1. The charity care policy provided states that "preliminary eligibility will be determined within two days of receipt of a completed application." You also attached a copy of the Maryland State Uniform Financial Assistance Application.

A. Is the Maryland State Uniform Financial Assistance Application the "application" referred to in the policy?

Applicant Response:

Yes, the Maryland State Uniform Financial Assistance Application is the application referred to in our policy.

B. Is documentation that validates the accuracy of the information provided on the application form required before a determination of preliminary eligibility is made?

Applicant Response:

Peninsula Regional's financial assistance policy (included as Attachment 7 in the original CON application – "Subject: Uncompensated Care / Financial Assistance") includes the required language of determination of probable eligibility within two business days. Page 3(c) is where this is stated. Documentation that validates the accuracy of the information provided on the application form is then followed-up on.

C. The charity care policy refers to a policy titled "Finance Division Policy FD-030." Is this policy included in the application, and if so, where? If it is not, please supply a copy.

Applicant Response:

Please find at Attachment A a copy of the "Finance Division Policy FD-030."

2. This standard asks applicants to "identify at least two alternative approaches that it considered for achieving" the proposed project's "primary objectives." It what way is "doing nothing" an alternative approach to "achieving" the "primary objectives listed on page 25?

Applicant Response:

PRMC agrees that the "do nothing" alternative would not achieve the primary objectives of establishing and operating an inpatient psychiatric unit for children and adolescents.

PRMC considers the "do nothing" alternative a matter of timing the implementation of the proposed child and adolescent inpatient psychiatric unit, not a permanent choice to continue to delay access to this needed service by the most vulnerable members of the lower Eastern Shore communities. From our point of view, it is no longer possible or necessary to continue the historic and current practice of referring children and adolescents who require inpatient psychiatric care to out-of-area hospitals, when sufficient space can be made available in a cost-effective manner to house, staff and operate this unit on the PRMC campus.

Consistent with the plain language of Project Review Standard (5), Cost Effectiveness, PRMC considered three alternatives approaches for achieving the proposed project's primary objectives. The first alternative renovation plan required the relocating PRMC's existing special care nursery (SCN) from its current location, renovating the space vacated by the SCN for the proposed unit. The second was to build a freestanding psychiatric hospital. The third was the proposed project to locate the unit in space that is either currently vacant or is used for non-clinical purposes for which alternative locations in the Hospital have been identified. In all three instances, the distinguishing feature that differentiates the two rejected alternatives from the preferred alternative was the capital cost: the cost of new construction for a freestanding hospital, and the relocation and re-building of the SCN in renovated space, would have been significantly more expensive than the proposed alternative plan for which the renovation costs were limited to renovating the space for the proposed inpatient psychiatric unit only.

3. As noted below, it appears that the psychiatric hospitalization use rate for children and adolescents is declining in the identified service area, a hospital program for children and adolescents closed on the Eastern Shore in recent years, and PRMC projects an increase in this hospital use rate. Reduced demand for hospitalization and a contraction of hospital spending for hospitalization could logically be viewed as a "good thing," no matter what the underlying causes may be. Why is it cost effective to develop a new psychiatric hospital program that appears to be predicated on arresting or reversing this trend in declining use?

Applicant Response:

PRMC leadership does not agree that the decline in discharges and patient days among residents of the proposed service area between 2010 and 2016, as shown on p. 29, represents a meaningful trend for addressing future patient care needs, much less a "good thing." At the heart of this proposal is our view that the past and current utilization of these services does not reflect the needs of this population, and the declining trend actually reflects the limitations on access to needed inpatient care. This is especially true with the closure of Adventist HealthCare's hospital in Cambridge in November 2016. In our view, the constraints on care availability, the decline in utilization, and the resulting contraction of hospital spending is the problem, not the solution for this vulnerable population.

For that reason, the need methodology employed in the application used the <u>average</u> number of discharges over the seven-year period to project the future utilization of the proposed service and unit at PRMC, not the declining trend in the utilization of hospital services by the service area population. The purpose of this application is not simply to provide an alternative setting for meeting the most current levels of care provided to this population in out-of-area hospitals or shift the location of care from out-of-area hospitals to PRMC. The purpose is to provide the capacity to increase utilization of needed care that has not been addressed sufficiently.

As described in the CON Application, it is our intent to increase the resources available to PRMC to serve this population in need. We fully expect an increase in discharges and patient days above current levels following the commencement of these new services at PRMC. To achieve this result, PRMC will negotiate an increase in its Global Budgeted Revenue ("GBR") with the Health Services Cost Review Commission ("HSCRC"). If access to and utilization of this service results in arresting or reversing the historic trends of declining use, and the treatment of a greater number children and adolescents in need, then the project will have succeeded.

4. Given that the patient population is only expected to spend, on average, 9.3 days in the hospital, why wouldn't it be more cost effective to continue to have children and adolescents from the PRMC service area hospitalized at existing facilities with established expertise in these services, while, as an alternative to this project, PRMC invests in the array of services needed by local children and adolescents after hospitalization and outpatient psychiatric services more generally, a continuum of care that will involve a much longer period of service provision and is likely to be more important to the long-term stability and mental health of this patient population?

Applicant Response:

PRMC leadership does not agree with the premise of this question, that investment in a continuum of care to provide an array of services, and continued outmigration to existing facilities with established expertise, would be a worthy alternative to this project. Rather, we believe that the project will add to and improve a comprehensive system of care. Such a system requires the establishment of the proposed inpatient psychiatric unit, located in our major community hospital in the lower Eastern Shore region, staffed by our local experts, to serve children and adolescents who are in crisis and need increased access to acute care. Such a unit would serve as a significant addition to the existing array of services currently available at PRMC and throughout the community to provide the resources necessary to identify and address the children and adolescents whose needs are not being met. A well-resourced continuum of care is clearly the goal of both PRMC and the Commission for our community, for which this proposed unit is an essential element.

5. The difference in capital costs reported for the one actual alternative approach considered for the new unit (the Special Care Nursery or SCN) was quite small ($600,000). Were there any differences in projected operational costs between the two sites? Are there advantages associated with having the proposed new psychiatric unit and the existing adult unit in close proximity, as the proposed project alternative appears to achieve? Explain why the SCN unit was the only alternative reconfiguration option considered.

Applicant Response:

There were no significant differences between the projected operational costs between the two alternative locations selected for the new inpatient psychiatric unit for children and adolescents. Some potential improvements in operational efficiencies of the adult unit and the child and adolescent unit are possible due to their proximity, but these have not been evaluated or quantified by Hospital management at this time. In addition, the management of PRMC also concluded that proximity of a child and adolescent unit to a special care nursery was not advantageous.

6. Child and adolescent psychiatric discharges being generated by the service area population declined at an average annual rate of 2.4% between 2010 and 2016 (table on page 29). This suggests that the use rate for this service is declining. However, it does not appear that the need analysis provided in the application takes this into account. Indeed, PRMC projects 373 discharges from its proposed unit in 2023, equivalent to 112% of the total Maryland hospital discharges identified for the total service area in 2016. How does PRMC account for the declining use rate for child and adolescent psychiatric hospital services in its need analysis?

Applicant Response:

Child and Adolescent discharges generated by Peninsula's service area population has declined in Maryland hospitals between 2010 and 2016 as submitted (CON table page 29). We concur with MHCC that discharges are a barometer of future community behavioral health demand, as this metric was used as the basis to define need. Historical perspective provides parameters and a baseline for future projections as one element; however, assessment of the current behavioral health environment from a national, state, regional, and community perspective provides multi-faceted incremental support that acute behavioral health demand is intensifying. The current and future regional environment signals crisis and strong demand as supported by our last three CHNA Surveys (Community Health Needs Assessment Survey); the 2016 closure of Adventist Behavioral Health in Cambridge; ER "boarding times" trending upwards (adolescents waiting to be admitted to any behavioral health facility); drive times to Maryland facilities are protracted leading to suboptimal care; socio-demographics transportation access to care issues; transfers to out-of- state behavioral facilities, room compliment limitations, public engagement & promotion; and the future fostering of strong referral patterns between local pediatricians, school psychologists, psychiatrists and County Health Departments lends support to demand projections and seamless behavioral health access.

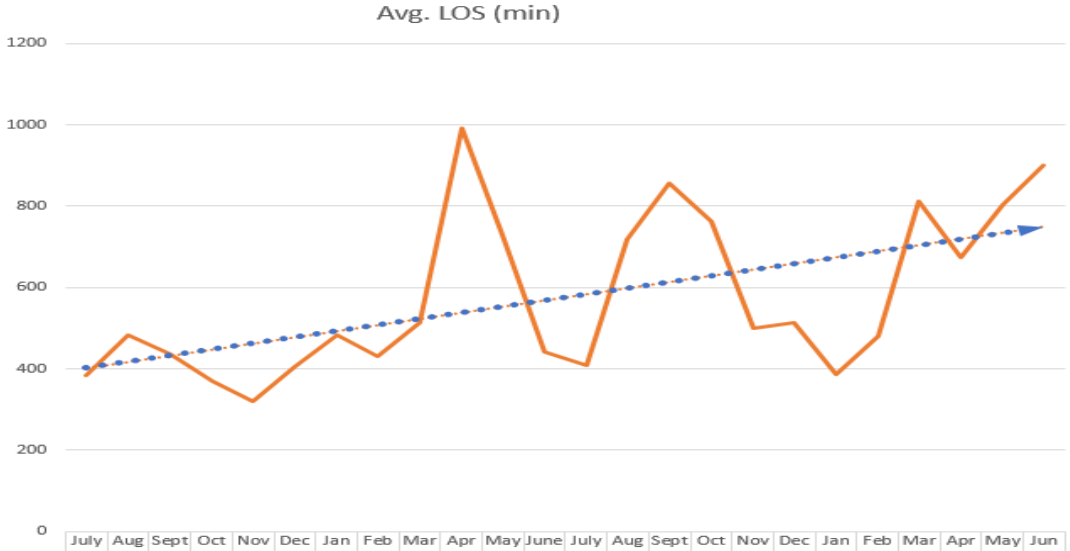
Community Health Needs Assessment Surveys:
PRMC's last two Community Health Needs Assessment Surveys (CHNA Surveys) show that behavioral health and its linkages to substance abuse are high areas of concern for community leaders and organizations. Primary source data from the 2018 CHNA Survey shows that respondents such as the Chesapeake YMCA, the Foundation of the Eastern Shore, the Tri-County Health Department Boards, and churches such as St. Paul's AME Zion Church of Salisbury rank substance abuse and mental health concerns first and second among health concerns. Unfortunately, this appears to only be part of a greater writing on the wall, as going back to the 2016 CHNA Survey, Mental Health Disorders were prioritized as number six overall among chief health concerns; only trailing ubiquitous health issues such as cancer care, diabetes and obesity. For far too long many in Wicomico, Somerset, and Dorchester Counties have been trapped by the words of St. Augustine in realizing "this life is a long sickness." The lower Eastern Shore over the last several years has been plagued with statistically higher incidences of Emergency Department visits and suicides than its counterparts within the State of Maryland. According to the 2016 CHNA report Wicomico County and Worcester County both tragically saw an average of 12 suicides for every 100,000 citizens for 2014 while the Maryland average rested at 9.2 deaths for the same time frame. Additionally, PRMC's Tri-County service area also had greater incidences of emergency room visits due to alcohol and substance abuse than the baseline average for the state of Maryland; with Wicomico County leading the way with 2870.5 ED visits per 100,000 residents nearly doubling the state average of 1591.3 ED visits for a population of 100,000. It becomes clear that behavioral health is not restricted to locality or residency as the diversity of the lower Eastern Shore from the farmlands to the urban streets have all fallen prey to the disease of mental health disorders. In proposing a new child and adolescent

psychiatric care unit, PRMC is seeking to listen and better serve community partners against the preventable maladies of behavioral health.

ER Boarding:

Pediatric behavioral health patients at PRMC are at a crucial turning point with the submission of the Child and Adolescent Inpatient Center Certificate of Need. Based on data gathered from Peninsula Regional's Emergency Department, there is an upward trend in the number of cases and the average length of stay of these patients in the Emergency Department before being transferred to another facility to receive treatment or being discharged. For example, as seen in Table 1 below, in FY 2015, there were 420 cases in the ED with an average length of stay of 473 minutes. These numbers increased substantially by FY 2018, with 711 cases and an average length of stay being 651 minutes. Those 651 minutes equates to almost 11 hours in the ED before a patient could receive treatment. Running a trend line for the average length of stay from July 2016 to July of 2018, the data indicates that the average length of stay is on a steady escalation. In extreme cases, pediatric patients are being boarded for 267 hours or 11 days, before being transferred to receive treatment. With the limited behavioral health treatment options on the Delmarva Peninsula, patients are being sent nearly1 ½ hours north to Dover Behavioral Health because there are no other inpatient treatment options without being transported across the Chesapeake Bay Bridge. The transfer process to facilities like Dover Behavioral Health or others in Maryland are not always optimal based upon available inpatient beds at these facilities. As a result, patients are kept in the ED until a bed becomes available; oftentimes waiting a week or more. This puts emotional, financial, and psychological strain on families, especially families in the local community who are already struggling to make ends meet. While the number of inpatient discharges may be slowly declining, the data shows that patients are having to wait longer to receive treatment. With the addition of a Child and Adolescent Inpatient unit at Peninsula Regional, these pediatric patients, who are in crisis, will receive care substantially quicker and the families will more involved with the treatment process of their son or daughter. According to the Wilder Foundation Research, a leader in national non-profit research and education, family involvement is one of the most important factors in helping individuals overcome behavioral health challenges (Melanie Ferris, "Family Involvement: Putting Policy into Practice," 2009).

Table 1: Emergency Room Boarding Wait Times



	July '16	Aug '16	Sept '16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr '17	May '17	June '17	July '17	Aug '17	Sept '17	Oct '17	Nov '17	Dec '17	Jan '18	Feb '18	Mar '18	Apr '18	May '18	Jun '18
Avg. LOS (min)	384	484	436	370	320	407	483	431	514	993	729	443	408	717	857	763	501	514	386	479	813	673	805	901

Source: *PRMC ER Wait Times Transfer Roster*

Transportation / Accessibility of Services:
Transportation is an issue for the Primary Service Area of Peninsula Regional. Between 7-12% of households in Worcester, Wicomico, and Somerset do not have a car (Conduent Health Communities Institute). Thus, showing the critical need of inpatient Child and Adolescent Behavioral services within an accessible distance for communities on Maryland's Eastern Shore. Currently, pediatric patients are transferred to facilities in Dover, DE or across the Chesapeake Bay Bridge. This transfer process over the last three fiscal years has pediatric patients waiting an average of 9.5 hours before then being transferred to another inpatient facility to receive treatment. The closing of Adventist HealthCare's Behavioral Health in Cambridge, MD in November of 2016 has only continued to make light of this issue as the next available behavioral health treatment center on the Delmarva Peninsula is Dover Behavioral Health. With Dover Behavioral Health 1 hour and 30 minutes away from Peninsula Regional (and even further if one considers those in the southern portion of the Primary Service Area) a patient from the Emergency Department must wait nearly 11 hours before entering treatment program at the Dover Behavioral Health facility. This is an important factor that can be of great significance considering that patients may have suicidal thoughts or are in an emergency state of crisis. The distance also puts a strain on families that may need to attend family or group therapy sessions with their son or daughter as part of treatment options assigned from behavioral health professionals. A centralized, local service will ensure the stresses of life will not be compounded by the fact that a parent cannot help their child due to time or distance. A long commute to therapy sessions adds to the stress of making ends meet financially, taking care of other children, and keeping employment. A parent/guardian being able to participate in family therapy or group therapy sessions with their child can make dramatic improvements in treatment, which is something PRMC wants to promote as part of the vision to improve the health of the community. Considering just Dover Delaware, driving 1.5 hours one way to participate in therapy with their son or daughter is financially, emotionally, and psychologically taxing on parents. This is even more exacerbated when considering providers on the other side of the Chesapeake Bay Bridge.

With a Secondary Service Area that extends South to Accomack County, VA, families must travel over one hour just to be seen at Peninsula Regional. For example, at the southernmost point of Accomack County, VA, a parent from Painter, VA will need to travel 2.5 hours or more just to see their son/daughter. Residents from Crisfield, MD will need to travel almost 2 hours to Dover Behavioral Health and 3 or more hours to any facility in Maryland. PRMC is just 45 minutes away from these communities. With a Child and Adolescent Behavioral Health Treatment Center, travel time is improved and expedites patients getting the attention and care they need. This also extends to populations North and West of Peninsula Regional. Residents of Cambridge, MD and Easton, MD can reach PRMC in 38 min and 55 min respectfully. Residents that were receiving treatment at the Adventist Behavioral Health Hospital in Cambridge, MD can receive similar treatment at PRMC without having to travel the longer distance to the Western Shore of Maryland. For the same residents to travel to Dover Behavioral Health or another inpatient facility across the Chesapeake Bay Bridge, the travel time is one to two hours. Close, quality, accessible, care is essential to helping these children and adolescents who are in critical condition. Waiting on average 9.5 hours to be transferred and receive appropriate attention is not always feasible nor is it in the patient's best interest. This roughly half-day time frame can lead to the complication of a patient's state and increase the cost of continued care (greater risk of worsening condition, prolonged chance of self-injury, and can necessitate adequate security and patient care management). Additionally, prolonged transfer time extends a parent or guardian missing work and puts continued financial strain on families who may already be in a financially limited state in addition to a familial crisis. The geographic constraints of the Shore and particularly the southern part of the Peninsula make it essential that families have medical, financial, and logistical access to services for their child.

Peninsula Regional's prime location makes access to behavioral health services feasible among residents from as far south as Painter, Accomack County, VA and as far north as Centerville, Queen Annes County, MD. This location also allows for parents or guardians to participate in their child's treatment and help improve the well-being of their son or daughter

Drive Times to Inpatient Child & Adolescent Behavioral Health Facilities
Table 2 below shows a map of the travel times originating from Salisbury to other facilities. In addition, it provides a radius from Salisbury extending out 30 and 45 minutes.

Table 3 provides drive times from selected cities to the various providers of child and adolescent psychiatric services.

Table 2

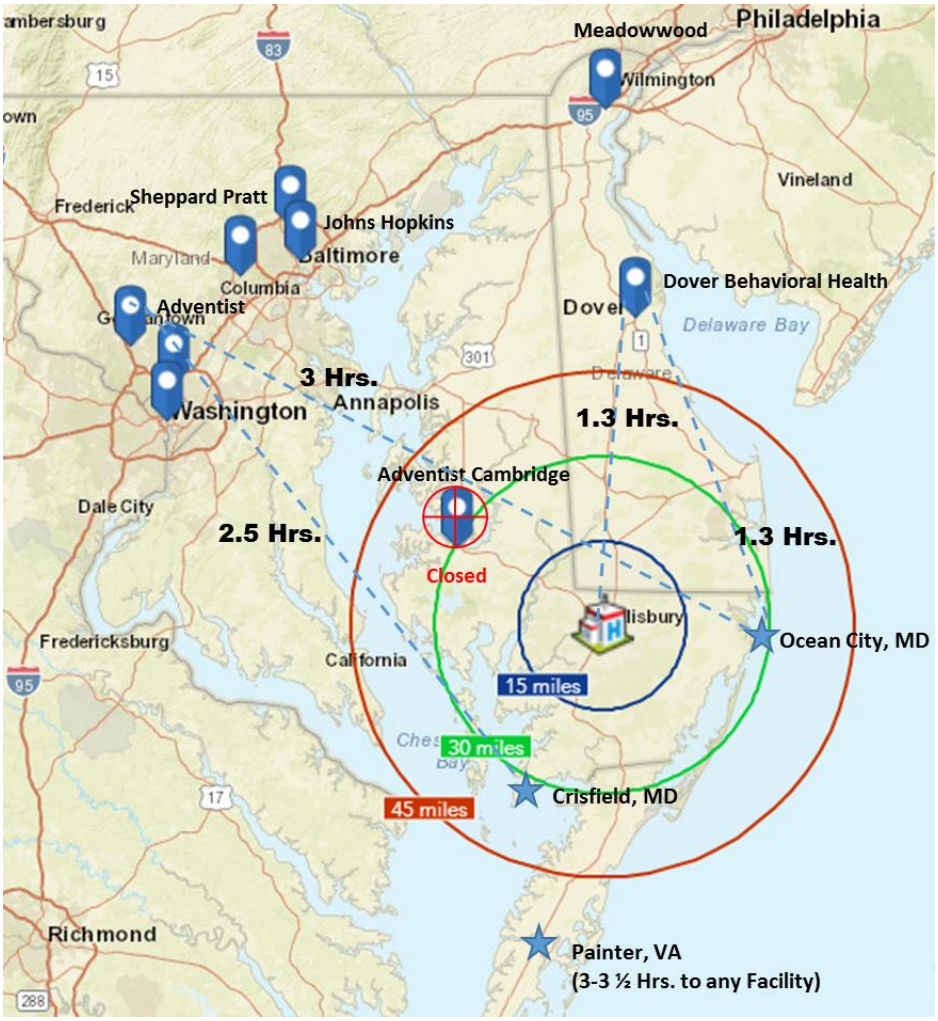


Table 3
Sample Drive Times

Cites	Sheppard Pratt Ellicott City	Johns Hopkins	Adventist at Shady Grove	Dover Behavioral Health DE
Painter, VA	3 hr. 28 min	3 hr. 34 min	3 hr. 45 min	2 hr. 28 min
Chincoteague Island, VA	3 hr. 9 min	3 hr. 15 min	3 hr. 27 min	2 hr. 11 min
Crisfield, MD	2 hr. 51 min	2 hr. 55 min	3 hr. 6 min	1 hr. 56 min
Ocean City, MD	3 hr. 20 min	2 hr. 46 min	2 hr. 56 min	1 hr. 25 min
Cambridge, MD	1 hr. 43 min	1 hr. 47 min	1 hr. 55 min	1 hr. 24 min
Easton, MD	1 hr. 33 min	1 hr. 31 min	1 hr. 37 min	1 hr. 8 min
Denton, MD	1 hr. 27 min	1 hr. 27 min	1 hr. 33 min	45 min
Seaford, DE	1 hr. 54 min	1 hr. 56 min	2 hr. 5 min	54 min

Source: *ESRI GIS Information Platforms*

Socio-Demographic Data:

The Delmarva Peninsula is a unique area of Maryland that has both rural and urban difficulties. These problems vary by county, whether it be economical, health related, or educational to name a few. The Primary Service Area (PSA) of Peninsula Regional has a higher unemployment rate and a lower median household income than the State of Maryland. To break down the PSA even further, Somerset County has many economic and health problems related to its residents. Currently, a staggering 20.22% of families in Somerset County are below the poverty line compared to 6.82% of families in Maryland. Also, the median household income of $37,253 (Truven Health Analytics) for all races in Somerset County is less than half of the median household income of $81,294 for all races in the State of Maryland. With such a discrepancy in household income, the health of the residents of Somerset County suffer as a result. Parents who are trying to care for their children cannot afford to buy fresh, healthy food to improve their child's diet. The Child Food Insecurity Rate is 10.4% higher in Somerset County than in Maryland. Again, this can be attributed to the median household income. An astonishing statistic is that 82.5% of students in Somerset County are eligible for the free lunch program, which is almost double the U.S. Value of 42.6%. The percentage of adolescents who are obese was 18.8% in 2016, 4.2% higher than the MD Value. Obesity is a major concern in Somerset County, as 72.7% of adults are overweight or obese compared to the MD value of 68.1%.

Economically, the Eastern Shore has lower median household incomes than the State of Maryland. In both the Primary and Secondary Service Areas, every county's median household income was lower than the Maryland median household income. In addition, because the Eastern Shore is both rural and urban in some places, there are areas in both types of places where grocery stores are scarce. As a result, if it is difficult to find a store that sells healthy food and residents choose fast food or precooked meals instead, which are not as healthy. The unemployment rate is higher in all three counties of the PSA when compared to the State of Maryland. Take into consideration all of the socio-demographic data and there represents an underserved and unmet need. The total population of the Primary and Secondary Service Areas, as seen in Table 4 below, will increase by 3% over the next five years representing an opportunity to provide services to these children and adolescents.

Table 4
Population Growth for Child & Adolescents (0-17)

County	2017 Population	2022 Population	Diff.	Growth %
Northampton County	2,469	2,540	71	3%
Caroline County	7,600	7,371	(229)	-3%
Talbot County	6,831	6,618	(213)	-3%
Wicomico County	22,703	22,846	143	1%
Worcester County	8,994	8,775	(219)	-2%
Sussex County	43,709	47,533	3,824	9%
Somerset County	4,528	4,679	151	3%
Queen Annes County	10,543	10,218	(325)	-3%
Dorchester County	6,936	7,080	144	2%
Accomack County	6,956	7,142	186	3%
Kent County	3,394	3,375	(19)	-1%
	124,663	**128,177**	**3,514**	**3%**

Source: *Truven Health Analytics*

When talking about how important a Child and Adolescent Behavioral Health unit would be to the community, a key statistic to evaluate is the Age-Adjusted ER Rate due to Mental Health. In Somerset County, the rate was 5,665.2 ER Visits per 100,000 population in 2014. That number is over 2,000 visits higher than the Maryland Value and over 2,000 visits higher than the Maryland SHIP 2017 target. Just to compare Wicomico County in the same statistic of Age-Adjusted ER Rate due to Mental Health, Wicomico County's rate was 6,207.9 ER Visits per 100,000 population. The Maryland SHIP target for 2017 was 3,152.6 ER Visits per 100,000 population. Combine this Age-Adjusted ER Rate due to Mental Health with the Average Length of Stay times, and a Child and Adolescent Behavioral Health Unit would help to mitigate these ER visits and shorten the Average LOS because the child can be seen at Peninsula Regional. (Conduent Healthy Communities Institute)

Rooming:

Within our service area, Peninsula Regional is seeking approval for a 15 licensed inpatient bed unit to treat children and adolescents with acute behavioral healthcare conditions Bed complement is critical within a child and adolescent behavioral health unit, as the very nature of this disease presents difficult rooming challenges compared to a typical acute- care hospital general med/surg semi private room. Co-location of the same gender including disparate ages is typical within an adult semi-private hospital room, whereas in a child and adolescent behavioral health unit it may be inappropriate or clinically non-conducive to co-locate adolescents in a semi-private room. Peninsula Regional's request for 15 licensed beds is based upon a complement of 3 private and 6 semi-private beds for a total of 9 rooms. Based upon gender, age-differences, developmental dissimilarities and behavioral health diagnosis the individuality of patients will dictate on a case-by-case basis how the rooms can be used. Consequently, for treatment purposes the number of rooms is effectively reduced from 15 to 9 beds as clinicians base room designation and occupancy on behavioral health diagnosis, developmental capabilities, socialization needs, and most importantly overall safety and comfort of these residents (ages 5-17). A semi-private

room is necessary and part of the overall care plan for certain individuals, therefore, our complement of 3 private and 6 semi-private rooms.

Collaboration & Referral Strengthening:
Peninsula Regional's vision encompasses inpatient acute care behavioral health services with complementary "wraparound" behavioral health services which expands access and improves transition times for the longitudinal progress of each patient. Part of this vision is based upon the conjoining of PRMC with existing behavioral health private organizations, community groups, substance abuse rehab centers, churches, donors, and the community at large to aid in transforming mental health patients from a state of crisis to wellness and wholeness. Components of this integrated team approach includes creating an adolescent partial hospitalization program building upon the Rebecca & Leighton Moore Child and Adolescent Outpatient Behavioral Health Unit. This unit offers intensive outpatient therapeutic behavioral health services, including individual therapy and medication management. The outpatient clinical team provides customized treatment plans designed to help our children successfully manage illness and maintain optimal activity at home, work, and school.

Integral to success is collaboration across the continuum of care with community partners. PRMC seeks to engage community leaders across the Peninsula by linking treatment and discharge planning through the standardization of communication, development of protocols for expedited referrals, codification of team-centric treatment, and complete discharge planning to improve the delivery of behavioral healthcare. As partnerships evolve and strengthen between the hospital and private/public community providers, treatment capabilities and outpatient programs will be expanded; allowing for integration and longitudinal patient management with an eye towards improving the quality of transitional care. This coalescing around Peninsula Regional as the tertiary regional referral center supports growing demand as referral patterns increase from local pediatricians, child psychologists, social workers, local schools, County Health Departments, community health workers and colleges. Peninsula Regional anticipates need intensification of inpatient child and adolescent demand as the collaboration develops a more stratified comprehensive care program in place of the current fragmented system.

Community Support:
The Child and Adolescent Behavioral Health Unit is not just a goal of Peninsula Regional. It is a collaborative effort between state leaders, local leaders, and the communities of the Eastern Shore to mitigate the lack of behavioral health treatment options on the Delmarva Peninsula. There are a number of local leaders who see what the lack of a Child and Adolescent Behavioral Health Unit has done to children in the community who need treatment. Lori Brewster, Health Officer for Wicomico County, has submitted a letter of support of the inpatient child and adolescent behavioral health unit. Roger L. Harrell, Health Officer of Dorchester County, also submitted a letter of support and explained the critical shortage of inpatient child and adolescent services for the children of the lower Eastern Shore of Maryland. Local pediatricians and behavioral health specialists echo the concerns of a lack of behavioral health options by Mrs. Brewster and Mr. Harrell. Maryland State Senator from District 38 James N. Mathias, Jr. has also issued a letter of support of a Child and Adolescent Behavioral Health Unit in his home district of the Lower Eastern Shore. As stated from his support letter, Senator Mathias stated, "An inpatient child and adolescent unit at PRMC would create a streamlined experience for those needing this level of care, alleviating the stress and burden of being transferred and delayed in their treatment as they wait for availability at another facility." Members of the Maryland House of Delegates such as Christopher T. Adams, Carl Anderton, and Johnny Mautz agree that there is a lack of access to child and adolescent

inpatient services and that PRMC should be granted the Certificate of Need (CON) to establish such a program. Community business owners and leaders Rebecca and Leighton Moore have generously donated and advocated for behavioral health and the need for improved services for the Delmarva Peninsula's children and adolescent population who need treatment. In addition, our foundation board has raised $2M towards this vision. With the full support of state and local leaders, donors from the community, and local population health leaders, there is validation for the Child and Adolescent Behavioral Health Unit at Peninsula Regional Medical Center.

7. How does the need analysis for child and adolescent psychiatric hospital services outlined in the application compare with the actual experience of PRMC in providing acute hospital services for adults with psychiatric disorders? Provide a service-area level analysis of the demand for adult psychiatric services experienced by PRMC that identifies the service area and service area market share and the proportion of demand coming from beyond the service area.

Applicant Response:

Peninsula Regional is located in Salisbury, Maryland on the headwaters of the Wicomico River, which is positioned at the crossroads between the Chesapeake Bay and the Atlantic Ocean. This unique location requires Peninsula to be the leader in health services to patients residing in three states: Maryland, Delaware and Virginia. Peninsula Regional serves as the regional tertiary care referral center and subsequently experiences the socio-demographic characteristic that mirror rural America. However, we also acutely experience like-kind characteristic associated with cities and urban areas including prevalent drug and alcohol use, suicide, depression and other related behavioral health issues. There are three components which support the assumption that 15% of admissions will be residents outside of Peninsula's PSA and SSA:

- Peninsula Regional's inpatient Adult Behavioral Health Unit patient origin used as a proxy for the "out-of-area" residents.
- Sensitivity Analysis performed for Adventists inpatient discharges for "out-of-area" patients.
- Unique tourist economy

As a result, using Peninsula Regional's Inpatient Adult mental health patient origin as a proxy for "out of service area" child & adolescent admissions, as seen in Table 5 below, the HSCRC non-confidential data set suggests that approximately 6.2% of inpatient adult admission are "out of service area."

Table 5
Out of Service Area %
Peninsula Regional's Inpatient Adult Behavioral Health

Other States excluding MD, DE & VA	1.9%
Baltimore City	.9%
Montgomery County	.7%
Anne Arundel County	.7%
Prince Georges County	.5%
Howard County	.4%
Harford County	.4%
Baltimore County	.4%
Frederick County	.3%
Total	**6.2%**

Source: PCAnow HSCRC-non-confidential data set.

For comparative purposes, there are limitations to this comparative proxy. For example, availability and access to inpatient adult behavioral health services is more established than services available to children and adolescents, consequently projecting higher "out of service area" percentages for this population.

Secondly, the service area of Adventist Healthcare and Behavioral Health Services located in Dorchester County, MD consisted of many counties located within Peninsula Regional's service area, and also counties located outside our defined service area, but still happen to be geographically close to Peninsula Regional. When compared to the limited behavioral health locations within the State of Maryland, Peninsula Regional does become an option for geographically close but "out of service area" residents when other institutions are full. Table 7 below provides Adventist's CY 2015 inpatient origin by county, which includes 303 inpatient discharges, 2,990 days and an average length of stay of 9.87 days. Using this data, the following Sensitivity Analysis was constructed in Table 6, identifying patients "within service area" and patients "outside of service area" – for those patients outside of our service area but still geographically close a sensitivity capture rate interval of 10% was used. If Peninsula Regional captures just a portion of these "out of service area" Adventist patients (20%-50%) it provides anywhere from 5% - 15% for "out of service" mix.

Table 6
Sensitivity Analysis
Adventist Patient Origin

	Adventist Inpatient Discharges*	PRMC Captures 20%	PRMC Captures 30%	PRMC Captures 40%	PRMC Captures 50%
Residents Within PRMC Service Area	228				
Residents Outside PRMC Service Area	75	19	23	30	38
Represents PRMC Out of Service Area %		5%	6%	8%	10%

*Discharge Source: PCAnow/New Health Analytics, HSCRC Non-confidential data set

Lastly, the residents on the Delmarva Peninsula rely on Peninsula Regional's leadership and vision to develop underserved healthcare services such as Inpatient Children & Adolescent Behavioral Health. A portion of the 15% admissions that come from outside of the apportioned (PSA & SSA) service area can be attributable to the cyclical nature of a tourist economy. Worcester County, Ocean City, Maryland and Sussex County, Delaware beaches continue to be destination centers of beach lovers for "sun and surf." As with all Peninsula Regional services, the influx of vacationers in the summer months and the continued growth of the shoulder months, i.e. spring (March – April) and fall (September- November) supports a small but growing percentage of "out of service area" patients. The population of Ocean City is small, approximately 7,000; however, during summer weekends the city hosts between 320,000 to 350,000 vacationers and up to 8 million annually. The co-occurring behavioral health patterns of increased drug/ alcohol use coupled with existing underlying behavioral health issues can trigger behavioral health crises. Existing research suggests that the number of adolescents who need health treatment exceeds the number of those treated.

In summation, all three of these components contribute to the 15% "out of service area" discharges however, the confidential nature of behavioral health data limits access to data by zip code, and data from Delaware and Virginia was not obtainable. The estimate of 15% takes into consideration these limitations, historical proxy, increases in ER behavioral health visits, and the expanding nature of a tourist economy and population. In addition, the closing of Adventist Healthcare and Behavioral Health Services in Dorchester County, Cambridge Maryland (15 acute-care beds) creates a vacuum along the Eastern Chesapeake Bay corridor; concluding with estimates that there will be some additional demand "out of service area demand."

Table 7

Patient Care Analyst 3.01

Adventist Cambridge
MD - Psychiatric Hospitals
Quarter 1, 2015 Through Quarter 4, 2015

	Patient County	Total Cases	Total Pat. Day	Avg. LOS
1)	Wicomico, MD (86708)	62	527	8.50
2)	Dorchester, MD (29671)	55	626	11.38
3)	Caroline, MD (31226)	35	408	11.66
4)	Worcester, MD (49796)	24	303	12.63
5)	Talbot, MD (34397)	24	197	8.21
6)	Anne Arundel, MD (507177)	24	207	8.63
7)	Montgomery, MD (937507)	17	132	7.76
8)	Somerset, MD (26315)	14	143	10.21
9)	Calvert, MD (86547)	13	118	9.08
10)	Queen Annes, MD (42537)	11	108	9.82
11)	St. Marys, MD (91619)	6	45	7.50
12)	Delaware	3	17	5.67
13)	Charles, MD (134449)	3	33	11.00
14)	Other States ()	2	17	8.50
15)	Unknown ()	2	0	0.00
16)	Harford, MD (232751)	2	13	6.50
17)	Washington, MD (134521)	1	19	19.00
18)	Cecil, MD (92830)	1	44	44.00
19)	Prince Georges, MD (844597)	1	6	6.00
20)	Howard, MD (253372)	1	10	10.00
21)	Virginia	1	6	6.00
22)	Baltimore County, MD (772271)	1	11	11.00
	Total for Patient County:	**303**	**2,990**	**9.87**

8. Are preventive and outpatient services for behavioral health issues in the child and adolescent population optimized in the lower Eastern Shore? How do hospitalization rates in the PRMC service area compare with use seen in other regions of Maryland and what does this comparison indicate about the relative need for investment in hospital facilities versus alternative, non-inpatient programming to address the needs of persons in the 5 to 17 age range. (We recognize that PRMC states that the absence of data on Delaware hospital use comparable to that available for Maryland and District of Columbia hospitals have led it to state that "there is no way to accurately measure historical comparative utilization." However, we feel it is imperative to have some understanding of the appropriateness of hospital use rates being used to inform the analysis of need for this project, so please respond to this questions as best you can, employing reasonable, fact-based assumptions as necessary.)

Applicant Response:

Preventive and outpatient services for behavioral health issues in the child and adolescent population is optimized within the constraints of existing resources. However, those resources are deficient in light of the absence of a local source of dedicated inpatient hospital services for this population in the region. In order to sustain a system of accessible services, including alternative and non-inpatient care for this population, a local high quality inpatient service is an essential component. Acute care needs require acute care resources. In terms of behavioral health needs of children and adolescents, this means an inpatient hospital unit, with dedicated beds and staffed by local clinical experts that are available and accessible.

We have reasonably and conservatively assumed that the future need and demand for the inpatient services being proposed in this Application is more closely related to the actual average number of discharges reported by some, but not all, of the hospitals which have provided inpatient hospital care to the children and adolescent residents of the lower Eastern Shore. To speculate on what the actual discharge rates might have been in the Delaware hospitals that do not report utilization data publicly is not a particularly useful exercise and would provide no useful guidance to the Commission.

The fact that historical patterns of hospital discharges and patient days are based on significant out-of-area migration also makes a comparison of use-rates problematic. No other population of Maryland residents bears the burden of traveling such distances to obtain admission to an inpatient bed when needed. It only seems reasonable to assume that these burdens have suppressed access to needed care below optimal levels.

In addition, the difficulty of determining the appropriateness of hospital use rates for this population is also complicated by the fact that it is very small relative to use rates for the comparable populations who live in the urban and suburban areas of the State, where there are multiple local providers of both community-based and hospital-based care.

In our view, it will likely take some time after the proposed unit becomes operational to understand the appropriateness of its utilization for a distinctly rural population without access to an existing local inpatient hospital unit, and whether the actual use rates are or are not comparable to other regions in the State. To do so without such data seems to be a premature exercise and would likely omit all of the distinctive aspects of this Project and the benefits it will provide.

9. Why did the Adventist HealthCare hospital in Dorchester close? Why was it unable to succeed as PRMC projects its proposed program will succeed? What are the key differences that will make success in Salisbury at a general hospital likely, in light of the demise of this facility?

Applicant Response:

Peninsula Regional Medical Center's executive team was not privy to the Adventist HealthCare's reasons for the closure of the Dorchester hospital, and has no knowledge of these matters beyond what is in the public record, as submitted directly to the Commission by Adventist HealthCare. It appears from that documentation that Adventist HealthCare temporarily delicensed the psychiatry beds and closed the facility because its lease expired, rather than closing because it was unable to succeed. We understand that Adventist HealthCare did not seek to relicense or relocate those beds within the allowable period of temporary delicensure.

10. Your application states that "a comprehensive statement of assumptions is provided in Attachment 3." However, we are unable to locate that document. Can you please clarify its location or provide it?

Applicant Response:

The statement on page 37 of the application was pointing to the table package as the assumptions. The table on page 38 outlines the model assumptions used for the financial tables. Question 11 below provides details on the volume assumptions.

11. Attachment 13 is identified as "data showing the historic utilization of Maryland hospitals for the inpatient psychiatric services provided to children and adolescents." Please provide a clear and simple summary of the data provided by the attachment for the time series 2010 to 2016 by the service area parameters being reviewed. Explain how this "historic utilization of services among residents of the PRMC service area" is reflected in the projections of use provided in Attachment 3, Table 1.

Applicant Response:

The need to provide a dedicated space for inpatient beds for children and adolescents at PRMC has emerged as a planning priority on the lower Eastern Shore following the closure of the Adventist HealthCare Dorchester hospital. This project for the proposed unit continues the development of the campus as a site for cost-effective and accessible inpatient hospital services.

Attachment 13 in the original application is historical inpatient child & adolescent behavioral health discharges and patient days among local service area residents for Maryland Hospitals. The source of this data is HSCRC (Health Services Cost Review Commission) non-confidential data set provided by vendor PCAnow, New Health Analytics @ www.info@newhealthanalytics.com

The foundation for the child and adolescent bed need analysis was developed using the most current data available to determine the existing numbers of hospital discharges and patient days of care provided to residents of the service area, ages 5-17, in 2010 through 2016 for Maryland Hospitals. The data in

"Attachment 13" of the original CON indicates on average over the last eight years there are over 370 discharges per year, over 3,400 patient days and an average daily census of between 9 and 10. These are children and adolescents in Peninsula Regional service area that are receiving inpatient behavioral health services at other Maryland Hospital/Psychiatric facilities "out of area". The majority of patients as indicated in "Attachment 13" were being transferred to Potomac Ridge Eastern Shore doing business as Adventist Healthcare and Behavioral Health and Wellness Services in Dorchester County, Cambridge Maryland. This facility closed in November 2016 creating a hardship on families having now to travel extended distances for inpatient care. The data in "Attachment 13" is summarized on page 29 of the CON narrative as follows indicating bed need:

Discharges and Patient Days		12-month period ending 2 quarter								
Behavioral Health: Ages 5-17										
PSA Dorch, Somerset, Sussex DE, Wicomico, Worcester, Accomack										
		2010	2011	2012	2013	2014	2015	2016	Total	Average
MD Acute General	Discharges	9	6	11	14	10	13	5	68	10
	Pt. Days	134	14	68	112	86	112	22	548	78
	ALOS	14.89	2.33	6.18	8.00	8.60	8.62	4.40	8.06	8.06
PSA Dorch, Somerset, Sussex DE, Wicomico, Worcester, Accomack										
MD Psych Hospitals		2010	2011	2012	2013	2014	2015	2016	Total	Average
	Discharges	264	276	302	230	252	212	191	1727	247
	Pt. Days	2934	2122	2551	2092	2347	2025	2017	16088	2,298
	ALOS	11.11	7.69	8.45	9.10	9.31	9.55	10.56	9.32	9.32
PSA TOTAL										
ALL MD Hospitals		2010	2011	2012	2013	2014	2015	2016	Total	Average
	Discharges	273	282	313	244	262	225	196	1795	256
	Pt. Days	3068	2136	2619	2204	2433	2137	2039	16636	2,377
	ALOS	11.24	7.57	8.37	9.03	9.29	9.50	10.40	9.27	9.27

SSA Northampton VA, Kent, Caroline, QA, Talbot										
MD Acute General		2010	2011	2012	2013	2014	2015	2016	Total	Average
		10	6	14	16	11	18	10	85	12
		41	25	69	142	82	114	51	524	75
		4.10	4.17	4.93	8.88	7.45	6.33	5.10	6.16	6.16
SSA Northampton VA, Kent, Caroline, QA, Talbot										
MD Psych Hospitals		2010	2011	2012	2013	2014	2015	2016	Total	Average
	Discharges	124	113	112	81	74	104	126	734	105
	Pt. Days	1343	872	981	807	796	995	1255	7049	1,007
	ALOS	10.83	7.72	8.76	9.96	10.76	9.57	9.96	9.60	9.60
SSA TOTAL										
ALL MD Hospitals		2010	2011	2012	2013	2014	2015	2016	Total	Average
	Discharges	134	119	126	97	85	122	136	819	117
	Pt. Days	1384	897	1050	949	878	1109	1306	7573	1,082
	ALOS	10.33	7.54	8.33	9.78	10.33	9.09	9.60	9.25	9.25
SSA+PSA TOTAL										
ALL MD Hospitals		2010	2011	2012	2013	2014	2015	2016	Total	Average
	Discharges	407	401	439	341	347	347	332		373
	Pt. Days	4,452	3,033	3,669	3,153	3,311	3,246	3,345		3,458
	ALOS	10.94	7.56	8.36	9.25	9.54	9.35	10.08		9.26

This preceding discharge data includes only Maryland hospitals, and not hospitals located in neighboring Delaware, and estimating the total service population's overall discharge rate is difficult because the Delaware hospitals do not report inpatient utilization publicly, and the service population of PRMC includes residents of Sussex County, Delaware, multiple Maryland counties, and two Virginia Eastern Shore counties. For this reason, it is difficult to make projections on future potential discharges and days of those residents of Delaware and Virginia who use Peninsula Regional. Our view is that any potential "gap" in utilization between the overall Maryland population and the population of Delmarva Peninsula could be a measure of unmet need. By increasing the availability and accessibility of these services over time, we fully expect the utilization of the proposed unit at PRMC could increase the discharge rate of residents.

12. Please clarify the discrepancy on page 2 of Attachment 13 (219 cases and 2,350 patient days for Maryland psychiatric hospitals for the 12 months ending with the second quarter of 2016) and the data shown on page 8 for the same hospitals and the same time period (191 cases and 2,017 patient days).

Applicant Response:

Accessing inpatient psychiatric data is extremely difficult due to the sensitive nature of the information. Peninsula Regional spent approximately six months requesting access and compiling data to be used as the basis for the need analysis. Three data sources referenced include: PCAnow New Health Informatics (HSCRC non-confidential data set); The St. Paul Group (HSCR non-confidential data set) and Peninsula Regional's Emergency Room Transfer Report. Both external vendor information was limited as to availability of data fields and in some instances incomplete data, which presented difficulties for comprehensive operating and planning analysis.

The difference as referenced is most likely a difference in timing of when the report was generated, or as with our decades of experience in data analysis, it can be attributable to corrections in retroactive adjudication by Maryland hospitals. The data presented in these reports was generated directly from these external vendors with data supplied from the HSCRC provided by the Institutions with no modifications from Peninsula Regional.

13. Are there any physician staffing expenses for this project? (There do not appear to by any shown in the work force table.) Explain the plan for providing medical direction for this program. How many child psychiatrists are on the staff of PRMC?

Applicant Response:

The physician expense is in the contractual services expense line item in both the New Facility Service uninflated and inflated tabs. A full-time child and adolescent acute inpatient psychiatrist will be hired to provide both psychiatric services and medical direction oversight to the unit. A secondary child and adolescent psychiatrist will also be hired to provide full-time psychiatric services. In addition, advanced practice practitioners are being explored as staffing options to complement and support the two psychiatrists. We currently have one psychiatrist providing child and adolescent services in the PRMC behavioral health outpatient clinic.

14. If available, please provide a PRMC financial statement for FYE June 30, 2018.

Applicant Response:

At Appendix B is a copy of the audited financial statements for FY 2018.

15. Specifically describe the way in which necessary separation of the child and adolescent sections of this unit will be controlled and maintained.

Applicant Response:

As seen in drawings provided behind Tab 4 in the original CON – "PRMC Peds + Adol Psych Unit Option 3_05", there is a separation included between the Children and Adolescent areas. The nurse station separates the two areas and the nurse station has a door on each side—one side to the adolescent area and another door to the pediatric area.

Standard AP 6
16. Please provide copies of the written quality assurance programs, program evaluations, and treatment protocols for child and adolescent psychiatric services, if any exist.

Applicant Response:

Attached you will find the following documents we have drafted in preparation for the opening of the unit:

Attachment C- Behavioral Health Services: Scope of Services for Professional Services for PRMC Behavioral Health Services
Attachment D – Patient Safety Plan
Attachment E – Performance Improvement Plan (PIP) 2019
Attachment F – Standing Orders and Standards of Care
Attachment G – Quality Management Plan

Standard AP 8
17. What is the level of uncompensated care for acute child and adolescent psychiatric patients in Maryland in the most recent 12-month period for which data is available?

Applicant Response:

Estimating the level of uncompensated care for acute child and adolescent psychiatric patients in Maryland hospitals is complicated by the fact that there is no clear measure of "uncompensated care" that is assigned to particular groups of hospital discharges.

We examined the discharge data of patients age 0-17 from Maryland Psychiatric hospitals for Quarter 1, 2016 through Quarter 4, 2016. There were 4,979 discharges, whose sources of payment were assigned to 11 different payer categories. The largest single category was "Unknown," which accounted for 1,610 discharges, or 32% of the total cases. Two categories might be considered proxies for uncompensated care: "Self Pay" and "Charity/No Charge," which accounted for 1.3% and 0.2% of the total respectively. (See Attachment H)

A similar examination was conducted among comparable patients discharged from any Maryland acute care general hospital. In this cohort of 567 discharges, "Self Pay" accounted for 0.5% of the total.

Based on these data, the level of "uncompensated care" is estimated to be approximately 1.4% of total discharges for the period examined.

Standard AP 12b
18. How many qualified private therapists are available in the service area to which PRMC will refer discharged patients? Do these therapists accept and treat Medicaid patients? Which staff persons identified in Table L are the "after-care coordinators?"

Applicant Response:

The approximate number of outpatient therapists who offer behavioral health services in the surrounding four counties is 150. At Attachment I is a list used as a guide and does not signify the exact number as some therapists work at more than one site. The therapists at the PRMC behavioral health outpatient clinic both accept and treat Medicaid patients.

The "after-care coordinator" or discharge planner was placed in the Unit Clerk/Secretary line in table L of the original CON application.

Standard AP 13
19. Describe the key facilities, programs, and organizations ("inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs") in the service area that will comprise the referral network for discharged child and adolescent psychiatric patients.

Applicant Response:

Please see Attachment N showing the various facilities, programs and organizations in our primary service area that constitute the referral network for children and adolescents when discharged from the acute care inpatient unit.

20. Please provide the written policies governing discharge planning and referrals between PRMC and other referral network services, if any exist.

Applicant Response:

Please see attached the following documents:

Attachment J – Behavioral Health Services: Admission/Discharge Criteria
This document is in draft form as the child and adolescent acute inpatient unit is being included. This document shows the unit's discharge criteria and the referral process to the next appropriate level of care.
Attachment K – PRMC Child & Adolescent Outpatient Referral Sources
This document reflects the current mix of outpatient therapists and providers in the primary service area. It should be noted that providers tend to work at more than one site so this list is only stating the number of available therapists/providers at any one site.

Attachment L – MOU w/Wicomico County Health Department
This document outlines the ongoing relationship established between PRMC and the WiCHD COAT Team members where PRMC patients experiencing substance issues are referred for follow-up services.
Attachment M – MOU w/Lower Shore Clinic
This document outlines the relationship established between PRMC and Lower Shore Clinic.
In addition, PRMC has signed a letter of intent for integration of services with McCready Health in Somerset County who offer an intensive outpatient behavioral health addiction program for individuals aged 12 and older.

21. Justify the assumption that PRMC will achieve a 75% and 35% market share, in the PSA and SSA, respectively.

Applicant Response:

We have assumed that some patient outmigration from the proposed service area will continue to out-of-area hospitals after the commencement of inpatient psychiatric services for children and adolescents at PRMC. This assumption is based on the fact that the new unit will be in a "ramp up" mode for some period of time, physicians and others may continue to refer their patients for acute care services provided at out-of-the-area hospitals, new physicians and others will need time to build the referral base for their practices, and other factors related to acuity of the patient, and patient preferences. In addition, because the unit will only have 15 beds, distributed between dedicated children and adolescent patient rooms, there may be occasions when the unit will be fully occupied, or will not have a sufficient number of beds to separate male and female patients, or patients with special medical needs requiring a private room. All of these factors were considered in assuming the unit's market share percentages of 75% and 35% for the PSA and SSA respectively.

22. Did your assessment of need consider the provision of services in non-hospital settings and/or population-health initiatives? Please elaborate.

Applicant Response:

Yes. PRMC continues to partner, when clinically appropriate, for the provision of behavioral health services for children and adolescents not in crisis. Post an acute need, the community-based services are appropriate, however, our CON is for a service not found within our region. Please see Attachment N for a listing of community based organizations/services.
In addition, we are looking at opportunities to proactively treat this population in the community by educating families, schools and other agencies on the early warning signs of a behavioral health crisis and work to connect them to the appropriate resources to ideally prevent an acute episode. To this same end, we are currently working to integrate behavioral health into primary care practice sites.

23. Please clarify the project financing plan. Will the source of funds for the project include four million dollars of philanthropic donations (as indicated on page 47) or two million (as indicated in the project budget schedule)?

Applicant Response:

As stated on page 47, there are commitments in hand of $2 million that are being used to finance this project. The foundation board recently approved a second phase of the campaign. The purpose of disclosing the second phase was to highlight the tremendous community support for the provision of child and adolescent inpatient services. As seen in Table E of the original CON application, we are only allocating $2M in foundation support and the remaining in cash.

24. Please identify the hospitals that will experience a projected impact as a result of implementing this proposed project and quantify that impact by projecting the shift in admissions that will occur.

Applicant Response:

We anticipate that Dover Behavioral Health, the Psychiatric Institute of Washington, and Sheppard Pratt will see a projected impact when the PRMC Child and Adolescent Behavioral Health Unit is operational and meeting the needs of the Delmarva Peninsula.

As seen on Table 8 below, data collected from PRMC's Emergency Room between October 2017 and September 2018, approximately 40 transfers were made to Dover Behavioral Health, 33 transfers were made to the Psychiatric Institute of Washington, and 34 transfers were made to Sheppard-Pratt facilities. We project that the transfers of patients from the PRMC Emergency Department to these respective inpatient behavioral health units will adjust upon commencement of the proposed 15-bed unit.

The 175 transfers indicated below represent the most recent four quarters of PRMC ER Transfers. This is an increase compared to the 153 transfers submitted in the original CON (Tab 12, "Peninsula Regional Medical Center Emergency Room Transfer Data") trended over multiple quarters since 2014. PRMC continues to experience a need for child and adolescent inpatient services locally.

Table 8
PRMC ER Transfer Data

	QTR 4 - 2017	QTR 1 - 2018	QTR 2 - 2018	QTR 3 - 2018	Grand Total
ADVENTIST REHAB HOSPITAL	2	2	1	2	7
A.I. DUPONT		2	1		3
BROOKLANE HEALTH SVS	3	3	2		8
CHILDREN'S NATIONAL MED	2	3		1	6
DOVER BEHAVIORAL HEALTH	11	7	15	7	40
JOHNS HOPKINS		1	1	1	3
MEDSTAR FRANKLIN SQUARE	2	1	2	1	6
MEADOW WOOD BEHAVIORAL HEALTH	2	1	2	1	6

PSYCHIATRIC INSTITUTE OF WASHINGTON	14	10	8	1	33
ROCKFORD MED CTR	2	2	5	2	11
SHEPPARD PRATT	6	7	8	12	33
SHEPPARD PRATT ELLICOTT CITY		1			1
SUBURBAN HOSPITAL	2			1	3
TERRY CHILDREN'S PSYCHIATRIC FACILITY		1			1
UNIVERSITY OF MARYLAND	4	3	1	6	14
Grand Total	50	44	46	35	175

Source: PRMC ER Transfer Data