,234,000

4. Investments (continued)

Amounts held by trustee are broken down as follows:

	June 30 2015	June 30 2014
Bond indenture	**$ 27,802,000**	$ 33,753,000
Other investments:		
Cash and cash equivalents	**$ 2,498,000**	$ 6,632,000
Equity mutual funds	**114,373,000**	116,634,000
Fixed income mutual funds	**126,230,000**	120,430,000
Hedge funds	**12,668,000**	11,919,000
	255,769,000	255,615,000
Less short-term investments	**2,484,000**	6,627,000
Investments	**$ 253,285,000**	$ 248,988,000

The components of investment income, net are as follows:

	June 30 2015	June 30 2014
Interest and dividend income, net	**$ 11,680,000**	$ 4,196,000
Realized gains, net	**4,904,000**	4,068,000
	$ 16,584,000	$ 8,264,000

5. Fair Value Measurements

ASC 820 defines fair value and establishes a framework for measuring fair value in accordance with U.S. generally accepted accounting principles. ASC 820 establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. These tiers include:

Level 1 – Defined as observable inputs, such as quoted prices in active markets;

Level 2 – Defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and

Level 3 – Defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Group believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

ASC 820 requires that the fair value of derivative contracts include adjustments related to the credit risks of both parties associated with the derivative transactions. The fair value of the Group's derivative contracts reflected in the accompanying consolidated financial statements includes adjustments related to the credit risks of the parties to the transactions.

5. Fair Value Measurements (continued)

The following tables present the fair value hierarchy for the Group's financial assets and liabilities measured at fair value on a recurring basis at June 30, 2015 and 2014:

	June 30, 2015			
	Total	Quoted Prices in Active Markets for Identical Assets Level 1	Significant Other Observable Inputs Level 2	Significant Unobservable Inputs Level 3
Assets				
Cash and cash equivalents	**$ 99,625,000**	**$ 99,625,000**	**$ –**	**$ –**
Trading securities and assets whose use is limited:				
Cash and cash equivalents	**20,406,000**	**14,346,000**	**6,060,000**	**–**
Equity securities	**133,916,000**	**125,001,000**	**8,915,000**	**–**
Fixed income securities	**143,011,000**	**130,598,000**	**12,413,000**	**–**
U.S. Government obligation securities	**13,456,000**	**–**	**13,456,000**	**–**
Hedge funds	**14,267,000**	**–**	**14,267,000**	**–**
Total	**325,056,000**	**269,945,000**	**55,111,000**	**–**
Collateral for interest rate swap:				
Cash and cash equivalents	**62,939,000**	**62,939,000**	**–**	**–**
Total assets	**$ 487,620,000**	**$ 432,509,000**	**$ 55,111,000**	**$ –**
Liabilities				
Derivative instruments	**$ (65,852,000)**	**$ –**	**$ (65,852,000)**	**$ –**
Total liabilities	**$ (65,852,000)**	**$ –**	**$ (65,852,000)**	**$ –**

5. Fair Value Measurements (continued)

	June 30, 2014			
	Total	Quoted Prices in Active Markets for Identical Assets Level 1	Significant Other Observable Inputs Level 2	Significant Unobservable Inputs Level 3
Assets				
Cash and cash equivalents	$ 76,168,000	$ 76,168,000	$ –	$ –
Trading securities and other assets whose use is limited:				
Cash and cash equivalents	21,809,000	12,097,000	9,712,000	–
Equity securities	137,720,000	128,399,000	9,321,000	–
Fixed income securities	138,107,000	125,026,000	13,081,000	–
U.S. Government obligation securities	21,656,000	–	21,656,000	–
Hedge funds	13,442,000	–	13,442,000	–
Total	332,734,000	265,522,000	67,212,000	–
Collateral for interest rate swap:				
Cash and cash equivalents	51,616,000	51,616,000	–	–
Total assets	$ 460,518,000	$ 393,306,000	$ 67,212,000	$ –
Liabilities				
Derivative instruments	$ (55,626,000)	$ –	$ (55,626,000)	$ –
Total liabilities	$ (55,626,000)	$ –	$ (55,626,000)	$ –

The Group's Level 1 securities primarily consist of U.S. Treasury securities, exchange-traded mutual funds, and cash. The Group determines the estimated fair value for its Level 1 securities using quoted (unadjusted) prices for identical assets or liabilities in active markets.

The Group's Level 2 securities primarily consist of U.S. government-sponsored entities bonds and money market funds. The Group determines the estimated fair value for these Level 2 securities using the following methods: quoted prices for similar assets/liabilities in active markets, quoted prices for identical or similar assets in non-active markets (few transactions, limited information, non-current prices, high variability over time), inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves volatilities,

5. Fair Value Measurements (continued)

default rates, etc.), and inputs that are derived principally from or corroborated by other observable market data. The System's hedge funds are also considered Level 2 investments as the System has the ability to redeem its investment with the investee at net asset value per share (or its equivalent) at the measurement date. Redemption can be made on the last day of any calendar quarter with 65 days' advanced written notice.

The Group's Level 2 securities also consist of derivative instruments, which are reported using valuation models commonly used for derivatives. Valuation models require a variety of inputs, including contractual terms, market fixed prices, inputs from forward price yield curves, notional quantities, measures of volatility, and correlations of such inputs.

The Group also has pledges receivable, which are measured at fair value on a non-recurring basis and are discounted to net present value upon receipt using an appropriate risk-free discount rate based on the term of the receivable. Since these inputs are not observable, pledges receivable would be considered Level 3 fair value measurements upon their initial recording. Pledges receivable are recorded net of an allowance for uncollectible pledges. The following table provides a reconciliation of the beginning and ending balances of pledges receivable that used significant unobservable inputs:

	Year Ended June 30	
	2015	**2014**
Pledges receivable:		
Balance at July 1	**$ 9,798,000**	$ 13,152,000
New pledges	**1,107,000**	2,019,000
Collections on pledges	**(3,084,000)**	(5,332,000)
Write-off of pledges	**(454,000)**	(217,000)
Changes in reserves	**52,000**	176,000
Balance at June 30	**$ 7,419,000**	$ 9,798,000

6. Long-Term Debt and Line of Credit

Long-term debt consists of the following:

	Interest Rate	Maturity Dates	June 30 2015	June 30 2014
Maryland Health and Higher Educational Facilities Authority Revenue Bonds – Series 2014	2.0-5.0%	2015-2040	**$ 127,305,000**	$ –
Maryland Health and Higher Educational Facilities Authority Revenue Bonds – Series 2012	2.0–5.0%	2013–2035	**69,775,000**	72,100,000
Maryland Health and Higher Educational Facilities Authority Revenue Bonds – Series 2010	4.0–5.0%	2011–2041	**78,145,000**	79,695,000
Maryland Health and Higher Educational Facilities Authority Revenue Bonds – Series 2009A	4.0–6.75%	2013–2040	**–**	117,730,000
Maryland Health and Higher Educational Facilities Authority Revenue Bonds – Series 2009B	Variable	2041–2044	**60,000,000**	60,000,000
2008 term loan from a bank	Variable	2019	**46,748,000**	48,715,000
Kent Island term loan from a bank	Variable	2017	**7,134,000**	7,486,000
2008 construction loan from a bank	Variable	2019	**24,530,000**	25,561,000
			413,637,000	411,287,000
Less current portion of long-term debt			**12,222,000**	8,523,000
Unamortized original issue premium, net			**11,895,000**	985,000
Long-term debt			**$ 413,310,000**	$ 403,749,000

These debt instruments are secured by the receipts of the Hospital and substantially all of the property and equipment of the consolidated group.

6. Long-Term Debt and Line of Credit (continued)

Principal payments due under all debt instruments as of June 30, 2015, are as follows:

2016	$ 12,222,000
2017	16,057,000
2018	9,671,000
2019	68,698,000
2020	6,770,000
Thereafter	300,219,000
	$ 413,637,000

Series 2014 Revenue Bonds

In November 2014, the Hospital entered into a loan agreement with Maryland Health and Higher Educational Facilities Authority (referred to as MHHEFA), for the issuance of Series 2014 Revenue Bonds (referred to as the 2014 Bonds). The proceeds of the 2014 Bonds were used to advance refund the Series 2009A Bonds previously provided by MHHEFA. The bonds being refunded were originally obtained to finance a portion of the costs of construction for an eight-story patient care building, two parking garages, and costs related to the issuance. The 2014 Bonds provide for annual principal payments each July 1, from 2015 through 2039. Interest is payable semi-annually each July 1 and January 1, beginning January 2015. The 2014 Bonds bear stated interest rates between 2.00% to 5.00% and were issued at a premium of $7,520,000 which is amortized over the life of the bonds using the straight line method which approximates the effective interest method. The effective annual interest rate for the 2014 Bonds for the year ended June 30, 2015 was 2.38%.

In connection with the advance refunding of the 2009A bonds, the hospital recognized a loss of $32,230,000 which is recorded as a loss on extinguishment of debt in the accompanying consolidated statements of operations and changes in net assets for the year ended June 30, 2015. The loss on extinguishment is comprised of a $29,049,000 pre-payment of interest due on the 2009A bonds prior to their call date in 2019 and a $3,181,000 write-off of deferred financing costs and unamortized bond discount. The $29,049,000 pre-payment of interest is included within repayments of long-term debt and capital lease obligations within the financing section of the accompanying statement of cash flows.

6. Long-Term Debt and Line of Credit (continued)

Series 2012 Revenue Bonds

In October 2012, the Hospital entered into a loan agreement with MHHEFA for the issuance of $73,625,000 of Series 2012 Revenue Bonds (referred to as the 2012 Bonds). The proceeds of the 2012 Bonds were used to repay the Series 2004A Bonds and the Series 1998 Bonds previously provided by the Authority. The bonds being refinanced were originally obtained to finance a new replacement hospital (1998 Bonds) and to finance major renovations to the Hospital's Cancer Center and land acquisition (2004A Bonds). The 2012 Bonds provide for annual principal payments each July 1, from 2013 through 2034. Interest is payable semi-annually on each July 1 and January 1, beginning July 1, 2013. The 2012 Bonds bear stated interest at rates of 2.00% to 5.00%, and were issued at a premium of $6,746,000. The effective annual interest rates for the 2012 Bonds for the years ended June 30, 2015 and 2014, were 3.75% and 3.69%, respectively.

The provisions of the 2014 and 2012 Bonds, together with the 2010 Bonds and 2009 Bonds, require the Parent and subsidiaries to comply with certain covenants on an annual basis, including a debt service coverage requirement, a debt to capitalization requirement, and a liquidity requirement. The Hospital, the Parent, and HCS are members of the obligated group for all of the revenue bonds issued by MHHEFA.

Series 2010 Revenue Bonds

In February 2010, the Hospital entered into a loan agreement with MHHEFA for the issuance of $85,410,000 of Series 2010 Revenue Bonds (referred to as the 2010 Bonds). The proceeds of the 2010 Bonds were used to repay the Series 2004B Bonds and Dedicated Financing previously provided by the Authority and are also being used to finance the expansion of the parking garage for the Hospital's acute care pavilion. The 2010 Bonds provide for annual principal payments each July 1, from 2011 through 2040. Interest is payable semi-annually on each July 1 and January 1, beginning July 1, 2010. The 2010 Bonds bear stated interest at rates of 4.00% to 5.00%, and were issued at an original issue discount of $1,507,000. The effective annual interest rates for the 2010 Bonds for the years ended June 30, 2015 and 2014, were 4.95% and 4.89%, respectively.

6. Long-Term Debt and Lines of Credit (continued)

Series 2009 Revenue Bonds

In January 2009, the Hospital entered into a loan agreement with MHHEFA for the issuance of $120,000,000 Series 2009A Revenue Bonds (the 2009A Bonds) and in February 2009, $60,000,000 Series 2009B Revenue Bonds (the 2009B Bonds) (collectively referred to as the 2009 Bonds). The proceeds of the 2014 Bonds were used to advance refund the Series 2009A Bonds previously provided by MHHEFA. The proceeds of the 2009 Bonds are being used to finance a portion of the costs of construction of an eight-story patient care building, two new parking garages, and certain costs relating to the issuance. The 2009A Bonds provided for annual principal payments each July 1, from 2012 through 2039. Interest was payable semi-annually on each July 1 and January 1, beginning July 1, 2009. The 2009B Bonds provide for annual principal payments each July 1, from 2040 through 2043. Interest is payable semi-annually on each July 1 and January 1, beginning July 1, 2009. The 2009A Bonds bore stated interest at rates of 4.00% to 6.75%. The 2009A Bonds were issued at an original issue discount of $4,817,000. The effective annual interest rates for the 2009A Bonds for the years ended June 30, 2015 and 2014, were 2.68% and 6.74%, respectively. The 2009B Bonds bear interest at variable rates, as set forth in the loan agreement. The maximum interest rate is 12% for the 2009B Bonds. The effective annual interest rates for the 2009B Bonds for the years ended June 30, 2015 and 2014, were 0.05% and 0.08%, respectively. The principal and interest payments on the Series 2009B Bonds are secured by a letter of credit equal to the original principal of the bonds plus an amount equal to 40 days' interest thereon, calculated at the maximum rate. The current letter of credit expires in July 1, 2020. Under certain circumstances, the Hospital would need to fully redeem the 2009B Bonds upon expiration of the letter of credit, unless a conforming replacement letter of credit was secured prior to such expiration.

6. Long-Term Debt and Line of Credit (continued)

The related balances are included in assets whose use is limited and consist of the following:

	June 30 2015	2014
Debt service funds	**$ 15,074,000**	$ 12,573,000
Debt service reserve funds	**12,517,000**	20,618,000
Construction fund and capitalized interest fund	**211,000**	562,000
	$ 27,802,000	$ 33,753,000

Bank Line of Credit and Term Loan

The Hospital maintains a line of credit with a bank providing available credit of $30,000,000. The agreement with the bank is reviewed for renewal on February 28 of each year. Interest on any borrowings accrues at the one month London Interbank Offered Rate (LIBOR) plus 1.5%. At June 30, 2015 and 2014, the Group has no balance on the line of credit.

On October 23, 2008, the Real Estate Company secured a term loan in the amount of $55,000,000 with a bank. The proceeds from the term loan were used to refinance line of credit proceeds and fund certain construction costs related to a medical office building. The loan bears interest at a variable rate, based on the LIBOR market index rate plus 1.25%. The term loan requires monthly payments of $221,000 with all remaining amounts due upon final maturity on November 5, 2018. The effective annual interest rate for the years ended June 30, 2015 and 2014, was 1.43%.

2008 Construction Loan

On October 23, 2008, the Real Estate Company entered into a construction loan in the amount of $30,000,000 with a bank to fund the construction of a medical office building. The loan was issued under the same loan agreement as the term loan discussed in the immediately preceding paragraph. The debt is secured by the medical office building. Interest only is due during the construction period at a rate equal to the LIBOR market index rate plus 1.25%. The loan converted to a term loan after the completion of the construction in July 2009. The term loan provides for monthly principal and interest payments and has a final maturity of November 5, 2018. The effective annual interest rates for the years ended June 30, 2015 and 2014, were 1.43% and 1.44%, respectively.

6. Long-Term Debt and Line of Credit (continued)

Kent Island Term Loan

In August 2007, KIMA entered into a construction loan agreement with a bank in the amount of $9,000,000 that would convert to a term loan after the completion of the construction. The proceeds were used to construct a medical office building. The debt is secured by the medical office building. Interest only was due during the construction period at a rate of the 30-day LIBOR plus 1.0%. The construction was completed in June 2008. The term loan provides for monthly principal and interest payments and has a final maturity of December 2016. The effective annual interest rate for the years ended June 30, 2015 and 2014, was 1.03%.

7. Capital Lease Obligations

The Group has entered into capital lease agreements for certain medical equipment and software at a cost of $7,432,000 as of June 30, 2015 and 2014. Accumulated amortization on these assets was $7,186,000 and $6,315,000 as of June 30, 2015 and 2014, respectively. Final payments under these capital lease obligations occurred in 2015 and totaled $90,000.

8. Pension Plan and Thrift Plan

The Hospital has a qualified noncontributory, defined benefit pension plan (the Plan) that covers substantially all employees. The Group's policy is to fund pension costs as determined by its actuary. Adopted by the Board of Trustees on June 11, 2009, and effective September 1, 2009, the Hospital amended the Plan to freeze future benefit accruals, and participants have not earned any additional benefits under the Plan since that date. However, subsequent to September 1, 2009, participants have continued to vest in benefits they have earned through September 1, 2009. The frozen benefit balance for the participants will only accrue interest credits until the participants' benefit commencement dates. FASB ASC 715, *Compensation – Retirement Benefits* (ASC 715), requires the Group to recognize the funded status (i.e., the difference between the fair value of plan assets and the projected benefit obligations) of its pension plan on its consolidated balance sheet, with a corresponding adjustment to unrestricted net assets. The pension liability adjustment to unrestricted net assets represents the change in net unrecognized actuarial losses that have not yet been recognized as part of revenues and gains in excess of expenses. These amounts are subsequently recognized as net periodic benefit cost pursuant to the Group's historical accounting policy for amortizing such amounts.

8. Pension Plan and Thrift Plan (continued)

During the years ended June 30, 2015 and 2014, a partial settlement of the Plan's defined benefit obligation was recognized. Since the settlement was more than minor, ASC 715 requires that a pro rata amount of the accumulated unrecognized net loss in unrestricted net assets is charged to revenues and gains in excess of (less than) expenses based on the proportion of the projected benefit obligation settled to the total projected benefit obligation. During the years ended June 30, 2015 and 2014, the Group determined that a settlement had occurred and recognized a loss of $2,927,000 and $2,482,000, respectively. For the years ended June 30, 2015 and 2014, the settlement loss is recorded within employee benefits and loss from joint ventures and other, net, respectively, in the consolidated statements of operations and changes in net assets.

The reconciliation of the beginning and ending balances of the projected benefit obligation and the fair value of plan assets for the years ended June 30, 2015 and 2014, and the accumulated benefit obligation at June 30, 2015 and 2014, is as follows:

	June 30	
	2015	**2014**
Accumulated benefit obligation	**$ 121,761,000**	$ 116,610,000
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	**$ 116,610,000**	$ 112,402,000
Service cost		–
Interest cost	**4,419,000**	4,789,000
Actuarial loss	**8,123,000**	6,593,000
Benefits paid	**(1,426,000)**	(1,303,000)
Settlements paid	**(5,965,000)**	(5,871,000)
Projected benefit obligation at end of year	**121,761,000**	116,610,000
Change in plan assets:		
Fair value of plan assets at beginning of year	**97,340,000**	81,798,000
Actual return on plan assets	**(466,000)**	12,456,000
Employer contribution	**9,576,000**	10,260,000
Benefits paid	**(1,426,000)**	(1,303,000)
Settlements paid	**(5,965,000)**	(5,871,000)
Fair value of plan assets at end of year	**99,059,000**	97,340,000
Net liability recognized	**$ (22,702,000)**	$ (19,270,000)

8. Pension Plan and Thrift Plan (continued)

	June 30 2015	2014
Net amounts recognized in the consolidated balance sheets consist of:		
Accrued pension costs	**$ (22,702,000)**	$ (19,270,000)
Amounts recognized in unrestricted net assets that have not been recognized in net periodic benefit cost consist of:		
Net actuarial loss	**$ 59,756,000**	$ 48,073,000

The following table sets forth the weighted-average assumptions used to determine benefit obligations:

	June 30 2015	2014
Discount rate	**4.15%**	3.85%
Rate of compensation increase	**N/A**	N/A

The following table sets forth the weighted-average assumptions used to determine net periodic benefit cost:

	Year Ended June 30 2015	2014
Discount rate	**3.83%**	4.45%
Expected return on plan assets	**7.50**	7.50
Rate of compensation increase	**N/A**	N/A

8. Pension Plan and Thrift Plan (continued)

Net periodic pension benefit cost included the following components:

	June 30	
	2015	**2014**
Service cost	**$ –**	$ –
Interest cost	**4,419,000**	4,789,000
Expected return on plan assets	**(7,225,000)**	(6,420,000)
Amortization of prior service cost	**–**	–
Recognized net actuarial loss	**1,205,000**	1,144,000
Loss recognized from partial settlement of projected benefit obligation	**2,927,000**	2,482,000
Net periodic benefit cost	**$ 1,326,000**	$ 1,995,000

The estimated net loss for the defined benefit pension plan that will be amortized from unrestricted net assets into net periodic benefit cost over the next fiscal year is $1,727,000.

The Hospital's defined benefit plan invests in a diversified mix of traditional asset classes. Investments in certain types of U.S. equity securities and fixed income securities are made to maximize long-term results while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. Risk tolerance of unexpected investment and actuarial outcomes is continually evaluated by understanding the pension plan's liability characteristics. Equity investments are used primarily to increase overall plan returns. Debt securities provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

The Hospital's target asset allocation percentages as of June 30, 2015, were as follows: 35.0% investment grade bonds, 27.5% international equity, 19.25% large cap domestic stocks, 8.25% small cap domestic stocks, and 10.0% hedge funds and exchange traded notes.

8. Pension Plan and Thrift Plan (continued)

The following tables present the fair value hierarchy of assets of the defined benefit pension plan at June 30, 2015 and 2014, respectively:

	June 30, 2015			
	Total	Quoted Prices in Active Markets for Identical Assets Level 1	Significant Other Observable Inputs Level 2	Significant Unobservable Inputs Level 3
Assets				
Cash and cash equivalents	**$ 2,265,000**	**$ –**	**$ 2,265,000**	**$ –**
Mutual funds:				
Equity	**27,587,000**	**27587,000**	**–**	**–**
Corporate bonds	**5,191,000**	**5,191,000**	**–**	**–**
Government bonds	**22,377,000**	**22,377,000**	**–**	**–**
International equity	**27,632,000**	**27,632,000**	**–**	**–**
International bonds	**5,012,000**	**5,012,000**	**–**	**–**
Exchange traded notes	**4,487,000**	**4,487,000**	**–**	**–**
Managed partnerships:				
Hedge funds	**4,508,000**	**–**	**4,508,000**	**–**
	$ 99,059,000	**$ 92,286,000**	**$ 6,773,000**	**$ –**

8. Pension Plan and Thrift Plan (continued)

	June 30, 2014			
	Total	Quoted Prices in Active Markets for Identical Assets Level 1	Significant Other Observable Inputs Level 2	Significant Unobservable Inputs Level 3
Assets				
Cash and cash equivalents	$ 4,336,000	$ –	$ 4,336,000	$ –
Mutual funds:				
Equity	26,935,000	26,935,000	–	–
Corporate bonds	6,138,000	6,138,000	–	–
Government bonds	20,915,000	20,915,000	–	–
International equity	26,760,000	26,760,000	–	–
International bonds	3,175,000	3,175,000	–	–
Exchange traded notes	5,081,000	5,081,000	–	–
Managed partnerships:				
Hedge funds	4,000,000	–	4,000,000	–
	$ 97,340,000	$ 89,004,000	$ 8,336,000	$ –

Level 1 securities primarily consist of exchange-traded mutual funds. Level 2 securities primarily consist of money market funds and hedge funds. Methods consistent with those discussed in Note 5 are used to estimate the fair values of these securities.

The overall rate of expected return on assets assumption was based on historical returns, with adjustments made to reflect expectations of future returns. The extent to which the future expectations were recognized considered the target rates of return for the future, which have historically not changed.

The Hospital currently intends to make voluntary contributions to the defined benefit pension plan of $9,576,000 in fiscal 2016.

8. Pension Plan and Thrift Plan (continued)

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid:

2016	$ 5,923,000
2017	6,134,000
2018	6,693,000
2019	7,111,000
2020	7,583,000
2021–2025	38,013,000

In addition to the noncontributory, defined benefit pension plan, the Hospital also offers an employee thrift plan. Participation in the plan is voluntary. Substantially all full-time employees of the Hospital are eligible to participate. Employees may elect to contribute a minimum of 1% of compensation, and a maximum amount as determined by Sections 403(b) and 415 of the Internal Revenue Code. Any employee making contributions to the plan is entitled to a Hospital contribution that will match the employee contribution at the rate of 50% to 75%, depending on the number of years of service, up to a maximum of 4% of qualified compensation. Matching contributions under this thrift plan were $3,338,000 and $2,913,000 in fiscal years 2015 and 2014, respectively.

9. Concentrations of Credit Risk

Certain members of the Group grant credit without collateral to their patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors prior to consideration of an allowance for doubtful accounts was as follows:

	June 30	
	2015	**2014**
Medicare	**28%**	32%
Medicaid	**4**	5
Blue Cross	**24**	19
Commercial, HMO, PPO, and other	**29**	28
Patients	**15**	16
	100%	100%

10. Malpractice Insurance Costs and Self-Insured Professional Liability

Until August 1, 1998, the Group maintained insurance coverage for general and professional liability claims on a claims-made basis. The professional liability coverage included a per-case deductible of $250,000, up to a maximum out-of-pocket amount of $750,000 annually. Effective August 1, 1998, the Group changed its professional liability coverage to a full coverage claims-made policy with no annual deductibles. This policy included tail coverage for claims incurred prior to August 1, 1998, but reported subsequently. Effective August 1, 2002, the Group changed its professional liability coverage back to a claims-made policy with a per-case deductible of $250,000, up to a maximum out-of-pocket amount of $750,000 annually. Also, the Group did not purchase tail coverage for claims incurred prior to August 1, 2002 not yet reported.

Effective March 1, 2004, the Group changed its professional liability coverage to a self-insurance trust with annual exposure limits of $2,000,000 per claim and $11,000,000 in aggregate. The Group carried an excess liability insurance policy for claims above these limits.

Effective July 1, 2005, Cottage was formed as a captive insurer to provide professional liability insurance for the Group. Cottage is a wholly owned subsidiary of the System, which was formed in the Cayman Islands. The primary layer of professional and general liability insurance coverage is self-insured through Cottage and the secondary layer is fully reinsured through several highly rated commercial carriers.

For the period July 1, 2005 to June 30, 2009, Cottage issued claims-made policies covering hospital professional liability (including employed physicians) and on an occurrence basis, comprehensive general liability risks of the Parent and certain affiliates. Policy limits were $2,000,000 per claim with a $9,000,000 policy aggregate. Effective July 1, 2005, Cottage assumed existing liabilities from the System's self-insured trust discussed above on a claims-made basis. Effective July 1, 2009, Cottage issued a claims-made policy providing $2,000,000 per claim hospital professional liability coverage and $1,000,000 per claim comprehensive general liability coverage, subject to a consolidated annual aggregate limit of $10,000,000.

For the period July 1, 2005 to June 30, 2008, Cottage also issued an excess umbrella coverage policy (covering hospital professional liability) with limits of $20,000,000 per claim and in the policy aggregate. For claims reported on and subsequent to July 1, 2008, the coverage limit provided is $30,000,000 per claim and in the policy aggregate. These excess limits are in excess of the primary policy, and the umbrella policies are 100% reinsured with highly rated third-party commercial reinsurers.

10. Malpractice Insurance Costs and Self-Insured Professional Liability (continued)

The provision for estimated professional liability claims, general liability claims, and workers' compensation claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. As of June 30, 2015 and 2014, the balance for outstanding claims reserves recorded at Cottage is $22,186,000 and $22,578,000, respectively. The remaining tail liability for claims incurred but not reported is $5,357,000 and $5,110,000 as of June 30, 2015 and 2014, with $4,527,000 of the 2015 liability and $4,222,000 of the 2014 liability recorded at the Hospital. The remainder of the liability is recorded at PE. The Group has employed an independent actuary to estimate the ultimate settlement of such claims. In management's opinion, the amounts recorded provide an adequate reserve for loss contingencies. However, changes in circumstances affecting professional liability claims could cause these estimates to change by material amounts in the short term.

11. Commitments and Contingencies

Operating Leases

Various members of the Group have operating leases for storage space, equipment, and offices. During 2015 and 2014, rent expense on these leases was approximately $10,176,000 and $10,275,000, respectively. Future minimum annual rental payments under noncancelable operating leases, which expire through 2021, are as follows:

2016	$ 9,675,000
2017	6,957,000
2018	4,494,000
2019	3,415,000
2020	2,381,000
Thereafter	5,004,000
	$ 31,926,000

Contracted Construction Commitments

Members of the Group have future construction commitments with outside contractors for various projects totaling $1,566,000 and $340,000 as of June 30, 2015 and 2014, respectively.

11. Commitments and Contingencies (continued)

Contingencies

Members of the Group have been named as defendants in various legal proceedings arising from the performance of their normal activities. In the opinion of management, after consultation with legal counsel and after consideration of applicable insurance, the amount of the Group's ultimate liability under all current legal proceedings will not have a material adverse effect on its consolidated financial position or results of operations.

The Group's revenues may be subject to adjustment as a result of examination by government agencies or contractors based upon differing interpretation of government regulations, medical diagnosis, charge coding, medical necessity, or other contract terms. The resolution of these matters, if any, often is not finalized until subsequent to the period during which the services were rendered. Section 302 of the Tax Relief and Health Care Act of 2006 authorized a permanent program involving the use of third-party recovery audit contractors (RACs) to identify Medicare overpayments and underpayments made to providers. We have established protocols to respond to RAC requests and payment denials. Payment recoveries resulting from RAC reviews are appealable through administrative and judicial processes, and we intend to pursue the reversal of adverse determinations where appropriate. In addition to overpayments that are not reversed on appeal, we will incur additional costs to respond to requests for records and pursue the reversal of payment denials. As of June 30, 2015 and 2014, the Group has recorded an estimated reserve regarding the Medicare overpayments. In the opinion of the Group's management, the ultimate settlement of this matter will not have a material adverse effect on the financial position of the Group.

12. Functional Expenses

Members of the Group provide general health care services to residents within their service area. Expenses related to providing these services are as follows:

	Year Ended June 30	
	2015	**2014**
Health care services	**$ 506,772,000**	$ 477,887,000
General and administrative	**101,485,000**	98,792,000
	$ 608,257,000	$ 576,679,000

13. Fair Value of Financial Instruments

The carrying amounts of cash and cash equivalents, patient receivables, prepaid expenses and other current assets, accounts payable, accrued salaries, wages and benefits, other accrued expenses, and advances from third-party payors approximate fair value, given the short-term nature of these financial instruments and/or their methods of valuation. The following methods and assumptions were used by the Group in estimating the fair value of other financial instruments:

Investments and Assets Whose Use Is Limited

Fair values are based on quoted market prices, if available, or estimated using quoted market prices for similar securities.

Pledges Receivable

The Group estimates that the carrying value of pledges receivable approximates fair value, given the discount rates applied.

Long-Term Debt

Fair values of the Group's fixed rate long-term debt are established using discounted cash flow analyses, based on the Group's current incremental borrowing rates for similar types of borrowing arrangements. The carrying amount of the Group's variable rate long-term debt approximates fair value. The estimated fair value of all long-term debt at June 30, 2015 and 2014 was $430,763,000 and $443,014,000, respectively.

14. Temporarily Restricted Net Assets

At June 30, 2015 and 2014, temporarily restricted net assets are restricted for use, as follows:

	2015	2014
Hospital capital additions	**$ 6,296,000**	$ 8,112,000
Hospital operating programs	**8,068,000**	8,522,000
	$ 14,364,000	$ 16,634,000

15. Subsequent Events

The Group has evaluated the impact of subsequent events through September 25, 2015, representing the date at which the consolidated financial statements were issued.

Supplementary Information

Anne Arundel Health System, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet

June 30, 2015

	Anne Arundel Health System, Inc.	Anne Arundel Medical Center, Inc. and Subsidiaries	Anne Arundel Health Care Enterprises, Inc.	Anne Arundel Real Estate Holding Company, Inc. and Subsidiaries	Cottage Insurance Company, Ltd.	AAHS Research Institute, Inc.	Physician Enterprise, LLC	Anne Arundel Medical Center Foundation, Inc.	Consolidating and Eliminating Entries		Consolidated
									Cottage Insurance Company, Ltd.	Other Subsidiaries	
Assets											
Current assets:											
Cash and cash equivalents	$ 725,000	$ 93,141,000	$ 7,000	$ 1,037,000	$ –	$ 136,000	$ 886,000	$ 3,693,000	$ –	$ –	$ 99,625,000
Short-term investments	–	2,062,000	–	–	–	–	–	422,000	–	–	2,484,000
Current portion of assets whose use is limited	–	15,073,000	–	–	2,648,000	–	–	–	–	–	17,721,000
Patient receivables, net	–	54,796,000	–	–	–	–	7,058,000	–	–	–	61,854,000
Current portion of pledges receivable, net	–	–	–	–	–	–	–	3,015,000	–	–	3,015,000
Inventories	–	8,033,000	97,000	–	–	–	–	–	–	–	8,130,000
Prepaid expenses and other current assets	23,000	9,614,000	2,467,000	1,021,000	120,000	11,000	15,000	81,000	(2,000,000)	(5,095,000)	6,257,000
Total current assets	748,000	182,719,000	2,571,000	2,058,000	2,768,000	147,000	7,959,000	7,211,000	(2,000,000)	(5,095,000)	199,086,000
Property and equipment	–	660,004,000	13,153,000	135,156,000	–	68,000	647,000	460,000	–	–	809,488,000
Less accumulated depreciation and amortization	–	(300,888,000)	(8,407,000)	(46,562,000)	–	(58,000)	(260,000)	(227,000)	–	–	(356,402,000)
Net property and equipment	–	359,116,000	4,746,000	88,594,000	–	10,000	387,000	233,000	–	–	453,086,000
Other assets:											
Investments	–	251,672,000	–	–	–	–	–	1,613,000	–	–	253,285,000
Investments in joint ventures	–	–	377,000	7,933,000	–	–	–	–	–	–	8,310,000
Pledges receivable, net	–	–	–	–	–	–	–	4,404,000	–	–	4,404,000
Assets whose use is limited	–	13,474,000	–	–	22,926,000	–	–	15,166,000	–	–	51,566,000
Deferred debt issue costs, net	–	4,430,000	–	215,000	–	–	–	–	–	–	4,645,000
Beneficial interest in net assets of AAMC Foundation, Inc.	–	25,947,000	–	–	–	–	–	–	–	(25,947,000)	–
Restricted collateral for interest rate swap contract	–	62,939,000	–	–	–	–	–	–	–	–	62,939,000
Investment in subsidiaries and other assets	414,327,000	14,212,000	–	1,663,000	8,535,000	–	1,224,000	462,000	–	(423,623,000)	16,800,000
Total assets	$ 415,075,000	$ 914,509,000	$ 7,694,000	$ 100,463,000	$ 34,229,000	$ 157,000	$ 9,570,000	$ 29,089,000	$ (2,000,000)	$ (454,665,000)	$ 1,054,121,000

Anne Arundel Health System, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet (continued)

June 30, 2015

	Anne Arundel Health System, Inc.	Anne Arundel Medical Center, Inc. and Subsidiaries	Anne Arundel Health Care Enterprises, Inc.	Anne Arundel Real Estate Holding Company, Inc. and Subsidiaries	Cottage Insurance Company, Ltd.	AAHS Research Institute, Inc.	Physician Enterprise, LLC	Anne Arundel Medical Center Foundation, Inc.	Consolidating and Eliminating Entries		Consolidated
									Cottage Insurance Company, Ltd.	Other Subsidiaries	
Liabilities and net assets											
Current liabilities:											
Accounts payable	$ –	$ 18,393,000	$ 2,087,000	$ 350,000	$ 2,202,000	$ 110,000	$ 23,000	$ 2,896,000	$ (2,000,000)	$ (4,576,000) (1)	$ 19,485,000
Accrued salaries, wages, and benefits	–	30,166,000	2,106,000	–	–	–	7,193,000	–	–	–	39,465,000
Other accrued expenses	–	19,257,000	215,000	731,000	2,584,000	–	–	247,000	–	–	23,034,000
Current portion of long-term debt and capital lease obligations	–	8,835,000	–	3,907,000	–	–	–	–	–	(520,000) (4)	12,222,000
Advances from third-party payors	–	22,465,000	–	–	–	–	–	–	–	–	22,465,000
Total current liabilities	–	99,116,000	4,408,000	4,988,000	4,786,000	110,000	7,216,000	3,143,000	(2,000,000)	(5,096,000)	116,671,000
Long-term debt and capital lease obligations, less current portion and unamortized original issue discount	–	338,285,000	–	79,184,000	–	–	–	–	–	(4,159,000) (4)	413,310,000
Interest rate swap contract	–	65,852,000	–	–	–	–	–	–	–	–	65,852,000
Accrued pension liability	–	22,702,000	–	–	–	–	–	–	–	–	22,702,000
Other long-term liabilities	–	–	–	5,137,000	19,602,000	–	909,000	–	–	(5,137,000) (1)	20,511,000
Total liabilities	–	525,955,000	4,408,000	89,309,000	24,388,000	110,000	8,125,000	3,143,000	(2,000,000)	(14,392,000)	639,046,000
Net assets:											
Unrestricted	389,578,000	363,057,000	3,286,000	11,154,000	9,841,000	47,000	1,445,000	1,178,000	–	(390,007,000)	389,579,000
Temporarily restricted	14,365,000	14,365,000	–	–	–	–	–	14,365,000	–	(28,731,000)	14,364,000
Permanently restricted	11,132,000	11,132,000	–	–	–	–	–	10,403,000	–	(21,535,000)	11,132,000
Total net assets	415,075,000	388,554,000	3,286,000	11,154,000	9,841,000	47,000	1,445,000	25,946,000	–	(440,273,000)	415,075,000
Total liabilities and net assets	$ 415,075,000	$ 914,509,000	$ 7,694,000	$ 100,463,000	$ 34,229,000	$ 157,000	$ 9,570,000	$ 29,089,000	$ (2,000,000)	$ (454,665,000)	$ 1,054,121,000

Anne Arundel Health System, Inc. and Subsidiaries

Supplementary Consolidating Schedule of Revenues, Expenses, Gains, and Losses

Year Ended June 30, 2015

	Anne Arundel Health System, Inc.	Anne Arundel Medical Center, Inc. and Subsidiaries	Anne Arundel Health Care Enterprises, Inc.	Anne Arundel Real Estate Holding Company, Inc. and Subsidiaries	Cottage Insurance Company, Ltd.	AAHS Research Institute, Inc.	Physician Enterprise, LLC	Anne Arundel Medical Center Foundation, Inc.	Consolidating and Eliminating Entries		Consolidated
									Cottage Insurance Company, Ltd.	Other Subsidiaries	
Operating revenue:											
Net patient service revenue	$ –	$ 536,220,000	$ –	$ –	$ –	$ –	$ 88,436,000	$ –	$ –	$ –	$ 624,656,000
Provision for bad debts	–	(16,196,000)	–	–	–	–	(3,235,000)	–	–	–	(19,431,000)
Net patient service revenue less provision for bad debts	–	520,024,000	–	–	–	–	85,201,000	–	–	–	605,225,000
Other operating revenue	1,593,000	15,796,000	11,237,000	20,776,000	2,955,000	1,235,000	24,599,000	3,153,000	(2,955,000)	(49,909,000)	28,480,000
Total operating revenue	1,593,000	535,820,000	11,237,000	20,776,000	2,955,000	1,235,000	109,800,000	3,153,000	(2,955,000)	(49,909,000)	– 633,705,000
Operating expenses:											
Salaries and wages	–	192,665,000	3,683,000	–	–	1,083,000	76,543,000	812,000	–	(1,895,000)	272,891,000
Employee benefits	–	35,738,000	596,000	–	–	227,000	6,591,000	171,000	–	(398,000)	42,925,000
Medical supplies and drugs	–	123,874,000	77,000	2,000	–	15,000	5,414,000	16,000	–	–	129,398,000
Purchased services	1,366,000	96,876,000	5,710,000	10,753,000	1,205,000	464,000	25,824,000	1,190,000	(2,955,000)	(44,891,000)	95,542,000
Professional fees	–	11,412,000	–	–	–	1,000	5,717,000	–	–	(324,000)	16,806,000
Foundation transfer to AAMC and subsidiaries	–	–	–	–	–	–	–	2,331,000	–	(2,331,000)	–
Depreciation and amortization	–	30,460,000	1,039,000	4,671,000	–	2,000	80,000	15,000	–	–	36,267,000
Interest	–	13,310,000	–	1,187,000	–	–	–	–	–	(70,000)	14,427,000
Total operating expenses	1,366,000	504,335,000	11,105,000	16,613,000	1,205,000	1,792,000	120,169,000	4,535,000	(2,955,000)	(49,909,000)	608,256,000
Operating income (loss)	227,000	31,485,000	132,000	4,163,000	1,750,000	(557,000)	(10,369,000)	(1,382,000)	–	–	25,449,000
Other income (loss):											
Investment income, net	–	15,301,000	–	26,000	1,162,000	–	–	95,000	–	–	16,584,000
Income (loss) from joint ventures and other, net	(21,199,000)	778,000	(3,000)	1,115,000	–	–	–	5,000	–	21,199,000	1,895,000
Loss on extinguishment of debt	–	(32,230,000)	–	–	–	–	–	–	–	–	(32,230,000)
Change in unrealized gains (losses) on trading securities, net	–	(14,882,000)	–	–	(1,055,000)	–	–	(94,000)	–	–	(16,031,000)
Realized and unrealized losses on interest rate swap contracts, net	–	(16,637,000)	–	–	–	–	–	–	–	–	(16,637,000)
Total other income (loss), net	(21,199,000)	(47,670,000)	(3,000)	1,141,000	107,000	–	–	6,000	–	21,199,000	(46,419,000)
Revenues and gains in excess of (less than) expenses	$ (20,972,000)	$ (16,185,000)	$ 129,000	$ 5,304,000	$ 1,857,000	$ (557,000)	$ (10,369,000)	$ (1,376,000)	$ –	$ 21,199,000	$ (20,970,000)

Anne Arundel Medical Center, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet

June 30, 2015

	Anne Arundel Medical Center, Inc.	Anne Arundel Health Care Services, Inc.	Anne Arundel General Treatment Services, Inc.	Consolidating and Eliminating Entries	Consolidated
Assets					
Current assets:					
Cash and cash equivalents	$ 59,842,000	$ 33,298,000	$ 1,000	$ –	$ 93,141,000
Short-term investments	2,062,000	–	–	–	2,062,000
Current portion of assets whose use is limited	15,073,000	–	–	–	15,073,000
Patient receivables, net	50,709,000	3,316,000	771,000	–	54,796,000
Inventories	8,033,000	–	–	–	8,033,000
Due from affiliates, net	5,318,000	22,146,000	2,055,000	(24,201,000)	5,318,000
Prepaid expenses and other current assets	4,137,000	157,000	2,000	–	4,296,000
Total current assets	145,174,000	58,917,000	2,829,000	(24,201,000)	182,719,000
Property and equipment	627,705,000	25,977,000	6,322,000	–	660,004,000
Less accumulated depreciation and amortization	(275,594,000)	(21,800,000)	(3,494,000)	–	(300,888,000)
Net property and equipment	352,111,000	4,177,000	2,828,000	–	359,116,000
Other assets:					
Investments	251,672,000	–	–	–	251,672,000
Assets whose use is limited	13,474,000	–	–	–	13,474,000
Deferred debt issue costs, net	4,430,000	–	–	–	4,430,000
Beneficial interest in net assets of Anne Arundel Medical Center Foundation, Inc.	25,947,000	–	–	–	25,947,000
Notes receivable from affiliate	4,159,000	–	–	–	4,159,000
Restricted collateral for interest rate swap contract	62,939,000	–	–	–	62,939,000
Investments in subsidiaries and other assets, net	77,180,000	–	–	(67,127,000)	10,053,000
Total assets	$ 937,086,000	$ 63,094,000	$ 5,657,000	$ (91,328,000)	$ 914,509,000

Anne Arundel Medical Center, Inc. and Subsidiaries

Supplementary Consolidating Balance Sheet (continued)

June 30, 2015

	Anne Arundel Medical Center, Inc.	Anne Arundel Health Care Services, Inc.	Anne Arundel General Treatment Services, Inc.	Consolidating and Eliminating Entries	Consolidated
Liabilities and net assets					
Current liabilities:					
Accounts payable	$ 15,005,000	$ 1,597,000	$ 27,000	$ –	$ 16,629,000
Accrued salaries, wages, and benefits	30,166,000	–	–	–	30,166,000
Other accrued expenses	19,257,000	–	–	–	19,257,000
Current portion of long-term debt and capital lease obligations	8,835,000	–	–	–	8,835,000
Intercompany payables	25,965,000	–	–	(24,201,000)	1,764,000
Advances from third-party payors	22,465,000	–	–	–	22,465,000
Total current liabilities	121,693,000	1,597,000	27,000	(24,201,000)	99,116,000
Long-term debt and capital lease obligations, less current portion and unamortized original issue premium	338,285,000	–	–	–	338,285,000
Interest rate swap contract	65,852,000	–	–	–	65,852,000
Accrued pension liability	22,702,000	–	–	–	22,702,000
Total liabilities	548,532,000	1,597,000	27,000	(24,201,000)	525,955,000
Net assets:					
Unrestricted	363,057,000	61,497,000	5,630,000	(67,127,000)	363,057,000
Temporarily restricted	14,365,000	–	–	–	14,365,000
Permanently restricted	11,132,000	–	–	–	11,132,000
Total net assets	388,554,000	61,497,000	5,630,000	(67,127,000)	388,554,000
Total liabilities and net assets	$ 937,086,000	$ 63,094,000	$ 5,657,000	$ (91,328,000)	$ 914,509,000

Anne Arundel Medical Center, Inc. and Subsidiaries

Supplementary Consolidating Schedule of Revenues, Expenses, Gains, and Losses

Year Ended June 30, 2015

	Anne Arundel Medical Center, Inc.	Anne Arundel Health Care Services, Inc.	Anne Arundel General Treatment	Consolidating and Eliminating Entries	Consolidated
Operating revenue:					
Net patient service revenue	$ 498,536,000	$ 31,593,000	$ 6,091,000	$	$ 536,220,000
Provision for bad debts	(14,580,000)	(1,153,000)	(463,000)	–	(16,196,000)
Net patient service revenue less provision for bad debts	483,956,000	30,440,000	5,628,000	–	520,024,000
Other operating revenue	26,953,000	–	59,000	(11,216,000)	15,796,000
Total operating revenue	510,909,000	30,440,000	5,687,000	(11,216,000)	535,820,000
Operating expenses:					
Salaries and wages	192,665,000	5,769,000	3,139,000	(8,908,000)	192,665,000
Employee benefits	35,738,000	1,212,000	659,000	(1,871,000)	35,738,000
Medical supplies and drugs	122,522,000	1,060,000	368,000	(76,000)	123,874,000
Purchased services	88,696,000	8,180,000	361,000	(361,000)	96,876,000
Professional fees	4,074,000	7,003,000	335,000	–	11,412,000
Depreciation and amortization	29,098,000	1,181,000	181,000	–	30,460,000
Interest	13,310,000	–	–	–	13,310,000
Total operating expenses	486,103,000	24,405,000	5,043,000	(11,216,000)	504,335,000
Operating income	24,806,000	6,035,000	644,000	–	31,485,000
Other income (loss):					
Investment income, net	15,301,000	–	–	–	15,301,000
Income from joint venture and other, net	7,456,000	–	–	(6,678,000)	778,000
Loss on extinguishment of debt	(32,230,000)	–	–	–	(32,230,000)
Change in unrealized losses on trading securities, net	(14,882,000)	–	–	–	(14,882,000)
Realized and unrealized losses on interest rate swap contracts, net	(16,637,000)	–	–	–	(16,637,000)
Total other income (loss), net	(40,992,000)	–	–	(6,678,000)	(47,670,000)
Revenues and gains in excess of (less than) expenses	$ (16,186,000)	$ 6,035,000	$ 644,000	$ (6,678,000)	$ (16,185,000)

Anne Arundel Health System, Inc. and Subsidiaries

Supplementary Description of Consolidating and Eliminating Entries

1. To eliminate intercompany payables/receivables.

2. To eliminate investment in subsidiaries and related net asset accounts.

3. To eliminate intercompany income/expense generated from management fees, staffing contracts, captive insurance premiums, and operating leases.

4. To eliminate intercompany notes.

5. To eliminate income of wholly owned subsidiaries.

6. To eliminate intercompany revenue/expense for interest and other miscellaneous transactions.

7. To eliminate the Hospital's beneficial interest in Anne Arundel Medical Center Foundation, Inc.

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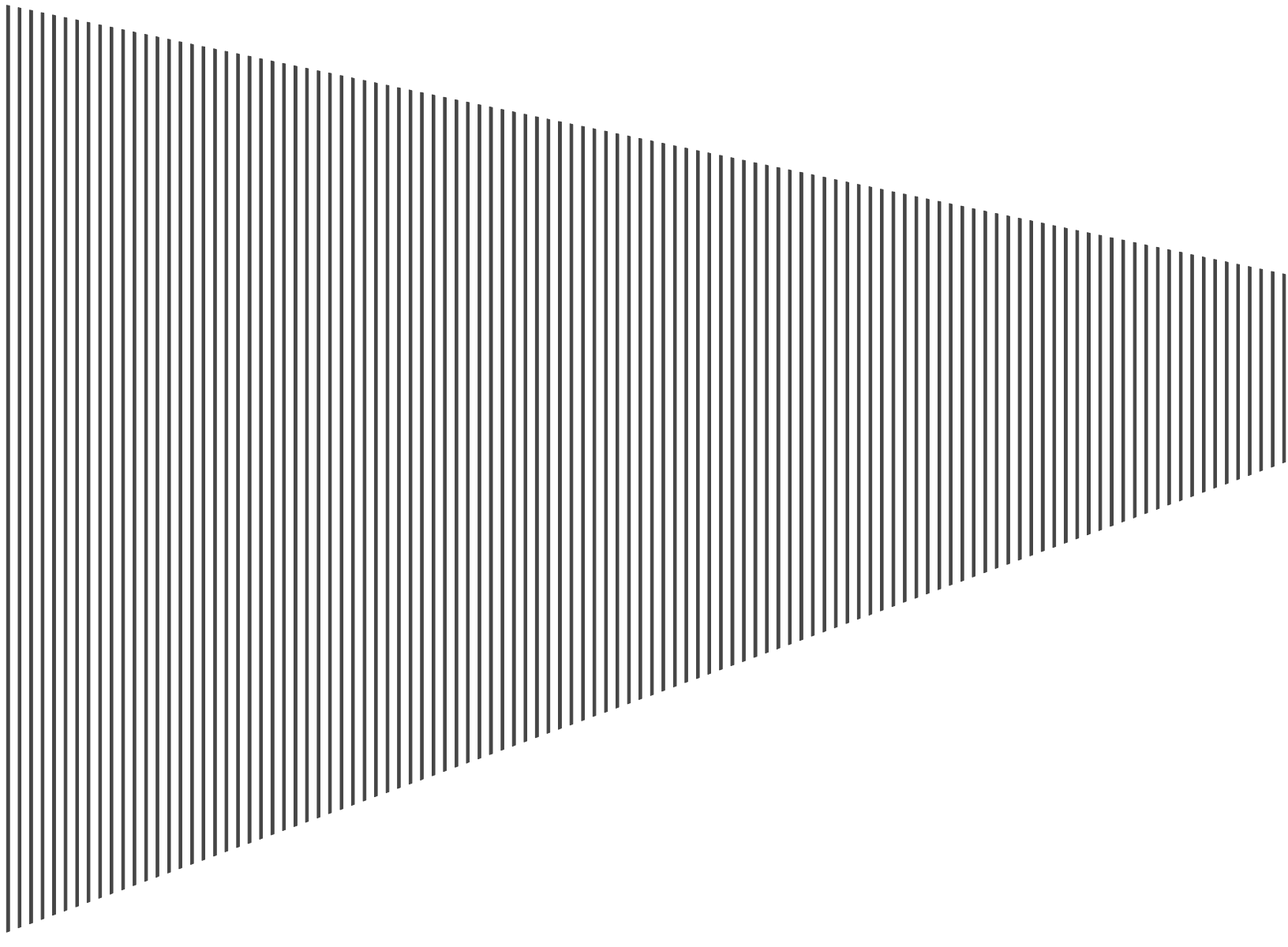

HR8.1.03 - Hiring

Scope
Anne Arundel Health System, Inc. ("AAHS")

Purpose
The Health System follows established procedures in the recruitment, screening, and hiring process. As part of this process, AAHS will verify that all employees are United States citizens or aliens lawfully authorized to work in the United States.

Definitions
None

Policy Statements & Procedures
1. Recruitment, Screening and Hiring Practices

A. Screening

External Applicants:

All applicants must complete an on-line employment application, available on the AAHS website, to be considered for employment.

Human Resources, in collaboration with the hiring supervisor, will review applications and conduct preliminary screening interviews as appropriate. Following screening, qualified candidates are referred to the hiring supervisor for interview.

Current AAHS employees:

All transfer requests are screened by Human Resources using the following criteria:

- Minimum qualifications as stated on the position description

- Disciplinary status:

o Employees who have received a suspension are ineligible for transfer for one year from the date of the suspension.

o An employee who receives a written warning is ineligible for transfer for six months from the date of the warning.

o The most recent performance review will also be taken into consideration.

Hiring supervisors may not interview an employee without a transfer form which has been reviewed by an HR representative.

B. Testing

Based upon the position description, the Health System may require applicants to pass skills tests as part of the screening process. Test results will be made available to applicants, if requested.

1. Interviews

a. Before interviews begin, the hiring supervisor will develop selection criteria, based upon the competencies listed on the current position description, by which candidates will be evaluated.

b. Interviews may be scheduled by Human Resources or the hiring department as agreed.

c. During the interview process, applicants will meet with a Human Resources representative as well as the hiring department management. Human Resources will provide each applicant with the relevant position description.

d. After interviews are complete, the hiring supervisor makes a selection and informs Human Resources. The supervisor will maintain documentation regarding the interview process.

e. The recruiter will confirm, prior to extending an offer, that the selected candidate meets all requirements of the position description including: licensure, certification, registration, background check and/or legal requirements as applicable.

2. Employment Eligibility Verification

A. Human Resources will require each newly hired AAHS employee to provide documentation establishing that the individual is a United States citizen or an alien authorized to work in the United States.

B. Each newly hired employee must sign an Employment Eligibility Verification form confirming that he or she is:

1. A citizen or national of the United States, or

2. An alien lawfully admitted in the United States for permanent residence, or

3. An alien authorized for employment in the United States under the Immigration Reform and Control Act (or by the U.S. Attorney General).

4. If a prospective new employee does not complete the eligibility and verification process before the first day of employment, the starting date will be delayed. If the individual cannot provide adequate documentation, the employment offer will be withdrawn. No one may begin work until the verification process is complete.

3. Offers of Employment

Human Resources extends all offers of employment for the Health System. All employment offers are made contingent upon satisfactory references, health screen, and background check, as coordinated by Human Resources.

4. Reference Checks

Human Resources is responsible for obtaining references for job candidates.

References
None

Cross References
None

Approval Date
VP, Human Resources - 06/2012
HPRC - 06/2012

Effective Date
2015-02-03

Owner
Human Resources

CONSULTING AGREEMENT

This Consulting Agreement (the "Agreement") is entered into and effective as of the 1st day of May, 2016 (the "Effective Date") between **Anne Arundel Health System, Inc.**, a Maryland non-profit corporation with its principal place of business at 2001 Medical Parkway, Annapolis, Maryland 21401 ("AAHS") and **Sheppard Pratt Health System, Inc.**, a Maryland non-profit corporation with its principal place of business at 6501 North Charles Street, Baltimore, MD 21204 ("Consultant").

WITNESSETH:

In consideration of the mutual covenants hereinafter contained, the parties hereto agree as follows:

1. **Engagement**. AAHS hereby engages the Consultant as an independent contractor to perform the consulting services described herein (the "Services"), and the Consultant hereby accepts such engagement.

2. **Services**. AAHS and the Consultant shall agree from time to time on the scope of the Services that AAHS shall provide hereunder, which shall be described in a Project Statement to be signed by the parties. The initial Project Statement is attached hereto as Exhibit A and its terms are incorporated herein. The Project Statement shall be effective only when signed by AAHS and the Consultant, and at that time shall be deemed a part of this Agreement.

3. **AAHS Clinical Services Contractor Terms and Conditions.** The Contractor shall comply with the Clinical Services Contractor Terms and Conditions attached hereto as Exhibit B and its terms incorporated herein.

4. **Payment for Services and Expenses.**

   a. Fee. In consideration of Consultant's provision of the Services, AAHS agrees to pay Consultant the fee set forth in Exhibit A.

   b. Expense Reimbursement. Travel and transit time shall not be considered as consulting time for purposes of calculating the fee set forth in Section 4(a) above. However, AAHS shall reimburse the Consultant for reasonable out-of-pocket expenses for travel requested by AAHS.

   c. Invoice and Payment. Following the end of each month during the Term of this Agreement, Consultant shall provide AAHS with a written invoice, which shall include an itemized list by date showing the time billed and a detailed description of the Services performed by Consultant and an itemized expense statement for any expenses. Consultant's first invoice shall be sent to the attention of Arleen D. Gleason, 2001 Medical Parkway, Annapolis MD 21401, and all subsequent invoices shall be submitted electronically using Transcepta or alternative electronic system

designated by AAHS. Payment for Services and approved expenses shall be made within thirty (30) days following approval by AAHS of the invoice statement submitted by Consultant.

5. **Term.** This Agreement shall commence on the Effective Date, and the initial term hereof shall be for three years, unless sooner terminated in accordance with the Clinical Services Contractor Terms and Conditions. Thereafter, this Agreement shall automatically renew for consecutive one (1) year terms, unless sooner terminated in accordance with the Clinical Services Contractor Terms and Conditions. The initial term and any renewal term(s) shall collectively be referred to as the "Term."

6. **Counterparts**. This Agreement may be executed in counterparts, each of which shall be deemed to be an original, and all of such counterparts shall together constitute one and the same agreement.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as of the day and year first above written.

ANNE ARUNDEL HEALTH SYSTEM, INC.

By: _____
Title: **Victoria W. Bayless**
President & Chief Executive Of
Anne Arundel Health System

SHEPPARD PRATT HEALTH SYSTEM, INC.

By: _____
By: Bonnie B. Katz
Title: Vice President, Business Development & Support Operations

EXHIBIT A
PROJECT STATEMENT

This Project Statement relates to, and its terms are incorporated by reference into, the Consulting Agreement between the undersigned parties.

General Scope

The Consultant shall provide technical advisory assistance to, and consultation with, AAHS in connection with AAHS's establishment of a new psychiatric special hospital at its Riva Road campus.

Description of Services

The Consultant's Services shall include, but not be limited to, the following:

1. Technical advisory assistance and consultation in connection with the certificate of need application, including the preparation of the CON application, response to completeness questions and review questions, and response to interested party comments.

2. Technical advisory assistance and consultation in operational matters in connection with the new psychiatric special hospital, which may include, but not be limited to, the following topics:
   a. Clinical programming development;
   b. Development of clinical and operational policies, procedures, and protocols;
   c. Drugs, medical devices, and other medical supply needs; and
   d. Payor contracting, billing, and collections.

3. Such other consulting and advisory services as reasonably requested by AAHS that are in the spirit and purpose of the General Scope outlined above.

The above-listed Services are intended to describe the general nature of the Services to be performed by the Consultant. They are not to be construed as an exhaustive list of all Services to be provided by the Consultant.

Time Commitment

The Consultant shall provide the Services from time to time on an as-needed basis at AAHS's request.

Fees

AAHS shall pay the Consultant a fee of [redacted] per hour when Consultant performs Services for AAHS.

REDACTED - PROPRIETARY

In order to evidence their agreement on the terms stated above, the parties have executed this Project Statement effective as of the last date set forth below.

"AAHS"

Anne Arundel Health System, Inc.

By: **Victoria W. Bayless**
Title: **President & Chief Executive Officer**
Date: **Anne Arundel Health System**

"CONSULTANT"

Sheppard Pratt Health System, Inc.

By: Bonnie B. Katz
Title: Vice President, Business Dev. & Supp. Ops.
Date: March 24, 2016

EXHIBIT B
CLINICAL SERVICES CONTRACTOR TERMS AND CONDITIONS

[Attached]

Anne Arundel Medical Center

ANNE ARUNDEL HEALTH SYSTEMS, INC.
AGREEMENT FOR PRODUCTS AND/OR SERVICES
(CLINICAL SERVICES CONTRACTOR TERMS AND CONDITIONS)

Anne Arundel Health System, Inc. is a not for profit corporation with a primary mission of serving Annapolis and the surrounding communities by providing quality healthcare, ethically and with compassion. It does so through its affiliates Anne Arundel Medical Center, Inc., Anne Arundel Health Care Enterprises, Inc., Anne Arundel Medical Center Foundation, Inc., Anne Arundel Health System Research Institute, Inc., Anne Arundel General Treatment Services, Inc. d/b/a Pathways, Anne Arundel Diagnostics, a tradename under Anne Arundel Health System, Inc., and Physician Enterprise, LLC (hereinafter, collectively, "AAHS"). AAHS receives funds from programs funded by the United States Government and the State of Maryland. It is committed to conducting its business ethically, legally and in accordance with the standards required of the Joint Commission on Accreditation of Healthcare Organizations. AAHS will enter business relationships only with those vendors who share our commitment to strive for the highest of ethical standards while maintaining compliance with governing laws. These terms and conditions are a necessary part of our business relationships.

1. Contractor Defined. "Contractor" means the person or entity on whose behalf this Agreement is signed and its affiliated entities, their directors, employees, agents, assigns, and sub-contractors.

2. Agreement Defined. "Agreement" refers to this document which is styled, "Anne Arundel Health Systems, Inc. Agreement for Products and/or Services (Contractor Terms and Conditions)", any Business Associate Agreement signed by the Contractor and any documents identified and incorporated by reference below.

3. "New Technology" Defined. "New technology" means any product filed with the FDA for Pre-Market Approval (PMA) designation, and assigned a PMA number which can be referenced at www.accessdata.fda.gov/scripts/cdrh/cfpma/pma.cfm and that has been on the market for less than 1 year. 510(k) designated products are never classified as New Technology because this designation by the FDA as substantially equivalent to another product on the market. No product has a PMA and 510(k) number.

4. Independent Contractor. The parties agree that Contractor is an independent contractor. Nothing in this Agreement shall be construed to make AAHS and Contractor in the relationship of partners, principal and agent, employer and employee or joint venturers and Contractor shall take no action and make no representation to third parties that would suggest otherwise. AAHS shall have no responsibility or liability for acts or omissions of Contractor. Contractors must carry and maintain such insurance (including, but not limited to, Workers' Compensation and unemployment insurance) as may be required by law and must further comply with all laws applicable to such insurance and with all tax laws and other requirements of governmental bodies with respect to any income, compensation, withholding, FICA, or other requirement applicable to Contractor. Contractor further agrees to indemnify and hold harmless AAHS with respect to all such amounts as AAHS may be required to pay as a result of Contractor's failure to make any of the aforementioned withholding payments to governmental authorities or to otherwise comply with this provision.

5. Subcontracting. Contractor will not use subcontractors to discharge its obligations under the Agreement without the prior written approval of AAHS. Should AAHS give express approval for the use of a sub-contractor, Contractor shall be responsible for ensuring that subcontractor is fully aware of the requirements of this Agreement, expressly require subcontractor to comply with all terms of the Agreement and Contractor will be liable for any breach of the Agreement or other wrongful act or omission resulting from use of the subcontractor.

6. Termination. Contractor or AAHS may terminate this Agreement, without cause, provided the terminating party provides sixty (60) days Notice to the non-terminating party. In the event of a material breach, the non-breaching party may terminate this Agreement thirty (30) days after a Notice of Cure is delivered to the breaching party that specifically identifies the nature of the breach, if the breaching party fails to cure. The

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non-breaching party must give Notice of its intent to terminate after the cure period has expired, although such termination may be immediate upon expiration of the cure period and Notice.

7. No Waiver. The failure of either Party to require performance of any provision of this Agreement at any time shall not affect its right at a later time to enforce the same or any other provision of this Agreement. No waiver by a Party of any condition or breach shall be effective unless Notice is given of an express waiver, and no such waiver shall be deemed a further or continuing waiver of such waived condition or breach in other instances nor a waiver of any other condition or breach.

8. Liability. Contractor is liable for any and all losses, including but not limited to, damage to, or loss of property (real, personal or intellectual), personal injury, wrongful death, regulatory fine or penalty, and harm to business or reputation, caused in whole, or in part, by the acts or omissions of Contractor. Contractor shall maintain General Liability, Property Damage and/or Professional Liability insurance, as required by law and/or at a minimum of One Million Dollars ($1,000,000.00) per incident and Three Million Dollars ($3,000,000.00) in the aggregate, which covers liability of Contractor's acts or omissions in performing hereunder, regardless of when such claim is made.

9. Indemnification. Contractor agrees to indemnify and hold harmless AAHS and its affiliates, their directors, officers, employees and agents from, and against, any and all claims, actions, liabilities, including attorneys' fees, arising out of Contractor's acts or omissions, and shall cooperate in the investigation and defense of any claims or suits.

10. Reasonable Restrictions. The Parties agree that the restrictions set forth in this Agreement are reasonable, proper, and necessitated by their respective business interests, and do not constitute an unlawful or unreasonable restraint on either of the Parties' ability to conduct its business.

11. No Third Party Rights. This Agreement has been made and entered solely for the benefit of the Parties hereto and their respective successors and permitted assigns. Nothing in this Agreement is intended to confer any rights or remedies on any entity or person other than the Parties hereto and their respective successors and permitted assigns. Nothing in this Agreement is intended to relieve or discharge the obligation or liability of any third persons outstanding to either Party to this Agreement.

12. Assignment. Contractor may not assign any of Contractor's rights or obligations under this Agreement without the prior written consent of AAHS. AAHS may assign any and all of its rights and obligations hereunder to an Affiliate. For purposes of this Agreement, an Affiliate is any legal entity which directly or indirectly controls or is controlled by, or is under common control with AAHS. Except as provided in the preceding two sentences, Hospital may not assign its rights or obligations hereunder without the prior written consent of Contractor.

13. Successors and Permitted Assigns. Notwithstanding anything to the contrary herein, this Agreement shall be binding upon, and shall inure to the benefit of, the Parties' respective successors and permitted assigns (to the extent specified in the assignments).

14. Complete Agreement. This Agreement along with any Business Associate Agreement executed by Contractor constitutes the complete and exclusive statement of the understanding between the Parties. It supersedes all prior written and/or oral statements, conditions, representations and/or warranties except as expressly provided otherwise herein.

15. Amendments. This Agreement may be amended at any time by mutual agreement of the Parties without additional consideration, provided such amendment is reduced to writing and signed by authorized agents of both Parties.

16. Modification Required by Government Action. In the event any governmental restrictions are imposed directly, through legislation, or by judicial or agency interpretation which would necessitate alteration of the Parties' relationship or the deliverables hereunder, Notice of the requisite modification which specifies the basis for the modification, shall be given as soon as practicable by either party having knowledge of such requisite modification. When the requisite modification results in a material alteration of a Party's responsibilities under this Agreement, the Party whose responsibilities have been, or will be, materially altered may terminate this

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Agreement upon thirty (30) days Notice or upon Notice as reasonably required to comply with governing laws, whichever period is longer.

17. Equal Opportunity. AAHS is a provider of health services that receives federal funds under Medicare Part A and Medicaid. Accordingly, we have a non-discrimination policy as required by Titles VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and the Americans with Disabilities Act. Specifically, it is against our policy to discriminate against employees, patients, or visitors on the basis of age, race, gender, sexual orientation, color, religion, national origin, or physical or mental disability. Contractor must comply with said policies and all Federal and State requirements concerning civil rights.

18. Conflict of Interest. Contractor acknowledges that AAHS has adopted a conflict of interest policy and represents it has disclosed to the AAHS Corporate Compliance Officer any actual or potential conflict of interest arising from any Contractor officer, director, employee, or their family member having any significant ownership, financial or other interest in, or arrangement with AAHS, its owners, officers, directors, employees, or their family members, and that Contractor will disclose such relationships and interests should they arise.

19. Gifts and Perquisites. Contractor acknowledges that AAHS employees are prohibited under the AAHS Code of Conduct from directly or indirectly soliciting gifts or business courtesies from Contractor, and from directly or indirectly offering, giving, or accepting any gifts, benefits, meals, lodging, travel, or other perquisites that could influence (or appear to influence) objective business judgment or results in a violation of applicable law or AAHS policies. Contractor will refrain from soliciting, offering, or accepting prohibited gifts.

20. Contractors Providing Goods - Condition and Packaging. Contractors providing goods (including equipment) to AAHS shall offer and ship only those goods in new condition and consistent with the purchase order and/or other agreed upon specifications, unless otherwise agreed in writing. Contractor shall provide reasonable notice prior to shipment of goods. All pricing quoted and bargained shall include costs for standard packaging.

21. Contractors Providing Services. Contractors providing services shall offer and contract to provide only those services Contractor is reasonably qualified through education, training and/or experience to offer. Services may not be provided using equipment, or by entities or persons, lacking necessary credentials, licensure or certification. Contractor must give Notice of any limitation, termination, suspension, expiration, or lapse of necessary credentials, licensure or certification during the term of this Agreement and any extension thereof (whether express or by operation of law).

    a. Compliance with Laws, Standards, Regulations and Policies. Contractor shall provide contracted services in compliance with the standards of the Joint Commission on Accreditation of Healthcare Organizations ("the Joint Commission") and other accrediting bodies, Medical Staff Bylaws, Rules, and Regulations, federal, state, and local laws, rules, regulations, and standards, including requirements for participation in the Medicare and Medicaid programs, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). In order to insure Contractor compliance therewith, and upon reasonable request therefor, AAHS may require written verification of the following:
        i. Education and training that is consistent with applicable legal and regulatory requirements and AAHS policy, monitoring compliance with same, and timely reporting of any suspected violations to AAHS;
        ii. Evidence of license, certification or registration, when applicable;
        iii. Evidence that an individual's knowledge, experience and competence are appropriate for his or her assigned responsibilities;
        iv. Evaluations of performance of all individuals performing Services, to be conducted and provided to AAHS annually;
        v Health screening as required by job responsibilities, in accordance with AAHS policy, and as required by federal, state and local law and regulation;
        vi. Criminal background check(s) on all individuals providing services on behalf of Contractor;
        vii. References, when applicable.

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b. Orientation. AAHS shall require successful completion of orientation to hospital-wide policies and procedures, including safety and infection control, and to the assigned department/service line including program-specific policies and procedures, **prior to providing patient care and/or services.**

c. Performance Measures. Contractor is responsible for establishing measures and collecting data to monitor its performance. Clinical performance measures will include process, outcome and patient care experiences, and will encompass inpatient and/or ambulatory care. Data is collected for the following purposes:

i. To establish and define a baseline for outcomes
ii. To identify opportunities for improvement
iii. To identify changes which will lead to improvement
iv. To monitor practice and changes implemented to assure improvement
v. The measures identified by Contractor are collected and aggregated, analyzed and reported quarterly to the appropriate service line Quality Council. The data will be used to monitor and provide information on Contractor performance, risk management issues/sentinel events, targeted areas where problems and/or departures from practice norms have been identified, and appropriateness of patient management.

22. Safety Standards. All manufactured items and/or fabricated assemblies provided hereunder and/or used for delivery of services, including those subject to operation under pressure, and/or operation by connection to an electric source shall be constructed and approved in a manner acceptable to the appropriate governing agency(ies) and/or state inspector which customarily requires the label or re-examination listing or identification marking of the appropriate safety standard organization (e.g., the American Society of Mechanical Engineers, the Underwriters Laboratories, and/or National Electrical Manufacturer's Association) where such approvals of listings have been established for the type(s) furnished. The Contractor shall meet all requirements of the Occupational Safety and Health Act (OSHA), and state and federal requirements relating to the nature of the deliverables hereunder.

23. No Exclusion/Debarment. Contractor represents that neither Contractor, Contractor's officers, partners or persons owning more than five percent (5%) of Contractor's equity interests, nor are any of Contractor's employees or agents who will provide health care services to AAHS or its patients, currently excluded, debarred, or otherwise ineligible to participate in any state or federal program and none have been convicted of a criminal offense related to the provision of health care items or services. Contractor agrees to immediately give Notice of any threatened or actual debarment, exclusion, or other event or circumstance that makes or may make Contractor or any of the described persons ineligible to participate in a state or federal program. Contractor acknowledges and agrees that AAHS will have the right to terminate this Agreement and its business relationship with Contractor in the event of any such debarment, exclusion, or other action unless Contractor takes immediate effective action to remedy such circumstance. Such termination may be effected without providing an opportunity for cure.

24. Arms Length Exchange. Nothing in this Agreement or in connection herewith contemplates, requires, shall require or contemplate the referral of any patient or the purchase, order or lease of any item or service from one Party or its affiliate to the other Party or its affiliate, nor shall it be construed as an offer of payment by one Party or its affiliate to the other Party or its affiliate, whether direct or indirect, overt or covert, for patient referrals or for recommending or arranging the purchase, lease or order of any item or service. The Parties intend and agree that all amounts paid under this Agreement are intended to, and do reflect the fair market value of the goods and/or services provided. It is specifically acknowledged by the Parties that no amount paid, or to be paid, hereunder is intended to, nor shall it be construed as an inducement or payment for the referral of a patient or for recommending or arranging the purchase, lease or order of goods or services.

25. Fraud and Abuse Education. Contractor must adhere to the AAHS Compliance Plan, including the AAHS Code of Business Ethics and Conduct ("Code of Conduct"). Based on the level of Medicaid payments the Health System receives, AAHS must provide education in accordance with Section 6032 of the Deficit Reduction Act ("DRA") to its vendors, contractors and agents. Accordingly, AAHS has provided a detailed description of the federal False Claims Act, the federal Program Fraud Civil Remedies Act, and a summary of the Health System's policies and procedures for detecting and preventing fraud, waste and abuse, as well as

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information regarding the rights of employees to be protected as whistleblowers in its Code of Conduct. A copy of the AAHS Code of Conduct can always be accessed via the Health System's web page in the Client Access section. You can request a copy of the Code of Conduct and seek answers to any questions you may have regarding the Code of Conduct or any aspect of the Health System's Compliance Plan from the Corporate Compliance Officer by telephone at (443) 481-1332 or by email at compliance@AAHS.org.

26. Compliance Reporting and Cooperation. Should Contractor obtain information that reasonably leads it to believe there may have been or may be a violation of law, ethical obligation, or AAHS policy by AAHS or its contractors, Contractor will promptly report same to the Corporate Compliance Officer by emailing compliance@AAHS.org, by telephoning the Compliance Ethics Hotline at (443) 481-1336, or by United States mail to, Corporate Compliance Officer, Anne Arundel Health System, Inc., 2001 Medical Parkway, Annapolis, Maryland, 21401. Contractor shall provide all information related to such belief in the report. Contractor will cooperate with AAHS in any investigation related to any compliance matters or other actions taken pursuant to the AAHS Compliance program. Information concerning matters taken under review by the Compliance Office will not be disclosed by Contractor except as minimally necessary to assist the Compliance Office in the investigation and resolution of compliance matters; to make a report to government personnel; or under the conditions described below. Nothing herein shall be construed as limiting, in any way, the right of Contractor to report or disclose to any governmental agency or personnel information Contractor is obligated to disclose hereunder. Contractor agrees, when such a report is made and when legally permitted, it will disclose to AAHS (i) when a disclosure regarding actual or potential violations of law has been made by Contractor to a governmental agency; or (ii) when any Contractor has been questioned by government personnel regarding AAHS.

27. Contractor Books and Records. Upon the written request of the Secretary of Health and Human Services or the Comptroller General or any of their fully authorized representatives, Contractor will make available Contractor's, books, documents and records necessary to verify the nature and extent of the costs of providing its services. Such inspection shall be available up to four (4) years after the rendering of such services. If Contractor carries out any of the duties of the Agreement through subcontract with a value of Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period with a related individual or organization, Contractor agrees to include this requirement in any such subcontract. This Article is included pursuant to and is governed by the requirements of Public Law 96-499, Section 952 (Section 1861(v)(i) of the Social Security Act) and the regulations promulgated thereunder. No attorney-client, accountant-client or other statutory or common law privilege shall be deemed as having been waived by AAHS or Contractor by virtue of having entered this Agreement.

28. Access to Information and Information Resources. Contractor's access and review of AAHS materials, data and information must be limited to that minimally necessary to perform its services hereunder. Contractor acknowledges and agrees that AAHS computers, applications, information storage, networks, and telecommunications systems, including telephones and facsimiles, ("Information Resources") are AAHS property. The Information Resources will be used only by properly identified and authorized individuals and will be used solely for AAHS business. All messages, content, data, information, and files composed, stored, sent, or received on the Information Resources are the property of AAHS, and Contractor acknowledges and agrees that Contractor has no expectation of privacy with respect to use of the Information Resources.

29. Patient Information. Contractor agrees that all patient information is confidential and protected by federal and state law and that such information must not be accessed, used, or disclosed except in accordance with AAHS Privacy Policies and Procedures, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and all other applicable federal, state and local laws.

30. Confidential Information. "Confidential Information" includes, but is not limited to, the following types of information, (whether or not reduced to writing): all documentation, discoveries, ideas, concepts, software, designs, drawings, specifications, techniques, models, source codes, object codes, diagrams, flow charts, procedures, policies, clinical data, patient information, trending information, tracking information, pricing information, purchasing history or patterns, quality reports and data, service line development, market research data, marketing plans, business plans, business procedures, financial information, "know-how" comprising all or any part of the information used by either AAHS or the Contractor in the course of fulfilling its obligations pursuant to this Agreement, and related information.

REVIEWED RETURNED

a. Duties Concerning Confidential Information. Contractor and AAHS shall each maintain strict confidentiality concerning the other's Confidential Information. Neither Contractor nor AAHS shall directly or indirectly use, disclose, or permit the disclosure of any of the other's Confidential Information. If either of the Parties receives a request for Confidential Information from a court, governmental agency, credentialing entity, or accrediting body, the receiving party shall give the other party prompt Notice prior to any disclosure of Confidential Information to allow the other party an opportunity to obtain an appropriate protective order or to otherwise respond.

b. Procedure Upon Termination of this Agreement. All Confidential Information obtained by Contractor in providing services under this Agreement belongs to, and shall remain, the exclusive property of AAHS. Upon the expiration or termination of this Agreement, Contractor shall destroy, or upon AAHS' request, return to AAHS all Confidential Information. All backup copies of electronic information provided to Contractor are to be returned or destroyed at the conclusion of the Agreement. Contractor agrees that it shall not directly or indirectly use any of AAHS's Confidential Information or any other information provided to Contractor under this Agreement for any purpose following termination of this Agreement.

c Information in the Public Domain. The restrictions regarding Confidential Information described in this Agreement do not apply to information that is (i) in the public domain at the time of its disclosure to the recipient or becomes part of the public domain without the fault of recipient, or (ii) is acquired by recipient from a third party bearing no obligation to confidentiality with respect to such information.

d. Exception. Notwithstanding any other provision of this Agreement to the contrary, AAHS shall have the right to disclose pricing and other terms of this Agreement to AAHS' physicians, attorneys, accountants, group purchasing consultants and other third parties retained by AAHS (collectively "AHHS Consultants"), provided all such AAHS Consultants agree to adhere to the same standards of confidentiality as those set forth in this Agreement.

31. Ownership of AAHS Information. AAHS retains full ownership of all documents, files, data, and work product, generated, developed or captured by, or on behalf of AAHS ("AAHS Information"). Upon termination of this Agreement, Contractor shall deliver and/or return, without retaining any copies or data sources, all AAHS Information in a reasonably useable format.

32. Advertising. Contractor agrees not to use, reference, or publish information relating to AAHS, its registered marks, photography or any depiction of its likeness, as part of Contractor's marketing efforts or otherwise, without the prior written approval of AAHS.

33. AAHS Staff. Contractor shall not solicit, hire, or employ, directly or indirectly, any employee of AAHS without the prior written consent of AAHS, at any time during the term of this Agreement, any extension thereof (whether express or by operation of law), or for one (1) year immediately following its termination.

34. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Maryland applicable to agreements made and to be performed wholly within that state, irrespective of such state's choice-of-law principles.

35. Jurisdiction and Venue. The parties submit to the jurisdiction of the courts of the State of Maryland. Any action brought hereunder must be brought in a court of competent jurisdiction in the State of Maryland.

36. Section Titles. The section titles of the numbered/lettered provisions of this Agreement are included for the purposes of convenience only and shall not affect the interpretation of any provision hereof.

37. Partial Invalidity: If any provision of this Agreement is found to be invalid or unenforceable by any court of competent jurisdiction, such provision shall be ineffective only to the extent that it is in contravention of applicable laws without invalidating the remaining provisions of this Agreement, unless such invalidity or unenforceability would defeat an essential business purpose of this Agreement.

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SIGNATURE REQUIRED

38. Survival of Provisions. The rights and responsibilities outlined in the provisions entitled, "Contractor Defined," "Independent Contractor," "Termination," "No Waiver," "Liability," "Indemnification," "Reasonable Restrictions," "No Third Party Rights," "Assignment," "Successors and Permitted Assigns," "Complete Agreement," "Contractor Books and Records," "Access to Information and Information Resources," "Confidential Information," "Patient Information," "Ownership of AAHS Information," "Advertising," "AAHS Staff," "Governing Law," "Jurisdiction and Venue," "Section Titles," "Partial Invalidity," "Survival of Provisions," "Notices," "Authority to Bind," and "Incorporated Documents" shall survive any expiration or termination of this Agreement.

39. Notices. All Notices under this Agreement must be in writing and shall be deemed given: (i) when received if personally delivered; (ii) on the second (2nd) business day following delivery by facsimile transmission to the telephone number provided by the party for such purposes, if simultaneously mailed as provided herein; (iii) on the second (2nd) business day following deposit for overnight delivery with a bonded courier holding itself out to the public as providing such Services, with charges prepaid; or (iv) on the fourth (4th) business day following deposit with the United States Postal Service, postage prepaid, and in any case addressed to the party's address set forth below, or to any other address that the party provides by Notice in accordance with this Section:

To Hospital:
Anne Arundel Health System, Inc.
2001 Medical Parkway
Annapolis, Maryland 21401
Attention: [Below Signatory]

With a copy to:
Anne Arundel Health System, Inc.
2001 Medical Parkway
Annapolis, Maryland 21401
Attention: Legal Department

To Contractor:
Shepherd's Health System
600 N Charles St
Baltimore MD 21204
c/o Bonnie Katz

40. Authority to Bind. The Parties hereby represent and attest that the signatories executing this Agreement on their behalf have the authority to bind the Party on whose behalf they are signing to the terms of this Agreement.

STANDARD AND REQUIRED

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41 Incorporated Documents. The following documents (including any attachments thereto that are appropriately identified/referenced therein), are attached hereto and their terms incorporated by reference.

DATE OF DOCUMENT	DESCRIPTIVE TITLE OF DOCUMENT
3/24/16	Consulting Agreement

42. Priority of Documents. In the event there is a conflict between, or among the provisions of the documents that constitute the Agreement as defined above, the order of priority shall be, the AAHS Terms and Conditions, followed by any Business Associate Agreement entered for the benefit of AAHS and its Tenants, followed by any other documents listed above as being incorporated herein, in the order listed.

IN WITNESS HEREOF, the Parties have executed this Agreement, effective this ____ day of _____ 20____

CONTRACTOR

Signature

Sheppard Pratt Health System, Inc

Bonnie B. Katz

Printed Name

Vice President

Title

3/24/16

Date

ANNE ARUNDEL HEALTH SYSTEM, INC.

Signature

Victoria W. Bayless

Printed Name

President & Chief Executive Officer
Anne Arundel Health System

Title

3-25-16

Date

STANDARD AND REQUIRED

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Anne Arundel Health System, Inc.

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement"), is entered into this 24th day of March 2016, by and between Sheppard Pratt Health System, Inc. (the "Business Associate"), and Anne Arundel Health System, Inc., and all related organizations, hereinafter collectively referred to as "Affiliates" (each a "Party" and collectively the "Parties").

RECITALS

WHEREAS. the Parties have entered into a prior written agreement or are contemplating entering into an agreement which may require the disclosure by Affiliates of Protected Health Information ("PHI") to the Business Associate or the Business Associate may create or receive PHI by or on behalf of the Affiliates; and

WHEREAS, Affiliates and Business Associate intend to protect the privacy of PHI disclosed to or created or received by Business Associate pursuant to the Agreement in compliance with applicable provisions of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and regulations promulgated thereunder by the U.S. Department of Health and Human Services ("the Privacy Regulations"), the privacy and security provisions of the American Recovery and Reinvestment Act (Stimulus Act) for Long Term Care, Public Law 111-5, the American Recovery and Reinvestment Act of 2009 (ARRA), Title XIII and related regulations, Health Information Technology for Economic and Clinical Health ("HITECH"), and other applicable laws; and

NOW THEREFORE, for and in consideration of the recitals above and the mutual covenants and conditions herein contained, Affiliates and Business Associate enter into this Agreement to provide a full statement of their respective responsibilities.

1. **Definitions.**

   Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms are currently defined in HIPAA, ARRA and the Privacy Regulations, as amended from time to time. All defined terms are capitalized.

2. **Services.**

   The Affiliates and the Business Associate have entered, and may in the future enter, into service agreements ("Service Agreements") pursuant to which the Business Associate provides the following services: consulting services ("Services") to the Affiliates that involve the use, access, and disclosure of PHI. Except as otherwise specified herein or as required by law, the Business Associate may make use of the PHI only as necessary for the purpose of providing the Services. All other uses not authorized by this Agreement are prohibited. Nothing in this Agreement shall prohibit Business Associate's disclosure of PHI received from or created or received on behalf of Affiliates, to Affiliates.

3. **Responsibilities of the Business Associate.**

a. With regard to its use and/or disclosure of PHI obtained from Affiliates, Business Associate agrees to:

i. Not to use, access, and/or disclose the PHI other than as permitted or required by this Agreement or as permitted or required by HIPAA, ARRA, the Privacy Regulations and all other provisions of law;

ii. To use appropriate safeguards to prevent use, access or disclosure of PHI not expressly permitted by this Agreement or as required by law. When able, Business Associate will secure PHI in accordance with the guidance issued by the Secretary of the Department of Health and Human Services. PHI is deemed secured if it is rendered unusable, unreadable, or indecipherable to unauthorized individuals by encryption or destruction;

iii. To mitigate, to the extent practicable, any harmful effects of which the Business Associate becomes aware that arise out of the use, access, and disclosure of PHI by the Business Associate or its agents or contractors that is in violation of this Agreement;

iv. To ensure compliance with HIPAA, ARRA and the Privacy Regulations by implementing administration safeguards (42 CFR §164.308), physical safeguards (42 CFR §164.310), technical safeguards (42 CFR §164.312), and ensuring compliance with the policies and procedures and documentation requirements set forth in 42 CFR §164.316;

v. To implement a compliance program to assist in detecting unauthorized access or use of PHI;

vi. To ensure that any agents, including subcontractors or employees, to whom the Business Associate provides any PHI received from the Affiliates or creates PHI by or on behalf of the Affiliates under this Agreement, agree, in writing, to adhere to the same restrictions and conditions on the use, access, and/or disclosure of PHI that apply to the Business Associate. Notwithstanding the foregoing, the Business Associate shall only disclose that PHI to such agents as is reasonably necessary to perform the Services or to fulfill a specific function required or permitted under this Agreement;

vii. Upon three (3) days prior notice from the Affiliates and during the regular business hours of the Business Associate, or at such times and upon such terms as the Secretary of Health and Human Services ("Secretary") may require, to make available all internal practices, records, books, agreements,

policies and procedures relating to the use, access, and/or disclosure of PHI received from, or created or received by the Business Associate from or on behalf of, the Affiliates necessary to allow the Secretary to determine whether the Affiliates is in compliance with HIPAA, ARRA and the associated Privacy Regulations;

viii. To document all disclosures of PHI and such other information related to the disclosure of PHI as may reasonably be necessary for the Affiliates to respond to any request by an individual for an accounting of disclosures of PHI as permitted by 45 C.F.R.164.528;

ix. Within ten (10) days of receiving a written request from the Affiliates, to provide to the Affiliates, or an Individual, all information collected in accordance with section 3(a)(viii) of this Agreement;

x. To disclose to its subcontractors, agents or other third parties, and request from the Affiliates, only the minimum PHI necessary to perform or fulfill a specific function required or permitted hereunder; and

xi. If the Business Associate maintains PHI in a Designated Record Set, upon three (3) days prior notice from the Affiliates and during all regular business hours of the Business Associate, to provide access to PHI to the Affiliates or, as directed by the Affiliates, to an individual, contained in such Designated record Set, as required by 45 C.F.R. 164.524;

xii. Within three (3) days of receiving written notice from the Affiliates, to make any amendment(s) to Protected Health Information contained in a Designated Record Set that the Affiliates directs or agrees to pursuant to 45 C.F.R. 164.526;

xiii. Report immediately to Affiliates in writing any use or disclosure of PHI of which Business Associate becomes aware that is not permitted or required by this Agreement or any Security Incident. Such report shall contain:

- A brief description of what happened, including the date of the unauthorized access or use of PHI and the date of the discovery of the unauthorized access or use of PHI;
- A description of the types of unsecured PHI that were involved in the unauthorized access or use of PHI;
- Any recommended steps the individual whose PHI was inappropriately disclosed should take to protect themselves from the potential harm; and

- A brief description of what the Business Associate is doing to investigate the unauthorized access or use of PHI.

xiv. Business Associate agrees that, if it has a legal obligation to disclose any PHI, it will notify Affiliates as soon as reasonably practical after it learns of such obligation, and in any event within a time sufficiently in advance of the proposed release date such that the rights of Affiliates and the Individual to whom the PHI relates would not be prejudiced. If Affiliates or the Individual objects to the release of such PHI, Business Associate will allow Affiliates and/or the Individual to exercise any legal rights or remedies Affiliates and/or the Individual might have to object to the release of the PHI, and Business Associate agrees to provide such assistance to Affiliates and the Individual, as Affiliates or the Individual may reasonably request in connection therewith.

4. **Responsibilities of the Affiliates.**

a. Affiliates shall provide Business Associates with a copy of its notice of privacy practices produced in accordance with 45 CFR §164.520, as well as any subsequent changes or limitations to such notice to the extent that such changes or limitations may affect Business Associate's use or disclosure of PHI.

b. Affiliates shall notify Business Associate of any changes in, or revocation of, permission by an individual to use, access, or disclose PHI, to the extent such change or revocation may affect the Business Associate's use, access, or disclosure of PHI; and

c. Affiliates shall notify Business Associate of any restriction(s) on the use, access, or disclosure of PHI that the Affiliates has agreed to in accordance with 45 C.F.R. 164.522, to the extent that such restriction(s) may affect the Business Associate's use, access, or disclosure of PHI.

5. **Permitted Uses, Access, and Disclosures or Protected Health Information.**

Except as otherwise limited by this Agreement, the Business Associate may use, access, or disclose the PHI to perform the Services, as set forth in the applicable Service Agreement, provided that such use, access, or disclosure, if made by the Affiliates, would not violate the Privacy Rules or the minimum necessary policies and procedures of the Affiliates.

6. **Specific Use, Access, and Disclosure Provisions.** Unless otherwise limited herein, the Business Associate may:

a. Use the PHI in its possession for the proper management and administration of the Business Associate to perform the Services and to fulfill any legal

responsibilities of Business Associate, provided that such uses, access, or disclosure does not violate the Privacy Rules or the minimum necessary policies and procedures of the Affiliates.

b. Disclose PHI to a third-party for the purpose of Business Associate's proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided any such disclosure (i) is required by law or (ii) the Business Associate obtains reasonable assurances from the Third Party to whom the information is disclosed that the PHI will remain confidential and will only be used, accessed, or further disclosed for the purpose for which it was disclosed to such Third Party or as many other wise be required by law, and the Third Party agrees to notify the Business Associate of any instances of which the Third Party becomes aware in which the confidentiality of the PHI has been breached.

c. Use the PHI to provide Data Aggregation Services to the Affiliates, as permitted by 45 C.F.R. 164.504(e)(2)(i)(B).

d. Disclose the PHI to report violations of law to appropriate federal and state authorities, consistent with 45 C.F.R. 154.502(j)(1).

7. **Term and Termination.**

a Term. This Agreement shall become effective on the date this Agreement is entered into by parties and shall terminate when all the PHI provided by the Affiliates to the Business Associate, or created or received by Business Associate on behalf of Affiliates, is destroyed or returned to Affiliates, or, if it is not feasible to return or destroy the Protected health Information, protections are extended to such information in accordance with this Section 7. Upon termination of the Underlying Contract(s), Business Associate shall promptly destroy or return to Affiliates or, if it is infeasible to return or destroy PHI, implement protections for such information, in accordance with the termination provisions in this Section.

b. Termination by the Affiliates for Cause. If the Business Associate breaches this Agreement, the Affiliates, in their sole discretion, may:

i. Provide the Business Associate with written notice that the Business Associate has breached this Agreement and provide the Business Associate an opportunity to cure the breach to the satisfaction of the Affiliates within ten (10) days, after which time this Agreement and all of the Service Agreements shall be automatically terminated if the breach is not cured; and

ii. Immediately terminate this Agreement and the Service Agreements if the Business Associate has breached a material term of this Agreement and cure is not possible.

c. Termination by Business Associate. So long as any Service Agreement by and between the Affiliates and the Business Associate shall exist, the Business Associate shall have no right to terminate this Agreement.

d. Effect of Termination. Upon the event of termination pursuant to this Section 7, the Business Associate agrees to do the following:

i. Cease and desist all uses and disclosures of Affiliates' PHI and shall immediately return or destroy (if Affiliates gives written permission) all PHI received from Affiliates, or created or received by Business Associate on behalf of Affiliates, if it is feasible to do so, in a manner consistent with HIPAA and the Privacy Regulations, provided, however, that Business Associate shall reasonably cooperate with Affiliates to ensure that no original PHI records are destroyed.

ii. Retain no copies of the PHI, and shall certify to Affiliates that all PHI has been returned (or destroyed) within 30 days after termination or expiration of this Agreement. In the event that the Business Associate believes that returning or destroying PHI is not feasible, the Business Associate will notify the Affiliates in writing within three (3) days of any termination hereof setting forth:

1. the conditions that the Business Associate believes make return or destruction of the PHI not feasible, and

2. the specific reasons for such determination.

Upon mutual agreement of the parties that return or destruction of PHI is not feasible, Business Associate agrees to extend any and all protections, limitations and restrictions contained in this Agreement to such PHI and shall limit further uses and/or disclosures of such PHI to the purposes that make its return or destruction not feasible.

iii. If the Affiliates determine that the return or destruction of Protected Health Information is not feasible, the Business Associate shall extend the Protections of this Agreement to such PHI and limit further uses, accesses, and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

iv. Recover any PHI in possession of its subcontractors or agents. If it is not feasible for Business Associate to obtain, from any subcontractor or agent any PHI in possession of the subcontractor or agent, the Business Associate must provide a written explanation to Affiliates and require the subcontractors and agents to agree to extend any and all protections, limitations and restrictions contained in this Agreement, and to limit any further uses and/or disclosures to purposes that make the return or destruction of the PHI infeasible.

8. **Indemnification.** The Business Associate agrees to indemnify, defend and hold harmless the Affiliates and its parent corporation, subsidiaries, and related entities, their directors, officers, agents, servants and employees (collectively "the Indemnitees") from and against any and all claims, causes of action, liabilities, judgments, fines, assessments, penalties, damages, awards or other expenses of any kind or nature whatsoever, including, without limitation, attorney's fees, expert witness fees, and costs of investigation, litigation or dispute resolution, incurred by the Indemnitees and relating to or arising out of any breach or alleged breach of the terms of this Agreement by Business Associate or any agent or subcontractor of Business Associate.

9. **DISCLAIMER.** AFFILIATES MAKES NO WARRANTY OR REPRESENTATION THAT COMPLIANCE BY BUSINESS ASSOCIATE WITH THIS AGREEMENT OR THE PRIVACY REGULATIONS WILL BE ADEQUATE OR SATISFACTORY FOR BUSINESS ASSOCIATE'S OWN PURPOSES. BUSINESS ASSOCIATE IS SOLELY RESPONSIBLE FOR ALL DECISIONS MADE BY BUSINESS ASSOCIATE REGARDING THE SAFEGUARDING OF PROTECTED HEALTH INFORMATION.

10. Miscellaneous

a. Survival. The respective rights and obligations of Business Associate set forth in Section 7 shall survive termination of this Agreement.

b. Interpretation. Any ambiguity in this Agreement shall be resolved to permit the parties hereto to comply with HIPAA, ARRA and the Privacy Regulations.

c. Amendments: This Agreement may not be amended except in a writing duly signed by authorized representatives of the Parties. Both parties hereto agree that this Agreement shall be amended to comply with any and all state or federal laws, rules, or regulations.

d. Waiver. No failure or delay in exercising any right, power, or remedy hereunder shall operate as a waiver thereof; nor shall any single or partial exercise of any right, power, or remedy hereunder preclude any other further exercise thereof or

the exercise of any other right, power, or remedy. The rights provided hereunder are cumulative and not exclusive of any rights provided by law.

e. Successors and Assigns. This Agreement and all rights and obligations hereunder shall be binding upon and shall inure to the benefit of he respective successors or assigns of the Parties hereto.

f. Notices. Any notices to be given hereunder to a Party shall be in writing and shall be deemed to have been duly given (a) when delivered personally, (b) the next business day following the day on which the same has been delivered prepaid to a nationally recognized overnight courier service, or (c) three (3) days after sending by registered or certified mail, postage prepaid, return receipt requested, in each case to the address set forth below to the attention of the person signing below, or to such other person at such other address as the party may designate by giving notice:

If to Business Associate, to:

Bonnie Katz
Sheppard Pratt Health System
6501 N. Charles St Towson MD 21204
Attention: Bonnie Katz
Fax: 410-938-3164

with a copy (which shall not constitute notice) to:

Robert Roca, MD
Same address

Attention: _____
Fax: _____

If to Affiliates, to:

Anne Arundel Health System, Inc.
Health Information Services
2001 Medical Parkway
Annapolis, MD 21401
Attention: Privacy Officer
Fax: (443) 481-4125

with a copy (which shall not constitute notice) to:

Anne Arundel Health System, Inc.
Health Information Services
2001 Medical Parkway
Annapolis, MD 21401
Attention: Legal Department
Fax: (443) 481-5266

Each Party named above may change its address and that of its representative for notice by the giving of notice thereof in the manner hereinabove provided.

g. Severability. In the event that any provision of this Agreement is adjudged by any court of competent jurisdiction to be void or unenforceable, all remaining provisions hereof shall continue to be binding on the parties hereto with the same force and effect as though such void or unenforceable provision had been deleted.

h. Counterparts; Facsimiles. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original. Facsimile copies hereof shall be deemed to be originals.

i. Disputes. If any controversy, dispute or claim arises between the Parties with respect to this Agreement, the Parties shall make good faith efforts to resolve such matters informally.

j. Entire Agreement. This Agreement and the Service Agreement constitute the entire agreement between the parties hereto relating to the subject matter hereof and supersede any prior or contemporaneous verbal or written agreements, communications, and representations relating to the subject matter hereof.

k. Choice of Law. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Maryland without regard to such state's conflict of laws provisions. Any controversy or claim arising out of or related to this Agreement shall be brought solely and exclusively in a court located in Anne Arundel County, Maryland; provided, however, that either party may enforce any judgment rendered by such court in any court of competent jurisdiction. The parties hereby consent to, and waive any such challenge or objection to, personal jurisdiction and venue in Anne Arundel County, Maryland.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name on its behalf as of the date first set forth above.

Anne Arundel Health System, Inc.

BUSINESS ASSOCIATE AGREEMENT

ANNE ARUNDEL HEALTH SYSTEM, INC.	Sheppard Pratt Health System, Inc.
By: _____	By: _____
Print Name: **Victoria W. Bayless**	Print Name: Bonnie B. Katz
Print Title: **President & Chief Executive Officer Anne Arundel Health System**	Print Title: Vice President
Date: 3/25/16	Date: 3/24/16

ADM1.1.91 - Patient Financial Services – Hospital Financial Assistance, Charity Care, Billing & Collection

Scope
Anne Arundel Medical Center, Inc. (AAMC)

Purpose
To promote access to all for medically necessary services regardless of an individual's ability to pay, to provide a method of documenting uncompensated care and to ensure fair treatment of all applicants and applications

Purpose:

• To assure the hospital communicates patient responsibility amounts in a fair and consistent manner.

• To provide opportunity to resolve questions regarding charges or insurance benefits paid.

• To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices.

• To provide opportunity to resolve questions regarding charges or insurance benefits paid.

• To define the hospital's decision making process for referral for collection or legal action.

• To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices.

Definitions
None

Policy Statements & Procedures
Hospital Financial Assistance Communications:

• The Financial Assistance Signage is conspicuously displayed in English & Spanish in the Emergency Department, Cashiering & Financial Counseling.

• Financial Assistance Policy as well as a printable Uniform Financial Assistance application is posted on the AAMC website.

• English/Spanish table top tents display this information at every patient entry point and it is included in each patient guide located in the inpatient rooms.

• Registration staff and Financial Coordinators are trained on how to refer patients for financial assistance.

• The financial assistance application is available at all registration points - but in particular the Emergency Department.

• A brochure "What you need to know About Paying for Your Health Services" is available at every patient access point. The brochure was developed by Patient Financial Services with guidance from Public Relations. This brochure includes information regarding financial assistance/contact points and is available in English/Spanish. Also, it is posted on AAMC's website.

• It is mandatory that all inpatients receive the "What you need to know about paying for your health services" brochure as part of the admission packet.

• Informational "business cards" are available through the patient access/registration staff to provide to the uninsured or any individual concerned about paying their hospital bill directing them to the hospital Financial Counseling office for assistance.

• Hospital Patient Financial Service staff receive extensive training on the revenue cycle and are incentivized to obtain AAHAM Technical (CPAT) certifications to demonstrate their expertise in billing and revenue cycle requirements.

Charity Care:

• Determination of Probable Eligibility: Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

• AAMC provides 100% charity to individuals with household income at or below 200% of the US Poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program.

• AAMC provides 100% charity to individuals enrolled in the Medicaid Primary Adult Care program and other means tested State & Local programs.

• AAMC provides a sliding fee scale for individuals with household income at or below 330% of the US poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program.

• AAMC provides financial assistance not only to the uninsured but to patients with a demonstrated inability to pay their deductibles, copayments and balance after insurance.

• The hospital excludes assets such as the patient's primary home, method of transportation and cash assets less than $15,000.

• For all income levels, AAMC will take into account special circumstances such as the amount of the bill compared to income and cumulative impact of all medical bills.

• AAMC developed an initiative with the Anne Arundel (AA) County Department of Health to help provide free prenatal diagnostic testing for uninsured unregistered immigrants. These individuals are not eligible for any Medicaid program.

• AAMC participates with an AA County specific program (REACH) administered through the AA County Department of Health to provide free care to low income uninsured or under-insured individuals (below 200% of the US Poverty Guideline). These individuals come to AAMC on an elective basis and are prescreened by the local Department of Social Services.

• Diagnostic and Treatment services are provide free of charge to referrals from the AAMC Outreach Free Clinic initiative located in downtown Annapolis.

• Payment plans are interest-free.

Billing:

Patient Statement of Charges:

• A Summary Bill of charges, formally referred to as the Uniform Summary Bill is mailed to every inpatient within 15 days of discharge from the hospital. This contains information on the insurance company billed as well as how to contact the Patient Financial Services office for questions or assistance.

• Uninsured patients receive this Summary as well.

• Each bill for outpatient services includes detail charge information on the first request for payment.

• At any time, the patient may request a copy of their detailed itemized bill.

• The HSCRC required Patient Billing Information sheet data is printed on the Uniform Summary Bill and the back of all patient billing statements.

• A representative list of services and charges is available to the public on the hospital's website and in written form. The website will be updated quarterly with the most recent average charge per case for each of the services.

• Requests and inquires for current charges for specific procedures/services will be directed to the ACP Financial Coordinator or if applicable the specific department Financial Coordinator. The Coordinator will communicate with the patient and the patient's provider of care to provide the best possible estimate of charges. Using the CPT code, service description and/or other supply/hospitalization time charge estimates are based on, a) review of the charge master for the CPT code/service description, and/or b) review of cost of similar surgical procedures/treatments/hospital stays. The patient will be informed cost quotes are estimates and could vary based on the actual procedure(s) performed, supplies used, hospital stay/OR time & changes in HSCRC rates. If the Coordinator requires guidance or additional information to

provide the estimate he/she will contact the Reimbursement Department. Every effort will be made to respond to the request for charges within 2 business days depending on information needed to fulfill the patient's request.

Patient Balance Billing:

• From the point in which it is known that the patient has a balance for which they are responsible the hospital begins billing the patient to request payment.

• Each patient receives a minimum of 3 requests for payment over a 90 day period.

• Each patient bill includes contact information for financial assistance and states where to call to request a payment plan.

• Each bill informs the patient they may receive bills from physicians or other professionals.

• Short and Long term interest free payment plans are available. The hospital takes into account the balance of the bill and the patient's financial circumstances in determining the appropriate agreement.

• Should the patient contact Patient Financial Services Customer Service unit regarding inability to pay - financial assistance is offered and the financial assistance screening process begins.

Collection Agency process:

• If there is no indication from the patient or a representative that they cannot pay and no attempt at payment or reasonable payment arrangements is made, the account is referred to a collection agency.

• The collection agency referral would typically occur between 90 - 110 days from the first request to the patient to pay assuming the patient made no attempt to work out payment arrangements or indicated financial need.

• The final statement to the patient communicates the account will be referred to an external agency if the balance is not satisfied.

Collections:
• The Director of Patient Financial Services oversees the hospital's business relationship with the Collection Agency.

• AAMC does not utilize a credit reporting bureau.

• AAMC does not charge interest to patients.

• The collection agency performs a financial checkpoint before taking the next step to legal action.

• AAMC staff reviews each case before being referred for legal action.

• The collection agency is educated on how to make referrals to AAMC's financial counseling department for individuals indicating they have an inability to pay.

• The collection agency will establish payment arrangements in compliance with AAMC's interest free commitment.

• As a last resort, AAMC will file suit for collection of debts.

• If the court makes judgment in the hospitals favor - a formal legal credit mark referred to as a "judgment" is placed on an individual's credit and remains intact for 10 years. Once the full payment is made the patient may request that the judgment reflects as satisfied on the credit rating.

• AAMC will file suit against estates and in some cases, when appropriate, trust funds.

• AAMC does actively enforce a lien against an individual's primary home.

References
None

Cross References
None

Approval Date
CFO - 01/2015
HPRC - 01/2015
BOT - 09/2012
F&A - 09/2012

Effective Date
2015-02-13

Owner
Finance

FY2014 Analysis - All Hospitals

FY 2014 Analysis - All Hospitals

Hospital	Hospital Name	Employees	Total Staff Hours CB Operations	Total Hospital Operating Expense	Total Community Benefit	Total CB as % of Total Operating Expense	FY 2014 Amount in Rates for Charity Care, DME, and NSPI*	Total Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
2	UMMC	8,288	1,164	1,305,636,000	201,474,942	15.43%	166,358,857	$35,116,085	2.69%	55,444,257
9	Johns Hopkins Hospital	0	7,063	1,928,280,000	188,270,622	9.76%	139,652,057	$48,618,565	2.52%	32,721,000
8	Mercy Medical Center	3920	2,785	426,907,600	61,821,825	14.48%	26,510,041	$35,311,784	8.27%	24,885,600
3	Dimensions Prince Georges Hospital Center	1,678	160	217,477,100	59,720,405	27.46%	21,789,161	$37,931,244	17.44%	15,861,400
12	LifeBridge Sinai	4,612	5,971	669,579,000	58,776,319	8.78%	28,174,027	$30,602,292	4.57%	12,880,700
29	Johns Hopkins Bayview Medical Center	3,367	1,256	530,603,000	58,159,948	10.96%	41,880,614	$16,279,333	3.07%	22,183,000
4	Holy Cross Hospital	3,293	5,776	390,575,586	55,856,400	14.30%	28,887,735	$26,968,665	6.90%	30,739,060
24	MedStar Union Memorial	2,256	0	394,669,299	42,190,902	10.69%	25,355,644	$16,835,258	4.27%	13,169,128
16	Adventist Washington Adventist*	1389	1,432	217,791,712	38,552,255	17.70%	12,498,455	$26,053,799	11.96%	14,404,325
27	Western Maryland Health System	2,141	324	282,308,921	36,523,850	12.94%	10,816,101	$25,707,749	9.11%	14,413,981
23	Anne Arundel Medical Center	4,136	1,440	514,545,000	36,050,991	7.01%	5,302,805	$30,748,186	5.98%	5,688,100
19	Peninsula Regional	2,538	184	368,170,415	35,900,136	9.75%	12,090,329	$23,809,807	6.47%	13,261,500
38	UM Midtown	1,120	1,188	178,869,000	35,810,878	20.02%	16,500,055	$19,310,823	10.80%	14,755,634
63	UM St. Joseph	2,332	0	310,933,000	35,667,680	11.47%	5,106,334	$30,561,346	9.83%	7,375,769
15	MedStar Franklin Square	3,309	3,360	469,241,214	35,491,348	7.56%	25,232,661	$10,258,687	2.19%	13,581,700
43	UM Baltimore Washington	2,909	104	319,031,000	31,234,487	9.79%	11,014,241	$20,220,246	6.34%	13,307,038
5	Frederick Memorial	2,110	0	319,313,000	30,580,563	9.58%	12,025,352	$18,555,211	5.81%	14,227,000
5050	Shady Grove*	2027	1,790	295,844,877	28,669,946	9.69%	10,389,097	$18,280,849	6.18%	10,015,261
11	St. Agnes	2,690	0	392,471,132	26,869,027	6.85%	17,150,268	$9,718,760	2.48%	11,750,468
2004	MedStar Good Samaritan	0	1,788	303,307,419	24,043,260	7.93%	12,097,308	$11,945,952	3.94%	7,581,945
1	Meritus Medical Center	0	828	292,347,127	23,844,610	8.16%	7,800,481	$16,044,128	5.49%	7,993,597
34	MedStar Harbor Hospital	1,241	177	189,700,114	22,372,526	11.79%	15,125,328	$7,247,198	3.82%	6,997,842
13	Bon Secours	785	0	119,439,002	22,271,852	18.65%	12,044,868	$10,226,984	8.56%	12,073,632
22	Suburban Hospital	1,753	1,797	225,204,531	21,432,492	9.52%	4,942,386	$16,490,105	7.32%	4,501,300
48	Howard County Hospital	1,671	803	231,080,000	21,136,745	9.15%	7,393,015	$13,743,730	5.95%	6,010,720
39	Calvert Hospital	1,400	183	119,481,772	19,895,054	16.65%	6,923,183	$12,971,872	10.86%	7,010,751
51	Doctors Community	1,466	2,200	176,796,204	18,627,103	10.54%	12,239,770	$6,387,333	3.61%	14,726,686
44	GBMC	2,559	4,370	381,697,000	18,320,492	4.80%	9,857,986	$8,462,507	2.22%	4,337,420
40	Lifebridge Northwest Hospital	1,607	583	212,164,000	17,551,055	8.27%	6,036,564	$11,514,492	5.43%	6,203,971
33	Carroll Hospital Center	2,027	2,080	209,384,000	16,040,970	7.66%	4,129,042	$11,911,928	5.69%	3,355,681
55	Dimensions Laurel Regional Hospital	743	160	104,245,600	15,661,030	15.02%	4,663,321	$10,997,709	10.55%	4,507,400
37	UM Shore Medical Easton	1,292	820	160,829,000	15,078,264	9.38%	4,515,632	$10,562,633	6.57%	5,828,000
49	UM Upper Chesapeake	2,037	2,197	236,718,000	15,009,652	6.34%	5,355,684	$9,653,968	4.08%	4,956,053
61	Atlantic General	835	158	101,574,098	14,249,336	14.03%	2,547,970	$11,701,367	11.52%	3,594,293
4000	Sheppard Pratt	2,485	395	198,270,704	12,705,185	6.41%	2,576,186	$10,128,999	5.11%	8,367,519
2001	UM Rehabilitation and Ortho Institute	686	728	102,736,500	11,513,710	11.21%	4,783,044	$6,730,666	6.55%	841,000
62	MedStar Southern Maryland	1,638	7,807	219,466,790	10,833,218	4.94%	3,632,453	$7,200,765	3.28%	3,582,453
32	Union Hospital of Cecil County	1,109	2,179	146,635,757	10,648,111	7.26%	3,615,342	$7,032,769	4.80%	3,064,396
28	MedStar St. Mary's Hospital	1,277	9,370	131,503,457	10,240,708	7.79%	4,758,783	$5,481,925	4.17%	3,430,456
18	MedStar Montgomery General	1,166	0	141,655,632	9,749,053	6.88%	5,570,270	$4,178,783	2.95%	4,722,141
35	UM Charles Regional Medical Center	0	1,622	108,755,000	9,583,933	8.81%	2,145,439	$7,438,494	6.84%	1,864,000
6	UM Harford Memorial	875	941	80,416,000	8,026,523	9.98%	3,150,843	$4,875,680	6.06%	3,428,179
30	UM Shore Medical Chestertown	374	500	47,354,000	7,895,987	16.67%	1,684,863	$6,211,124	13.12%	2,067,000
10	UM Shore Medical Dorchester	627	375	39,674,000	5,394,100	13.60%	1,819,933	$3,574,167	9.01%	2,305,000
17	Garrett County Hospital	344	80	38,194,377	4,687,445	12.27%	3,088,090	$1,599,356	4.19%	3,225,760
4013	Adventist Behavioral Health Rockville*	395	146	33,990,541	4,309,098	12.68%	80,000	$4,229,098	12.44%	2,546,393
60	Ft. Washington	417	0	38,620,727	2,222,903	5.76%	3,327,251	-$1,104,348	-2.86%	1,614,129
64	Lifebridge Levindale	832	520	74,832,811	1,955,388	2.61%	52,499	$1,902,889	2.54%	767,401
3029	Adventist Rehab of Maryland*	414	170	33,160,122	1,792,947	5.41%	51,233	$1,741,714	5.25%	756,000
5034	Mt. Washington Pediatrics	650	1,677	50,042,312	1,567,465	3.13%	49,447	$1,518,018	3.03%	173,338
3478	Adventist Behavioral Health at Eastern Shore*	131	42	9,317,745	1,084,396	11.64%	-	$1,084,396	11.64%	161,347
45	McCready	250	30	14,682,491	758,175	5.16%	664,775	$93,400	0.64%	572,384
		77,805	**78,722**	**$ 14,105,523,689.90**	**$ 1,498,125,311.34**	**10.62%**	**$ 773,456,819.73**	**$ 724,668,491.61**	**5.14%**	**$ 483,833,108.27**
		1,763	**1,543**			**10.47%**			**6.18%**	

* The Adventist Hospital System has requested and received permission to report their Community Benefit activities on a CY Basis. This allows them to more acurately reflect their true activities during the Community Benefit Cycle. The numbers listed in the 'FY 2014 Amount in Rates for Charity Care, DME, and NSPI' Column reflect the Commission's activities for FY14 and therefore will be different from the numbers reported by the Adventist Hospitals.

Maryland Health Care Commission Quality Data
State Mean and AAMC Data
April 1, 2014 – March 31, 2015

CONSUMER RATINGS		
Metric	**State Mean 66**	**Performance Improvement Action Plan**
How often were the patients' rooms and bathrooms always kept clean?	**AAMC 67**	**Better than average**
Metric	**State Mean 60**	**Performance Improvement Action Plan**
How often did patients always receive help quickly from hospital staff?	**AAMC 62**	**Better than average**
Metric	**State Mean 68**	**Performance Improvement Action Plan**
How often was patients' pain always well-controlled?	**AAMC 68**	**Average**
Metric	**State Mean 56**	**Performance Improvement Action Plan**
How often was the area around patients' rooms always kept quiet at night?	**AAMC 62**	**Better than average**
Metric	**State Mean 76**	**Performance Improvement Action Plan**
How often did nurses always communicate well with patients?	**AAMC 77**	**Better than average**
Metric	**State Mean 79**	**Performance Improvement Action Plan**
How often did doctors always communicate well with patients?	**AAMC 80**	**Better than average**
Metric	**State Mean 60**	**Performance Improvement Action Plan**
How often did staff always explain about medicines before giving them to patients?	**AAMC 62**	**Better than average**
Metric	**State Mean 86**	**Performance Improvement Action Plan**
Were patients always given information about what to do during their recovery at home?	**AAMC 87**	**Better than average**
Metric	**State Mean 48**	**Performance Improvement Action Plan**
How well do patients understand their care when they leave the hospital?	**AAMC 57**	**Better than average**
Metric	**State Mean 65**	**Performance Improvement Action Plan**
How do patients rate the hospital overall?	**AAMC 74**	**Better than average**
Metric	**State Mean 66**	**Performance Improvement Action Plan**
Would patients recommend the hospital to friends and family?	**AAMC 78**	**Better than average**

STROKE		
Metric	**State Mean 7.8275**	**Performance Improvement Action Plan**
How often patients who came in after having stroke subsequently died in the hospital.	AAMC 12.5992	ED Standing Operating Procedure (SOP) was created, altering and enhancing patient flow to ensure immediate use of the NIH stroke scale and CT scan upon arrival; this facilitates early recognition and interventions needed (e.g., TPA). Concurrent rounding is performed by the Stroke Coordinator for proactive management of patient care. Rounding includes communication with the medical staff members when needed.

Metric	State Mean 14.2	Performance Improvement Action Plan
Death rate for stroke patients	**AAMC 17.2**	**Average**
Metric	**State Mean 12.4**	**Performance Improvement Action Plan**
Rate of unplanned readmission for stroke patients	**AAMC 13.6**	**Average**
COPD (Chronic Obstructive Pulmonary Disease)		
Metric	**State Mean 7.8**	**Performance Improvement Action Plan**
Dying within 30-days after getting care in the hospital for CPOD	AAMC 10.1	Review 100% of medical records of patients who died after hospitalization utilizing the Hospital Mortality Tool Rules for Patient Record Review from IHI.
Metric	**State Mean 20.3**	**Performance Improvement Action Plan**
Returning to the hospital after getting care for chronic obstructive pulmonary disease (COPD)	**AAMC 20.2**	**Average**
ED		
Metric	**State Mean 385.7**	**Performance Improvement Action Plan**
How long patients spent in the ED before leaving for their hospital room.	AAMC 553.0	Providing quarterly feedback to Clinical and Medical Director ED The Patient Care VSA has been brought together to review the issues that contribute to these measure results; the team includes nursing and physician leadership influencing throughput from the ED to the inpatient unit.
Metric	**State Mean 158.9**	**Performance Improvement Action Plan**
How long patient spent in the ED after the doctor decided the patient would stay in the hospital before leaving for their hospital room.	AAMC 326.0	Providing quarterly feedback to Clinical and Medical Director ED The Patient Care VSA has been brought together to review the issues that contribute to these measure results; the team includes nursing and physician leadership influencing throughput from the ED to the inpatient unit.
Metric	**State Mean 184.7**	**Performance Improvement Action Plan**
How long patients spent in the ED before being sent home.	AAMC 192.0	The organization has taken a multi-tiered Value Stream approach to improving ED Patient Throughput as measured by internal standards and core measures. Highlights of improvements include: • Hospitalist workflow for Early Discharge (increased early morning discharges through implementation of physician and nurse bedside rounding and focused discharged rounds) • ED to Inpatient throughput (decreased time of patient throughput from ED to floor from 120 minutes to 60 minutes) • EVS Dirty Bed to Clean Bed Turnaround time (Overall reduction on room cleaning average from 11 minutes to 74 minutes) • Stroke Clinical Pathway (Improved Stroke Pathway that have decreased overall LOS for Stroke Patients), Telemetry Process (Eliminated telemetry stock outs, which was a throughput flow stopper)

Metric	State Mean 43.0	Performance Improvement Action Plan]
How long patients spent in the ED before they were seen by a healthcare professional.	AAMC 48.0	The organization has taken a multi-tiered Value Stream approach to improving ED Patient Throughput as measured by internal standards and core measures. Highlights of improvements include: • Hospitalist workflow for Early Discharge (increased early morning discharges through implementation of physician and nurse bedside rounding and focused discharged rounds) • ED to Inpatient throughput (decreased time of patient throughput from ED to floor from 120 minutes to 60 minutes) • EVS Dirty Bed to Clean Bed Turnaround time (Overall reduction on room cleaning average from 11 minutes to 74 minutes) • Stroke Clinical Pathway (Improved Stroke Pathway that have decreased overall LOS for Stroke Patients), Telemetry Process (Eliminated telemetry stock outs, which was a throughput flow stopper)
Metric	**State Mean 2.2**	**Performance Improvement Action Plan]**
Patients who left the emergency department without being seen	**AAMC 1**	**Better than average**
Metric	**State Mean 66.6**	**Performance Improvement Action Plan]**
How long patients who came to the emergency department with broken bones had to wait before receiving pain medication	**AAMC 43.0**	**Better than average**
MATERNITY & NEWBORN		
Metric	**State Mean 2.7**	**Performance Improvement Action Plan**
Newborn deliveries scheduled 1-3 weeks earlier than medically necessary.	AAMC 4.0	• Continued weekly review of obstetrical C-section cases by the Chair of Women's & Children's Services, Dr. Henry Sobel. • Monthly review of cases for breast feeding being reviewed by clinical educator of mother-baby unit to determine education needs for staff • Patient family advisor participating on the strategic and planning committee.
Metric	**State Mean 31.9427**	**Performance Improvement Action Plan**
Percentage of births (deliveries) that are C-sections	**AAMC 32.1607**	**Average**
Metric	**State Mean 12.5119**	**Performance Improvement Action Plan**
How often babies in the hospital are delivered vaginally when the mother previously delivered by cesarean section (no complications)	**AAMC 13.1929**	**Average**
Metric	**State Mean 20.1538**	**Performance Improvement Action Plan**
How often babies in the hospital are delivered using cesarean section when this is the mother's first birth.	**AAMC 19.5284**	**Average**

Metric	State Mean 12.1580	Performance Improvement Action Plan
How often babies are born vaginally when the mother has had a C-section in the past (includes complications)	**AAMC 13.1115**	**Average**
OTHER SURGERIES		
Metric	**State Mean 25.7253**	**Performance Improvement Action Plan**
How often patients die in the hospital during or after a surgery to fix the artery that carries blood to the lower body when it gets too large	AAMC 95.0234	Review 100% of medical records of patients who died after hospitalization utilizing the Hospital Mortality Tool Rules for Patient Record Review from IHI.
Metric	**State Mean 2.5034**	**Performance Improvement Action Plan**
How often patients die in the hospital during or after surgery on the esophagus	**AAMC 0.000**	**Average**
Metric	**State Mean 1.6719**	**Performance Improvement Action Plan**
How often patients die in the hospital during or after pancreas surgery	**AAMC 0.000**	**Average**
ALL CAUSES DEATHS OR RETURNS TO THE HOSPITAL		
Metric	**State Mean 15.6**	**Performance Improvement Action Plan**
Returning to the hospital for any unplanned reason within 30 days after being discharged	**AAMC 14.7**	**Better than Average**
HEART SURGERIES AND PROCEDURES		
Metric	**State Mean 1.9104**	**Performance Improvement Action Plan**
How often the hospital uses a procedure to find blocked blood vessels in the heart on both sides of the heart instead of on only one side. Doing this procedure on both sides of the heart often leads to more complications.	**AAMC 0.4608**	**Better than Average**
PREVENTIVE CARE		
Metric	**State Mean 96.5**	**Performance Improvement Action Plan**
Patients in the hospital who got the flu vaccine if they were likely to get flu	**AAMC 98.0**	**Average**
HEART ATTACK AND CHEST PAIN (RECOMMENDED CARE INPATIENT)		
Metric	**State Mean 92.3**	**Performance Improvement Action Plan**
Heart attack patients given procedure to open blood vessels within 90 minutes of getting to the hospital	**AAMC 99.0**	**Better than Average**
HEART FAILURE (RECOMMENDED CARE)		
Metric	**State Mean 99.0**	**Performance Improvement Action Plan**
Test of how well the heart is able to pump blood	**AAMC 100**	**Better than Average**

HIP AND KNEE REPLACEMENT SURGERY		
Metric	**State Mean 3.3**	**Performance Improvement Action Plan**
Complications after hip or knee replacement surgery	**AAMC 3.6**	**Average**
Metric	**State Mean 5.2**	**Performance Improvement Action Plan**
Returning to the hospital after getting hip or knee replacement surgery	**AAMC 4.8**	**Average**
NURSING CARE		
Metric	**State Mean 6.6643**	**Performance Improvement Action Plan**
How often patients in the hospital get a blood clot in the lung or leg vein after surgery	**AAMC 4.1533**	**Better than Average**
PATIENT SAFETY (RESULTS OF CARE COMPLICATIONS)		
Metric	**State Mean 0.2550**	**Performance Improvement Action Plan**
How often the hospital accidentally makes a hole in a patient's lung	**AAMC 0.0776**	**Average**
Metric	**State Mean 1.2054**	**Performance Improvement Action Plan**
How often patients accidentally get cut or have a hole poked in an organ that was not part of the surgery	**AAMC 1.0537**	**Average**
PNEUMONIA (RECOMMENDED CARE)		
Metric	**State Mean 96.6**	**Performance Improvement Action Plan**
Patients given the right antibiotics to treat pneumonia	**AAMC 97.0**	**Average**
PREVENTION AND TREATMENT		
Metric	**State Mean 4.1**	**Performance Improvement Action Plan**
Patients who developed a blood clot while in the hospital and did not get treatment that could have prevented it	**AAMC 0.0**	**Better than Average**
SURGICAL PATIENT SAFETY (RESULTS OF CARE)		
Metric	**State Mean 104.7946**	**Performance Improvement Action Plan**
How often patients die in the hospital because a serious condition was not identified and treated?	**AAMC 113.6745**	**Average**
Metric	**State Mean 4.1166**	**Performance Improvement Action Plan**
How often patients in the hospital had to use a breathing machine after surgery because they could not breathe on their own?	**AAMC 5.1065**	**Average**
Metric	**State Mean 6.6643**	**Performance Improvement Action Plan**
How often patients in the hospital get a blood clot in the lung or leg vein after surgery?	**AAMC 4.1533**	**Better than Average**

	Admission Nursing Assessment
Dates Previously Reviewed/Revised: **Newly Reviewed By: Approval Date:** **Effective Date:**	**Owner:**
Approver Title: CNO _____ Approval Signature	

Scope: Anne Arundel Medical Center, Inc. (AAMC)

Policy Statement: The goal of the nursing admission assessment is to determine the appropriate care, treatment, and services to meet the patient's initial needs. The initial assessment involves obtaining relevant information from multiple sources. This may include obtaining information from the patient, a family member, or other sources including healthcare providers. This policy will describe the information that is to be obtained during the initial assessment and the time frame for conducting the initial assessment.

Definitions: None

Procedure:

1) The admission assessment will be performed by a RN when a patient is directly admitted to the unit or is a transfer from another unit. The RN will meet, interview the patient and initiate an admission assessment within 8 hours of admission.

2) The information gathered during the initial assessment must include the following, as relevant to the care, treatment, and services:
   a) Physical assessment, as appropriate
   b) Psychological assessment, as appropriate (see NAP12.1.19 - "Psychological care assessment")
   c) Social assessment, as appropriate
   d) Abuse/domestic violence screening
   e) Immunization history
   f) TB screening
   g) Allergies
   h) Medication history
   i) Translation needs
   j) Legal history
   k) Patient self assessment coping inventory
   l) Suicide Risk Assessment
   m) Mental status assessment

n) Nutrition and hydration status (see NAP12.1.16 - "Nutrition screening")
o) Functional status, as appropriate
p) Pain assessment (see NAP12.1.18 - "Pain assessment, management and resources")
q) Additional clinical information

Additional required documentation for admitted patients

a) Completion of Medication reconciliation (see MED16.1.25 - "Medication reconciliation")
b) Nursing problem list and Plan of Care documented within 24 hours

3) Time frame for conducting the initial patient assessments follow:

a) A registered nurse must complete a nursing admission assessment within 24 hours of inpatient admission.
b) The nutritional screening, when warranted by the patients' needs or condition, is completed within 24 hours of inpatient admission.
c) Daily routine assessments are done every 24 hours and may be done more frequently depending on the patient, and or the unit.
d) The functional status screening, when warranted by the patients' needs or condition, is completed within 24 hours of inpatient admission.

References:

Joint Commission E-dition. (2013) Hospital, Accreditation, Provision of Care, Treatment and Services. https://e-dition.jcrinc.com/MainContent.aspx

Cross References:

NAP12.1.19 - "Psychological care assessment"

NAP12.1.16 - "Nutrition screening"

NAP12.1.18 - "Pain assessment, management and resources"

NAP12.1.21 - "Adult inpatient fall prevention and management program"

MED16.1.25 - "Medication reconciliation"

History and Physical

Dates Previously Reviewed/Revised: **Newly Reviewed By:** HPRC TBD **Approval Date:** **Effective Date:**	**Owner:** Executive Director, Mental Health Reviewed (date & initials): _____
Approver Title: TBD _____ Approval Signature	

Scope:

This policy applies to patients admitted to the AAMC inpatient mental health unit.

Policy Statement:

Every patient admitted to the AAMC inpatient mental health unit will receive a medical history and physical (H&P) within 24 hours of admission to the unit in accordance with JCAHO guidelines.

Definitions:

None

Procedure:

1. The medical history and physical (H&P) is ordered by the attending/admitting psychiatrist or qualified covering professional if not already completed prior to the patient's transfer to the unit, and the order will be noted on the admission orders.
2. The H&P will be:
    a. Completed by the adult nurse practitioner, or corresponding qualified covering professional, for patients admitted directly to the unit, or patients transferred from the emergency department or a medical or surgical unit of another hospital.
    b. Completed by a physician, PA, or NP on medical and surgical units and in the emergency department of AAMC, on those patients being admitted to the mental health inpatient unit as transfers from medical or surgical units or the emergency department of AAMC.
3. The adult nurse practitioner or corresponding qualified covering professional is notified when a medical H&P is needed as each patient is admitted to the inpatient mental health unit.
4. All medical H&P requests are logged in the medical H&P request book. Each log will include date and time of admission, name of patient, room number, date ordered and by whom, date/time examining medical provider was notified of request and date and time medical H&P was completed.
5. If the adult nurse practitioner or qualified covering professional determines there is an ongoing or potential medical presentation in a patient admitted to the inpatient mental health unit, he or she will

document it in the medical H&P and advise the attending psychiatrist or corresponding qualified covering professional about the need for follow-up and management. Medical follow-up for issues identified by the adult nurse practitioner or qualified covering professional requires an order from the attending psychiatrist or corresponding qualified covering professional. Medical issues will be included in the patient's treatment plan and documented treatment progress.

References:

Cross references:

Anne Arundel Medical Center	**Treatment Protocols**
Dates Previously Reviewed/Revised: Newly Reviewed By: **Approval Date:** **Effective Date:**	**Owner:**
Approver Title: _____ Approval Signature	

Scope: Role of the Attending Psychiatrist

Policy Statement: N/A

Procedure:

1. The attending psychiatrist directs the psychiatric care of individual patients.
2. The initial responsibilities of the attending psychiatrist include:
    a. Providing admission orders.
    b. Developing a psychiatric diagnosis
    c. Collaborating with the treatment team, planning the patient's treatment and making any modifications to the multidisciplinary treatment plan.
    d. Educating the patient about prescribed medications and changes to prescribed medications.
3. The attending psychiatrist is expected to clearly communicate with other the staff regarding his/her plan for the patient.
4. The attending psychiatrist will be aware of the Division of Mental Health and Substance Use policies.
5. The attending psychiatrist will support the patient's family, the clinical staff, and nursing care interventions being carried out by the nursing staff.
6. <u>The attending psychiatrist or qualified covering professional must see the patient within twenty-four (24) hours of admission, including on weekends and holidays, and shall document progress in a note every day.</u>
7. Admitting psychiatrists (or their designee providing coverage) are expected to be available by phone or page at all times for emergencies.
8. The patient's ability to participate in the program will be a large part of the patient's treatment on the unit. Special circumstances regarding safety, suicidality, criminal acts and extensive daily nursing care because of infirmity or acute medical problems might preclude a patient's stay on the inpatient mental health unit. If such issues arise, the psychiatrist is expected to respond to team concerns and to provide guidance, consultation and education.

9. The psychiatrist will participate in multidisciplinary treatment team meetings.
10. The attending psychiatrist or qualified covering professional will assume responsibility for disposition and discharge orders.
11. Attending psychiatrists will oversee communication between the treatment team and the patient's outpatient psychiatrist and/or therapist regarding treatment and medication.
12. Attending psychiatrists will oversee timely, early and appropriate contact between the treatment team and the patient's family or significant others as appropriate for the treatment plan.

References:

Cross references:

RESTRAINTS AND SECLUSION POLICY

Dates Previously Reviewed/Revised: **Newly Reviewed By:** HPRC TBD **Approval Date:** **Effective Date:**	**Owner:** Executive Director, Behavioral Health Reviewed (date & initials): _____
Approver Title: TBD _____ Approval Signature	

Scope:

This policy covers the use of restraint and seclusion in the AAMC inpatient mental health unit and throughout the medical center.

Policy Statement:

I. **Purpose:** To define the appropriate and safe use of restraints and seclusion in order to protect patients from harming themselves or others and to establish procedures for use of restraints and seclusion in compliance with Maryland State Law, The Joint Commission, CMS Conditions of Participation and other applicable standards.

II. **Philosophy:** Anne Arundel Medical Center is committed to creating an environment that eliminates the use of restraints (physical or chemical) and seclusion whenever possible and limits their use to only those situations that are clinically justified and appropriate. The objective is to protect the patient's health and safety while protecting patient rights with dignity and respect, and to educate the staff about possible alternatives.

Definitions:

I. **Definition and Classification of Restraints**
   a. **Definition of restraints**
      i. **Physical Restraint:** Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.
         1. *Category I restraint:* 4 point restraints, safety suits or other devices which limits a patient's mobility to the extent that the patient would not be able to independently reposition himself or herself or would otherwise be rendered helpless in an emergency.
         2. *Category II restraint*: Any device which is not considered a category I restraint.

ii. **Chemical Restraint**: A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
Note:-A drug or medication that is used according to FDA and manufacturer indications (or) follows national practice standards of care (or) is used in the treatment of a patient's specific clinical condition to enable the patient to more effectively or appropriately function in the world around them is not considered a chemical restraint.

b. **Classification of restraints based on reason for use**
   i. **Restraint for management of patients with *non-violent /non-self-destructive behavior*:** A restraint applied on a *non-violent, non-self-destructive* patient for the purpose of ensuring the physical safety of the patient, such as when the patient is may be interfering with lines, tubes or drains.
   ii. **Restraint for management of patients with *violent /or self-destructive behavior*:** A restraint applied on a person who is exhibiting *violent and self-destructive* behavior for the purpose of ensuring the physical safety of the patient, staff or other persons in the patient's vicinity.
   iii. **Short-term restraint / physical hold:** Restraints applied for a short duration such as the temporary act of physically holding a patient down for the purpose of administering a medication against the patient's will in emergency situations or when there is a court order for the medication treatment.
   Upon administration of medication the restraint order is discontinued. When initiated in an emergency the same face-to-face evaluation requirements are followed as in the restraint for management of patients with *violent /or self-destructive behavior* emergency initiation process.

c. **Devices not considered a restraint**
A restraint does not include devices, such as orthopedically-prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm.

The following are not typically deemed to be restraints:
   i. Medically-necessary surgical positioning or securing devices.
   ii. A medically-necessary restraint used for recovery from anesthesia in critical care or a PACU prior to patient recovery from the effects of anesthesia.
   iii. Intravenous arm boards.
   iv. Temporary immobilization devices used during radiotherapy procedures, or to prevent removal of tubes and drains while a patient is awakening from anesthesia (Note, once fully recovered from anesthesia, the device then becomes a restraint.)
   v. Temporary immobilization devices used for the protection of surgical and treatment sites in pediatric patients.
   vi. Side rails to prevent patients from falling out of bed or off stretchers such as when they are recovering from anesthesia, being transported or experiencing involuntary movements.

vii. Picking up, redirecting, or holding an infant, toddler, or preschool-aged child to comfort the patient.
viii. Devices that can be easily removed by the patient such as geriatric chairs or recliners, only if the patient can easily remove the restraint in the same manner as it was applied by the staff and get out on his or her own.
ix. Age or developmentally-appropriate protective safety interventions, such as stroller safety belts, swing safety belts, high chair lap belts, raised crib rails, and crib covers, that a safety-conscious child care provider outside a health care setting would utilize to protect an infant, toddler, or preschool-aged child.
x. Adaptive devices or mechanical supports used to achieve proper body position, balance, or alignment to allow greater freedom of mobility than would be possible without the use of such a mechanical support, such as the use of leg braces for patients who are unable to walk otherwise, or neck, head or back braces for patients who are unable to sit upright otherwise.
xi. Physical escort using a light grasp from which a patient can easily escape or therapeutic holds for physical examination or tests unless patient refuses the examination or test.
xii. The use of handcuffs or other restrictive devices applied by law enforcement officials who are not hospital employees for custody, detention and public safety reasons.
xiii. Sheets are not considered restraints unless they are tucked in so tightly that the patient cannot move.

II. **Definition of Seclusion.** Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.

Procedure:

I. **Indications and Contraindications for the use of a restraint or seclusion.** Patients have the right to be free from physical or mental abuse, and corporal punishment and free from restraints or seclusion of any form that are not clinically necessary to protect the patient and/or others.
   a. A restraint or seclusion may only be used to ensure the immediate physical safety of the patient (including serious disruptions to the therapeutic environment), a staff member or others.
   b. A restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.
   c. A restraint or seclusion may only be used in accordance with an appropriate physician or nurse practitioner order, unless initiated by a trained RN in limited emergency situations, when a physician is unavailable.
   d. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.
   e. A restraint or seclusion may never be used for the convenience of the staff, as a substitute for adequate staffing, or as a means of coercion, discipline or retaliation.
   f. A restraint or seclusion may never be used on the basis of a standing or PRN order.
   g. Restraints and Seclusions may not be ordered or used simultaneously.

h. 4 point restraints may not be ordered or used on children under the age of 12.

II. **Ordering, renewal and reordering of restraints or seclusions**

a. **Prior to ordering the restraint or seclusion**

i. Assess for medical conditions that may be causing the behavior, the treatment of which may make the use of restraints or seclusion unnecessary (e.g. temperature elevations, hypoxia, hypoglycemia, electrolyte imbalances, drug interactions and drug side effects).

ii. Determine if there is a handicap (e.g. deafness) or language barrier which may cause or contribute to the patient's behavior, and provide appropriate accommodations.

iii. If circumstances permit, attempt other alternatives such as diversion activities, family or sitter remaining with the patient, reading materials, scheduled walks, frequent toileting, and protective devices including but not limited to hand mitts, and skin sleeves. On the mental health inpatient unit, other alternatives include the use of a quiet room and medications that are part of the patient's standard treatment. Document all alternative measures, including where appropriate any less intrusive restrictive interventions tried or determined to be ineffective prior to the introduction of more restrictive measures.

iv. Determine and document whether the risks associated with the use of restraints or seclusion is outweighed by the risk of not using it.

v. Document the specific behavior requiring the use of restraints or seclusion.

b. **Ordering restraints and seclusions**

i. The least restrictive form of restraint or seclusion that protects the physical safety of patient, staff or others must always be ordered.

ii. Restraint use must be in accordance with a written modification to the patient's plan of care.

iii. Orders must be placed by a physician or a certified nurse practitioner responsible for the care of the patient. In limited emergency circumstances when a physician is not available, a restraint for management of patients with *violent /or self-destructive behavior* may be initiated by a registered nurse.

iv. If the person ordering the restraint is not the attending physician, then he or she must consult with the attending physician as soon as possible.

v.

c. **Ordering a Short-term Restraint**

i. A short term restraint must be accompanied by a face-to-face evaluation.

ii. In the event that restraint is needed for the administration of a medication, an order for the restraint/hold is required for each episode. The order will be discontinued after each medication administration.

d. **Ordering a restraint for management of patients with *non-violent /non-self-destructive behavior***

i. A written or verbal order for a restraint for management of patients with *non-violent /non-self-destructive behavior* must be given by a physician or nurse practitioner responsible for the care of the patient.

ii. The order must be renewed every calendar day.

e. **Ordering a restraint for management of patients with *violent /or self-destructive behavior* or Ordering Seclusion**

If possible prior to ordering a restraint for management of patients with *violent /or self-destructive behavior* advise the patient and/or family in a non-threatening manner that continuation of a specific behavior may result in the use of restraints or seclusion. Document this interaction in the medical record. If the use of restraint or seclusion is appropriate, the staff involved will make a reasonable effort to verbally persuade the patient to be cooperative with the restraint.

i. A documented face-to-face evaluation must be completed within one hour of initiating the restraint at least once every 24 hours by a physician responsible for the ongoing care of the patient prior to ordering a restraint or seclusion.
ii. Within the 24 hour period, the existing restraint or seclusion order must be *renewed* within the following time frames:
    1. 4 hours for adults 18 years of age or older.
    2. 2 hours for children and adolescents 9 to under 18 years of age.
    3. 1 hour for children under 9 years of age.

    The physician may renew the order based on the nursing assessment and evaluation of the patient. A new face to face evaluation is not needed for order renewals within the 24 hour time period.

    Note: - 4 point restraints must not be ordered or used on children under the age of 12.
iii. If a restraint or seclusion has been used for more than 48 hours continuously, then the treating physician must document that release from the restraint would present a danger to the patient or others or severely disrupt the therapeutic environment and the Medical Director or his or her designee, neither of whom may be the treating physician must complete a documented face to face evaluation and authorize the continued use by countersigning the treating physician's new order before the new order can be implemented for an additional
    1. 48 hour period for a Category I restraint or
    2. 7 day period for a Category II restraint or seclusion

f. **Initiating a restraint for management of patients with *violent /or self-destructive behavior* or seclusion in an emergency situation**
    i. A physician, nurse practitioner or registered nurse may initiate a restraint for management of patients with *violent /or self-destructive behavior* or seclusion in an emergency situation.
    ii. A documented face to face evaluation must be completed within one hour of initiating the restraint, and every 24 hours thereafter for all subsequent restraint orders by a physician.
    iii. Non-clinical staff, such as security staff who respond to the emergency, will remain under the direction of clinical staff.
g. **Ordering a Chemical Restraint**
    i. A chemical restraint may only be ordered in a behavioral emergency when the individual's behavior presents a danger to self or serious bodily harm to others.
    ii. Medication ordering will take into account the patient's age, weight and other factors contributing to the decision on the drug dose, indication and monitoring requirements.

III. **Safe restraint or seclusion application**

a. The patient and/or family will be provided education regarding the need for the restraint or seclusion, the plan of care, and the specific change in behavior that will result in the discontinuation of the restraint or seclusion use.
b. Restrained patient must be placed in supine (face-up) position
c. Place the patient in restraint or seclusion in as dignified a manner as the situation permits, using the least amount of physical force necessary. Use reasonable efforts to persuade the patient to cooperate with the restraint or seclusion. Additional staff (including security personnel) may be used as necessary to place a patient in restraint or seclusion. Patients will be searched for potentially harmful objects and, if found, the object(s) will be confiscated and secured with security. The patient will be asked in a non-threatening manner to surrender the objects before they are taken from the patient.
d. Unless contraindicated for safety reasons, patients shall be permitted to wear eyeglasses, hearing aids, dentures, or prosthetic devices.
e. Unless a physician or registered nurse determines that it is unsafe to do so, a patient on the inpatient mental health unit will be permitted to wear all or portions of the patient's own clothes if appropriate, or other clinically appropriate attire.
f. The staff shall inspect each restraining device to assure that the device is safely and securely applied. While every effort should be made to avoid causing a patient undue discomfort, staff will be cautious of loose application of restraints that may permit a patient to work free or become entangled in the restraints. As necessary and appropriate, ensure that each restraint is padded to provide appropriate protection for the patient.
g. The seclusion room shall have a mattress unless it is clinically contraindicated. At the beginning of each shift, the room used for seclusion will be inspected for proper temperature, ventilation, safety, lighting, sanitation, and freedom from dangerous conditions. The seclusion room will have a means of observation that affords a view of the entire room and permits the staff to observe any patient in the room.
h. When applying a restraint on a child under the age of 12 staff shall avoid the application of force on long bone joints.

IV. **Ongoing restraints or seclusion monitoring and assessments**

An appropriately trained nurse or staff member must continually monitor and assess the patient to ascertain his/her condition, level of distress and agitation, mental status, and cognitive functioning. The frequency of monitoring should be made on an individual basis based upon the individual patient's medical needs and health status. All assessments must be documented. Determine the continued need for the restraint or seclusion and discontinue the restraint or seclusion at the earliest possible time. If it is determined that the patient needs to continue on restraints then determine if a less restrictive restraint may now be used and use this method if safely possible.

a. **Restraint for management of patients with *non-violent /non-self-destructive behavior***
    i. Assessment frequency is determined by the patient's needs and health status at a frequency no less than every (2) two hours.
    ii. Care & assessment must include the following as needed
        1. Vital Signs
        2. Mental status of the patient including level of distress, any agitation, and cognitive functioning
        3. Nutrition and hydration needs

4. Toileting and elimination needs
5. Physical comfort
6. Skin integrity & circulation checks
7. Provision of range of motion / exercise

b. **Restraint for management of patients with *violent /or self-destructive behavior***
   i. Patients must receive a 1:1 observation while in a Category 1 restraint by meeting the two criteria below.
      1. One Staff member shall be assigned to continuously watch the patient
      2. The patient will be kept in full view at all times
   ii. Patient must be protected from harm by others.
   iii. Observe the patient every 15 minutes and document the observation
   iv. Assess / provide care every hour for the following
      1. Determine if the patient has any special needs that need attention.
      2. Check circulation of extremities.
      3. Recognize signs of incorrect application of restraints and adjust the restraining devices as needed
      4. Realign the body or massage extremities as needed.
   v. Assess / provide care every 2 hours for the following
      1. Assess nutrition and hydration needs and offer fluids
      2. Provide range of motion / exercise as needed
      3. Address elimination and offer toileting
      4. Appropriateness of continuing the restraint
   vi. Once in 24 hours
      1. Offer bathing and oral hygiene at least once during a 24-hour period.
   vii. In addition ongoing care and assessments must include the following as needed
      1. Check vital signs as clinically indicated
      2. Determine if the patient has signs of any injury caused by restraint
      3. Check skin integrity and take steps to prevent skin breakdown.
      4. Provide meals at regularly scheduled hours and under the supervision of nursing personnel.
      5. Address physical and psychological status and comfort.
      6. Assess whether to contact a physician to evaluate and/or treat the patient's physical status.

c. **Seclusion**
   i. Observe the patient every 15 minutes and document the observation
   ii. Assess every hour for the following , unless the patient is asleep at night
      1. Make personal contact with the patient to determine if the patient has any special needs that need attention
   iii. Assess every 2 hours for the following, unless the patient is asleep at night
      1. Assess nutrition and hydration needs and offer fluids
      2. Address elimination and offer toileting
      3. Appropriateness of continuing the seclusion
   iv. Once in 24 hours
      1. Offer bathing and oral hygiene at least once during a 24-hour period.
   v. In addition, ongoing care and assessments must include the following as needed
      1. Check vital signs as clinically indicated

2. Provide meals at regularly scheduled hours and under the supervision of nursing personnel.

vi. Within 7 days of initiation regardless of whether the patient remains in restraint for management of patients with *violent /or self-destructive behavior* or seclusion, contact clinical leadership to initiate a treatment team evaluation of the restraint or seclusion
    1. for appropriateness of use of restraint or seclusion.
    2. to establish and implement a plan to eliminate further need for the restraint or seclusion.
    3. to identify a team member who will explain to the patient the potential risks and benefits of continued use of the restraint or seclusion

d. **Chemical Restraint**
    i. Monitor the patient for adverse effects of drug therapy. Notify physician and discontinue medication in case of any adverse drug reaction.

V. **Mental Health Unit Quiet Room**

A patient's request for use of a quiet room should be granted unless clinically contraindicated. Unless staff terminates use of the quiet room for clinical reasons, the patient may terminate the self-initiated use of the quiet room at any time.

a. When staff determines that the use of the quiet room is clinically indicated, staff may request that a patient voluntarily enter into the quiet room. Staff may not coerce a patient to enter the quiet room.
b. When the patient enters the quiet room, staff shall discuss with the patient:
    i. The recommended length of stay in the quiet room
    ii. The behaviors expected of the patient before and after return to the environment; and
    iii. The primary interventions to be initiated if the use of the quiet room is terminated by the patient prior to the time recommended by the staff or is determined to be ineffective.
c. Staff shall determine the need for removal of any harmful objects in the room or from the patient. If staff determines a need for objects to be removed, staff will ask the patient, in a non-threatening manner, to surrender the objects.
d. While the quiet room is in use, staff will ensure that the quiet room door is not locked or in a position that prevents a patient from exiting the room voluntarily.
e. One or more staff members will be assigned to monitor the patient and the safety of the environment while a patient is in the quiet room.
f. When the quiet room is used as a clinical intervention:
    i. Staff should observe the patient at least once every 30 minutes and document the observance in the patient's record.
    ii. At least every 2 hours, staff should evaluate the effectiveness and document the clinical reason for continued use of the quiet room.
    iii. A physician shall review the use of the quiet room after 6 hours and, if use of the quiet room is continued, at least every 24 hours after that.
g. Use of a quiet room may be terminated at any time based upon
    i. the decision of the patient or

ii. a clinical determination made by staff.

VI. **Release from (Discontinuing of) restraints or seclusions.**

a. A nurse may make the decision to discontinue restraint or seclusion based on the assessment and reevaluation of the patient's condition and the determination of the need for continuation of the restraint or seclusion.

b. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.
Note: For restraint for management of patients with violent /or self-destructive behavior or seclusion if the physician specifically requires concurrence with termination, nurses must consult with the physician prior to termination.

c. For patients in a restraint for management of patients with violent /or self-destructive behavior or seclusion, the patient must be made aware as early as possible of the rationale for the restraint or seclusion and the behavior criteria that will result in discontinuation thereof. The restraint or seclusion must be discontinued as soon as the patient meets the criteria.

d. While the patient is restrained or secluded, staff may release the patient from restraints as needed to clinically evaluate and/or treat the patient and then restart the restraint or seclusion.
Note: A temporary release that occurs for the purpose of caring for a patient's needs, for example, toileting, feeding, and range of motion, is not considered a discontinuation of the intervention.

e. Staff may not discontinue restraint or seclusion for any other reason and then restart it without a new order. Trial periods in which a patient is released from restraint or seclusion and placed under close observation with the intent of putting the patient back in restraint or seclusion pursuant to the original order if the patient were to exhibit the symptoms that had prompted their prior use, are prohibited.

f.

VII. **Education and training**

a. **Physician and nurse practitioner training**

i. New physicians and nurse practitioners joining the hospital's medical staff will receive both education on restraints and seclusion and the hospital restraint policy along with the rest of the physician orientation.

ii. Existing physicians and nurse practitioners will receive this information every two years thereafter.

iii. All physicians and nurse practitioners who order restraints must have a working knowledge of the hospital restraint policy.

b. **Other staff training**

i. No staff member may participate in the application of restraint, implementation of seclusion, or the monitoring, assessment, or providing care for a patient in restraint or seclusion, without having completed training and demonstrated competency appropriate for their job position.

ii. All staff must receive training appropriate for their job position as part of orientation, before participating in the use of restraint or seclusion and on an annual basis thereafter.

iii. Training will include but is not limited to

1. Recognizing signs of any incorrect application of restraints.
2. Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition
3. Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia)
4. Recognizing readiness for discontinuing restraint or seclusion, including clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary
5. Monitoring the physical and psychological well-being of the patient who is restrained or secluded including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, nutritional and hydration needs, hygiene and elimination needs.
6. Use of first-aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification
7.

c. **Special training for restraint for management of patients with *violent /or self-destructive behavior***

In addition to the general training for all staff who apply restraint or seclusion on the inpatient mental health unit and all staff who function as primary responders to a crisis, comprehensive training will be completed every two years in the safe techniques for application of a restraint for management of patients with *violent or self-destructive behavior* or seclusion, including but not limited to

i. Recognizing when to contact a medically-trained licensed independent practitioner or emergency medical services to evaluate and/or treat the patient's physical status.
ii. Identifying the underlying causes of threatening behaviors exhibited by the patients.
iii. Use of strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion.
iv. Use of nonphysical intervention skills.
v. Understanding that sometimes a patient may exhibit an aggressive behavior that is related to a patient's medical condition and not related to his or her emotional condition (for example, threatening behavior that may result from delirium in fevers or other medical conditions).
vi. Understanding how staff behaviors can affect the behaviors of the patients.
vii. De-escalation, mediation, self-protection, and other techniques such as time-out.
viii. The use of non-physical intervention skills.
ix. How to recognize signs of physical distress in patients who are being held, restrained, or secluded.
x. The safe use of restraint, including physical holding techniques, take-down procedures, and the application and removal of restraints.
xi. Recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which a patient reacts to physical contact.

xii. Using behavior criteria for discontinuing restraint or seclusion and how to help patients in meeting these criteria.

d. **Trainer qualification**
   i. Individuals providing staff training must be qualified as evidenced by education, training and experience in techniques used to address patients' behaviors. Competency for these individuals has been established through workshops, orientation and competency-based training programs.
   ii.

VIII. **Documentation requirements**

The following elements must be documented in the medical record

a. **Orders:** Initial orders, renewal orders and new orders must include the following:
   i. The specific rationale for the restraint: patient's behavior, condition or symptom(s) that warranted the use of the restraint or seclusion.
   ii. The special precautions taken to safeguard the patient: alternatives or other less restrictive interventions attempted.
   iii. The specific type of restraint to be used.
   iv. Starting and ending date; starting and ending time of the restraint or seclusion.
   v. The identity of the person giving the order and in case of a verbal order the identity of the person documenting the order.
   vi. Date and time the order was written and signature of the person documenting the order.
   vii. 24-hour countersign of all verbal orders.
   viii. For chemical restraints, the reason why the drug dosage, duration and indication are appropriate, and if applicable confirmation that the previous attempts of dosage reduction have been unsuccessful.
   ix. Enter all orders into the electronic documentation system

b. **Implementation** of a restraint for management of patients with *violent /or self-destructive behavior* or seclusion must include the following documentation.
   i. Description of behavior that led to the restraint.
   ii. Use of less restrictive techniques – why? or why not?
   iii. Was a formal call placed for facility staff response?
   iv. The names of staff assisting in the process.
   v. The circumstances at the time of restraining the patient.
   vi. The readily observable physical condition of the patient.
   vii. Whether the patient was allowed to wear their own clothes and if not why.
   viii. A description of physical injury to the patient or others resulting from the placement.
   ix. Date and time of the restraint and signature of the recorder.

c. **Patient evaluations:** All elements of the face to face evaluations performed for restraint for management of patients with *violent /or self-destructive behavior* or Seclusion including
   i. An evaluation of the patient's immediate situation.
   ii. The patient's reaction to the intervention.
   iii. The patient's medical and behavioral condition.
   iv. The need to continue or terminate the restraint or seclusion.

d. **All patient assessments and reassessments** including

i. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.
ii. The intervals for monitoring.
iii. The patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion.
iv. Injuries to the patient.
v. In the case of chemical restraints, complications of drug therapy, as well as evidence of the patient's subjective or objective improvement or maintenance of function while on the medication.

e. **Attending physician** notification of the use of restraint or seclusion.
f. **Consultations** made in reference to the restraint or seclusion.
g. **Treatment team evaluations** of restraint for management of patients with *violent /or self-destructive behavior* or seclusion.
h. **Release from restraint for management of patients with *violent /or self-destructive behavior***
    i. Behavioral criteria for discontinuing restraint or seclusion.
    ii. If a physician orders the restraint release then write, sign and date a note no later than 24 hours after the order to release, which includes the rationale for release.
    iii. If a nurse terminates the restraint, document, sign and date the rationale for termination.
i. **Plan of Care** must include provisions for discontinuation of restraints as well as revisions made to the plan of care due to the use, modification or discontinuation of the restraint or seclusion.
j. **Death** associated with a restraint or seclusion as well as the date and time CMS was notified.
k. **Education and Training:** Documentation will be maintained in the staff personnel records that the training and demonstration of competency were successfully completed.

IX. Reporting and Quality Improvement

a. If a problem or injury occurs during the use of a restraint or seclusion, an incident report is to be completed and risk management shall be notified.
b. The medical director of the mental health inpatient unit shall review daily all instances of restraint or seclusion use on patients admitted to the unit and investigate any unusual or possibly unwarranted patterns of use.
c. Data on all restraint and seclusion episodes will be collected and reviewed.
d. The mental health and substance use quality council shall review periodically, but not less than quarterly, the use of restraint or seclusion to assure the standards maintained by the hospital are, at a minimum, consistent with Maryland law, The Joint Commission on Hospital Accreditation Standards, CMS Conditions of Participation, and other applicable standards.
e. The mental healh and substance use quality council shall measure and assess the use of restraint and seclusion to identify opportunities to introduce preventive strategies, alternatives to use, and process improvements that reduce the risks associated with restraint and seclusion use.

f. The mental healh and substance use quality council shall collect restraint and seclusion data to monitor and improve performance of processes that involve risks or may result in sentinel events. It shall use the data to perform the following:
    i. Ascertain that restraint and seclusion are used only as an emergency.
    ii. Identify opportunities for incrementally reducing the rate and increasing the safety of restraint and seclusion use.
    iii. Identify any need to redesign care processes.

X. **CMS Death Report**

a. The following information will be reported to the Centers for Medicare & Medicaid Services (“CMS”)
    i. Each reportable death that occurs while a patient is in restraint or seclusion.
    ii. Each reportable death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
    iii. Each reportable death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient’s death. “Reasonable to assume” in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.
b. Each death referenced above will be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient’s death.
c. The Quality and Patient Safety Office will make these reports to CMS and record in the patient’s medical record the date and time the death was reported to CMS.

The Quality and Patient Safety Office will maintain a log of the patients who are not reportable to CMS but are required by CMS to be tracked on an internal log.

Admission Criteria for Inpatient Mental Health Unit

Dates Previously Reviewed/Revised: **Newly Reviewed By:** HPRC TBD **Approval Date:** **Effective Date:**	**Owner:** TBD Reviewed (date & initials): _____
Approver Title: TBD _____ Approval Signature	

Scope: Inpatient Mental Health Unit

Policy Statement: The AAMC inpatient mental health unit is a short-term, acute psychiatric treatment inpatient service accepting both voluntary and involuntary patients. All patients admitted to the unit must have a primary DSM-V diagnosis.

Definitions: None

Procedure:

1) Admissions to the inpatient mental health unit may be voluntary or involuntary, and patients must sign an Application for Voluntary Admission or the referring ED must provide a signed Application for Involuntary Admission and two signed Certificates for Involuntary Admission.

2) Patients admitted to the inpatient mental health unit should be those suited to the unit environment, program structure, skill mix and competency of unit staff and those whose safety and medical needs can be provided for in the program milieu.

3) Dementia and delirium states will not constitute criteria for admission to the inpatient mental health unit. Admission may be justified for some patients based on acute onset, presenting behavior, aberration and/or deterioration of thought processes and reasonable expectation that short-term, acute psychiatric inpatient care will result in effective treatment and that physiologic determinants of delirium are not more appropriately addressed through a medical admission.

4) A patient who is totally dependent on staff for care, such as hygiene, eating, or mobility or whose independent functioning is severely limited may require evaluation with regard to the appropriateness of admission to the inpatient mental health unit. The patient must be manageable within the unit and with available unit staff and areas of expertise.

5) Patients will be considered medically stable by the admitting psychiatrist or covering health professional before admission to the inpatient mental health unit.

    a) The route of admission will determine method of medical clearance:

i) AAMC ED Admission- Patients will receive appropriate medical evaluation leading to stabilization and medical clearance prior to acceptance for transfer to the inpatient mental health unit. Medical documentation and nursing reports will reflect this status. Medical clearance will include CBC, CMP, drug screen, urinalysis and pregnancy test (where appropriate), and other tests as indicated and at the request of the admitting psychiatrist or covering health professional.
ii) Transfers from other hospitals –Evidence of medical clearance including CBC, CMP, drug screen, urinalysis and pregnancy test (where appropriate), other tests as appropriate, and supporting documentation are required for initial review and approval by the admitting psychiatrist or covering health professional prior to the patient being accepted for transfer.
iii) Direct admissions- Patients will be accepted for direct admission upon referral from outpatient providers at the discretion of the admitting psychiatrist or covering health professional, based on available information about the patient and any medical issues present. Patients accepted for direct admission will have CBC, CMP, drug screen, urinalysis and pregnancy test (where appropriate) and other appropriate tests completed at admission.

b) **Certain patients will not be eligible for admission to the inpatient unit**. These are:
i) Prisoners
ii) Patients < 18 years of age
iii) Patients who require total care (e.g. continuous IV infusion, TPN, central lines, oxygen, suctioning, are physically confined) or whose principal need for intervention is medical or surgical
iv) Patients who require negative pressure rooms or isolation
v) Patients who have significant intellectual disabilities or who suffer other cognitive impairments who will not be appropriate, safe, or able to benefit from the therapeutic milieu.
vi) Unit staff, their significant others or family members
vii) Patients with serum alcohol, potassium, or blood glucose outside safely-managed levels.

c) Questions or problems regarding the appropriateness of a patient for admission to the inpatient mental health unit will be resolved by the program director, nursing director, and medical director. Pre-Certification by the patient's insurance carrier must be obtained prior to admission into the inpatient mental health unit.

6) Notification of Patients' Rights and Status
a) The Notification to Individual of Admission Status and Rights (must be completed by the nursing staff and placed in the patient's chart within twelve (12) hours of admission.
b) In the event that the patient is unable to understand the notification, the patient's rights will be explained to their next of kin and documentation of this discussion will be made in the patient's record.

7) Hearings for Patients Involuntarily Admitted
a) An administrative hearing will be held to determine whether an involuntary patient may be involuntarily committed under Maryland law. An impartial Administrative Law Judge will hear the case and decide whether the patient is to be admitted to or released from the hospital.
b) Scheduling hearings

i) Hearings must be held within ten calendar days of the patient's confinement unless a postponement has been arranged. Hearings will be scheduled on a weekly basis. The involuntary patient's hearing will take place on the designated hearing day following confinement. For individuals entering the hospital involuntarily less than 48 hours before a scheduled hearing day, the hearing will be held the following week in order to allow the patient time to obtain legal counsel and to allow an adequate period for observation.
ii) The date of the hearing may be postponed or continued by the Administrative Law Judge for good cause shown, but in any event, the hearing shall be concluded and a decision made within 17 calendar days from the date of confinement. If a patient and/or his/her legal counsel requests a different hearing date, every effort will be made to schedule the hearing at a time acceptable to all involved. The patient must be present at the hearing unless he/she refuses or waives the right to attend. Any waiver must be knowingly and intelligently made by the patient in the presence of the Administrative Law Judge and the patient's legal representative.

References *(required for clinical)***: None**

Cross References: None

Anne Arundel Medical Center	**Treatment/Discharge Planning**
Dates Previously Reviewed/Revised: Newly Reviewed By: **Approval Date:** **Effective Date:**	**Owner:**
Approver Title: _____ Approval Signature	

Scope: Patients being discharged from inpatient psychiatric unit

Policy Statement: Each patient admitted to the inpatient mental health unit will have an individualized, multidisciplinary treatment plan. The patient will be included in the treatment planning process. This policy will outline the treatment objectives and define the role of each member of the treatment team.

Procedure:

1. The treatment plan is initiated at the time of admission and is formulated collaboratively by the treatment team. The plan identifies goals for treatment and planned interventions.
2. The plan is individualized to the patient and addresses acute symptoms and contributing biological, social or environmental, and psychological factors. Patient strengths and limitations will be incorporated into the plan.
3. Roles of the team members are as follows:
   a. The psychiatrist is the attending physician, responsible for the overall care of the patient. The psychiatrist is the leader of the treatment team.
      i. The psychiatrist or qualified covering professional sees the patient daily.
      ii. The psychiatrist or qualified covering professional requests consultation from other medical specialists as needed.
   b. Registered nurses provide 24-hour care. They monitor and manage medical and psychiatric care according to the psychiatrist's or qualified covering professional's orders. The nurses monitor and report compliance with treatment. The nurses assess the patient's interaction with family and significant others during visits. The nurses assess suicide risk and educate patients about medications, the patient's illness and treatment. The nurses inform the treatment team about patient behavior, complaints, and function over every 24-hour period.
   c. Social Workers conduct assessments and conduct psychotherapy with patients individually, in groups, and with their families, in accordance with the treatment plan. The social worker assists the discharge coordinator in formulating a discharge plan in collaboration with the treatment team. The social worker keeps the treatment team informed about clinical and/or family issues and the progress of the discharge plan. The social worker assists with utilization review as needed.
   d. The Occupational Therapist assesses function in daily living as well as cognition. They facilitate group therapy with an emphasis on life skills, coping techniques and leisure. They participate in formulation of the treatment plan and the discharge plan.
   e. The Art Therapist works to foster the patient's expression of inner experience graphically, individually and in group and works to foster adaptive coping.

f. Utilization Review Staff conduct concurrent reviews according to payor requirements. They monitor the length of stay, keep the treatment team informed and assist with identification of community resources.

4. Treatment rounds and treatment plans
   a. Treatment rounds are held daily.
      i. Every patient's progress is discussed.
      ii. Written treatment plans are updated at a minimum every third day.
      iii. Patients' behavior and the status of acute psychiatric symptoms over the previous 24-hour period are reviewed at each treatment rounds.
      iv. New patients' clinical and family information is reviewed, and progress and discharge plans for existing patients are reviewed at treatment rounds. Team social workers are responsible for updating written treatment plans.
      v. The treatment recommendations are discussed with the patient and the patient is asked to sign the treatment plan.

References:

Cross References:

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

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

NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.

Before the Project							After Project Completion						
Hospital Service	Location (Floor/Wing)*	Licensed Beds: July 1, 2015	Based on Physical Capacity				Hospital Service	Location (Floor/Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity
ACUTE CARE							ACUTE CARE					
General Medical/Surgical*					0	0	General Medical/Surgical*				0	0
					0	0					0	0
					0	0					0	0
					0	0					0	0
					0	0					0	0
SUBTOTAL Gen. Med/Surg*							SUBTOTAL Gen. Med/Surg*					
ICU/CCU					0	0	ICU/CCU				0	0
Other *(Specify/add rows as needed)*					0	0					0	0
TOTAL MSGA							TOTAL MSGA					
Obstetrics					0	0	Obstetrics				0	0
Pediatrics					0	0	Pediatrics				0	0
Psychiatric		0	0	0	0	0	Psychiatric	2nd floor	16		16	16
TOTAL ACUTE		0	0	0	0	0	TOTAL ACUTE		16	0	16	16
NON-ACUTE CARE							NON-ACUTE CARE					
Dedicated Observation**					0	0	Dedicated Observation**				0	0
Rehabilitation					0	0	Rehabilitation				0	0
Comprehensive Care					0	0	Comprehensive Care				0	0
Other *(Specify/add rows as needed)*					0	0	Other *(Specify/add rows as needed)*				0	0
TOTAL NON-ACUTE							TOTAL NON-ACUTE					
HOSPITAL TOTAL		0	0	0	0	0	HOSPITAL TOTAL		16	0	16	16

* Include beds dedicated to gynecology and addictions, if unit(s) is separate for acute psychiatric unit

** Include services included in the reporting of the "Observation Center". Service furnished by the hospital on the hospital's promise, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient; Must be ordered and documented in writing, given by a medical practitioner.

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

INSTRUCTION: Add or delete rows if necessary. See additional instruction in the column to the right of the table.

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET					
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is		Total After Project Completion
BASEMENT FLOOR:						
Ambulance Bay	0	1,455	0	0		1,455
Laundry	0	939	0	0		939
Staff Lounge	0	295	0	0		295
Toilet	0	48	0	0		48
Toilet	0	52	0	0		52
Secure Vestibule	0	189	0	0		189
Search	0	61	0	0		61
Intake	0	75	0	0		75
Toilet	0	52	0	0		52
Vestibule	0	100	0	0		100
Intake Office	0	99	0	0		99
Electrical	0	1,045	0	0		1,045
Dirty Storage/Staging	0	1,161	0	0		1,161
Office	0	142	0	0		142
Office	0	97	0	0		97
Body Room	0	92	0	0		92
Staging	0	933	0	0		933
Grounds Equipment	0	467	0	0		467
Emergency Generator	0	396	0	0		396
Loading Dock	0	1,008	0	0		1,008
Clean Storage	0	767	0	0		767
Mechanical	0	1,118	0	0		1,118
Kitchen	0	743	0	0		743
Storage	0	695	0	0		695
Grossing Factor	0	4,659	0	0		4,659
Basement Floor Subtotal	**0**	**16,688**	**0**	**0**		**16,688**
FIRST FLOOR:						
Vestibule	0	187	0	0		187
Vending	0	114	0	0		114
Family Lockers	0	109	0	0		109
Security	0	172	0	0		172
Multipurpose Room	0	260	0	0		260
Office Waiting/Reception	0	370	0	0		370
Shared Office	0	209	0	0		209
U.R. Specialist	0	106	0	0		106
Clinical Director	0	115	0	0		115
Psychiatric Nurse	0	87	0	0		87
Activities Therapist	0	85	0	0		85
H & M Office	0	85	0	0		85
Office	0	87	0	0		87
Medical Director	0	126	0	0		126
Public Toilet - Women	0	124	0	0		124
Public Toilet - Men	0	124	0	0		124
Shell Space	0	5,796	0	0		5,796
I.T. Closet	0	86	0	0		86
Electrical Closet	0	78	0	0		78
PHP Reception	0	114	0	0		114
PHP Consult	0	89	0	0		89
PHP Multipurpose Room	0	566	0	0		566
PHP Adult Patient Toilet	0	54	0	0		54
PHP Adult Nourishment	0	134	0	0		134
PHP Adult Group Room	0	294	0	0		294
PHP Adolescent Patient Toilet	0	55	0	0		55
PHP Adolescent Nourishment	0	84	0	0		84
PHP Adolescent Group Room	0	300	0	0		300
Environmental Services	0	71	0	0		71
PHP Nurse Station	0	129	0	0		129
PHP Medication Room	0	71	0	0		71
PHP Staff Lounge	0	180	0	0		180
PHP Staff Toilet	0	48	0	0		48
PHP Psychiatrist Office	0	89	0	0		89
PHP Psychiatrist Office	0	89	0	0		89
PHP Treatment Planning	0	117	0	0		117
Grossing Factor	0	5,884	0	0		5,884
First Floor Subtotal	**0**	**16,688**	**0**	**0**		**16,688**
SECOND FLOOR: Inpatient Unit						
Waiting	0	365	0	0		365
Team Room	0	560	0	0		560
Public Toilet - Men	0	48	0	0		48
Public Toilet - Women	0	48	0	0		48
Office 1	0	103	0	0		103
Office 2	0	112	0	0		112
Office 3	0	81	0	0		81
Office 4	0	80	0	0		80
Office 5	0	77	0	0		77
Office 6	0	81	0	0		81
Office 7	0	107	0	0		107
Office 8	0	98	0	0		98
Office Supplies/Copy Room	0	144	0	0		144
Consult 1	0	92	0	0		92
Consult 2	0	91	0	0		91

Additional Instruction

Consult 3	0	93	0	0		93
Secure Vestibule	0	202	0	0		202
Patient Room 1	0	131	0	0		131
Patient Room 1 Toilet	0	48	0	0		48
Patient Room 2	0	130	0	0		130
Patient Room 2 Toilet	0	48	0	0		48
Patient Room 3	0	131	0	0		131
Patient Room 3 Toilet	0	48	0	0		48
Patient Room 4	0	130	0	0		130
Patient Room 4 Toilet	0	48	0	0		48
Patient Room 5	0	131	0	0		131
Patient Room 5 Toilet	0	48	0	0		48
Patient Room 6	0	130	0	0		130
Patient Room 6 Toilet	0	48	0	0		48
Patient Room 7	0	131	0	0		131
Patient Room 7 Toilet	0	48	0	0		48
Patient Room 8	0	130	0	0		130
Patient Room 8 Toilet	0	48	0	0		48
Social Space - Noisy	0	182	0	0		182
Social Space - Quiet	0	185	0	0		185
Group Therapy	0	289	0	0		289
Dining and Multipurpose	0	1,110	0	0		1,110
Electrical Closet	0	49	0	0		49
IT Closet	0	38	0	0		38
Phlebotomy	0	94	0	0		94
Examination	0	90	0	0		90
Clean Utility	0	88	0	0		88
Soiled Utility	0	94	0	0		94
Staff Lounge/Lockers	0	194	0	0		194
Patient Storage	0	75	0	0		75
Patient Laundry	0	70	0	0		70
Support Staff	0	227	0	0		227
Nourishment/Pantry	0	166	0	0		166
Staff Toilet - Men	0	51	0	0		51
Staff Toilet - Women	0	51	0	0		51
Anteroom	0	62	0	0		62
Toilet	0	48	0	0		48
Quiet Room	0	107	0	0		107
Nurse Station	0	129	0	0		129
Pharmacy	0	144	0	0		144
Electrical Closet	0	44	0	0		44
IT Closet	0	45	0	0		45
Group Therapy	0	289	0	0		289
Social Space - Quiet	0	185	0	0		185
Social Space - Noisy	0	182	0	0		182
Patient Room 9	0	131	0	0		131
Patient Room 9 Toilet	0	48	0	0		48
Patient Room 10	0	130	0	0		130
Patient Room 10 Toilet	0	48	0	0		48
Patient Room 11	0	131	0	0		131
Patient Room 11 Toilet	0	48	0	0		48
Patient Room 12	0	130	0	0		130
Patient Room 12 Toilet	0	48	0	0		48
Patient Room 13	0	131	0	0		131
Patient Room 13 Toilet	0	48	0	0		48
Patient Room 14	0	130	0	0		130
Patient Room 14 Toilet	0	48	0	0		48
Patient Room 15	0	131	0	0		131
Patient Room 15 Toilet	0	48	0	0		48
Patient Room 16	0	130	0	0		130
Patient Room 16 Toilet	0	48	0	0		48
Occupational Therapy/Storage	0	379	0	0		379
Occupational Therapy	0	318	0	0		318
Occupational Therapy Office	0	98	0	0		98
Occupational Therapy Toilet	0	68	0	0		68
Grossing Factor	0	6,299	0	0		6,299
Second Floor Subtotal	**0**	**16,688**	**0**	**0**		**16,688**
THIRD FLOOR:						
Shell Space	0	16,688	0	0		16,688
Third Floor Subtotal	**0**	**16,688**	**0**	**0**		**16,688**
Building Total	**0**	**66,752**	**0**	**0**		**66,752**

TABLE C. CONSTRUCTION CHARACTERISTICS

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

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☑	☐
Class B	☐	☐
Class C	☐	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☑	☐
Excellent	☐	☐
Number of Stories	4	

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement	16,688	
First Floor	16,688	
Second Floor	16,688	
Third Floor	16,688	
Fourth Floor	0	
Average Square Feet	**16,688**	
Perimeter in Linear Feet	**Linear Feet**	
Basement	810	
First Floor	810	
Second Floor	810	
Third Floor	810	
Fourth Floor	0	
Total Linear Feet	**3,240**	
Average Linear Feet	**810**	
Wall Height (floor to eaves)	**Feet**	
Basement	15' - 0"	
First Floor	13' - 4"	
Second Floor	13' - 4"	
Third Floor	13' - 4"	
Fourth Floor	0	
Average Wall Height	**13' - 8"**	
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger	2	
Freight	1	
Sprinklers	**Square Feet Covered**	
Wet System	64,732	
Dry System	2,020	
Other	**Describe Type**	
Type of HVAC System for proposed project		
Type of Exterior Walls for proposed project		

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

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

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation	Included below	$0
Utilities from Structure to Lot Line	Included below	$0
Subtotal included in Marshall Valuation Costs	**$0**	**$0**
Site Demolition Costs	$40,000	$0
Storm Drains	$150,000	$0
Rough Grading	$80,000	$0
Hillside Foundation	$0	$0
Paving	$50,000	$0
Exterior Signs	$25,000	$0
Landscaping	$75,000	$0
Walls	$30,000	$0
Yard Lighting	$15,000	$0
Normal Site Preperation	$150,000	$0
Utilities from Strucutre to Lot Line	$121,545	
Sediment & Erosion Control	$50,000	
Site Work (ramps, curbs, sidewalks, courtyard	$150,000	$0
Subtotal On-Site excluded from Marshall Valuation Costs	**$936,545**	**$0**
OFFSITE COSTS		
Roads	$10,000	$0
Utilities	$40,000	$0
Jurisdictional Hook-up Fees	$374,528	$0
Other *(Specify/add rows if needed)*	$0	$0
Subtotal Off-Site excluded from Marshall Valuation Costs	**$424,528**	**$0**
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$1,361,073**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$1,361,073**	**$0**

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

TABLE E. PROJECT BUDGET

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

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

	Hospital Building	Other Structure	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. Land Purchase	**$0**		**$0**
b. New Construction			
(1) Building	$12,790,057		$12,790,057
(2) Fixed Equipment	Included above		$0
(3) Site and Infrastructure	$1,361,073		$1,361,073
(4) Architect/Engineering Fees	$1,373,350		$1,373,350
(5) Permits (Building, Utilities, Etc.)	$23,757		$23,757
SUBTOTAL	**$15,548,237**	**$0**	**$15,548,237**
c. Renovations			
(1) Building	$0		$0
(2) Fixed Equipment (not included in construction)	$0		$0
(3) Architect/Engineering Fees	$0		$0
(4) Permits (Building, Utilities, Etc.)	$0		$0
SUBTOTAL	**$0**	**$0**	**$0**
d. Other Capital Costs			
(1) Movable Equipment	$900,000		$900,000
(2) Contingency Allowance	$550,000		$550,000
(3) Gross interest during construction period	$0		$0
(4) Other *(minor equipment)*	$0		$0
SUBTOTAL	**$1,450,000**	**$0**	**$1,450,000**
TOTAL CURRENT CAPITAL COSTS	**$16,998,237**	**$0**	**$16,998,237**
e. Inflation Allowance			**$0**
TOTAL CAPITAL COSTS	**$16,998,237**	**$0**	**$16,998,237**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c. Legal Fees			$0
d. Non-Legal Consultant Fees			$0
e. Liquidation of Existing Debt			$0
f. Debt Service Reserve Fund			$0
g. Other *(Specify/add rows if needed)*			$0
SUBTOTAL			**$0**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$16,998,237***	***$0***	***$16,998,237***
B. Sources of Funds			
1. Cash	**$16,998,237**		$0
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	**$16,998,237**		**$16,998,237**
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
1. DISCHARGES							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	718	879	886	892	892		
Total Acute	***718***	***879***	***886***	***892***	***892***	***0***	***0***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL DISCHARGES	***718***	***879***	***886***	***892***	***892***	***0***	***0***
2. PATIENT DAYS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**-**	**-**	**-**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	4,409	5,397	5,440	5,477	5,477		
Total Acute	***4,409***	***5,397***	***5,440***	***5,477***	***5,477***	***0***	***0***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL PATIENT DAYS	***4,409***	***5,397***	***5,440***	***5,477***	***5,477***	***0***	***0***

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
3. AVERAGE LENGTH OF STAY							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	6.14	6.14	6.14	6.14	6.14		
Total Acute	6.14	6.14	6.14	6.14	6.14		
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL AVERAGE LENGTH OF STAY	6.14	6.14	6.14	6.14	6.14		

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	16	16	16	16	16		
Total Acute	***16***	***16***	***16***	***16***	***16***	***0***	***0***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL LICENSED BEDS	***16***	***16***	***16***	***16***	***16***		
5. OCCUPANCY PERCENTAGE *IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA							
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric	**75.5%**	**92.2%**	**93.2%**	**93.8%**	**93.8%**		
Total Acute	**75.5%**	**92.2%**	**93.2%**	**93.8%**	**93.8%**		

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL OCCUPANCY %	**75.5%**	**92.4%**	**93.2%**	**93.8%**	**93.8%**		

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

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

	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables J and K.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**		
6. OUTPATIENT VISITS							
a. Emergency Department							
b. Same-day Surgery							
c. Laboratory							
d. Imaging							
e. Partial Hospitalization	4,699	5,679	5,718	5,758	5,799		
TOTAL OUTPATIENT VISITS	***4,699***	***5,679***	***5,718***	***5,758***	***5,799***	***0***	***0***
7. OBSERVATIONS**							
a. Number of Patients							
b. Hours							

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

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

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**		
1. REVENUE							
a. Inpatient Services	$ 6,225,114	$ 7,620,996	$ 7,690,357	$ 7,751,047	$ 7,751,047		
b. Outpatient Services	$ 1,955,596	$ 2,626,533	$ 2,645,752	$ 2,665,119	$ 2,684,637		
Gross Patient Service Revenues	***$ 8,180,710***	***$ 10,247,529***	##########	##########	##########	$ -	$ -
c. Allowance For Bad Debt	$ 665,984	$ 834,123	$ 841,355	$ 847,892	$ 849,489		
d. Contractual Allowance	$ 1,548,736	$ 1,939,741	$ 1,956,558	$ 1,971,759	$ 1,975,474		
e. Charity Care	$ 125,002	$ 156,561	$ 157,919	$ 159,146	$ 159,445		
Net Patient Services Revenue	***$ 5,840,988***	***$ 7,317,104***	***$ 7,380,277***	***$ 7,437,370***	***$ 7,451,275***	$ -	$ -
f. Other Operating Revenues							
NET OPERATING REVENUE	***$ 5,840,988***	***$ 7,317,104***	***$ 7,380,277***	***$ 7,437,370***	***$ 7,451,275***	$ -	$ -
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 4,891,417	$ 5,099,538	$ 5,099,538	$ 5,099,538	$ 5,099,538		
b. Contractual Services	$ 133,298	$ 210,920	$ 187,059	$ 188,206	$ 189,361		
c. Interest on Current Debt	$ -	$ -	$ -	$ -	$ -		
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -		
e. Current Depreciation							
f. Project Depreciation	$ 504,609	$ 508,949	$ 508,949	$ 424,956	$ 424,956		
g. Current Amortization	$ -	$ -	$ -	$ -	$ -		
h. Project Amortization	$ -	$ -	$ -	$ -	$ -		
i. Supplies	$ 100,099	$ 129,783	$ 130,916	$ 131,929	$ 132,091		
j. Other Expenses (Pharmaceuticals)	$ 93,845	$ 114,888	$ 115,934	$ 116,849	$ 116,849		
k. Other Expenses (Recruitment, Training, Orientation)	$ 63,407	$ 63,407	$ 63,407	$ 63,407	$ 63,407		
l. Other Expenses (Other Misc. Expenses)	$ 351,725	$ 366,698	$ 366,698	$ 376,698	$ 366,698		

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**		
TOTAL OPERATING EXPENSES	**$ 6,138,400**	**$ 6,494,183**	**$ 6,472,501**	**$ 6,401,583**	**$ 6,392,900**	**$ -**	**$ -**

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**		
1. REVENUE							
a. Inpatient Services	$ 6,225,114	$ 7,761,381	$ 7,976,280	$ 8,187,295	$ 8,338,080		
b. Outpatient Services	$ 1,955,596	$ 2,674,865	$ 2,744,018	$ 2,814,015	$ 2,885,804		
Gross Patient Service Revenues	***$ 8,180,710***	***$ 10,436,246***	***$ 10,720,298***	***$ 11,001,310***	***$ 11,223,884***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 665,984	$ 849,342	$ 872,355	$ 895,104	$ 913,081		
d. Contractual Allowance	$ 1,548,735	$ 1,975,154	$ 2,028,648	$ 2,081,551	$ 2,123,355		
e. Charity Care	$ 125,002	$ 159,420	$ 163,737	$ 168,007	$ 171,381		
Net Patient Services Revenue	***$ 5,840,989***	***$ 7,452,330***	***$ 7,655,558***	***$ 7,856,648***	***$ 8,016,067***	***$ -***	***$ -***
f. Other Operating Revenues	$ -	$ -	$ -	$ -	$ -		
NET OPERATING REVENUE	***$ 5,840,989***	***$ 7,452,330***	***$ 7,655,558***	***$ 7,856,648***	***$ 8,016,067***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 4,892,610	$ 5,190,324	$ 5,281,303	$ 5,374,101	$ 5,468,747		
b. Contractual Services	$ 133,646	$ 214,950	$ 194,766	$ 199,644	$ 204,644		
c. Interest on Current Debt	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**		
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -		
e. Current Depreciation	$ -	$ -	$ -	$ -	$ -		
f. Project Depreciation	$ 504,609	$ 508,949	$ 508,949	$ 424,956	$ 424,956		
g. Current Amortization	$ -	$ -	$ -	$ -	$ -		
h. Project Amortization	$ -	$ -	$ -	$ -	$ -		
i. Supplies	$ 100,099	$ 132,356	$ 136,158	$ 139,923	$ 142,863		
j. Other Expenses (Pharmaceuticals)	$ 93,845	$ 117,186	$ 120,618	$ 124,001	$ 126,481		
k. Other Expenses (Recruitment, Training, Orientation)	$ 63,407	$ 64,675	$ 65,969	$ 67,288	$ 68,634		
l. Other Expenses (Other Misc. Expenses)	$ 354,118	$ 377,198	$ 384,654	$ 402,259	$ 400,016		

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**		
TOTAL OPERATING EXPENSES	**$ 6,142,334**	**$ 6,605,638**	**$ 6,692,417**	**$ 6,732,172**	**$ 6,836,341**	**$ -**	**$ -**

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

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

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**		
3. INCOME							
a. Income From Operation	**$ (301,345)**	**$ 846,692**	**$ 963,141**	**$ 1,124,476**	**$ 1,179,726**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (301,345)***	***$ 846,692***	***$ 963,141***	***$ 1,124,476***	***$ 1,179,726***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ (301,345)***	***$ 846,692***	***$ 963,141***	***$ 1,124,476***	***$ 1,179,726***	***$ -***	***$ -***
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	28.2%	28.2%	28.2%	28.2%	28.2%		
2) Medicaid	39.4%	39.4%	39.4%	39.4%	39.4%		
3) Blue Cross	14.7%	14.7%	14.7%	14.7%	14.7%		
4) Commercial Insurance	11.5%	11.5%	11.5%	11.5%	11.5%		
5) Self-pay	4.6%	4.6%	4.6%	4.6%	4.6%		
6) Other	1.6%	1.6%	1.6%	1.6%	1.6%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	28.4%	28.4%	28.4%	28.4%	28.4%		
2) Medicaid	39.3%	39.3%	39.3%	39.3%	39.3%		
3) Blue Cross	14.8%	14.8%	14.8%	14.8%	14.8%		
4) Commercial Insurance	11.4%	11.4%	11.4%	11.4%	11.4%		
5) Self-pay	4.7%	4.7%	4.7%	4.7%	4.7%		
6) Other	1.5%	1.5%	1.5%	1.5%	1.5%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***

Anne Arundel Medical Center

Certificate of Need Application: Acute Psychiatry

Data Sources and Technical Notes

Data sources

Population data

- Nielsen Site Reports
    - Population projections prepared for age cohort 18+ years based on COMAR definition for adult psychiatry services

Hospital utilization data

- Maryland hospitals: HSCRC Discharge Abstract Database and Experience Report
- Anne Arundel Medical Center: HSCRC Confidential Dataset for data on readmissions
- Washington, DC hospitals: District of Columbia Hospital Association Discharge Database (CY2014), obtained through the Maryland Health Care Commission
    - Total adult mental health admissions were documented for Anne Arundel County residents and determined to be very modest volume; therefore, this market volume was not incorporated into market projections

Definitions adopted for analyses

"Mental health" - The definition adopted for documenting "mental health discharges" and "mental health emergency room visits" was based on Clinical Classifications Software for ICD-10 codes ("CCS codes") defined for Mental Health (Level 2 codes, 5.1-5.15). High level market analyses and utilization trends were documented on the basis of a mental health CCS code as primary.

- This definition adopted for this analysis excluded substance use-related disorders and alcohol-related disorders (5.11-5.12)

"AAMC-eligible mental health volume" - This phrase refers to the patient populations expected to be served by the proposed unit at the AAMC Specialty Mental Health Campus. AAMC plans to serve adult patients, age 18 years or more, including involuntary admissions and including those patients identified as suicidal who require treatment in a psychiatric unit. Patients with a substance use disorder as the primary diagnosis are not expected to be served in this unit.

The AAMC-eligible acute care volume was defined by age, diagnosis code and days in an acute psychiatric unit:

- All adult discharges (age 18+ years old) documented with a psychiatric DRG (DRG 750-760)
- All adult discharges with an ICD-9 psychiatric diagnosis code *and* having had at least 1 or more days in an acute psychiatry unit in Maryland
- All adult discharges with an ICD-9 diagnosis code identifying suicidal risk and accompanied by at least 1 day in an acute psychiatry unit

A number of patient populations are not expected to be served in the proposed unit, and were therefore excluded from the total market volume and demand projection base on diagnosis codes. Patient cohorts excluded from the analyses were those patients identified by any one of the following diagnoses as a primary diagnosis:

- Substance use disorders (ICD 9 codes 290-294)
- Eating disorders (DRG 759)
- Dementia/neurologic disorders (ICD9 290-294)
- Developmental disabilities/intellectual disorders (ICD(codes 317-319)

Service area definition for acute psychiatry for adult patients

The proposed service area for cardiac surgery was defined in whole county units to include Anne Arundel County, Kent County, and Queen Anne's County.

TABLE L. WORK FORCE INFORMATION

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables G and J. See additional instruction in the column to the right of the table.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost (FY23)** *(should be consistent with projections in Table J)*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Administrative Director	0.0	$0	$0	1.0	$136,639	$136,639			$0	1.0	$136,639
Clinical Director	0.0	$0	$0	1.0	$94,286	$94,286			$0	1.0	$94,286
Total Administration			$0	2.0		$230,925			$0	2.0	$230,925
Direct Care Staff *(List general categories, add rows if needed)*											
Activity Therapist	0.0	$0	$0	1.0	$64,286	$64,286			$0	1.0	$64,286
Nurse Manager	0.0	$0	$0	1.0	$98,711	$98,711			$0	1.0	$98,711
Nurse Practitioner	0.0	$0	$0	2.0	$122,039	$244,078			$0	2.0	$244,078
Occupational Therapist	0.0	$0	$0	1.0	$82,885	$82,885			$0	1.0	$82,885
Psych Tech	0.0	$0	$0	15.0	$37,818	$567,273			$0	15.0	$567,273
Psych Therapist	0.0	$0	$0	2.0	$75,000	$150,001			$0	2.0	$150,001
Psychiatrist	0.0	$0	$0	2.5	$235,215	$588,038			$0	2.5	$588,038
RN	0.0	$0	$0	10.0	$82,891	$828,908			$0	10.0	$828,908
Social Workers	0.0	$0	$0	2.5	$60,878	$152,194			$0	2.5	$152,194
Total Direct Care			$0	37.0		$2,776,374			$0	37.0	$2,776,374
Support Staff *(List general categories, add rows if needed)*											
Discharge Coordinator	0.0	$0	$0	1.5	$52,314	$78,471			$0	1.5	$78,471
Finance Staff	0.0	$0	$0	3.0	$65,441	$196,323			$0	3.0	$196,323
Food & Nutrition Staff	0.0	$0	$0	2.5	$36,165	$90,412			$0	2.5	$90,412
Pharmacist	0.0	$0	$0	1.0	$117,870	$117,870			$0	1.0	$117,870
Pharmacy tech	0.0	$0	$0	1.0	$44,808	$44,808			$0	1.0	$44,808
Reception/Office Asst.	0.0	$0	$0	3.5	$43,444	$152,055			$0	3.5	$152,055
Security officer	0.0	$0	$0	7.2	$41,564	$299,259			$0	7.2	$299,259
UR/Billing	0.0	$0	$0	2.5	$45,753	$114,383			$0	2.5	$114,383
Total Support			$0	22.2		$1,093,581			$0	22.2	$1,093,581
REGULAR EMPLOYEES TOTAL			$0	***61.2***		$4,100,880.62			$0	61.2	$4,100,881
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
Somatic NP (CPT)	0.0	$0	$0	0.5	$115,000	$59,427.65			$0	0.5	$59,428
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0	0.5		$59,428			$0	0.5	$59,428
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0	***0.5***		$59,428			$0	0.5	$59,428
Benefits *(State method of calculating benefits below)*:											
23% of staff salary and 20% of physician salary											
TOTAL COST	***0.0***		***$0***	***61.7***		***$5,099,538***	***0.0***		***$0***		***$5,099,538***

Anne Arundel Medical Center

Certificate of Need Application: Acute Psychiatry

Data Sources and Technical Notes

Data sources

Population data

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Board Resolutions

Anne Arundel Medical Center

2001 Medical Parkway
Annapolis, Md. 21401
443-481-1000
TDD: 443-481-1235
askAAMC.org

AAHS/AAMC Board of Trustees
Resolution

Inpatient Mental Health Unit Certificate of Need Application

Whereas, Anne Arundel Medical Center (AAMC) strives to respond to the health needs of the communities it serves, and

Whereas, Anne Arundel County has documented an 11 percent increase in the number of residents seeing mental health services in the past year, nearly 145 percent greater than a decade ago, and

Whereas, the County's most recent Healthy Anne Arundel Coalition's Community Health Needs Assessment has identified a rise in mental health issues, higher stress levels among families and children, and a lack of services and service providers, and

Whereas, Anne Arundel County has witnessed an almost three-fold increase in the number of heroin-related deaths between 2010 and 2014, while co-occurring disorders often go untreated due to lack of appropriate care, and

Whereas, AAMC offers services to meet many of these needs, including Pathways, its 40-bed substance use treatment facility, as well as an outpatient mental health clinic and other outpatient services, and

Whereas, AAMC is one of Maryland's busiest hospitals where staff faced the need last year to transfer nearly 1,000 patients from its emergency room for inpatient psychiatric treatment to other facilities, causing a disruption of care and added stress on patients and families, and

Whereas , AAMC has submitted an application to the Maryland Health Care Commission for a Certificate of Need to establish an inpatient mental health unit - the missing component of its otherwise comprehensive mental health program – and,

Whereas, this unit will complement AAMC's existing mental health services and provide a critical anchor for the County's network of outpatient services for mental health,

Now, therefore, be it resolved on this 28th day of January, 2016, that the AAHS/AAMC Board of Trustees, its officers and members, does hereby fully endorse AAMC's Certificate of Need application for an inpatient mental health unit and urges the Maryland Health Care Commission to grant permission as expeditiously as possible to meet this growing need in our community.

Signature _____
Ed Gosselin, Chairman
AAHS/AAMC Board of Trustees

Signature _____
Maulik Joshi, Dr. P.H., Secretary
AAHS/AAMC Board of Trustees

01/28/16

Anne Arundel Medical Center
Foundation

2001 Medical Parkway
Belcher Pavilion, Suite 604
Annapolis, MD 21401
443-481-4747
askAAMC.org

AAMC Foundation Board of Directors Resolution

Inpatient Mental Health Unit Certificate of Need Application

Whereas, Anne Arundel Medical Center (AAMC) strives to respond to the health needs of the communities it serves, and,

Whereas, Anne Arundel County has documented an 11 percent increase in the number of residents seeking mental health services in the past year, nearly 145 percent greater than a decade ago, and,

Whereas, the County's most recent Healthy Anne Arundel Coalition's Community Health Needs Assessment has identified a rise in mental health issues, higher stress levels among families and children, and a lack of services and service providers, and,

Whereas, Anne Arundel County has witnessed an almost three-fold increase in the number of heroin-related deaths between 2010 and 2014, while co-occurring disorders often go untreated due to lack of appropriate care, and,

Whereas, AAMC offers services to meet many of these needs, including Pathways, its 40-bed substance use treatment facility, as well as an outpatient mental health clinic and other outpatient services, and,

Whereas, AAMC is one of Maryland's busiest hospitals where staff faced the need last year to transfer nearly 1,000 patients from its emergency room for inpatient psychiatric treatment to other facilities, causing a disruption of care and added stress on patients and families, and,

Whereas, AAMC has submitted a request to the Maryland Health Care Commission for a Certificate of Need to establish an inpatient mental health unit - the missing component of its otherwise comprehensive mental health program – and,

Whereas, this unit will complement AAMC's existing mental health services and provide a critical anchor for the County's network of outpatient services for mental health.

Now, therefore, be it resolved on this 25th day of January, 2016, that the Anne Arundel Medical Center Foundation Board of Directors, its officers and members, does hereby fully endorse Anne Arundel Medical Center's Certificate of Need for an inpatient mental health unit and urges the Maryland Health Care Commission to grant permission as expeditiously as possible to meet this growing need in our community.

Richard C. Springer
Chair

Catherine A. Adelman
Secretary

Board Members

December 2, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

Anne Arundel Medical Center is my hospital of choice. For many years, AAMC has been providing many of the mental health and substance use services that the community relies on, such as substance use treatment and outpatient mental health clinics. They're also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. I have had to personally make the out of area one hour commute to the closest facility and have friends in the community who also have had to leave the area for mental health care. An inpatient mental health unit would certainly improve the quality and access of mental healthcare available in my community.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in my community.

Thank you in advance for your consideration.

Sincerely,

Laura J. Westervelt

Laura J. Westervelt

cc: Anne Arundel Medical Center

Edward Gosselin

December 10, 2015

Mr. Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Re: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

I am writing to state my support for Anne Arundel Medical Center's Certificate of Need application to establish an inpatient mental health unit. As Chairman of the Board of Trustees I recognize the critical need for this program in Anne Arundel County, which is where I reside. The new facility and services will improve the quality and access of mental healthcare available to the community

For many years, AAMC has been providing mental health and substance use services for which the community relies. I have personally witnessed the positive impact these substance use services and treatment have had on patients. Combined with a psychiatric day treatment hospital program that AAMC is developing, an inpatient mental health unit will create a seamless experience for those needing a higher level of care, and alleviate the burden and disruption in being transferred or waiting to be transferred to another facility.

AAMC has the resources, support of the Board of Trustees and commitment to implement a mental health program of the highest quality for the community.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in our community.

Thank you for your consideration.

Sincerely

Edward W Gosselin

CC: Anne Arundel Medical Center

268 Providence Road Annapolis, Maryland 21409

Gary Jobson
10 Thompson Street
Annapolis, Maryland 21401

December 18, 2015

Mr. Kevin R McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland. 21215

SUBJECT: LETTER OF SUPPORT: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

I serve as Vice Chair of the Board of Directors of Anne Arundel Medical Center. As a board member for the past six years it has become very clear that our county has a severe shortage of inpatient medical health services. According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for mental health disorders has been fragmented and disconnected. We are facing a crisis with mental health and substance abuse that has resulted in severe long time term problems including suicides. We are working to deal with this growing issue by increasing access to integrated mental health and substance use treatment for people in our county. For this reason we believe it is vital that we establish an inpatient mental health unit.

The case for this Certificate of Need is strong. In 2014 over 1,000 people who came to our emergency room needing inpatient mental health care. We had to transfer these people to other facilities in the state. Regrettably, many people are forced to wait for long periods until space becomes available. There are simply not enough adequate facilities in Anne Arundel County. Our plan is to address this growing need.

An Inpatient Mental Health Unit would allow patients to seamlessly transition among levels if care at our facility. This would improve care, and reduce the length of stay. Costs for these services would be reduced. Many of our dedicated donors, and supporters recognize the need for this type of care, and we expect strong philanthropic support.

Anne Arundel Medical Center is dedicated to providing the highest level of health care for our growing community. We are dedicated to serving people during their times of need. We are grateful for your support for this essential service.

Sincerely,

Gary Jobson
Vice Chairman
Board of Trustees

Kevin R.McDonald,Chief
Certification of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore MD 21215-2299

November 24, 2015

Letter of Support:AAMC 's Certification of Need Application
For an Inpatient Mental Health Unit

Dear Mr McDonald

I am writing to offer my strong support for AAMC to establish an inpatient mental health unit. This service is critically needed in our region.
AAMC my hospital of choice,has been providing many of the mental health and substance use services that our community relies on.An inpatient mental health unit would create a more seemless experience for those needing this level of care and would improve the quality and access of mental health care available in my community.
I fully support this project and hope MHCC will see the value and benefit of AAMC's application to provide this service.

John M. Belcher
Executive Chairman
System Enterprise Solutions
443-454-6195
256 Riverside Road,Edgewater MD 21037
Sent from my iPad

The Ellerson Group

415 Fourth Street, Suite 101
Annapolis, MD 21403

December 11, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

Anne Arundel Medical Center is my hospital of choice. For many years, AAMC has been providing many of the mental health and substance use services that the community relies on, such as substance use treatment and outpatient mental health clinics. They're also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in my community.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in my community.

Thank you in advance for your consideration.

Sincerely

James P. Ellerson

cc: Anne Arundel Medical Center

410.280.3103 • 800.269.9229 • FAX 410.280.9024

Anne Arundel Medical Center

2001 Medical Parkway
Annapolis, MD 21401
443-481-1000
TDD: 443-481-1235
www.aahs.org

November 30, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

As President of the Anne Arundel Medical Center (AAMC) Auxiliary, I appreciate the opportunity to offer my support for AAMC's Certificate of Need application to establish an inpatient mental health unit. I am aware of AAMC's longstanding commitment to providing critically-needed mental health and substance use treatment services to our community. Establishing an inpatient mental health unit to complement these existing quality services will help meet a growing need.

As you know, AAMC is one of the busiest hospitals in Maryland. In 2014, more than 1,000 people who came to AAMC's emergency room needing inpatient mental health care were transferred to other Maryland facilities. Because of the overwhelming shortage of this type of care, patients often are forced to wait for space to become available, causing delays in care. Unfortunately, I have had personal experience with this within my own family.

In response to the community health needs assessment conducted in 2012, the vision for AAMC's mental health and substance use program includes coordinated, individualized, evidence-based care plans that put patients on the path to healing and recovery. There are not enough inpatient mental health services available in Anne Arundel County—a critical piece for coordinated care.

According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for co-occurring disorders (mental health and substance use) has been fragmented and disconnected. In fact, it is the top disparity in Anne Arundel County. The rates for suicide and binge drinking are higher in Anne Arundel County as compared to state and national averages. AAMC is working to address this by increasing access to integrated mental health and substance use treatment for county residents. An inpatient mental health unit is one important piece of this.

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely,

Sherry Morrissette

Sherry Morrissette
President, Anne Arundel Medical Center Auxiliary

cc: Anne Arundel Medical Center

Theodore I. Pincus

2157 Sand Castle Ct.

Annapolis, MD 21403

December 10, 2015

Kevin R. McDonald, Chief

Certificate of Need

Maryland Health Care Commission

4160 Patterson Ave

Baltimore, MD 21215-2299

Subject:Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

I am writing to offer my personal strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This service is more than critically needed in our region.

I'm sure you are aware that AAMC has already been providing many of the mental health and substance use services that the community relies on, including substance use treatment and outpatient mental health clinics. They're also developing a psychiatric day treatment hospital program to help meet our community's growing needs. An inpatient mental health unit would improve the quality and access of mental healthcare available in my community and help relieve the burden to patients of being transferred to another facility and probably experiencing detrimental delays in treatment. There are simply not enough inpatient mental health services available in Anne Arundel County.

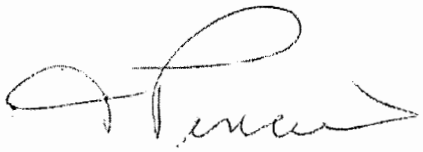
AAMC has a reputation for providing high-quality cost-effective healthcare, including mental health and substance use services through its Pathways treatment facility and programs. Pathways has earned national recognition for delivering highly successful, cost-effective inpatient substance use treatment. The ability for patients to seamlessly transition among levels of care would clearly reduce the total cost of care.

AAMC also has a proven history of generating significant philanthropic support from the community to augment the cost of its programs, and I am certain that support for this project will be readily forthcoming.

My family has personally experienced some of the mental health issues that this project will address so I know that the availability of an inpatient mental health unit will relieve a lot of the stress and concern that many families in the community experience. For all of these reasons I strongly urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration.

Sincerely,



Theodore I. Pincus

cc: Anne Arundel Medical Center

12/1/15

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

Anne Arundel Medical Center is my hospital of choice. For many years, AAMC has been providing many of the mental health and substance use services that the community relies on, such as substance use treatment and outpatient mental health clinics. They're also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in my community.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in my community.

Thank you in advance for your consideration.

Sincerely,

Todd Mohr
116 Riverbreeze PL
Arnold, MD 21012

cc: Anne Arundel Medical Center

March 25, 2016

To:

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

From:

David F. Todd, MD, MHA, Vice President
AAMC Medical Staff

Subject: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

As a physician and active member of the medical staff at AAMC, I appreciate the opportunity to offer my support for Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish an inpatient mental health unit. AAMC has a longstanding commitment to providing critically-needed mental health and substance use treatment services to our community. Establishing an inpatient mental health unit to complement these existing quality services will help meet a growing need.

Anne Arundel County has a critical shortage of inpatient mental health services. In 2014, Anne Arundel Medical Center transferred more than 1,000 people who came to the emergency room needing inpatient mental health care to other Maryland facilities. Because of the need for this care, patients often are forced to wait for available beds, causing delays in care.

Anne Arundel Medical Center is committed to providing a continuum of mental health and substance use services for the community. Pathways, AAMC's 40-bed substance use and mental health treatment facility, treats on average 50-60 patients a day. Pathways provides compassionate, confidential inpatient and outpatient care for teens and adults who suffer from drug and alcohol dependence, as well as those suffering from a combination of substance use and mental health issues.

In 2014, AAMC opened an outpatient mental health clinic providing a full range of services including counseling, therapy and medication compliance consultations. Adding an inpatient mental health unit would help close a gap in the continuum of this type of care in Anne Arundel County. The vision for AAMC's mental health and substance use program includes coordinated, individualized, evidence-based care plans that put patients on the path to

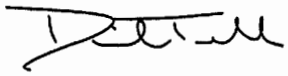
healing and recovery. Inpatient mental health services are a critical missing piece to the continuum of care

According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for co-occurring disorders (mental health and substance use) has been fragmented and disconnected. In fact, it is the top disparity in Anne Arundel County. The rates for suicide and binge drinking are higher in Anne Arundel County as compared to state and national averages. AAMC is working to address this by increasing access to integrated mental health and substance use treatment for county residents. An inpatient mental health unit is one important piece of this.

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely,



David F. Todd, MD, MHA

cc: Anne Arundel Medical Center

Government

JOHN P. SARBANES
3rd District, Maryland

COMMITTEE ON
ENERGY AND COMMERCE

2444 Rayburn House Office Building
Washington, DC 20515
(202) 225-4016
Fax: (202) 225-9219

Congress of the United States
House of Representatives
Washington, DC 20515–2003

www.sarbanes.house.gov

December 10, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. McDonald:

I would like to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit.

Anne Arundel Medical Center has provided high-quality healthcare services to a diverse population for many years, including critical outpatient mental health and substance use services that the community relies on. They are also developing a psychiatric day treatment hospital program to help meet the growing needs of Marylanders. Unfortunately, Anne Arundel County still has a critical shortage of inpatient mental health services and patients are often forced to wait for available beds, causing a delay in care.

An inpatient mental health unit at AAMC would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. This would also improve the quality and access of mental healthcare available throughout the community.

AAMC has clearly demonstrated its ongoing commitment to promoting the health and wellness of our residents. Given their excellent reputation and the county's critical lack of access to these types of inpatient services, I strongly support this project and trust that you will give every appropriate consideration to AAMC's Certificate of Need application.

Sincerely,

John P. Sarbanes
Member of Congress

500 Baltimore Avenue
Suite 303
Towson, MD 21204
(410) 832-8890
Fax: (410) 832-8898

44 Calvert Street
Suite 349
Annapolis, MD 21401
(410) 295-1679
Fax: (410) 295-1682

PRINTED ON RECYCLED PAPER

MICHAEL E. BUSCH
SPEAKER OF THE HOUSE

30th Legislative District
Anne Arundel County

H-101 State House
Annapolis, Maryland 21401-1991
410-841-3800 · 301-858-3800
800-492-7122 *Ext.* 3800

THE MARYLAND HOUSE OF DELEGATES
OFFICE OF THE SPEAKER
ANNAPOLIS, MARYLAND 21401-1991

November 24, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Dear Mr. McDonald:

I am writing to give my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

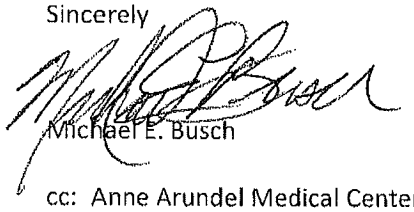
For many years, AAMC has been providing many of the mental health and substance use services that the community relies on, such as substance use treatment and outpatient mental health clinics. There is growing heroin use in Anne Arundel County and another reason why there is an urgent need for an inpatient mental health unit. County health officials have said that on average one resident a week dies of an opiate overdose.

Anne Arundel Medical Center is also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in the community.

I fully support this project and respectfully request the Maryland Health Care Commission approve AAMC's application to provide this much needed service in our community.

Thank you in advance for your consideration.

Sincerely



Michael E. Busch

cc: Anne Arundel Medical Center

JOHN C. ASTLE
30th Legislative District
Anne Arundel County

Vice Chair
Finance Committee

James Senate Office Building
11 Bladen Street, Room 123
Annapolis, Maryland 21401
410-841-3578 · 301-858-3578
800-492-7122 *Ext.* 3578
Fax 410-841-3156

The Senate of Maryland

November 30, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

Anne Arundel Medical Center is my hospital of choice. For many years, AAMC has been providing many of the mental health and substance use services that the community relies on, such as substance use treatment and outpatient mental health clinics. They're also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in my community.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this

project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in my community.

Thank you in advance for your consideration.

Sincerely,

John C. Astle

cc: Anne Arundel Medical Center

EDWARD R. REILLY
33rd Legislative District
Anne Arundel County

Finance Committee

James Senate Office Building
11 Bladen Street, Room 316
Annapolis, Maryland 21401
410-841-3568 · 301-858-3568
800-492-7122 *Ext.* 3568
Fax 410-841-3067 · 301-858-3067
Edward.Reilly@senate.state.md.us

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

November 24, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

I am writing in support of Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish an inpatient mental health unit at their facility.

It is unfortunate but a reality that so many citizens in our region are in need of inpatient mental health care. As an elected official it is my responsibility to make sure the needs of my constituents are met. With the addition of inpatient beds and services for mental health needs, patients in crisis would receive a more efficient and immediate response to their episode. It would create a more seamless experience and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility outside of the community.

AAMC has been providing many of the mental health and substance use services that the community relies on through their substance use treatment and outpatient mental health clinics. The addition of inpatient services, along with a psychiatric day treatment hospital program that they are developing, will be a tremendous addition to their dedicated efforts to help meet the growing mental health needs of our community.

I appreciate your time with my request for support of AAMC's application for an Inpatient Mental Health Unit and look forward of learning of your approval for these most needed inpatient services to a fragile and needy population.

Sincerely,

Edward R. Reilly

Edward R. Reilly

cc: Anne Arundel Medical Center ✓

HERB MCMILLAN
Legislative District 30A
Anne Arundel County

Health and Government
Operations Committee
Subcommittees
Insurance
Public Health and
Minority Health Disparities

The Maryland House of Delegates
6 Bladen Street, Room 164
Annapolis, Maryland 21401
410-841-3211 · 301-858-3211
800-492-7122 *Ext.* 3211
Herb.McMillan@house.state.md.us

The Maryland House of Delegates
ANNAPOLIS, MARYLAND 21401

December 7, 2015

Kevin R. McDonald, Chief
Certificate of Need – Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald,
It is critical that Anne Arundel Medical Center (AAMC) establish an inpatient mental health unit, therefore I strongly urge you to support the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC).

For many years, AAMC has been providing many of the mental health and substance use services that my District relies on, such as substance use treatment and outpatient mental health clinics. They're also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would provide better and more effective support for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability of another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in my district, Anne Arundel County, and Maryland.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in my community. Thank you in advance for your consideration.

Warm Regards,

Herb McMillan

Cc: Anne Arundel Medical Center

PAMELA G. BEIDLE
CHAIR

THEODORE J. SOPHOCLEUS
VICE CHAIR

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401
ANNE ARUNDEL COUNTY HOUSE DELEGATION

December 30, 2015

Dr. Craig Tanio, MD
Chair, Maryland Healthcare Commission
4160 Patterson Ave
Baltimore, MD 21215

Dear Chairman Tanio;

For years, Anne Arundel Medical Center has been providing many mental health and substance use services that our community needs. Pathways, AAMC's center for the treatment of substance use and co-occuring mental health disorders, has been faithfully serving our community for 23 years. Last year, AAMC opened an outpatient mental health clinic providing a full range of services including counseling, therapy and medication compliance consultations. Soon after opening, the clinic grew and providers now see 50 to 60 patients each day. Most recently this clinic added a child and adolescent psychiatrist, serving patients as young as 3 years old.

The need for psychiatric services is great, and current services are not sufficient. In as much as AAMC works to provide appropriate community-based outpatient services, nearly half of the patients who need inpatient mental health care must wait up to five days in our emergency room for space to open up in the other hospitals. In 2014, the hospital transferred more than 1,000 people who needed this higher level of inpatient mental health care. This can't continue.

AAMC is seeking to add an inpatient mental health unit to help close the gap in mental health and substance use treatment in Anne Arundel County. The Capital newspaper called this plan "welcome news" for the community and we hope that you feel the same way. It is for these reasons that the Anne Arundel County Delegation support the AAMC Certificate of Need Application to add an inpatient mental health unit in our County.

Mental health and substance use continues to be a top health concern for Anne Arundel County, as found in our Community Health Needs Assessment. As the third busiest hospital in the state, and a dedicated partner in the community, AAMC feels it is their duty to improve access to these services. Our Delegation to the Maryland General Assembly overwhelmingly supports their efforts. We urge the Maryland Health Care Commission to approve the Anne Arundel Medical Center application.

Sincerely,

Theodore J. Sophocleus

Delegate Theodore J. Sophocleus, Chair

The Maryland House of Delegates · 6 Bladen Street, Room 166 · Annapolis, Maryland 21401
410-841-3402 · 800-492-7122 *Ext.* 3402 · *Fax* 410-841-3235

STEVEN R. SCHUH
County Executive

ANNE ARUNDEL COUNTY
MARYLAND

P.O. Box 2700 | Annapolis, Maryland 21404
(410) 222-1821 | countyexecutive@aacounty.org | www.aacounty.org

December 11, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

For many years, AAMC has been providing many of the mental health and substance abuse services on which our community relies, including treatment clinics and outpatient mental health clinics. AAMC is also developing a psychiatric day treatment hospital program to help meet the growing needs of our citizens. An inpatient mental health unit would create a more seamless experience for those needing this level of care and would alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. An inpatient mental health unit would improve the quality of and access to mental healthcare available in our community.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I support fully this project and hope that MHCC will see the value and benefit of AAMC's application to provide this much needed service.

I would also like to take this opportunity to reiterate my belief that all CON requirements in Maryland should be scrapped. This antiquated law stifles competition, inflates prices and inconveniences patients. Furthermore, research has shown definitively that CON laws do not save money. It is for all these reasons that most jurisdictions around the Country have eliminated CON requirements.

Thank you in advance for your consideration.

Sincerely,

Steven R. Schuh

cc: Anne Arundel Medical Center

ANNE ARUNDEL COUNTY
MARYLAND

Department of Health
J. Howard Beard Health Services Building
3 Harry S. Truman Parkway
Annapolis, Maryland 21401
Phone: 410-222-7375 Fax: 410-222-4436
Maryland Relay (TTY): 1-800-735-2258
www.aahealth.org

Jinlene Chan, M.D., M.P.H.
Health Officer

December 16, 2015

Mr. Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

RE: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for An Inpatient Mental Health Unit

Dear Mr. McDonald:

As the Health Officer for Anne Arundel County, Maryland, I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region. There are currently only 14 beds available in the county at University of Maryland-Baltimore Washington Medical Center for our population of over 550,000 people. It is almost always at capacity and is not able to fully meet the growing demand for this level of care in our county.

AAMC has been providing many of the mental health and substance use services that the community relies on, such as substance use treatment and outpatient mental health clinics. They are also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility.

The Anne Arundel County Department of Health (AACDOH) partners with AAMC and other Anne Arundel County organizations on the Healthy Anne Arundel Coalition. In 2012 a Community Health Needs Assessment was conducted and some key health issues were identified, including the management of mental health and substance abuse as co-occurring disorders. AAMC's work in the areas of mental health and substance abuse are vital to the work of the coalition in developing actionable strategies to address this critical health issue.

The AACDOH strongly supports AAMC's Certificate of Need Application for an Inpatient Mental Health Unit, which will provide much needed services for Anne Arundel County residents.

Sincerely,

Jinlene Chan, M.D., M.P.H.
Health Officer

Cc: Victoria Bayless

Anne Arundel County Mental Health Agency, Inc

PO Box 6675, MS 3230
1 Truman Parkway, Suite 101
Annapolis, MD 21401
Adrienne Mickler, CPA, MS, Executive Director
Frank Sullivan, LCSW-C, Executive Director, Emeritus

Sponsor of Anne Arundel County's information website: www.networkofcare.org

Web Site: www.aamentalhealth.org
Email: mhaaac@aol.com
Phone: 410-222-7858
Fax: 410-222-7881

January 7, 2016

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

Anne Arundel Medical Center is one of our two community hospitals serving almost 560,000 residents. For many years, AAMC has been providing many of the mental health and substance use services that the community relies on, such as substance use treatment and outpatient mental health clinics. They're also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in Anne Arundel County.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service to our residents.

Thank you in advance for your consideration.

Sincerely,

Adrienne Mickler
Executive Director

cc: Anne Arundel Medical Center

Board of Directors
Lynn Krause; Chairman; Janet Owens, Board Emeritus; Timothy Altomare; Pam Brown; Jinlene Chan; Rodney Davis; Ron Elfenbein; Michael Irwin; Phillip Livingstone; Michael Maher; Phyllis Marshall; Rosalie Mallonee; Sheryl Menendez; Kathy Miller, Yevola Peters, Livia Pazourek; Sheryl Sparer

COUNTY COUNCIL OF ANNE ARUNDEL COUNTY, MARYLAND

Legislative Session 2015, Legislative Day No. 40

Resolution No. 59-15

Introduced by Mr. Trumbauer, Mr. Smith, and Mr. Pruski

By the County Council, December 21, 2015

RESOLUTION supporting Anne Arundel Medical Center's request for a Certificate of Need from the Maryland Health Care Commission for an inpatient mental health unit.

WHEREAS, Anne Arundel Medical Center (AAMC) has submitted a request to the Maryland Health Care Commission for a Certificate of Need to establish an inpatient mental health unit; and

WHEREAS, in FY15, AAMC, one of Maryland's busiest hospitals, transferred more than 1,000 patients from its emergency room for inpatient psychiatric treatment to other facilities causing a disruption of care and adding stress on patients and families; and

WHEREAS, in Anne Arundel County, the number of residents receiving mental health services has increased by almost 145% since 2002; and

WHEREAS, Anne Arundel County has witnessed a nearly three-fold increase in the number of heroin-related deaths between 2010 and 2014, with co-occurring disorders often going untreated due to lack of appropriate care; and

WHEREAS, the County's most recent Healthy Anne Arundel Coalition's Community Health Needs Assessment recognizes a rise in mental health issues, higher stress levels among families and children, and a lack of services and service providers; and

WHEREAS, a mental health unit will complement AAMC's existing behavioral health services and provide a critical anchor for AAMC's and the County's network of outpatient services for mental health; and

WHEREAS, the Anne Arundel County Council is concerned for the physical and mental well-being of County citizens; now, therefore, be it

Resolved by the County Council of Anne Arundel County, Maryland, that the Anne Arundel County Council supports AAMC's request for a Certificate of Need for an inpatient mental health unit and urges the Maryland Health Care Commission to provide swift approval to this request; and be it further

Resolved, That a copy of this Resolution be sent to Steven R. Schuh, County Executive, Victoria W. Bayliss, President & CEO, Anne Arundel Medical Center, and Kevin R. McDonald, Chief, Certificate of Need, Maryland Health Care Commission.

READ AND PASSED this 21st day of December, 2015

By Order:

Elizabeth E. Jones
Administrative Officer

I HEREBY CERTIFY THAT RESOLUTION NO. 59-15 IS TRUE AND CORRECT AND DULY ADOPTED BY THE COUNTY COUNCIL OF ANNE ARUNDEL COUNTY.

Derek J. Fink
Chairman

Queen Anne's County

County Commissioners:
James J. Moran, At Large
Jack N. Wilson, Jr., District 1
Stephen Wilson, District 2
Robert Charles Buckey, District 3
Mark A. Anderson, District 4

THE COUNTY COMMISSIONERS OF QUEEN ANNE'S COUNTY
The Liberty Building
107 North Liberty Street
Centreville, MD 21617

Telephone: (410) 758-4098
Fax: (410) 758-1170
e-mail: QACCommissioners&Administrator@qac.org

County Administrator: Gregg A. Todd
Executive Assistant to County Commissioners: Margie A. Houck
County Attorney: Patrick Thompson, Esquire

December 1, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

We are writing to offer our strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

Anne Arundel Medical Center is our hospital of choice. For many years, AAMC has been providing many of the mental health and substance use services that the community relies on, such as substance use treatment and outpatient mental health clinics. They're also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in our community.

We understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. We fully

support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in my community.

Thank you in advance for your consideration.

Sincerely

THE COUNTY COMMISSIONERS OF
QUEEN ANNE'S COUNTY

James J. Moran, President

Jack N. Wilson, Jr.

Stephen Wilson

Robert Charles Buckey

Mark A. Anderson

cc: Anne Arundel Medical Center

Michael Pantelides, Mayor
160 Duke of Gloucester Street
Annapolis, MD 21401-2517

Chartered 1708

November 23, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

For many years, AAMC has been providing many of the mental health and substance use services that the community relies on and inpatient mental health unit would create a more seamless experience for those needing this level of care while alleviating the burden of being transferred or waiting for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in our community.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in my community.

Thank you in advance for your consideration.

Sincerely,

Michael Pantelides

Michael Pantelides
Mayor

Anne Arundel County Partnership
for Children, Youth & Families

ANNE ARUNDEL COUNTY
MARYLAND
County Executive John R. Leopold

November 23, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

On behalf of the Anne Arundel County Partnership for Children, Youth and Families, I am offering my support for Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish an inpatient mental health unit. I am aware of AAMC's longstanding commitment to providing critically-needed mental health and substance use treatment services to our community. Establishing an inpatient mental health unit to complement these existing quality services will help meet a growing need.

As you know, AAMC is one of the busiest hospitals in Maryland. In 2014, more than 1,000 people who came to AAMC's emergency room needing inpatient mental health care were transferred to other Maryland facilities. Because of the overwhelming shortage of this type of care, patients often are forced to wait for space to become available, causing delays in care.

According to the community health needs assessments conducted in 2012 and 2015, there are not enough inpatient mental health services available in Anne Arundel County—a critical piece for coordinated care. The rates for suicide and binge drinking are higher in Anne Arundel County as compared to state and national averages. AAMC is working to address this by increasing access to integrated mental health and substance use treatment for county residents. An inpatient mental health unit is one important piece of this.

Anne Arundel Co. Partnership for Children, Youth & Families
Pamela M. Brown, Ph.D., Executive Director
1 Harry S. Truman Parkway, Suite 103 ♦ Annapolis, MD 21401 ♦ Ph: 410-222-7423 ♦ Fax: 410-222-7674
www.aacounty.org/Partnership/index.cfm

Anne Arundel County Partnership
for Children, Youth & Families

ANNE ARUNDEL COUNTY
MARYLAND
County Executive John R. Leopold

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration of this very important matter.

Sincerely,

P M Brown

Pamela M. Brown Ph.D.
Executive Director
Anne Arundel County Partnership for Children, Youth and Families (Local Management Board)

Cc Anne Arundel Medical Center

Anne Arundel Co. Partnership for Children, Youth & Families
Pamela M. Brown, Ph.D., Executive Director
1 Harry S. Truman Parkway, Suite 103 ♦ Annapolis, MD 21401 ♦ Ph: 410-222-7423 ♦ Fax: 410-222-7674
www.aacounty.org/Partnership/index.cfm

Community Organizations

December 18, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave.
Baltimore, MD 21215

Subject: Letter of Support for Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

I am writing to offer MADC's strong support for the Certificate of Need application submitted by Anne Arundel Medical Center to establish an inpatient mental health unit. MADC is a state-wide nonprofit association of behavioral health professionals that advocates for quality addiction services to promote healthy individuals, strong families and thriving communities. MADC initiates, facilitates and supports advocacy, outreach, research, publication and educational activities that improve access to quality substance use disorder (SUD) services. It has a membership of public, private, nonprofit and for-profit programs.

Anne Arundel County residents experiencing mental health and substance use as co-occurring disorders confront a local health delivery system that is fragmented and disconnected, according to Healthy Anne Arundel Coalition's Community Health Needs Assessment. Emergency room patients needing inpatient mental health care currently confront significant delays in waiting for available beds or must be transferred to other Maryland facilities. Establishing an inpatient mental health unit at AAMC will fill a significant gap in the continuum of mental health care in Anne Arundel County.

AAMC has earned a reputation for providing high-quality healthcare, including mental health and substance use services through its Pathways treatment facility and programs. In 2014 Pathways earned Platinum award designation from Optum *(formerly United Behavioral Health)* for delivering highly effective, cost-effective inpatient substance abuse treatment. AAMC seeks to further its vision to provide coordinated, evidence-based care plans that put mental health and substance use patients on the path to healing and recovery and an inpatient mental health unit would fill a critical missing piece to the continuum of care at AAMC.

An inpatient mental health unit, which is expected to receive philanthropic support, will ensure that adults and teens facing crises in mental health and substance use in Anne Arundel County have full access to appropriate levels of care, which ultimately will reduce lengths of stay and the total cost of care.

We are pleased to offer our support to Anne Arundel Medical Center and look forward to the continued important contribution they make to our community.

Sincerely,

Tracey Myers-Preston
Executive Director, MADC

1206 Brook Meadow Drive ▪ Towson, MD 21286 ▪ 443.834.5866

MARYLAND ADVOCACY & POLICY CENTER

Friday, November 27, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

Living in Anne Arundel County since 1998, I have grown confident in knowing Anne Arundel Medical Center is there to serve the health care needs of my family and our community. Community service is my life work and that of my family. My wife and our daughter teach in Anne Arundel County public schools, our oldest son works in the arts community, and our youngest son serves our nation in the United States Navy. All three of our children are graduates of Broadneck High School and, throughout the years, AAMC has been an intricate part of our lives providing the highest quality in health care.

My confidence in AAMC motivates me to offer support for their request for a Certificate of Need application to establish an inpatient mental health unit. As a former pastor for almost 16 years in Annapolis, a member of the CareFirst Board, and active in community service, I am keenly aware of AAMC's longstanding commitment to offer mental health and substance abuse treatment services. On countless occasions I have dealt directly with individuals and families affected by serious mental health issues. Awareness of the quality mental health care AAMC offers made it easy for me to refer these individuals and families to use their services. Establishing an inpatient mental health unit to complement these existing services will help meet the ever growing need.

In 2014, as one of the busiest hospitals in Maryland, more than 1,000 people admitted to AAMC's emergency room needing inpatient mental health care were transferred to other facilities. Anyone dealing with families experiencing mental health or substance abuse crisis is aware of the overwhelming shortage for this type of care. Patients often are forced to wait for space to become available, causing delays in care with greater costs to the families and community.

Responding to the community health needs assessment conducted in 2012, the vision for AAMC's mental health and substance use program includes coordinated, individualized, evidence-based care plans that put patients on the path to healing and recovery. There are not enough inpatient mental health services available in Anne Arundel County. This is a critical and essential piece for coordinated care to the individuals and families in crisis.

According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for mental health and substance abuse is fragmented and disconnected in our County. Additionally, suicide and binge drinking rates are higher in Anne Arundel County as compared to state and national averages. AAMC works to address this by increasing access to integrated mental health and substance abuse treatment for county residents. An inpatient mental health unit will help meet our growing need.

The reputation of AAMC is stellar and they are prepared to meet the challenges before us. I respectfully urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care.

Thank you for your kind consideration to this request.

Sincerely,

Henry Green, Director
cc: Anne Arundel Medical Center

191 Main Street, Third Floor, Annapolis, Maryland 21401
henry@marylandapc.org – (443) 534-3414

Care. Connect. Contribute.
community foundation
of anne arundel county

December 14, 2015

Kevin McDonald, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Ave.
Baltimore, MD 21215-2299

Subject: **Letter of Support for Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

On behalf of the Community Foundation of Anne Arundel County, I am writing to offer my strong support for the Certificate of Need Application submitted by the Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. Mental illness and addiction impacts every public and private system across all populations – individual, family, medical, education, employment, and criminal justice to name a few. There is an urgent need for increased inpatient mental health and substance use services in Anne Arundel County.

According to 2015 data from the Anne Arundel County Mental Health Agency, there was an 11 percent increase in the number of residents seeking mental health services in 2014 – almost double the increase from 2012 to 2013. The 2014 increase is 145 percent greater than the comparable number in 2002. There is also a critical need for co-occurring mental health and substance abuse integrated treatment. AAMC is working to address these needs by increasing access to integrated mental health and substance use treatment for county residents.

Given the outstanding reputation of AAMC and Anne Arundel's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely,

Melissa H. Curtin

Melissa H. Curtin
Executive Director

cc: Anne Arundel Medical Center

914 Bay Ridge Road Suite 220 Annapolis, MD 21403
410.280.1102 www.cfaac.org

Kari Alperovitz-Bichell, MD, MPH
Community Health Center at the Morris Blum Apartments
701 Glenwood Street
Annapolis, Maryland 21401

Date 11/23/15

Kevin R. McDonald, Chief
Certificate of Need, Maryland Health Care Commission
4160 Patterson Ave, Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

I am writing to express my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. Our area has a great need for this unit!

I am a primary care physician working in a community health center in Annapolis. I have many patients who have significant psychiatric disease, and many do require inpatient psychiatric services. Anne Arundel Medical Center is the hospital these patients rely upon. When they have psychiatric decompensations, they go to AAMC's ER, where staff competently evaluate them. However, they then wait in the ER, sometimes for days, for an available psychiatric inpatient bed somewhere in Maryland. Finally, they get transferred to an inpatient unit, often many miles from home. When they are discharged form that unit, the plan for follow-up services is often sub-optimal or ineffective, since staff at the distant facility are not integrated with Annapolis area outpatient resources. This situation is very far from ideal for psychiatrically frail patients.

For years, AAMC has been providing many of the mental health and substance abuse services that our community requires (e.g. substance use treatment and outpatient mental health clinics). My understanding is that they are also developing a much-needed psychiatric day treatment hospital program. An inpatient mental health unit would create a much better access to needed inpatient services, and more seamless follow up plan. I believe that it would improve the quality of my patients' the mental health care and access significantly.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. For the above reasons, I fully support this project, and hope the MHCC will approve it.

Thank you for your consideration of this issue.

Sincerely,

MD

Kari Alperovitz-Bichell, MD, MPH

SEVERNA PARK
COMMUNITY CENTER

living in motion

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

December 17, 2015

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

Anne Arundel Medical Center is my hospital of choice. For many years, AAMC has been providing many of the mental health and substance use services that the community relies on, such as substance use treatment and outpatient mental health clinics. They're also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in my community.

At the Severna Park Community Center, we provide a "healthy, vibrant, connected, community gathering place whose purpose is to provide positive recreation. learning and to be proactive in good mental health activities. But some individuals need more than we can offer.

Thus, we support AAMC's effort to establish an inpatient mental health unit to help individuals to recover from the debilitating effects of mental illness.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in my community.

Thank you in advance for your consideration.

Sincerely

Newth Morris
Executive Director
Severna Park Community Center

cc: Anne Arundel Medical Center

ARUNDEL LODGE behavioral health
hope re-imagined

December 14, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

As the Executive Director of Arundel Lodge, I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

Arundel Lodge is a CARF- accredited and community-based community behavioral health center providing a comprehensive continuum of treatment and support services for individuals diagnosed with mental health and substance use disorders. Arundel Lodge operates a Residential Rehabilitation Program (RRP) that services 110 individuals in 32 homes; a Psychiatric Rehabilitation Program that includes a Day Program with an average daily attendance of over 100, home-based Supportive Living services for persons living in their own housing, Peer Support Specialists who call upon their lived experience to assist our consumers with their Wellness and Recovery Planning, an Evidence-based Supported Employment Program, and a Health Home. These services are in addition to our Mental Health and Substance Use Disorders Outpatient Clinics for children, adolescents and adults that are treating 3000 persons per year and offer same day access.

Arundel Lodge has established important partnerships with the AAMC inpatient units and the AAMC Community Health Center through our Health Home. Arundel Lodge and AAMC work closely together to achieve patient satisfaction, improve health outcomes, reduce healthcare costs, and prevent unnecessary hospitalizations. This seamless partnership includes the AAMC Community Health Center

2600 Solomons Island Rd • Edgewater, MD 21037
main 443.433.5900 • fax 410.841.6045 • video ph 443.569.7132
www.ArundelLodge.org

as a consultant to our Health Home and AAMC Community Health Center providing primary care in our facility for the individuals we serve through our PRP.

Arundel Lodge will partner with AAMC by leveraging our same day access, health home, case management, treatment and outreach services to develop programs that will engage those who are not receiving outpatient treatment and support services. We believe that the initiatives that we develop with AAMC will prevent unnecessary hospitalizations and help ensure that these proposed inpatient resources provide high quality treatment for individuals who need this level of care.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in our community.

Thank you in advance for your consideration.

Sincerely,

Michael J. Drummond, LCSW-C
Executive Director

cc: Anne Arundel Medical Center

2600 Solomons Island Rd • Edgewater, MD 21037
main 443.433.5900 • fax 410.841.6045 • video ph 443.569.7132
www.ArundelLodge.org

623 Lakeland Road South Severna Park 21146

Date 12/01/15

Kevin R. McDonald, Chief

Certificate of Need

Maryland Health Care Commission

4160 Patterson Ave

Baltimore, MD 21215-2299

Subject: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

As a volunteer/AAMC Auxillian), I appreciate the opportunity to offer my support for Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish an inpatient mental health unit. I am aware of AAMC's longstanding commitment to providing critically-needed mental health and substance use treatment services to our community. Establishing an inpatient mental health unit to complement these existing quality services will help meet a growing need.

As you know, AAMC is one of the busiest hospitals in Maryland. In 2014, more than 1,000 people who came to AAMC's emergency room needing inpatient mental health care were transferred to other Maryland facilities. Because of the overwhelming shortage of this type of care, patients often are forced to wait for space to become available, causing delays in care.

In response to the community health needs assessment conducted in 2012, the vision for AAMC's mental health and substance use program includes

coordinated, individualized, evidence-based care plans that put patients on the path to healing and recovery. There are not enough inpatient mental health services available in Anne Arundel County—a critical piece for coordinated care.

According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for co-occurring disorders (mental health and substance use) has been fragmented and disconnected. In fact, it is the top disparity in Anne Arundel County. The rates for suicide and binge drinking are higher in Anne Arundel County as compared to state and national averages. AAMC is working to address this by increasing access to integrated mental health and substance use treatment for county residents. An inpatient mental health unit is one important piece of this.

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely,

Rodney J. Hobbs

Rodney J. Hobbs

cc: Anne Arundel Medical Center

NAMI AAC
National Alliance on Mental Illness | Anne Arundel County
P.O. Box 309 • Arnold, MD 21012
www.namiaac.org
443-569-3498

January 28, 2016

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

As a resident of Anne Arundel County, as a longtime caregiver for my son with mental illness, as a very concerned county citizen, and as the Executive Director of the National Alliance on Mental Illness for the Anne Arundel County, MD affiliate, I appreciate the opportunity to offer my support for Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish an inpatient mental health unit. I am aware of AAMC's longstanding commitment to providing critically-needed mental health and substance use treatment services to our community. Establishing an inpatient mental health unit to complement these existing quality services will certainly help meet a growing need.

As a resident caregiver for my own son who has the need to be hospitalized at various times and as the Executive Director of NAMI Anne Arundel County, I see up close how our county does not have enough psychiatric beds for our population and urgent needs for this devastating illness. Time and time again suffering people have to be transferred over 50 miles away for a psychiatric acute center bed. Families, caregivers, and those with mental illness call us at our helpline over and over crying out for help to find acute psychiatric beds. The people with the mental illness in our county sit in a hospital emergency room for days and hours until a bed can be found many miles away. Their families and caregivers do not understand what to do and how to get them the acute care and bed they need quickly. People and families are stung with the already existing stigma and then they find out there are not enough beds in Anne Arundel County when their loved ones need immediate acute psychiatric care. We in NAMI AACO have been urging for more beds to be established at AAMC for years and now we urge you to make the decision to move ahead and to approve the AAMC Certificate of Need application to make an inpatient mental health unit happen.

As for further evidence of this need, AAMC is one of the busiest hospitals in Maryland. In 2014, more than 1,000 people who came to AAMC's emergency room needing inpatient mental health care were transferred to other Maryland facilities. Because of the overwhelming shortage of this type of care, patients often are forced to wait for space to become available, causing delays in care. Then they have to be transferred to other county mental health inpatient facilities several miles away making it more difficult for families.

In response to the community health needs assessment conducted in 2012, the vision for AAMC's mental health and substance use program includes coordinated, individualized, evidence-based care plans that put patients on the path to healing and recovery. There are not enough inpatient mental health services available in Anne Arundel County—a critical piece for coordinated care.

According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for co-occurring disorders (mental health and substance use) has been fragmented and disconnected. In fact, it is the top disparity in Anne Arundel County. We at NAMI AAC see it all the time. The rates for suicide and binge drinking are higher in Anne Arundel County as compared to state and national averages. AAMC is working hard to address this by increasing access to integrated mental health and substance use treatment for county residents. An inpatient mental health unit is one important piece of this. We at NAMI AAC support them 100% and are there to help in every way.

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely,

Fred Delp

Fred Delp, Executive Director
NAMI Anne Arundel County, a 501c(3) corporation
info@namiaac.org

United Way
of Central Maryland

100 South Charles Street
5th Floor, P.O. Box 1576
Baltimore, MD 21203-1576
tel 410.547.8000
fax 410.547.5640
www.uwcm.org

January 27, 2016

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

On behalf of the United Way of Central Maryland (UWCM), I welcome the opportunity to offer my support for Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish an inpatient mental health unit. UWCM is focused on the health and wellness of all of our partner communities and recognizes that mental heath and substance use care is a critical factor to overall health. The increasing need in Anne Arundel County for mental services supports establishing inpatient mental health units to complement the existing quality services and will help meet a documented growing need.

UWCM is embarking on a strategic plan which includes the analysis of needs in our region. Our research indicates that mental and behavioral health needs are growing in every jurisdiction, including Anne Arundel County. Mental health related calls from Anne Arundel County to the 2-1-1 Maryland call center increased 14% from 2013 to 2015. The community health needs assessment conducted in 2012, clearly documented the deficit of inpatient mental health services available in Anne Arundel County—a critical piece for coordinated care.

According to the recently released *"Poverty Amidst Plenty V: Striving to Achieve Progress for All, 5th edition 2015"* by the Community Foundation of Anne Arundel County, there was an "11% recorded increase in the number of residents seeking mental health services in 2014 – almost double the increase from 2012 to 2013."

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely,

Mark S. Furst
President & CEO

Sandy Monck
Chief Impact Officer

cc: Anne Arundel Medical Center

From: **Kathy Miller** kathymillerma@aol.com
Subject: Letter of Support for Inpatient Mental Health Unit
Date: December 27, 2015 at 6:32 PM
To: gfusco@aahs.org
Cc: Kathy Miller kathymillerma@aol.com

Oasis The Center For Mental Health
175 Admiral Cochrane Drive
Annapolis, MD 21401

Kathy Miller, MA LCPC
President, Oasis

12/18/15

Kevin R McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for
An Inpatient Mental Health Unit

Dear Mr. McDonald:

I am the owner of an urgent care mental health clinic in Annapolis. I have worked very closely with AAMC emergency department and with Pathways for the past 11 years. Oasis has provided care to patients referred from Pathways and the emergency department of the hospital.

Oasis has also referred patients to Pathways and to the ED as well. It has been an excellent partnership. As one of the participants on the CON committee and as a provider of behavioral healthcare, it gives me a particular vantage point to support AAMC in their drive to add an inpatient psychiatric unit to our regional hospital.

We have been in the difficult position of having to refer Anne Arundel County patients to other counties since we have had so few beds in our county. It has been a drawback to our otherwise excellent care delivery system between AAMC and community providers of mental health in our county.

AAMC has been providing many of the mental health and substance use services that the community has come to depend upon in our county. AAMC is also developing a psychiatric day treatment program planned to open February 2016. An inpatient mental health unit would create a more seamless experience for those patients needing this additional level of care. It would improve the quality and access of mental healthcare in our community.

I fully support the project adding inpatient mental health beds at AAMC and hope the MHCC will see the value and benefit, therefore approving our application for the beds.

Thanks in advance for your consideration.

Sincerely,

Kathy Miller, MA LCPC

Sent from my iPad

First Presbyterian Church
ANNAPOLIS MD

December 2, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

Anne Arundel Medical Center is the closest hospital to our congregation and most frequently used by our members. After watching our membership flounder to find quality mental health care, I strongly recommend an inpatient mental health unit at AAMC. It would alleviate the traumatic burden of being transferred to another facility and the experience of detrimental delays in treatment as people wait for a bed to open up at other facilities. An inpatient mental health unit would improve the quality and access of mental healthcare available to our community.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in my community.

Thank you in advance for your consideration.

Sincerely,

Heather Shortlidge

Rev. Dr. Heather G. Shortlidge

cc: Anne Arundel Medical Center

William L. Hathaway, Pastor
Heather G. Shortlidge, Associate Pastor
171 Duke of Gloucester Street, Annapolis, MD 21401
office@annapolis-presbyterian.com
www.annapolis-presbyterian.com
410.267.8705
Fax: 410.268.9643

Saint Stephen's Episcopal Church
SEVERN PARISH

1110 ST. STEPHEN'S CHURCH ROAD
CROWNSVILLE, MD 21032
PHONE: (410) 721-2881
FAX: (410) 721-0043

November 23, 2015

Kevin R. McDonald, Chief
Certificate of Need Division of the MD Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of support for Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit.

Dear Mr. McDonald,

As a resident of Anne Arundel County and a clergyman serving for almost 12 years in the county, I appreciate the opportunity to offer my support for Anne Arundel Medical Center's Certificate of Need application to establish an inpatient mental health unit.

Having previously served as Vice-President of the Board of Directors of East Bay Mental Health in Rhode Island, I have been deeply aware of the ongoing need to establish good community mental health services in the wake of the closing of many large state institutions several years ago.

I often encounter mental health needs in my work and believe that an inpatient mental health unit at AAMC would serve an important growing need in our community.

I have also worked for the Good News Prison Ministries Program at the Jennifer Road Detention Center in Annapolis for the past 10 years. My focus has been the A 3 unit where mental health and substance abuse needs are prominent. I believe improved community services will help decrease the need for mental health matters to be dealt with in our overly stressed criminal justice system.

Many members of my church and family have been well served in a variety of medical needs by AAMC and I believe it would be very good for our community for an inpatient mental health unit to be established there.

Sincerely,

The Rev. Steven Hagerman
Rector, St. Stephen's Episcopal Church

SEVERNA PARK
United Methodist Church

Rev. Ron Foster
Pastor
rfoster@severnaparkumc.org

Rev. Nicole C. Houston
Executive Pastor
nchristopher@severnaparkumc.org

Rev. Byron Brought
Minister of Pastoral Care
bbrought@severnaparkumc.org

Rev. Lee S. Ferrell
Minister of
Education and Youth
lferrell@severnaparkumc.org

Erica Benjamin
Director of
Children's Ministries
ebenjamin@severnaparkumc.org

Jon Brewer
Director of Music &
Worship Arts
jbrewer@severnaparkumc.org

Beth Frank
Office Manager/
Ministry Coordinator
bfrank@severnaparkumc.org

Ryan Hennesy
Director of Communications
rhennesy@severnaparkumc.org

David McKinney
Facilities Manager
dmckinney@severnaparkumc.org

Nicola Patterson
Organist
npatterson@severnaparkumc.org

731 Benfield Road
Severna Park, MD 21146
(410) 987-4700 Phone
(410) 987-6040 Fax
www.severnaparkumc.org

November 23, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21225-2299

Dear Mr. McDonald:

I write in strong support of an inpatient mental health unit at Anne Arundel Medical Center.

As a clergyperson serving in Anne Arundel County I frequently come in contact with persons in need of mental care and also care for substance abuse. Currently there is a need for additional inpatient care in this area, and I believe that an inpatient care unit at Anne Arundel Medical Center could be extremely helpful in meeting this need.

Thank you for your consideration of this letter of support.

Sincerely,

Byron P. Brought

Heritage Baptist Church

November 22, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

This letter is to state our strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

Anne Arundel Medical Center is my hospital of choice. For many years, AAMC has been providing many of the mental health and substance use services that the community relies on, such as substance use treatment and outpatient mental health clinics. They're also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in my community.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. Ours is a congregation of people seeking to live out Jesus' call to care for those in need. As Interim Pastor of Heritage Baptist Church I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in my community.

Thank you in advance for your consideration.

Shalom,

Rev. Stephen G. Price, M.A., M.S.

cc: Anne Arundel Medical Center

1740 Forest Drive * Annapolis, MD 21401 * 410-263-6680 * 410-263-0996-Fax
www.heritagebaptistonline.com

124 Park Avenue
Edgewater, MD 21037
26 November 2015

Mr. Kevin McDonald, Chief
Certificate of Need
MD Healthcare Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Letter of Support: Anne Arundel Medical Center's Application for Certificate of Need
Inpatient Mental Health Unit

Dear Mr. McDonald:

As a volunteer member of the Anne Arundel Medical Center's Mental Health and Substance Abuse Council plus a family member of one who is dual diagnosed, I offer unqualified support and urgently request approval for Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish an inpatient mental health unit. I

I am a member of a local women's philanthropy circle, Anne Arundel Women Giving Together, www.givingtoether.org. We have studied the issue of mental health and substance use treatment services and had several programs to educate ourselves over the past two year. To our horror, we've learned about the existing gap of services in our community. Some members have been affected directly by this gap. While Anne Arundel Medical Center has expanded its valued services, establishing an inpatient mental health unit to complement these existing quality services will help meet a rapidly growing need.

As you know, AAMC is one of the busiest hospitals in Maryland. In 2014, more than 1,000 people who came to AAMC's emergency room needing inpatient mental health care were transferred to other Maryland facilities. Because of the overwhelming shortage of this type of care, patients often are forced to wait for space to become available, causing delays in care.

In response to the community health needs assessment conducted in 2012, the vision for AAMC's mental health and substance use program includes coordinated, individualized, evidence-based care plans that put patients on the path to healing and recovery. There are not enough inpatient mental health services available in the Greater Baltimore area including Anne Arundel County. This remains a critical piece for coordinated care.

According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for co-occurring disorders (mental health and substance use) has been fragmented and disconnected. In fact, it is the top disparity in Anne Arundel County. The rates for suicide and binge drinking are higher in Anne Arundel County as compared to state and national averages. AAMC is working to address this by increasing access to integrated mental health and substance use treatment for county residents. An inpatient mental health unit is one important piece.

Please give careful and swift consideration to the request by Anne Arundel Medical Center.

Very truly yours,

Tara Balfe Clifford

cc: Gina Fusco, AAMC

O'Neill
621 Harbor Dr
Annapolis, MD 21403
Date 11/23/2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

As a pastoral care visitor, I appreciate the opportunity to offer my support for Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish an inpatient mental health unit. I am aware of AAMC's longstanding commitment to providing critically-needed mental health and substance use treatment services to our community. Establishing an inpatient mental health unit to complement these existing quality services will help meet a growing need.

As you know, AAMC is one of the busiest hospitals in Maryland. In 2014, more than 1,000 people who came to AAMC's emergency room needing inpatient mental health care were transferred to other Maryland facilities. Because of the overwhelming shortage of this type of care, patients often are forced to wait for space to become available, causing delays in care.

In response to the community health needs assessment conducted in 2012, the vision for AAMC's mental health and substance use program includes coordinated, individualized, evidence-based care plans that put patients on the path to healing and recovery. There are not enough inpatient mental health services available in Anne Arundel County—a critical piece for coordinated care.

According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for co-occurring disorders (mental health and substance use) has been fragmented and disconnected. In fact, it is the top disparity in Anne Arundel County. The rates for suicide and binge drinking are higher in Anne Arundel County as compared to state and national averages. AAMC is working to address this by increasing access to integrated mental health and substance use treatment for county residents. An inpatient mental health unit is one important piece of this.

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely,

Blanche O'Neill

Blanche O'Neill
Eucharistic Minister Form St. Mary's Catholic Church in Annapolis

cc: Anne Arundel Medical Center

O'Neill
621 Harbor Dr
Annapolis, MD 21403
Date 11/23/2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

As a pastoral care visitor, I appreciate the opportunity to offer my support for Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish an inpatient mental health unit. I am aware of AAMC's longstanding commitment to providing critically-needed mental health and substance use treatment services to our community. Establishing an inpatient mental health unit to complement these existing quality services will help meet a growing need.

As you know, AAMC is one of the busiest hospitals in Maryland. In 2014, more than 1,000 people who came to AAMC's emergency room needing inpatient mental health care were transferred to other Maryland facilities. Because of the overwhelming shortage of this type of care, patients often are forced to wait for space to become available, causing delays in care.

In response to the community health needs assessment conducted in 2012, the vision for AAMC's mental health and substance use program includes coordinated, individualized, evidence-based care plans that put patients on the path to healing and recovery. There are not enough inpatient mental health services available in Anne Arundel County—a critical piece for coordinated care.

According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for co-occurring disorders (mental health and substance use) has been fragmented and disconnected. In fact, it is the top disparity in Anne Arundel County. The rates for suicide and binge drinking are higher in Anne Arundel County as compared to state and national averages. AAMC is working to address this by increasing access to integrated mental health and substance use treatment for county residents. An inpatient mental health unit is one important piece of this.

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely,

John O'Neill
Eucharistic Minister Form St. Mary's Catholic Church in Annapolis
Spiritual Care Advisory Committee member

cc: Anne Arundel Medical Center

March 24, 2016

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

I am writing on behalf of the Board of Directors for the Annapolis and Anne Arundel County Chamber of Commerce to offer our strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

Anne Arundel Medical Center is the hospital of choice for many businesses and their employees in the Chamber of Commerce service area. For many years, AAMC has been providing many of the mental health and substance use services that the business community relies on, such as substance use treatment and outpatient mental health clinics. They're also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in our community.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. The Annapolis and Anne Arundel County Chamber of Commerce fully supports this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in our community.

Thank you in advance for your consideration.

Sincerely

Bob Burdon
President/CEO

ANNE ARUNDEL COMMUNITY COLLEGE
101 College Parkway | Arnold, Maryland 21012-1895 | 410-777-AACC (2222) | www.aacc.edu

March 23, 2016

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

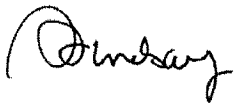
I understand the key role that Anne Arundel Medical Center has in the community and as President of Anne Arundel Community College I am grateful that AAMC also is a critical part of the support network the college uses to train students in health professions.

For many years, AAMC has been providing mental health and substance use services that the community relies on, such as substance use treatment and outpatient mental health clinics. They're also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in this community.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in our community.

Thank you in advance for your consideration.

Sincerely,



Dr. Dawn Lindsay
President

cc: Anne Arundel Medical Center

Community Members

John and Jill DePaola
2511 Coxshire Lane
Davidsonville, MD 21035

December 18, 2015

Kevin R. McDonald, Chief
Maryland Health Care Commission
4160 Patterson Ave.
Baltimore, MD 21215 – 2299

Dear Mr. McDonald,

We are writing in support of the Certificate of Need Application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit in our community. Sadly, my wife and I know firsthand how desperately this is needed in our community.

Our child struggled with bipolar disorder and addiction way before we ever understood what any of this was. We were never sure what was truly going on and had very few answers since mental illness or addiction does not run in our family.

What we do know is that when our son was having a manic episode in November of 2014 there was not a hospital bed in the state of Maryland available for him. We sent him to Father Martin's Ashley's and two dual-diagnosis programs in California over a three week period because there were not beds in Anne Arundel County or the State of Maryland during this time. What else do we know? We know that these places are not equipped with weekend Psychiatrist staff to care for anyone in a manic episode especially where mental illness supersedes the addiction. Our son was released from each center on a Friday because none of them had weekend resources in place. We as a family were left with no medical care for him during his most critical time of need.

What we also know is how important an inpatient mental health unit is in time of crisis. When we brought him home while in the middle of a manic episode, there was no inpatient mental health units in Anne Arundel County. Once home it took four weeks to get an appointment with a Psychiatrist at the AAMC outpatient program. Of course, we could not wait four weeks in a crisis situation for a doctor who accepted insurance so our only course was to seek out a doctor who did not accept insurance to get an earlier appointment and get our son on a medicine regime to manage the manic episode. We also know that most families do not have this luxury and most have to wait for a doctor who accepts insurance. This is contrary to proper healthcare.

When someone is in a manic episode that is an emergency situation. Often, the family is not equipped with the medicines or expertise to understand or handle the patient. We were fortunate to find a Psychiatrist who could take us within the week of our emergency. He was available because he was expensive. He did not accept insurance. An inpatient program could have been a life saver for us and our child at that time. He did well for about 5 months and then just stopped taking his medicine and sought self-medication. Sadly, he passed in our home from an overdose.

We believe if we had gotten him in a proper inpatient program for an extended period of time rather than a weekly Psychiatrist visit, we may have gotten the proper education needed to understand his illness and move him towards a cure. With the proper facilities present in our community we could have gotten familiar with what was going on a lot quicker and found him the right team of doctors and specialists to deal with his mental illness.

After a lot of research we found NAMI. This organization helped our family the best they could with the limited resources they had. At NAMI, we learned that his addictions were a direct result of his mental illness. We also learned that 65% of those with addiction have some form of mental illness.

If a Crisis Navigator was available to help us get a diagnosis early and help us evaluate our options, we believe our son could be here with us today on a path to recovery. There was just too much delay and too much confusion to help him. The navigator would have helped us with a master plan to help him get back to health. We also needed the resources at our local hospital to care for him and treat him.

We are obviously not alone in this serious epidemic.

Thank you for listening and please seriously consider granting this Certificate of Need. Lives are at stake and the opportunity to create a community of resources is right before us. Although there is no guarantee that our situation would have turned out any differently, it would have given us awareness and a fighting chance much earlier in our son's illness. Many of the components currently exist within our county. The opportunity exists to bring these resources together with the goal of a comprehensive approach to mental illness. We will be working to help facilitate these resources in our area. We are committed to doing our part. We ask for your careful consideration as the pattern of AAMC is to do a terrific job with any illness they decide to address. So few are willing to take this on and we are hopeful you will help facilitate the combined efforts of AAMC and the community to attack this serious medical challenge by approving the application before you.

Thank you so much for your consideration.

In support,

John and Jill DePaola

Rock Creek

12/14/2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

As a lifelong advocate for accessible mental health services for the people of Maryland, I recently learned through a friend that Anne Arundel Medical Center (AAMC) is applying for a Certificate of Need (CON) to establish an inpatient mental health unit. With this letter I affirm my strong support for this CON and urge the Maryland Health Care Commission to grant a favorable response to AAMC's application.

In the years since I worked for the citizens of our state from Annapolis, AAMC has become one of our state's busiest hospitals. Its reputation for high quality services and its responsiveness to its community are well known. AAMC has highlighted a need for an inpatient mental health service to connect with and complement the growing network of outpatient services in its area. Apparently, this past year more than 1,000 individuals had to be transferred from AAMC's emergency department for lack of inpatient mental health beds.

Research clearly underlines the need for this type of service. Mental health and substance abuse disorders require a coordinated approach to ensure the most effective diagnosis and treatment. Anne Arundel County ranks higher than the state average in suicide rates and binge drinking. Deaths from heroin overdose are averaging nearly one a week. These statistics are frightening and clearly demand the state's attention. Establishing an inpatient mental health unit to complement AAMC's existing quality services will help to meet this growing need.

Given AAMC's outstanding reputation and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Sincerely,
Kathleen Kennedy Townsend

Kathleen Kennedy Townsend, Managing Director

Cc: Anne Arundel Medical Center

1133 Connecticut Avenue N.W. | Washington, D.C. 20036 | Telephone: (202) 331-3400 | Facsimile: (202) 331-3420

3320 Old Point Road
Edgewater, Maryland 21037
November 29, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for An Inpatient Mental Health Unit**

Dear Mr. McDonald:

As a retired social worker and psychotherapist and board member of Arundel Lodge Behavioral Health Center in Edgewater, Maryland, I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit.

Anne Arundel County has a critical shortage of inpatient mental health services. In 2014, Anne Arundel Medical Center transferred more than 1,000 people who came to the emergency room needing inpatient mental health care to other Maryland facilities. Because of the need for this care, patients often are forced to wait for available beds, causing delays in care. An inpatient mental health unit would improve the quality and access of mental healthcare available where it is needed. The ability to transition among levels of care provided would reduce lengths of stay and the total cost of care.

Given the outstanding reputation of AAMC and Anne Arundel's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration of this matter.

Sincerely,
Beverly Marcus

December 7, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

As an AAMC Volunteer, I appreciate the opportunity to offer my support for Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish an inpatient mental health unit. I am aware of AAMC's longstanding commitment to providing critically-needed mental health and substance use treatment services to our community. Establishing an inpatient mental health unit to complement these existing quality services will help meet a growing need.

As you know, AAMC is one of the busiest hospitals in Maryland. In 2014, more than 1,000 people who came to AAMC's emergency room needing inpatient mental health care were transferred to other Maryland facilities. Because of the overwhelming shortage of this type of care, patients often are forced to wait for space to become available, causing delays in care.

In response to the community health needs assessment conducted in 2012, the vision for AAMC's mental health and substance use program includes coordinated, individualized, evidence-based care plans that put patients on the path to healing and recovery. There are not enough inpatient mental health services available in Anne Arundel County—a critical piece for coordinated care.

According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for co-occurring disorders (mental health and substance use) has been fragmented and disconnected. In fact, it is the top disparity in Anne Arundel County. The rates for suicide and binge drinking are higher in Anne Arundel County as compared to state and national averages. AAMC is working to address this by increasing access to integrated mental health and substance use treatment for county residents. An inpatient mental health unit is one important piece of this.

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely,

Suzanne Rapin
1309 Bristol Ridge Place
Crownsville, MD 21032

Cc: Anne Arundel Medical Center

Cindy & Tim O'Neill
463 Honering Trail
Annapolis, MD 21401

December 16, 2015

Mr. Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave.
Baltimore, MD. 21215-2299

Subject: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

We are writing to offer our strong support for the Certificate of Need Application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This service is critically needed in our region.

We are personally acquainted with several citizens in our community who have had to seek in-patient mental health care services for family members at facilities outside of Maryland due to the lack of available services and capacity in our state. This causes delays in treatment and additional stress and hardship to patients and families during an already difficult time. We are convinced that many of these patients could have been successfully treated at AAMC if inpatient mental health care had been available during their time of need.

Anne Arundel Medical Center has a proven history of providing successful treatment for substance abuse and outpatient mental health needs. They are planning to add a psychiatric day treatment hospital program to meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing delays in treatment while waiting for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in our community.

We understand and appreciate that the Maryland Health Care Commission (MHCC) must give approval to hospitals in Maryland that seek to provide inpatient mental health services. We fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in our community.

Thank you in advance for your consideration.

Sincerely,

Cindy and Tim O'Neill

Cindy and Tim O'Neill

cc: Anne Arundel Medical Center

December 10, 2015

Kevin R. McDonald, Chief

Maryland Health Care Commission

4160 Patterson Ave

Baltimore, MD 21215-2299

Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald

I am writing this letter to offer my strong support for the certificate of need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

My name is Steven T. Brown Jr. I am an employee at Clifton T. Perkins Hospital Center and Anne Arundel Medical Center (AAMC). Since I work in the mental health field, I see the overwhelming shortage and demand for mental health care. Patients are forced to wait for care, because of lack of space. Anne Arundel County not only needs to address co-occurring disorders, but also needs to address psychological disorders such as schizophrenia. The state hospitals stay at full capacity at all times making them unable to accommodate patients whom are in need of treatment, which causes a delay in care. This is why I am expressing my concern and support towards this project.

Sincerely,

Steven T. Brown Jr

Conley
2137 Sandcastle Court
Annapolis, MD 21403

December 7, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

We are writing to offer our strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. We are parents of a young man diagnosed with Schizophrenia and know first hand how very much this program is needed locally.

When our son first became sick were advised by our family doctor (office is on AAMC campus) to forgo AAMC because AAMC did not have psych beds and head straight to North Arundel Hospital, now named Baltimore Washington . Then when we arrived at North Arundel they were so overcrowded with psych patients that our son was placed in a tiny conference area and told to get comfortable on a short couch and that his chances of being admitted to a psych bed that day were extremely slim. We will never be able to erase the terrible image in our minds of our son curled in a fetal position, laying on a tiny couch, asking for us to help him get help. We knew he needed immediate help and realized he was not going to get the help he needed without immediate treatment. Consequently, we chose to forgo local treatment and transferred him to Shepherd Pratt where he was promptly diagnosed and treated.

Anne Arundel Medical Center is our hospital of choice and it is unconscionable to force those suffering a mental health crisis to go to private facilities or out of the area-public facilities that are all too often overcrowded and not available.

An inpatient mental health unit at AAMC is long overdue. People suffering from mental illness need a seamless experience. They cannot afford detrimental delays in treatment as they wait for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in my community.

We urge the Maryland Health Care Commission (MHCC) to approve AAMC's application to provide inpatient mental health services. This is a much needed service in this area of Maryland.

Sincerely,

Jeffrey B. Conley

Joyce P. Conley

1731 Forestville Road
Edgewater, Maryland 21037
December 7, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Re: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

I write to offer my support for the Certificate of Need application being submitted by Anne Arundel Medical Center to establish an inpatient mental health unit.

I have resided in Anne Arundel County since 1969 and have been a patient at Anne Arundel Medical Center from time to time for medical tests, surgeries, delivery of babies, caring for elderly parents, and a terminally ill spouse. I am currently a member of the volunteer auxiliary and a patient advisor. As a result of my experiences with the hospital, I see a genuine need for an inpatient mental health unit because of the growing needs in our County. Having a family member in need of treatment is difficult enough without having to search for treatment availability and traveling outside the immediate area. Family participation in the treatment of these patients will improve success of treatment.

I fully support this project and sincerely hope that MHCC will approve AAMC's application to provide this needed service.

Thank you for your consideration.

Very truly yours,

Yvette C. Garity

Yvette C. Garity

1011 Upton Road
Glen Burnie, Maryland 21060
December 7, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Re: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

I am writing to offer my strong support for the Certificate of Need Application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our area. From 1911 until its closure in 2004, Crownsville Hospital Center was the predominant inpatient psychiatric facility in Anne Arundel County. Upon closing, approximately 200 patients were moved to other facilities in two different counties (Spring Grove Hospital Center in Catonsville, Baltimore County, and Springfield Hospital Center in Sykesville, Carroll County). Having worked as a psychiatric nurse for 22 years, I understand the importance of this vulnerable population being heard; that patient teaching be on-going regarding medications; the importance of refraining from illicit drugs/alcohol use; and that family participation be encouraged in their care. Family participation is problematic for working families having to travel to different counties.

I was employed at Crownsville Hospital Center from 1993 until its closure in 2004. As a result, some of the patients that I cared for at Crownsville and Spring Grove are now being treated at Clifton T. Perkins Hospital Center, the State's only forensic psychiatric facility where I currently work. Many of these patients have had numerous admissions and are considered dual diagnoses, i.e., a history of alcohol/substance abuse as well as mental illness. When these patients stop taking all or some of their psychiatric medications, or start to use alcohol or drugs, the need inpatient treatment becomes necessary because they become symptomatic, unpredictable and a potential danger to themselves and/or others.

An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of transferring them out of the County causing detrimental delays in treatment as they wait for availability at another facility. When the mentally ill are unstable, they require more extensive care than what an outpatient clinic or day program can provide. Statistics have shown that the rate for suicide and binge drinking are higher in Anne Arundel County as compared to State and national averages. When the mentally ill can get expedient care, their lives and the lives of others can be drastically improved. In addition, when the mentally ill have family that are in the area, family members can encourage compliance with care.

Thank you for your consideration in this matter.

Sincerely,

Regina Acton, RN, BSN

Marc T. Wirig
710 Americana Drive, #58
Annapolis, Maryland 21403

December 2, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:
I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.
Anne Arundel Medical Center is my hospital of choice. I am also a member of the AAMC Volunteer Auxiliary. For many years, AAMC has been providing many of the mental health and substance use services that the community relies on, such as substance use treatment and outpatient mental health clinics. They're also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in my community.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in my community.

Thank you in advance for your consideration.

Sincerely,

Marc Wirig
cc: Anne Arundel Medical Center

Community United Methodist Church
1690 Riedel Road, Crofton, MD 21114
410.721.9129 • Fax: 410.721.9997
www.CUMC.net
https://www.facebook.com/CUMC.Crofton

Pastor Stan Cardwell
Lead Pastor
scardwell@cumc.net

December 1, 2015

Kevin McDonald, Chief
Certificate of New Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Subject: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

It is my pleasure write a letter in support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit.

Nearly half of the patients who need inpatient mental health care must wait up to five days in AAMC's emergency room for space to open up in other hospitals. In 2014, AAMC transferred more than 1,000 people who needed this higher level of inpatient care. An inpatient mental health unit at AAMC will help close the gap in mental health and substance use treatment in Anne Arundel County.

In conclusion, I fully support the efforts of Anne Arundel Medical Center as they seek to meet the critical need of a major health concern for Anne Arundel County. Thank you for your consideration.

Blessings,

Pastor Stan Cardwell
Lead Pastor

Cc: Anne Arundel Medical Center

December 3, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject:Letter of Support: AAMC's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

As a resident of Anne Arundel county and volunteer with the AAMC Auxilliary, I appreciate the opportunity to offer my support for Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish an inpatient mental health unit. I am aware of AAMC's longstanding commitment to providing critically-needed mental health and substance use treatment services to our community. Establishing an inpatient mental health unit to complement these existing quality services will help meet a growing need.

As you know, AAMC is one of the busiest hospitals in Maryland. In 2014, more than 1,000 people who came to AAMC's emergency room needing inpatient mental health care were transferred to other Maryland facilities. Because of the overwhelming shortage of this type of care, patients often are forced to wait for space to become available, causing delays in care.

In response to the community health needs assessment conducted in 2012, the vision for AAMC's mental health and substance use program includes coordinated, individualized, evidence-based care plans that put patients on the path to healing and recovery. There are not enough inpatient mental health services available in Anne Arundel County—a critical piece for coordinated care.

According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for co-occurring disorders (mental health and substance use) has been fragmented and disconnected. In fact, it is the top disparity in Anne Arundel County. The rates for suicide and binge drinking are higher in Anne Arundel County as compared to state and national averages. AAMC is working to address this by increasing access to integrated mental health and substance use treatment for county residents. An inpatient mental health unit is one important piece of this.

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely,

Laura Loomis

Laura Loomis
3505 Horseman Way
Davidsonville, MD 21035

cc: Anne Arundel Medical Center

Date 12/2/2015

Kevin R. McDonald, Chief

Certificate of Need

Maryland Health Care Commission

4160 Patterson Ave

Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

Anne Arundel Medical Center is my hospital of choice. For many years, AAMC has been providing many of the mental health and substance use services that the community relies on, such as substance use treatment and outpatient mental health clinics. They're also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in my community.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in my community.

Thank you in advance for your consideration.

Sincerely

Chuck and JoAnn Rohan

1915 Towne Centre Boulevard
Unit 410
Annapolis, Maryland 21401-3583

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Subject: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

I am writing in support of the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) for establishment of an inpatient mental health unit. Based on my own experience, I cannot advocate too strongly for the need to have such a service available for residents of this region.

After my husband, a retired cardiologist, became ill with Alzheimer's (concurrently with several episodes of syncope that required emergency room treatment), he received excellent care at AAMC whenever needed—with the exception of two very stressful occasions.

When he required a level of physical care that I could not provide at home, I moved my husband to a local dementia residential facility, but one whose staff—inadequately trained in redirection and diversion—proved unable to accommodate his combination of cognitive impairment and continued mobility.

On two separate occasions, my husband was taken to the emergency at AAMC with the requirement that he be hospitalized in a facility that could provide a psychiatric evaluation of his condition and recommendations for medication. On the first occasion he was transferred to Maryland General Hospital and on the second to Sheppard Pratt Health System, each time remaining in Baltimore for a period of five days to a week.

My daily visits thus required not a twenty-minute round trip but an hour's drive each way. I was fortunate to have lived in Baltimore during the time that my husband was in medical school and post-graduate training and was therefore familiar with the city. And because his was borderline early onset Alzheimer's, I was young enough to be able to make the trip without having to call on friends (no family member lives nearby) for assistance with the driving. This was, nonetheless, a stressful addition to an already stressful situation.

As our population ages and more and more elderly adults develop Alzheimer's, this scenario will undoubtedly become more and more common. Many of the family members affected by it will be less able to cope with the additional burden than I could do. Nor will the present resources of the referral institutions be able to accommodate the additional patient load without expansion of space and personnel. Surely it is more efficient (green, if you will) to provide this vital care within the community where it is and will increasingly be needed.

My husband died at AAMC in May 2012. He received excellent care during his last stay there and my children and I experienced nothing but sympathetic and attentive concern for our needs as well as his. I would have greatly valued the same level of care and concern at AAMC when he needed psychiatric, as opposed to medical, help. I hope that the Maryland Health Care Commission will see the value and benefit of AAMC's application to provide this much needed service to the community already so well-served by AAMC in other ways.

Thank you for your consideration of my views,

Jean B. Russo

Jean B. Russo

cc: Anne Arundel Medical Center

Fusco, Gina

From: BetteAnn Kennedy <betteann313@comcast.net>
Sent: Thursday, December 03, 2015 4:59 PM
To: Fusco, Gina
Subject: Inpatient Mental Health

December 2, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

We are writing to offer our strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region. I, BetteAnn Kennedy, worked for 25 years of a 45 year career in an ED serving those in need of behavioral health services. Everyday, I became acutely aware of the the need in community and the lack of resources available. On a daily basis, we are made aware of the dangers of the untreated mentally ill in the world.

Anne Arundel Medical Center is our hospital of choice. For many years, AAMC has been providing many of the mental health and substance abuse services that the community relies on, such as substance abuse treatment and outpatient mental health clinics. They are also developing a psychiatric day treatment program to help meet the growing needs of our community. An inpatient mental health unit would alleviate the burden of a patient being transferred causing detrimental delays in treatment while they wait for an "out of community bed" and occupy valuable space in an already over burdened ED. An inpatient mental health unit also would facilitate the participation and support of family and friends and provide an easier transition to outpatient care in their community. Their success and stabilization in a timely manner is a win for everyone.

We understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. We fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in our community.

Thank you for your consideration.

Respectfully,

BetteAnn and Steve Kennedy

2411 Hamden Court
Crofton, MD 21114

December 2, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for Inpatient Mental Health Unit

Dear Mr. McDonald,

This letter is to declare my absolute support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region. **I bring to you my personal perspectives having served hundreds of hours as a volunteer in the Emergency Department at AAMC.**

Invariably, there are times at the Emergency Department where individuals seek mental health assistance/evaluation and must wait because resources are not available. I have seen these individuals walk in and our of our waiting areas because they need immediate attention and are trying to cope with the long and arduous wait, or returning multitude of times to the restroom to wash their hands repeatedly, to individuals who literally ask me, a volunteer, not to leave their side and to focus my eyes on them. It is humbling that in a small way I can help these individuals seeking help from the one place where resources should be available.

Anne Arundel Medical Center most assuredly needs approval immediately. This blessed facility has been providing many of the mental health and substance use services that the community relies on, such as substance use treatment and outpatient mental health clinics. Undoubtedly, an inpatient mental health unit would create a more effective and efficient experience for those needing care and simultaneously remove the unnecessary transfer outside of AAMC. An inpatient mental health unit would improve the quality and access of mental healthcare available in my community, and I greatly support this development.

Maryland Health Care Commission (MHCC) must approve AAMC's application for Inpatient Mental Health Unit.

Sincerely,
Mitchell B. Karpman Ph.D.

cc: Anne Arundel Medical Center

Physicians/Leadership

Anne Arundel Medical Group
Mental Health Specialists

December 10, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

As an employee of AAMC, I appreciate the opportunity to offer my support for Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish an inpatient mental health unit. I am aware of AAMC's longstanding commitment to providing critically-needed mental health and substance use treatment services to our community. Establishing an inpatient mental health unit to complement these existing quality services will help meet a growing need.

As you know, AAMC is one of the busiest hospitals in Maryland. In 2014, more than 1,000 people who came to AAMC's emergency room needing inpatient mental health care were transferred to other Maryland facilities. Because of the overwhelming shortage of this type of care, patients often are forced to wait for space to become available, causing delays in care.

In response to the community health needs assessment conducted in 2012, the vision for AAMC's mental health and substance use program includes coordinated, individualized, evidence-based care plans that put patients on the path to healing and recovery. There are not enough inpatient mental health services available in Anne Arundel County—a critical piece for coordinated care.

According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for co-occurring disorders (mental health and substance use) has been fragmented and disconnected. In fact, it is the top disparity in Anne Arundel County. The rates for suicide and binge drinking are higher in Anne Arundel County as compared to state and national averages. AAMC is working to address this by increasing access to integrated mental health and substance use treatment for county residents. An inpatient mental health unit is one important piece of this.

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely,

Dawn K Hurley
Executive Director of Behavioral Health
Anna Arundel Medical Center

cc: Anne Arundel Medical Center

Pathways
Alcohol & Drug Treatment Center
Anne Arundel Health System
2620 Riva Road
Annapolis, MD 21401
410-573-5400
800-322-5858
Fax: 410-573-5401

December 11, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

As an employee of AAMC, I appreciate the opportunity to offer my support for Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish an inpatient mental health unit. I am aware of AAMC's longstanding commitment to providing critically-needed mental health and substance use treatment services to our community. Establishing an inpatient mental health unit to complement these existing quality services will help meet a growing need.

As you know, AAMC is one of the busiest hospitals in Maryland. In 2014, more than 1,000 people who came to AAMC's emergency room needing inpatient mental health care were transferred to other Maryland facilities. Because of the overwhelming shortage of this type of care, patients often are forced to wait for space to become available, causing delays in care.

In response to the community health needs assessment conducted in 2012, the vision for AAMC's mental health and substance use program includes coordinated, individualized, evidence-based care plans that put patients on the path to healing and recovery. There are not enough inpatient mental health services available in Anne Arundel County—a critical piece for coordinated care.

According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for co-occurring disorders (mental health and substance use) has been fragmented and disconnected. In fact, it is the top disparity in Anne Arundel County. The rates for suicide and binge drinking are higher in Anne Arundel County as compared to state and national averages. AAMC is working to address this by

increasing access to integrated mental health and substance use treatment for county residents. An inpatient mental health unit is one important piece of this.

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely,

Helen Reines, BA, RN

Helen Reines, BA, RN
Executive Director
Pathways

cc: Anne Arundel Medical Center

Pathways
Anne Arundel Medical Center

2620 Riva Road
Annapolis, MD 21401
410-573-5400
askAAMC.org

December 14, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

As the medical director of Pathways, a drug and alcohol rehabilitation facility associated with AAMC, I appreciate the opportunity to offer my support for Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish an inpatient mental health unit. I am aware of AAMC's longstanding commitment to providing critically-needed mental health and substance use treatment services to our community. Establishing an inpatient mental health unit to complement these existing quality services will help meet a growing need.

As you know, AAMC is one of the busiest hospitals in Maryland. In 2014, more than 1,000 people who came to AAMC's emergency room needing inpatient mental health care were transferred to other Maryland facilities. Because of the overwhelming shortage of this type of care, patients often are forced to wait for space to become available, causing delays in care.

In response to the community health needs assessment conducted in 2012, the vision for AAMC's mental health and substance use program includes coordinated, individualized, evidence-based care plans that put patients on the path to healing and recovery. There are not enough inpatient mental health services available in Anne Arundel County—a critical piece for coordinated care.

According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for co-occurring disorders (mental health and substance use) has been fragmented and disconnected. In fact, it is the top disparity in Anne Arundel County. The rates for suicide and binge drinking are higher in Anne Arundel County as compared to state and national averages. AAMC is working to address this by increasing access to integrated mental health and substance use treatment for county residents. An inpatient mental health unit is one important piece of this.

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely,

Elizabeth Winter, MD
Medical Director
Pathways
cc: Anne Arundel Medical Center

Anne Arundel Medical Group
Mental Health Specialists
2620 Riva Road
Annapolis, MD 21401
410-573-9000 phone
410-573-9001 fax
AAMGMentalHealthSpecialists.org

1 February 20016

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. McDonald,

It is my pleasure to write a letter in support of Anne Arundel Medical Center's certificate of need application to the Maryland Health Care Commission for 16 adult inpatient psychiatric beds. For the past 27 months, I have had the privilege of leading the division of mental health and substance abuse at Anne Arundel Medical Center, and to be a shepherd of the strategic vision for these services in our community. As the medical center moves to achieve its goal of responding ever more comprehensively to the health needs of the individuals living and working within our area, the importance of an inpatient psychiatric program in our community as part of a vertically-integrated and community-based care continuum becomes only more evident. The opportunity to build a facility to house not only an inpatient program but also the programs of partial psychiatric hospitalization and intensive outpatient psychiatric treatment, and to serve as a resource and a meeting place for programs of self-help and recovery in our community, is one which can and should be seized now, to provide the cornerstone for a new vision of health care for residents of Anne Arundel County and areas nearby which would be served by such a care facility in Annapolis.

The gaps and fragmentation in current systems and programs, and the lack of inpatient care in proximity to the communities where our patients and their families live and work, can be addressed most effectively and efficiently with a vertically-integrated center for mental health treatment, similar and in parallel to what Anne Arundel Medical Center has achieved for disorders of substance use at Pathways Treatment Center.

Inpatient psychiatric care is an essential component of the spectrum of interventions required to meet the mental health needs of the community, and is most effectively utilized when fully integrated and coordinated with community-based programs. The current geographic distance to such inpatient programs serves as an obstacle to such coordination, and is one that can be overcome in significant

measure with the addition of inpatient psychiatric beds to the spectrum of other programs, current and planned, offered at AAMC to serve individuals in our community.

I personally urge the Maryland Health Care Commission to approve Anne Arundel Medical Center's certificate of need application for 16 adult inpatient psychiatric beds, and look forward to the opportunity, as a partner with the medical center, to continue to optimize early identification, timely intervention, and promotion of recovery for those who suffer from mental illness in Annapolis and our surrounding areas.

Sincerely,

Raymond S. Hoffman, MD

Raymond S. Hoffman, MD
Anne Arundel Mental Health Specialists
Medical Director
Division of Mental Health and Substance Abuse
Anne Arundel Medical Center

Anne Arundel Medical Center

2001 Medical Parkway
Annapolis, Md. 21401
443-481-1000
TDD: 443-481-1235
askAAMC.org

November 23, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald,

I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

As a primary care physician and as AAMC's Chair of Clinical Integration, I am very familiar with the needs of individual patients as well as those of our regional population. If there is one gaping medical need in our community, it is for behavioral health services. Beyond our ongoing efforts in treating substance misuse, AAMC is doing foundational work to create new, and bolster existing, mental health resources in the community by having opened an outpatient psychiatry practice and now developing partial hospitalization and intensive outpatient programs. Hence the timing is perfect to open an inpatient mental health unit: there will be appropriate programs in place in the community to welcome discharged patients and support them as they continue on their journey to mental well-being.

Somatic and mental health are inextricably connected. Notably, 66% of AAMC's high-utilizing Medicare population are individuals with at least one behavioral health problem in addition to their chronic medical conditions. As AAMC does its part to help Maryland meet All Payer Model goals of reducing per capita hospital utilization, we must be allowed to address the health needs of our high-utilizing population locally and efficiently. We will not be successful in reducing potentially avoidable utilization if we do not address mental health issues that present obstacles to self-management of chronic disease.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service.

Thank you in advance for your consideration.

Sincerely,

Patricia Czapp, MD, FAAFP
Chair of Clinical Integration

Barbara D. Maxwell
358 Overlook Trail
Annapolis, MD 21401

November 23, 2015

Kevin R. McDonald, Chief
Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. The AAMC has had a longstanding commitment to providing mental health and substance use treatment services to our community. Establishing an inpatient mental health unit to complement these existing quality services will help meet a growing need. Inpatient mental health services is a critical piece for coordinated care.

As you know, AAMC is one of the busiest hospitals in Maryland. In 2014, more than 1,000 people who came to AAMC's emergency room needing inpatient mental health care were transferred to other Maryland facilities. Because of the overwhelming shortage of this type of care, patients often are forced to wait for space to become available, causing delays and fragmented and disconnected care

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely,

Barbara D Maxwell

cc: Anne Arundel Medical Center

ANNAPOLIS INTERNAL MEDICINE
AIM for the Best Health

George C. Samaras, M.D.
Emeritus

Joseph N. Friend, M.D.
Internal Medicine • Endocrinology

Howard D. Goldstein, M.D.
Internal Medicine

Stephen C. Hamilton, M.D.
Internal Medicine

Michele Smadja-Gordon, M.D.
Endocrinology

Titus C. Abraham, M.D.
Internal Medicine

Kevin M. Groszkowski, M.D.
Internal Medicine

Courtney A. Milne-Krohn, M.D.
Internal Medicine

Katherine J. Anderson, M.D.
Internal Medicine

Mollie D. Sourwine, M.D.
Internal Medicine

Rita J. Shkullaku, M.D.
Internal Medicine

Jennifer L. Cuhran, M.D.
Internal Medicine

Tim G. Woods, M.D.
Internal Medicine

Ilene S. Bloom, P.A.
Physician Assistant • Dermatology

Wynn H. Boyle, C.R.N.P.
Diabetes Education

Sara C. Adelman, C.R.N.P.

Brenda Mathews-Vitello, C.R.N.P.

Eun Y. Cho, C.R.N.P.

Madhumitha P. Bezwada, C.R.N.P.

November 25, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

Anne Arundel Medical Center is my hospital of choice. For many years, AAMC has been providing many of the mental health and substance use services that the community relies on, such as substance use treatment and outpatient mental health clinics. They're also developing a psychiatric day treatment hospital program to help meet the growing needs of our community. An inpatient mental health unit would create a more seamless experience for those needing this level of care and alleviate the burden of being transferred and experiencing detrimental delays in treatment as they wait for availability at another facility. An inpatient mental health unit would improve the quality and access of mental healthcare available in my community.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in my community.
Thank you in advance for your consideration.

Sincerely,

Titus C. Abraham, MD
Managing Physician
Annapolis Internal Medicine

cc: Anne Arundel Medical Center

DESPA
DOCTORS EMERGENCY SERVICE P.A.

November 24, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Re: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

As the Director of the Pediatric Emergency Department at Anne Arundel Medical Center I am writing to offer my strong support for the Certificate of Need application submitted by AAMC to establish an inpatient mental health unit. I know from first-hand experience how vital this service is and how badly this type of service is needed in our region.

AAMC's Pediatric ED sees over 18, 000 ill and injured children every year. Last year more than 750 children and teens came to our hospital for Emergency Psychiatric Evaluations. The vast majority were teenagers who had attempted or were on the verge of suicide. Over half of these young patients, more than one every single day of the year, required hospitalization for Inpatient Psychiatric treatment. 100% of these children had to be transferred to an out-of-town facility, as AAMC cannot currently offer such treatment. Our teens and their families deserve better.

After caring for sick children for more than 34 years, I am convinced that psychiatric illness, in fact, causes more cumulative suffering than physical illness. That may sound hard to believe, and I personally find it astounding, but my observations tell me that it is so. As AAMC strives to care for the entire individual, not just the flesh and bones parts, we must put ourselves in a position to care for their mental health as well as their physical health. Our mission to relieve suffering is incomplete until we have an Inpatient Psychiatric Unit at AAMC.

As you know all too well, there is a dearth of Mental Health beds in our state, and even more so in Anne Arundel County. Anne Arundel Medical Center stands ready to do our part to improve that situation. Not for reasons of finance or prestige, but because it is the right thing to do for the families we serve.

Mental Health has always been the poor sister to Physical Health. It is time for that to change. Please allow Anne Arundel Medical Center to play its part.

Thank you for your consideration in this most important matter.

2001 MEDICAL PARKWAY · ANNAPOLIS, MD 21401 · 443-481-1293 (OFFICE) · 443-481-1370 (FAX)

Sincerely,

Michael R. Clemmens, MD
Director
Pediatric Emergency Department and Inpatient Unit
Anne Arundel Medical Center
2001 Medical Parkway
Annapolis, MD, 21401
mclemmens@aahs.org

cc: Anne Arundel Medical Center

DESPA
DOCTORS EMERGENCY SERVICE P.A.

March 23, 2016

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

As Medical Director of AAMC's Emergency Services, I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC), to establish an inpatient mental health unit. This type of service is critically needed in our region.

On a daily basis, I see citizens of Anne Arundel and surrounding counties in need of mental health services. AAMC can offer them many of these services and we've developed an extensive outpatient network to help. There is a robust system of mental health consultants, substance abuse specialists, and psychiatrists who provide acute mental health evaluations and treatment. AAMC also is in the process of developing a psychiatric day treatment hospital program.

However, these services are not enough. We can only do so much on an outpatient or community-network basis. Many of our patients require inpatient services that we cannot provide. The number of inpatient beds available in this county, and even the state, is woefully inadequate. It is not unusual for patients to spend a day or more - and in some cases, many more - in the emergency department, while our mental health consultants and placement specialists try to find an inpatient facility with capacity to accept them. Establishment of an inpatient mental health unit would not only provide for a more seamless experience for those patients already receiving mental health services at AAMC, but it would also provide another option for mental health care providers in the region, whose patients require inpatient services.

I recognize and appreciate the Maryland Health Care Commission's (MHCC) role in the approval of hospitals in Maryland that seek to provide inpatient mental health services. That's why I urge the MHCC to support AAMC in providing this much needed service to our community.

Thank you in advance for your consideration.

Sincerely,

C. Michael Remoll, MD
Medical Director, Emergency Services

2001 MEDICAL PARKWAY · ANNAPOLIS, MD 21401 · 443-481-1293 (OFFICE) · 443-481-1370 (FAX)

Anne Arundel Medical Group
Mental Health Specialists

December 15, 2015

Kevin R. McDonald, Chief
Certificate of Need / Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

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According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for co-occurring disorders (mental health and substance use) has been fragmented and disconnected. In fact, it is the top disparity in Anne Arundel County. The rates for suicide and binge drinking are higher in Anne Arundel County as compared to state and national averages. AAMC is working to address this by

increasing access to integrated mental health and substance use treatment for county residents. An inpatient mental health unit is one important piece of this.

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely

cc: Anne Arundel Medical Center

Anne Arundel Medical Group Mental Health Specialists, 2635 Riva Road, Suite 108, Annapolis, MD 21401

Anne Arundel Medical Group
Mental Health Specialists

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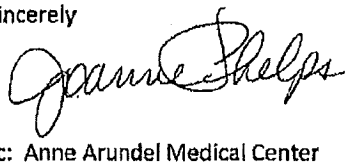

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Sincerely Jenna Barnes

cc: Anne Arundel Medical Center

Anne Arundel Medical Group Mental Health Specialists, 2635 Riva Road, Suite 108, Annapolis, MD 21401

Anne Arundel Medical Group
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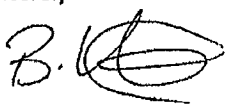

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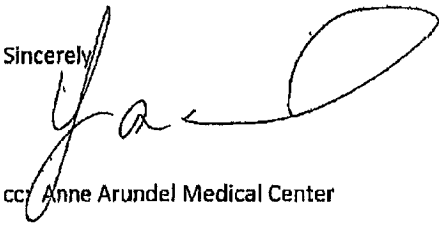

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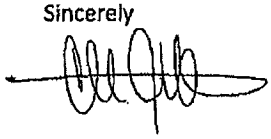

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Anne Arundel Medical Group
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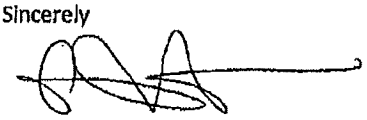

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Ruth Milsten, LCSW-C

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Craig Thomas

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Aruna Gogineni PhD; LCPAC

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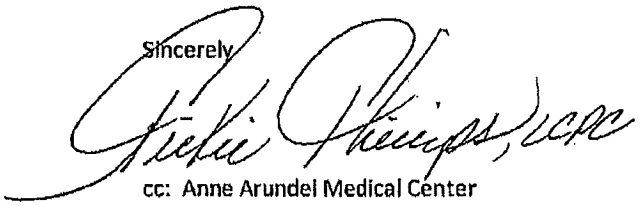
According to Healthy Anne Arundel Coalition's Community Health Needs Assessment, the treatment for co-occurring disorders (mental health and substance use) has been fragmented and disconnected. In fact, it is the top disparity in Anne Arundel County. The rates for suicide and binge drinking are higher in Anne Arundel County as compared to state and national averages. AAMC is working to address this by

increasing access to integrated mental health and substance use treatment for county residents. An inpatient mental health unit is one important piece of this.

Given the outstanding reputation of AAMC and Anne Arundel County's critical lack of access to inpatient mental health programs, I urge the Maryland Health Care Commission to approve AAMC's application to provide inpatient mental health care as soon as possible.

Thank you for your consideration in this very important matter.

Sincerely,



cc: Anne Arundel Medical Center

Anne Arundel Medical Group
Mental Health Specialists

December 15, 2015

Kevin R. McDonald, Chief
Certificate of Need / Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Mr. McDonald:

As an employee of AAMC, I appreciate the opportunity to offer my support for Anne Arundel Medical Center's (AAMC) Certificate of Need application to establish an inpatient mental health unit. I am aware of AAMC's longstanding commitment to providing critically-needed mental health and substance use treatment services to our community. Establishing an inpatient mental health unit to complement these existing quality services will help meet a growing need.

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Sincerely

Melissa Wellner, MD

cc: Anne Arundel Medical Center

Anne Arundel Medical Group Mental Health Specialists, 2635 Riva Road, Suite 108, Annapolis, MD 21401

December 15, 2015

Kevin R. McDonald, Chief
Certificate of Need / Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

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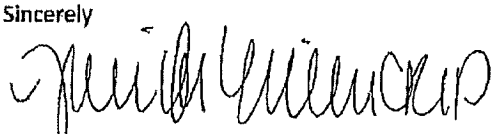

cc: Anne Arundel Medical Center

Anne Arundel Medical Group Mental Health Specialists, 2635 Riva Road, Suite 108, Annapolis, MD 21401

Anne Arundel Medical Group
Mental Health Specialists

December 15, 2015

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Certificate of Need / Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

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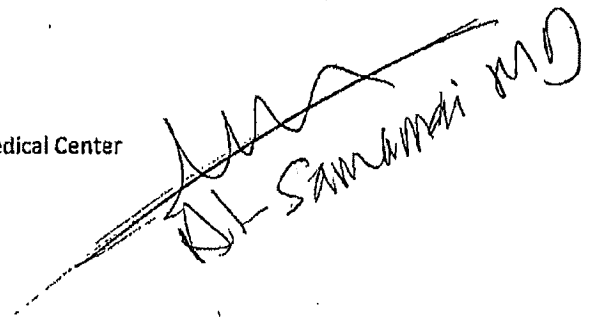


cc: Anne Arundel Medical Center

Anne Arundel Medical Group Mental Health Specialists, 2635 Riva Road, Suite 108, Annapolis, MD 21401

Anne Arundel Medical Center

2001 Medical Parkway
Annapolis, MD 21401
443-481-1000
TDD: 443-481-1235
www.aahs.org

March 25, 2016

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Subject: **Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit**

Dear Dr. McDonald:

I am writing to offer my strong support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit. This type of service is critically needed in our region.

I have practiced medicine in Anne Arundel County for 40 years and recognize the need for mental health and substance abuse services. While I utilize the current substance abuse facility for my patients, finding inpatient care for those with mental health problems is always challenging.

Referral and treatment of these patients becomes a difficult process with inadequate treatment and untimely referrals. Acute issues require sending patients to the ED where their disposition and the inpatient treatment they need often is delayed for days. Final admission is normally at a far away institution where follow- up care is almost non-existent.

My role has changed now from a practicing primary care physician to Chairman of the Department of Medicine at AAMC. The mental health service is within my department and I experience now the frustration and difficulty these patients have on a daily basis. Delay in service, inadequate treatment until inpatient beds can be found and, finally, treatment in hospitals far away from their communities occur in record numbers.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. I fully support this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service in my community.

Thank you in advance for your consideration.

Sincerely,

George Samaras, M.D., F.A.C.P.
Chairman, Department of Medicine

Payors

Chet Burrell
President and Chief Executive Officer

CareFirst BlueCross BlueShield
1501 S. Clinton Street, 17th Floor
Baltimore, MD 21224-5744
Tel: 410-605-2558
Fax: 410-781-7606
chet.burrell@carefirst.com

March 24, 2016

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Subject: Anne Arundel Medical Center's Certificate of Need (CON) Application for an Inpatient Mental Health Unit

Dear Mr. McDonald,

CareFirst BlueCross BlueShield strongly supports AAMC's application for inpatient mental health beds and urges the MHCC to give serious consideration to this request that will provide needed services to many citizens within the State.

The diagnosis and treatment of mental health and substance abuse conditions are critical to successful patient centered care coordination and management. We believe that AAMC offers a cost effective opportunity within the Central Maryland region to address these issues.

Sincerely,

Chet Burrell
President & CEO

CareFirst BlueCross BlueShield is an Independent licensee of the Blue Cross and Blue Shield Association, ® Registered trademark of the Blue Cross and Blue Shield Association, ®' Registered trademark of CareFirst of Maryland, Inc.

Hospitals and Health Systems

JOHNS HOPKINS
MEDICINE

Ronald R. Peterson

President
Johns Hopkins Health System
The Johns Hopkins Hospital

Executive Vice-President
Johns Hopkins Medicine

December 17, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

RE: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald,

I am writing to offer my support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit.

Currently AAMC provides many of the mental health and substance use services upon which the community relies, such as substance use treatment and outpatient mental health services. AAMC is developing a psychiatric day hospital treatment program to help meet the growing needs of the community. However, without an inpatient mental health unit, patients needing that higher level of care must be transferred and often experience detrimental delays in treatment as they wait for availability at another facility. I understand that in 2014, more than 1,000 people came to AAMC's emergency room in need of inpatient mental health care and had to be transferred to other Maryland facilities.

In fact, across the state hospitals struggle to move patients in need of psychiatric care out of our emergency departments (EDs) and into an appropriate inpatient setting in a timely manner. Many patients spend not just hours, but days in a holding status in the ED waiting for an appropriate placement. The days these patients spend in the ED waiting for an inpatient placement are very difficult them, pose a significant challenge for ED staff, and impede patient through-put. This results in a continual drain of resources just to maintain patients safely while they await treatment.

733 North Broadway, BRB 104, Baltimore, Maryland 21205, 410-955-9540 phone, 410-955-0856 fax, rpeters@jhmi.edu

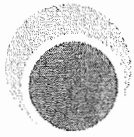
Inpatient care can and should be averted whenever possible by having available a robust array of outpatient and community-based services, as is present at AAMC. However, an inpatient unit is an essential component of the continuum of care, and when needed, it is critically important that it be available. An inpatient psychiatric unit at AAMC would create a more seamless experience for those needing this level of care and alleviate the burden of being held in limbo and ultimately transferred. Given the volume of patients needing this service at AAMC and the demand across the state for psychiatric services, there is a significant need for this project.

Thank you for the opportunity to offer my support for Anne Arundel Medical Center's certificate of need for an inpatient mental health unit.

Sincerely,

Ronald R. Peterson

cc: Victoria Bayless



Sheppard Pratt
HEALTH SYSTEM
We help. You heal.

Office of the President &
Chief Executive Officer
6501 North Charles Street
Baltimore, MD 21204
Phone: 410.938.3401
Fax: 410.938.3450
ssharfstein@sheppardpratt.org

December 23, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

RE: Letter of Support for Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

On behalf of Sheppard Pratt Health System, I am pleased to provide this letter of support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit in the Annapolis area.

As Maryland's largest provider of mental health services, we know firsthand that psychopathology and serious comorbid addiction illnesses inform a robust epidemiology in our community. Because the public mental health system no longer provides the safety net for individuals whose illnesses require containment and prompt stabilization, it has become incumbent on the private sector to provide services needed to assure personal and public safety.

Anne Arundel Medical Center has an active psychiatric emergency room and the need for general adult beds and related services in which to stabilize those needing higher levels of care is overdue.

As a relatively close neighbor resource in Howard County, we look forward to collaboration and leverage of synergies that may evolve from such arrangements. We encourage you to endorse this application and create more stabilization services for individuals in need of help.

Sincerely,

Steven S. Sharfstein, M.D.
President and Chief Executive Officer

Calvert Memorial Hospital
Tradition. Quality. Progress.

November 30, 2015

Kevin R. McDonald, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299

Subject: Letter of Support: Anne Arundel Medical Center's Certificate of Need Application for an Inpatient Mental Health Unit

Dear Mr. McDonald:

I am writing to offer my support for the Certificate of Need application submitted by Anne Arundel Medical Center (AAMC) to establish an inpatient mental health unit.

For many years, AAMC has provided many of the mental health and substance abuse services that Calvert County residents use as an additional resource when the Calvert Memorial Hospital facility is stretched beyond its capacity. An inpatient mental health unit would create an additional referral option for those needing this level of care and alleviate the potential for patients to experience detrimental delays in treatment as they wait for availability at another facility much farther away from Calvert County than AAMC.

I understand and appreciate that the Maryland Health Care Commission (MHCC) must approve hospitals in Maryland that seek to provide inpatient mental health services. Calvert Health System fully supports this project, and hope the MHCC will see the value and benefit of AAMC's application to provide this much needed service.

Thank you in advance for your consideration.

Sincerely

DEAN A. TEAGUE, FACHE
President & CEO

cc: Anne Arundel Medical Center

100 HOSPITAL ROAD • PRINCE FREDERICK, MD 20678
410-535-4000 • 301-855-1012 • TDD 410-535-5630 • www.calverthospital.org