BOARD OF CHILD CARE

BALTIMORE CAMPUS
T: 410-922-2100 • F: 410-496-5620
3300 Gaither Road
Baltimore, Maryland 21244
boardofchildcare.org

CERTIFICATE OF NEED APPLICATION

Bridge Program- Adolescent Hospital Overstay

Authorizing Official:

Laurie Anne Spagnola
President & CEO
laspagnola@boardofchildcare.org

Contact Person Regarding Application:

Rochon Steward
Director, Special Operations
rsteward@boardofchildcare.org

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MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

_____

DATE DOCKETED

_____

GENERIC APPLICATION FOR CERTIFICATE OF NEED (CON)

Bridge Program: Cottage 1

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Board of Child Care of the United Methodist Church, Inc.

Address: 3300 Gaither Road Baltimore, MD 21244 County: Baltimore

2. Name of Owner

Board of Child Care is a 501c3 private, non-profit organization. Information pertaining to the Board of Directors and President & CEO is also contained in Exhibit 1 of this application.

Below is our current list of Board of Child Care Board of Directors for FY2023: Table 1.

Board of Directors	Position	Committee	Location
Kerwin Stetler	Board Chair	Asset Management Committee; Executive Committee	Pennsylvania
Joshua Savadove	Vice- Chair	Asset Management Committee; Executive Committee	Maryland
Gabriela Romo	Secretary	Executive Committee	Maryland
Jan tenPas III	Treasurer	Asset Management Committee; Executive Committee	West Virginia
Dr. Barton McCann	Board Member	Risk, Compensation Outcomes Committee; Executive Committee	Maryland
Ziyan Ding	Board Member	Marketing and Development Committee	Maryland
Roberto Allen	Board Member	Risk, Compensation Outcomes Committee	Maryland
Janice Mozee	Board Member	Marketing and Development Committee	Maryland
Karen Winegardner	Board Member	Risk, Compensation Outcomes Committee	Maryland
Sue Everhart	Board Member	Marketing and Development Committee; Executive Committee	Maryland
Chick Zoll	Board Member	Asset Management Committee	Maryland
Michael Latimer	Board Member	Asset Management Committee	Maryland
Marciel Rojas Rosario	Board Member	Risk, Compensation Outcomes Committee	Maryland
Derek Simmons	Board Member	Risk, Compensation Outcomes Committee	Maryland
Sheila McDonald	Board Member	Risk, Compensation Outcomes Committee	Maryland
Alan Hubbard	Board Member	Marketing and Development Committee	Maryland
Rev. Ann LaPrade *B/W conference rep*	Board Member		Maryland
Rev. Amor Woolsey *Pen/Del conference rep*	Board Member	Marketing and Development Committee	Maryland

3. APPLICANT

Legal Name of Project Applicant (Licensee or Proposed Licensee):

Board of Child Care of the United Methodist Church, Inc,

Address: 3300 Gaither Road Baltimore MD County: Baltimore

Telephone: 410-922-2100

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

Same as above

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

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

A. Governmental ☐

B. Corporation

(1) **Non-profit** ☒

(2) For-profit ☐

(3) Close ☐

State & Date of Incorporation ☐

C. Partnership

General ☐

Limited ☐

Limited Liability Partnership ☐

Limited Liability Limited Partnership ☐

Other (Specify):

D. Limited Liability Company ☐

E. Other (Specify): ☐

To be formed: ☐

Existing : ☐

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

A. Lead or primary contact:

Name and Title: Rochon K. Steward, Director of Special Operations

Company Name Board of Child Care of the United Methodist Church, Inc.

Mailing Address: 3300 Gaither Road Baltimore, MD 21244

Telephone: 410-922-2100 x5394

E-mail Address (required): rsteward@boardofchildcare.org

Fax:

If company name is different than applicant briefly describe the relationship N/A

B. Additional or alternate contact:

Name and Title: Nicole Smith, Executive Director – MD & DC Programs

Company Name Board of Child Care of the United Methodist Church, Inc.

Mailing Address: 3300 Gaither Road Baltimore, MD Zip: 21244

Telephone: 410-922-2100

E-mail Address (required): nsmith@boardofchildcare.org

Fax:

If company name is different than applicant briefly describe the relationship N/A

7. TYPE OF PROJECT

The following list includes all project categories that require a CON pursuant to COMAR 10.24.01.02(A). Please mark all that apply in the list below.

If approved, this CON would result in (check as many as apply):

(1)	**A new health care facility built, developed, or established**	☒
(2)	An existing health care facility moved to another site	☐
(3)	A change in bed capacity of a health care facility	☐
(4)	A change in the type of scope of any health care service offered by a health care facility	☐
(5)	A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf	☐

8. PROJECT DESCRIPTION

A. Executive Summary

Project Description & Rationale

The Maryland Children's Cabinet in conjunction with the Maryland Department of Health (MDH) has identified an immediate need to support adolescent populations experiencing extended and repetitive stays in hospitals for psychiatric purposes. In July 2021, MDH released a Notice of Funding Availability with the goal of providing support for the development of short-term enhanced stabilization treatment services to enable adolescents experiencing hospital overstay to transition from the hospital to the least restrictive supportive environment.

In Maryland, personnel from the Department of Human Services (DHS) report that between Jan 2020 and July 2021, a total of 628 youth in DHS care were hospitalized in MD. Of these youth, 13% (84) were considered to be "overstay" youth. On July 12, 2021, 12 DHS youth were in the hospital on overstay status, considered to be beyond medical necessity according to DHS personnel[1].

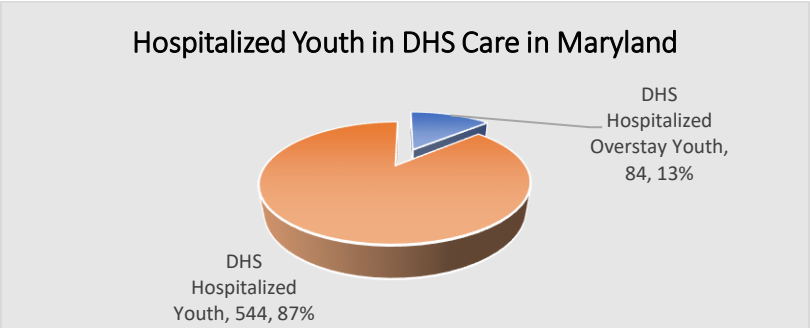


Figure 1.

[1] Data verbally reported by MD Social Services Administration (SSA) during a meeting with National Association of Social Workers – MD Chapter on July 12, 2021 (update reference).

Board of Child Care (BCC) responded to the notice of funding availability and has developed an overstay program, named the Bridge Residential Treatment Program, that will provide intensive stabilization services for youth upon discharge from an inpatient setting. In order to deliver the Bridge Program, Board of Child Care is proposing to obtain licensure as a Psychiatric Residential Treatment Center (RTC) in an existing facility on the BCC Baltimore Campus. Youth served in this program will present with a high level of psychiatric, behavioral, emotional, educational and/or medical needs and will require skilled, on-site therapeutic care, clinical services, educational programming, intense structured supervision, and behavioral supports in a secure, trauma responsive environment. Board of Child Care will have the ability to provide services to male or female youth ages 14-20 years old who present with Emotional, Cognitive and Developmental Disabilities (ECDD) and do not meet the criteria for inpatient treatment services.

Board of Child Care will be establishing the Bridge Program as a standalone program to support the need for Adolescent Hospital Overstay "patient beds". It is imperative that youth with complex needs have access to services, and Board of Child Care supports MD's Children's Cabinet Interagency Plan which acknowledges the importance of access to care to all of the services they require to grow and thrive[2]. The program has been developed with the intention to fully support the placement of overstay youth and is prepared to provide continual placement support services with little to no annual vacancy.

If this project is approved, the intended 4-beds that are the subject of this application will provide treatment for males and females, with co-occurring psychiatric and developmental diagnosis.

The total startup costs of the project including renovations and working capital costs are estimated to be around $922.238.

[2] State of Maryland Children's Cabinet. Interagency Plan: Developing Resources to Address the Complex Needs of Maryland Youth in Care. April 2020 – Updated February 2021.

Figure 2.

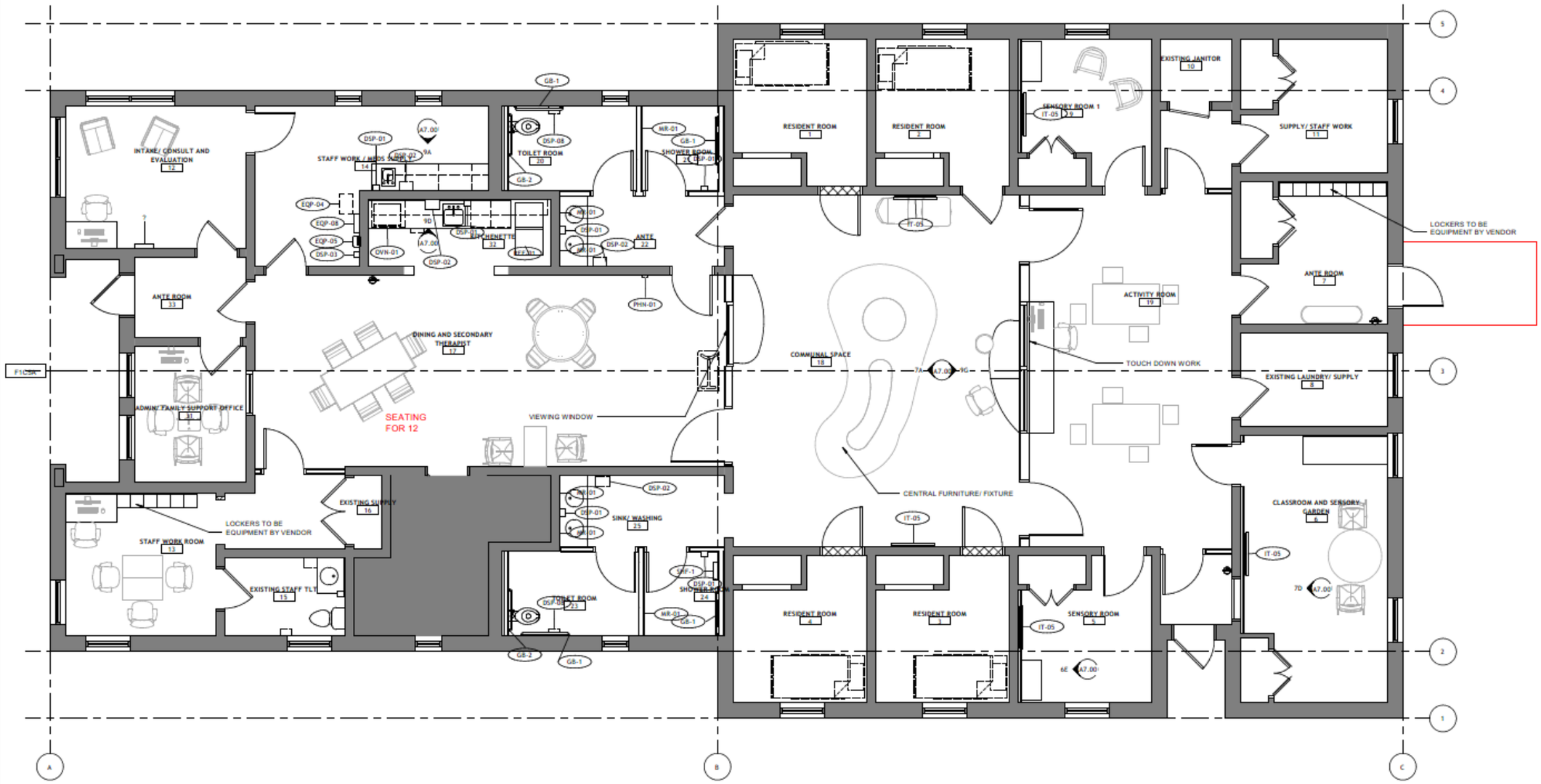
B. Comprehensive Project Description:

The property is located at 3300 Gaither Road, Windsor Mill, MD 21244. The area is centralized in Baltimore County in a residential community setting. The “Baltimore Campus” location opened in 1960 on a campus spanning 32.15 acres. The Baltimore Campus hosts 14 residential living units, “Cottages” including four living units licensed to serve youth determined to have Emotional Cognitive Developmental Disabilities (ECDD). See Exhibit 2 to review the Overall Baltimore Campus Map & Aerial Photos.

The unit, “Cottage 1” is being proposed for the Bridge Program. Cottage 1 is a single unit structure which sits on 0.26 acres that will be licensed as an RTC for four (4) youth. The building is constructed of brick and masonry, with reinforced concrete footers. The roof, recently replaced in 2019 is a 30-year asphalt architectural shingles. The campus parking can accommodate approximately 217 vehicle spaces and the lot is well lit with exterior lighting surrounding the property. The bedrooms are about 10’x10’ with common and private spaces including sensory rooms, offices, waiting/meeting for a total of 4700 square feet. See Exhibit 2 for Site Description and more information about the site.

The property is one floor with a main common area. With renovations, the secured facility will include an administrative office, intake office and waiting room in the front of the building. The waiting room, intake or administrative office will have secured doors leading to an open shared space for dining and communal activities. The dining hall is a large open room with vaulted drop ceiling. The kitchenette is located just off the dining hall offering staff the flexibility to utilize the space and interact with clients as needed. The facility also offers staff lounges, storage spaces, classroom, and two (2) bathrooms for youth and one bathroom for staff. The renovation will also include the installation of Lexan/polycarbonate windows. The renovated area will have a plenty of lighting, new furniture, and updated IT equipment. Figure 3 depicts the overall plan for changes to Cottage 1. Exhibits 2 & 3 offer the architectural renderings and proposed IT/Network Management changes for the Bridge Residential Program.

Figure 3.


INTAKE/ CONSULT AND EVALUATION
12
STAFF WORK / MEDS
14
TOILET ROOM
20
SHOWER ROOM
21
RESIDENT ROOM
1
RESIDENT ROOM
2
SENSORY ROOM 1
9
EXISTING JANITOR
10
SUPPLY/ STAFF WORK
11
LOCKERS TO BE EQUIPMENT BY VENDOR
ANTE ROOM
33
KITCHENETTE
32
ANTE
22
ANTE ROOM
7
ACTIVITY ROOM
19
DINING AND SECONDARY THERAPIST
17
COMMUNAL SPACE
18
TOUCH DOWN WORK
ADMIN/ FAMILY SUPPORT OFFICE
31
SEATING FOR 12
VIEWING WINDOW
EXISTING LAUNDRY/ SUPPLY
8
EXISTING SUPPLY
16
LOCKERS TO BE EQUIPMENT BY VENDOR
SINK/ WASHING
25
CENTRAL FURNITURE/ FIXTURE
CLASSROOM AND SENSORY GARDEN
6
STAFF WORK ROOM
13
EXISTING STAFF TLT
15
TOILET ROOM
23
SHOWER ROOM
24
RESIDENT ROOM
4
RESIDENT ROOM
3
SENSORY ROOM
5
A
B
C
1
2
3
4
5

The proposed project design creates an accessible, one-story building that will be designed and constructed to meet all the applicable requirements of the current International Building Code and National Fire Protection Agency. The design features are consistent with Board of Child Care's high standards including behavioral safe, anti-ligature finishes and doors, along with strategically placed lighting, a centrally located nurses' station, and other regulatory requirements to provide high quality care to youth in a safe and secure environment. Exhibits 3 depicts Architectural Renderings of Cottage 1- Bridge Program. Some of the design features are outlined below:

- Patient Rooms: The patient room design layout includes a private bedroom, which provides the youth with privacy. The wardrobe/dress is designed to be accessible to those in a wheelchair and has room to store patient belongings. The walls will be painted with cool neutral colors to maximize lighting and offer a calming environment for youth.
- Furniture and decorations: The standard furniture layout includes a bed, patient wardrobe/dresser, and a table and chair for visitors. Furnishings will promote safety by offering reduced ligature and anti-weaponization features as well as anti-infection materials.
- Residence independence: The layout of the Bridge Program unit allows youth to move throughout the building in the least restrictive option allowed under the RTC license. The new facility will be designed to meet the appliable provisions of the American Disabilities Act.

Figures 4 & 5 offers a few architectural renderings of proposed facility renovations.

Figure 4. Bedroom Example

Figure 5. Common Space Example

Table A. Physical Bed Capacity Before and After Project.

Before the Project							After the Project						
	Location	Licensed Beds	Based on Physical Capacity					Location	Based on Physical Capacity				
			Room Count			Bed Count			Room Count			Bed Count	
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity	
ACUTE CARE							**ACUTE CARE**						
General Medical/ Surgical*					0	0	**General Medical/ Surgical***				0	0	
SUBTOTAL Gen. Med/Surg*							**SUBTOTAL Gen. Med/Surg***						
ICU/CCU					0	0	**ICU/CCU**				0	0	
TOTAL MSGA							**TOTAL MSGA**						
Obstetrics					0	0	**Obstetrics**				0	0	
Pediatrics					0	0	**Pediatrics**				0	0	
Psychiatric		0	0	0	0	0	**Psychiatric**	**Cottage 1**	**4**	**0**	**4**	**4**	
TOTAL ACUTE		0	0	0	0	0	**TOTAL ACUTE**		4	0	**4**	**4**	
NON-ACUTE CARE							**NON-ACUTE CARE**						
Dedicated Observation**					0	0	**Dedicated Observation****				0	0	
Rehabilitation					0	0	**Rehabilitation**				0	0	
Comprehensive Care					0	0	**Comprehensive Care**				0	0	
Other *(Specify/add rows as needed)*					0	0	**Other** *(Specify/add rows as needed)*				0	0	
TOTAL NON-ACUTE							**TOTAL NON-ACUTE**						
HOSPITAL TOTAL		**0**	**0**	**0**	**0**	**0**	**HOSPITAL TOTAL**		**4**	**0**	**4**	**4**	

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Intake/Consultant and Evaluation Room (formerly Office 1)	105		105		105
Staff Work/Medical Supplies	110		110		110
Kitchenette	61		61		61
Bathroom 1	176		0		0
*New Resident Bathroom- Toilet Area 1	0		52		52
*New Resident Bathroom- Shower Area 1	0		54		54
*New Resident Bathroom- Ante/Sink Area 1	0		70		70
Admin/Family Support Office	62		62		62
Staff Workroom with Lockers	141		141		141
Bathroom 2	176		0		0
*New Resident Bathroom- Toilet Area 2	0		52		52
*New Resident Bathroom- Shower Area 2	0		54		54
*New Resident Bathroom- Ante/Sink Area 2	0		70		70
Resident Bedroom 1	100		100		100
Resident Bedroom 2	100		100		100
Resident Bedroom 3 (Formerly Bedroom 9)	100		100		100
Resident Bedroom 4 (Formerly Bedroom 10)	100		100		100
*New- Sensory Room 1 (Formerly Bedroom 3)	100		100		100
*New- Sensory Room 2 (Formerly Bedroom 8)	100		100		100
Janitor's Closet (Exhaust fans only)	24		0	24	24
*New Supply/Staff Workroom- Back (Former Bedroom 4)	100		100		100
*New Ante Room Back with Lockers (Former Bedroom 5)	100		100		100
Old Resident Bedroom 6	100		0		0

Old Resident Bedroom 7	**100**		**0**		**0**
***New- Classroom and Sensory Garden (Former Bedrooms 6 & 7)**	**0**		**201**		**201**
Laundry/Supply Room (Windows only)	**50**		**0**	**50**	**50**
Activity Room Open	**972**		**400**		**400**
***New- Communal Space (Part of Activity Room)**	**0**		**568**		**568**
Foyer	**47**		**47**		**47**
Staff Bathroom	**44**		**44**		**44**
Enclosed Space - Outside	**0**		**900**		**900**
Total					**3,867**

In addition to the residential milieu, the single-site program will contain defined locations for educational programming, medical and clinical services as well as recreational wellness and other programming supports. Exterior to the unit will be outdoor space designated for use solely by the Bridge Program, secured by an anti-scale privacy fence and containing spaces designed for reflection, mindfulness, and healthy engagement. Dedicated office space for program personnel will be contained within the unit, ensuring the unit supervisor, therapist and key personnel are available to support the needs of the youth. Exhibit 4 outlines the Proposed Technology changes needed for Cottage 1.

Bridge Program anticipates the first use of the 4-unit facility will occur in the third quarter of FY23. It anticipates opening the new unit, if approved, approximately six months after the CON approval, early spring.

9. Current Capacity and Proposed Changes:

Table A- Physical Bed Capacity

Table A outlined below and included in the table package for this application notes the new units proposed for the Bridge Program.

Service	Unit Description	Currently Licensed/ Certified	Units to be Added or Reduced	Total Units if Project is Approved
ICF-MR	Beds	____/____		
ICF-C/D	Beds	____/____		
Residential	**Beds**	**0 / 0**	**4 beds**	**4 beds**
Ambulatory Surgery	Operating Rooms			
	Procedure Rooms			
Home Health Agency	Counties	____/____		
Hospice Program	Counties	____/____		
Other (Specify)				
TOTAL			**4 beds**	**4 beds**

10. Identify any community-based services that are or will be offered at the facility and explain how each one will be affected by the project.

a. Strawbridge School - The Strawbridge School is a Type I full day and residential Special Education program with a total capacity to serve 140 students. Located in a 22,000 square foot state of the art facility, the Strawbridge School serves individuals in both day and residential programs through a 10-month plus Extended School Year (ESY) program and is approved by the Maryland State Department of Education (MSDE).

The educational services provided within the Bridge Program will be an extension of the Strawbridge School. Strawbridge School administrative personnel will oversee the delivery of educational services in accordance with MSDE regulations and each student's IEP. As educational services will be provided inside the Bridge facility and not in the Strawbridge facility, no additional impact is anticipated.

b. High Intensity Group Home Programs – BCC's high intensity group home programs are located on the Baltimore Campus and serve youth placed by the MD Department of Human Services (DHS), MD Department of Juvenile Services (DJS) and the federal Office of Refugee Resettlement (ORR).

Administrative leadership and oversight of the Bridge Program will be conducted by personnel shared with some of the high intensity group home leadership. As all activities and services provided by the Bridge Program will occur within the Bridge facility, there is no additional impact anticipated by the addition of this program to the campus.

c. Treatment Foster Care – The administrative and clinical staff for BCC's Treatment Foster Care (TFC) program are located in the administrative offices on the Baltimore Campus. There is no impact to the daily program operations of the TFC program anticipated.

With relationships at the core of BCC's approach to treatment delivery, the development of relational safety becomes both a treatment intervention and an outcome. Integration of the Bridge Program into the existing Baltimore Campus environment will include a detailed plan to ensure the physical environment of the program promotes youth safety, comprehensive staff oversight and research proven environmental supports. Staffing patterns will be designed to deliver services within a self-contained environment, therefore limiting the impact to other programs operating on the Baltimore Campus.

11. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: **0.26** acres

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

The required permits for this project have been submitted. However, approvals have yet to be received. As of 08/16/2022, the status of the permits are still pending, as the permit is in “Comments” status.

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

(1) Owned by: Board of Child Care of the United Methodist Church Inc.

(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.

12. PROJECT SCHEDULE

(INSTRUCTION: IN COMPLETING THE APPLICABLE OF ITEMS 10, 11 or 12, PLEASE CONSULT THE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

For new construction or renovation projects.
Project Implementation Target Dates

A. Obligation of Capital Expenditure__12 _____ months from approval date.
B. Beginning Construction _____3 _____months from capital obligation.
C. Pre-Licensure/First Use ____9 _____months from capital obligation.
D. Full Utilization __9_____ from first use.

BCC has partnered with Maryland Bay Construction to deliver the proposed renovations to Cottage 1 for the Bridge Program. Based on the project schedule, interior demolition will begin on this project in September 2022. Construction for the proposed project is outlined conservatively for five (5) months, ending at the end of January 2023. Full utilization of the space is estimated for January- March 2023. A copy of the Project Schedule is also available as Exhibit 5.

Board of Child Care
3300 Gaither Road
Cottage 1 renovations construction schedule

	start	*end*	
1	19-Aug	19-Aug	General conditions (construction project management, administration, overhead & profit)
2	19-Aug	19-Aug	Contact Miss Utility to mark locations for 6x6 posts at rear enclosure
3	22-Aug	9-Sep	Set 6x6 pressure-treated posts for rear enclosure, install horizontal stringers & vertical deck boards @ interior/exterior
4	12-Sep	30-Sep	Interior demolition per A1.00 (walls, R.O.'s, partitions, cove base, doors, millwork) [A] • Coordination with ADT for removal of existing swip readers & panel prior to demo • Coordination with ECI for removal of IT switches, cables, WiFi, cameras before/during demo • New masonry openings for windows/doors • Demo/disposal of doors, existing shower walls, bathroom tiled floors, toilet partitions/stalls
5	27-Sep	30-Sep	Exterior window demo (8) and installation of polycarbonate windows per A2.00 & A7.00
6	3-Oct	7-Oct	Metal stud framing, plywood backing & GWB per A2.00
7	10-Oct	21-Oct	Mechanical demo, ductwork modifications, new air handler & heat pump per M0.02, M1.01, M2.01, M3.01
8	17-Oct	21-Oct	Install new water heater, supply lines, new boiler per P1.01 & P1.02
9	24-Oct	4-Nov	Plumbing demo & rough-ins per P0.02
10	7-Nov	18-Nov	Electrical demo per E0.02 & electric rough-in/wiring per E1.01 & E2.01
11	21-Nov	29-Nov	Install drywall and patch & repair all walls & ceilings damaged during demo/installation of MEP fixtures
12	30-Nov	7-Dec	Install welded metal window frames/Lexan, doors & hardware
13	6-Dec	7-Dec	Furnish/install double doors at kitchenette
14	8-Dec	16-Dec	Installation of trims, moldings, cove base & specialty woodwork
15	19-Dec	23-Dec	Furnish/install all flooring/floor finishes per ID0.00
16	27-Dec	6-Jan	Interior painting & wall finishes per ID0.00
17	9-Jan	13-Jan	Furnish/install all millwork, necessary blocking per A7.00, A9.10
18	16-Jan	18-Jan	Furnish/install all plumbing fixtures per P2.02
19	19-Jan	25-Jan	Furnish/install all electrical fixtures per E3.01
20	19-Jan	25-Jan	Furnish/install all equipment & accessories per Equipment Key on EQ1.00 [B]
21	26-Jan	31-Jan	Final post-construction cleaning & grout cleaning/sealing

[A] Identify/label fixtures and materials for salvage (door locks); BOCC to remove all furnishings from Cottage 1 prior to commencement of demo

[B] Security grab bars, mirrors, recessed resident safe shelves, etc. (see page EQ1.00)

13. PROJECT DRAWINGS

The project side for the Bridge Program on the Baltimore Board of Child Care Campus is located in Windsor Mill, Maryland. The location is outlined in Figure 6. The site is one of fourteen Cottages on the 32.15-acre campus.

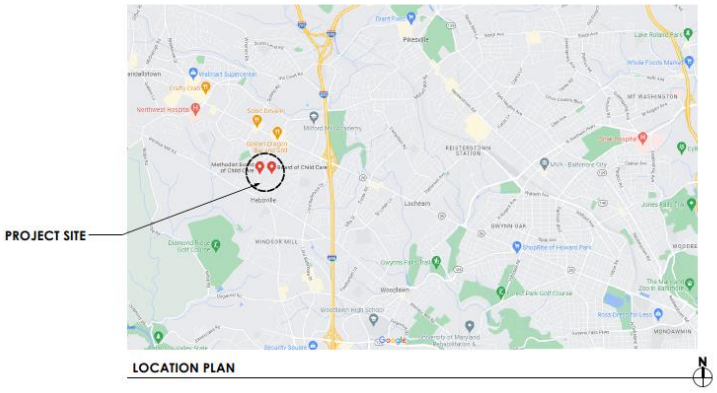
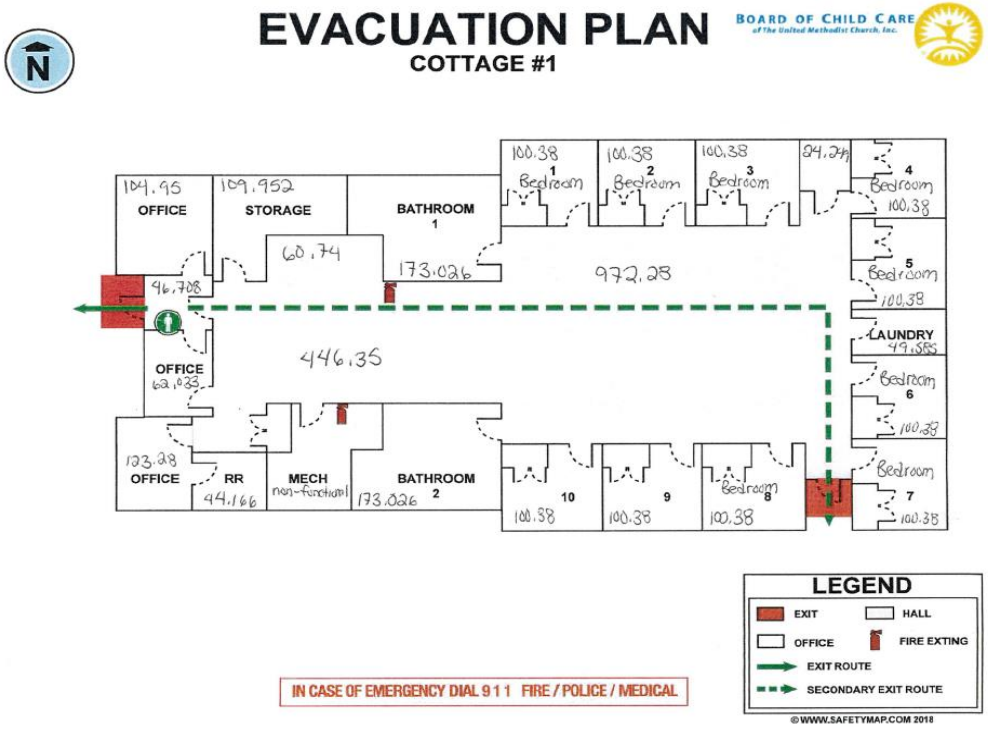
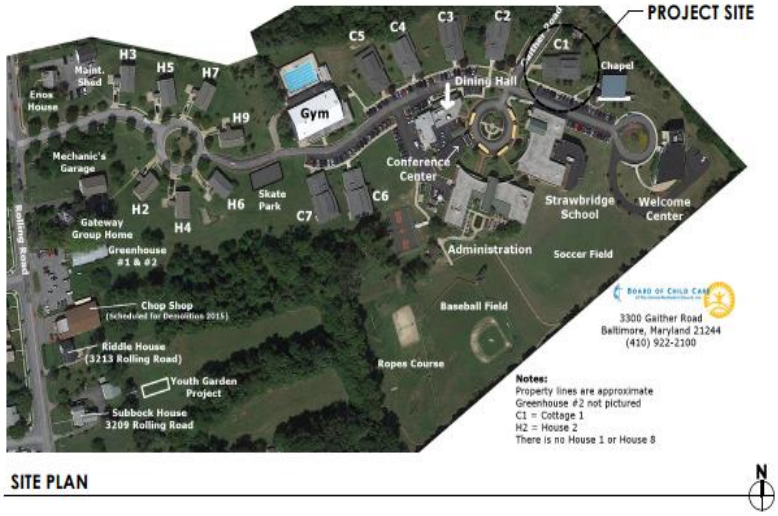


Figure 7. offers an example of the existing floor plan for “Cottage 1” prior to the proposed renovations. The floor plan offers an illustration of the facility in its current state. The current floor plan depicts “Cottage 1” as a 10-unit residential facility. However, the proposed project, the Bridge Program will be a self-contained unity with four (4) residential units, and the other proposed rooms will offer functionality for sensory intervention opportunities (3 spaces), one (1) classroom space, two (2) intake rooms, and two (2) workspaces for staff assigned to this unit, including nursing, educational and behavioral staff.





The site plan is outlined in Figure 8. Specific information related to the project drawings for the Bridge Program can be found in the Exhibit 6., *Construction Documents*. Specifications regarding Renovations can be found in the *Construction Project Manual*, Exhibit 7.

Before (Pre-Renovation)

The photos below offer a glimpse of the facility which will house the Bridge Program, prior to renovations. The photos will offer some detail to functional area and/or dimensions. More details related to the proposed facility renovations can be found in Exhibit 8.

Front of the building- Entrance- Cottage 1

Left side of building- Cottage 1

Back of building- Cottage 1-

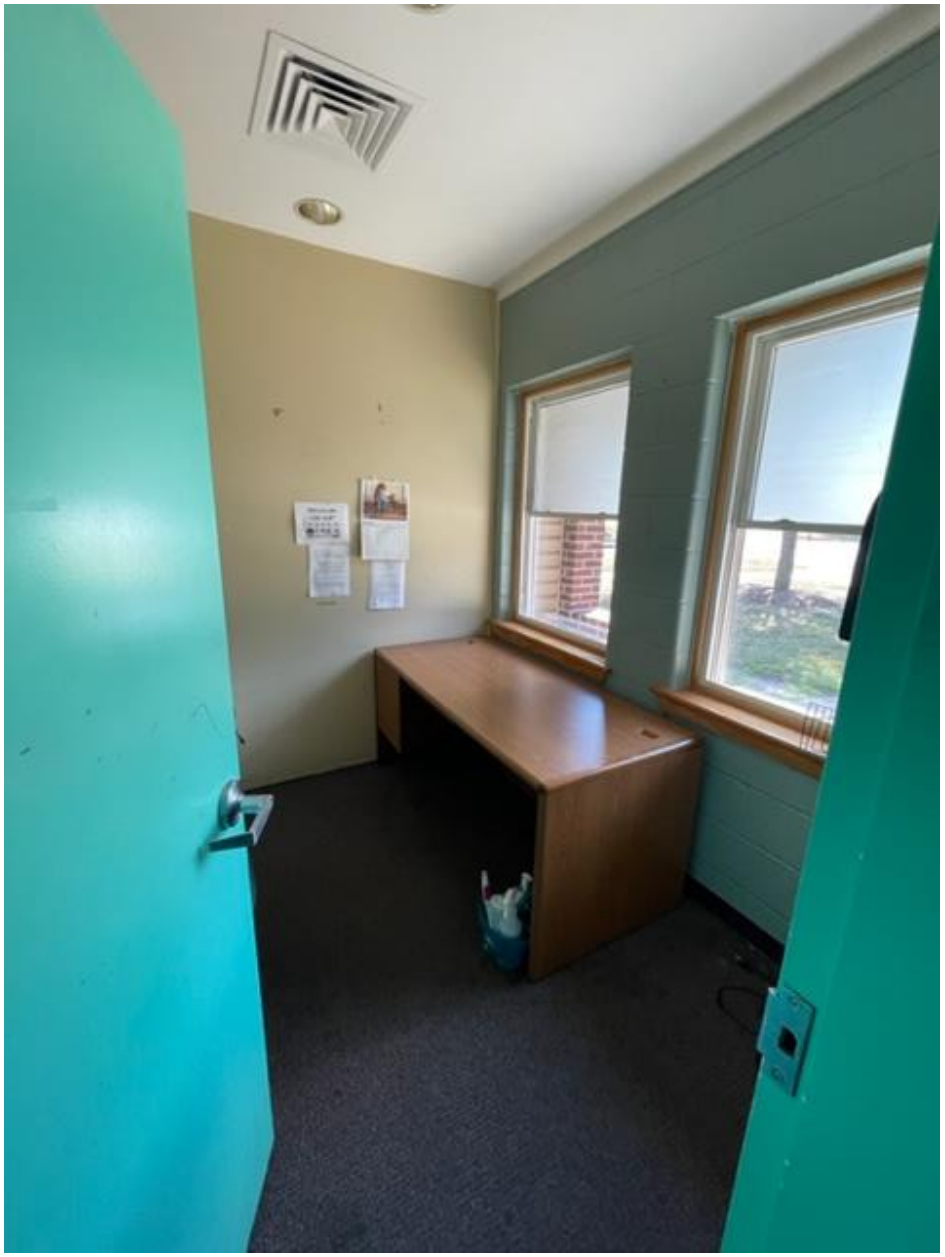
An enclosed sensory integration space is proposed for this space.

Space on the right side of the building- Cottage 1

The gate proposed will end on each end of the building. Two trees will be removed.

Space on Left side of building- Cottage 1

Space in the back of the building – Cottage 1



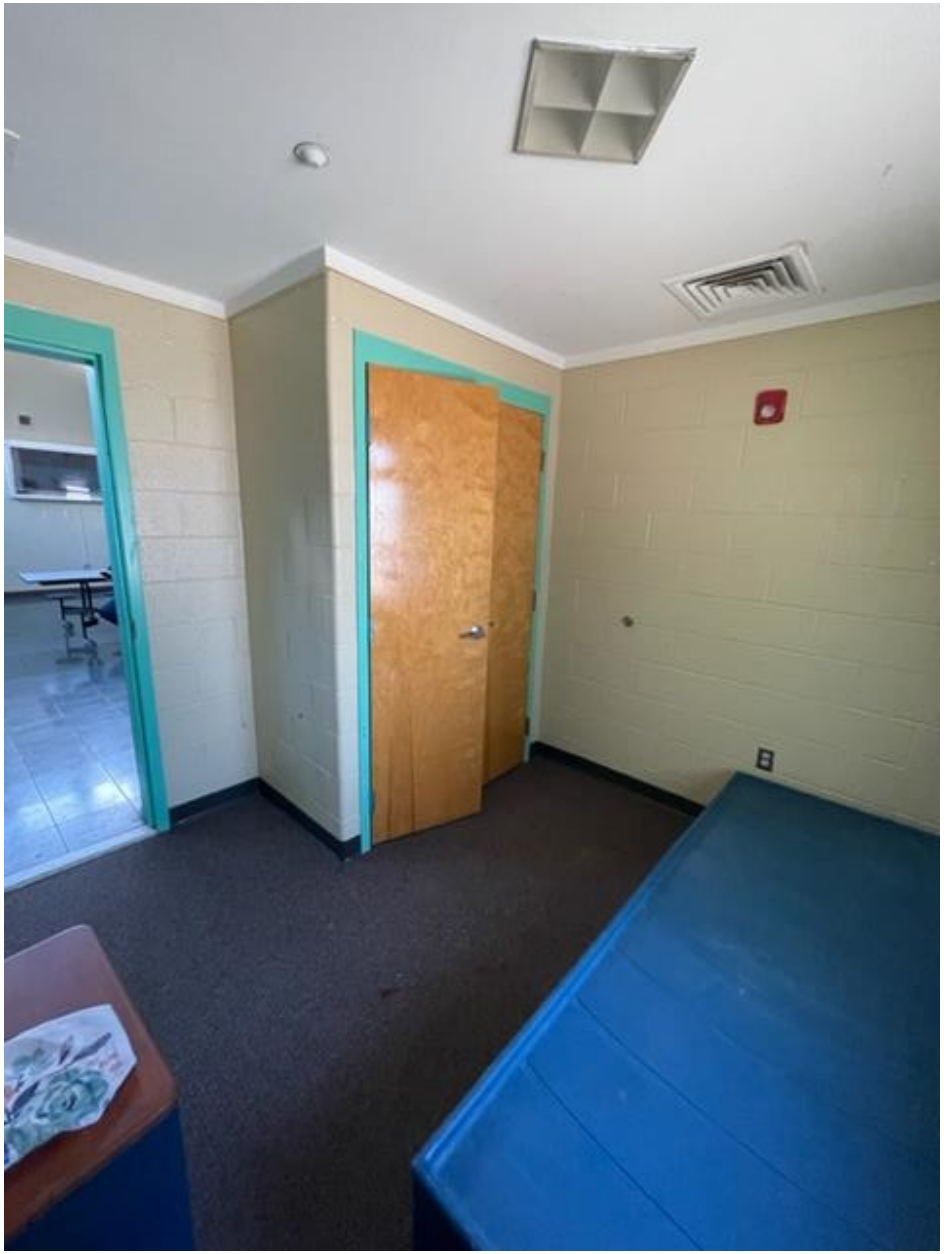
Current two front offices for residential staff. Smaller office will be Admin/Family Support Office.

Larger office will be renovated for staff work room with lockers.

Utility/Supply Room- Cottage 1

Current Kitchenette- Cottage 1. Renovated kitchenett will not have stove or dishwasher.

All meals will be provided from cafeteria for this unit.



Patient Rooms- Dimensions 10x10 square feet- 100.8 gross square feet

Renovations to four (4) of the 10 current residential bedroom spaces will be included with this proposal. Below is a brief description of the proposed updates.

Updated furnishings- Current furnishing will be replace with updated residential style furnishings.

Wall updates- Walls will be painted with fresh neutral colors to offer a calming effect for residents.

Updated flooring- New carpeting will be added to all residential rooms.

Updated Ceilings- New ceiling drywalled and painted.

Updated Lighting- Updated lighting fixtures

Secure Doors- Updated doors for all rooms.

Sensory Rooms- Dimensions 10x10 square feet- 100.38 gross square feet.

Renovations to two of the current residential bedrooms will be converted into sensory rooms. Each room will have one (1) dual data port, one (1) security camera and one (1) television. The closets will be removed from each space to offer more functional space in the sensory room.

Other spaces (Staff Offices w/Supplies and Medical, Ante Room (back), Classroom)

The remaining old residential bedrooms will be converted into other spaces. One space will be a Staff Office with supply/medical room. This room will have two (2) dual data ports and one (1) phone. This room will have one camera outside the hallway leading to the room and inside the room. This space is approximately 100.38 gross square feet.

Another space is includes the back Ante (waiting) room. This space will have one security camera inside the room.

The last two former residential bedrooms will be converted into a classroom. This space will be approximately 200.76 gross square feet. The space will have three (3) dual data ports, one (1) quad ports, one (1) phone and one (1) television. The space will have two security cameras inside the room.

Resident Bathrooms- Shower- Cottage 1

Resident Bathroom- Sink Area- Cottage 1

Resident Bathroom Renovations

Toilet and Sink Angle- Resident Bathroom- Cottage 1

The proposed renovations will include complete remodel to the bathroom area adding walls to each section of the bathroom space, to close off the toilet areas, a separated wall and doors for the showers, and adding a door from the open communal space to the bathroom ante area of the bathroom.

Both bathrooms will receive the updates described above. For additional detail, review Exhibit 6., *Construction Documents* or *Construction Project Manual*, Exhibit 7.

Laundry Room

There is one laundry room in the unit. The laundry area has one washer and dry for and utility sink. Currently, there are no major renovations planned for the laundry room, with the exception of painting and installation of new windows. One security camera will be installed inside the laundry room.

The laundry room is approximately 49.585 gross square feet.

Open Area- Dining Area

The space proposed for dining was previously used for residents to complete schoolwork. Desks were outside this area and staff were able to assist residents with schoolwork. This space will now be used for dining purposes and a therapist space. A wall will be added to divide the space from the activity and communal spaces. This wall will have a viewing window for observational purposes only.

For residents, the space will include two tables to eat meals and engage with staff and residents. The space is proposed to seat 12 individuals.

The proposed dining area will be approximately 446.35 gross square feet. The space will have two video cameras for security and safety. The space will also include 4 (four) dual data ports, one (1) phone, and one (1) WIFI APP.

Current Open Area (Former Activities Area)

This space will be divided into two spaces, one for communal space and the other space will be used as an activity room.

Activity Room

The activity room will be approximately 400.24 gross square feet. There will be one wall to divide the space, with two doors to enter into the activity rooms (doors swinging out to activity space). The room will have five (5) Dual data ports, one (1) phone, one (1) WIFI APP, and one (1) wall-mounted television. The space will have two tables for staff and residents to connect. The space will have two video cameras for security and safety. The space will also include a small desk and chair area for residential/behavioral staff.

Communal space

The communal space will be approximately 567.96 gross square feet. There will be 5 additional dual data ports, one (1) phone, and two (2) mounted televisions in this space. The space will have two video cameras for security and safety. The space will include a huge communal seating area with a small desk and chair for residential/behavioral staff.

14. FEATURES OF PROJECT RENOVATION

Information Technology Systems

The unit has adequate space/rooms for technology requirements for a standalone site. There will be rooms/offices/secure space to house the technology required to operate the facility. The site is currently configured with three securable locations to house any services or storage requirements to operate efficiently. The rooms have with the technology updates are noted on the maps below. See Figures 9 & 10 IT/Network Layout with Proposed Updates.

Figure 9. IT/Network Layout with Proposed Updates

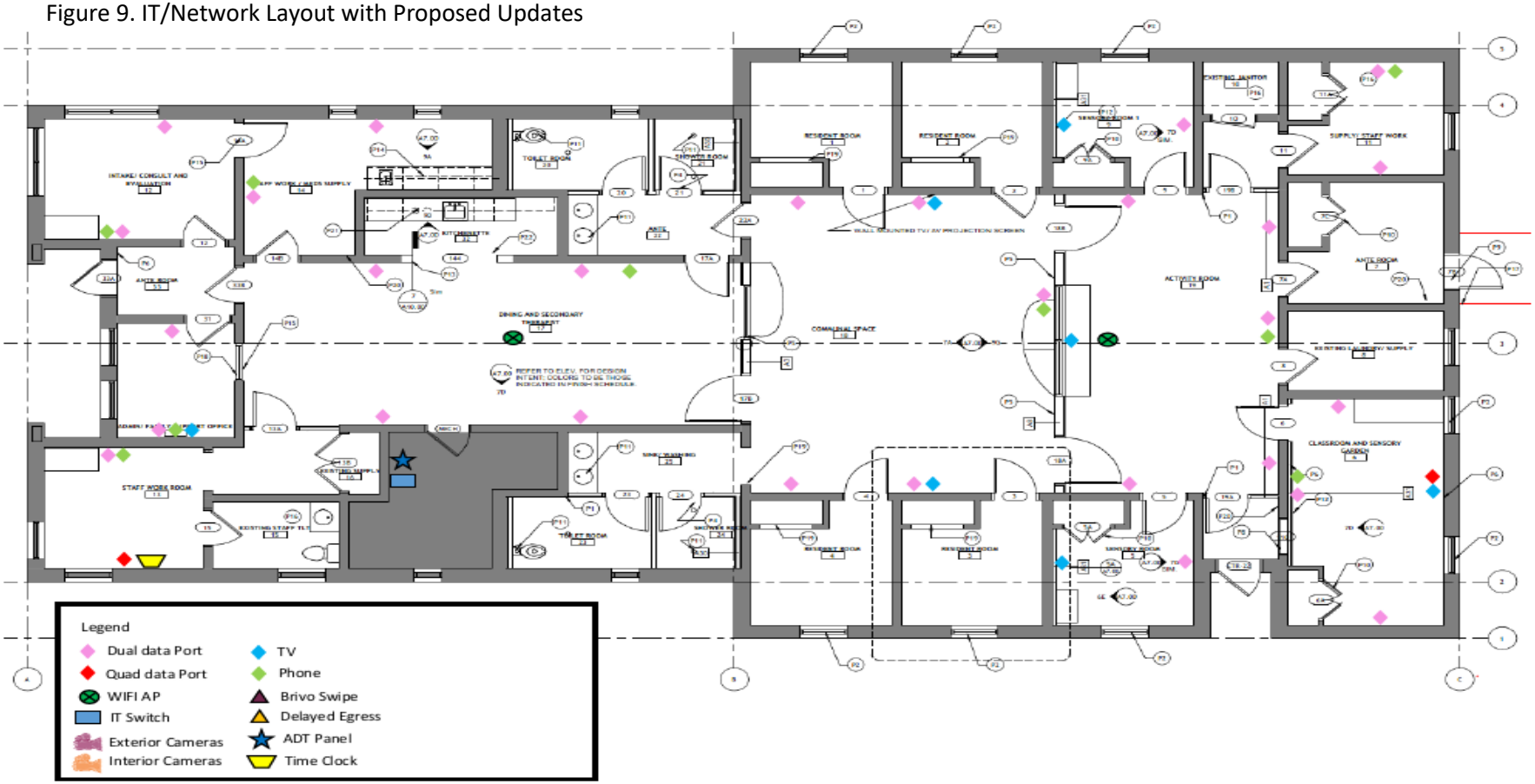
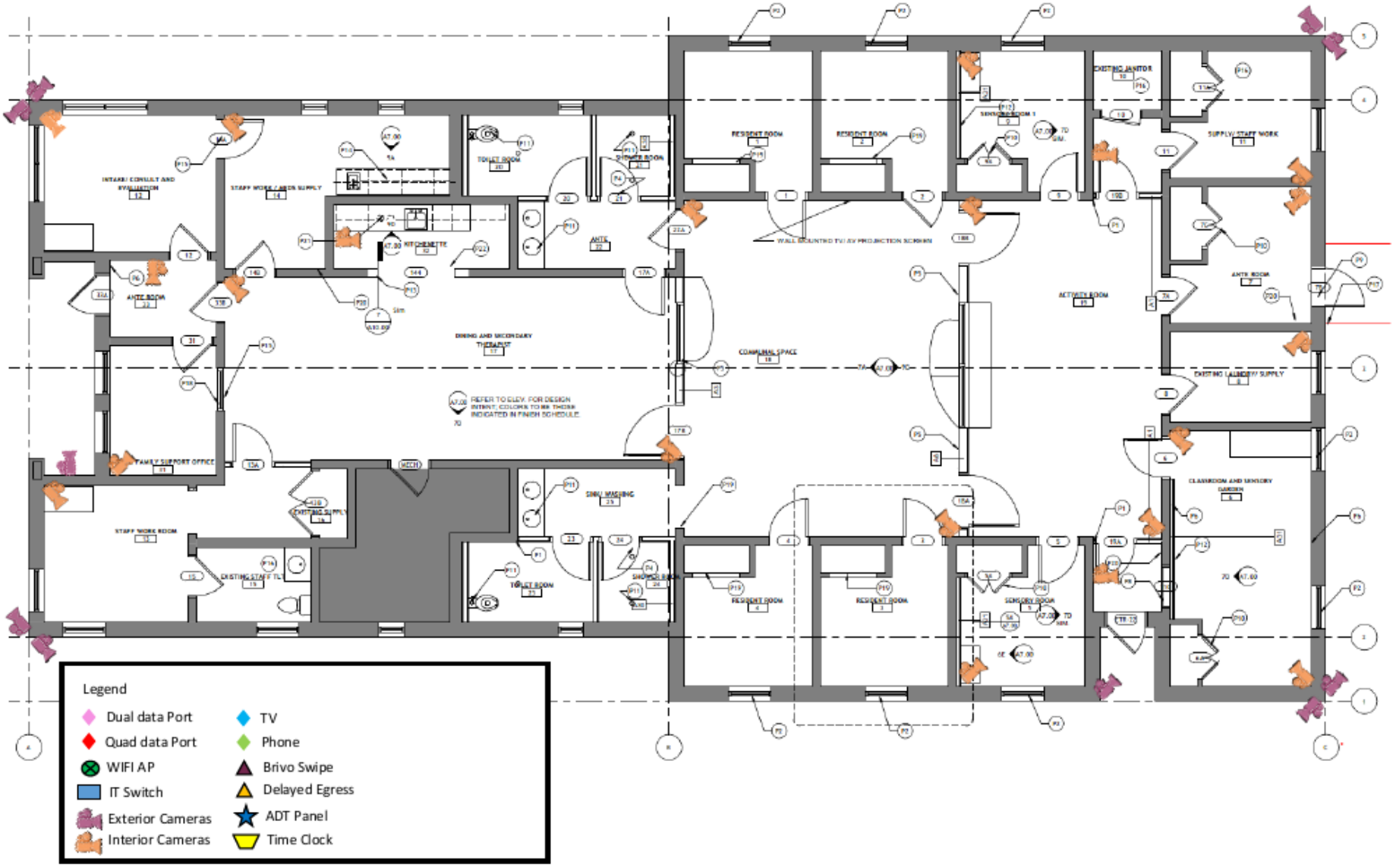


Figure 10. IT/Network Layout with Proposed Updates



See Exhibit 3 for full proposed Technology/IT/Network Management for Adolescent Hospital Overstay Program. The table below outlines the costs needed for the updates for technology. See Exhibit 4 for the copy of the IT/Network Management costs for the Bridge Program:

	Items In Need	Quantity	Manufacturer	Price
Door Access Controls	Plenum Profusion Access Cable	350	ADT	Equipment & Installation Total
	125 khz Proximity Reader	3		
	Two Reader Expansion Board with OSDP	1		
	ACS6100 Regular Panel, 1- B-ACS6000-MBE (2) Reader Ether Control Board with Wi-Fi antenna 1-B-ACS6100R-EXP Regular chassis	1		$7,921.00
Camera & Installation	Camera- Dome Xtream NC-4MKA-V21 Bullet Camera Xtream NC-4MKA-B21 NVRSN8-C1600 16 POE + HD (2HDD bay) HDD8T Universal Junction BoxCA-JB-L Single CAT6 Data Cables 48 port patch panel-ICC Misc. material		ECI	Equipment & Installation Total
	Camera Installation- Run (35) single cat6 drops for cameras, install (3) 16 port NVR's with (6) 8TB HDD, (35) dome and (10) bullet cameras. Terminate and test.			$30,655.10
Cabling & Installation	Dual CAT6 data Cables- AP drops Dual CAT6 Data Cables Quad CAT6 Data Cables 48 port patch panel 12U wall rack Misc. material		ECI	Equipment & Installation Total
	Run (29) dual. (2) AP and (2) quad CAT6 drops. Install 7ft track with (2) 48 port patch panels. Terminate and Test			$14,792.74

The total cost of proposed Technology/IT/Network Management for Adolescent Hospital Overstay- Bridge Program is estimated at $53,368.84.

The proposed facility is a Class C building with a "Good" type of renovation planned. Approximately 2,967 square feet of interior space will be renovated, and 900 total square feet of exterior space will be renovated for this project. More details related to construction characteristics can be found on Table C of the table package of this application.

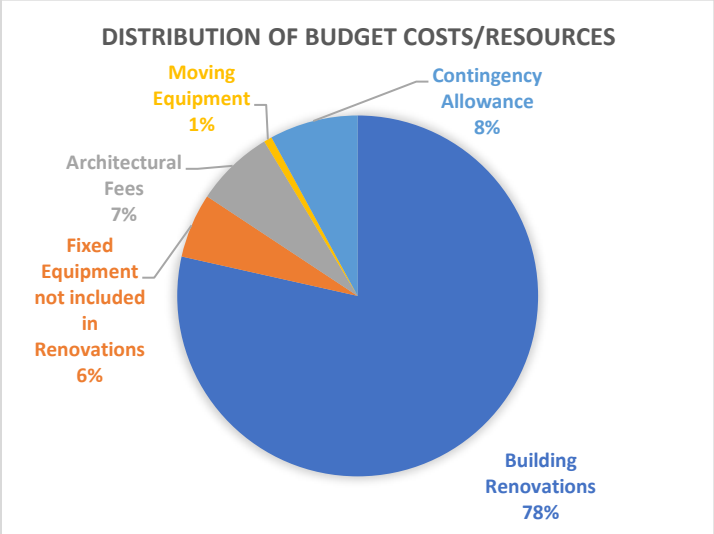
Onsite and offsite costs included and excluded in Marshall Valuation costs considers the $21,300 for site demolition which will be excluded from Mashal Valuation costs. Table D of the table package for this application details the Marshall Valuation costs. The facility designated for

this project has been actively utilized as a residential living unit pending the initiation of the capital projects detailed in this application. All utilities are available and adequate, functioning as applicable in compliance with COMAR 14.31.05 -.07. Water & Sewer services are provided by Baltimore County, Gas and electric are provided by Baltimore Gas & Electric (BGE) and waste collection is provided by the Waste Management of Maryland.

PART II - PROJECT BUDGET

The costs outlined in the Adolescent Hospital Overstay Bridge Program Renovation budget include costs for (1) Overall Project Renovations, including installation & materials, labor costs, and project management- minus contingency costs and movable equipment costs, ($724,040), (2) Fixed Equipment, including IT/Network equipment such as cameras, card door scanners and dual data ports ($53,369), (3) Architectural Fees ($65,000), (4) Moving Equipment, including general materials/construction rentals ($6,750.00), and Contingency Allowance ($73,079.00). Figure 11. outlines the Distribution of Budget Costs and Resources.

Figure 11. Distribution of Budget Resources



The total costs for the Bridge Project proposal including renovations, equipment, IT/Network updates and Architectural fees is estimated to be $922,238.

Table E highlights the full budget including renovations, capital costs, working capital startup funds, cash, philanthropy, authorized bonds, working capital loans, federal grants and/or appropriations. A copy of Table E is also included in the table package for this application.

TABLE E. PROJECT BUDGET

TABLE E. PROJECT BUDGET

			Hospital Building	Other Structure	Total
A.	**USE OF FUNDS**				
	1.	**CAPITAL COSTS**			
	a.	**New Construction**			
	(1)	Building		$0	$0
	(2)	Fixed Equipment		$0	$0
	(3)	Site and Infrastructure		$0	$0
	(4)	Architect/Engineering Fees		$0	$0
	(5)	Permits (Building, Utilities, Etc.)		$0	$0
		SUBTOTAL	**$0**	**$0**	**$0**
	b.	**Renovations**			
	(1)	Building		$724,040	$724,040
	(2)	Fixed Equipment (not included in construction)		$53,369	$53,369
	(3)	Architect/Engineering Fees		$65,000	$65,000
	(4)	Permits (Building, Utilities, Etc.)			$0
		SUBTOTAL	**$0**	**$842,409**	**$842,409**
	c.	**Other Capital Costs**			
	(1)	Movable Equipment		$6,750	$6,750
	(2)	Contingency Allowance		$73,079	$73,079
	(3)	Gross interest during construction period			$0
	(4)	Other *(Specify/add rows if needed)*			$0
		SUBTOTAL	***$0***	***$79,829***	**$79,829**
		TOTAL CURRENT CAPITAL COSTS	**$0**	**$922,238**	**$922,238**
	d.	***Land Purchase***			
	e.	**Inflation Allowance**			$0
		TOTAL CAPITAL COSTS	**$0**	**$922,238**	**$922,238**
	2.	**Financing Cost and Other Cash Requirements**			
	a.	Loan Placement Fees			$0
	b.	Bond Discount			$0
	c	CON Application Assistance			
		c1. Legal Fees			$0
		c2. Other (Specify/add rows if needed)			
	d.	Non-CON Consulting Fees			
		d1. Legal Fees			$0
		d2. Other (Specify/add rows if needed)			$0
	e.	Debt Service Reserve Fund			$0
	f	Other *(Specify/add rows if needed)*			$0
		SUBTOTAL	***$0***	***$0***	**$0**
	3.	**Working Capital Startup Costs**			$0
		TOTAL USES OF FUNDS	***$0***	***$922,238***	***$922,238***
B.	**Sources of Funds**				
	1.	**Cash**			$0
	2.	**Philanthropy (to date and expected)**			$0
	3.	**Authorized Bonds**			$0
	4.	**Interest Income from bond proceeds listed in #3**			$0
	5.	**Mortgage**			$0
	6.	**Working Capital Loans**			$0

7.	**Grants or Appropriations**				
	a.	**Federal**			$0
	b.	**State**			$0
	c.	**Local**			$0
8.	**Other *(Specify/add rows if needed)***				$0
		Line of Credit		$922,238	
		TOTAL SOURCES OF FUNDS		$922,238	**$922,238**
			Hospital Building	***Other Structure***	***Total***
Annual Lease Costs (if applicable)					
1.	**Land**				$0
2.	**Building**				$0
3.	**Major Movable Equipment**				$0
4.	**Minor Movable Equipment**				$0
5.	**Other *(Specify/add rows if needed)***				$0

A.1.b. and c.- Renovations and Other Capital Costs

The costs of each of these sections are described at the beginning of this section. IT capital costs include encapsulating security cameras, TVs, computers and monitors- all other IT costs are noted for fixed equipment. Fixed equipment for renovations includes both heater/boiler system, but included in the overall renovation budget. All other Facilities costs are for renovations to the building as described in the Building Renovation section.

A.3. – Working Capital Startup Funds

The project timeline projects that the renovations may take five (5) months to complete. The assumptions in determining the total of working capital startup funds is the costs for renovations, materials, and associated services and startup activity including IT costs. The costs will be provided as a part of our ongoing operation and line of credit.

This projection is also based on the combined Human Resource, Program, Client, Occupancy, Transportation, and other direct expenses (such as depreciation) for months prior to reimbursement being collected for RTC Medicaid and MSDE revenue. One month of Human Resource and utilities expenses are also added to account for recruiting and training staff.

B.1. Cash

Board of Child Care of the United Methodist Church (BCC) is based in Baltimore, Maryland and has offices throughout Maryland, Pennsylvania, West Virginia and the District of Columbia. The total operating budget for Board of Child Care is over $60 million annually. In addition, Board of Child Care maintains a fund called Endowment, which has drawn from the past to help fund new development projects such as the one proposed in Baltimore, Maryland.

B.2. Philanthropy

Board of Child Care employs a Development and Marketing Department, which receives marketing support and consultation from C360. Over the last three years, they have raised $1,767,000 on average.

Year to date, as o the end of July 2022, the Development Department has raised over $8,000 to the operating budget. The Development Department mainly works with various donors and foundations to raise funds for youth and families receiving services at Board of Child Care. Some operating donations will still be diverted to the Bridge Adolescent Hospital Overstay Program; however, to date, our fundraising capabilities have not been initiated.

B.3. – Authorized Bonds

Board of Child Care has secured funding from the Governor's budget delegated to the Maryland Department of Health to assist with funding the project. Approved annually, this has been a successful strategy while raising funds for similar projects in this field in the past.

B.6. -Working Capital Loans

No working capital loan will be used for this project.

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

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

Board of Child Care of the United Methodist Church, Inc. is the entity responsible for the implementation of the proposed project. Representing Board of Child Care of the United Methodist Church, Inc. as applicants is Laurie Anne Spagnola, President & CEO, and Nicole Smith, Executive Director, Maryland & DC Programs.

Are the applicant, owners, or the responsible persons listed in response to Part 1, questions 2, 3, 4, 7, and 9 above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

Board of Child Care of the United Methodist Church, Inc. (BCC)currently owns and operates the Cottage 1 located on BCC's Baltimore Campus at 3300 Gaither Road. In addition, BCC currently operates the following facilities which provide behavioral healthcare services and are licensed by the State of Maryland Department of Human Resources.

Residential Child Care Program – Group Home
3300 Gaither Road
Baltimore, MD 21244

Residential Child Care Program – Group Home
54 Randolph Road
Colesville, MD 20904

Residential Child Care Program – Group Home
27993 Substation Road
Denton, MD 21629

Residential Child Care Program – Group Home
3223 Rolling Road
Baltimore, MD 21244

Residential Child Care Program – Group Home
13420 Herman Myers Road
Hagerstown, MD 21742

Residential Child Care Program – Group Home
Address Available upon Request
Reisterstown, MD 21136

The following facilities are licensed by the Maryland Department of Health, Behavioral Health Administration.

Outpatient Mental Health Center
27993 Substation Road
Denton, MD 21629

Outpatient Mental Health Center
3300 Gaither Road
Baltimore, MD 21244

Outpatient Mental Health Center
30049 Business Center Drive
Charlotte Hall, MD 20622

Outpatient Mental Health Center
8028 Ritchie Highway #312
Pasadena, MD 21122

Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Question 2, above, been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, 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.

Board of Child Care attests that the licenses or certifications associated with this organization have never been suspended, revoked or been subject to any disciplinary action in the last five (5) years.

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) received inquiries in last from 10 years from any federal or state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with any 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.

Board of Child Care attests that the applicants and other BCC locations have never received inquiries as it relates to non-compliance with regulations or accreditation standards for the provision of, the quality of, or payment for health care services, or adherence to accreditation standards that resulted in actions leading to penalties, admission bans, probationary status or any other sanctions.

Have the applicant, owners or responsible individuals listed in response to Part 1, questions 2, 3, 4, 7, and 9, above, ever 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, 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).

Board of Child Care also attests that the proposed facility or other BCC locations have never pled guilty to or been convicted of criminal offenses related to the ownership, development or management of the proposed facility or any other health care facility owned, developed or managed by BCC and its Board members.

A copy of the above authorization signed by the President & CEO of Board of Child Care United Methodist Church, Inc. can be found in Exhibit 9. The undersigned is the owner, or Board-designated official of the proposed facility.

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

Based on guidance from the Director of Health Care Facilities Planning and Development, COMAR 10.24.07 is a remnant of the State Health Plan (SHP), which addresses the review of CON applications to establish or expand the psychiatric hospital and residential treatment center (RTC) services. Although the Maryland Health Care Commission repealed and replaced COMAR 10.24.07 with COMAR 10.24.21 to address psychiatric hospital services, it reestablished 10.24.07 to include only the RTC standards still relevant. In order to establish BCC's RTC, this application for the Bridge Residential Program will address the following thirteen standards (a-m) of COMAR 10.24.07.02(3) with this proposal. BCC received guidance in April 2022 on applicable standards for Certificate of Need Application Establishment of the Residential Treatment Center, included as Addendum x.

10.24.07.02(3) (a) Need.

Maryland's Children's Cabinet, along with the Maryland Department of Health, Department of Human Services, Department of Juvenile Services, Maryland Department of Disabilities, Maryland Department of Education and the Governor's Office of Crime Prevention, Youth and Victim Services collectively developed the Interagency plan to address the concerns expressed by the General Assembly and House Bill 1382[3]. The original bill authorized hospitals, emergency facilities or inpatient facilities to petition a court to compel a local department to remove an "overstay" child/adolescent from the hospital, regardless of placements.

In response, BCC was identified as one of two providers to develop an Adolescent Hospital Overstay program to serve as an intermediate remedy, or a "bridging" program to address the needs of adolescent with complex trauma, who have been historically difficult to place. The program will also address the insufficient reimbursement rates to meet the service provider's need to deliver adequate service provisions for this population[4].

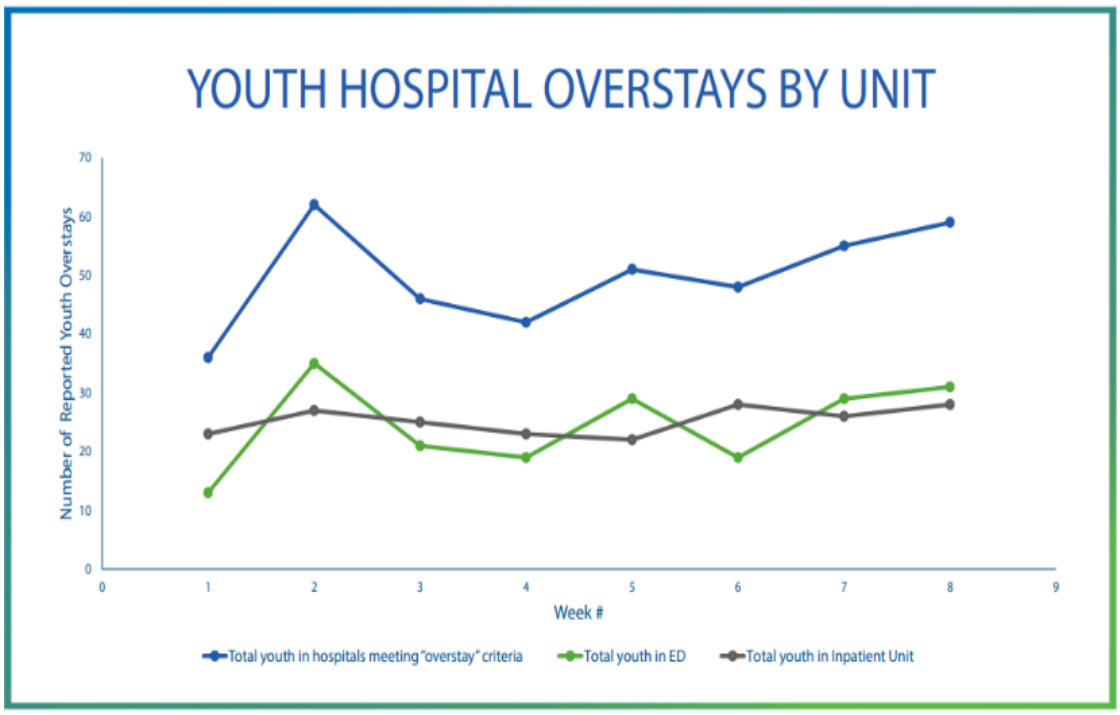
The need for the Bridge Adolescent Hospital Overstay program is demonstrated by the limited number of providers offering the provision of services for adolescents experiencing extended and repetitive stays in hospitals and clinical needs are beyond the capacity of current residential treatment settings licensed by MDH, the Department of Human Services, and/or Department of Juveniles Services (DJS) and as such have been denied or expected to be denied acceptance by available providers.

According to the Maryland Hospital Association's Pediatric Hospital Overstay Data Collection Project, youth meeting the "Overstay Criteria" were youth in inpatient units and patients in

[3] http://goccp.maryland.gov/wp-content/uploads/Childrens-Cabinet-Interagency-Hospital-Overstays-Plan.pdf
[4] https://www.youtube.com/watch?v=iQgYCnY0Y94

emergency departments across 39 hospitals across Maryland. The chart in Figure x. below outlines the number of reported youth in overstay, across a number of weeks.

Figure 12. Maryland's Youth Hospital Stays Across Units (Overstay, ED, Inpatient)[5]



Of the 39 hospitals noted in the Maryland Hospital Association Pediatric Hospital Overstay Data Collection Project, six (6) hospitals reported overstays every week in three counties in Maryland, Baltimore City, Baltimore County and Montgomery County. BCC is positioned to serve youth from all three counties to meet the complex health and residential needs of youth who meet the "overstay criteria".

In response to the need, Maryland Department of Health established a workgroup with the Department of Human Services (DHS) and the Department of Juvenile Services (DJS) to address capacity needs, develop rate methodology to match support needs to reimbursement and provide additional oversight and technical support to ensure quality in these complex services[6].

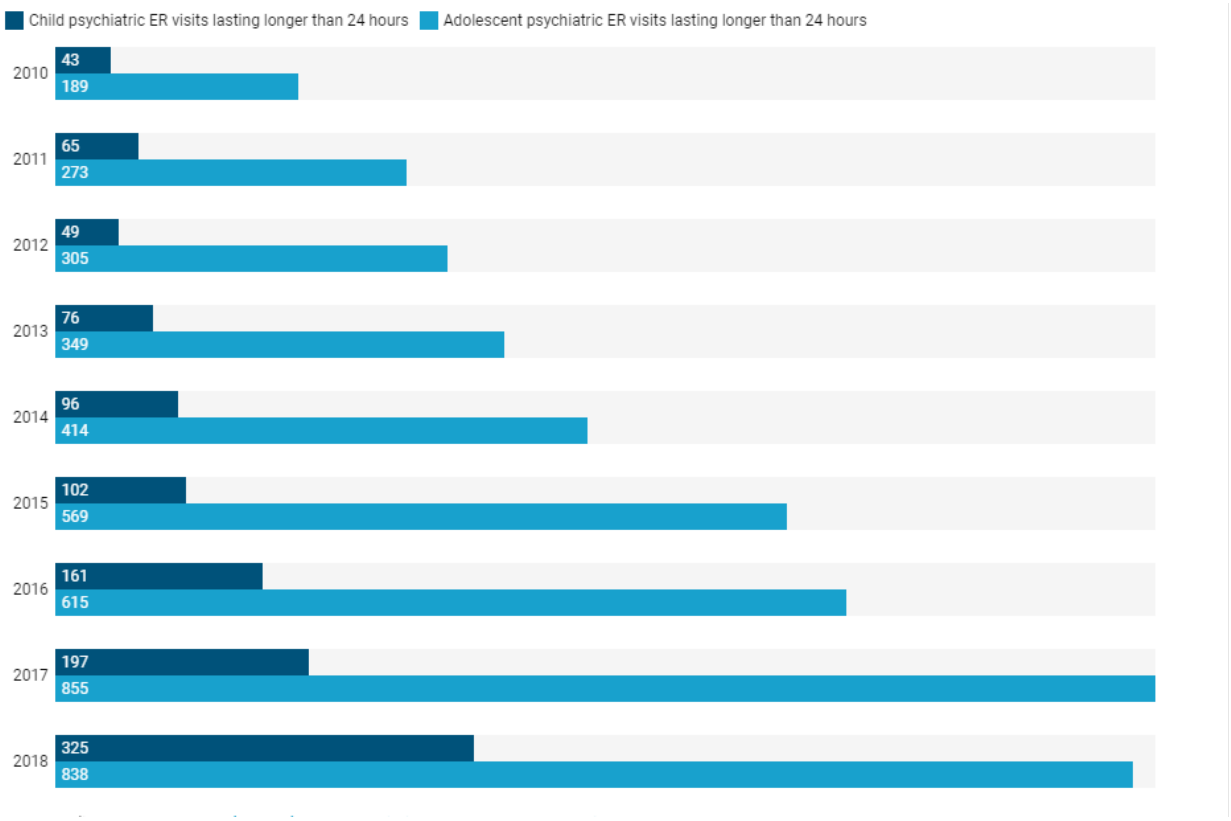
[5] https://www.mhaonline.org/docs/default-source/position-papers/2022/house/hb-406-children-in-out-of-home-placements--placements-in-medical-facilities--support-with-amendments.pdf?sfvrsn=361ad287_4

[6] https://maryland.optum.com/content/dam/ops-maryland/documents/provider/Alerts/december-2021/BH%20Monthly%20Partner%20Letter.%20Dec%202021%20final%2012.21.21%20FINAL.pdf

In 2019, there were only five (5) acute psychiatric care units that provided services for children and seven (7) units that provided inpatient care for adolescents[7]. This creates barriers to access for needed services to meet the needs of complex youth across Maryland, especially those on the Eastern shore region of Maryland.

From 2010 to 2018, more children in Maryland have had to wait for mental health beds to meet their complex needs. The shortage of inpatient and community mental health resources in the state is a reflection of the lack of adequate services across the state. The figure below highlights the number of youth who spend 24 hours or more than 20 days in an emergency department, waiting on a mental health facility.

Figure 13. Number of Children waiting for mental health beds (Child & Adolescent)[8]



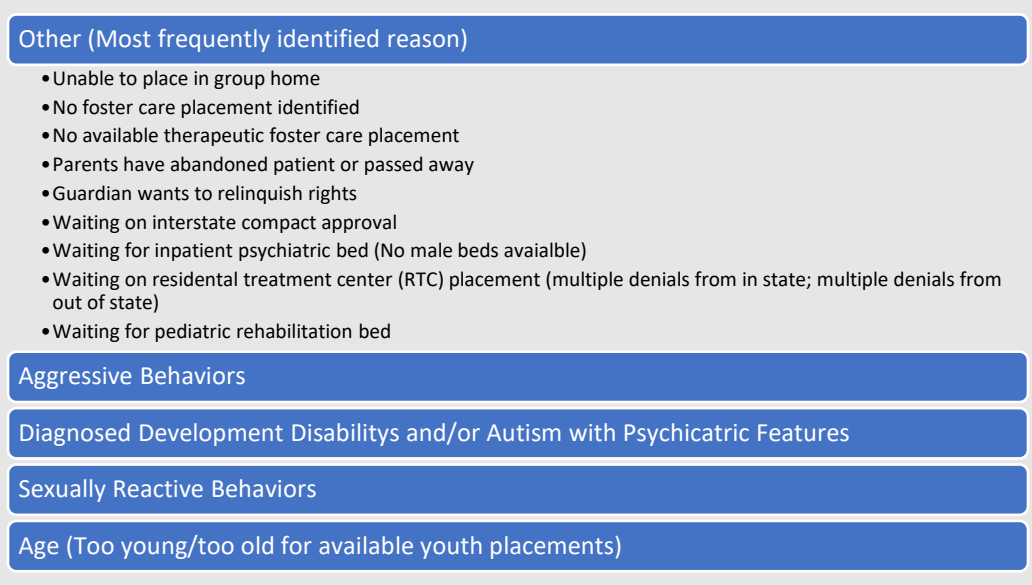
Since the COVID-19 pandemic, Maryland has seen a rise in the need for mental health services for children and adolescents, so this may have increased since this report was established. Based on the data outlined above, BCC's Bridge Program will address the highest need in the state, serving adolescents 14-20 years old. Common characteristics of patients profiled in the Maryland Hospital Association Pediatric Hospital Overstay Data Collection Project included adolescents, averaging 14 years old, evenly split between males and females, who were waiting

[7] https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_Annual_Rpt_Hosp_Services_FY2018.pdf

[8] https://cnsmaryland.org/2019/12/11/md-youths-needing-psychiatric-care-find-long-waits-drives/

for inpatient psychiatric placement or waiting for DSS to find adequate placement to meet their complex needs[9]. Primary reasons for discharge delays included the following:

Figure 14. Deeper Dive into "Other"



According to the Governor's Office of Crime Prevention, Youth and Victim Services FY2020 State of Maryland Out-of-Home Placement and Family Preservation Resource Plan, the characteristics of Maryland youth most in need of specialized services are[10]:

- Autism spectrum disorder diagnosis paired with aggression (directed at self, others, and/or property) or sexualized behaviors
- Developmental delay or disability paired with aggression (directed at self, others, and/or property) or sexualized behaviors
- Youth with a history of:
    - Highly aggressive behaviors
    - Victims of Human trafficking
    - Sexual reactive behaviors
    - Fire-setting behaviors

Many of the Residential Treatment Centers (RTCs) in Maryland do not offer the programming necessary to meet the needs of these youth, or often times have a minimum IQ requirement. This leads to the unfortunate situation in which youth with dual diagnosis including developmental disabilities to be rejected from placements.

[9] https://www.mhaonline.org/docs/default-source/position-papers/2022/house/hb-406-children-in-out-of-home-placements--placements-in-medical-facilities--support-with-amendments.pdf?sfvrsn=361ad287_4
[10] http://goccp.maryland.gov/wp-content/uploads/2020-OOHP-Report.pdf

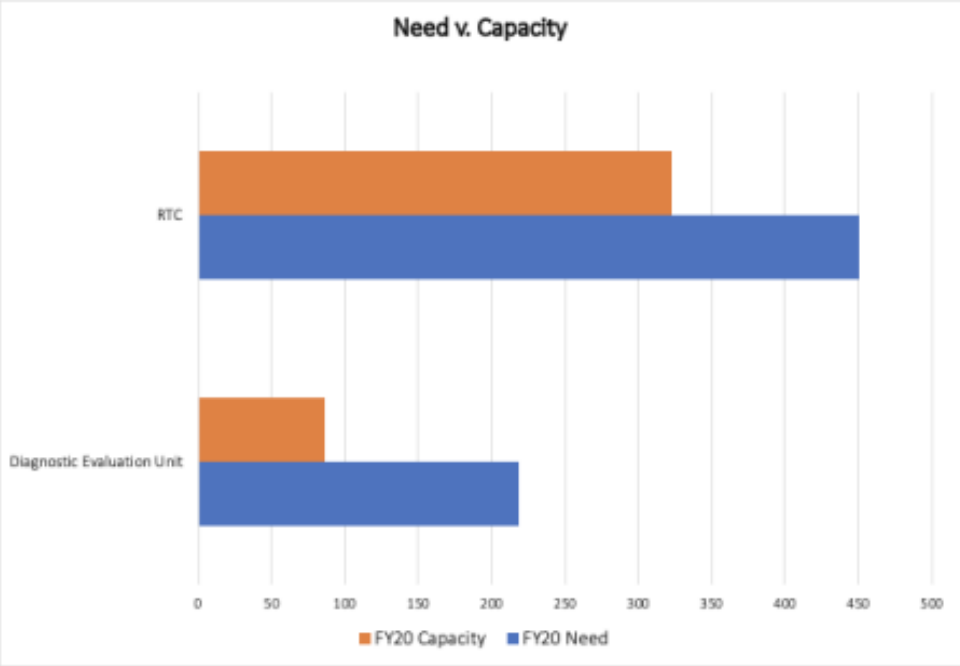


Figure 15. FY 20 Need Vs Capacity of RTC Beds

In the same report, the state noted in FY 2020 Maryland's total capacity of RTC beds and Diagnostic Evaluation Units did not meet the needs in Maryland, as depicted in Figure 15. above.

10.24.07.02(3) (b) Sex Specific Programs

Board of Child Care will have the ability to provide services to male or female youth ages 14-20 years old who present with Emotional, Cognitive and Developmental Disabilities (ECDD) and do not meet the criteria for inpatient treatment services. With the approval of Office of Health Care Quality (OHCQ) Licensing and Monitoring, Board of Child Care intends for youth that are transgendered to reside with the gender that they identify with. Board of Child Care also implements evidence supported interventions with youth, such as Not a #Number, which is a trafficking prevention curriculum developed for youth 12-18, including male, female and youth that identify as LGBTQ. Not a #Number is applicable across gender, ethnic, and socioeconomic backgrounds.

Another intervention utilized across BCC programs is Girls Circle. Girls Circle is gender-specific group model for girls and for lesbian, gay, bisexual, transgender (LGBT) youth who identify with female adolescence. Girls Circle is designed to address girls' unique risks, strengths, and needs by utilizing gender-responsive principle and practices to build healthy connections, address challenges, reduce risks, and build social-emotional skills. Girls Circle is the first ever gender-

specific program to have demonstrated effect on reducing delinquency in rigorous evaluation sponsored by the OJJDP.

A companion curriculum to Girls Circle, The Council for Boys and Young Men (aka Boys Council) is a strengths-based gender specific group approach to promote boys' and young men's safe and healthy passage through pre-teen and adolescent years. Boys Council meets a developmental need for positive relationships, the opportunity to address masculinity definitions and behaviors and to build leadership capabilities individually and collectively.

10.24.07.02(3) (c) Special Clinical Needs

As complex needs of the youth served over recent years have evolved, BCC recognized an early need to transform its treatment paradigm. BCC invested its own resources to move from an individual focused, level-based behavior modification model to evidence-based practices that have nationwide, proven therapeutic success with youth exposed to traumatic events and toxic stress. BCC recognized that real life does not have a level system- it has logical consequences for actions. In 2015, BCC developed and began its strategic initiative to guide all residential services away from level-based systems to nationally recognized, evidence-based practices. It was an invaluable experience that resulted in bringing relationship-based, brain science infused, trauma-informed, and evidence-based treatment to BCC's Residential programs.

Over the years, BCC has continued investing significant resources to adopt evidence-based treatment interventions proven to be effective in the treatment of complex trauma. All service lines utilize this universal relationship-based treatment agenda and have been trained to deliver the evidence-based interventions, allowing for continuity of treatment as youth and family work through the continuum of care. BCC utilizes evidence supported interventions to address coexisting mental health and developmental disability with interventions such as Trauma Focused Cognitive Behavioral Therapy (TF-CBT), a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems. TF-CBT has a scientific rating of 1, noting that is well supported by research evidence. Motivational Interviewing (MI) is also an evidenced supported intervention used at BCC. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. MI can be used by itself, as well as in combination with other treatments. It is often utilized at BCC in pre-treatment work to engage and motivate the clients for other treatment modalities.

BCC also utilizes The Seven Challenges program with youth in care. It is designed to motivate a decision and commitment to change and to support success in implementing the desired changes. The Seven Challenges is used specifically for young people with drug problems and aims to help young people address their drug problems as well as their co-occurring life skills deficits, situational problems and psychological problems. The model is based in a cognitive/emotional decision-making model that meets the youth where they are at, focusing on

helping youth identify their own motivation for recovery and empowers youth to meet their needs in positive ways.

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an intervention also used with programming at BCC. SBIRT is a comprehensive, integrated, public health approach for early identification and intervention with patients whose patterns of alcohol and/drug use put their health at risk. SBIRT components are universal annual, brief intervention and referral to treatment. The two most common behavioral therapies used in BSIRT programs are brief versions of cognitive behavioral therapy and motivational interviewing, or some combination of the two.

Sensory rooms, although still emerging through the trauma-informed framework, have become part of an effort to reduce seclusion and restraint in mental health services. The Bridge Program will utilize sensory processing integration techniques to meet the needs of the youth in the program. Sensory-based interventions address an individual's sensory system in a therapeutic manner to create change and enable adaption to one's physical environment and have been used in occupational therapy with children with behavioral issues and complex trauma histories.[11] Research has proven sensory room intervention as effective in reducing aggression and promoting enhanced interpersonal engagement and supporting self-management, resulting in the improvement in emotional distress, independence, and self-esteem.[12]

Within the Bridge Program, clinical team members will have access to this comprehensive menu of clinical interventions to support the delivery of individual, group, and family treatment opportunities onsite as part of the daily milieu programming.

10.24.07.02(3) (d) Minimum Services

Board of Child Care Practices an integrated approach with multi-dimensional, individualized care team that wraps their expertise/experiences around the youth and their family throughout treatment. Care teams are comprised of a large variety of roles as depicted in the diagram below. BCC's care team for the Bridge Program consists of several pertinent positions. BCC's treatment model believes that safety and transition planning begin at admission through the development of partnership with the youth and family.

Youth served in BCC programming receive intense structured supervision, and behavioral supports in a secure, trauma responsive environment. BCC will utilize its existing theory of change to expand the continuum of services to include Overstay services for youth requiring intensive stabilization following an inpatient hospitalization. All youth entering the Bridge Program will undergo initial and ongoing clinical assessments to prescribe the most appropriate

[11] https://www.emerald.com/insight/content/doi/10.1108/IJOT-10-2019-0014/full/pdf
[12] https://scholarworks.wmich.edu/cgi/viewcontent.cgi?article=4325&context=honors_theses

treatment interventions to meet the youth and family needs at ta given time. Through the use of initial and ongoing clinical assessments, the therapist working with the youth and family are able to make informed and appropriate modifications in consideration of the youth cognitive and developmental levels. Expressive therapies such as Art Therapy, are utilized as appropriate to complement the therapeutic process. Clinical assessment tools include Child and Adolescent Needs and Strengths (CANS) Assessment, Casey Life Skills (CLS) Assessment, CRAFFT screening tool for Substance Use and the Adverse Childhood Experiences (ACE) survey, which is embedded within a universal trauma assessment tool which will be completed with all youth during the clinical admission process.

Within 72 hours of intake, the Bridge Program Psychiatrist will conduct a medication review and full psychiatric evaluation will be completed withing the first 30 days of placement. Ongoing psychiatric services, including medication management and re-evaluations will be completed at minimum every 30 days, and more frequently as needed. The Bridge Program Psychiatrist is an active member of the youth's treatment team and will have regular communication with the Therapist and youth's family members throughout the course of placement.

BCC develops individualized treatment plans (ITP) informed by comprehensive and culturally relevant assessments. Plans of care and decisions related to the delivery of treatment are resourced by coordinated collective decision making that serves the needs and interests of the youth and their family. Engaging youth in the assessment and treatment planning process empowers the youth to become invested in their treatment. ITPs are based on the youth's: abilities and strengths, current diagnosis, assessed and stated needs, and transition plan. Care Team members review the ITP during treatment team meetings, as well as via the youth's Electronic Health Record (EHR). The therapist and case manager participate in weekly unit meetings to provide ongoing treatment updates and ensure consistent coordination of care and services. Initial ITP's are developed by the youth's 5th visit with their therapist (no later than 30 days), and review ITP's are conducted every 90 days or more frequently to discuss the youth's progress in treatment, functioning within the placement setting, family resources and transition/discharge planning. The Bridge Program Psychiatrist will consult on the development of and review/approve final ITPs. To maximize the benefit of the ITP meeting, BCC will send out the pertinent information for the case in writing 10 days prior to the scheduled meeting.

Treatment interventions will focus on increasing the youth's capacity to self-regulate while at the same time offering milieu and educational programming supports that promote regulation and the building of durable daily skills. BCC offers integrated medical services to address the 24-hour somatic and behavioral health needs of the youth served. The Bridge Program will be supported by Registered Nurses, providing 24-hour somatic healthcare along with medication management and monitoring of the youth's physical needs.

BCC recognizes the value of partnership with community partners, the youth, family and other natural supports to facilitate a successful discharge planning process. Through the engagement of the local care team and other interagency partners, transition and discharge plans will be created that wrap the youth and family with relevant and critical services, planning for a purposeful transition out of the Bridge program and into a supported environment at a lower level of care. Transition and discharge planning are continual throughout the treatment process in order to ensure that the youth's treatment is optimized, and discharge occurs in a manner that continues to strengthen progress made. Collaboration across systems and with members of the youth and family team is critical to ensuring proper supports are in place before, during and after discharge in order to promote stability upon release to a lesser restrictive environment.

10.24.07.02(3) (e) Treatment Planning and Family Involvement

BCC elevates the voice and participation of both youth and families with lived experience, ensuring their perspective is reflected in policies, practices, and program development across the residential service continuum. Treatment team goals are written using the youth's language and cultural preferences. For each level of programming throughout the BCC continuum, Care Team roles are adjusted to meet the individual needs of the youth and family to promote the support necessary to achieve treatment gains for the youth being served in the program. Care teams are comprised of a large variety of roles, as depicted in the diagram below. In order to engage both the youth and their family in the treatment process, the BCC care team wraps services around the family as a whole. The care team establishes a frequent schedule for visitation, as family reunification/ permanency is usually a large part of treatment.

An essential responsibility of the Case Manager is family engagement and identification of strengths and needs. The CANS assessment provides care team members the opportunity to facilitate a conversation with the youth and their family, allowing for collaboration in planning and decision making and providing a tool that will objectively monitor, measure and assess progress over time.

Figure 16. Youth & Family Care Team

BCC leverages the experience and diversity of care team embers to partner with youth and family during quarterly family engagement activities, family therapy sessions, case management sessions and supported visitation opportunities. The development, implementation, and review of the individualized Treatment Plans (ITPs) include the youth, family, or significant others, placing agency, interdisciplinary treatment team members, and any additional supports who are involved in the youth's care. BCC understands that as youth begin to experience increased feelings of physical, emotion and relational safety, their ability to self-regulate increases and dangerous, risk-taking behaviors decrease. Ensuring that family and other support individuals are engaged throughout the placement process honors the strengths and importance of those relationships to the youth and provides reassurance to the youth those relationships will be valued throughout the treatment process. With the Bridge Program, BCC will continue to align resources to support an integrated approach to service delivery via the Care Team.

To demonstrate BCC's commitment to maintaining family connections throughout the COVID 19 state of emergency, data gathered between July 2020 and September 2021 demonstrates that family engagement throughout those challenging months remained strong, with a total of 531 "check in" contacts (video calls with family) and 1594 meetings, hearings or therapy sessions taking place between July 2020 and September 2021.Althoug in person visitation has been reinstated across all of BCC programs, youth and families continue to enjoy the ability to maintain connection via virtual means throughout the week.

10.24.01.08G(3)(f). Education

Educational services will be provided in the facility via BCC's Strawbridge School. The Strawbridge School is a Type I full day and residential Special Education program with a total capacity to serve 140 students. The Strawbridge School serves individuals in both day and residential programs through a 10-month plus Extended School Year (ESY) program and is approved by the Maryland State Department of Education (MSDE).

The Strawbridge School's Type 1 full day and residential Special Education for Preschool (age 4), Kindergarten, Elementary School (Grades 1 through 8) and Secondary School (Grades 9 through 12) serves students with intellectual disability, multiple disabilities, other health impairments, emotional disability, specific learning disability, and autism. The Type I Special Education program provides individually designed instruction and programming necessary to meet the unique needs of students who cannot function in a less restrictive environment. The Type I Special Education program provides academics, vocational opportunities, counseling service and a school wide behavior management system to ensure academic success. The school provides an integrated approach in an effort to return the student to a less restrictive environment in a public-school setting. The Type I General Education program serves students in Nursery School (age 4). Kindergarten, Elementary School (Grades 1 through 8) and Secondary School (Grades through 12); Pre-GED and GED programs are also offered. Students are provided education which complies with State and county academic requirements. The Pre-GED and GED TESTS portions of the program allow for students to prepare and take the GED assessment as an alternative to a high school diploma.

Strawbridge also offers a Type III Elementary and Secondary School (Grades 4 through 12) Transitional program is offered to children and adolescents who enter the Board of Child Care's residential group homes and are awaiting a school placement. Prior to transfer, students are observed, assessed and provided instruction by certified teachers to determine the appropriate school placement.

A dedicated Strawbridge School education team will be integrated into the daily programming of the Bridge Program, providing therapeutic behavioral support (TBS) expertise through the presence of a Behavior Coordinator and Behavior Staff. Bridge Program support staff will be trained in TBS skills and have the opportunity to work alongside Strawbridge personnel as they model the delivery of behavioral modification plans in the milieu setting.

Youth placed in the Bridge Program will have educational services delivery by Strawbridge School certified teachers. The Strawbridge School currently offers two tracks of completion, and students are able to pursue a MD high school diploma or a MD high school certification of completion. When a student enters the program, his/her file will immediately be audited using the MSDE's Review of Student Record Form. For high school students, it is especially important to have the student's current high school transcript. Once the transcript is obtained, a student schedule is created based on the specific graduation requirements from the student's home county.

Student schedules/transcripts are audited bi-annually by the Principal and Director of Education to ensure the student is taking the correct required courses for graduation. The IEP/Testing Coordinator audits the students file for testing information; based on the student's grade level, eligible waivers and course (s) the student has already taken, the IET/Testing Coordinator will enroll the student in the necessary tests required for graduation.

The Strawbridge School's success lies in the ability to deliver education and behavioral health services in an integrated and effective manner for highly complex students. With programming designed to provide at-risk and/or disaffected students a nontraditional program that will meet their individualized academic, vocational, social, and emotional needs, Strawbridge creates an environment where youth are allowed to work towards passing grade level expectations and successful reintegration into a traditional classroom setting. Special instructional and supportive services are provided to help students develop more effective patterns of behavior and assist them with a planned transitional return to their home school environment.

Individualized student instruction is offered through 1:1, small group and/or full group instruction. When there are students that have the same credit/course requirements, instruction may lend itself to small group and even full group instruction. When students are working on varying coursework requirements, individualization based on student needs, strengths and weakness, can occur through scaffolding, multi-sensory activities and tailoring instruction to fit student interest.

Strawbridge will support the delivery of educational services in the Bridge Program through a variety of innovative methods:

- Reading Intervention Programs – Placement in a particular intervention will be determined based upon the student's incoming records, including IEP's and current academic transcripts as well as information gleaned through informal assessments.

- Lesson plans will be developed from a wealth of resources, digital content and instructional programs; the extensive resources allow for student individualization and

differentiation and support the requirement for delivery of individualized instruction and classroom management in basic skills (i.e. reading, language arts, and math) via one-on-one or small group instruction using differentiated materials and research - based instructional strategies.

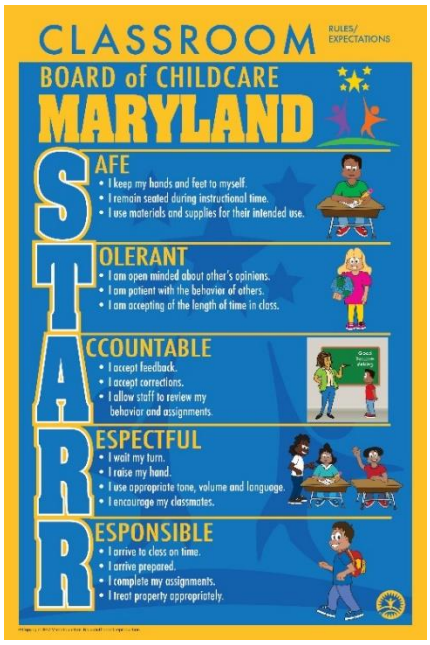
- Modifications and accommodations required by the students' IEPs will be implemented as well as principles found within the UDL (Universal Design of Learning). In addition, time is allotted within the schedule for the students to have intentional teaching of specific IEP goals/objectives.

- Offering trauma informed behavioral supports and skills teachings that promote self-regulation, the development of social skills, coping mechanisms and positive replacement behaviors.

- Engaging students in transitional services that provide support while in high school and also offer preparation for an engaged and productive adult life.

- A meaningful, therapeutic learning environment is provided through a warm caring atmosphere among program staff and students. BCC firmly believes, that in this environment, the teacher serves as a facilitator, providing learning experiences in not only the subject matter, but in the interests and needs of the individual youth. Further, effective teachers understand that students who have a clear understanding of expectations, are provided frequent and specific feedback, receive more guidance and praise than criticism, and experience a sense of connection to their teachers, tend to be more engaged in their lessons, behave more appropriately, and achieve at higher levels academically. Teachers foster structured classroom environments that are conducive to learning and address the academic, social, emotional, and developmental needs of the students. In order to create a classroom environment that is conducive to learning, all teachers will establish and enforce clear classroom rules that identify general expectations and procedures that communicate specific behaviors.

- PBIS at the Strawbridge School begins with behavioral expectations for all students. Within each of these expectations it is important to share with all students what each of these behaviors would look like in the school setting. Once students are aware of behavioral expectations, it is the duty of the program personnel to remind students of these expectations in a unified manner. This includes displaying required posters, using the aligned language, addressing student behavior in a positive tone and recognizing appropriate behavior with students. Staff are constantly looking for examples of students meeting behavioral expectations and reinforce them through the use of specific feedback as well as a point or points in the electronic PBIS system. The Strawbridge School utilizes PBIS Rewards, a multi-device platform that makes it easy to continuously recognize students for meeting behavior expectations from anywhere in the school, not just the classroom. At



Strawbridge, PBIS Rewards helps to foster accountability and fidelity in the PBIS program. It also creates an enjoyable and engaging experience for the students, as they can monitor their point accumulation and track their personal progress with real time data.

- Behavioral progress and interventions utilized in the program will be tracked through a combination of PBIS data and youth point sheets. Point sheets are individualized for each student and support shaping behavior through the delivery of immediate, frequent feedback. They also provide clear expectations for the student by outlining specific daily goals; students can then take ownership of their own behavioral growth by consistently having a visual reminder. Point sheets support the development of collaborative and healthy student/staff relationships by encouraging dialogue between the two parties.

10.24.01.08G(3)(g). Medical Assistance

Board of Child Care's Clinical and Health Suite teams provide holistic clinical treatment and medical care for the youth served throughout the residential programs. Youth and families served by BCC have access to a full suite of integrated clinical and medical services to address the 24-hour somatic and behavioral health needs for its youth. Nurses will provide training and psychoeducation for program personnel and youth family members, a critical support needed to ensure youth and family success after discharge from Board of Child Care. The nurses in the Bridge Program will be supported by BCC's experienced medical team, led by a Board-Certified Child Psychiatrist who serves as Medical Director. This position lends their leadership to additional Psychiatrists, a Pediatric Nurse Practitioner, and a team of Registered Nurses.

To support the delivery of the clinical and holistic supports described throughout this application, BCC employees and contracts a cadre of licensed and credentialed medical and clinical personnel. Within twenty-four (24) hours of arrival to Board of Child Care, youth receive an Initial Health Screen completed by the Health Suite. A Comprehensive Health Assessment is completed within seventy-two (72) hours of admission. The Psychiatrist completes medication review within 72 hours and a psychiatric evaluation within 30 days of admission. In conjunction with their parents / guardians and placing agency worker, BCC's experienced clinical and medical teams plan, facilitate and coordinate preventative, routine and emergency medical, dental and behavioral health needs for the youth placed in our residential programs.

To ensure that the youth's medical and treatment needs are being met through the Bridge Program services and the youth's progress is recognized, an Individual Treatment Plan meeting will be held 30 days and every 90 days thereafter. This meeting will include the youth, youth's family, BCC Care Team, placement agency and other involved stakeholders. The goal of the meeting is to provide placement recommendations that can meet the youth's medical needs in a collaborative way. Individualized Treatment Plans (ITPs) are developed by trauma-certified, licensed therapists, with review and approval by BCC's Medical Director.

BCC's medical staff will educate youth about their diagnosis and health care needs related to individualized needs and ongoing wellness. Medical staff teach youth about the medication they are prescribed including its purpose, side effects, and interactions with other medications as well as information on over-the-counter medications. Youth in placement beyond 120 days will receive an updated evaluation by the treating psychiatrist with a recommendation as to

whether or not the youth meets medical necessity for continued placement in the Bridge Program.

10.24.01.08G(3)(h). Staff Training

BCC's central goal in the current strategic plan is to foster a healthy culture where we engage with joy and purpose.

A key component to achieving this goal is offering professional development opportunities to all talent. Prior to working directly with our youth and families, all new employees participate in an extensive, 10-day (80 hours) orientation to equip them with the tools that they need for success, including:

- Client rights
- HIPAA
- Suicide prevention
- Emergency preparedness
- CPR/First Aid
- Trauma informed care
- Therapeutic crisis intervention
- Collaborative Problem Solving
- Positive Behavioral Intervention Supports
- Equity, Diversity and Inclusion
- RCYCP training modules

All direct care talent members are required to be certified as Residential Child and Youth Care Practitioners (RCYCP). RCYCP training includes an overview of the direct care profession, child development, communication, life skills development, legal and ethical issues, health and safety standards, and trauma-informed care. BCC has developed a proven protocol to support direct care workers in completion of the requirements for certification within in their first six months of employment and be prepared for re-licensure every 2 years. At the time of submission, over 200 BCC staff have completed RCYCP certification, including direct care, unit supervisors, case managers and various program support personnel.

During Orientation, personnel are educated on four modalities to guide their interventions and de-escalate youth during crisis situations: Therapeutic Crisis Intervention (TCI), Trauma Informed Care, Collaborative Problem Solving (CPS) and Positive Behavioral Intervention Supports (PBIS).

TCI is a nationally recognized, evidence-based intervention designed to provide a crisis prevention, de-escalation, and intervention model. Although TCI provides staff comprehensive training in safe "hands on" interventions and restraint techniques, the TCI approach also provides staff with tools and supportive techniques that prevent crises from occurring, de-escalate potential crises and effectively managing acute crises. More so, TCI equips staff with the road map by which they empower the youth to better understand their crisis cycle and give voice to the interventions that need to happen early on in order to prevent crises from occurring. BCC offers additional training that specializes the TCI philosophy for working with youth with developmental disabilities and families. Direct care talent are required to attend TCI training refreshers on a quarterly basis.

In order to develop services in a manner that recognizes and responds to the past traumatic experiences of the youth and families served, BCC trains all talent in the tenants of Trauma Informed Care utilizing the NCTSN Child Welfare Trauma Training Toolkit. Training includes two foundational trainings, Trauma 101 and Trauma Informed Child Welfare 101. The 3.5-hour Trauma 101 training curriculum focuses on understanding the types of trauma and their impact on those who experience it; how trauma intersects with safety, permanency, and well-being; and the critical role of resilience in helping children, youth, and families heal. The 4-hour Trauma-Informed Child Welfare 101 training curriculum for provides a foundational overview of The Essential Elements of a Trauma-Informed Child Welfare System and educates staff on the impact of Secondary Traumatic Stress and the importance of self-care to promote professional resilience.

Building upon the strong foundational knowledge developed through the NCTSN training process, BCC operationalizes the principles of trauma informed care in daily practice through use of the Collaborative Problem Solving (CPS) model. CPS is an evidence based, strengths focused, neurobiologically grounded approach that provides clear strategies to operationalize trauma-informed care as well as empower youth and family voice. CPS offers a clinical framework for identifying deficits in critical skill areas and offers understanding of how those skills deficits impair the youth's ability to develop strategies for skill building. CPS targets risk factors including aggression and conduct disordered behaviors, and prevents / mitigates trauma by promoting resiliency factors, including healthy relationships, improved communication skills, emotional regulation skills, impulse control, problem solving skills and the development of empathy. Through the use of CPS, staff teach youth the tools needed to remain calm and learn to solve problems, all while engaging in a reciprocal relationship with one another.

In addition to CPS, BCC utilizes Positive Behavior Interventions & Supports (PBIS) as a foundational approach to daily programming across the residential and educational service areas. PBIS creates consistency across the program regarding what and how youth are taught. Through the PBIS system, staff are given the tools they need to teach youth positive behaviors and create a positive culture in the milieu. Board of Child Care has developed the PBIS system in collaboration with the Maryland State Department of Education (MSDE), the Mid-Atlantic PBIS Network and Johns Hopkins Bloomberg School of Public Health. We currently practice the primary level of PBIS within our daily programing and treatment. This includes universal interventions; they are implemented which target ALL youth. Research demonstrates that positive approach interventions improve maladaptive behaviors for approximately 80-90% of youth. Board of Child Care's Maryland Programs have established five overarching behavioral expectations which guide our approach – these expectations are phrased using "I am" language, which empowers the youth and reinforces that they will be successful.

In addition to the above orientation offerings, BCC's training program allows for the opportunity to participate in a variety of trainings throughout the year. BCC's Professional Curriculum & Training Manager oversees the agency's extensive training program and is responsible for developing a training calendar of relevant professional development opportunities annually to assist BCC talent to meet the requirement of 40 hours of annual training. In person and live virtual trainings are supported by BCC's Relias Learning Management system, which is also used to support training needs across the organization. Relias provides web based continuing education and compliance training modules as well as the option of being able to customize training tracks for individual employees, departments and progress across the organization. The flexibility of the Relias system lends itself to providing training and policy updates related

to specific program, contract and/or population changes as they arise in an efficient and comprehensive manner. Training records for all BCC personnel are maintained within the Relias system, with transcripts placed into individual employee personnel files. Training records include the names and credentials for the trainers, staff in attendance, and copies of the curriculum. Relias prompts each employee, as well as supervisors and program administrators, when trainings are due to be completed which allows for real time monitoring to ensure that training, certifications and licensure requirements remain in compliance. BCC's Human Resources department manages the Relias system and oversees compliance to with annual training requirements as prescribed in COMAR, additional state and federal training regulations, agency and accreditation standards.

Various personnel connected to the Bridge Program will have the ability to develop and administer behavioral modification plans, individualized to the needs of each youth. The Director of Behavior and Related Service at the Strawbridge School is Board Certified Behavior Analyst (BCBA) / Licensed Behavior Analyst (LBA). They will provide guidance and oversight to the development of behavior modification plans in collaboration with the Bridge Program Therapist. A dedicated Strawbridge School education team will be integrated into the daily programming of the Bridge Program, providing therapeutic behavioral support (TBS) expertise through the presence of a Behavior Coordinator and Behavior Staff. Bridge Program staff will be trained in TBS skills and have the opportunity to work alongside Strawbridge personnel as they model the delivery of behavioral modification plans in the milieu setting. Section 7.6 provides a comprehensive overview of the Strawbridge School and their approach towards delivering education services.

BCC's care teams are comprised of various interdisciplinary team members, many of whom are credentialed in their field of expertise, including: Licensed Social Workers (LMSW, LCSW-C), Licensed Mental Health Counselors (LGPC, LCPC), Certified Clinical Trauma Professionals (CCTP), Registered Nurses (RN), Psychiatrists (MD) and Certified Medication Technicians (CMT).

Youth referred to the Bridge Program will be connected to a trauma certified, licensed mental health therapist who is trained in evidence-based modalities for working with youth that present with an ECDD profile. BCC values the use of evidence proven treatments and will ensure that the Therapist in the Bridge Program will have specialized training in modalities including, but not limited to: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Motivational Interviewing (MI), Collaborative Problem Solving (CPS), Botvin Life Skills, SBIRT and Seven Challenges. The Bridge Program Therapist will be a part of BCC's Baltimore clinical team and participate in weekly individual supervision with a licensed Clinical Supervisor, as well as biweekly clinical group supervision with Therapists from across the Maryland Programs. The clinical oversight for this program falls under the leadership of BCC's Director of Behavioral Health Services.

The treatment of complex trauma is not best defined using a singular model. BCC intentionally offers a menu of evidence supported clinical interventions that incorporate aspects of psychoeducation, trauma narration, group treatment, cognitive restructuring, development of coping and stress tolerance skills as well as post-treatment planning. The Therapist providing clinical services to program participants will be certified as certified trauma professionals through Evergreen Certifications utilizing a national continuing education model. Additional areas of clinical treatment will focus on interpersonal and social skill building, self-regulation, family engagement and mindfulness. This holistic, multidimensional approach to treatment offers opportunities for youth to build skills often not developed prior to placement. It is through

the complementary application of this menu of clinical interventions and proven approaches that the youth and families served by BCC can begin their journeys of healing and recovery. A detailed review of evidenced supported modalities offered by BCC has been included in Addendum I of this application.

In addition to clinical counseling services, psychiatric care for all youth in the Bridge Program will be provided by one of BCC's Board-Certified Psychiatrists. BCC has a team of Child & Adolescent Psychiatrists that support the evaluation and medication management needs of the youth in our programs. The Bridge Program Psychiatrist will ensure that all youth receive psychiatric evaluations upon admission to the program and will regularly consult with the program Therapist and Care Team to offer clinical insight, review treatment and medication efficacy, assist with crisis management and evaluation and offer ongoing evaluation updates as needed.

10.24.01.08G(3)(i). Staffing.

Board of Child Care practices an integrated approach with the multi-dimensional, individualized care team that wraps their expertise/experience around the youth and their family throughout treatment. Care teams are comprised of a large variety of roles, as depicted in the diagram below. For each level of programming throughout the BCC continuum, Care Team roles are adjusted to meet the individual needs of the youth and family and promote the supports necessary to achieve treatment gains for the youth being served in the program.

BCC's care team for the Bridge Program consists of several pertinent positions, including but not limited to: Assistant Program Director, Therapist, Unit Supervisor, Wellness Coordinator, Certified Residential Child and Youth Care Professionals (RCYCP), Lead Treatment Support Specialist, Educational Coordinator, Special Educator, RN, Pediatric NP and Psychiatrist.

Assistant Program Director

The Assistant Program Director provides adaptive leadership and oversight to the care team. This position is key to supporting the training and professional development of the team members, as well as supporting the wellness of employees by addressing the emotional fatigue employees face when serving youth with complex trauma and behavior challenges. When not addressed properly, these factors have a direct impact on treatment through the turnover of talent.

Therapist

The therapist acts in a dual role, supporting both the case management and therapeutic services for all youth. The therapist will be the primary point of contact for family members and will deliver clinical intervention, including but not limited to individual, group and family therapies. All of BCC's therapist are credentialed and certified trauma professionals within their first year at BCC. The therapist works closely with all members of the care team to design and implement guidance and treatment plans for the youth in order to develop, support and encourage safe behaviors, self regulation and healthy relationships.

Unit Supervisor

The unit supervisor is responsible for ensuring the daily needs of our youth are being met in a trauma responsive environment. Working closely with the therapists, they ensure that the

certified child and youth care professionals are implementing the structured schedule and individualized plans for each youth.

Wellness Coordinator

The Wellness Coordinator supports the emotional and recreational wellness needs of the youth through the implementation of therapeutic recreation and resilience building initiatives within the program. The Wellness Coordinator will be responsible for engaging youth voice in the development of a monthly calendar of events and activities focused on promoting emotional wellness and positive engagement of the youth in the program.

Direct Care Staff - Certified Residential Child and Youth Care Professionals

A critical member of the Care Team, all direct care personnel are certified as Residential Child and Youth Care Professionals (RCYCP). Direct care staff provide the foundation for the relationship-based treatment Board of Child Care has adopted. Board of Child Care invests significant resources in the professional development of our workforce to equip them as agents of change for our youth and families.

Medical Team

BCC offers integrated medical services to address the 24-hour somatic and behavioral health needs for the youth served. The Bridge Program will be supported by Registered Nurses, providing 24-hour somatic healthcare along with medication management and monitoring of the youth's physical needs. Nurses will provide training and psychoeducation for program personnel and youth family members, a critical support needed to ensure youth and family success after discharge from Board of Child Care. The nurses in the Bridge Program will be supported by BCC's experienced medical team, led by a Board-Certified Child Psychiatrist who serves as Medical Director. This position lends their leadership to additional Psychiatrists, a Pediatric Nurse Practitioner, and a team of Registered Nurses.

In addition to clinical counseling services, psychiatric care for all youth in the Bridge Program will be provided by one of BCC's Board Certified Psychiatrists. BCC has a team of Child & Adolescent Psychiatrists that support the evaluation and medication management needs of the youth in our programs. The Bridge Program Psychiatrist will ensure that all youth receive psychiatric evaluations upon admission to the program and will regularly consult with the program Therapist and Care Team to offer clinical insight, review treatment and medication efficacy, assist with crisis management and evaluation and offer ongoing evaluation updates as needed.

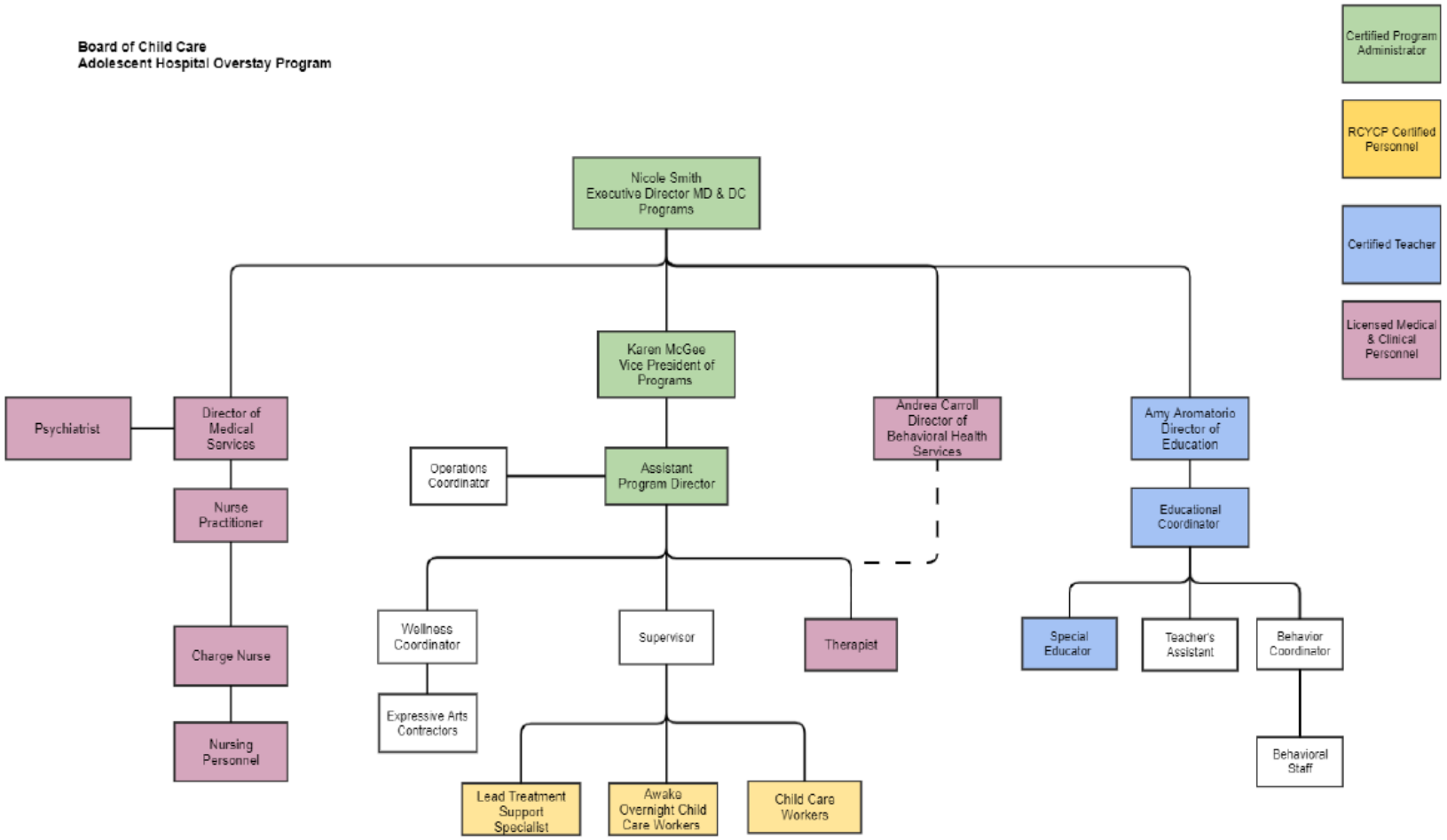
Strawbridge Certified Teachers/Personnel

Youth placed in the Bridge Program will have educational services delivery by Strawbridge School certified teachers. Certified teachers assigned to the Bridge Program include two Behavioral staff personnel, one Teacher's Assistant, and one Special Educator, who report to the Educational Coordinator. The Director of Education at BCC will oversee the educational services of youth in the Bridge Program.

Included in the Figure below is the proposed Bridge Program Organizational Chart which demonstrates programmatic oversight and direct lines of supervision. A copy is also available in Exhibit 10.

Addendum II: Bridge Program Organizational Chart

Figure 17. Bridge Program Organizational



The Bridge Program will operate with a 2:1 staff to youth ratio during awake hours and a 1:1 staff to youth ratio during overnight hours. The rationale for this staffing pattern is based on BCC's current DHS contract for High Intensity ECDD Group Home services, which requires a 2:1 staff to youth ratio 24 hours per day. BCC acknowledges that youth may not require a 2:1 ratio for the duration of their placement in the program but given BCC's experience delivering services to an ECDD population and the high level of acuity that youth will present with as they enter into the Bridge Program, a 2:1 ratio during waking hours provides the safest approach to effectively deliver stabilization services.

Additionally, as the Bridge Program will be functioning as a standalone program, the 2:1 staffing pattern ensures that an adequate number of staff are available to provide crisis response and support as needed to safely conduct physical restraints. Per TCI methodology, a minimum of three staff are required to safely enact hands on interventions and best practices dictate that an additional staff be available to observe the intervention and assess the safety of the youth at all times. Staff that are not involved in managing crisis situations are responsible for ensuring that the remaining youth in the program are removed from the environment in a manner that promotes calm and reassures them that they are safe and secure in their environment. To support the staffing requirements of the population, BCC has also developed a significant recruitment plan that will need to be enacted prior to the opening of this program. The recruitment plan considers not only recruitment of personnel, but also the onboarding and training that will be required to open the program. Exhibit 12 offers a sample of the staffing Pattern developed for the Bridge Program

10.24.01.08G(3)(j). State Regulations

MDH Guidelines & Executive Orders

BCC's current continuum of programs operates in accordance with COMAR 14.31.05 through 07, as well as MD DHS policies and regulations. For the Bridge Program, BCC anticipates adapting current practices to achieve compliance with RTC standards as detailed in COMAR 10.07.04. BCC ensures that services are delivered in compliance with COMAR regulations and requirements in a variety of different ways. COMAR regulations are embedded, along with CARF and EAGLE accreditation standards, in the agency policy and procedure manuals but also in everyday practices. In addition to COMAR and DHS regulations, BCC has been working closely with Baltimore County Department of Health and with their guidance, has successfully adopted various CDC and health department guidelines, practices and protocols to safely respond to the COVID-19 public health emergency.

BCC has a history of complying with all State and federal laws, regulations, MD DHS policies, standards and guidelines affecting the care and supervision of youth, striving to exceed the minimum standards in most regulated areas. The agency's senior administration and the QI Department are constantly monitoring for updated and new regulations or policies that affect service provision. BCC's Certified Residential Child Care Program Administrators (CRCCPA) attend quarterly meetings that are hosted by DHS- Office of Licensing and Monitoring to remain informed on any changes that impact the operations and adjust BCC policies and procedures accordingly to achieve compliance. In addition, BCC senior leaders are involved in many different state-level workgroups, taskforce and advisory groups that influence the practices at BCC.

Aligning current practices with this section of COMAR regulations, BCC will work collaboratively with MD Office of Health Care Quality (OHCQ) during the license application process to adopt OHCQ policies, standards and guidelines affecting the treatment, care and supervision of youth in the program. BCC's Residential Policy manual will be updated to reflect policies and procedures for the Bridge Program, aligned with OHCQ and MDH philosophy of service and guidelines, including (but not limited to) implementation of CDC guidance and emergency executive orders. BCC ensures that policies and procedures reflect the most current information through an established process of quarterly review and updates to the manuals, followed by an annual approval by the agency Board of Directors.

BCC is a member of state and national child advocacy groups and accreditation bodies that keep the agency current with child welfare trends and best practices. Such national advocacy organizations include but are not limited to: Association of Children's Residential Child Care Centers, Family Focused Treatment Association (FFTA), Maryland Association of Resources for Family & Youth (MARFY), Children's Home Society of America (CHSA), and United Methodist Association.

Strawbridge School

The Strawbridge School adheres to the Code of Federal Regulations relating to implementation of the Individuals with Disabilities Act (IDEA) and Section 504, offering specifically designed instruction that is adapted, as appropriate to the needs of an eligible child under this part, the content, methodology or delivery of instruction to ensure access of the general education curriculum so that the child can meet the educational standards with the jurisdiction of the public agency that apply to all children.

Student records are audited/reviewed upon entrance to ensure appropriate and necessary services are provided; delivered/owed services (OT, SLP and clinical) are tracked/managed by the Clinical Supervisor and the Director of Behavior & Related Services through the use of internal auditing procedures and through the EHR database.

The Strawbridge School also has procedures in place to meet State standards pursuant to the MD Education Article and its corresponding regulations. The process is overseen by a BCC Recruitment Specialist and all BCC new hires are subject to the regulation and therefore required to submit documentation upon hire. The procedure is as follows:

- Step 1: For ALL applicants, the Recruitment Specialist will complete and send the Request for Information on Applicant's Certification Status Form to MSDE, requesting MSDE to certify whether the applicant holds a valid certificate and whether such certificate has been suspended or revoked due to child abuse or child sexual misconduct.

- Step 2: For all applications, the applicant must complete and provide Board of Child Care (BCC) – The Strawbridge School with the top of page 1 and all of page 2 of the Employment History Review Form for (1) the applicant's current employer; and (2) ALL of the applicant's former employers listed on application (applies to out-of-state and out-of-country employers). Forms must be completed by the applicant during their scheduled interview; advise the applicant that the employers listed on their application should match those listed on the resume submitted.

- Step 3: The assigned Recruitment Specialist will send the Employment History Review Form via email, fax, or mail to each current and former employer, who shall have 20 calendar days to respond. HR will make a copy and keep record of the dates they sent the document, along with any response received from the current or former employer. If, after three documented attempts, the current or former employer still has not responded, the prospective employer may hire the employee, but should note what information is missing from the employee's background. The Recruitment Specialist will notate this information on the MSDE tracker located in the MSDE HR Forms folder.

  Upon receipt of a completed Employment History Review Form from a current or former employer, the Recruitment Specialist will record the following information on the bottom of page 2 of the form:

  [EMPLOYER USE ONLY] -- Date Form Received: _____received by: _____

- Step 4: AS NEEDED. If the current or former employer does not respond or refuses to respond due to an internal policy within 20 calendar days, after three documented attempts to contact the employer, BCC – The Strawbridge School may hire the applicant, but must complete and send the MSDE Employer Report Form to MSDE notifying of the employer's failure to comply with the law.

- Step 5: AS NEEDED. If a current or former employer answers yes to any question on the Employment History Review Form and BCC – The Strawbridge School wishes to further consider an applicant for employment, the Recruitment Specialist must (1) notify Amy Aromatorio and Nicole Wojcak; and (2) request additional information, including all records related to child sexual abuse or sexual misconduct. The current or former employer must provide this additional information within 60 days to both the prospective employer and the applicant

- Step 6. AS NEEDED. If BCC – The Strawbridge School suspects an applicant has failed to disclose information, or provided false information, Applicant Report Form must be completed and sent to the MSDE.

10.24.01.08G(3)(k). Accreditation and Certification

BCC has an extensive quality improvement process that monitors compliance with COMAR and other regulations, CARF and EAGLE accreditation standards, and generally national best practices. BCC's quality improvement efforts can be summarized by these four categories:

- Internal monitoring
- External licensing and contract monitoring
- CARF and EAGLE Accreditations
- Quality Measures

Accreditations hold BCC service delivery programs and support departments to national best practices standards. Accreditation monitoring visits and recommendations are utilized to continue improving all aspects of BCC's operations.

Commission on Accreditation of Rehabilitation Facilities (CARF)

BCC selected CARF accreditation because CARF is considered to have the highest standards in behavioral health and administrative practices for behavioral health organizations like BCC. BCC initiated accreditation with CARF in 2014 and went through its self-study and site visit in early December 2015. BCC was awarded three year accreditation in early 2016, scoring an amazing 98.4 percent proficiency in adherence to CARF standards. In November 2021, BCC went through a reaccreditation process with CARF International and EAGLE. Due to the high quality of services provided by programs across the agency's continuum, BCC was awarded with a 3 year accreditation period, which is the highest possible term for accreditation. Prior to CARF, BCC was accredited through COA (Council on Accreditation) for over 25 years. CARF has been approved by Health & Human Services as an accepted accreditation body for QRTP under the Families First Prevention Services Act (FFPSA). Visit carf.org for more information.

Educational Assessment Guidelines Leading Toward Excellence (EAGLE)

EAGLE is the only faith-based accrediting body in the world. It focuses on outreach ministry with older adults and children. BCC voluntarily seeks this accreditation, which is provided through the United Methodist Association, to go beyond the minimum requirements of licensure to improve operational processes and outcomes with an eye towards wellness. An update report is due annually and site visits are conducted every four years. EAGLE has been approved by several states as an approved accreditation body for QRTP services under FFPSA. Visit ouruma.org/programs-services/eagle/ for more information.

BCC intends for The Bridge Program to be accredited as an RTC program by CARF. The accreditation application, along with Medicaid certification, will be submitted as soon as permissible after opening and be jointly licensed as a Special Hospital Psychiatric Facility (COMAR 10.07.01) and as a Residential Treatment Centers (COMAR 10.07.04). CARF is accepted by the Center for Medicare and Medicaid Services (CMS) as an accrediting body for psychiatric residential treatment facilities. BCC looks forward to opportunities to partner with the Maryland Health Care Commission on considering CARF as an acceptable accreditation body for this program.

10.24.01.08G(3)(l). Criminal Background Investigations.

The safety and well-being of the youth entrusted to our care is of paramount concern to BCC. BCC requires that pre-employment CPS and criminal background checks are completed in the jurisdiction in which the employee resides and coordinates continuous updated checks and certifications as ongoing safeguards. Any new charges, arrests or convictions are directly communicated to the HR Department within 24 hours allowing the agency to respond quickly to ensure the safety of all youth. Any employee with a new finding, convicted or otherwise, is subject to termination of employment after an investigation of the occurrence. BCC completes CPS clearance every two years on all current employees for the jurisdiction in which they live and updates criminal background checks on an ongoing basis.

All BCC employees undergo an extensive LiveScan Fingerprint process to assess criminal history records. The program investigates the following:

- The age at which the individual committed the crime;
- The circumstances surrounding the crime;
- Any punishment imposed for the crime, including but not limited to any subsequent court actions regarding that punishment;
- The length of time that has passed since the crime;
- Subsequent work history;
- Employment and character references; and
- Other evidence that demonstrates whether the employee, contractor, or volunteer poses a threat to the health or safety of a program participant, program staff, or a member of the public.

Hiring Decisions- The program may not hire any individual, whether employee, contractor or volunteer if the program doesn't receive and consider the criminal history record information. If the criminal background check shows the individual has been convicted at any type of child abuse or child sexual abuse; or if the individual has been convicted of any type of abuse or neglect or a vulnerable adult.

If CHRI reveals charges that were not disclosed on the application, an employee shall be terminated for falsifying information. Clearances are kept under lock and key in the Human Resources Department, according to the Criminal History Record (CHRI) Policy.

10.24.01.08G(3)(m). Security.

Through consistency in daily routines, BCC strives for the youth to feel safe, secure, calm, and well in their environment to promote healthy development and positive social and behavioral functioning. Structure, predictability and consistent expectations helps the youth build a sense of security and psychological safety, leading to the development of relational safety and a sense of mastery in handling their lives.

The milieu environment will be designed in a way that promotes self-regulation, with direct care personnel present and attentive to the needs of the youth, attuned to their reactions and responses. The physical environment, combined with minimal unstructured time, provides opportunities for staff to teach and model self-regulation and relational skills in a setting that reinforces feelings of safety and wellness.

A number of physical site safety improvements will have to be made to the current living environment to ensure that the youth placed in this program are provided with a living environment that is therapeutically conducive to their stabilization and healing, while also safe, secure and optimized to deliver onsite educational and clinical services. Developing a fully contained program will minimize transitions for the youth and thus mitigate precipitating factors often involved in dysregulation, elopement and crisis escalation. Proposed modifications to the current available structure included: establishing secure exterior fencing to prevent unauthorized exit and entry to the designated area surrounding the Bridge facility; installation of enhanced exterior and interior security cameras; installation of anti-ligature hardware and installation of secure door systems. The physical modifications being considered as part of this proposal are critical to ensure the physical and emotional safety of high acuity youth as they stabilize in a therapeutic environment. BCC intends for physical facility improvements to be

initiated upon notice of contract award and to occur concurrently with the RTC licensure process.

In 2021, BCC received funding to support one time security enhancements to the existing infrastructure on BCC's Baltimore Campus. The enhancements include perimeter fencing and a video monitored entry / exit gate which support passive diversion of unauthorized persons on the campus, as well as provide monitoring capabilities to BCC personnel tasked with oversight of campus supervision and operations.

BCC further demonstrates its commitment to safety through the designation of a full-time Safety / Security Coordinator. This position is responsible for oversight, inspection, and evaluation of security related systems and processes on the Baltimore campus, including quarterly safety inspections and emergency response drills

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.

The impact of hospital overstay is wide reaching. For the behavioral health system, the impact translates to a lack of inpatient bed availability, extended ER stays, and a myriad of financial stressors. For the youth, the impacts are even more profound. These youth, who are diagnostically complex and already experiencing significant emotional and behavioral health challenges, are left feeling alone, isolated, and unwanted. The prolonged stay in an inpatient environment exacerbates the impacts of traumatic stress being experienced by the youth, interrupting their educational progress, and intensifying any existing deficits in their social and emotional development.

Board of Child Care's Bridge Program will accept placements for youth 14-20 who present with Emotional, Cognitive, and Developmental Disabilities (ECDD) and do not meet the criteria for inpatient treatment services to divert youth from hospitalization or other restrictive interventions and/or provide step-down support for youth transitioning from inpatient care or other restrictive settings.

The BCC hospital overstay program is designed to support youth that present with the following treatment needs:

1. Emotional & Developmental Delays
2. Impaired Cognitive Function (Moderate-Severe)
3. Self-Injurious Behaviors
4. Assistance with Daily Living Skills
5. Need for Increased Support
6. Poor Peer & Social Interactions
7. Speech & Language Delays
8. Aggressive / Assaultive Behavior
9. Frequent / Repeated Property Destruction
10. Fire Setter (history not recent/active)
11. Exposure to Adverse Childhood Traumatic Experiences

RELATED DSM 5 & NEURODEVELOPMENTAL DISORDERS

1. Autism Spectrum Disorders
2. Pervasive Developmental Disorders

3. Disruptive Mood Dysregulation Disorder
4. Bipolar Disorder
5. Depression and other Mood Disorder
6. Anxiety Disorder
7. Attention Deficit Hyperactivity Disorder
8. Conduct Disorder
9. Oppositional Defiant Disorder
10. Posttraumatic Stress Disorder (PTSD)
11. Co-Occurring Substance Use and Mental Health Disorders
12. Co-Occurring Mental Health Disorders and Medical Conditions

Due to the nature of the continuum of services offered on the Baltimore Campus, BCC's Bridge Program is not able to serve youth that have the following status or medical needs:

1. Sexual Offender (adjudicated)
2. Chronic Physical Health Condition (not yet well-managed)
3. Under Adult Probation
4. Violent Offender
5. Medically fragile
6. Pregnant

Youth referred for admission to the Bridge Program will be assessed based on a review of the following behavioral and diagnostic factors:

	Prioritized Population	Accepted	Not Served
First-time Misdemeanor Offender	☐	☒	☐
Adjudicated Delinquent	☐	☒	☐
Under Adult Probation	☐	☐	☒
Violent Offender	☐	☐	☒
Chronic Offender	☐	☒	☐
Aggressive/ Assaultive Behavior	☒	☐	☐
Frequent/ Repeat Property Destruction	☐	☒	☐
Fire Setter (recent/ active)	☐	☐	☒
Fire Setter (history/ only)	☐	☒	☐
Gang-Involved	☐	☒	☐
Sexual Offender	☐	☒	☐
Sexual Behavior Problem (NOT adjudicated as a sex offender)	☐	☒	☐
Alcohol and/or Drug User or Abuser	☐	☒	☐
Co-Occurring Substance Use and Mental Health Disorders	☐	☒	☐
Co-Occurring Mental Health Disorder and Medical Conditions	☐	☒	☐
Serious Emotional Disorder/Serious Mental Illness	☒	☐	☐
Anxiety Disorder	☒	☐	☐
Posttraumatic Stress Disorder (PTSD)	☒	☐	☐
Exposure to Domestic and/or Community Violence	☒	☐	☐
Reactive Attachment Disorder (history)	☒	☐	☐

Fetal Alcohol Syndrome	☐	☒	☐
Attention-Deficit Hyperactivity Disorder (ADHD)	☐	☒	☐
Conduct Disorder	☐	☒	☐
Oppositional Defiant Disorder	☐	☒	☐
Depressive and/or Other Mood Disorders	☒	☐	☐
Personality Disorder	☐	☒	☐
Autism Spectrum Disorder	☒	☐	☐
Learning Disorder/ Communication Disorder	☐	☒	☐
Mild Intellectual Disability (Intellectual Developmental Disorder)	☒	☐	☐
Severe Intellectual Disability (IDD)	☐	☒	☐
Eating Disorder	☐	☒	☐
Victim of Child Abuse/ Maltreatment/ Neglect	☒	☒	☐
Victim of Human Trafficking/ Commercially-Exploited	☐	☒	☐
Self-Harm/Self-Injurious Behavior	☒	☐	☐
Suicidal Ideation	☐	☒	☐
Homicidal Ideation	☐	☒	☐
Chronic Physical Health Condition (managed)	☐	☒	☐
Chronic Physical Health Condition (not yet well-managed)	☐	☒	☐
Medically Fragile	☐	☐	☒
Deaf/ Hard of Hearing	☐	☒	☐
Blind/ Visual Impairment	☐	☒	☐
Pregnant	☐	☐	☒
Teen Parent (i.e. serves as caregiver)	☐	☐	☒
LGBTQ	☐	☒	☐
Homeless/ Housing Unstable	☐	☒	☐
Runaway	☐	☒	☐
Truant/ Drop- Out	☐	☒	☐
Graduated High School/ Obtained GED	☐	☒	☐

Board of Child Care has developed the Bridge Program to provide residential stabilization services specifically tailored to meeting the needs of these highly complex, unpredictable and often aggressive youth. Leveraging our experience utilizing advancements in neuroscience to treat complex trauma, BCC will apply evidence-based, trauma responsive interventions to effectively support the youth entering into the program, engage families in treatment and work in partnership to find stability as the youth and families begin their journeys of healing and recovery.

The Bridge Program is seeking a new license for the facility at Cottage 1. The Bridge Program will be the first Residential Treatment Center under the Board of Child Care (BCC). BCC currently has licensure for ECDD, High Intensity, and Group Homes for youth residents. Therefore, the statistical projections for the entire facility will only reflect statistical projections for “Other” programs outlined in Table F of the table package for this application.

Table 1: Statistical Projections- Proposed Project

	Projected Years				
	FY2022	**FY2023**	**FY2024**	**FY2025**	**FY2026**
Total Patient Days	**1095**	**1095**	**730**	**730**	**730**
Total Average Length of Stay	**273.75**	**273.75**	**182.5**	**182.5**	**182.5**
Total Licensed Beds	**4**	**4**	**4**	**4**	**4**
Total Occupancy %	**100%**	**100%**	**100%**	**100%**	**100%**

To benefit from BCC's array of services, we believe the average length of stay will be roughly the same as the average length of stay for current residents at the Board of Child Care due to the significance of youth's need will be likely comparable to the Emotional, Cognitive and Developmental Disabilities (ECDD) youth we are currently serving. Board of Child Care also serves High Intensity adolescent youth who have histories of complex trauma and exhibit extreme aggressive behaviors. The population identified for the Bridges program will have similar characteristics from both groups. The average length of stay for ECDD youth is about 12 months and the average length of stay for High-Intensity youth average length of stay is approximately 9 months. However, the length of service of the other funded hospital overstay program is approximately 6 months. Assuming the length of stay will be approximately the same, we are conservatively projecting the length of stay for youth participating in the Bridge program for approximately 9 months (Mean of High Intensity and ECDD youth and other MDH hospital overstay providers), and decrease over time to align with similar providers (6 months)

Quality of Discharge

Understanding the quality of discharge and our ability to project quality moving forward depends on several factors. On average, across programming, 58% of clients have had a successful discharge. Successful discharges include transitioning back to family, lower level of care, or successfully completed program. Unsuccessful discharge includes transitioning to a higher level of care, need for more restrictive placement, or detained/transferred to a juvenile detention center. BCC will continue to monitor quality of discharge with programming including the proposed Bridge Program.

Admissions FY 21	**Monthly range**	**Yearly**
ECDD	1-5	10
High Intensity-Baltimore	3-5	15
High Intensity- Denton	0-1	3
CSE	0-3	7
Discharges FY 21	**Successful**	**Unsuccessful/Unknown**
ECDD	42%	58%
High Intensity- Baltimore	69%	31%
Denton	67%	33%
CSE	44%	56%

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 project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing facilities.

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 cost 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 goal and objective achievement or the most effective solution to the identified problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative 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.

The Hospital evaluation offered insight into the availability of placements for hospital overstay youth. Current RTCs don't offer the types of services needed to adequately address the ongoing needs of youth identified as at risk for hospital overstay. RTCs have not modified their services and programming address the needs of youth currently recommended for high level placement. However, such modifications would require reform and modification of RTC rates. In addition to issues discussed in the "Need" section of this application. In 2001 there were 14 RTCs with approximately 765 licensed and approved beds operating in eight jurisdictions. But in fast forward to 2018, three RTCs were closed, and the demand for RTC beds has continuously increased since 2018. In FY21 there were only six active residential treatment centers operating in Maryland with approximately 350 beds in only three jurisdictions.

Hospital overstay costs can range from approximately $2000-$9,000 a day depending on the lever of needs for the patient. The costs for RTC placements are about $561 per bed-day, on average in FY21 in Maryland. This rate is based on the patient maintenance costs. However, BCC proposes to:

1. Meet the immediate safety and crisis stabilization needs for youth and families.
    a. Within 24 hours of entry to the program, program participants will have created a personal safety plan.
    b. Within 72 hours of entry to the program, identified family or external supports will be contracted by a member of the care team.
    c. Identified family or external supports will be invited to participate in the youth's treatment planning.
    d. With these supports in place, the goal is to have youth served report an increased feeling of safety while in the Bridge Program.

2. Develop individualized treatment plans informed by comprehensive and culturally relevant assessments.
    a. Youth will have a CANS assessment completed after 30 days in the program.
    b. Youth will have a trauma assessment/ACE survey completed after 30 days in the program.
    c. Initial treatment plans will demonstrate inclusion of youth voice in the development of treatment goals.
    d. Youth referred for a neuropsychological evaluation will be scheduled for the evaluation while at BCC.
3. Assist youth and families in the development of skills that promote self-regulation, personal safety and health behaviors.
    a. Within 14 days of entry to the program, youth will have participated in at least 2 therapy sessions.
    b. Within 90 days of entry to the program youth will have participated in at least 8 life skills sessions.
    c. Within 90 days of entry to the program, youth will have attended educational programming.
    d. Within 120 days of entry to the program, youth will have demonstrated progress in treatment goals relating to their ability to self-regulate.
4. Engage supportive services and natural resources to successfully transition youth to lower levels of care.
    a. Youth will have a transition and discharge plan established as part of their initial treatment plan.
    b. Youth will be referred to local care team within 30 days prior to discharge
    c. Youth will be referred to community passed aftercare support within 30 days prior to discharge
    d. Youth discharged to lower level of care will be maintained in that level of care 30 days post discharge from BCC.

State health officials has dedicated approximately $5 million in funding to providers like BCC to offer services to those experiencing long hospital stays. They have also increased the daily rate for residential treatment providers can charge for services, increased the number of beds at residential treatment facilities, and soliciting assistance from providers like BCC to provide psychiatric treatment residential facilities for youth discharging from hospital overstay.

Hospital overstay cost drivers for the Bridge Adolescent Hospital Overstay Program should considers several factors to the overall per bed-day rate:

- Adjustment for inflation- Costs for inflation should include inflation for wages and compensation, as well as inflation in medical prescription drugs.
- Care Coordination- Staff costs, training and care coordination between nursing staff, behavioral health staff, educational staff and psychiatric staff all working to meet the needs of the youth in care.
- Set-aside for unforeseen adjustments- Many youth in hospital overstay present with aggressive and violent behavior towards self, staff and/or property. Depreciation and funding to cover unforeseen adjustments such as destroyed windows, doors, furniture, should all be considered to cost drivers for the Bridge Program.
- Complexity and innovation- Youth targeted for this program present with emotional and cognitive development disabilities, including autism. The complexity of supporting ECDD youth includes utilizing sensory integration therapy and research supported and/or

evidence-based interventions. See BCC's menu of Evidence-Supported Interventions in Exhibit 14.

- Meeting Maryland State educational requirements for youth in care on-site in "Cottage 1"- All youth in the Bridge program will participate in the Strawbridge School curriculum. This educational opportunity will take place in the Cottage 1 facility with the support of educational and behavioral support staff. A classroom will be available for students in the double locked facility.
- No Eject, No Reject policy- BCC has adjusted policy for this program, committing to take on the most challenging and hardest to place youth. See the No Eject No Reject Policy in Exhibit 15.

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

The Commission shall consider the availability of financial and non-financial 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 Tables 3 and/or 4 below, as applicable. Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item.

See Tables 3 & 4, to accompany the narrative below detailing each revenue and expense line item.

The funding plan includes the Maryland Department of Health grant award funding. This grant was awarded to BCC on March 11, 2022, with annual funding renewals anticipated through FY26, contingent upon the final approval of MDH proposed budget. Eligibility for the proposed project is supported by the fact that the grant funding awarded by MDH is specifically for the provision of services proposed within the Bridge Program. Medicare and MSDE reimbursements will also be used as part of the funding plan. Philanthropic sources of funds may be considered as fundraising/donor outreach will be targeted to meet the needs of the youth or program implementation. Additionally, BCC has an Endowment fund to use as part of the funding plan, as needed. No debt financing is expected for this proposal. Please refer to the Project Budget section of this application for more information.

Table

Expense Items	Description
Architect Fee	Consultation & engagement for ensuring the unit meets Institution fire and safety codes; Drafting of concept drawing and construction documents.
Bridge Program (Cottage 1) Security Upgrades	Bathroom (2) renovation with antiligature hardware installation, door hardening throughout interior unit, delayed egress door installation - entry vestibule, full perimeter fencing enclosing exterior green space.

Expense Items	Description
Bridge Program (Cottage 1) Flooring	Installation of wide width medical grade seamless vinyl flooring in all living spaces, with 4" wall coverage.
Construction Costs	Interior bifurcation / zoning of kitchen, medical, educational and living space, installation of sound panels, electric / HVAC modifications; installation of secure door systems.
Secure Door Systems	Installation of secure entry / exit exterior unit doors (3) and secure entry / exit gate.
Security Cameras	Security cameras will need to be added both to the interior and exterior of the unit. Four exterior cameras will be needed, the number of interior cameras will be dependent upon the final design of the unit but for the purpose of this estimate, BCC is assuming at least 6 additional interior cameras will be required. Estimate includes cost of cameras, cabling and installation.
Education Program – Technology & Classroom Materials	Classroom space will be equipped with 6 computers (laptops and desktops) for use by students during classroom time. TV's will be installed and secured for use in casting of lessons. Hot spots will be needed to support consistent Wi-Fi access for the devices. The classroom space dedicated to this program will be newly designed and basic equipment along with trauma informed classroom supplies will be used to create supported learning environments within the facility. Items including bulletin boards, games, fidgets, sensory / calming materials will be purchased from start up expenses.
Furniture	The unit will be fitted with safe, durable furnishings specifically designed for use in institutional settings. BCC utilizes Norix furniture, which is molded in specially formulated, high impact, fire-retardant polyethylene, offering contraband resistant, antiligature and hygienic options that are also aesthetically welcoming. It is estimated that furnishings for four bedrooms, two classrooms spaces and two shared space living areas will be needed. Additional office furnishings will be purchased for program personnel, including teacher's desks.

- Complete Table L (Workforce) from the Hospital CON Application Table Package.

TABLE H. WORKFORCE INFORMATION												
INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G.												
	CURRENT ENTIRE FACILITY			***PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)***			***OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)***			***PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) ****	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Assistant Program Director	6.0	$70,000	$420,000	1.0	$70,000	$70,000			$0	7.0	$490,000
Associate Program Director	2.0	$70,000	$140,000			$0			$0	2.0	$140,000
Assistant Principal	1.0	$80,000	$80,000			$0			$0	1.0	$80,000
Care Team Manager	2.0	$63,410	$126,820			$0			$0	2.0	$126,820
Chief Financial Officer	1.0	$165,000	$165,000							1.0	$165,000
Chief Human Resources Officer	1.0	$137,978	$137,978							1.0	$137,978
Chief Operating Officer	1.0	$147,481	$147,481							1.0	$147,481
Coordinator of Literacy	1.0	$86,165	$86,165							1.0	$86,165
Development Manager	1.0	$52,603	$52,603							1.0	$52,603
Director of Health Suite Program	1.0	$135,978	$135,978							1.0	$135,978
Director - Program	3.0	$86,453	$259,359							3.0	$259,359
Director of Behavioral & Intervention Support	1.0	$86,008	$86,008							1.0	$86,008

Director of Behavioral Health Services	1.0	$91,569	$91,569							1.0	$91,569
Director of Education	1.0	$99,340	$99,340							1.0	$99,340
Director of Finance	1.0	$120,245	$120,245							1.0	$120,245
Director of MD Foster Care	1.0	$96,000	$96,000							1.0	$96,000
Director of Program Supports	1.0	$83,000	$83,000							1.0	$83,000
Director of Programs in PA	1.0	$93,910	$93,910							1.0	$93,910
Director of Quality Improvement & Training	1.0	$98,000	$98,000							1.0	$98,000
Director of Res Programs	1.0	$105,560	$105,560							1.0	$105,560
Director of Residential Services	1.0	$89,898	$89,898							1.0	$89,898
Director of Support Services - WV & PA	1.0	$113,115	$113,115							1.0	$113,115
Director of Support Services - MD and DC	1.0	$102,000	$102,000							1.0	$102,000
Education Coordinator	3.0	$59,975	$179,925	1.0	$65,000	$65,000				4.0	$244,925
Electronic Health Record &QI Manager	1.0	$80,779	$80,779							1.0	$80,779
Executive Director - WV & PA	1.0	$154,234	$154,234							1.0	$154,234
Executive Director of Caminos	1.0	$150,020	$150,020							1.0	$150,020
Executive Director of MD & DC	1.0	$173,022	$173,022							1.0	$173,022
Finance Manager	1.0	$72,065	$72,065							1.0	$72,065
Human Resources Manager	1.0	$65,000	$65,000							1.0	$65,000
Interim Program Director	1.0	$81,027	$81,027							1.0	$81,027
IT Manager	1.0	$88,525	$88,525							1.0	$88,525
President and CEO	1.0	$390,000	$390,000							1.0	$390,000
Principal	1.0	$93,599	$93,599							1.0	$93,599
Professional Curriculum and Training Manager	1.0	$50,977	$50,977							1.0	$50,977
Senior Director of Development & Marketing	1.0	$104,000	$104,000							1.0	$104,000
Vice President of Programs	1.0	$127,773	$127,773							1.0	$127,773
Total Administration	48.0	$3,964,710	$4,740,976	2.0	$135,000	$135,000	0.0	$0	$0	50.0	$4,875,976

Direct Care Staff ***(List general categories, add rows if needed)***											
Awake Overnight Campus Supervisor	1.0	$58,551.00	$58,551			$0			$0	1.0	$58,551
Awake Overnight CCW Lead	2.0	$38,646	$77,292			$0			$0	2.0	$77,292
Awake Overnight CCW Frontend	4.0	$34,850	$139,402			$0			$0	4.0	$139,402
Awake Overnight Campus Supervisor Backend	1.0	$48,298	$48,298			$0			$0	1.0	$48,298
Behavior Coordinator	1.0	$71,628	$71,628							1.0	$71,628
Behavioral Intervention Specialist	1.0	$35,939	$35,939							1.0	$35,939
Campus Supervisor	4.0	$55,236	$220,946			$0			$0	4.0	$220,946
Campus Supervisor Weekend	2.0	$58,994	$117,988							2.0	$117,988
Care Team Coordinator	1.0	$61,000	$61,000							1.0	$61,000
Case Manager	24.0	$49,936	$1,198,469							24.0	$1,198,469
Case Manager - 11 month	1.0	$48,213	$48,213							1.0	$48,213
Casework Specialist	3.0	$53,171	$159,512							3.0	$159,512
Charge Nurse	1.0	$88,569	$88,569							1.0	$88,569
Child Care Associate	1.0	$44,054	$44,054							1.0	$44,054
Child Care Worker - Floater	66.0	$2,915	$192,368							66.0	$192,368
Child Care Worker Awake Overnight Backend	7.0	$33,775	$236,422							7.0	$236,422
Child Care Worker	126.0	$32,221	$4,059,899	24.0	$37,440	$898,560				150.0	$4,958,459
Child Care Worker Awake Overnight	9.0	$33,849	$304,640	8.0	$37,440	$299,520				17.0	$604,160
Child Care Worker Awake Overnight Frontend	5.0	$36,302	$181,509							5.0	$181,509
Child Care Worker Awake Overnight Frontend LD	2.0	$44,974	$89,947							2.0	$89,947
Child Care Worker Backend	4.0	$34,970	$139,880							4.0	$139,880
Child Care Worker Backend LD	1.0	$42,129	$42,129							1.0	$42,129
Child Care Worker Front End	14.0	$34,356	$480,984							14.0	$480,984
Child Care Worker Senior	2.0	$38,268	$76,535							2.0	$76,535
Cook	4.0	$30,586	$122,346							4.0	$122,346
Education Support Specialist	9.0	$36,752	$330,765							9.0	$330,765
Intensive Case Manager - VOCA	1.0	$55,000	$55,000							1.0	$55,000

Interim Lead Teacher	1.0	$42,890	$42,890							1.0	$42,890
Interim Teacher Assistant	1.0	$39,505	$39,505							1.0	$39,505
Lead Case Manager	3.0	$56,411	$169,234							3.0	$169,234
Lead Child Care Worker	1.0	$38,834	$38,834							1.0	$38,834
Lead Treatment Specialist	3.0	$39,409	$118,227	4.0	$40,000	$160,000				3.0	$278,227
Lead Treatment Support Specialist	11.0	$40,329	$443,618							11.0	$443,618
Nurse	3.0	$79,495	$238,486	3.0	$77,000	$231,000				3.0	$469,486
Nurse On-Call	3.0	$978	$2,935	3.0	$40,000	$120,000				3.0	$122,935
On-Call Supervisor	1.0	$51,172	$51,172							1.0	$51,172
One-to-One Aides	33.0	$32,145	$1,060,781							33.0	$1,060,781
Overnight Supervisor	3.0	$37,859	$113,578							3.0	$113,578
Permanent Technician SWAN Program	2.0	$24,856	$49,712							2.0	$49,712
Recreation Coordinator	2.0	$43,586	$87,173							2.0	$87,173
Strengthening Families Program Facilitator	1.0	$475	$475							1.0	$475
Teacher	7.0	$59,691	$417,836	1.0	$60,000	$60,000				7.0	$477,836
Teacher 11month	2.0	$73,596	$147,191							2.0	$147,191
Teacher - Art	1.0	$86,326	$86,326							1.0	$86,326
Teacher Assistant	21.0	$37,928	$796,480	1.0	$37,771	$37,771				21.0	$834,251
Teacher Assistant - 11 month	1.0	$36,114	$36,114							1.0	$36,114
Teacher Assistant DC	11.0	$34,050	$374,545							11.0	$374,545
Teacher Lead	9.0	$44,785	$403,069							9.0	$403,069
Teacher Music	1.0	$54,843	$54,843							1.0	$54,843
Teacher Phys ED 11 mth	1.0	$61,923	$61,923							1.0	$61,923
Teacher Provisional	6.0	$52,366	$314,198							6.0	$314,198
Teacher Prov 11 mth	1.0	$54,425	$54,425							1.0	$54,425
Treatment Team Manager	6.0	$64,188	$385,130							6.0	$385,130
Unit Supervisor	23.0	$45,692	$1,050,923	1.0	$50,000	$50,000				23.0	$1,100,923
Total Direct Care	455.0	$2,437,053.08	$15,321,907.65	45.0	$379,651	$1,856,851	0.0	$0	$0	487.0	$17,178,760
Support Staff *(List general categories, add rows if needed)*											
Administrative Assistant	7.0	$33,462	$234,233			$0				7.0	$234,233

Admissions Coordinator/Centralized Admission Coordinator	3.0	$57,428	$172,283			$0				3.0	$172,283
Bilingual TFC Recruitment Coordinator	1.0	$49,000	$49,000			$0				1.0	$49,000
Billing/Insurance Coordinator	1.0	$51,960	$51,960							1.0	$51,960
Business Coordinator	2.0	$51,818	$103,637							2.0	$103,637
Caminos Therapist II	1.0	$66,899	$66,899							1.0	$66,899
Caminos Therapist III	3.0	$69,767	$209,302							3.0	$209,302
Caminos Intake Specialist/Program Admin Assistant	3.0	$44,929	$134,786							3.0	$134,786
Clinical Supervisor	2.0	$63,850	$127,700							2.0	$127,700
COVID Screener	1.0	$30,440	$30,440							1.0	$30,440
Custodian/Housekeeper	3.0	$33,472	$100,417							3.0	$100,417
Development Associate	1.0	$44,990	$44,990							1.0	$44,990
Development Relations Coordinator	1.0	$51,489	$51,489							1.0	$51,489
Dietary Supervisor	1.0	$44,577	$44,577							1.0	$44,577
Executive Assistant	1.0	$68,931	$68,931							1.0	$68,931
Expressive Art Therapist	1.0	$63,000	$63,000							1.0	$63,000
Fleet Manager/Fleet Mechanic	1.0	$50,690	$50,690							1.0	$50,690
Grant Accountant	1.0	$61,915	$61,915							1.0	$61,915
Health & Wellness Coordinator	1.0	$38,480	$38,480							1.0	$38,480
HR/Recruitment Coordinator	2.0	$49,302	$98,605							2.0	$98,605
Human Resources Assistant	1.0	$52,291	$52,291							1.0	$52,291
Human Resources Generalist	3.0	$53,000	$159,000							3.0	$159,000
IEP Coordinator	1.0	$60,650	$60,650							1.0	$60,650
Intake Coordinator	1.0	$40,498	$40,498							1.0	$40,498
Intern	1.0	$12,480	$12,480							1.0	$12,480
IT Support Analyst	2.0	$51,893	$103,786							2.0	$103,786
Lead Therapist	1.0	$74,210	$74,210							1.0	$74,210
Maintenance Supervisor	2.0	$54,392	$108,784							2.0	$108,784
Maintenance Technician	10.0	$39,863	$398,630							10.0	$398,630
Medical Assistant	1.0	$48,402	$48,402							1.0	$48,402
Medical Coordinator	1.0	$72,950	$72,950							1.0	$72,950
Medical Office Assistant CMT	1.0	$39,603	$39,603							1.0	$39,603
Office Coordinator	1.0	$42,453	$42,453							1.0	$42,453

Office Manager	2.0	$52,495	$104,991							2.0	$104,991
On-Call Therapist IV	1.0	$4,187	$4,187							1.0	$4,187
On-Call Trainer	1.0	$520	$520							1.0	$520
Operations Administrative Assistant	3.0	$40,723	$122,168							3.0	$122,168
Operations Coordinator	2.0	$52,595	$105,189							2.0	$105,189
Program Manager	3.0	$63,637	$190,910							3.0	$190,910
Program Team Lead	1.0	$48,033	$48,033							1.0	$48,033
QI Associate	4.0	$46,497	$185,989							4.0	$185,989
Receptionist	1.0	$31,949	$31,949							1.0	$31,949
Recruiter	3.0	$48,333	$145,000							3.0	$145,000
Recruitment Assistant	1.0	$41,955	$41,955							1.0	$41,955
Regional Navigator	1.0	$50,393	$50,393							1.0	$50,393
Safety and Security Coordinator	1.0	$55,827	$55,827							1.0	$55,827
Senior Accounts Receivable Coordinator	1.0	$51,418	$51,418							1.0	$51,418
Spiritual Life Coordinator	2.0	$49,296	$98,592							2.0	$98,592
Therapist/Clinician	19.0	$59,330	$1,127,266	1.0	$57,855	$57,855				19.0	$1,127,266
Training Specialist	1.0	$55,000	$55,000							1.0	$55,000
Wellness Coordinator				1.0	$55,000	$55,000					
Wraparound Facilitators	2.0	$53,112	$106,223							2.0	$106,223
Wraparound Family Engagement Specialist	2.0	$32,321	$64,641							2.0	$64,641
	114.0	***$2,506,704***	$2,506,704	***2.0***	***$112,855***	$112,855	***0.0***	***$0***	$0	116.0	$2,619,559
Total Support											
REGULAR EMPLOYEES TOTAL											
2. Contractual Employees			$0			$0			$0	0.0	$0
Administration *(List general categories, add rows if needed)*			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration	0.0	$0	$0	0.0	$0	$0	0.0	$0	$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*			$0			$0			$0	0.0	$0

			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff	0.0	$0	$0	0.0	$0	$0	0.0	$0	$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CONTRACTUAL EMPLOYEES TOTAL											
TOTAL COST	***114.0***		***$22,569,588***	***49.0***		***$2,104,706***	***0.0***		***$0***		***$24,674,295***
Benefits *(State method of calculating benefits below)**:***			$5,868,093			$547,224					$6,415,317
Benefits are calculated at 26% of base pay. The agency provides for FICA, state unemployment and, workers compensation insurance in accordance with the federal and state laws. In addition, medical and dental insurance is provided to each full time employee after the completion of the first full month of employment. The agency pays 73% of the coverage and the employee is responsible for 27% of the cost. The agency provides term life insurance at 2 times the base salary of each employee, Long Term Disability and an Employee Assistance Program at no cost to the employee. The agency maintains a defined contribution pension plan (403b) and other voluntary benefit options.											

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.

Board of Child Care (BCC) is over 140 years old and has provided a diverse portfolio of services in multiple State and County jurisdictions. Board of Child Care, designated as a 5013c non-profit (see Exhibit 13), has a proven track record of financial integrity during all types of business and economic cycles. BCC utilizes Microsoft Dynamics 2018 accounting package to account for all agency financial transactions. This program is configured to account for federal, state and other applicable awards in accordance with OMB requirements as promulgated in the applicable circulars. Third party financial monitoring includes annual independent audit procedures conducted by Clifton Larson Allen. All financial audits are submitted to the BCC Board of Directors for review. BCC's business operation has well-tested financial infrastructure and fiscal policies that are governed by GAAP, overseen by a seasoned management team and Board of Directors, and thoroughly and routinely scrutinized by its independent auditing firm, Clifton Larson Allen, as well as multiple accrediting bodies that include CARF and EAGLE.

During the review of BCC's financial capability, it is important to note that the organization has a long history of providing significant support to its programs through fundraising efforts and substantial contributions from its investment resources. The organization maintains an annual investment policy that designates assets to be used for the continued support of its programs. Audited financial statements have been included in the Budget Package (see Exhibit 11a & b) with this application to demonstrate evidence of the organization's financial stability and working capital.

- If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.

There is no debt financing proposed as part of this project. The Bridge Program is funded by a grant through the Maryland Department of Health. This grant was awarded to BCC on March 11, 2022 with annual funding renewals anticipated through FY26, contingent upon the final approval of MDH proposed budget. Eligibility for the proposed project is supported by the fact that the grant funding awarded by MDH is specifically for the provision of services proposed within the Bridge Program.

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

The Maryland Department of Health (MDH) developed the Adolescent Overstay Grant Program to provide support to adolescent populations experiencing extended and repetitive stays in the hospital for psychiatric purposes. This program was developed in conjunction with the Maryland

Children's Cabinet and benefits from the expressed support of the Maryland Department of Human Services (DHS) as well as the Maryland Department of Juvenile Justice.

Board of Child Care has met with officials from DHS to notify them of the proposed project and is working in collaboration with DHS to ensure that the project is brought forward without disruption to the DHS licensed facilities also operated by Board of Child Care. DHS continues to be a supportive partner in the development of BCC's Bridge Program.

- Identify the performance requirements applicable to the proposed project (see question 12, "Project Schedule") 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, obtaining State and local land use, environmental, and design approvals, contracting 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(s).

Two project leads have been identified to initiate implementation of the project. The Director of Support Services for MD/DC will monitor the scheduled renovations on Cottage 1. The Director of Special Operations will monitor the program installation (training plan, recruitment, staffing plan) and initial implementation of the programming (bed capacity met, program reporting). The project team identified will use Asana, for project management purposes, tracking the workflow and moving parts of the implementation of the Bridge Program, including construction/renovations, staff training, staff recruitment, licensing, fiscal matters, and other program implementation activities. The performance requirements are marked in Asana as milestones (deliverables) and will be assigned to the Director of Special Operations and/or Executive Director of MD/DC Program for completion in compliance with performance requirements. We have received the permit to initiate renovations to "Cottage 1". The project schedule outlined in Exhibit 5 demonstrates that the project can be completed within the applicable time frame(s). Additionally, Exhibits 6 (Construction Documents) & 7 (Construction Project Manual) outline the renovation/construction project in detail.

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**					
1. REVENUE										
Purchase of Care	$ 36,834,595	$ 41,349,356	$ 56,750,435	$ 61,290,470	$ 66,193,707					
Gifts and Bequests	$ 788,761	$ 1,176,547	$ 828,199	$ 869,609	$ 913,089					
Grants	$ 1,585,089	$ 2,819,838	$ 870,571	$ 914,100	$ 959,805					
Contributions	$ 762,860	$ 589,033	$ 1,134,200	$ 1,190,910	$ 1,250,456					
Adoption Reimbursements	$ 29,400	$ 40,000	$ 28,000	$ 29,400	$ 30,870					
Gross Patient Service Revenues	***$ 40,000,705***	***$ 45,974,774***	***$ 59,611,405***	***$ 62,160,079***	***$ 67,106,797***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt										
d. Contractual Allowance										
e. Charity Care										
Net Patient Services Revenue	***$ 40,000,705***	***$ 45,974,774***	***$ 59,611,405***	***$ 62,160,079***	***$ 67,106,797***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 80,359	$ 53,519	$ 55,000	$ 57,750	$ 60,638					
NET OPERATING REVENUE	***$ 40,081,064***	***$ 46,028,293***	***$ 59,666,405***	***$ 62,217,829***	***$ 67,167,434***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 39,891,369	$ 40,832,847	$ 48,578,825	$ 51,007,766	$ 53,558,155					
Contractual Services	$ 1,077,703	$ 1,251,455	$ 1,078,602	$ 1,132,532	$ 1,189,159					
Interest on Current Debt	$ 85,194	$ 91,725	$ 85,497	$ 89,772	$ 94,260					
Office Equipment	$ 236,367	$ 610,453	$ 518,907	$ 544,852	$ 572,095					

Depreciation	$ 2,625,843	$ 2,826,307	$ 2,683,795	$ 2,817,985	$ 2,958,884					
Recreational Expenses	$ 32,003	$ 39,373	$ 68,038	$ 71,440	$ 75,012					
Telephone	$ 648,613	$ 671,347	$ 712,824	$ 748,465	$ 785,888					
Postage	$ 58,180	$ 58,258	$ 59,780	$ 62,769	$ 65,907					
Occupancy/Utilities/Repairs	$ 3,360,310	$ 3,975,454	$ 4,533,713	$ 4,760,399	$ 4,998,419					
Printing Publications	$ 162,710	$ 167,968	$ 252,529	$ 265,155	$ 278,413					
Mileage/Travel/Vehicle/Lodging	$ 359,707	$ 461,308	$ 834,827	$ 876,568	$ 920,397					
Assistance to Children	$ 670,867	$ 633,880	$ 747,543	$ 784,920	$ 824,166					
Dues	$ 87,053	$ 281,912	$ 322,296	$ 338,411	$ 355,331					
Recruitment/Staff Development	$ 768,737	$ 652,692	$ 762,977	$ 801,126	$ 841,182					
Project Amortization				$ -	$ -					
Supplies	$ 2,218,680	$ 2,271,401	$ 2,457,270	$ 2,580,134	$ 2,709,140					
Other Expenses (Specify/add rows if needed)	$ 138,689	$ 108,948	$ 118,133	$ 124,040	$ 130,242					
TOTAL OPERATING EXPENSES	**$ 52,422,025**	**$ 54,935,328**	**$ 63,815,556**	**$ 67,006,334**	**$ 70,356,650**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
3. INCOME										
a. Income From Operation	**$ (12,340,961)**	**$ (8,907,035)**	**$ (4,149,151)**	**$ (4,788,505)**	**$ (3,189,216)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income	$ 23,894,287	$ 9,762,012	$ 4,300,388	$ 10,250,113	$ 10,762,618					
SUBTOTAL	***$ 11,553,326***	***$ 854,977***	***$ 151,237***	***$ 5,461,608***	***$ 7,573,402***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 11,553,326***	***$ 854,977***	***$ 151,237***	***$ 5,461,608***	***$ 7,573,402***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%					
2) Medicaid	6.0%	6.0%	9.0%	9.0%	9.0%					
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%					

4) Commercial Insurance	0.0%	0.0%	0.0%	0.0%	0.0%					
5) Self-pay	0.0%	0.0%	0.0%	0.0%	0.0%					
6) Other	94.0%	94.0%	91.0%	91.0%	91.0%					
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%					
2) Medicaid	6.0%	6.0%	9.0%	9.0%	9.0%					
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%					
4) Commercial Insurance	0.0%	0.0%	0.0%	0.0%	0.0%					
5) Self-pay	0.0%	0.0%	0.0%	0.0%	0.0%					
6) Other	94.0%	94.0%	91.0%	91.0%	91.0%					
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTION: Each applicant should complete this table for the proposed project only)

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY										
1. REVENUE										
Purchase of Care	$ 36,834,595	$ 41,349,356	$ 59,587,957	$ 64,354,993	$ 69,503,393					
Gifts and Bequests	$ 788,761	$ 1,176,547	$ 828,199	$ 869,609	$ 913,089					
Grants	$ 1,585,089	$ 2,819,838	$ 914,100	$ 959,805	$ 1,007,795					
Contributions	$ 762,860	$ 589,033	$ 1,190,910	$ 1,250,456	$ 1,312,978					
Adoption Reimbursements	$ 29,400	$ 40,000	$ 29,400	$ 30,870	$ 32,414					
Gross Patient Service Revenues	***$ 40,000,705***	***$ 45,974,774***	***$ 62,550,565***	***$ 67,465,732***	***$ 72,769,669***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt										
d. Contractual Allowance										
e. Charity Care										
Net Patient Services Revenue	***$ 40,000,705***	***$ 45,974,774***	***$ 62,550,565***	***$ 67,465,732***	***$ 72,769,669***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 80,359	$ 53,519	$ 57,750	$ 62,370	$ 67,360					
NET OPERATING REVENUE	***$ 40,081,064***	***$ 46,028,293***	***$ 62,608,315***	***$ 67,528,102***	***$ 72,837,028***	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 39,891,369	$ 40,832,847	$ 51,007,766	$ 53,558,155	$ 56,236,062					
Contractual Services	$ 1,077,703	$ 1,251,455	$ 1,132,532	$ 1,189,159	$ 1,248,617					

Interest on Current Debt	$ 85,194	$ 91,725	$ 89,772	$ 94,260	$ 98,973					
Office Equipment	$ 236,367	$ 610,453	$ 544,852	$ 572,095	$ 600,700					
Depreciation	$ 2,625,843	$ 2,826,307	$ 2,817,985	$ 2,958,884	$ 3,106,828					
Recreational Expenses	$ 32,003	$ 39,373	$ 71,440	$ 75,012	$ 78,762					
Telephone	$ 648,613	$ 671,347	$ 748,465	$ 785,888	$ 825,183					
Postage	$ 58,180	$ 58,258	$ 62,769	$ 65,907	$ 69,203					
Occupancy/Utilities/Repairs	$ 3,360,310	$ 3,975,454	$ 4,760,399	$ 4,998,419	$ 5,248,340					
Printing Publications	$ 162,710	$ 167,968	$ 265,155	$ 278,413	$ 292,334					
Mileage/Travel/Vehicle/Lodging	$ 359,707	$ 461,308	$ 876,568	$ 920,397	$ 966,417					
Assistance to Children	$ 670,867	$ 633,880	$ 784,920	$ 824,166	$ 865,374					
Dues	$ 87,053	$ 281,912	$ 338,411	$ 355,331	$ 373,098					
Recruitment/Staff Development	$ 768,737	$ 652,692	$ 801,126	$ 841,182	$ 883,241					
Project Amortization				$ -	$ -					
Supplies	$ 2,218,680	$ 2,271,401	$ 2,580,134	$ 2,709,140	$ 2,844,597					
Other Expenses (Specify/add rows if needed)	$ 138,689	$ 108,948	$ 124,040	$ 130,242	$ 136,754					
TOTAL OPERATING EXPENSES	**$ 52,422,025**	**$ 54,935,328**	**$ 67,006,334**	**$ 70,356,650**	**$ 73,874,483**	**$ -**	**$ -**	**$ -**	$ -	$ -
3. INCOME										
a. Income From Operation	**$ (12,340,961)**	**$ (8,907,035)**	**$ (4,398,018)**	**$ (2,828,548)**	**$ (1,037,455)**	**$ -**	**$ -**	**$ -**	$ -	$ -
b. Non-Operating Income	$ 23,894,287	$ 9,762,012	$ 4,945,446	$ 5,439,991	$ 5,983,990					
SUBTOTAL	***$ 11,553,326***	***$ 854,977***	***$ 547,428***	***$ 2,611,443***	***$ 4,946,535***	**$ -**	**$ -**	**$ -**	$ -	$ -
c. Income Taxes										
NET INCOME (LOSS)	***$ 11,553,326***	***$ 854,977***	***$ 547,428***	***$ 2,611,443***	***$ 4,946,535***	**$ -**	**$ -**	**$ -**	$ -	$ -
4. PATIENT MIX										

a. Percent of Total Revenue										
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%					
2) Medicaid	6.0%	6.0%	7.0%	7.0%	7.0%					
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%					
4) Commercial Insurance	0.0%	0.0%	0.0%	0.0%	0.0%					
5) Self-pay	0.0%	0.0%	0.0%	0.0%	0.0%					
6) Other	94.0%	94.0%	93.0%	93.0%	93.0%					
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	0.0%	0.0%	0.0%	0.0%	0.0%					
2) Medicaid	6.0%	6.0%	7.0%	7.0%	7.0%					
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%					
4) Commercial Insurance	0.0%	0.0%	0.0%	0.0%	0.0%					
5) Self-pay	0.0%	0.0%	0.0%	0.0%	0.0%					
6) Other	94.0%	94.0%	93.0%	93.0%	93.0%					
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

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

No Certificates of Need have been issued to Board of Child Care over the past 15 years.

On June 1 2019, Board of Child Care was awarded contracts resulting from Maryland Department of Human Services (DHS) Statement of Need solicitations seeking Residential Child Care (RCC) providers to develop population specific programs to serve:

- The increasing numbers of youth found to be victims of child maltreatment because of involvement in sex trafficking, and
- Youth described as Emotionally, Cognitively and Developmentally Delayed (ECDD).

Board of Child Care has maintained compliance with the terms and conditions of both awards and has been awarded the opportunity to expand programming for the ECDD population from 6 beds to a total of 20 beds across two Maryland locations.

Additional information pertaining to the Statement of Need compliance is available should it be necessary for the purposes of this application.

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. 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, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:

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;

Based on the Maryland Department of Health and Behavioral Health Administration, and the Maryland Hospital's Association report, the volume of service provided by other existing health care providers are limited to this population. As a result of the Pediatric Hospital Data Collection Project, none of the existing providers will be impacted because the current landscape doesn't have the capacity to serve the youth identified for this program. Many of the current providers have limitations on the level of services needed for this population. As a result, only two new providers have been identified to offer a "bridging residential therapeutic environment" in a Residential Treatment Center capacity, those providers include Board of Child Care and one additional facility located in Western Maryland. Board of Child Care anticipates limited impact to existing health care providers as currently structured; however, as the need increases for adolescent hospital overstay beds, current RTC's may choose to make adjustments to meet the needs of these youth, in turn having an impact on the volume of service provided by similar health care/behavioral health providers. The Needs assessment of this application offers addition detail to the need for the Bridge Program.

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant for a new nursing home claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.

The Board of Child Care (BCC) Adolescent Overstay "Bridge" Program has been designed to provide intensive services for stabilization of youth following discharge from an inpatient hospitalization. This proposed rate supports placement needs of an Overstay population meeting the profile of youth with Emotional, Cognitive and Developmental Disabilities (ECDD). Additional positions are included to support delivery of educational services in compliance with state and federal regulations and provide support for the clinical, crisis response and stabilization needs of this highly acute population. A 2:1 awake hour ratio is currently required by contract for BCC's ECDD High Intensity Group Home program. BCC acknowledges that youth may not require a 2:1 ratio for the duration of their placement in the program.

RTC Medicaid Rate is estimated reimbursement for BCC's RTC Medicaid rate, utilizing a per diem of $600 for this calculation. Utilizing a 90% occupancy rate, it is estimated that BCC will receive $788,400 annually in Medicaid reimbursement for the Bridge Program.

MSDE Rate: Also included in this calculation is BCC's current MSDE per diem rate for Type I (Level V, NP) education students. The current MSDE per diem is $326.55. Based on the assumption that 100% of the youth referred to this program will be Type I eligible, it is estimated that BCC will receive $274,302 annually in MSDE reimbursement for educational costs associated with the Bridge Program.

Board of Child Care is interested in working with the Department of Health to develop program parameters and contractual agreements for multi-year award of funding for a period of up to five (5) years subject to compliance with performance standards and expectations of care. BCC acknowledges that as a new service line, many assumptions and unknowns have been accounted for in the development of this annual budget. BCC is willing to participate in a single source audit after one year of operations in order to evaluate the true cost of care for the Bridge Program and will adjust the annual budget as needed based upon the audit findings.

The impact on payer mix, as a result of this project will have limited impact due to the limited number of providers serving this population coupled with the overall capacity of this project. The number served in this program is limited to four (4) youth. Board of Child Care plans to negotiate better fees to meet the level of services offered for this program, outside of the services for other Board of Child Care programs. This fee will address the dual diagnosed and behavioral health needs of the youth. As Medicaid would be the primary source of funding for youth in this residential treatment, the impact would be negligible.

Given that the Bridge Program is specifically designed to serve a population that is negatively impact Maryland's behavioral healthcare system, it is reasonable to state that the addition of Adolescent Overstay beds to the current Statewide availability of RTC beds will generate positive financial impacts for the hospital system as well as strengthen the referral pipeline for traditional RTC providers across the State. The Bridge Program is designed to provide a stepdown level of care for youth from an inpatient setting. Once in the program, youth will receive secure stabilization, assessment and treatment supported by comprehensive discharge planning. Once youth have achieved stability in the Bridge Program environment, the team will work to transition the youth to a lower level of care, which may include a traditional RTC environment.

c) 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);

The access to the health care services for this population will offer placement opportunities for "hard to place" youth discharging from the hospital, preventing overstay youth. Many "hard to place youth" transitioning from the hospital may display aggressive behaviors, dual diagnosed development disabilities and/or autism with psychiatric features, sexually-reactive behaviors, or too young or too old which may disqualify them for current service providers. The Bridge Program's No Reject, No Eject policy. The policy details the following:

Policy: Board of Child Care strives to ensure that the individual clinical needs of the youth can be met in the most comprehensive yet efficient, effective and economical manner possible. BCC's Bridge Residential Treatment Program serves youth with a need for short-term crisis stabilization while awaiting placement in either a higher or lower-level care. BCC will operate contractually according to a "no eject/no reject" policy with regards to admissions and discharges. That is, all youth referred by the program's contracting agency that meet the BCC provider profile will be eligible for services.

This policy and the structure of the Bridge Program increases access to health care services for this population, as outlined in this the Interagency Plan: Developing Resources to Address the Complex Needs of Maryland Youth in Care report[13]. See Exhibit 15 for a copy of the No Eject No Reject Policy.

d) On costs to the health care delivery system.

The health care system would benefit from having an increased number of therapeutically indicated beds available for vulnerable youth with ECDD that have been medically cleared for discharge from an inpatient setting and are pending placement into a safe, supported and appropriate environment. With Maryland's limited capacity to meet the needs of these youth with existing RTC's, the Bridge Program offers an opportunity to decrease the current bottleneck of youth negatively impacting psychiatric bed availability across Maryland hospitals. By offering an alternative to inpatient care, BCC's Bridge Program provides families and the various State of Maryland systems that support youth some relief to the costs associated with hospital overstay. The Bridge Program provides an option for overstay youth to transition to a structured, therapeutic environment with evidence-based treatment. Additionally, the Bridge Program provides an appropriate level of step-down care for these youth. Placing adolescents in appropriate settings after discharge gives them the opportunity to get expert care around the clock, gain strength in their recovery through intensive psychotherapy offered through the Bridge Program, resulting in a decrease in psychotic episodes, decrease in aggressive behaviors and/or suicide attempts – all of which have a long term positive impact to the health care delivery system, as well as the communities in which these youth and families live.

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

[13] http://goccp.maryland.gov/wp-content/uploads/Childrens-Cabinet-Interagency-Hospital-Overstays-Plan.pdf

Not Applicable. The proposed project does not currently exist as part of the continuum of services offered by Board of Child Care.