LUMINIS HEALTH DOCTORS COMMUNITY MEDICAL CENTER
CERTIFICATE OF NEED APPLICATION
TO ESTABLISH A 16-BED
ADULT INPATIENT PSYCHIATRIC UNIT

April 9, 2021

Luminis Health℠

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MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Doctors Community Medical Center

Address:

8118 Good Luck Rd	Lanham	20706	Prince George's
Street	City	Zip	County

Name of Owner (if differs from applicant):
Luminis Health Doctors Community Medical Center, Inc.

2. OWNER

Name of owner: Luminis Health Doctors Community Medical Center, Inc.

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

Legal Name of Project Applicant
Luminis Health Doctors Community Medical Center, Inc.

Address:

8118 Good Luck Rd	Lanham	20706	MD	Prince George's
Street	City	Zip	State	County

Telephone: 301-552-8118

Name of Owner/Chief Executive: Deneen Richmond, President

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

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

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

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	X☐	
	(2) For-profit	☐	
	(3) Close	☐	State & date of incorporation 6/27/1989
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☐	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	X☐	

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

A. Lead or primary contact:

Name and Title: Jessica Farrar, Vice President of Strategic Planning and Decision Support

Mailing Address:

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

Telephone: 443-481-3449

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

Fax:

B. Additional or alternate contact:

Name and Title: Marta Harting, Counsel

Mailing Address:

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

Telephone: 410-244-7542

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

Fax: 410-244-7742

7. TYPE OF PROJECT

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

If approved, this CON would result in:

(1)	A new health care facility built, developed, or established	☐
(2)	An existing health care facility moved to another site	☐
(3)	A change in the bed capacity of a health care facility	X
(4)	A change in the type or scope of any health care service offered by a health care facility	**X**
(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

Luminis Health Doctors Community Medical Center (LHDCMC) proposes to establish a 16-bed adult psychiatric unit as an essential component of a comprehensive behavioral health program to be developed on the LHDCMC campus. LHDCMC is committed to providing local access to acute care services for patients with serious mental illness or in behavioral health crisis. The acute care unit will serve adult patients with a primary psychiatric diagnosis and will accommodate adult patients with co-occurring substance use disorders and/or limited medical comorbidities. Along with the emergency department and the ambulatory behavioral health services offered on the LHDCMC campus, the psychiatric acute care unit will allow LHDCMC to provide the full contniuum of behaiovral health care, alligned with the needs of the community.

The new unit at LHDCMC will be located in newly-renovated space on the LHDCMC campus together with a continuum of other behavioral health services.

(2) Rationale for the Project

Prince George's County spans an area of 500 square miles and is home to nearly 1 million residents. However, there are only 2 acute care psychiatric units located in Prince George's County. The Southern Maryland Region has, by far, the lowest number of psychiatric beds per population in Maryland. In CY2019, more than half of the adult psychiatric admissions (approximately 1,900 discharges) were treated in out-of-County hospitals. More than 900 patients required a hospital-to-hospial transfer for pschiatric admission. As a result, medical care and behavioral health management are more disjointed, and cross-county post-acute services are more difficult to arrange from a distance. Of additional concern, behavioral health patients often must establish new relationships with behavioral health providers closer to home following discharge.

In the most recent Community Health Needs Assessment conducted by the County (Exhibit 2), behavioral health services ranked as a leading health challenge. It is critical to provide multiple access points for behavioral health care. The County is home to a highly diverse population. Approximately 80% of the population is diverse, and immigrants make up more than 20% of the County's population. Health equity gaps have been documented and the stigma associated with behavioral health services is identified as one barrier. More access points, greater cultural competence, and a culturally diverse health workforce will be key to effective outreach and provider relationships.

The proposed 16-bed psychiatric unit at LHDCMC will operate as one component of a continuum of behavioral health services at LHDCMC. The new unit at LHDCMC will minimize the need for out of county admissions, integrate medical and behavioral health care management, and provide direct linkage to the broader continuum of behavioral health services at LHDCMC. The acute care program will engage patients and families in recovery and bridge continuity in care after discharge to increase rates of successful recovery, reduce relapses, and prevent futher exacerbation of serious mental illness. LHDCMC will leverage the continuum of services on campus to support smooth care transitions and earlier return to the community. In sum, the continuum of care at LHDCMC will encourage use of the right service, at the right time, in the lowest cost setting to reduce the total costs of care and achieve high quality outcomes.

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

(3) Cost.

The capital cost of this project is $7,787,303. Details regarding the capital cost are contained in Table E of the CON Application

Tables (Exhibit 1).

(4) Master Facility Plans

The existing LHDCMC campus consists of eight buildings, including the two-story building in which the new inpatient psychiatric unit would be established (previously the location of a the Magnolia Gardens licensed comprehensive care facility) on the second floor of the building. The other seven buildings include the main hospital building, a service building, two parking garages, a professional services building, a fitness center and a rehabilitation and patient care facility.

The comprehensive renovation of an existing building on campus for this project has several advantages from the perspective of the overall master facility plan and long term plans for campus development. The availability of the former nursing home for adaptive re-use on the LHDCMC hospital campus is preferred due to its proximity to the emergency department, which allows integration of the inpatient psychiatric unit into the existing medical facilities' resources without major disruption. All other possible adjacencies to the existing emergency department require site development, relocation of site infrastructure, and/or impede any future expansion of the main hospital building. Another advantage of putting the unit in this building is that it enables it to be co-located with a full range of other behavioral health services being established by LHDCMC on the first floor of the building, as described further in the Comprehensive Project Description below.

The existing LHDCMC campus has two primary areas for potential future expansion for the primary zones of clinical service located to the east and west of the main hospital building. With the proposed adaptive reuse of the existing building situated to the south of the main hospital building for behavioral health, these growth zones remain available for long term campus development.

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

(1) Construction, renovation, and demolition plans;
(2) Changes in square footage of departments and units;

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

Applicant Response:

The Applicant's Comprehensive Project Description is organized into three parts: Part 1 (Background); Part 2 (The Proposed Project and Its Impact); and Part 3 (Facility Details) which includes the Applicant's specific responses to Application Question 8.B(1)-(5).

PART 1 -- BACKGROUND

Overview of Doctors Community Medical Center (LHDCMC) and Luminis Health Initiatives

LHDCMC was founded in 1975 as a physician-led facility. Today, it is a not-for-profit, acute care hospital in Lanham, Maryland. It provides ambulatory services throughout the County and acute care services on its hospital campus. It is recognized particularly for its comprehensive breast care program, its rehabilitation services and its community engagement and outreach.

In 2019, Luminis Health was formed, creating, a new regional health system that is re-imagining what community health means. Luminis Health formed to expand access, improve population health and provide high-quality care closer to home for the communities it serves.

The current service area for LHDCMC (defined in conventional terms, based on approximately 85% of its discharges) includes 25 zip codes. This region accounts for 85% of the total Prince George's County population. A major priority of LHDCMC is to bring more services to its local community.

The Critical Need for Behavioral Health Services in Prince George's County

Prince George's County is home to nearly one million residents and spans an area of 500 square miles. However, this County, the second largest of 24 counties in the State, includes only two acute care psychiatric units. More broadly, the Southern Maryland Region has, by far, the lowest number of psychiatric beds per population in Maryland. It is not surprising, then, that more than half of the adult behavioral health admissions from Prince George's County (1,900 discharges) are treated in out-of-County hospitals. This utilization pattern has serious consequences, including:

(1) The transfer process from area EDs to out-of-County hospitals can result in significant treatment delays;

(2) Medical care and behavioral health management are more disjointed, with "hand-offs" required across clinical teams, disrupting care management under an integrated network;

(3) Post-acute services are more difficult to arrange from a distance; and

(4) Behavioral health patients often must establish a relationship with a new behavioral health provider closer to home following discharge.

Prince George's County also faces distinct challenges for service delivery and achieving health improvement targets, which include:

- Access to Care. - The 2018 County Health Rankings (produced by the Robert Wood Johnson Foundation) ranks Prince George's County as having one of the lowest ratios of behavioral health providers across all Maryland counties, ranking 21st lowest out of 24 counties. https://www.countyhealthrankings.org/app/maryland/2021/measure/factors/62/data?sort=sc-3 (see Exhibit 3) This is corroborated by the Prince George's County Health Department, which documents the patients per provider ratio in Prince George's County to be nearly half of the overall ratio for the Maryland population (Exhibit 4, page 5).

- Addiction rates. – Between 2019-2020, the number of opioid-related deaths in Prince George's County more than doubled, reflecting high addiction rates with tragic consequences (Exhibit 5, page 8).

- Health disparities across communities of color. – Health disparities have been well-documented in Prince George's County. These disparities reflect language barriers, cultural barriers, transportation barriers and/or concerns about legal status. Distinct barriers tied to use of behavioral health services also exist; community surveys have identified a stigma associated with use of behavioral health service, and this results in the development of more serious mental illness conditions. It is particularly important to integrate behavioral health services with trusted and established medical provider relationships.

Access to Care: Acute Bed Capacity for Psychiatric Care

Currently, there are just two acute psychiatric units (UM Capital Region Prince George's Hospital Center and MedStar Southern Maryland Hospital) in Prince George's County, leaving the County ill-equipped to meet the significant challenges it faces. The closure of Laurel Regional Hospital impacted access to care for County residents. Total psychiatric bed capacity remained the same, but beds were consolidated at UM Prince George's Hospital Center, which resulted in a 30-minute drive for Laurel-area residents to the closest psychiatric unit. At this time, the Health Planning Region of Southern Maryland shows one of the lowest bed ratios for acute psychiatric beds in the State (see Table 3 included in response to COMAR 10.24.01.08G(3)(b) (Need) below). Additionally, the closure of Providence Hospital in the District of Columbia further reduced acute care capacity and access to care for Prince George's County residents.

Between 2018-2019, psychiatric admissions for Prince George's County adults declined, reflecting the intense focus on high utilizers and efforts to better address social determinants of health. However, County residents continued to account for 75 occupied beds, far exceeding the psychiatric bed capacity in Prince George's County. (Note: The discharge volume documented below does not include patients with substance use disorders as a primary diagnosis, although these patients may also occupy beds in acute psychiatric units.)

Table 1
Total Adult Psychiatric Hospital Volume
Prince George's County Residents
Calendar Year 2017-2019

	CY 2017	CY 2018	CY 2019	CAGR %
# Outpatient ED Only visits[1]	3,890	4,112	4,017	1.6%
% Change, Year to Year		5.7%	-2.3%	
# Mental Health Discharges[2]	4,071	4,228	3,710	-4.5%
% Change, Year to Year		3.9%	-12.3%	
Average Length of Stay for Mental Health Discharges (ALOS)	7.0	6.9	7.3	2.4%
# Occupied Beds for Mental Health	78	80	75	-2.3%

Source: CY 17 - CY 19 Maryland inpatient and outpatient data, psych specialty hospital data, and DC inpatient data

Notes:

[1] Outpatient ED visits are any visits with behavioral health principal dx (F code) with an ED charge

[2] Mental health discharges are any mental health related non-SUD primary diagnosis

Dependence on Out-of-County Care

In CY2019, more than 50% of the Prince George's County adult psychiatric patients (1,900 discharges) were hospitalized for behavioral health conditions at an out-of-County hospital. More than 900 of these patients required hospital-to-hospital transfer for a psychiatric admission, and this transfer process can result in significant treatment delays.

Table 2
Total Adult Psychiatric Discharges by Hospital
Prince George's County Residents
Calendar Year 2019

Hospitals	CY 2019	% of Total
Prince George's	1,166	31.4%
So MD	606	16.3%
Shady Grove	316	8.5%
Sheppard Enoch Pratt Hospital (Private	314	8.5%
Washington Adventist	226	6.1%
Suburban	101	2.7%
Holy Cross Germantown	58	1.6%
Howard Co	41	1.1%
Franklin Sq	33	0.9%
Northwest	33	0.9%
Montgomery Gen	32	0.9%
Doctors Community	31	0.8%
St. Mary's	29	0.8%
Calvert	26	0.7%
Hopkins	24	0.6%
Grace	24	0.6%
UM Midtown	24	0.6%
Harbor	22	0.6%
UM BWMC	22	0.6%
UMMC	16	0.4%
Holy Cross	16	0.4%
UM SJMC	15	0.4%
Levindale	12	0.3%
AAMC	10	0.3%
Sinai	8	0.2%
Bayview	7	0.2%
Frederick	6	0.2%
Ft. Washington	6	0.2%
PRMC	4	0.1%
Union of Cecil	4	0.1%
Carroll	4	0.1%
Mercy	2	0.1%
Harford Memorial	1	0.0%
Subtotal Maryland Hospitals	**3,240**	**87.3%**
MedStar Washington Hospital Center	158	4.3%
United Medical Center	125	3.4%
George Washington University	64	1.7%
MedStar Georgetown University Hospit	38	1.0%
Sibley Memorial Hospital	38	1.0%
Howard University Hospital	27	0.7%
Brook Lane (Private)	19	0.5%
MedStar National Rehabilitation Hospit	1	0.0%
Subtotal DC Hospitals	**470**	**12.7%**
Total all hospitals	**3,710**	**100.0%**

Source: CY 17 - CY 19 Maryland inpatient and outpatient data, psych specialty hospital data, and DC inpatient data
Note: Mental health discharges are any mental health related non-SUD primary diagnosis

This heavy dependence on out of area hospitals has very real consequences for quality of care, including:

- Disjointed care management. A significant percentage of patients with psychiatric conditions are also afflicted with chronic medical conditions. Transfer to another hospital for psychiatric care means that medical management and psychiatric management is disconnected, weakening the more effective integrated care management model that LHDCMC provides. Out of county admissions also mean more hand-offs across clinical teams. In contrast, local acute care at LHDCMC would provide care management within an integrated provider network and easy information exchange across clinicians.

- More complicated discharge planning. Out of county admissions challenge clinicians/team members to arrange follow-up services; team members working in one county are simply less familiar with the resources and agencies in other counties.

- Requirement to build a new provider relationship. Patients return home after a crisis episode without an established relationship with a local provider. Patients are often required to establish a relationship with a new therapist after discharge. This adds hardship for a patient who has just begun a relationship with a clinician.

- Disruptions in continuity of care across levels of care. The psychiatric acute care unit should function as one part of a larger continuum to support successful recovery. Patients should maintain a relationship with the same clinician across the continuum. If a patient does relapse or suffer another acute episode, support systems are local and the team of clinicians are familiar with the patient's need to respond most effectively.

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

Episodic ED Management

Many patients with chronic behavioral health conditions continue to rely on EDs for episodic behavioral health care. In CY2019, behavioral health ED visits increased, and high utilizers continued to be of concern. Specifically, during the 12-month period, a total of 169 patients from Prince George's County accounted for 848 behavioral health ED visits, an average of 5 ED visits per patient in one year. This pattern underscores the need for an improved delivery system for behavioral health services. The lack of an acute care unit may be contributing to under-treatment and return ED visits, and the lack of integration with medical management may be contributing to relapse and episodic care.

LHDCMC's proposed program seeks to provide a comprehensive program to reduce the dependence on the hospital ED for episodic care and support long-term emotional well-being in the community.

Unmet Need and Community Priorities

In the most recent Community Health Needs Assessment conducted by the Prince George's County Department of Health (Exhibit 2), LHDCMC, and other health systems serving Prince George's County, residents and stakeholders ranked behavioral health services as a leading health challenge. It is critical to provide multiple access points for behavioral health care. The County is home to a highly diverse population. Approximately 80% of the population are diverse and immigrants make up more than 20% of the County's population. Health equity gaps have been documented and the stigma associated with behavioral health services is identified as one barrier. More access points and greater cultural competence will be key to building provider relationships and effectively responding to the community's need.

PART 2 -- The Proposed Project and Its Impact

The Proposed Adult Psychiatric Unit

LHDCMC proposes to establish a 16-bed adult psychiatric unit as an essential component of a comprehensive program for behavioral health services on the LHDCMC campus. LHDCMC is committed to providing local access to care for patients in behavioral health crisis and those with serious behavioral health illness. The acute care service at LHDCMC will allow psychiatric care to be tied to medical management under an integrated provider network, including integration with care management services.

The new unit will be located in renovated space within an existing building on the LHDCMC campus. This unit will provide evaluation, treatment and care management for adult patients with a psychiatric disorder as the primary diagnosis; however, the unit will admit patients with limited medical comorbidities and/or substance use as a co-occurring disorder. Both voluntary and involuntary adult admissions will be accepted.

The new unit will provide the latest in best practices available to best serve our patients. We will serve those individuals with depression, psychosis, schizophrenia, co-occurring substance use disorders and, in some cases, limited medical complexities. Staff comprised of psychiatrists, psychiatric nurse practitioners, psychiatric nurses, psychiatric social workers, behavioral health peers and an array of support team member will be dedicated and trained to best meet the needs of the individual in need.

The new unit would be part of a continuum of behavioral health services located in the same building, including outpatient services to provide an alternative to an inpatient admission and/or an array of services available upon discharge from the inpatient unit. These additional services will include:

- A *behavioral health clinic* for community-based care: This clinic will provide close-to-home access to behavioral health professionals with the training and cultural competence particularly responsive to the diverse communities of Prince George's County. This service will serve as a bridge or transition clinic to meet the needs of an individual until they can be transferred to a long-term psychiatrist or therapist in the community. Local access to outpatient services will provide greater convenience and the opportunity to build steady clinical relationships, which will reduce crisis episodes and minimize the need for episodic treatment in the Emergency Department.

- *Urgent care center* dedicated to behavioral health episodes: This walk-in setting will be dedicated behavioral health care and will respond to crisis episodes and urgent needs for psychiatric evaluation, stabilization, and/or medication management. This walk-in setting will be highly patient-focused and will serve as an alternative to the Emergency Department setting which is typically not conducive to managing patients in behavioral health crisis: ED settings in general hospitals generally do not have dedicated space for patients in crisis with behavioral health conditions, nor are EDs typically staffed with behavioral health professionals. The Urgent Care Center will also provide experienced staff to coordinate linkage to community-based resources including behavioral health services, addiction services, housing services, peer counseling, patient education, wellness services, and family supports. The Urgent Care Center will be invaluable to law enforcement who will utilize the Urgent Care Center as a safe and therapeutic service site for individuals in need of evaluation, which will reduce volume in the ED and in the jails. Clinic staff will also build strong relationships with community practitioners so that LHDCMC can provide support community-based clinicians with an after-hours alternative to the ED for both pediatric and adult patients.

- *Two partial hospitalization programs* to serve adults and adolescents (PHP): The PHP will provide a supportive and therapeutic setting after hospitalization and permit earlier discharge from the hospital by providing a daily treatment program and continuity of care with a team of professionals. It is expected to help prevent recurring hospitalizations and help maintain steady relationships with providers. Located on the LHDCMC campus, this program will reduce the travel time/daily hardship for patients and their families who may live miles from existing PHP programs located across Prince George's County. The projected course of treatment is one to three weeks. At this length of stay, the program will have the capacity to treat 500 individuals on an annual basis.

- *Intensive outpatient treatment program (IOP):* Similar to a partial hospitalization program, the IOP enables patients to live at home, continue with their normal, day-to-day lives, and receive treatment to help adjust to family life and/or community life. The program is designed to build coping strategies, establish support mechanisms, and help with relapse management.

- *Linkage to community-based services*: The program will be well-integrated with community-based services, including self-help and family programs to strengthen patient engagement. The goals will be to sustain the patient in the community and to require inpatient admission only when absolutely necessary for the patient's health and safety.

- *8-bed residential crisis unit*: This unit will make available a new level of behavioral health services to the LHDCMC service area, not currently available to local area residents. The center will provide 24/7 crisis counseling, same day evaluation and intervention, individualized treatment planning, and treatment coordination for ongoing care. Staff will assess other needs such as housing, eligibility for entitlements and substance abuse treatment, peer coaches, and wellness services. As a lower intensity service setting, it will provide an alternative to acute care admission: Patients may be admitted from the ED, from the Urgent Care Center, or directly from the community to avoid hospital admission in the more costly setting. In addition, the residential crisis center will serve as a lower intensity care transitions setting: behavioral health patients who require continuing care in a supervised setting after an acute stay may be discharged to the residential crisis center where health care, social service supports and housing needs can be addressed more comprehensively.

Through the existing Behavioral Health Service Line at Luminis Health Anne Arundel Medical Center (LHAAMC), existing clinical and administrative professionals will build the inpatient psychiatric program at LHDCMC based on a model similar to the 16-bed J. Kent McNew Family Medical Center (psychiatric hospital) at LHAAMC. In addition, that expertise will assist in the development of the outpatient behavioral health services at LHHDCMC described above to provide both an alternative to an inpatient admission and/or an array of services upon discharge from the inpatient unit.

In most cases, the inpatient unit together with the other behavioral health programs described above to be provided at LHDCMC will provide access to a comprehensive, lower cost, continuum-of-care in one location instead of transferring to higher cost hospitals and relying on their ability to disposition the individual to an appropriate community setting.

Stated simply, the new program will provide the right services, in the right setting, at the right time in the lowest cost service setting. The program will provide local and timely care for patients in acute crisis. The program will provide local access to outpatient services and step-down care, minimize the need for expensive hospital-based services, strengthen continuity of care and support steady provider relationships. The project will improve quality while reducing the costs of care.

Collaboration with Prince George's County

Recognizing the need to expand access to behavioral health in the County, the Prince

George's County Health Department has agreed to provide a capital grant for the renovations of the building in which the proposed inpatient unit and the other behavioral health programs described above will be located. In order to best meet the needs of the County, Prince George's County Department of Health was involved in the programmatic planning process, design of the building and will serve in an ongoing advisory capacity.

Impact to the Community

The project is expected to have the following positive impacts for the community:

- **Minimize the need for hospital-to-hospital transfers and reduce delays in treatment for patients in crisis.**
    - In CY19 and CY20, patients spend 16 and 31 hours respectively in the LHDCMC ED waiting for an inpatient psychiatric transfer as a result of lack of access and capacity at surrounding inpatient psychiatric units. The new inpatient psychiatric unit will reduce these delays.

- **Improve continuity of care.**
    - Reduce the high number of out-of-county admissions for psychiatric care that often results in fragmented service delivery and less effective discharge planning.
    - Strengthen provider relationships by building continuity of care across the continuum: Behavioral health clinicians will follow patients across the continuum of care (inpatient, PHP, outpatient behavioral health services). This will ease care transitions for patients and avoid communication gaps that can occur during "hand-offs" from one clinical team to another.

- **Support integrated behavioral health and medical management.**
    - Luminis Health physicians are connected through an integrated electronic medical record which supports greater care coordination and communication across medical and psychiatric clinicians.
    - Strengthen opportunities to respond effectively to social determinants of health.
    - With an integrated network responsible for care management, a shared medical record, and a strong familiarity with local social services supports, clinicians can respond effectively to both medical and social service needs.

- **Increase family involvement in the recovery process by providing a nearby location and removing the hardship of travel that may discourage family involvement.**

- **Minimize length of stay and admission rates by leveraging outpatient resources.**
    - Clinicians will maximize the use of the partial hospitalization program, the intensive outpatient treatment program, and the residential crisis program. This will shorten acute care length of stay and/or avoid the need for short hospital

stays altogether for many patients currently admitted for 1 or 2 day hospital stays.

- **Increase access to the continuum of services and encourage early intervention.**

  Establish the close-to-home LHDCMC campus as an access point for the continuum of behavioral health services. Encourage community members to seek behavioral health supports earlier on and to establish steady support systems; prevent problem escalation and serious mental illness.

- **Reduce relapse rates, readmissions and return visits to the ED.**
  - This comprehensive program will "fill gaps" in the continuum of care creating a post-acute setting that will be supportive for patients. In addition, the care team will work closely with community services/community agencies so that symptoms are identified earlier on to prevent problem escalation, relapse, and the need for hospitalization.

- **Further reduce the need for ED visits by allowing direct admissions to the acute psychiatric unit.**
  - The program's managing physician will be able to arrange direct admission to the acute unit. This will reduce the delays, the patient hardships and the costs associated with the ED visit as the only pathway to an acute admission. This will also reduce visit volume in the hospital ED.

- **Reduce the total per capita costs of care by leveraging the continuum of behavioral health services.**
  - The acute care unit at LHDCMC will be one component of a larger continuum of services that provides step-down care and intensive outpatient programs to support earlier discharge and reduce readmissions.
  - The residential crisis unit will serve a broad patient base and function as a resource to behavioral health providers across the County who seek a lower cost service setting; the opportunity for cost savings extends beyond the patient base originating at LHDCMC.

- **Provide more options to the County's diverse population**
  - The continuum of care will respond to one of the highest priority health service needs identified by community members. In the 2019 Community Health Needs Assessment prepared by the Prince George's County Health Department, community members ranked behavioral health services as one of the most important issues to them. See Exhibit 2.
  - More access points, greater cultural competence, and a culturally diverse health workforce may be key to effective outreach and building provider relationships.

- **Respond to documented behavioral health crisis nationwide and in Prince George's County.**

- Prince George's County must respond to forecasts of increased demand for behavioral health services in response to the pandemic. According to the United States Centers for Disease Control and Prevention, elevated levels of adverse mental health conditions, substance use and suicidal ideation were reported by adults in June 2020. This trend is disproportionately effecting minorities and is not new to COVID-19 (Czeiler, 2020, Exhibit 6). As published in the Journal of the American Medical Association, statewide analysis of suicide mortality in Maryland indicated a doubling of suicides for African Americans during the height of the COVID-19 pandemic while the rates for wives approximately halved (Johnathan, 2020, Exhibit 7).

PART 3 -- FACILITY DETAILS

(1) Construction, Renovation, and Demolition Plans.

The existing LHDCMC campus consists of eight buildings including the building in which the proposed new unit would be established (previously the location of a nursing home). LHDCMC proposes to renovate interior space of the building to accommodate the new unit, specifically, a comprehensive renovation of the second level of the existing two-story building. The building is immediately adjacent to the Emergency Department of the Hospital. The first floor of the building will be fully utilized with outpatient services and crisis beds, so the renovation of the second floor take place in such a manner as to not disrupt the existing services and allowing treatment to continue.

Site Work: This proposed project does not include site work or new building construction.

Parking: Existing parking is sufficient to support the inpatient program.

Connection to Main Hospital: The unit will be directly connected to the main hospital via a connecting corridor.

Building Envelope: The thermal & moisture protection of the exterior walls is acceptable. However, the windows will be upgraded with new windows to meet the specialized safety requirements for a behavioral health inpatient unit.

Interior Spaces: The interior second floor of the building will be renovated to accommodate sixteen (16) inpatient beds, administrative functions, therapy spaces, and support functions. Base building components for vertical circulation including stairs and an elevator is acceptable. Family and visitors will enter the facility into the main lobby that includes reception, public restrooms, and supporting functions. Security is immediately adjacent to the lobby. All patient rooms are single occupancy with code compliant toilet and shower facilities. The nurse station is centrally located on the unit with unobstructed sight lines of both corridors and visibility of the activity/day room. The front of the unit contains group rooms, therapy spaces, clinical support functions, and a pantry. The patient corridor is dedicated to 16 patient rooms.

(2) Changes in Square Footage of Departments and Units

Changes to the square footage are detailed in Exhibit 1 (CON Table Package) in Table B.

(3) Physical Plant or Location Changes

All base building systems and equipment are adequate to support the construction of a new inpatient unit. New mechanical infrastructure and distribution systems will be provided the inpatient unit area as required. All new HVAC systems for the inpatient unit area will be sized to meet the air changes per hour and filtration requirement of the FGI Guidelines and ASHRAE 170. The interior power distribution will be completely new in the project area with panels located in electrical rooms. The wet pipe sprinkler system and fire alarm system will be modified and expanded as part of the build out of the new inpatient unit. The entire building is equipped with an emergency generator which will be connected to the area of proposed work as part of completing this project.

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

The connection to the main facility will allow the clinical and support services to support the inpatient unit.

(5) Multi-Phase Project Description

Not applicable. The inpatient fit-out construction will occur in a single phase under one construction contract.

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

Applicant Response: Please refer to Exhibit 1 for Table B.

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

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

Applicant Response: The bed capacity worksheet (Table A) is provided in in the CON Table Package attached as Exhibit 1.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: 40 acres.
B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES__X___ NO _____ (If NO,

describe below the current status and timetable for receiving necessary approvals.)

The health campus is a permitted use in the R-80 zone subject to the approval of a Special Exception which is approved, however an amendment to the Special Exception will be required to accommodate the proposed improvements. Unless legislation is adopted by the County Council that otherwise permits the use by right.

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

(1) Owned by: Luminis Health Doctors Community Medical Center, Inc (f/k/a Doctors Community Hospital LLC)
Please provide a copy of the deed.

Applicant Response: The deed is attached as Exhibit 8.

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

(3) Land Lease held by: _____
Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: _____
Please provide a copy of the option to lease as an attachment.

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

11. PROJECT SCHEDULE

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

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date	4	months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	4	months
Completion of project from capital obligation or purchase order, as applicable	10	months
Multi-Phase Project for an existing health care facility (Add rows as needed under this section)		
One Construction Contract		months
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.		months
Initiation of Construction within 4 months of the effective date of the binding construction contract.		months
Completion of 1st Phase of Construction within 24 months of the effective date of the binding construction contract		months
Fill out the following section for each phase. (Add rows as needed)		
Completion of each subsequent phase within 24 months of completion of each previous phase		months
Multiple Construction Contracts for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1st Phase within 12 months of the CON approval date		months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1		months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.		months
To Be Completed for each subsequent Phase of Construction		
Obligation of not less than 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase		months
Initiation of Construction on each phase within 4 months of the effective date of binding construction contract for that phase		months
Completion of each phase within 24 months of the effective date of binding construction contract for that phase		months

12. PROJECT DRAWINGS

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

completely legible and include dates.

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

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

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

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

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

Applicant Response: Please see Exhibit 9, Project Drawings.

13. FEATURES OF PROJECT CONSTRUCTION

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

Applicant Response: Please refer to Exhibit 1 (CON Table Package) for Tables C and D.

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

Applicant Response:

Water: The site is currently served by Washington Suburban Sanitary Commission (WSSC). The existing building has a combined 6 inch fire/domestic water service that enters the building in the basement at the south end of the building. The existing water service is adequate, and will be redistributed in the proposed project area as required.

Sewer: The site is currently served by Washington Suburban Sanitary Commission (WSSC). Allocation for sewer will occur at Preliminary Plan

approval, however, previous use of the building indicates available capacity to support this project.

Power: The existing building is served by a PEPCO secondary electrical service rated at 1600A, 208Y/120V. The electrical utility was upgraded in 2006 as part of a campus utility feeder upgrade project. A pad-mounted transformer and utility metering cabinet were provided. The service was sized for approximately 20 watts per square foot and is adequate for the proposed renovation. All interior power distribution will be replaced in the proposed project area.

Gas: The site is currently served by Washington Gas. Existing system is adequate.

Telephone/Communications: The site is serviced by Verizon. The proposed project will utilize existing services.

PART II - PROJECT BUDGET

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

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

Applicant Response: Table E is included in Exhibit 1 (CON Table Package). Please also refer to Exhibit 10 (Marshall Valuation Segregated Cost Form).

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

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

Applicant Response:

Deneen Richmond
Luminis Health Doctors Community Medical Center, Inc.
8118 Good Luck Road
Lanham MD, 20706

Luminis Health, Inc.
2001 Medical Parkway
Annapolis, MD 21401

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

Applicant's Response: Yes. Please refer to Exhibit 11 (organizational chart). Health care facilities under the CON law are shown in in yellow.

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

Applicant's Response: None of the health care facilities listed above have had their license or certification suspended, revoked or subjected to disciplinary action in the last 5 years.

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

Applicant Response: Please refer to Exhibit 12 for a description of responsive matters and documentation.

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been

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

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

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

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

04/09/21

Date

Signature of Owner or Board-designated Official

President, Luminis Health Doctors Community Medical Center, Inc.

Position/Title

Deneen Richmond

Printed Name

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

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

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

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

10.24.01.08G(3)(a). <u>The State Health Plan</u>.

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

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

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

Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp

10.24. 07	**State Health Plan: an overview** ○ **Psychiatric services** ○ **EMS**
10.24. 09	**Specialized Health Care Services - Acute Inpatient Rehab Services**
10.24. 11	**General Surgical Services**
10.24. 12	**Inpatient Obstetrical Services**
10.24. 14	**Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services**
10.24. 15	**Organ Transplant Services**
10.24. 17	**Cardiac Surgery and Percutaneous Coronary Artery Intervention Services**
10.24. 18	**Neonatal Intensive Care Services**
Capital Projects Exceeding the CON Threshold for Capital Expenditures	**Hospital Capital Projects Exceeding the CON Threshold for Capital Expenditures** Hospital projects that require CON review because the capital expenditure exceeds the CON threshold for capital expenditures but do not involve changes in bed capacity, the addition of new services, and otherwise have no elements that are categorically regulated should address all applicable standards in **COMAR 10.24.10: Acute Care Hospital Services** in their CON application. Applicants should consult with staff in a pre-application conference about any other SHP chapters containing standards that should be addressed, based on the nature of the project.

10.24.01.08G(3)(b). Need.

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

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

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

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

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

Explain how the applicant considered the unmet needs of the population to be served in arriving at a determination that the proposed project is needed. Detail the applicant's consideration of the provision of services in non-hospital settings and/or through population-based health activities in determining the need for the project.

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

Applicant Response:

Please refer to Exhibit 1 (CON Table Package) for Tables F and I.

The Applicant's response to this Standard is organized into the following subsections:

A. Introduction: Factors Driving the Continued Need for Inpatient Psychiatric Resources
B. Evidence of Unmet Need in Prince George's County: Adult Behavioral Health Utilization
C. Projecting Need and Sizing the New Unit at LHDCMC

A.

INTRODUCTION: FACTORS DRIVING THE CONTINUED NEED FOR INPATIENT PSYCHIATRIC RESOURCES

1.

Definitions

The proposed acute psychiatric unit at LHDCMC will serve adult patients, age 18+ years old, with a psychiatric diagnosis documented as the primary diagnosis. For purposes of the market analysis and need assessment, a primary psychiatric diagnosis is defined by F-Codes F1-F99, with the exclusion of those F-codes identifying substance use as the primary diagnosis (See "Technical Notes," Exhibit 13).

"**Total adult psychiatric volume**" documented in this section represents adult patients with a primary behavioral health diagnosis served in the acute setting, the ED setting, or the ED Observation setting. Patient volume may include patients with a substance use disorder coded as a co-occurring diagnosis. However, as noted above, psychiatric volume does not include patients with a substance use/alcohol-related disorder coded as the primary diagnosis.

"**LHDCMC-eligible volume**" is a slightly narrower definition of psychiatric discharges: This volume excludes patient populations who are not expected to be admitted to the LHDCMC unit based on requirements for specialized resources that the LHDCMC unit will not be equipped to support. Excluded cohorts are defined by diagnoses of neurodevelopmental disorders, intellectual disabilities, dementia, and eating disorders (see "Technical Notes" for list of exclusions**).** LHDCMC determined that these patient populations would be optimally served at other programs such as Sheppard Pratt where specialized resources and staff are centralized, continually trained, and best supported. The LHDCMC-eligible volume excludes only 3% of total adult psychiatric discharges documented for Prince George's County.

2.

The Continued Need for Inpatient Psychiatric Resources

While the industry continues to drive down utilization rates across specialties, the need for inpatient psychiatric services will continue to be significant, reflecting a combination of factors:

- The increase in rates of chronic disease, strongly correlated with higher rates of depression and other behavioral health conditions;
- The addiction rates in Maryland that remain stubbornly high, accompanied by psychiatric conditions and family stress that has intensified bed need;
- The growing (and positive) recognition of the improved outcomes and the sustained benefits produced by inpatient psychiatric care, particularly for those patients with both medical and psychiatric conditions. Clinicians and payors recognize the value of the inpatient setting to provide:
    - The integration of medical and psychiatric treatment planning in a single service site, and the designation of a single care management team;
    - An effective setting for intensive, concentrated patient education to establish healthy patterns of self-management/self-care; and
    - Adequate time and treatment intensity that is more effective at preventing readmission and relapse even though the "front-end" costs may be higher relative to community-based interventions.

Lastly, the effects of the pandemic on prevalence and severity of behavioral health conditions are likely to intensify the demand for psychiatric care. According to the United States Centers for Disease Control and Prevention, elevated levels of adverse mental health conditions, substance use and suicidal ideation were reported by adults in June 2020. This trend is disproportionately effecting minorities and is not new to COVID-19 (Czeiler, 2020, Exhibit 6). As published in the Journal of the American Medical Association, statewide analysis of suicide mortality in Maryland indicated a doubling of suicides for African Americans during the height of the COVID-19 pandemic while the rates for wives approximately halved (Johnathan, 2020, Exhibit 7).

Thus, while community-based care remains the preferred service site where appropriate, there remains a critical need for an acute care setting in this region. Inpatient care continues to be a necessary component in the continuum of care for developing a treatment plan, evaluating the efficacy/tolerance of medication(s), establishing ongoing clinical relationships, and/or providing self-management training that will support treatment adherence and successful recovery. For the large majority of patients who present in the ED with a behavioral health diagnosis, an inpatient unit may be critical for safety, treatment, care planning and successful recovery.

3.

Distinct Challenges for Behavioral Health Service Delivery in Prince George's County

Prince George's County faces a number of distinct challenges for service delivery and population health improvement, including:

Geographic expanse and drive time – The geographic expanse of Prince George's County poses significant challenges in effectively positioning resources. While it is not sensible to operate acute psychiatric units in every community hospital, the two units that currently operate in Prince George's County do not provide adequate geographic access. As a result, patients in behavioral health crisis who utilize their local ED (i.e. LHDCMC) face the hardships of transfer and delays in treatment.

Barriers to using behavioral health services – Providers must address the barriers to care that are rooted in cultural and racial communities. Throughout the most recent Community Health Needs Assessment it is well documented that "many respondents believed that seeking behavioral health treatment was traditionally stigmatized in the African American community and other communities of color and that not enough was being done to reduce the stigma." See https://www.dchweb.org/sites/doctors-community-hospital/files/community_health_assessement2019.pdf p. 157. In addition, providers must address language barriers, particularly in light of the rapidly changing demographics within northern Prince George's County. Local access points for outreach and service delivery will be particularly important in these efforts. However, access alone will not overcome the barrier of cultural apprehension and the stigma of seeking treatment for mental illness. Culturally-appropriate hiring, marketing and outreach, and communications are an essential part of the solution. Partnerships with existing organizations in the County, including community and faith-based groups will be an important part of the strategy to build trust in the program. While the details will evolve through program design and conception, it is certain that the investment in the development of a significant Behavioral Health Program on the LHDCMC campus sends the message to the community that Behavioral Health is a key component to the delivery of all healthcare in Prince George's County.

LHDCMC has agreed to goals with Prince George's County to develop:

- a plan for recruiting and retention of staff who are residents of Prince George's County;
- a plan for recruiting and retention of staff who are racially, ethnically, culturally, and linguistically matching the individuals who will be served;
- a plan for providing culturally and linguistically sensitive care by meeting the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards).

Thus, the acts of designing, resourcing and opening this program will demonstrate commitment to this service from LHDCMC and County leadership and will continue to lessen this stigma. Bringing these services and this investment to this community sends a message of the importance of this service, just as it would were a health system to open any other new health service.

B.

EVIDENCE OF UNMET COMMUNITY NEED IN PRINCE GEORGE'S COUNTY: ADULT PSYCHIATRIC UTILIZATION

1.
Limited access to local acute psychiatric beds

Southern Maryland has the lowest ratio for the number of psychiatric beds-to-population across all Health Planning Regions in Maryland. Bed capacity has been reduced even as the average daily census for Prince George's County residents has remained high.

Licensed bed capacity – Table 3 below documents that the Southern Maryland Region has, by far, the lowest ratio of population-to-licensed-psychiatric beds:

Table 3
Bed-to-Population Ratio for Psychiatric Services by Health Planning Region

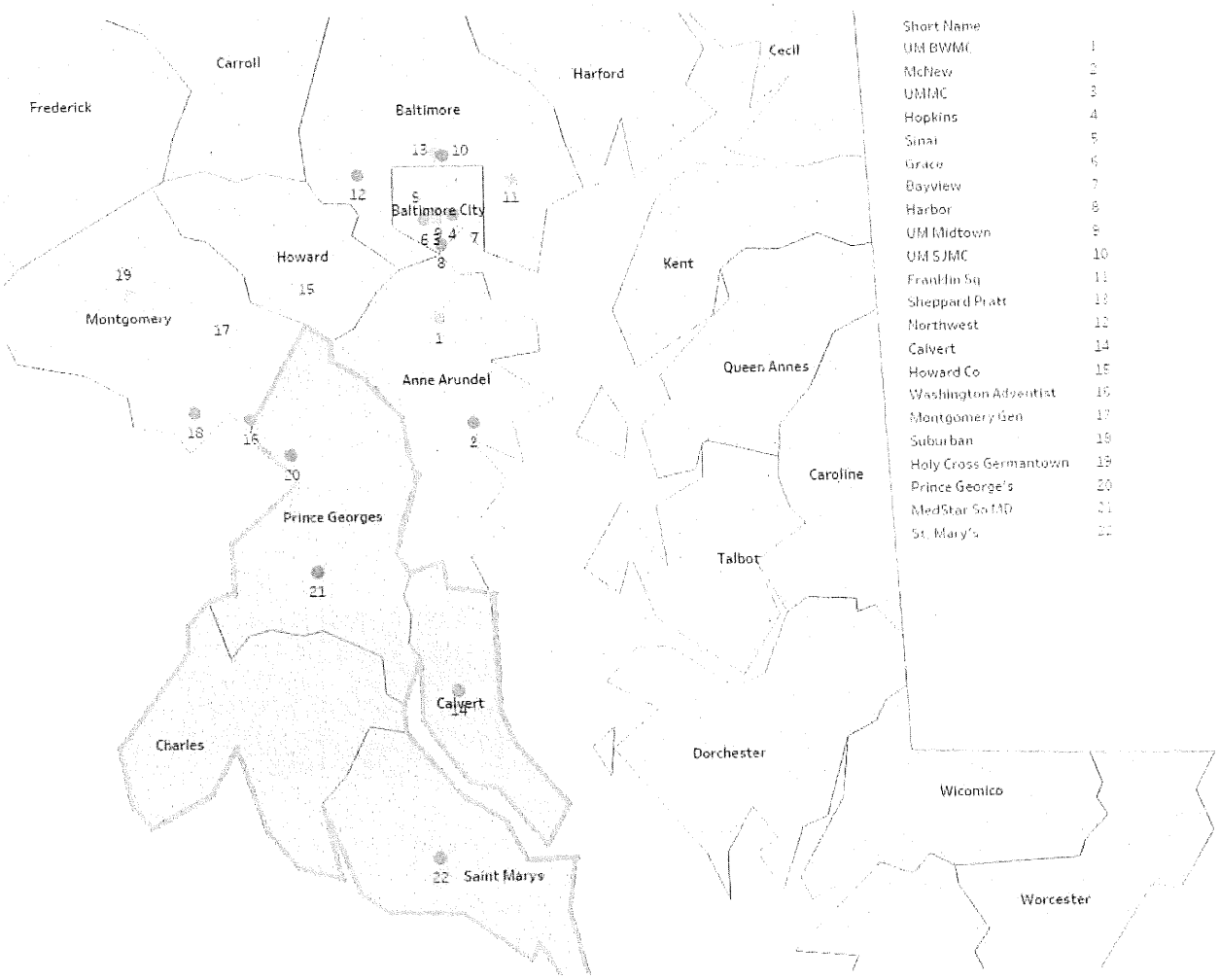
Region	2019 Estimated Population	# Psych Beds In 2019[1]	Beds per 100,000 Residents
Southern Maryland	1,280,913	80	6.2
Eastern Shore	456,110	37	11.4
Western Maryland	518,127	56	10.8
Montgomery County	1,083,777	187	17.3
Central Maryland	2,759,493	486	17.8
Total Acute Hospitals	**6,098,420**	**846**	

Sources: Population per Nielson-Claritas, 2019 Estimates
Licensed Acute Care Beds by Hospital and Service per Maryland Health Care Commission (MHCC), FY 2020 (effective July 1, 2019)

Geographic distribution of beds - The under-resourced Southern Maryland region—including Prince George's County—is further highlighted by the map below (Map 1) which

shows the concentration of acute psychiatric services in Baltimore City and the poorer distribution of resources across the Southern Maryland Region.

Map 1
Acute Psychiatric Units in General Hospitals and Specialty Psychiatric Hospitals
Southern Maryland Health Planning Region



The issue of access is of particular concern in Prince George's County where just two acute psychiatric units operate. These units are located at UM Capital Region Prince George's Hospital Center and at MedStar Southern Maryland Hospital, and have a total of 60 beds. The closure of Laurel Regional Hospital reduced access to acute psychiatry for residents of Prince George's County. While the psychiatric program from Laurel has been consolidated at UM Prince George's Hospital Center, bed capacity there remains at 32 beds. Therefore, total bed capacity for the County was reduced, and residents of the Laurel area now have nearly a 30-minute drive to the nearest acute psychiatric unit. The closure of Providence Hospital in Washington, DC further reduced acute care capacity and access to care for residents of Prince George's County who live in communities near the Washington, DC border communities.

2.
Acute care volume

In CY2019, the number of psychiatric admissions for Prince George's County residents continued to account for 75 occupied beds, and this does not include patients with substance use disorders as the primary diagnosis.

Between 2018-2019, total psychiatric discharges declined but the County population continued to account for 75 occupied beds, even without including the volume from patients with substance use disorders as a primary diagnosis.

Table 4
Psychiatric Hospital Volume: ED and Inpatient
Prince George's County Adult residents
CY 2017- CY 2019

	CY 2017	CY 2018	CY 2019	CAGR %
ED Mental Health Outpatient Visits[1]	3,890	4,112	4,560	8.3%
% Change, Year to Year		5.7%	10.9%	
Mental Health Discharges[2]	4,071	4,228	3,710	(4.5%)
% Change, Year to Year		3.9%	(12.3%)	
Average Length of Stay	7.0	6.9	7.3	2.4%
Occupied Beds for Mental Health Principal Dx	78	80	75	(2.3%)

Source: CY 17 - CY 19 Maryland inpatient and outpatient data, psych specialty hospital data, and DC inpatient data
Notes:
[1] ED visits defined as outpatient volume at acute Maryland hospitals with ED charges and behavioral health principal diagnosis (excluding substance use)
[2] Mental health discharges defined as discharges from acute Maryland and DC hospitals as well as psychiatric specialty hospitals in Maryland with a behavioral health principal diagnosis (excluding substance use)

3.

The Consequences of Out-of-County Admissions

In CY2019, more than half of adult psychiatric admissions from Prince George's County were treated at hospitals outside of the County (1,900 discharges). Table 5 below documents the total number of CY2019 adult psychiatric discharges, by hospital. More than half of these discharges, or 1,900 cases, were treated at out-of-County hospitals.

Table 5
Total Inpatient Adult Psychiatric Discharges, by Hospital
Prince George's County Adult Residents
CY 2019

	# Discharges	% Discharges
Specialty Psychiatric Hospitals		
Sheppard Enoch Pratt Hospital (Private)	414	8.5%
Brook Lane (Private)	19	0.5%
Subtotal, Specialty Psychiatric Hospitals	**433**	**9.0%**
In-County Acute Hospitals		
Doctors Community Medical Center	31	0.8%
Adventist Fort Washington Medical Center	6	0.2%
Prince George's Hospital Center	1,166	31.4%
MedStar Southern Maryland Hospital Center	606	16.3%
Subtotal, In-County Acute Hospitals	**1,809**	**48.8%**
Out-of-County Acute Hospitals		
Maryland		
Adventist HealthCare Shady Grove Medical Center	316	8.5%
Adventist HealthCare Washington Adventist Hospital	226	6.1%
Suburban Hospital	101	2.7%
Holy Cross Germantown Hospital	98	2.6%
Howard County General Hospital	41	1.1%
MedStar Franklin Square Medical Center	33	0.9%
Northwest Hospital	33	0.9%
MedStar Montgomery Medical Center	32	0.9%
MedStar Saint Mary's Hospital	29	0.8%
Calvert Health Medical Center	26	0.7%
UM Midtown	24	0.6%
The Johns Hopkins Hospital	24	0.6%
Grace Hospital	24	0.6%
MedStar Harbor Hospital Center	22	0.6%
UM Baltimore Washington Medical Center	22	0.6%
Holy Cross Hospital	16	0.4%
University of Maryland Medical Center	16	0.4%
UM St. Joseph Medical Center	15	0.4%
Levindale Hebrew Geriatric Center and Hospital	13	0.3%
Anne Arundel Medical Center	10	0.3%
All Other Maryland Hospitals (<10 cases)	37	1.0%
Subtotal, Maryland	**1,117**	**30.1%**
Washington D.C.		
United Medical Center	125	3.4%
MedStar Washington Hospital Center	158	4.3%
George Washington University	64	1.7%
Sibley Memorial Hospital	38	1.0%
Howard University Hospital	27	0.7%
MedStar Georgetown University Hospital	38	1.0%
Subtotal, Washington D.C.	**450**	**12.1%**
Subtotal, Out of County Acute Hospitals	**1,567**	**42.2%**
Total	**3,709**	**100.0%**

Sources:

CY 2019 DC inpatient dataset. Primary diagnosis in F category

CY 2019 MD inpatient and outpatient dataset. Primary diagnosis in F category

CY 2019 MD Psych hospital dataset. Primary diagnosis in F category

Note 1: Included discharges are any discharge performed in DC, MD or MD Psych hospitals in 2019 where principal diagnosis began with F and excludes substance use disorder

Note 2: Adult patients defined as age 18+

Note 3: Prince George's and Montgomery County residents defined as any zip code in MD ZIP code

Note 4: Inpatient cases are from MD IP, DC IP, and MD Psych IP data

While high-quality programs operate outside the county, use of out-of-area hospitals has serious consequences for patients, families and quality outcomes. As described above in more detail in the Comprehensive Project Description above, the negative consequences include disjointed care management, more complicated discharge planning, the requirement for a new provider relationship to be established, disruption in continuity of care across levels of care, and disengagement of families.

Additionally, length of stay in out-of-county facilities tends to be longer than necessary because out-of-county programs are not as well-integrated with local, community-based resources in Prince George's County. Discharge planning across counties is simply more time-consuming; therefore, acute hospital stays often are unnecessarily extended. This is reflected in the comparatively longer length of stay for Prince George's County patients at in-County vs. out-of-County hospitals, as shown on Table 6 below.

Table 6
Average Length of Stay Psychiatric Admissions
In County vs. Out of County Hospitals
Prince George's County Adult Residents
CY 2019

	Discharges	ALOS
In-County Acute Hospitals	1,809	6.9
Specialty Psychiatric Hospitals	333	10.9
Out-of-County Acute Hospitals	1,568	7.5

Sources
CY2019 DC Inpatient data set, Primary diagnosis in F category
CY2019 MD Inpatient and outpatient data set Primary diagnosis in F category
CY2019 MD Psych hospital data set Primary diagnosis in F category

Note 1 Included discharges are any discharge performed in DC, MD, or MD Psych hospitals in 2019 where principal diagnosis begins with F, and excludes substance use disorder
Note 2 Adult patients defined as age = 18+
Note 3 Prince George's and Montgomery County resident defined as an in-county ZIP code
Note 4 Inpatient cases are from MD IP, DC IP, and MD Psych IP data

4.

Delays in Treatment at the Point of Crisis

Nearly 1,000 Prince George's County psychiatric patients required a hospital-to-hospital transfer for a psychiatric admission. This adds hardship for patients and delays in treatment, often at the point of crisis. Persons in crisis rely heavily on their community hospitals as the first point of contact. But hospitals without a licensed psychiatric unit can only provide stabilization in the ED and must then transfer patients who require psychiatric admission to another hospital. Patients in crisis must wait in the ED as calls are made to locate an available hospital bed and as the necessary transfer arrangements are made. In CY2019, a total of 984 Prince George's County adult psychiatric patients required a hospital-to-hospital transfer for admission to a psychiatric unit. This means that patients utilize their local Emergency Department during a crisis episode/acute care need but have to experience the long wait and transfer process in an ED setting. EDs in general acute hospitals are typically not designed for behavioral health crisis episodes nor are these EDs generally resourced with behavioral health professionals. As a result, patient conditions may escalate rather than deescalate until transfer is completed.

The transfer process also means that treatment is delayed, and the delays in care can be significant. At LHDCMC, the total volume of patients in the ED is more modest, but the average delay in the ED until transfer can be made continues to be is indicative of what likely occurs across the County. On average, patients in the ED at LHDCMC wait 31 hours (CY20) between arrival to the ED and transfer to acute care at another hospital.

5.

High ED Utilization and Episodic Care

The number of high ED utilizers for behavioral health care is evidence of episodic treatments and weak care management for behavioral health conditions. In CY2019, a total of 169 patients from Prince George's County patients accounted for 848 behavioral health ED visits, an average of 5 behavioral health ED visits per patient in one year. This pattern underscores the need for an improved delivery system for psychiatric services. The lack of an acute care unit may be contributing to under treatment and return ED visits; the lack of integration and steady relationships with local providers may be contributing to relapse rates.

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

6.

Overdose Death Rates

The alarming rise in death rates from drug and alcohol-related deaths in Prince George's County calls for investment in behavioral health services. Unlike other counties in Maryland that are demonstrating reductions, Prince George's County reports a continued increase in overdose death rates. Between 2019-2020, the number of opioid-related deaths in Prince George's County more than doubled. Behavioral health services are critical to effective prevention efforts in order to address root causes and prevent those suffering from behavioral health problems from turning to drugs and alcohol. The behavioral health system has not adequately met the service needs of Prince George's County patients and this has contributed to tragic consequences.

The LHDCMC unit will admit patients with a substance use disorder identified as a co-occurring diagnosis. The National Institute for Mental Health estimates around half of individuals with a substance use disorder have co-occurring psychiatric conditions. Having local behavioral health services will allow individuals with both substance use disorders and psychiatric disorders to engage in care.

7.

Community Residents Report That Their Behavioral Health Service Needs Are Not Being Met

In the most recent Community Health Needs Assessments (CHNAs) prepared by the Prince George's County Health Department, residents/stakeholders ranked behavioral health services as a top priority need. Stated simply, County residents communicated that their needs are not being adequately met.

The continued need for inpatient care, the addiction rates, the signs of maternal depression, and the direct statements made in the Community Health Needs Assessment are a call for help and indicators that the needs of the Prince George's County population are not being met. The indicators documented in this application reflect a period *prior to* the pandemic; the need for services is known to have intensified with the pandemic.

LHDCMC is committed to responding to this need by offering a full continuum of behavioral health care services, including acute care, to the community. For the severely ill and for those in crisis episodes, an inpatient stay is critical to evaluation and effective treatment planning. More broadly, for those with episodes of illness, the inpatient unit is critical to integrating medical and behavioral health management and establishing a local and steady therapeutic relationship for ongoing support. The most effective program model – and the one the LHDCMC is following -- is to provide a comprehensive program in the local community to support continuity of care, maintain steady therapeutic relationships and allow integrated medical and psychiatric care management.

C.

PROJECTING NEED AND SIZING THE PSYCHIATRIC UNIT AT LHDCMC

There is no published bed need projection in effect for child, adolescent and adult psychiatric beds, and the need projection methodology contained in the State Health Plan Chapter is recognized as obsolete. Accordingly, LHDCMC prepared a need assessment and a volume projection for its proposed acute care unit based on hospital utilization patterns and based on other indicators that identify community need. LHDCMC's analysis supports the need for a 16-bed acute care unit. The unit is expected to operate at 83 percent occupancy by Year 2 of operation.

This subsection is organized as follows:

1) Service Area Definition and Population Base: Prince George's County
2) Patient Populations to be Served
3) Evidence of Need for Additional Capacity
4) Projected Volume for New Unit

1.

Service Area Definition and Population Base: Prince George's County

As described earlier, this project is a collaborative initiative LHDCMC and the Prince George's County Department of Health. The Department is investing heavily in this new unit and is committed to providing equitable resources to residents across Prince George's County. As a collaborative initiative, this project defines Prince George's County as the service area for the acute psychiatric unit. This service area definition reflects the following 3 program objectives:

- Provide LHDCMC's primary service area with local access to acute psychiatry, a continuum of outpatient behavioral health services, and continuity of care across the continuum to strengthen care management and improve quality outcomes.
- Provide Prince George's County - - the most under-bedded region in Maryland - - with expanded bed capacity for acute psychiatric care.
- Successfully recruit high quality clinicians through a comprehensive program, to better meet the professional shortage for behavioral health care services and improve quality outcomes.

LHDCMC is strongly positioned to serve as a specialty provider of psychiatric services to the overall Prince George's County population. LHDCMC already serves the large majority of communities in Prince George's County; LHDCMC's service area includes 25 zip codes that encompass approximately 80 percent of the Prince George's County population. Moreover, an examination of where the LHDCMC-eligible population residents shows that 87% of these patients reside in the LHDCMC service area.

Population projections

The total adult population in Prince George's County (age 18 years or older), is approximately 700,000 residents with an annual growth rate of approximately 0.7% percent per year through Year 2023. Even as alternative service settings come to substitute for admission, the population growth of this region will continue to drive the need for inpatient care.

Table 7
Population Estimates and Projections: Prince George's County
CY 2019 Estimated and CY 2024 Projected

Age Cohort	CY 2019 Estimated	CY 2024 Projected	Annual Growth Rate
Age 0 -14	172,124	175,512	0.39%
Age 15 - 17	32,935	35,020	1.24%
Age 18 - 64	582,697	578,432	-0.15%
Age 65+	124,055	152,525	4.22%
Total	**911,811**	**941,489**	**0.64%**

Source: Nielson Claritas Population Estimates, 2019 and 2024

2.

Patient Populations to be served

(a) Age cohorts

LHDCMC plans to admit adult psychiatric patients, including voluntary and involuntary admissions. LHDCMC will be licensed as an adult psychiatric unit, serving patients age 18+ years.

(b) Clinical definitions

The inpatient unit will serve adults patients, age 18+ years, with a primary psychiatric diagnosis. Psychiatric diagnoses, as defined here, do not include patients with a substance use/alcohol-related disorder coded as the primary diagnosis. However, the LHDCMC unit will admit patients with a substance use disorder identified as a co-occurring diagnosis. Case volume documented with a co-occurring substance use disorder was included in all analyses and volume projections below.

For purposes of analysis, a psychiatric diagnosis was defined by a primary diagnosis documented with an F-Code (F1-F99), with the exclusion of those F-codes identifying substance use as the primary diagnosis (See "Technical Definitions," Exhibit 13).

The inpatient unit will not be admitting a number of distinct diagnostic cohorts determined to be best served at specialty psychiatric hospitals/larger psychiatric units with specialty program resources. DCMC determined that these patient populations would be optimally served at facilities like Sheppard Pratt, where specialized resources and staff are centralized, continually trained, and best supported. These patient populations were therefore *excluded* from the market assessment and the need projection based on diagnosis codes:

- Eating disorders
- Dementia/neurologic disorders
- Neurodevelopmental disabilities/intellectual disorders

The total patient volume with psychiatric disorders as a primary diagnosis, excluding the categories above, are referred to as "**LHDCMC-eligible patients**." Exclusions (defined above) account for only 3% of total adult psychiatric discharges in Prince George's County. For purposes of volume projections, all market share analyses, use rate analyses, and need projections in this section are based on the definition of **"LHDCMC- eligible patients."**

3.

Evidence of Need for Additional Capacity

LHDCMC previously described the factors driving demand for inpatient psychiatric care and provided the evidence of need for acute psychiatric beds in the County. The following section narrows this analysis to document volume for the LHDCMC-eligible population, specifically to provide the basis for LHDCMC volume projections and impact analyses.

(a) Acute care volume, CY2017-2019

The number of LHDCMC-eligible discharges declined in CY2019. However, with the increase in length of stay, the Prince George's County population continued to account for approximately 70 occupied beds.

Table 8
LHDCMC-Eligible Discharges, by Age Court
Prince George's County
Calendar Year 2017-2019

	CY 2017	CY 2018	CY 2019
Age 18-64	3,555	3,795	3,403
Age 65+	190	255	181
Total Acute Psychiatric Discharges	**3,745**	**4,050**	**3,584**
% Change		*8.1%*	*-11.5%*
ALOS	7.1	6.8	7.0
Total Days	26,486	27,372	25,006
ADC	73	75	69

Sources:

CY2019 DC Inpatient data set. Primary diagnosis in F category

CY2019 MD Inpatient data set. Primary diagnosis in F category

CY2019 MD Psych hospital data set. Primary diagnosis in F category

Note 1: DCH Eligible discharges are any discharge performed in DC, MD, or MD Psych hospitals in 2019 where principal diagnosis begins with F, and excludes intellectual disability, dementia, eating disorders, neurodevelopmental, and substance use disorder

Note 2: Prince George's County resident defined as an in-county ZIP code

(b) Out-of-county care

More than 50% of LHDCMC-eligible discharges (1,900 discharges) were served at out-of-county hospitals. More than 400 of these cases traveled to Washington, DC hospitals for care.

Table 9
LHDCMC-Eligible Discharges, by Hospital
Prince George's County Adult Residents
CY 2019

	# Discharges	% Discharges
In-County Acute Hospitals		
Doctors Community Medical Center	10	0.3%
Adventist Fort Washington Medical Center	2	0.1%
Prince George's Hospital Center	1,144	31.9%
MedStar Southern Maryland Hospital Center	594	16.6%
Subtotal, In-County Acute Hospitals	**1,750**	**48.8%**
Out-of-County Acute Hospitals		
Maryland		
Specialty Psychiatric Hospitals		
Sheppard Enoch Pratt Hospital (Private)	306	8.5%
Brook Lane (Private)	18	0.5%
Subtotal, Specialty Psychiatric Hospitals	**324**	**9.0%**
Acute Hospitals		
Adventist HealthCare Shady Grove Medical Center	315	8.8%
Adventist HealthCare Washington Adventist Hospital	222	6.2%
Suburban Hospital	101	2.8%
Holy Cross Germantown Hospital	55	1.5%
Howard County General Hospital	39	1.1%
MedStar Franklin Square Medical Center	33	0.9%
Northwest Hospital	33	0.9%
MedStar Montgomery Medical Center	32	0.9%
MedStar Saint Mary's Hospital	31	0.9%
CalvertHealth Medical Center	26	0.7%
UM Midtown	24	0.7%
Grace Hospital	24	0.7%
The Johns Hopkins Hospital	22	0.6%
MedStar Harbor Hospital Center	22	0.6%
UM Baltimore Washington Medical Center	22	0.6%
University of Maryland Medical Center	15	0.4%
UM St. Joseph Medical Center	15	0.4%
All Other Maryland Hospitals (<10 cases)	46	1.3%
Subtotal, Maryland	**1,075**	**30.0%**
Washington D.C.		
United Medical Center	120	3.3%
MedStar Washington Hospital Center	152	4.2%
George Washington University	63	1.8%
Sibley Memorial Hospital	37	1.0%
Howard University Hospital	27	0.8%
MedStar Georgetown University Hospital	35	1.0%
Subtotal, Washington D.C.	**434**	**12.1%**
Subtotal, Out of County Acute Hospitals	**1,833**	**51.2%**
Total	**3,583**	**100.0%**

Sources:

CY 2019 DC Inpatient data set. Primary diagnosis in Frequency

CY 2019 MD Inpatient and Outpatient data set. Primary diagnosis in Frequency

CY 2019 MD Psych Hospital data set. Primary diagnosis in Frequency

Note 1: Excluded Discharges are records discharge petitioned to DC, ND or MD Psych hospitals in 2019 where principal diagnosis began event window, excluded substance use disorder

Note 2: Adult patients defined as age >18

Note 3: Prince George's and Montgomery County residents defined as with county ZIP code

Note 4: Inpatient data from MCBH, DC IP, and MD Psych IP data

These utilization patterns adversely affect the quality of care and the costs of care, as described above in the Comprehensive Project Description.

(c) Length of stay indicators

Nearly 300 discharges had lengths of stay greater than 15 days (291 discharges). This may reflect challenges of discharge planning for out-of-county patients and also reflects the lack of outpatient service delivery tied to acute care providers.

Table 10
Current Volume of Inpatient Stays by Age and LOS Categories
Residents of Prince George's County/DCH Eligible Discharges[1,2]
Calendar Year 2019

	Inpatient Cases[3]					
Age Group	0-1 day	2 days	3-7 days	8-14 days	15+ days	Total Discharges
0-14	5	5	95	63	29	197
15-17	2	5	97	73	23	200
18-64	173	340	2,032	607	251	3,403
65+	11	10	67	53	40	181
Total	**191**	**360**	**2,291**	**796**	**343**	**3,981**
Total Days	**173**	**720**	**10,842**	**8,009**	**9,456**	**29,200**
ALOS	**0.9**	**2.0**	**4.7**	**10.1**	**27.6**	**7.3**
Total # Adults, only (Age 18+)	184	350	2,099	660	291	3,584
% Adults with SUD as co-occurring[6]	0.0%	0.0%	0.0%	0.0%	0.0%	52.2%

Sources
CY2019 DC Inpatient data set, Primary diagnosis in F category
CY2019 MD Inpatient and outpatient data set. Primary diagnosis in F category
CY2019 MD Psych hospital data set. Primary diagnosis in F category

Note 1: Prince George's County resident defined as an in-county ZIP code
Note 2: DCH Eligible discharges are any discharge performed in DC, MD, or MD Psych hospitals in 2019 where principal dagnosis begins with F, and excludes intellectual disability, dementia, eating disorders, neurodevelopmental, and substance use disorder
Note 3: Inpatient data per MD IP, DC IP, and MD Psych IP data
Note 4: Observation > 24 hours Defined as RCUNIT80_OBV>23, not admitted as IP; observation data is unavailable for MD Psych hospitals, DC hospitals
Note 5: "Total Days" for Observation >24 hours is the sum of hours charged for outpatient observation cases with a stay over 23 hours divided by 24
Note 6: Adult cases with SUD as co-occurring defined as cases where patient age = 18+ and at least one SUD Dx code is present in Dx positions 2-30

(d) Cost of care differentials

Because of the lack of inpatient psychiatric beds in the LHDCMC market, more than 300 discharges were treated at Sheppard Pratt where, because of their overall specialized services, hospital costs are considerably higher relative to what the cost would be at LHDCMC for routine inpatient services. Once open, LHDCMC will provide that lower cost environment for the more routine inpatient admission.

The comparison of charges shows that Sheppard Pratt's charge per care is approximately $1,432 higher relative to the average charge per case at psychiatric units in community hospitals. There is an opportunity, then, to reduce the costs of care by shifting/distributing more acute psychiatric services to lower cost community hospitals in service areas where the volume can support a viable program. This savings opportunity is further discussed in the response to COMAR 10.24.01.08G(3)(f)(impact on costs to the health care delivery system) in Table 14.

4.

Projected Volume for the New Unit

LHDCMC prepared volume projections for the new unit based on the following need analysis:

- **Patient age**: The proposed psychiatric unit will serve patients age 18 years and older.

- **Patient origin**: The defined service area is Prince George's County. Approximately 95 percent of discharges will be drawn from the defined service area; 5 percent of discharges will be drawn from out of County.

- **Clinical definition:** All admissions will be defined by a LHDCMC-eligible psychiatric diagnosis as the primary diagnosis.

- **Use rate decline**: Volume projections incorporate a use rate reduction for psychiatric discharges in Prince George's County by the Year 2023. This reflects investments planned for alternative service settings by both LHDCMC and other health systems (urgent care center; partial hospitalization; outpatient clinics; residential crisis units). The following assumptions were applied to the projection model:

    - The number of 1-day and 2-day psychiatric hospital stays will decline significantly through the use of urgent care, partial hospitalization, and community-based services *in place of hospitalization*. These lower cost settings will come to substitute for 20 percent of the

current 1- and 2- day psychiatric admissions.
    - The number of long-stay psychiatric admissions (> 15 days) will also decline through the use of lower cost settings; this includes residential crisis units for step-down care and home-based care with technology supports

- **LHDCMC market share**: LHDCMC will achieve 19% market share for psychiatric admissions in Prince George's County (as a percentage of LHDCMC-eligible admissions, only). This is comparable to LHDCMC's market share of just under 20% for adult medical/surgical admissions in Prince George's County.

- **Average length of stay**: The average length of stay for volume at LHDCMC is projected to remain stable at 7.0 days, reflecting the following factors:
    - The use rate decline projected for the region is tied to a reduction in short stay admissions. Reducing the number of low intensity, short stay patients will leave the longer stay patients—including involuntary patients—driving length of stay patterns in the acute care unit.
    - A higher percentage of admissions will be those patients who require extended evaluation, medication management, and therapeutic protocols after a crisis episode. These stays will continue to require nearly one week's inpatient stay.
    - National reports/clinical studies emphasize the need to assure that length of stay is adequate for efficacy and tolerance of new medication(s) and adequate time to establish patient self-management skills in order to prevent readmissions.

- **Ramp up:** Ramp-up of volume is expected to be rapid, reflecting the following factors:
    - Urgent care center that will have been operating for an estimate year to opening of the acute care unit.
    - Established relationships with emergency medical teams and law enforcement that will very immediately direct volume to DCMC.

Based on these assumptions, volume projections are presented below. These figures support a 16-bed acute care unit, projected to operate at 84 percent occupancy by Year 3 of operation.

Table 11
Acute Psychiatric Unit at LHDCMC
Projected Volume FY2023-2025

	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
Total number of discharges	557	695	700	705	710
Average length of stay (ALOS)	7.0	7.0	7.0	7.0	7.0
Total patient days	3,900	4,868	4,901	4,934	4,967
Average Daily Census (ADC)	10.7	13.3	13.4	13.5	13.6
Occupancy rate @ 16-bed unit	66.8%	83.4%	83.9%	84.5%	85.1%
DCMC, total discharges					
Prince George's County	531	662	667	671	676
Out of area	27	33	33	34	34
Total	557	695	700	705	710
DCMC market share					
Prince George's County	15.6%	19.4%	19.4%	19.4%	19.4%

Source:
CY2019 DC Inpatient data set, Primary diagnosis in F category
CY2019 MD Inpatient data set, Primary diagnosis in F category
CY2019 MD Psych hospital data set, Primary diagnosis in F category

Note 1: DCH Eligible discharges are any discharge performed in DC, MD, or MD Psych hospitals in 2019 where principal dagnosis begins with F, and excludes intellectual disability, dementia, eating disorders, neurodevelopmental, and substance use disorder
Note 2: Adult patients defined as age = 18+
Note 3: Prince George's County resident defined as an in-county ZIP code

Table 12 presents a population-based model to present a consolidated picture of projected use rate decline, length of stay, and inpatient volume at LHDCMC.

Table 12
Population Based Uses Rate Model, 2019-2025
Projected Adult Psychiatric Discharges at LHDCMC

	Actual	Projection					Shift to FY				
	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
Prince George's County, DCMC BH definition, adult only											
Population[3]	706,752	711,528	716,336	721,177	726,051	730,957	728,504	733,427	738,383	743,373	748,396
Discharges per 100k	507	503	498	493	489		489	489	489	489	489
BH Discharges, Prince Georges Co (Adj Market)	3,584	3,576	3,567	3,559	3,550		3,562	3,586	3,611	3,635	3,659
Average Length of Stay (ALOS)	7.0	7.0	7.0	7.0	7.0		7.0	7.0	7.0	7.0	7.0
Patient Days	25,006	24,947	24,888	24,829	24,770		24,854	25,022	25,191	25,361	25,533
Average Daily Census (ADC)	68.5	68.3	68.2	68.0	67.9		68.1	68.6	69.0	69.5	70.0
Projected DCMC Cases											
Prince George's County market share							14.9%	18.5%	18.5%	18.5%	18.5%
DCMC Discharges							531	662	667	671	676
Out of area volume: 5% additional							27	33	33	34	34
Total discharges with year 1 @ 12 months of operation							557	695	700	705	710
Average length of stay (ALOS)							7.0	7.0	7.0	7.0	7.0
Average daily census							11	13	13	14	14
Occupancy rate at 16 beds							67%	83%	84%	84%	85%

Source:
CY2019 DC Inpatient data set. Primary diagnosis in F category
CY2019 MD Inpatient data set. Primary diagnosis in F category
CY2019 MD Psych hospital data set. Primary diagnosis in F category
Nielsen-Claritas 2019 Estimate, 2020-2024 Projections

Note 1: DCH Eligible discharges are any discharge performed in DC, MD, or MD Psych hospitals in 2019 where principal dagnosis begins with F, and excludes intellectual disability, dementia, eating disorders, neurodevelopmental, and substance use disorder
Note 2: Adult patients defined as age = 18+
Note 3: Prince George's County resident defined as an in-county ZIP code
Note 4: Inpatient cases are from MD IP, DC IP, and MD Psych IP data

Accordingly, the proposed 16-bed acute care unit is projected to operate at 84 percent occupancy by Year 3 of operation, The qualitative and quantitative analysis above demonstrates unmet need for inpatient psychiatric care in the population to be served and that the proposed unit will meet those needs as required by this standard.

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

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

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

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

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

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

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

Applicant Response:

LHDCMC's primary objectives for the proposed project are:

- Provide high-quality behavioral health services; driven by a commitment to continuously advance unparalleled, evidence-based care.
- Provide behavioral health services to the community in an operationally efficient, functional, safe and comforting facility.
- Provide a comprehensive continuum of care supportive of the patients we serve.

LHDCMC evaluated several alternative approaches for implementing behavioral health services and considered the following alternatives:

Option A: Do Nothing

Option B: Convert Existing Hospital Space

Option C: Construct New Building on Campus

Option D: Adaptive Reuse of Existing Building (Selected Option)

Option A: Do Nothing

Doing nothing to add inpatient psychiatric beds at the LHDCMC campus was considered and rejected.

Option B: Convert Existing Hospital Space

An option to convert an existing medical/surgical beds in the North Tower into 16 psychiatric beds was explored. The estimated total project cost range is $7.7M - $10.1M, but this does not account for the cost of the displaced services. In addition, the comprehensive renovation activity needed to prepare the existing space in the hospital for this specialized healthcare service would be highly disruptive to the ongoing operation of the hospital for medical/surgical services which currently operates at full capacity.

There are several additional drawbacks to this option. The only potential area that could be renovated for this program in the existing facility is on floors three or above. This is a very poor location for a behavioral health locked unit for voluntary admissions or those admissions committed by the court. The adjacencies, access for patients' visitors, and security for patients and visitors are less than ideal. Given the continuing demand and utilization for these beds and services, converting existing space for an inpatient psychiatric unit is not a practical nor a cost-effective alternative.

Option C: Construct New Building on Campus

Another alternative considered was to construct a new freestanding psychiatric hospital on the LHDCMC campus separate from the main hospital building. A new facility was explored because it affords minimal impact to existing operations during construction while providing maximum ability to accommodate the full continuum of behavioral health services in one location.

In order to avoid the disruption of existing site infrastructure and significant impact to the existing parking spaces, areas immediately adjacent to the main hospital building were not considered viable. This reduced the potential location of a new building on the campus to portions of the undisturbed site along the perimeter of the property where there is mature forested land and steep sloping terrain. Development of this land would add significant time to construct and cost to the overall project.

A freestanding facility capable of housing 16 inpatient beds, support a complement of outpatient and crisis services, and provide future flexibility would be approximately 58,000 SF. A review of potential options and conceptual estimates for this project indicate a total capital investment in excess of $33.6M.

Option D: Adaptive Reuse of Existing Building (Selected Option)

An option to renovate a portion of an existing building on campus that supports outpatient behavioral health services and crisis beds was explored and selected.

The second floor contains approximately 12,008 SF of previously developed space. The space was once used as part of a nursing home with a food preparation kitchen, dining area, support areas, and resident beds. The facility nursing home portion of the facility has been out of service for over 5 years and will need to be fully reconstructed. The facility is located in close proximity to the Emergency Department and directly adjacent to parking. Reusing the space within the facility allows for the seamless integration of inpatient beds with the existing outpatient behavioral health services. The conceptual estimate to reconstruct the currently unused space is $7.8M.

This is the preferred option as it is the most cost-effective solution to provide inpatient psychiatric services on the LHDCMC campus.

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

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

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

- Complete applicable Revenues & Expenses (Tables G, H, J and K as applicable), and the Work Force information (Table L) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable.
- Describe and document relevant community support for the proposed project.
- Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.

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

Applicant Response:

Tables:

The required tables are included in Exhibit 1 (CON Table Package). These tables demonstrate that the proposed project is sustainable because the project generates a positive margin in the first year.

Funding Plan:

The capital cost of this project will be paid for through a combination of cash and capital grant from Prince George's County. A promissory note evidencing the grant is attached as Exhibit 14.

Staffing Plan:

LHDCMC will recruit staff utilizing the recruitment of expertise of the Luminis Health recruitment services. We would expect to fill staffing needs with the allure of a "new" facility that is state-of-the-art, contemporary and safe. It is also believed that many individuals from the LHDCMC catchment area work in behavioral health in other areas because of the lack of positions currently available at LHDCMC. The possibility of working closer to home will likely result in a number of experienced staff returning to the area to continue their professional career.

Community Support:

The project enjoys widespread support within the Prince George's County community. Letters of support for the project are collected at Exhibit 15. Certain letters of support are highlighted below.

Dr. Ernest Carter, MD, PhD, the Prince George's County Health Officer explains in his letter of support for the project:

> *"The County is operating with limited bed capacity at a time when public health professionals across the country warn of a "mental health tsunami", an aftermath of the pandemic (Sullivan, 2021). Furthermore, because of the disproportionate impact of COVID-19 on our community, according to the United States Centers for Disease Control and Prevention, national trends indicate that the behavioral health sequelae will be even more tremendous for our predominantly minority community (Czeisler, 2020). As published in the Journal of the American Medical Association, statewide analysis of suicide mortality in Maryland indicated a doubling of suicides for African Americans during the height of the COVID-19 pandemic while the rates for whites approximately halved (Johnathan, 2020).The new inpatient program will respond to this concerning trend and build the infrastructure need to achieve behavioral health equity within our own community for our current needs and that which is to come."*

State and local elected officials also support this project. This includes County Executive Angela Alsobrooks, who explains in her letter of support that "*the County is operating with limited bed capacity at a time when clinicians across the country warn of a "mental health tsunami" in the aftermath of the pandemic. The new inpatient program will respond to this need and reduce the number of out of county admissions. At a time when the impacts of healthcare disparities have been magnified by the pandemic, this facility is a critical piece to help ensure that we provide quality behavioral and mental health services that our community needs and deserves.*"

Sheppard Pratt had endorsed this project, explaining that it will "*reduce the number of residents needing to travel out of the county for a general psychiatric admission.*"

Several of the area's largest churches and faith-based organizations have expressed their support for LHDCMC's inpatient mental health unit, including Community Ministry of Prince George's County and Ebenezer Church of God.

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

Applicant Response: If the project is approved, LHDCMC will obligate 51% of the approved capital expenditure within 4 months of the date of the CON, initiate construction no later than 4 months after the effective date of the binding construction contract and document, and complete the project within 12 months after the effective date of the binding construction contract.

- LHDCMC has selected an architectural firm (A/E), Kezlo Group, as the lead architect and Marshall Craft Associates as the medical planner for the Certificate of Need application. The combined team includes in-house medical planners, clinical consultants, designers, and code reviewers. Leach Wallace are the mechanical and electrical engineers. Meetings have occurred between LHDCMC, the design team/consultants and the Prince George's County Medical Director for Behavioral Health. At the point in which the project moves forward, architectural design firm will be selected to provide design and engineering services associated with the internal renovations.
- LHDCMC will be engaging the services of a program manager to advise the owner, provide cost and schedule controls, and provide risk management and mitigation services.
- A construction management (CM) firm will be engaged early in the project to provide pre-construction services and selection will follow LHDCMC's procurement policies. After the pre-construction is completed and permit documents are submitted to the respective authorities, a construction management firm will be selected and contracted with.
- Additional services related to 3rd party inspections, equipment and transition planners, and other such services will follow LHDCMC's procurement policies.

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

Applicant Response: Please refer to Exhibit 16.

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

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

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

Applicant Response:

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

1. 2006 CON-Waiver to provide Primary PCI without Cardiac Surgery On Site- Docket No. 06-16-0011
2. 2007 CON-Renewal of the Primary PCI without Cardiac Surgery Waiver- Docket No. 07-16-0025

   Granted extension for 6 months then recommended to cease Primary PCI.

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

1. 2016 CON-Application to build an inpatient Mental Health Hospital - Docket No. 16-02-2375
2. 2015 CON-Application to provide Cardiac Surgery - Docket No. 15-02-2360
3. 2004 CON-Application to Construct a Patient Tower – Docket No. 04-02-2153

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

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

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

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project[1];

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

c) On costs to the health care delivery system.

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

Applicant Response:

a) On the volume of service provided by all other existing health care providers

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

that are likely to experience some impact as a result of this project;

LHDCMC plans to operate this inpatient psychiatric program without adversely affecting existing acute psychiatric programs in Prince George's County. The core objectives of the program are to reduce the number of out of County admissions (particularly those admissions now served at Washington, DC hospitals) and provide local access for Prince George's County residents to inpatient adult psychiatric care.

The volume shifts associated with the proposed project are not expected to affect any existing inpatient psychiatric unit in such measure as to compromise the financial viability of the existing program. This is based on the following assumptions:

- More than 20% of the volume (approximately 150 discharges) will be drawn from Sheppard Pratt where the shift will not adversely program operations. Sheppard Pratt represents the highest volume program in the State of Maryland and the hospital plans to launch several new specialty programs at its Towson campus that will create needed capacity for higher acuity cases to offset this volume shift. Sheppard Pratt leadership is supportive of LHDCMC's establishment of this inpatient program.
- Approximately 75 discharges are expected to shift from the Washington Hospital Center, where the occupancy rate is reported to be 96%. Therefore, this shift will not adversely impact program operations at the WHC.
- Approximately 80 discharges are expected to come from other Washington, DC hospitals. This volume is now distributed in small numbers across hospitals; volume shifts will not produce a material impact.

The projected impact is summarized in Table 13 below which presents current occupancy rates, the projected volume shifts by hospital, and the impact on overall occupancy rates at each hospital. This analysis incorporates assumptions about demographic growth which helps offset some of the volume shift occurring at each hospital:

Table 13
Projected Volume Shifts to LHDCMC Acute Psychiatric Unit, by Hospital
In CY2019 Volumes

	CY 2019	Total # Psych Admits: CY2019 Actual			DCMC-eligible Volume, Age 18+	DCMC-eligible Volume, Age 18+ after Market Adjustments: Prince George's County Residents			Montgomery County Cases	Impact on Existing Providers: Impact Based on CY 2019 Volume			With Demographic Growth 2019-2023
Hospital	Licensed Beds	Cases	ADC	Occupancy Rate	Cases	# Discharges	Shift: % Discharges	Shift: # Discharges	Shift: # Discharges	Balance, Total # Psych Discharges	Total Psych ADC	Effect on Psych Occupancy %	Effect on Psych Occupancy %
Maryland Hospitals													
UM Capital Region Prince George's	32	1,665	25.2	78.8%	1,144	1,098	10%	110	-	1,509	22	68.9%	71.0%
MedStarSouthern MD	28	1,222	19.3	68.8%	594	576	10%	58	-	1,147	18	64.1%	66.1%
Shady Grove Adventist	117	3,157	84.1	71.9%	315	308	10%	31	-	3,120	83	71.1%	73.3%
Sheppard Pratt	414	7,830	297.8	71.9%	306	303	50%	151	-	7,675	293	70.8%	73.0%
White Oak Medical Center (formerly Wash Adv)	26	654	12.5	48.2%	222	216	10%	22	-	627	12	46.3%	47.7%
Suburban Hospital	24	1,451	16.5	68.8%	101	97	10%	10	-	1,437	16	68.2%	70.3%
Other Maryland Hospitals	684	28,884	519.6	76.0%	458	447	30%	134	-	28,729	516	75.4%	77.8%
Subtotal, Maryland Hospitals	1,325	44,863	975.0	73.6%	3,150	3,046	0%	515	-	44,244	961	72.5%	74.7%
Washington DC Hospitals													
United Medical Center		1,504	20.3		120	111	30%	33	-	1,462	20		
MedStar Wash Hosp Center	46	2,167	44.2	96.0%	152	146	30%	44	32	2,086	43	92.6%	95.5%
George Washington Univ	20	998	14.9	74.5%	63	58	30%	17	-	976	15	72.7%	74.9%
Sibley Hospital	21	683	14.5	68.8%	37	36	30%	11	-	671	14	67.4%	69.5%
Howard Univ Hosp	18	655	8.2	45.4%	27	24	30%	7	-	645	8	44.9%	46.3%
MedStar Georgetown Univ	-	585	11.9		35	34	30%	10	-	574	12		
Subtotal, Washington DC Hospitals	105	6,592	113.9		434	410	0%	123	32	6,413	111		
Total Existing Programs	1,430	51,455	1,088.9		3,584	3,456	0%	638	32	51,327	1,084		
Total Shift, Maryland & DC Hospitals								670					
DCMC Market Share, PG County								18.5%					

Source:
CY2019 DC Inpatient data set, Primary diagnosis in F category
CY2019 MD Inpatient data set, Primary diagnosis in F category
CY2019 MD Psych hospital data set, Primary diagnosis in F category

Note 1: DCH Eligible discharges are any discharge performed in DC, MD, or MD Psych hospitals in 2019 where principal diagnosis begins with F, and excludes intellectual disability, dementia, eating disorders, neurodevelopmental, and substance use disorder
Note 2: Adult patients defined as age = 18+
Note 3: Prince George's County resident defined as an in-county ZIP code
Note 4: Inpatient cases are from MD IP, DC IP, and MD Psych IP data

The overall occupancy level for acute psychiatric units in Maryland is projected to increase, even as LHDCMC expands the number of licensed beds. This reflects the fact that the unit at LHDCMC will function to redirect volume currently treated at Washington, DC hospitals thereby increasing utilization of psychiatric beds.

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

The new unit will increase access on multiple levels:

- The new unit will bring Prince George's County residents to comprehensive, state-of-the-art behavioral health resources.
- The new unit will reduce drive time for patients/families who are now admitted to hospitals in Washington, DC or at Sheppard Pratt for care, and reduce the number of transfers currently required for admission to a psychiatric unit.
- The broader behavioral health program on the LHDCMC campus will expand access to outpatient behavioral health services and make available new service settings for the DCMC service area (behavioral health urgent care; residential crisis unit; intensive outpatient treatment)

The new program will increase access to behavioral health professionals for Prince George's County residents. The project will demonstrate a serious program commitment and offer attractive opportunities for practitioners seeking a well-resourced program. The inpatient unit - - as a core component of the continuum - - is central to attracting high-quality clinicians focused on treating those with severe mental illness.

c) *On costs to the health care delivery system*

LHDCMC will provide a lower-cost alternative for inpatient psychiatric care and reduce the per capita costs of specialty care for Maryland residents by shifting volume from higher cost facilities to LHDCMC. The average payment per case at LHDCMC's new program is projected to be $11,438 relative to the statewide average and 10 percent lower relative to Sheppard Pratt, where the majority of Prince George's County residents are now served. Therefore, the new program at DCMC can be expected to produce more than $952,839 of savings in hospital spending to the state. In addition, the broader behavioral health program at LHDCMC will demonstrate to payers the opportunities for total cost of care savings by leveraging residential crisis units and other post-acute services to support long-term recovery.

Table 14 present this analysis and the projected impact on patients, payers, and the State of Maryland performance.

Table 14
Psychiatric Unit: Projected Reduction in the Costs of Acute Psychiatric Services
FY 2027

	FY 2025 - Payments					
	Cases	Average Payment	Total Payment	VCF	Payment @ VCF	
Doctors Community Health Projected Cases	710	$11,281	$8,009,471	50%	$4,004,735	
Incremental Revenue	710	11,281	8,009,471	50%	4,004,735	
Estimated Payment at 95.44% [2]					$3,822,120	[A]
Impact on Hospitals with Volume Reductions:						
Prince George's	(227)	10,612	(2,408,879)	50%	(1,204,439)	
Southern Maryland Hospital	(118)	11,899	(1,404,089)	50%	(702,045)	
Adventist Shady Grove	(62)	9,127	(565,901)	50%	(282,951)	
Sheppard-Enoch Pratt Hospital	(61)	12,874	(785,315)	100%	(785,315)	
Adventist White Oak	(44)	9,496	(417,816)	50%	(208,908)	
Suburban	(20)	6,300	(125,992)	50%	(62,996)	
MedStar Washington Hospital Center	(30)	11,360	(340,794)	100%	(340,794)	
United Medical Center	(24)	11,018	(264,438)	100%	(264,438)	
George Washington University	(12)	11,694	(140,323)	100%	(140,323)	
Other DC Hospitals[4]	(19)	12,768	(242,591)	100%	(242,591)	
Other Maryland Hospitals	(93)	13,239	(1,231,229)	50%	(615,614)	
Total Estimated Payment	(710)	11,165	(7,927,366)	61%	(4,850,414)	[B]
Net Savings on Total Health Care Spend ( ) = Savings					**($1,028,294)**	[A-B]

Notes:

[1] Year 5 of operations, stated in FY2021 dollars without added inflation

[2] Payment discount calculated at 5.79% (94.21%), a blend of the 7.7% discount for Medicare/Medicaid (66.5% of Maryland

[3] DC hospital payments estimated as a blend of payments for Medicaid, Medicare and other payer payments based on historical

[4] Other (not Doctor's) hospital charges are based on CY2019 case mix data times inflation for 1.5 years for the past two year's of

COMAR 10.24.10 (ACUTE CARE HOSPITAL SERVICES CHAPTER)

.04 STANDARDS

A. General Standards

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

(1) Information Regarding Charges

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

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

Applicant Response:

(a) LHDCMC operates under the Luminis Health written policy entitled *Patient Financial Services-Hospital Financial Assistance, Billing & Collection Policy* (Exhibit 17). That policy sets forth the procedure for providing a Representative List of Services and Charges. The list is available to the public in written for upon request or at any time by accessing https://www.LHDCMCweb.org/patients-visitors/price-transparency.
(b) The *Patient Financial Services-Hospital Financial Assistance, Billing & Collection Policy* sets forth the procedure for responding to individual request for current charges for specific services and procedures. Requests are directed the ACP Financial Coordinator (or the appropriate department Financial Coordinator) and the Coordinator response to the request promptly according to the prescribed procedure. (Please refer to the final bullet under "Billing" on page 4 of Exhibit 17.)
(c) All Luminis Health and LHDCMC staff and Financial Coordinators are educated and trained on appropriately handling inquiries regarding charges and services, including the use of the Patient Financial Services-Hospital Financial Assistance, Charity Care, and Billing & Collection Policy.

(2) Charity Care Policy

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

(a) The policy shall provide:

a. Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

b. Minimum Required Notice of Charity Care Policy.

i. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;

ii. Notices regarding the hospital's charity care policy shall be posted in admissions office, business office, and emergency department areas within the hospital; and

iii. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

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

Applicant Response:

Determination of Probable Eligibility:

LHDCMC maintains a written policy titled *Patient Financial Services — Hospital Financial Assistance* (Exhibit 17). The *Financial Assistance* policy (page 2) outlines the process for determination of Probable Eligibility. If charity care is requested, the patient is given a determination of probable eligibility within two business days of receipt of a patient's request for charity care services or application for medical assistance.

The specific language from the policy is as follows (see Exhibit 17 at page 2):

"The following two-step process shall be followed when a patient or a patient's representative requests or applies for financial assistance, Medical Assistance, or both:

- *Step One: Determination of Probable Eligibility. Within two business days following the initial request for financial assistance, application for Medical Assistance, or both, Luminis Health shall: (1) make a determination of probable eligibility, and (2) communicate the determination to the patient and/or the patient's representative. In order to make the determination of probable eligibility, the patient or his/her representative will be required to provide information about family size, insurance, assets and income, and the determination of probable eligibility will be based solely on the information provided by the patient or patient's representative. No application form, verification or documentation of eligibility will be requested or required for the determination of probable eligibility.*
- *Step Two: Final Determination of Eligibility. Following a determination of probable eligibility, Luminis Health will make a final determination of eligibility for Financial Assistance, which (except as otherwise provided in this Policy) will be based on a completed Uniform Financial Assistance Application and supporting documentation of eligibility."*

Public Notice of Charity Care Policy:

The Financial Assistance Policy also describes LHDCMC's procedure for providing required notification to the public and patients regarding the charity care available at LHDCMC under the *Hospital Financial Assistance Communications* section (Exhibit 17, page 6), including:

1. The Financial Assistance Policy is available in English and Spanish on the hospital website. https://www.dchweb.org/patients-visitors/financial-assistance-program
2. The Financial Assistance Policy is posted in English and Spanish in the Emergency Department, Cashiering, & Financial Counseling office. Examples of postings are in Exhibit 18.
3. LHDCMC provides individuals notice of the Financial Assistance Policy at the time of admission.

The specific language regarding hospital financial assistance communication in the policy is as follows (see Exhibit 17, at page 6):

"*Hospital Financial Assistance Communications*

- *The Financial Assistance Signage is conspicuously displayed in English & Spanish in each hospital's Emergency Department, Cashiering & financial Counseling office. Patients desiring to discuss financial assistance in another*

language may call the contact numbers in this policy and interpretive services will be provided.

- *The Financial Assistance Policy as well as printable Uniform Financial Assistance Application is posted on the hospitals' websites.*
- *Financial Assistance information is included in each patient guide located in the inpatient rooms.*
    - *Registration staff and Financial Coordinators are trained on how to refer patients for financial assistance.*
    - *The Uniform Financial Assistance Application is available at all registration points in each hospital, including the Emergency Department.*
- *A brochure "Patient Information Sheet" is available at every patient access point in each hospital and is posted on the Luminis Health website. This brochure includes information regarding financial assistance/contact points and is available in English/Spanish. https://www.dchweb.org/patients-visitors/financial-assistance-program*
- *Individual notice regarding the Financial Assistance Policy shall be provided at the time of admission or preadmission to each person who seeks services in the hospital. It is mandatory that all inpatients receive the "Patient Information Sheet" brochure as part of the admission packet.*
- *Information is available through the patient access/registration staff to provide to the uninsured or any individual concerned about paying their hospital bill directing them to the hospital's Financial Counseling office for assistance.*
- *Hospital Patient Financial Service staff receive extensive training on the revenue cycle and are incentivized to obtain AAHAM technical (CRCS) certification to demonstrate their expertise in billing and revenue cycle requirements."*

Level of LHDCMC Charity Care:

LHDCMC's charity care as a percentage of total operating expense falls within the top quartile for Maryland hospitals as reported in the most recent Health Services Cost Review Commission Community Benefit Report. LHDCMC has a very generous charity care policy, providing 100% financial assistance to households at or below 300% of the US Poverty Line and a sliding fee scale for households at or below 350% of the US Poverty Line. Due this generous charity care policy and our patient demographics, LHDCMC provided $8.4M in charity care in FY19 (Exhibit 19).

(3) Quality of Care

An acute care hospital shall provide high quality care.

(a) Each hospital shall provide high quality care.

a. Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;
b. Accredited by the Joint Commission; and
c. In compliance with the conditions of participation of the Medicare and Medicaid programs.

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

Applicant Response: LHDCMC provides high quality care, as evidenced by the following accreditation and recognitions:

a. LHDCMC provides high quality care:
    a. LHDCMC is in possession of Maryland Department of Health and Mental Hygiene Office of Health Care Quality License Number 16022. The license is attached as Exhibit 20.
    b. LHDCMC is accredited by The Joint Commission. The last full survey by The Joint Commission successfully concluded on December 1, 2018. See Exhibit 21 for LHDCMC's Joint commission accreditation certificate.
    c. LHDCMC is in full compliance with the Conditions of Participation for CMS.
b. Based on guidance from MHCC, this standard is outdated as currently written. LHDCMC has identified any "below average" ratings. Of the applicable measures, LHDCMC was below average in a total of thirteen measures. Exhibit 22 identifies the measure, Maryland State Mean, LHDCMC's data and applicable action plans in place to improve performance.

COMAR 10.24.07 (Psychiatric Services Chapter)

Approval Policies

Availability

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

Applicant Response: There is no published bed need projection in effect for child, adolescent and adult psychiatric beds, and the need projection methodology contained in the State Health Plan Chapter is recognized as obsolete. Accordingly, LHDCMC prepared a needs assessment and a volume projection for its proposed psychiatric unit based on hospital utilization patterns and based on other indicators that identify community need. Please refer to the Applicant's Response to COMAR 10.24.01.08G(3)(b). LHDCMC's analysis firmly supports the need for a 16-bed psychiatric unit; the new hospital is expected to operate at above 70 percent occupancy beginning in Year 1 of operation.

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

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

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

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

(ii) that an equal or greater number of operating beds in state facilities which would have served acute psychiatric patients residing in the jurisdiction of the applicant hospital will be closed and delicensed, when the beds for the former state patients become operational;

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

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

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

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

Applicant Response: This standard does not apply; this application is not part of a comparative review.

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

Applicant Response: Emergency inpatient psychiatric care in LHDCMC's inpatient psychiatric unit will be available 24 hours per day and 7 days per week, with no special limitation for weekends or late-night shifts. LHDCMC operates a special treatment area as a physically separate part of its Adult Emergency Department, which is available for emergency psychiatric care 24 hours a day/7 days a week, without limitation. In addition, LHDCMC's inpatient psychiatric unit will have physician coverage 24 hours a day/7 days a week without limitation.

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

Applicant Response: LHDCMC currently has a contractual relationship with Adventist Health System to provide adult psychiatric consultations via tele-consultation and with Children's National Hospital to provide child and adolescent psychiatric consultation via tele-consultation and on-site. LHDCMC intends to transition adult psychiatric consultation, within the next six months, to an internal Luminis Health team that will provide access to both tele-consultation and on-site services.

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

Applicant Response: LHDCMC has 2 dedicated ligature free behavioral health rooms in the emergency department. The inpatient unit will include a seclusion room. The LHDCMC Emergency Department does not have capacity for a seclusion room but Emergency Department staff will utilize all contemporary de-escalation and behavioral health safety techniques for safety and security of

the environment. Security staff will be trained in all contemporary de-escalation and behavioral health safety techniques. In the event of a severe escalation, emergency department staff will have been thoroughly trained to utilize standard restraint techniques for limited duration to quell safety concerns.

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

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

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

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

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

Applicant Response: LHDCMC currently has a contractual relationship with Adventist Health System to provide adult psychiatric consultations via tele-consultation and with Children's National Hospital to provide child and adolescent psychiatric consultation via tele-consultation and on-site. LHDCMC intends to transition adult psychiatric consultation, within the next six months, to an internal Luminis Health team that will provide access to both tele-consultation and on-site services.

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

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

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

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

Accessibility

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

1. intake screening and admission;
2. arrangements for transfer to a more appropriate facility for care if medically indicated; or
3. necessary evaluation to define the patient's psychiatric problem and/or
4. emergency treatment.

Applicant Response:

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

2. Transfers to a more appropriate facility for care if medically indicated: If a patient is in need of medical attention that exceeds the inpatient facility's ability to stabilize the patient, the patient will be transported to LHDCMC's acute general hospital for treatment. The patient will be transported through a corridor connecting the inpatient program and the acute general hospital.

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

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

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

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

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

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

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

The evidence of quality improvement activities will include:

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

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

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

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

Inpatient psychiatric reporting will also include The Joint Commission requirements for Hospital- Based Inpatient Psychiatric Services:

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

LHDCMC's Quality Improvement Program for its inpatient psychiatric unit will follow the Quality Improvement Program for the LHAAMC's McNew Family Medical Center attached as Exhibit 23.

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

Applicant Response: LHDCMC's psychiatric unit will routinely accept patients who are admitted as involuntary patients on Certificates. These patients will be placed on observation status until they go to hearing before an Administrative Law Judge. If the patient is retained at hearing, they will be administratively discharged as involuntary admissions. LHDCMC's policy for the inpatient psychiatric unit pertaining to certified patients will be in the form attached as Exhibit 24.

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

Applicant Response: LHDCMC's uncompensated care as a percentage of gross patient revenue is projected to be 9.7 percent, which exceeds the average level of uncompensated care (4.11 percent) of all acute hospitals in LHDCMC's health service area.

Please refer to Table 15 below.

Table 15
Hospital Bad Debt and Uncompensated Care
CY2019

County	Hospital	Annual Filing Year	Gross Patient Revenue	Provisions for Bad Debts	Charity Care	Uncompensated Care Percentage
			A	B	C	D = ((B+C)/A
Montgomery	Germantown ED	2019	$14,446	$1,973	$760	18.7%
Queen Anne's	UM-Queen Anne	2019	$7,158	$1,064	$176	16.6%
Prince George's	UM-Bowie Healt	2019	$21,263	$2,082	$1,198	15.4%
Prince George's	UM Laurel Regio	2019	$70,706	$6,626	$2,044	12.3%
Prince George's	UM Prince Geor	2019	$327,530	$18,768	$10,166	8.8%
Montgomery	HC-Germantown	2019	$111,194	$5,257	$4,150	8.5%
Montgomery	Holy Cross	2019	$518,074	$17,314	$25,977	8.4%
Prince George's	Ft Washington	2019	$53,091	$3,432	$961	8.3%
Montgomery	Adventist White	2019	$300,980	$15,193	$9,634	8.2%
Prince George's	Doctors Commu	2019	$256,445	$10,121	$8,411	7.3%
Garrett	Garrett Co Memo	2019	$68,470	$1,483	$2,959	7.0%
Harford	UM-Harford Mer	2019	$108,110	$5,109	$1,862	6.4%
Baltimore City	UM-Shock Traun	2019	$373,150	$10,393	$3,366	6.3%
Anne	UM-BWMC	2019	$448,593	$20,102	$6,285	5.9%
Washington	Brook Lane	2019	$22,565	$837	$467	5.8%
Dorchester	UM-SRH at Dorch	2019	$45,197	$2,058	$433	5.6%
Kent	UM-SRH at Chest	2019	$50,208	$2,355	$451	5.4%
Somerset	McCready Meme	2019	$16,060	$522	$343	5.4%
Allegany	Western Marylar	2019	$836,134	$7,951	$10,081	5.4%
Cecil	Union Hospital o	2019	$164,358	$6,907	$1,829	5.3%
Charles	UM-Charles Regi	2019	$155,775	$7,111	$987	5.3%
Prince George's	MedStar Souther	2019	$279,965	$8,468	$6,864	5.2%
Baltimore City	UMMC - Midtow	2019	$280,108	$6,155	$3,819	5.2%
Baltimore City	JH Bayview	2019	$691,568	$16,738	$19,138	5.2%
Montgomery	Shady Grove	2019	$470,397	$15,348	$8,908	5.1%
Baltimore City	Mercy Medical C	2019	$553,683	$3,413	$18,674	5.1%
Baltimore County	Northwest Hospi	2019	$171,509	$11,789	$1,928	5.1%
Baltimore City	St Agnes Hospita	2019	$438,311	$855	$20,357	4.9%
Worcester	Atlantic General	2019	$110,793	$3,004	$2,743	4.7%
Baltimore City	Levindale	2019	$60,471	$2,319	$510	4.7%
Frederick	Frederick Memo	2019	$354,358	$10,082	$6,392	4.6%
Baltimore City	MedStar Harbor	2019	$187,756	$5,658	$5,016	4.6%
Washington	Meritus Medical	2019	$369,067	$12,934	$4,091	4.6%
Baltimore City	UM BOI	2019	$134,573	$3,929	$1,668	4.5%
St Mary's	MedStar St Mar	2019	$190,672	$4,082	$4,445	4.5%
Baltimore City	MedStar Good Sa	2019	$256,874	$5,375	$6,086	4.3%
Calvert	Calvert Health M	2019	$158,315	$1,883	$4,660	4.3%
Baltimore City	UMMC	2019	$1,567,658	$45,767	$19,627	4.1%
Harford	UM-Upper Chesa	2019	$323,917	$8,336	$4,041	4.1%
Howard	Howard County (	2019	$307,992	$7,543	$5,238	4.1%
Baltimore County	UM-St Joseph M	2019	$583,174	$6,980	$8,014	3.9%
Wicomico	Peninsula Regio	2019	$465,208	$7,941	$8,303	3.8%
Montgomery	Suburban	2019	$336,635	$7,614	$4,480	3.6%
Baltimore County	MedStar Franklii	2019	$554,969	$9,148	$10,277	3.5%
Montgomery	MedStar Montgo	2019	$180,055	$3,089	$2,495	3.1%
Talbot	UM SRH at Easto	2019	$231,728	$5,834	$2,028	3.4%
Baltimore County	Sheppard Pratt	2019	$169,885	$186	$5,231	3.4%
Baltimore City	MedStar Union M	2019	$420,493	$4,725	$7,793	3.0%
Baltimore City	Sinai Hospital	2019	$760,819	$19,198	$4,185	3.0%
Anne	Anne Arundel Me	2019	$533,657	$13,291	$4,024	2.7%
Baltimore City	Johns Hopkins	2019	$2,270,649	$38,049	$25,938	2.8%
Baltimore County	GBMC	2019	$477,483	$11,183	$1,173	2.6%
Baltimore City	Grace Medical C	2019	$111,845	$2,165	$380	2.3%
Carroll	Carroll Co Hospi	2019	$213,904	$5,174	$276	2.5%
Baltimore City	Mt Washington	2019	$86,002	$661	$37	1.1%
Total			$17,758,127	$363,281	$320,980	4.4%

Source: 2019 Annual Filings, RE Schedule, regulated services
Note: All dollar amounts in thousands (000s)

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

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

Accessibility: Variant LHPA Standard

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

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

Cost

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

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

Applicant Response: This standard is not applicable because the proposed project is not an expansion of existing adult acute psychiatric beds at LHDCMC.

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

Applicant Response: LHDCMC compared its projected charge per case to the age and case-mix adjusted charge per case to cases in Prince George's County. LHDCMC charges are below (1.2 percent) those of comparable hospitals on an age and case mix adjusted basis.

Table 16
Comparison of Age-Adjusted Average Charge per Case

Age Group	Statewide Acute Hospital Cases	Statewide CY19 Charges	Statewide Average Charge CY19	Update Factor FY20	Update Factor FY21	Statewide Avg Charge Inflated to FY21	DCH Projected Cases Year 1	DCH Projected Charges Year 1 in FY21 $	DCH Projected Avg Chg FY21	DCH % Variance to Statewide
18-29	1,093	$10,505,343	$9,611	2.96%	2.77%	$10,024	216	$2,116,530	$9,811	(2.1%)
30-64	1,590	18,337,763	11,533	2.96%	2.77%	12,028	314	3,753,621	11,961	(0.6%)
65+	139	2,489,487	17,910	2.96%	2.77%	18,678	27	503,099	18,337	(1.8%)
Total	**2,822**	**$31,332,593**	**$11,103**	**2.96%**	**2.77%**	**$11,579**	**557**	**$6,373,250**	**$11,442**	**(1.2%)**

[1] Source: Maryland acute hospitals CY2019 inpatient abstract data
[2] Criteria: CMS_MDC=19 for mental health & Age >=18, limited to principal diagn truncated 3 digits F20-48,F51-69,F99
[3] Statewide cases limited to discharges in the DCH service area (PG County)
[4] Statewide charges inflated to FY21 using 50% of FY20 HSCRC overall update factor and 100% of FY21 update factor
[5] DCH charges based on FY21 approved HSCRC rates and statewide FY21 median rate for IP psychiatric daily room charge
[6] DCH charges were built up based on acute care adult mental health utilization and age mix from CY2019 from DCH service area

Quality

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

Applicant Response: Inpatient psychiatric services at LHDCMC will be under the clinical supervision of a psychiatrist who is qualified to provide the leadership required for an intensive treatment program. All psychiatrists on staff meet the training requirements for certification by the American Board of Psychiatry and Neurology.

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

Applicant Response: The multidisciplinary team at LHDCMC will include Psychiatrists, licensed Clinical Social Workers, Clinical Psychologists and/or licensed Marriage and Family Therapists, Occupational Therapists (OT's), Nurses (RN's), patient care technicians (PCT's) and Nurse Practitioners (both Psychiatric and Family). Patients will be assigned a Social Worker/Case Manager during the course of their treatment. The patient will participate with the team on a treatment plan for hospital. At discharge, each patient will participate in and receive an individual aftercare plan including a Safety Plan. The Social Worker/Case Manager will follow-up with all patients that are discharged to confirm an appointment, follow-up that the referral was helpful and offer additional support.

LHDCMC's inpatient treatment program will be an intensive, short-term, acute service that provides programming for patients seven days per week. A psychiatrist/nurse practitioner will see patients daily and provide on call coverage 24/7. Social workers, OT's and Nursing staff will provide groups daily. Social Workers will provide family therapy as indicated.

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

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

Continuity

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

Applicant Response: The LHDCMC comprehensive continuum combines many programs, policies, practices, and resources to treat psychiatric disorders and to support affected individuals. The continuum of care will include services ranging from outpatient, partial hospital and inpatient treatment, and ongoing support services to prevention and education programs. At discharge, patients admitted to the psychiatric unit will be referred to an appropriate array of clinical and support programs to ensure continuity of care and continued stabilization. LHDCMC will have a written discharge policy governing the inpatient psychiatric unit in the form attached as Exhibit 25.

Acceptability

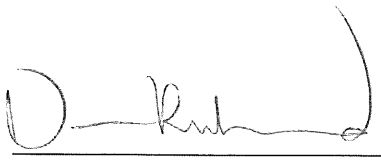
AP 14: Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:

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

Applicant Response: Please refer to Exhibit 26.

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to establish a hospital-based 16-bed adult psychiatric unit are true and correct to the best of my knowledge, information and belief.



Name: Deneen Richmond
Title: President, Luminis Health Doctors Community Medical Center
Date: 04-02-2021

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to establish a hospital-based 16-bed adult psychiatric unit are true and correct to the best of my knowledge, information and belief.

Name: Luke Klock
Title: Director, Capital Projects
Date: 4/7/2021

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to establish a hospital-based 16-bed adult psychiatric unit are true and correct to the best of my knowledge, information and belief.

Name: Miriam Suldan
Title: Senior Managing Consultant, Berkeley Research Group
Date: April 2, 2021

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to establish a hospital-based 16-bed adult psychiatric unit are true and correct to the best of my knowledge, information and belief.

Name: Jeanette M Cross, CPA, FHMFA, CPC
Title: Managing Consultant
Date: 4/2/2021

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to establish a hospital-based 16-bed adult psychiatric unit are true and correct to the best of my knowledge, information and belief.

Name:
Title: Manager, Business Development
Date: 4/5/24

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to establish a hospital-based 16-bed adult psychiatric unit are true and correct to the best of my knowledge, information and belief.

Name: Rod Kornrumpf
Title: VP-Behavioral Health, Luminis Health
Date: April 2, 2021

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to establish a hospital-based 16-bed adult psychiatric unit are true and correct to the best of my knowledge, information and belief.

Name: Jessica Farrar
Title: Vice President, Strategic Planning
Date: April 3, 2021