Ruby Potter
Health Facilities Coordinator
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Hope Health Systems, Inc – Matter No. 20-03-2444 – Completeness Response

Dear Ms. Potter,

On behalf of applicant Hope Health Systems, Inc., we are submitting four (4) copies of its Response to the MHCC Request for Completeness Information dated November 22, 2020.

Sincerely,

Bryan Niehaus

Bryan Niehaus, JD, CHC
Vice President
Advis

STATE OF MARYLAND

Robert E. Moffit, Ph.D.
CHAIRMAN

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

November 22, 2020

VIA E-MAIL

Mr. Yinka Fadiora
Hope Health Systems
1726 Whitehead Road
Woodlawn, Maryland 21207

Re: Application for Certificate of Need to Establish a Freestanding Inpatient Psychiatric Hospital for Children and Adolescents, Matter No. 20-03-2444

Dear Mr. Fadiora:

Commission staff has reviewed the above-referenced application for a Certificate of Need (CON). We have a number of completeness questions which will require a response before we can docket this application; please respond to the following questions and requests for additional information or clarification.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. You failed to state the date and state of incorporation (p. 4 of the application). Please provide this information.

2. In Exhibit 8, it appears that the approval of land for the use of a psychiatric hospital has not been finalized. In addition, you provide that the land is currently zoned for "manufacturing-light." According to Baltimore County zoning classification, such zoning permits "light industrial uses such as assembly plants and processing." Please document that operating an inpatient psychiatric hospital is an allowed use on this site.

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

3. Identify the facilities that each of the three owners listed on page 12 were involved with, their role at each one, and the dates of their involvement.

4. Please provide an organization chart for your company showing the relationships between the applicant and the corporate entities.

COMAR 10.24.07, State Health Plan for Facilities and Services: Psychiatric Services

Standard AP 4b

5. You have specified in the drawings that there are separate sleeping and nursing units for each age cohort. Specifically describe the way in which necessary separation of the child and adolescent sections of this unit will be controlled and maintained beyond sleeping areas to include dining area, social areas, and therapy space.

Standard AP 5

6. Describe the efforts you have made to acquire transfer agreements (to and from) with local acute care hospitals.

Standard AP 6

7. Please provide draft copies of the written quality assurance programs, program evaluations, and treatment protocols for child and adolescent psychiatric services.

Standard AP 12c

8. What is the content of the additional training that will be provided to the staff prior to opening the new inpatient hospital program?

Standard AP 13

9. 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.

Standard AP 14

10. No letter from DHMH was provided; please provide such a letter.

Other Criteria from COMAR 10.24.01.08G

Need

11. As discussed in our application review phone call of November 13, it would be helpful to MHCC staff if you could provide a tighter, more concise explanation of how the data you presented in the various tables in this section weave together into the conclusions you reach.

12. Some of your figures (figure 10, figure 11, and figure 17) are not labeled appropriately and thus the existing or intended service area is not clearly defined throughout your analysis. Please label the defined population in each figure correctly.

13. Many of the tables (you label them "Figures") in your response to the Need criterion do not cite the source of the information. Please provide citations for each figure.

14. In Figure 13, it shows multiple psychiatric hospitals with occupancy rates well over 100 percent. Please explain exactly how occupancy rates of over 100 percent were calculated and reported.

15. The Need criterion requests the applicant to address "the equipment included in the project, with information that supports the validity of these assumptions." Per Exhibit 1, Table E you are allocating $131,250 for fixed equipment under renovations. Please provide what equipment you will be purchasing and why it is needed.

Availability of More Cost-Effective Alternatives

16. The instructions under this criteria ask you to address:

a) the expansion of existing programs with current providers of acute inpatient psychiatric services to children and adolescents as an alternative as well as,
b) how HHS believes community based care, using population health measures, can been optimized to provide an alternative to inpatient hospitalizations.

Please examine and answer these two alternatives in your response.

Tables

Table E

17. Please provide more explanation regarding the possible expenditures to be covered by the $697,134 on line f, described in the assumptions as "additional contingency for miscellaneous items and troubleshooting throughout the start up process."

Table I

18. Explain why you project an ALOS decrease from 9.2 to 8.3 between 2022 and 2028?

Tables J and K

19. As the instruction on the tables require, please specify the expenses accounted for in line j, "Other Expenses."

Table L

20. What are the job titles of the 2.0 FTE's in Administration?

21. In the text of the application, you state that the facility will employ "Aides," but no such position is listed.

Please submit four copies of the responses to completeness questions and the additional information requested in this letter within ten working day of receipt. Also submit a response electronically, in both Word and PDF format, to Ruby Potter (ruby.potter@maryland.gov).

All information supplementing the application must be signed by person(s) available for cross-examination on the facts set forth in the supplementary information, who shall sign a statement as follows: "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."

Should you have any questions regarding this matter, feel free to contact me at (410) 764-5982.

Sincerely,

Eric Baker
Program Manager/CON Analyst

cc: Gregory William Branch, M.D., MBA, CPE, FACP, Baltimore County Health Officer
Patricia Nay, M.D., Executive Director, Office of Health Care Quality, MDH
Suellen Wideman, Assistant Attorney General
Jeanne Marie Gawel, Program Manager MHCC

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. You failed to state the date and state of incorporation (p. 4 of the application). Please provide this information.

Applicant Response: 09/16/1999 / Maryland

2. In Exhibit 8, it appears that the approval of land for the use of a psychiatric hospital has not been finalized. In addition, you provide that the land is currently zoned for "manufacturing- light." According to Baltimore County zoning classification, such zoning permits "light industrial uses such as assembly plants and processing." Please document that operating an inpatient psychiatric hospital is an allowed use on this site.

Applicant Response:

As staff note, the property is currently zoned M.L. – Manufacturing Light. HHS is actively pursuing a final zoning approval plan with the Zoning Commissioner. HHS will provide an updated response on this item as soon as it confirms the required steps and timeline with Baltimore County.

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

3. Identify the facilities that each of the three owners listed on page 12 were involved with, their role at each one, and the dates of their involvement.

Applicant Response:

1. Woodlawn, MD
6707 Whitestone Rd
Suite 106
Baltimore, MD 21207
Phone 1: 410.944.HOPE
Phone 2: 410.265.8737
Fax: 410.265.1258
Email: info@hopehealthsystems.com
All the programs including: Outpatient mental health clinic, Behavioral health coordination, Expanded School based Mental health, Mobile Treatment Services Unit, Health homes, Psychiatric Rehabilitation Program (PRP), Correctional and aftercare mental health services, Case management, Adult services, Intensive outpatient program, Partial hospitalization Programs, Substance abuse Treatment and consulting services.

Oladipo Fadiora – CEO – June 2006-Present
Lanre Fadiora – CFO – June 2006-Present
Yinka Fadiora – Executive Director – June 2006-Present

2. Greenspring, MD
2605 Banister Rd
Baltimore, MD 21215
Phone: 410.878.0236
Fax: 410.567.0399
All the programs including: Outpatient mental health clinic, Behavioral health coordination, Expanded School based Mental health, Mobile Treatment Services Unit, Health homes, Psychiatric Rehabilitation Program (PRP), Correctional and aftercare mental health services, Case management, Adult services, Intensive outpatient program, Partial hospitalization Programs, Substance abuse Treatment and consulting services.

Oladipo Fadiora – CEO – May 2013-Present
Lanre Fadiora – CFO – May 2013-Present
Yinka Fadiora – Executive Director – May 2013-Present

3. Carroll County No PHP AND IOP
6210 Georgetown Blvd
Suites A, B & C
Eldersburg, MD 21784
Phone: 410.216.5500
Fax: 410.567.0401

All the programs including: Outpatient mental health clinic, Behavioral health coordination, Expanded School based Mental health, Mobile Treatment Services Unit, Health homes, Psychiatric Rehabilitation Program (PRP), Correctional and aftercare mental health services, Case management, Adult services, Substance abuse Treatment and consulting services.

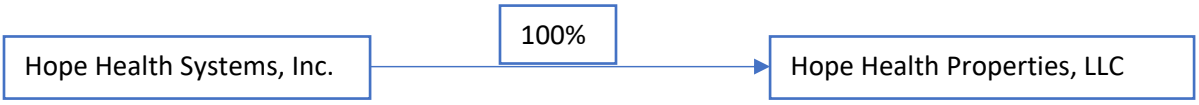
Oladipo Fadiora – CEO – October 2015-Present
Lanre Fadiora – CFO – October 2015-Present
Yinka Fadiora – Executive Director – October 2015-Present

4. Middletown, DE
417 E Main St
Middletown, DE 19709
Phone: 302.376.9619
Fax: 302.378.1028
All the programs including: Outpatient mental health clinic, Behavioral health coordination, Expanded School based Mental health, Mobile Treatment Services Unit, Health homes, Psychiatric Rehabilitation Program (PRP), Correctional and aftercare mental health services, Case management, Adult services, Substance abuse Treatment and consulting services.

Oladipo Fadiora – CEO – November 2017-Present
Lanre Fadiora – CFO – November 2017-Present
Yinka Fadiora – Executive Director – November 2017-Present

4. Please provide an organization chart for your company showing the relationships between the applicant and the corporate entities.

Applicant Response: The applicant Hope Health Systems, Inc. does not have a parent company. The applicant is the only direct owner. The applicant does have 100% direct ownership of Hope Health Properties, LLC, which owns the building and site.



COMAR 10.24.07, State Health Plan for Facilities and Services: Psychiatric Services

Standard AP 4b

5. You have specified in the drawings that there are separate sleeping and nursing units for each age cohort. Specifically describe the way in which necessary separation of the child and adolescent sections of this unit will be controlled and maintained beyond sleeping areas to include dining area, social areas, and therapy space.

Applicant Response: The facility is designed to meet current best practices and FGI Guideline requirements. As seen in Exhibit 2, the child rooms shall be designated as Bedrooms 037, 038, 040, & 041. The nursing unit, room 035 will oversee the child rooms. The dining, social, and therapy space will be used by both age groups, however the plans of care and timing of use will differ between each age cohort to ensure clinically appropriate separation between children and adolescents. This is in keeping with existing clinical operations of like facilities within the State.

Standard AP 5

6. Describe the efforts you have made to acquire transfer agreements (to and from) with local acute care hospitals.

Applicant Response:

HHS has begun outreach to area hospitals to discuss agreements being put into place for clinically necessary and appropriate patient transfers should the project be approved by MHCC and progress towards licensure and active operations. HHS will contact each acute care hospital within the Central Planning Region to ensure coverage for patient transfers in advance of the facility becoming operational. HHS will work with any provider in good standing to execute transfer agreements to ensure that both incoming patients in need of our care and outgoing patients in need of care we cannot provide are accommodated. In addition to written transfer agreements with area hospitals, HHS will follow established protocols and procedures under the Maryland Emergency Medical Services (EMS) System.

Standard AP 6

7. Please provide draft copies of the written quality assurance programs, program evaluations, and treatment protocols for child and adolescent psychiatric services.

Applicant Response: HHS has included additional draft policies and procedures to document that it will have separate written quality assurance programs, program evaluations and treatment protocols for its distinct patient populations. The written Quality Assurance and Performance Improvement plan, Screening and Admission policy, and Treatment Plan are included as Exhibit 11. The multidisciplinary team will develop and follow individualized care plans for each patient to provide clinically appropriate care based on their age and diagnoses.

Standard AP 12c

8. What is the content of the additional training that will be provided to the staff prior to opening the new inpatient hospital program?

Applicant Response: HHS will implement a role-specific staff training and competency evaluation system based on peer-to-peer training using evidenced-based resources to ensure each medical staff and support staff member meets the experience and training requirements for children and adolescent acute inpatient psychiatric care. In addition to onboarding and initial credentialing/competencies, there will be regular training and competency evaluations in keeping with applicable laws and best practices.

HHS intends to utilize competency management software and reference materials from database resources to guide and develop the materials and tools used in the staff training and competency documentation process. The Joint Commission, Lippincott Solutions, the CDC, and HealthStream Assess resources, databases, and vendor services are all options for HHS to use in implementing training and competency evaluation for staff.

Standard AP 13

9. 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: HHS intends to work with any provider of services in good standing that is seeking care for a patient we can treat (i.e. incoming admissions/transfer) or that can treat a patient in our care (i.e. discharged or transferred patients). Patient choice will always be respected by HHS and while our own outpatient services will be an option for any inpatient discharges, our care coordinators and discharge plans will also work within the wider community to provide options that best suit the needs and preferences of our patients.

Examples of area providers that may comprise the referral network include:

- Hospitals: https://www.mhaonline.org/about-mha/member-hospitals
- Local Health Departments: https://msa.maryland.gov/msa/mdmanual/01glance/html/healloc.html
- Community Providers: http://www.mdcbh.org/membership-agencies

In addition, Agape Health Systems, Optimum Health System, Leading by Example Behavioral Health, Prince George's County Health Department, Baltimore City Health Department, and Baltimore County Health Department are some of the outpatient and local health departments that have supported this filing in our support letters that would comprise part of our referral network for patients. We have worked with and expect further opportunity for referrals from others such as Kennedy Krieger Institute affiliated with Johns Hopkins and the Baltimore City and County Public Schools. We have continued to field interest in our proposed facility to serve the needs of patients from other providers in the market, and we will add written support letters as available for consideration.

Standard AP 14

10. No letter from DHMH was provided; please provide such a letter.

Applicant Response: HHS has attached a copy of the letter of acknowledgment as Exhibit 12.

Other Criteria from COMAR 10.24.01.08G Need

11. As discussed in our application review phone call of November 13, it would be helpful to MHCC staff if you could provide a tighter, more concise explanation of how the data you presented in the various tables in this section weave together into the conclusions you reach.

Applicant Response: HHS' presentation of the need for the proposed inpatient psychiatric facility is intended to highlight the mental health care crisis occurring in Maryland from the available data points. Below, HHS provides a short summary of each section with some clarifications informed by our MHCC discussions.

I. Service Area Definition (Pg. 42)

Relation to Need: Overall, Sections I and II are simply presenting foundational data regarding the service area boundaries and populations.

Summary/Clarifications: HHS intends to serve the central planning region, with a focus on the patients within a 30- and 60-minute drive time of the proposed location, as demonstrated in figure 5. This area was used as a basis for determining the patient population in the section II.

II. Population Estimates (Pg. 43)

Relation to Need: Overall, Sections I and II are simply presenting foundational data regarding the service area boundaries and populations.

Summary/Clarifications: In keeping with the service area definition described above, HHS identified the population estimates and projected population growth of the proposed service area. This was based upon the Maryland Department of Planning population projections. The Department of Planning age ranges were 0-4, 5-9, 10-14, 15-19. Therefore, the age groups were reanalyzed by HHS in order to group them into the state's definition of Children (ages 0-12) and Adolescents (ages 13-17). HHS assumed an equal population distribution within each age group provide by the Department of Planning.

The results of the population are reflected in the Figure 6 (State population) and Figures 7 and 8 (Central Planning Region). These figures were used within the analysis in Section IV- Figure 12 State of Maryland Bed Demand / Need Calculation.

III. Bed Shortages Based on Expert's Bed per Population Standards (Pg. 44)

Relation to Need: Section III is more of a contextual reference point for MHCC staff that is not directly correlated with the other Sections.

Summary/Clarifications: The Treatment Advocacy Center (TAC) estimates that a community should have access to approximately 50 inpatient psychiatric beds per 100,000 population. Although this estimate is specifically based upon the adult population, HHS identified no other clinical or academically published bed count recommendation specifically for children and adolescent age groups. Based upon the TAC benchmark, HHS concluded that there is a shortage of inpatient psychiatric beds, when assessed solely for the adolescent and children age groups,

as seen in figure 9. The Adolescent and Children analysis from Figure 9 have been combined and summarized below:

	Population	Staffed Bed Count	Beds Per 100,000 in Population	Staffed Bed Count at "Single Occupancy"	Beds Per 100,000
Maryland (Ages 0-17)	**1,352,663**	**221**	**16.34**	**158**	**11.68**

As noted during our verbal discussion with MHCC staff, this “expert consensus” is not a central pillar of HHS’ need analysis. Rather, HHS wanted to share it as a reference point for MHCC staff given the undefined need methodology for inpatient psychiatric beds under current State regulations.

IV. Historical Discharge Analysis (Pg. 45)

Relation to Need: Section IV begins the presentation of substantive data analysis showing the need for children and adolescent inpatient bed capacity based on historical use rates from HSCRC data, the total population, reported licensed/staff beds, and occupancy assumptions.

Summary/Clarifications: To further demonstrate need and the bed shortage for the adolescent and child age categories, HHS identified the hospital discharge rates published by the Maryland Health Care Commission in the April 2019 “White Paper: Maryland Acute Psychiatric Hospital Services”, which was complete through 2017 (Figure 10). HHS also requested HSCRC Public Use Data to identify discharge rates for 2017 – 2019. HHS identified minor differences between our rate and the rate identified by MHCC’s White Paper. HHS used the most recent 2019 discharge rates HHS identified in Figure 11 to create a Bed Need Calculation in Figure 12 on page 46.

Figure 12 shows an overall need for four (4) additional children beds and forty-eight (48) adolescent beds based upon population rates (Section II Figure 7 & 8), historical discharge rates (Figure 11), and Average Length of Stay (ALOS) from the 2019 HSCRC public use data obtained by HHS. Based on the higher need for adolescents, the applicant is requesting four (4) child beds and twelve (12) adolescent beds. The need is greater when the bed count is assessed as single occupancy. The single occupancy analysis was included as facilities are often unable to fully utilized beds in dual occupancy rooms due to patient safety considerations, reducing overall capacity and access.

The need determination was made based upon a 70% occupancy rate, which has been discussed by the MHCC Staff and Psychiatric Services Work Group as a level at which the state should consider evaluation of additional beds for facilities under 20 beds.

V. Needs Based on Historical Bed Occupancy Rates (Pg. 47)

Relation to Need: Section V builds in additional data indicating a system in need of additional capacity - presenting data from HSCRC regarding high occupancy rates at existing freestanding psychiatric hospitals and how high occupancy impacts patients being delayed or denied admission.

Summary/Clarifications: HHS prepared an analysis of the occupancy rates at the two freestanding inpatient psychiatric hospitals in the State of Maryland for Children and Adolescents, Sheppard Pratt and Brook Lane. The data presented in the original application was based upon combining the HSCRC Public Use Data HHS obtained and Financial Annual Reports filed by the providers with the HSCRC. Other general acute care facilities were not included in the HHS analysis since acute care hospitals do not report specific volumes or bed counts in the revenue rate center for the monthly Financial Reports to HSCRC that is specific to child and adolescent beds counts - "PCD PSYCHIATRIC - CHILD/ADOLESCENT".

In keeping with verbal discussions with MHCC, HHS notes that the analysis is far from perfect. There are no firm bed count numbers for children and adolescent psychiatric beds maintained by the State of Maryland. HHS' table in the original application combined two data sources (HSCRC Public Use volume figures + HSCRC Financial Report bed counts) to estimate occupancy rates. Below HHS reproduces one table using just the HSCRC volume and bed count data and our original table using HSRC Public Use volume data and HSCRC Financial Report data for reference. Depending on the data referenced, occupancy rates may range from around 85% to above 100%.

Occupancy rates in the analysis can go above 100% both because (1) HSCRC Financial report data can undercount "flexed" bed capacity at providers (See below response to Question #14) and (2) we do not have a bed count data element that correlates with the HSCRC public use files.

Bed Occupancy Rates FY2017-FY2019

Provider	Time Period	Total Patient Days[1]	Total Patient Admissions[1]	ALOS[1]	Bed Count[2]	Occupancy Rate
Sheppard Pratt	FY 2019	36,491	2,442	14.94	96	**104.14%**
	FY 2018	35,582	2,739	12.99	96	**101.55%**
	FY 2017	35,168	2,933	11.99	96	**100.37%**
Brook Lane	FY 2019	9,871	954	10.35	28	**96.59%**
	FY 2018	13,112	1,043	12.57	28	**128.30%**
	FY 2017	8,921	1,016	8.78	28	**87.29%**

[1]Based on HSCRC Public Use Volume data obtained by HHS
[2]Based on HSCRC Final Experience Report: https://hscrc.maryland.gov/Pages/hsp_Data2.aspx

Bed Occupancy Rates FY2017-FY2019

Provider	Time Period	Total Patient Days[1]	Total Patient Admissions[1]	ALOS[1]	Bed Count	Occupancy Rate[1]
Sheppard Pratt	FY 2019	31,871	2,480	12.85	96	**90.96%**
	FY 2018	31,633	2,758	11.46	96	**90.28%**
	FY 2017	29,543	2,909	10.16	96	**84.31%**
Brook Lane	FY 2019	10,142	1,046	9.69	28	**99.24%**
	FY 2018	11,342	1,259	9.01	28	**110.98%**
	FY 2017	10,606	1,027	10.32	28	**103.77%**

[1]Based on HSCRC Final Experience Report: https://hscrc.maryland.gov/Pages/hsp_Data2.aspx

HHS understands the above data could have flaws, but it represents the most concrete data available from HSCRC and the State of Maryland for documenting occupancy rates for children and adolescent beds. Given the need discussed in relation to the discharge delays and ED Boarding in Section VI, HHS felt it was important to show how existing facilities are experiencing high occupancy and correlated patient turn-away that is in part leading to these negative patient outcomes. Adding inpatient capacity through the proposed project is designed to help address these access issues and reduce negative outcomes.

VI. Need Based on Discharge Delays & ED Boarding (Pg. 49)

Relation to Need: Section VI builds on the indications of need for additional capacity seen in Sections IV and V by presenting research and data on an observable patient outcome issue tied to lack of existing bed capacity for children and adolescents: ED Boarding & Discharge delays. Section VI data is based on MHA surveys, HSCRC data, and some HHS extrapolation of the data sources, which was completed to visualize and document how many patients are experiencing negative outcomes (ED Boarding & Discharge Delays) tied to bed shortages

Summary/Clarifications: Emergency Departments exhibiting extended wait times for psychiatric patients (i.e. "ED Boarding") is a sign of inadequate inpatient psychiatric bed supply. The Maryland Hospital Association ("MHA") issued a report that indicated in 2018 there were 4,106 child visits and 8,198 adolescent visits to emergency departments across the state for psychiatric issues (12,304 total), with approximately 3,385 (27.5%) of those patients experiencing a delayed discharge.

Pursuant to the report from MHA, the reason for the delay in 45% of those 3,385 patients was: "waiting for bed space in an appropriate placement setting". The remaining reasons are summarized in Figure 15. Figure 16 demonstrates the total ED boarding numbers from 2010-2018 as published by the MHA.

HHS uses those statistics to demonstrate the proposed facility could help alleviate this burden. As seen in the final two columns of figures 18 & 19 (combined below); an estimated 1,523 child and adolescent patients were boarded at the ED due to lack of appropriate inpatient psychiatric beds. The proposed facility would be able to treat 534 of those patients, operating at 85% capacity.

Age Group	2018 Psychiatric ED Visits	Psychiatric ED Patients Who Experienced a Delayed Discharge	45% of Patients Who Waited on Appropriate Placement	Patients Served by the Proposed Hospital
Children (0-12)	4,106	1,130	508	234
Adolescents (13-17)	8,198	2,255	1,015	300
Total	**12,304**	**3,385**	**1,523**	**534**

VII. Re-Admission (Pg. 53)

Relation to Need: Section VII covering re-admission data touches on how increasing re-admission rates in the patient populations shows additional need for linkages between inpatient and outpatient care.

Summary/Clarifications: HHS further identifies a trend in inpatient psychiatric care that results in high re-admission rates. This is generally due to poor discharge planning and lack of outpatient support services. HHS already has a robust community-based outpatient and partial-hospitalization service line that will help reduce these concerns for recently discharged patients.

VIII. Mental Health Professional & CAP Shortages (Pg. 54)

Relation to Need: Section VIII covering provider shortages builds in yet another reference point for the need for additional psychiatric care resources within Maryland. The data is not a direct tie to additional inpatient capacity, but is presented because HHS believes adding a new inpatient facility will assist in further recruiting, developing, and increasing providers within the market for children and adolescents.

Summary/Clarifications: HHS provides information confirming the proposed location is designated by the Health Resources and Services Administration (HRSA) as a mental health professional shortage area (HPSA) and also identifies the location as a Child & Adolescent Psychiatrist (CAP) shortage area. By establishing the proposed hospital, HHS would help address these shortages.

IX. Additional Factors Indicative of Growing / Unmet Need (Pg. 56)

Relation to Need: Section IX presents additional reference points from research and data showing a growing and unmet need for treatment for mental health and behavioral disorders. This data builds in additional context for MHCC to consider regarding the size, variety, and pressing issues driving need for psychiatric care, including inpatient providers needed to address these issues.

Summary/Clarifications: HHS identifies several additional macro issues regarding the lack of mental health services for the adolescent and child age groups for the Board's consideration and reference. HHS plans to help alleviate these systematic issues.

X. Cumulative Project Need / Discharge Assumptions (Pg. 58)

Relation to Need: Section X presents an estimate to quantify how the data shows sufficient need to fill the proposed facility at 85% occupancy.

Summary/Clarifications: Based upon the identifiable need addressed in the above sections, HHS estimates the utilization of the proposed hospital. The majority of the patients coming to the proposed location would help to alleviate the ED boarding issue (identified in Figure 18 & 19 analysis), while a smaller minority are identified from general unmet need in the proposed service area (identified in Figure 12 analysis). HHS also projects ALOS and occupancy rates at the proposed hospital for the Board's reference.

XI. Hope Health Systems, Inc.'s Background & Rationale for Project (Pg. 59)

Relation to Need: Section XI is focused on HHS' background for MHCC.

12. Some of your figures (figure 10, figure 11, and figure 17) are not labeled appropriately and thus the existing or intended service area is not clearly defined throughout your analysis. Please label the defined population in each figure correctly.

Applicant Response: Figures 10, 11, and 17 all demonstrate State-wide population statistics based on data from HSCRC for the applicable age groups. We have re-produced each below for reference with additional notes regarding the source materials and definitions.

Figure 10 Psychiatric Discharge Rates per 100,000 Population, CY 2008-CY 2017[1]

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Use Rate Change
Child (0-12)	179	189	204	209	217	201	192	170	175	183	2.30%
Adolescent (13-17)	1,008	1,199	1,190	1,291	1,294	1,328	1,329	1,318	1,273	1,273	26.40%
Adult (>18)	853	896	896	905	887	869	850	804	802	772	-9.60%
All Ages	752	799	801	816	804	790	775	734	731	709	-5.60%

Source: MHCC staff analysis of HSCRC discharge abstract data, District of Columbia discharge abstract data, and private psychiatric hospital data, CY 2008 to CY 2017; Population data from the U.S. Census Bureau for 2008 and 2009; Maryland Department of Planning Projections, March 2018.

Note: For the HSCRC and DC data, psychiatric discharges are defined as records with major diagnostic category (MDC) coded for mental diseases and disorders. All records from private psychiatric hospitals are included regardless of the MDC category. The discharge rates do not incorporate discharges from State psychiatric hospitals.

Figure 11 Psychiatric Discharge Rates per 100,000 Population, CY 2017-CY 2019[2]

	2017	2018	2019
Child (0-12)	200	198	188
Adolescent (13-17)	1,319	1,280	1,133

Source: HHS analysis of HSCRC discharge data abstract.

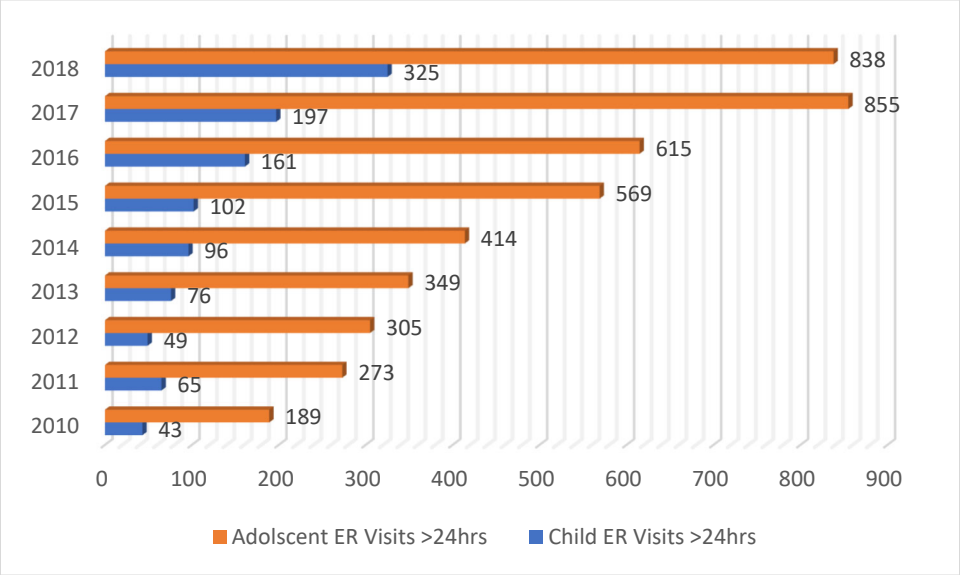
Note: For the HSCRC data, psychiatric discharges are defined as records with APR-DRG 740-776. Population data from the U.S. Census Bureau for 2017, 2018, and 2019.

1 Maryland Health Care Commission: "White Paper: Maryland Acute Psychiatric Hospital Services". April 2019

2 Based on HSCRC data extracts for APR-DRGs

Figure 17[34]

ED Visits for Children / Adolescents - >24 Hours



Source: MHCC staff analysis of HSCRC outpatient data, CY 2010-CY 2018.

Note: Psychiatric visits are defined as those with a primary psychiatric diagnosis in the following ranges for ICD-9 codes: 293-302 and 306-319 or a corresponding ICD-10 code. Records with an emergency department charge greater than zero are counted. Emergency department visits that resulted in admission to the same hospital are captured in HSCRC discharge data and not included in this analysis. Children are defined as age zero to 12 years of age. Adolescents are those age 13 to 17 years.

3 https://baltimore.cbslocal.com/2019/12/14/maryland-youth-needing-psychiatric-care-find-long-waits-drives/

4https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/Psych%20work%20group/Additional%20Handouts_20191106.pdf

13. Many of the tables (you label them "Figures") in your response to the Need criterion do not cite the source of the information. Please provide citations for each figure.

Applicant Response:

Figure Number	Description	Page No.	Citation
1	Uncompensated Care Percentage	24	https://hscrc.maryland.gov/Documents/Hospitals/gbr-tprupdate/FY-2020/UCCCareReport.pdf
2	Average Total Cost of Acute Psychiatric Admission – Central Planning Area	25	Maryland HSCSC custom data set
3	Current Clinical Staff	27	Internal information
4	Map of Proposed Service Area	42	Created with https://mapchart.net/usa-counties.html
5	Drive Time Map	42	Drafted from https://www.oalley.net/ using the proposed facility location. OALLEY is a map that shows you how far you can travel for a given time or a chosen distance. Depending on the means of transport chosen, OALLEY takes into account several criteria (speed limit on each type of road (city, countryside, motorway), timetables for public transport, cycle paths, etc.) and draws the limit area that you can reach for the specified distance or travel time.
6	State Population Estimates – Adolescents + Children	43	https://planning.maryland.gov/MSDC/Pages/s3_projection.aspx
7	Planning Area Population Estimate - Children	43	https://planning.maryland.gov/MSDC/Pages/s3_projection.aspx
8	Planning Area Population Estimate - Adolescents	44	https://planning.maryland.gov/MSDC/Pages/s3_projection.aspx
9	Bed estimated per 100,000	45	https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3696 & https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/Psych%20work%20group/Agenda%20Item%203_part1.docx.pdf
10	Psychiatric Discharge Rates per 100,000 Population	45	Maryland Health Care Commission: "White Paper: Maryland Acute Psychiatric Hospital Services". April 2019; https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/documents/psychiatric_services/con_shp_comar_10_24_07_White_Paper_Md_Acute_Psych_Hosp_Services.pdf

11	Psychiatric Discharge Rates per 100,000 Population, CY 2017-CY 2019	46	Maryland HSCSC custom data set
12	State of Maryland Bed Demand / Need Calculation	47	1: Population based on Maryland Department of Planning and estimates from Section (II) in this response. 2: Discharge Rate based on 2019 discharge rates reported for age group from HSCRC data 3: ALOS based on CY 2019 ALOS reported for age group from HSCRC data
13	Bed Occupancy Rates 2017-2019	47	HSCRC financial data final reports & Maryland HSCSC custom data set
14	Average Occupancy Rates & Patient Turn-Away	48	Jones, Rodney. (2013). Optimum bed occupancy in psychiatric hospitals.
15	MHA Report Chart on Reasons for Emergency Department Delays	51	https://www.mhaonline.org/docs/default-source/resources/mha-report-jan-2019.pdf?sfvrsn=74b0d40d_2
16	ED Visits for Children + Adolescents by Estimated Time	52	Maryland Health Care Commission: "White Paper: Maryland Acute Psychiatric Hospital Services". April 2019; https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/documents/psychiatric_services/con_shp_comar_10_24_07_White_Paper_Md_Acute_Psych_Hosp_Services.pdf
17	ED Visits for Children / Adolescents - >24 Hours	52	Maryland Health Care Commission: "White Paper: Maryland Acute Psychiatric Hospital Services". April 2019; https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/documents/psychiatric_services/con_shp_comar_10_24_07_White_Paper_Md_Acute_Psych_Hosp_Services.pdf
18	Patient Admissions Based on Alleviating ED Boarding – Children (0-12)	53	https://www.mhaonline.org/docs/default-source/resources/mha-report-jan-2019.pdf?sfvrsn=74b0d40d_2 & Maryland Health Care Commission: "White Paper: Maryland Acute Psychiatric Hospital Services". April 2019; https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/documents/psychiatric_services/con_shp_comar_10_24_07_White_Paper_Md_Acute_Psych_Hosp_Services.pdf

19	Patient Admissions Based on Alleviating ED Boarding – Adolescents (13-17)	53	https://www.mhaonline.org/docs/default-source/resources/mha-report-jan-2019.pdf?sfvrsn=74b0d40d_2 & Maryland Health Care Commission: "White Paper: Maryland Acute Psychiatric Hospital Services". April 2019; https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/documents/psychiatric_services/con_shp_comar_10_24_07_White_Paper_Md_Acute_Psych_Hosp_Services.pdf
20	Readmission Rates for Maryland Residents per 100 Psychiatric Discharges	54	Maryland Health Care Commission: "White Paper: Maryland Acute Psychiatric Hospital Services". April 2019; https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/documents/psychiatric_services/con_shp_comar_10_24_07_White_Paper_Md_Acute_Psych_Hosp_Services.pdf
21	HRSA HPSA Designations in Baltimore Area	55	https://data.hrsa.gov/tools/shortage-area/hpsa-find
22	Map of HPSA Designations in Baltimore Area	55	https://data.hrsa.gov/tools/shortage-area/by-address
23	Need Addressed by HHS – Children Beds	58	Internal estimates
24	Volume Assumptions – Children Beds	58	Internal estimates
25	Need Addressed by HHS – Adolescent Beds	59	Internal estimates
26	HHS Volume Assumptions – Adolescent Beds	59	Internal estimates
27	HHS' integrated care continuum	60	Internal Data and Documents
28	Impact on Existing Providers (Children)	71	Maryland HSCSC custom data set
29	Impact on Existing Providers (Adolescents)	72	Maryland HSCSC custom data set

14. In Figure 13, it shows multiple psychiatric hospitals with occupancy rates well over 100 percent. Please explain exactly how occupancy rates of over 100 percent were calculated and reported.

Applicant Response: Pursuant to discussions with Bob Gallion and Dennis Phelps at HSCRC, the occupancy rates reported were over 100% for some years due to the hospital 'flexing' some rooms that are not typically reported as staffed beds. The state identifies the average licensed bed count for each provider, and it is based upon the number of beds that were needed over a given monthly period. That number is then averaged for the final annual report. Thus, some months the provider exceeded the number of licensed beds, which HHS understands is permissible under state guidelines. The staffed beds in the HSCRC Final Experience Reports are defined as the number of beds regularly maintained (set up and staffed for use) for inpatients.

Final Experience Reports available at: https://hscrc.maryland.gov/Pages/hsp_Data2.aspx

15. The Need criterion requests the applicant to address "the equipment included in the project, with information that supports the validity of these assumptions." Per Exhibit 1, Table E you are allocating $131,250 for fixed equipment under renovations. Please provide what equipment you will be purchasing and why it is needed.

Applicant Response: This is for the inclusion of an emergency back-up generator that is required by code for the facility.

Availability of More Cost-Effective Alternatives

16. The instructions under this criteria ask you to address:

a) the expansion of existing programs with current providers of acute inpatient psychiatric services to children and adolescents as an alternative as well as,
b) how HHS believes community-based care, using population health measures, can been optimized to provide an alternative to inpatient hospitalizations.

Please examine and answer these two alternatives in your response.

Applicant Response

In arriving at the decision to pursue this project for an inpatient psychiatric hospital facility, HHS' primary consideration in planning was how HHS would be able to further deliver excellence in mental health services and provide needed services for the community. As a provider of outpatient behavioral health services, we witnessed the gaps in access for our adolescent and children patients. Our experiences were echoed by others within the provider community. As we analyzed the market and data, we came to the conclusion that our biggest gap in serving the community was the ability to increase access to and provide inpatient services for adolescents and children.

HHS believes this proposed project was a superior option to expanding existing programs with current providers of acute inpatient psychiatric services to children and adolescents. To start, HHS is not in control of other provider's expanding, decreasing, or even eliminating its programs for inpatient psychiatric services. As a result, we concluded our project could help address the need for additional access to care and we are now seeking State approval. Further, we believe our organization has the support of the provider and patient communities to bring another high-quality option for inpatient care that is not an extension of an existing program. The cost to our organization of expanding access through existing provider is $0.00, but our planning process led us to believe our development of high-quality and cost-effective inpatient psychiatric services was superior to the alternative of waiting/hoping the existing provider market maintained or increased access.

HHS does not believe this project is an alternative to population health, but rather a necessary component of an effective care continuum for those patients that truly require acute inpatient treatment. No population health initiative can replace inpatient acute psychiatric care for patients in need, and so it cannot serve as a true alternative to this project. However, HHS firmly believes in using population health frameworks and interventions to effectively manage community behavioral health to decrease the need for inpatient hospitalizations. We agree with the American Psychological Association's guiding principles for Population Health Framework for Behavioral Health, including:

- Use data and the best available science to inform policies, programs, and resources.
- Prevent when possible and otherwise intervene at the earliest moment.
- Strategize, analyze, and intervene at the community/population level (in addition to the individual).
- Reach broad and diverse audiences through partnerships and alliances.
- Utilize a developmental approach (e.g., change over time, age-appropriate interventions).
- Consider the "whole person" and the structural/systemic factors impacting individual behavior.
- Be culturally sensitive while also thinking transculturally.

- Recognize that inherent in every community is the wisdom to solve its own problems.
- Champion equity by addressing systemic issues (e.g., social determinants of health, access to treatment).

HHS already partners with area providers to impact behavioral health upstream (e.g. screening/referral at a primary care appointment for behavioral health conditions) rather than waiting for downstream outcomes (e.g. patient with unaddressed clinical condition deteriorates until hospitalization is required). We work to coordinate and integrate our services with the wider provider community to support education, access, and improved outcomes. HHS is a member of the Community Behavioral Health Association of Maryland, where the aim for improved Population Health in Maryland is central aspect of policy and advocacy efforts. However, we have also witnessed the budgetary constraints and complexity of our reimbursement systems hinder such population health efforts. Consensus on best approaches and initiatives are still being researched and developed. In the meantime, we feel the need for additional inpatient capacity is not one we should wait to pursue for children and adolescents.

In summary, the alternative of expanding existing programs or using population health to reduce inpatient utilization are both valid and worthy options to address the need for inpatient psychiatric care. However, they were not judged to be an immediate or superior solution to developing the proposed facility. We believe this project will help enable HHS to take an even more active role in championing population health for behavioral healthcare. As a provider of inpatient and outpatient services, HHS would be capable of participating and leading on issues and programs in a more meaningful manner compared to our current role as a non-hospital outpatient only provider.

Tables

Table E

17. Please provide more explanation regarding the possible expenditures to be covered by the $697,134 on line f, described in the assumptions as "additional contingency for miscellaneous items and troubleshooting throughout the startup process."

Applicant Response: The applicant has included significant contingencies to account for costs associated with necessary and unforeseeable building updates as the building transitions from business occupancy to health facility occupancy, as well as: site plan updates in keeping with occupancy requirements, increasing costs of supplies and materials brought on as a result of the pandemic, additional funds for supplies and necessary improvements needed to maintain enhanced safety protocols. Unused portions of the loan shall be retained as liquid capital.

Table I

18. Explain why you project an ALOS decrease from 9.2 to 8.3 between 2022 and 2028?

Applicant Response: The applicant believes in continuous improvement of the healthcare profession and finds it important to establish benchmarks and set goals associated with those improvement measures. The applicant set the ALOS in keeping with the current industry metrics in year 1, yet believes it shall be able to help reduce the ALOS through continuous improvements of its own processes and through more robust outpatient service options that will be provided to its patient population within the HHS continuum of care setting.

Tables J and K

19. As the instruction on the tables require, please specify the expenses accounted for in line j, "Other Expenses."

Applicant Response: The amount includes the following: annual lease, recruitment and training, marketing, and other miscellaneous expenses.

Table L

20. What are the job titles of the 2.0 FTE's in Administration?

Applicant Response: Administrator – 1.0 FTE ($158,400) and Clinical Director – 1.0 FTE ($109,300).

21. In the text of the application, you state that the facility will employ "Aides," but no such position is listed.

Applicant Response: A more formal name of psychiatric technician (psych tech) was utilized in Table L.

Additional Questions from MHCC

- On November 30, 2020, MHCC staff requested clarity via email regarding cost in the "Other Structure" column of Table E – Project Budget.

  Applicant Response: Per email communication with MHCC staff on December 1, 2020, HHS is providing a replacement Table E within this response. The replacement Table E places all the capital costs in the "Hospital Building" column.

- On December 15, 2020, MHCC staff requested clarity regarding a contradiction in the project summary whereby it was noted HHS both owns and leases the building where the proposed project will be developed.

  Applicant Response: HHS has provided a replacement page for Pages 5 of the application to correct the misstatement that Hope Health System, Inc. ("HHS") owns the building. As noted within the corrected page, Hope Health Properties, LLC owns the building which HHS will lease. HHS is the sole member of Hope Health Properties, LLC. Further the lease in Exhibit 3 of the filing references Hope Health Hospital, which is meant to refer to Hope Health Systems, LLC as the legal entity. HHS can provide an amended lease if deemed necessary by MHCC.

EXHIBIT 11

Hope Health Systems, Inc. Plan for Improving Organizational Performance

Scope – This policy is designed to address quality assurance programs, program evaluations, and performance Improvement

The Quality Assurance and Performance Improvement (QAPI) plan is designed to assess, monitor and improve the delivery of care to our patients. It is accomplished by a data-driven system that assesses patient care services, systems, and support processes in an ongoing manner to identify improvement opportunities and proactive strategies that will improve patient outcomes, patient safety, patient satisfaction, employee safety and professional/ administrative practice. This plan is designed to:

- Build on the strengths of HHS commitment to quality and safety performance measurement and improvement.
- Share our quality and safety performance measurement and improvement information in an atmosphere of collegiality and cooperation.
- Strive to achieve the highest possible standards of performance measurement, improvement activities, clinical care and service quality.
- Maintain accountability to our patients, community, and each other to maintain high standards for the quality of our work.
- Focus on system and process improvement.
- Make decisions based on data, which includes the care providers, and other stakeholders; evidence-based recommendations; data analysis of process and outcomes indicators; comparison of performance against benchmarks of national trends; staff and provider culture of safety surveys; and patient safety activities to enhance patient care practices.
- Adhere to regulatory requirements.
- Support performance improvement by encouraging our employees to support each other as well as be accountable for their own professional performance and practice.
- To provide a framework for defining quality and continuous improvement opportunities through:
    - setting priorities for the scope of the plan
    - selecting measures that are meaningful and address the needs of the patient
    - Identifying the frequency of data collection
    - Collection of Data
    - Performing data analysis to identify trends and outliers
    - Implementing and reporting actions taken to resolve the identified problems
    - Prioritizing improvement initiatives when necessary
- To maintain a plan for a non-punitive approach to identifying and reporting medical errors and managing all types of occurrences ranging from near misses to sentinel events.

Performance Improvement Steering Committee

The Medical Executive Committee and Executive leadership charges the Performance Improvement Steering Committee to develop and oversee implementation of the plan for improving performance and to assess and monitor the organization's performance; to respond to external review of the organization's performance; and to receive reports and monitor outcomes from the medical staff subcommittees and clinical departments.

METHODOLOGY FOR PERFORMANCE IMPROVEMENT

Plan Do Study Act

Plan-Do-Study-Act (PDSA) is a methodology to implement when making changes to improve. It is based on breaking down change into manageable chunks by testing change on a micro level and analyzing the results to validate improvement before implementing across the organization.

Root cause analysis

A process improvement and error or defect prevention tool that examines the individual processes within a system, identifies the control or decision points, and uses a series of "why" questions to determine the reasons for variations in the process paths.

Opportunities for quality performance measurement and improvement initiatives may also come from a variety of sources, including:

- Individual caregivers who identify a specific quality concern and develop a plan for improving a clinical process;
- Trends uncovered through occurrence reviews;
- Retrospective chart reviews;
- Review of claims and financial data;
- Patient complaints/grievances;
- Patient and staff satisfaction surveys;
- Regulatory agency requirements;
- Infection Prevention surveillance.

Departmental and Unit Level Opportunities

Service Line or Unit Level opportunities may be determined based on the following:

- Proactive risk assessment of high-risk processes
- High volume, high risk, problem-prone processes
- Patient safety and error reduction/ prevention
- Patient Outcomes
- Evidence-based care
- Infection Prevention
- Patient Experience/ Satisfaction
- Operational efficiency
- Staff Safety

Data Management

Data collection is systemic and organized, and is utilized to establish performance baselines, describe process capability, and sustain performance. The Quality Department works in collaboration with departments/individuals collecting data to ensure reliability, validity, completeness and accuracy of the data. The Quality Department is responsible for data collection on selected quality initiatives at HHS, including

- Gathering/coordinating information needed by the quality & process improvement and patient safety program.
- Providing guidance and consultation to the Board, medical staff, leaders and other hospital staff.
- Providing support and consultation to departments responsible for data collection and performance improvement and patient safety initiatives.
- Providing expertise in the data analysis arena.

- Documenting improvement activities via complete, timely and reliable reports.
- Submitting data to external agencies, the corporate quality office, and all stakeholders within established timeframes.
- Establishing and managing systems to ensure confidentiality of all data related information.
- Maintaining appropriate documentation of quality and process improvement activities, including cumulative profile findings, studies, etc.
- Providing continuing education on topics and tools related to performance improvement and patient safety.

Quality and process improvement and patient safety reports include analysis of aggregate data and statistical analysis, when indicated. Performance goals and measure indicators are reflected on dashboards and reports. Tools utilized for analysis may include dashboards, bar charts, control charts, Pareto charts, histograms, root cause analysis, failure mode effects analysis and hospital developed tools.

Data is analyzed and compared over time to identify levels of performance, patterns, trends, and variation. Benchmark comparisons are identified that trigger focused assessment and evaluation of the function, process, and/or care provided.

External sources are used for benchmark comparison when available. Internal comparisons are utilized when external benchmarks are not available or when internal benchmarks result in better performance. Results of data analysis are used to identify improvement opportunities, identify service delivery performance goals and indicators.

Quality Education
Continuing education and self-learning for all staff is promoted. The commitment to quality and process improvement & patient safety begins with each employee. Staff is asked to provide input into quality and process initiatives, and is routinely solicited for their feedback regarding initiatives. The organization strives to provide opportunities to train and enhance staff and leadership awareness of continuous quality, process improvement and patient safety strategies. Outcomes are communicated to stakeholders via a variety of mechanisms.

Communication and Reports
Results and performance improvement activities are communicated to the appropriate committees and governing bodies as depicted in the Performance Improvement Structure. This reporting is designed to allow each group to determine whether the expected activities are being carried out, what significant issues were identified and what improvements were made. Outcomes are communicated to stakeholders via a variety of mechanisms.

A list of the ongoing Quality and Safety Improvement initiatives for each FY shall be developed and included in Attachment A.

ATTACHMENT A: FY____ QUALITY AND SAFETY IMPROVEMENT INITIATIVES

TBD

HOPE HEALTH SYSTEMS, INC SCREENING AND ADMISSION POLICY

Scope: Inpatient Programs conduct the following screenings and assessments:

DESCRIPTION/OVERVIEW

This guideline defines in writing the data and information gathered during the initial screening and assessment process of clients seeking treatment.

1. Risk of harm to self or others
    a. Determine the need for immediate intervention to reduce risk of harm to self or others
2. Physical Health Assessment
3. Medical history and physical is completed within 24 hours of admission
    a. If a comprehensive medical history and physical examination have been completed by an LIP within 30 days of admission, a durable, legible copy of this report may be used in the case record
    b. The report must be reviewed by an LIP and any changes to the client's condition since the history and physical were performed must be recorded in the medical record
4. Nursing Assessment
    a. A registered nurse completes a nursing assessment within 24 hours of admission

Psychosocial Assessments

i. Data to be collected by clinical staff from the client and, as appropriate, relevant collateral sources (for example, family members, domestic partners, treatment guardians) includes but is not limited to:

1. Environment and living situation
2. Leisure and recreational activities
3. Religion and spiritual orientation
4. Childhood history
5. Military history, if applicable
6. Financial issues
7. Usual social, peer-group, and environmental setting
8. Sexual history
9. Physical abuse (either as the abuser or the abused)
10. Family circumstances, including the constellation of the primary family group
11. Current living situation
12. Social, ethnic, cultural, emotional and health factors

ii. If grief and/or bereavement are part of the client's presenting concerns, or become part of the client's concerns during treatment, staff further assesses the social, cultural and spiritual variables that might affect the client's grieving process

iii. The psychosocial assessment is completed within 72 hours of admission

Emotional and Behavioral Assessments:

i. Data to be collected by clinical staff from the client and, as appropriate, relevant collateral sources (for example, family members, domestic partners, treatment guardians) includes but is not limited to:

1. History of mental, emotional, behavioral, substance use problems: their co-occurrence and treatment
2. Current mental, emotional and behavioral functioning including but not limited to:
    a) Mental status exam
    b) Maladaptive or problem behaviors

c) Community resources that have been accessed by the client

ii. Emotional and behavioral assessments are completed within 72 hours of admission

When indicated, the following evaluations are conducted:

1. Mental status
2. Psychiatric
3. Psychological
4. Language, self-care, visual-motor, and cognitive functioning

Nutritional Exam

i. A nutritional screening is completed

1. The need for additional nutritional assessment and evaluation is determined and a referral for a nutritional assessment is generated based on data collected in the nutritional screening – for example:
    a) Recent (past month) weight gain or loss of 10 or more pounds
    b) Recent (past month) history of binging or purging
    c) Recent (past month) history of chewing, swallowing or tooth problems
    d) Diagnosis of diabetes mellitus and desires nutritional education
    e) Religious or spiritual dietary preferences
    f) Food allergies
    g) Poor or no dentition
    h) Appearance including frail, undernourished, very thin

ii. Nutritional screening is completed within 24 hours of admission

Educational

i. An educational screening is completed

1. The need for additional educational assessment and evaluation is determined
    a. A referral for an educational assessment is generated based on data collected in the educational screening

ii. Educational screening is completed within 24 hours of admission

Functional screening

1. A functional screening is completed
2. The need for additional functional assessment and evaluation is determined within 24 hours of admission

Falls Screening

i. Per guidelines

Legal

i. A legal screening is completed

1. The need for additional legal assessment and evaluation is determined
    a. A referral for a legal assessment is generated based on data collected in the legal screening, for example: outstanding warrants, court appearances, multiple incarcerations

ii. Legal screening is completed within 24 hours of admission

Client's perception of needs and preferences for treatment are discussed with client and included in treatment planning within 72 hours of admission

Family and/or significant others perception of client needs and preferences, in accordance with protected health information and confidentiality regulations, is obtained if possible and relevant

Patients are reassessed:

1. To evaluate response to care, treatment and services
2. To respond to a significant change in status and/or diagnosis or condition
3. To satisfy legal and/or regulatory requirements
4. To meet time intervals determined by the course of the care, treatment, and services provided

Discharge Planning Screening:

i. All patients will be evaluated for discharge planning needs. Any inpatient who is identified to be at risk for adverse health consequences or negative outcomes without the benefits of appropriate discharge planning shall have a plan developed and monitored for appropriateness as the patient progresses in their medical treatment

HOPE HEALTH SYSTEMS, INC. TREATMENT PLAN

Scope: Treatment plan for all patients. Distinctions between children and adolescent age cohorts are required.

DESCRIPTION/OVERVIEW

This guideline describes the multi-disciplinary approach used at HHS to support patients during their behavioral recovery. While HHS provides the highest level of intensive care, all HHS program staff interactions are guided by the least drastic-means principle to maintain the safety of our patients and others.

HHS strives to follow the least restrictive and/or most evidenced-based patient behavioral interventions; with a goal of eliminating the use of seclusion and restraint. This guideline outlines structures and staff interventions that are designed to foster individualized behavioral recovery.

All HHS personnel are expected to incorporate the appropriate interventions using these guidelines in their interactions with patients.

Treatment Plan

i. The process of developing a multidisciplinary treatment plan begins at admission and is continuously evaluated and updated throughout patient stay.
ii. The individualized treatment plan incorporates patient and family identified strengths, barriers, target behaviors, goals and interventions. +

Family Involvement

i. Family involvement is expected throughout the treatment process. The following activities encourage family involvement and promote better patient outcomes.

Behavior Expectations

i. Patients are encouraged to identify their own treatment interfering behaviors and incorporate new patient-identified skills to further develop their coping skills to manage their intense emotions, thoughts, and urges.
ii. Program staff will support patients in identifying treatment interfering behaviors and coach patients in the development and application of skills in a non-judgmental manner.
iii. In the event a patient's behaviors place themselves or others in immediate danger, program staff will support the patient with the least restrictive intervention possible to ensure their safety and the safety of others. This may also entail modifying the patient's treatment plan to ensure uniformity of the goals and interventions to be employed to ensure the patient's and staff's safety.

Coping Skills Development

i. Program staff begins introducing and coaching skills when a patient is admitted. Focus is placed on learning coping skills in the following areas:
    1. Mindfulness
    2. Distress Tolerance
    3. Emotion Regulation

4. Interpersonal Effectiveness

Group/Unit Activities

i. HHS provides continual group and individual activities
ii. Both patient and program staff actively participate in all skills group activities.
iii. All unit and group activities shall be distinguished between adolescent patients and child age patients. The two shall not comingle within a group treatment setting.

Program Fidelity

i. The HHS clinical leadership team reviews and updates the program structure continuously, based on clinical quality measures and informed practices. Additionally, the HHS clinical leadership team meets with the clinical leadership of each age cohort to provide support and consultation on programming, milieu, and clinical application of treatment plans as the need arises.

Consistency

i. To meet developmental and cognitive needs of differing age groups, the model reflects uniform adaptations based on age, developmental level, and clinical presentation.

Therapeutic Interventions

i. Individual needs for patient behavioral recovery are assessed upon admission and this information is communicated to unit staff as soon as possible. Assessed behavioral needs are re-evaluated during treatment team rounds. All unit staff that provide care are responsible for attaining updated knowledge of each patient's strengths, barriers, goals, and interventions.
ii. The decision to place a patient in a specific clinical track is based on, but not limited to assessment of the following:
    1. Chronological age
    2. Developmental age
    3. Social, legal, and psychiatric history
    4. Emotion/Impulse regulation skills
    5. Abuse/neglect history
    6. Cognitive strengths and challenges
    7. Psychiatric/medical diagnosis
    8. Attachment history
    9. Placement history and permanency plan
    10. Receptive and expressive language skills
    11. Response to therapeutic milieu and program interventions
    12. Physical strengths/deficits
    13. Problem-solving skills
    14. Substance abuse history

Least Restrictive Interventions

All HHS program staff interactions are guided by the least restrictive means principle. Least restrictive interventions include, but are not limited to the following:

i. Early identification and supportive interruption of barrier behaviors as identified at time of admission.
ii. When interrupting a treatment interfering behavior, do so privately, validating, teaching and coaching alternative coping strategies to manage their behaviors.
iii. Continuous active engagement with patients in all milieu, program, and school activities.
iv. Provide support, validation, and encourage the use of coping skills at the first sign of distress
v. Use active listening and validation to elicit patient concerns and perspectives
vi. Support and validate patient's choices and options to help them control their own behaviors
vii. Increased tolerance for patient's non-threatening barrier behaviors
viii. Provide alternative activity choices to alter attention
ix. Provide 1:1 attention
x. Allow patients to take their own space and time to be alone to calm down before re-engaging them to resolve their conflict.
xi. Change the environment via milieu and/or program expectation and interventions

EXHIBIT 12

Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Acting Secretary

Behavioral Health Administration
Aliya Jones, M.D., MBA
Deputy Secretary Behavioral Health
55 Wade Ave., Dix Bldg., SGHC
Catonsville, MD 21228

December 16, 2020

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen,

The Department of Health and Mental Hygiene hereby acknowledges notification by Hope Health Systems (HHS) that it is seeking a Certificate of Need to establish a new mental health hospital for adolescents and children. HHS has provided me with the executive summary of the project from its Certificate of Need application. This new facility will house 16 inpatient psychiatric beds at its Baltimore County site.

The Behavioral Health team looks forward to learning more about this program. If you need anything more, feel free to email me at aliya.jones@maryland.gov or call (410) 402-8452.

Sincerely,

Aliya Jones, M.D., MBA
Deputy Secretary Behavioral Health

cc: Maria Rodowski-Stanco, M.D.
Aastha Vashist, Hope Health Systems

EXHIBIT 1 –
TABLE E REPLACEMENT

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.

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.d 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. New Construction			
(1) Building			$0
(2) Fixed Equipment			$0
(3) Site and Infrastructure	$50,000		$50,000
(4) Architect/Engineering Fees	$9,400		$9,400
(5) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$59,400**	**$0**	**$59,400**
b. Renovations			
(1) Building	$2,287,498		$2,287,498
(2) Fixed Equipment (not included in construction)	$131,250		$131,250
(3) Architect/Engineering Fees	$128,500		$128,500
(4) Permits (Building, Utilities, Etc.)	$2,500		$2,500
SUBTOTAL	**$2,549,748**	**$0**	**$2,549,748**
c. Other Capital Costs			
(1) Movable Equipment	$875,000		$875,000
(2) Contingency Allowance	$318,718		$318,718
(3) Gross interest during construction period			$0
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$1,193,718***	***$0***	**$1,193,718**
TOTAL CURRENT CAPITAL COSTS	**$3,802,866**	**$0**	**$3,802,866**
d. *Land Purchase*			
e. Inflation Allowance			$0
TOTAL CAPITAL COSTS	**$3,802,866**	**$0**	**$3,802,866**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c CON Application Assistance	**$60,000**		$60,000
c1. Legal Fees			$0
c2. Other (Specify/add rows if needed)			$0
d. Non-CON Consulting Fees			$0
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)			$0
e. Debt Service Reserve Fund			$0
f Other *(Specify/add rows if needed)*	**$637,134**		$637,134
SUBTOTAL	***$697,134***	***$0***	**$697,134**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$4,500,000***	***$0***	***$4,500,000***
B. Sources of Funds			
1. Cash	**$4,500,000**	**$0**	$4,500,000
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	**$4,500,000**	**$0**	**$4,500,000**
	Hospital Building	**Other Structure**	**Total**
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building	**$180,000**		$180,000
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. Initial intent to lease is for 5 year with options to extend up to 6 six years. The annual cost of the lease shall be 180,000 with out interest

Replacement Page 5 of Application

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_20140301.pdf ☐

8. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is; why you need/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

The applicant, Hope Health Systems Inc. ("HHS") is proposing to establish a 16- bed psychiatric hospital specifically for children and adolescents. The facility will provide for four (4) single patient rooms to treat the child patient population and twelve (12) single patient rooms to treat the adolescent patient population. The inpatient facility would be established in a renovated portion of a building that HHS leases from Hope Health Properties, LLC in Woodlawn, Baltimore county. The facility already includes an outpatient facility with a psychiatric partial hospitalization program (for children and adolescents below 18 years of age).

The hallmark of HHS' mental health hospital will be to provide an integrated, comprehensive, personalized mental health treatment facility to children and adolescents in Baltimore county and city area. Specifically, the project will: provide improved access to care for patients, increase access for those who are publicly insured, provide high-quality care through its step-down approach before discharging the patient to the community, diversify the provider market for inpatient mental health care, deliver culturally competent care, integrate the care continuum for patients, improve care coordination, and ultimately help reduce readmission rates.

HHS currently provides a number of services to the community, including partial hospitalization, outpatient mental health, expanded school mental health, DOJ service, rehabilitation programs, substance abuse, and mobile treatment. As a result, HHS is uniquely positioned to provide its

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.

December 15, 2020
Date

Signature of Owner or Board-designated Official

CEO
Position/Title

Oladipo Fadiora
Printed Name

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.

12/14/2020

Date

Signature of Owner or Board-designated Official

Executive Director

Position/Title

Yinka Fadiora

Printed Name

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.

12/14/2020
Date

Signature of Owner or Board-designated Official

CFO
Position/Title

Lanre Fadiora
Printed Name