

## 2. Project Description

Steward Health Care System LLC (“Steward” or the “Applicant”) with a principal place of business at 1900 Pearl Street, Suite 2400, Dallas, TX 75201 is filing a Notice of Determination of Need (“Application”) with the Massachusetts Department of Public Health (“Department”) for a substantial capital expenditure for Good Samaritan Medical Center (“GSMC”) located at 235 North Pearl St., Brockton, MA 02301. GSMC is an acute-care hospital with 224 beds and provides comprehensive inpatient and outpatient psychiatric services and is the Level III Trauma center serving Brockton and 22 neighboring communities.

The patient panel (and Massachusetts at large) continues to experience an increased prevalence of behavioral health conditions, further exacerbated by the COVID-19 Pandemic. In addition, the project will fulfill the Applicant’s obligation to replace the closed inpatient psychiatric beds at Norwood Hospital, while improving access to both inpatient and outpatient psychiatric services. To that end, the Applicant seeks approval to construct a new behavioral health facility on GSMC’s campus, that will accommodate sixteen (16) inpatient psychiatric beds relocated from GSMC’s main campus and sixty-one (61) inpatient psychiatric beds (39 adult beds; 22 geriatric beds) previously operated at Norwood Hospital, for a total of 77 beds, as well as one floor of shell space for future build out (“Proposed Project”). The facility will have 2 adult inpatient units (39 beds) and 2 geriatric inpatient units (38 beds). In addition, the facility will provide services to inpatients and outpatients, including electroconvulsive therapy (“ECT”), partial hospitalization program, trans-magnetic stimulation (“TMS”) and activity therapy. Through the Proposed Project, the Applicant will meet the needs of its patient panel by providing timely access to psychiatric care in the most appropriate setting, improving outcomes and meeting the Commonwealth’s goals for cost containment.

### Factor 1: Applicant Patient Panel Need, Public Health Values and Operational Objectives

#### F1.a.i

##### **Patient Panel:**

**Describe your existing Patient Panel, including incidence or prevalence of disease or behavioral risk factors, acuity mix, noted health disparities, geographic breakdown expressed in zip codes or other appropriate measure, demographics including age, gender and sexual identity, race, ethnicity, socioeconomic status and other priority populations relevant to the Applicant’s existing patient panel and payer mix.**

#### A. Steward Health Care System LLC

The Applicant is a for-profit healthcare system with a large network of acute care hospitals, urgent care centers, and physician practices. The Applicant operates 9 hospitals in Massachusetts. To determine need for the Proposed Project, the Applicant relied on patient panel information from its Massachusetts hospitals (“Steward Northeast”)<sup>1</sup> and the patient panel of GSMC to determine need for the Proposed Project.

Steward Northeast hospitals serve a large and diverse patient panel, as demonstrated by the utilization data for the 36-month period covering Fiscal Years (“FY”) 19 (Quarter 4, or Q4), 20, 21, and 22 (Q1-Q3).<sup>2</sup> In FY22 (Q1-Q3), Steward served approximately 350,342 patients (467,123 annualized), an increase of 6.22% from FY20. The following table details the characteristics of Steward Northeast hospitals’ Patient Panel.

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<sup>1</sup> Carney Hospital, Good Samaritan Medical Center, Holy Family Hospital, Morton Hospital, Nashoba Valley Medical Center, New England Sinai Hospital, Norwood Hospital, St. Anne’s Hospital, and St. Elizabeth’s Medical Center.

<sup>2</sup> The Applicant and GSMC’s fiscal year (“FY”) is defined as the calendar year of January 1 – December 30 throughout the entirety of this narrative.

**TABLE 1: Steward Northeast Overall Patient Panel**

Demographic Measure	FY19 (Q4)		FY20		FY21		FY22 (Q1, Q2, Q3)	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
<b>Age</b>								
0 to 18	18,742	10.36%	44,771	10.18%	42,530	9.64%	33,280	9.50%
19 to 45	51,738	28.61%	142,402	32.38%	140,359	31.80%	107,634	30.72%
46 to 64	58,481	32.34%	139,779	31.79%	140,233	31.78%	108,735	31.04%
65+	51,860	28.68%	112,819	25.65%	118,178	26.78%	100,693	28.74%
Total	180,821	100.00%	439,771	100.00%	441,300	100.00%	350,342	100%
<b>Gender</b>								
Female	104,267	57.66%	246,184	55.98%	249,777	56.60%	198,927	56.78%
Male	75,409	41.70%	191,150	43.47%	189,830	43.01%	149,489	42.67%
Unknown <sup>3</sup>	1,145	.63%	2,437	.55%	1,693	.38%	1,926	0.55%
Total	180,821	100.00%	439,771	100.00%	441,300	100.00%	350,342	100.00%
<b>Race</b>								
African American	19,236	10.64%	47,025	10.69%	47,756	10.82%	38,756	11.06%
American Indian or Alaska Native	250	0.14%	597	0.14%	578	0.13%	496	0.14%
Asian	5,843	3.23%	11,935	2.71%	12,382	2.81%	10,296	2.94%
Declined <sup>4</sup>	2,123	1.17%	6,008	1.37%	6,104	1.38%	3,819	1.09%
Hispanic	20,615	11.40%	48,291	10.98%	51,886	11.76%	44,586	12.73%
Native Hawaiian or Other Pacific Islander	102	0.056%	211	0.048%	188	0.043%	172	0.049%
Other <sup>5</sup>	8,206	4.54%	27,345	6.22%	25,899	5.87%	20,695	5.91%
Unable to Obtain <sup>6</sup>	1,255	0.69%	5,572	1.27%	5,252	1.19%	4,460	1.27%
White	123,191	68.13%	292,787	66.58%	291,255	66%	227,062	64.81%
Total	180,821	100.00%	439,771	100.00%	441,300	100.00%	350,342	100.00%

<sup>3</sup> “Unknown” is defined as not recorded as male or female.

<sup>4</sup> “Declined” indicates the patient declined to provide.

<sup>5</sup> “Other” indicates not included in any of the categories mentioned in the table.

<sup>6</sup> “Unable to Obtain” indicates staff was unable to obtain from the patient due to trauma situations or patient was unconscious.

Payer	FY19	FY20	FY21
Commercial PPO/Indemnity	13.22%	13.26%	13.23%
Commercial HMO/POS	12.67%	12.85%	12.57%
MassHealth	12.55%	12.81%	13.34%
Managed Medicaid	6.73%	6.92%	6.91%
Commercial Medicare	11.68%	12.56%	14.92%
Medicare FFS	37.30%	35.52%	33.12%
All Other <sup>7</sup>	5.84%	6.06%	5.92%
Total	100%	100%	100%

Payer	FY19	FY20	FY21
APM/ACO Contracts	22.96%	22.32%	21.80%
Non-APM/Non-ACO Contracts	77.04%	77.68%	78.20%
Total	100%	100%	100%

**Age:** The age breakdown of Steward's Patient Panel remained relatively consistent between FY19 (Q4) and FY22 (Q1-Q3), with the largest percentage of patients in the 46-64 age cohort, followed by 19-45 and 65+ age cohorts, accordingly.

**Gender:** Steward's Patient Panel is approximately 57% female, 43% male, and 1% unknown. These percentages are largely unchanged between FY19 (Q4) and FY22 (Q1-Q3).

**Race and Ethnicity:** Data reported between FY19 (Q4) and FY22 (Q1-Q3) indicate that the majority of Steward's patients self-identified as White (66%). Patients also self-identified as Hispanic (12%), African American (11%), Other (6%), Asian (3%) and Declined (1%). Less than 1% self-identified as American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, or "unable to obtain". These percentages were largely unchanged between FY19 (Q4) and FY22 (Q1-Q3).

**Payer Mix:** Between FY19 and FY21, on average, 35% of all Steward patients were covered by Medicare Fee for Service ("FFS"); followed by approximately 26% of patients who had commercial insurance and approximately 13% of patients who had MassHealth and Commercial Medicare. From FY19 to FY21, there was a slight increase of 3.24% in patients who were covered by Commercial Medicare, and a slight decrease of approximately 4.18% in patients who had Medicare FFS.

#### B. Good Samaritan Medical Center

There are an estimated 603,240<sup>8</sup> people that reside in GSMC's service area. GSMC is an acute-care hospital with 224 beds and provides comprehensive inpatient, outpatient, and Level III Trauma emergency services to Brockton and 22 neighboring communities. GSMC provides services that also include orthopedics, oncology, cardiology, specialized care in surgery, family-centered obstetrics with Level II special care nursery, and advanced diagnostic imaging. GSMC is the only Level III trauma center in Region V. GSMC's primary service area includes: Brockton, Taunton, Stoughton, Norwood, Raynham, Randolph, Mansfield, Norton, Bridgewater, Canton, East Bridgewater, West Bridgewater, Whitman, Abington, Avon,

<sup>7</sup> "All Other" includes but is not limited to: Medicaid-Other; Noninsurance payors; QHP-Connector Plans; and Self-pay/free care.

<sup>8</sup> UMass Donahue Institute, *Massachusetts Population Estimates by City and Town* (2021), available at [https://donahue.umass.edu/data/pep/dashboards/2019\\_census\\_subcounty.html](https://donahue.umass.edu/data/pep/dashboards/2019_census_subcounty.html). Data source is U.S. Census Bureau, Population Division.

Middleborough, Attleboro and New Bedford. The following table details the characteristics of GSMC's Patient Panel.

**TABLE 2: GSMC's Overall Patient Panel**

Demographic Measure	FY19 (Q4)		FY20		FY21		FY22 (Q1, Q2, Q3)	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
<b>Age</b>								
0 to 18	2,590	8.75%	7,138	9.32%	7,353	9.07%	5,155	8.39%
19 to 45	8,722	29.48%	24,122	31.50%	24,528	30.25%	17,532	28.54%
46 to 64	9,748	32.95%	24,850	32.45%	26,380	32.53%	19,844	32.30%
65+	8,528	28.82%	20,478	26.74%	22,825	28.15%	18,906	30.77%
Total	29,588	100.00%	76,588	100.00%	81,086	100.00%	61,437	100.00%
<b>Gender</b>								
Female	17,547	59.30%	43,181	56.38%	46,356	57.17%	35,571	57.90%
Male	12,000	40.56%	33,272	43.44%	34,486	42.53%	25,566	41.61%
Unknown <sup>9</sup>	41	0.14%	135	0.18%	244	0.30%	300	0.49%
Total	29,588	100.00%	76,588	100.00%	81,086	100.00%	61,437	100.00%
<b>Race</b>								
African American	6,709	22.67%	16,658	21.75%	17,847	22.01%	14,000	22.79%
American Indian or Alaska Native	38	0.13%	102	0.13%	108	0.13%	91	0.15%
Asian	290	0.98%	841	1.10%	1,111	1.37%	802	1.31%
Declined <sup>10</sup>	257	0.87%	826	1.08%	776	0.96%	442	0.72%
Hispanic	1,681	5.68%	4,141	5.41%	4,333	5.34%	3,565	5.80%
Native Hawaiian or Other Pacific Islander	16	0.05%	29	0.04%	31	0.04%	31	0.05%
Other <sup>11</sup>	1,760	5.95%	4,786	6.25%	5,047	6.22%	3,848	6.26%
Unable to Obtain <sup>12</sup>	142	0.48%	789	1.03%	835	1.03%	700	1.14%
White	18,695	63.18%	48,416	63.22%	50,998	62.89%	37,958	61.78%
Total	29,588	100.00%	76,588	100.00%	81,086	100.00%	61,437	100.00%

<sup>9</sup> "Unknown" is defined as not recorded as male or female.

<sup>10</sup> "Declined" indicates the patient declined to provide.

<sup>11</sup> "Other" indicates not included in any of the categories mentioned in the table.

<sup>12</sup> "Unable to Obtain" indicates staff was unable to obtain from the patient due to trauma situations or patient was unconscious.

Payer	FY19	FY20	FY21
Commercial PPO/Indemnity	12.33%	12.77%	12.91%
Commercial HMO/POS	13.08%	13.32%	12.80%
MassHealth	13.82%	13.04%	13.29%
Managed Medicaid	4.88%	5.29%	5.08%
Commercial Medicare	12.28%	12.76%	15.17%
Medicare FFS	36.04%	35.45%	34.05%
All Other <sup>13</sup>	7.58%	7.36%	6.71%
Total	100%	100%	100%

Payer	FY19	FY20	FY21
APM/ACO Contracts	24.09%	24.05%	23.48%
Non-APM/Non-ACO Contracts	75.91%	75.95%	76.52%
Total	100%	100%	100%

As illustrated in the table above, GSMC's overall Patient Panel is similar to Steward Northeast's Patient Panel with some notable differences. Like the Steward Northeast Patient Panel, the majority of GSMC patients are female, with 58% of the patients identifying as female and 42% as male. GSMC's Patient Panel differs from Steward Northeast with respect to race and ethnicity. While the predominant self-reported race at Steward Northeast and GSMC patients was White, GSMC's second predominant self-reported race was African American (22% compared to 11%) whereas Steward Northeast's second predominant self-reported race was Hispanic. GSMC had approximately 9% less patients self-reporting as Hispanic (3% compared to 12%). GSMC patients also self-identified as Asian at significantly lower rates (1% compared to 3%). Steward Northeast and GSMC have a similar proportion of patients who self-identified as Other race/ethnicity and Declined, and less than 1% self-identified as American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, or unable to obtain. In FY22 (Q1-Q3), GSMC served approximately 61,437 patients (81,916 annualized), an increase of 6.22% from FY20.<sup>14</sup> GSMC's payor mix was very similar to Steward Northeast's payor mix.

#### *Good Samaritan Inpatient Psychiatric Patient Panel*

GSMC offers inpatient psychiatric treatment for those 65 and older in 16 geriatric inpatient psychiatric beds. GSMC's inpatient psychiatric service offers comprehensive assessment, short-term intensive treatment and discharge planning services with a variety of acute emotional health problems. Patients may present to GSMC for inpatient psychiatric care voluntarily or on involuntary holds. The following table details the characteristics of GSMC's inpatient psychiatric Patient Panel.

<sup>13</sup> "All Other" includes but is not limited to: Medicaid-Other; Noninsurance payors; QHP-Connector Plans; and Self-pay/free care.

<sup>14</sup> Overall, unique patients decreased from FY19 (Q4) to FY22 (Q1-Q3) likely due to patient avoidance of hospitals during the COVID-19 Pandemic.

**TABLE 3: GSMC Inpatient Psychiatric Unit Patient Panel**

Demographic Measure	FY19 (Q4)		FY20		FY21		FY22 (Q1, Q2, Q3)	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
<b>Age</b>								
0 to 18	0	0.00%	0	0.00%	0	0.00%	0	0.00%
19 to 45	297	60.24%	821	57.98%	588	55.47%	0	0.00%
46 to 64	138	27.99%	410	28.95%	306	28.87%	<11 <sup>15</sup>	14.29%
65+	58	11.76%	185	13.06%	166	15.66%	<11	85.71%
<b>Total</b>	<b>493</b>	<b>100.00%</b>	<b>1,416</b>	<b>100.00%</b>	<b>1,060</b>	<b>100.00%</b>	<b>&lt;11<sup>16</sup></b>	<b>100.00%</b>
<b>Gender</b>								
Female	167	32.86%	505	35.03%	333	31.42%	<11	57.14%
Male	326	66.13%	911	64.34%	706	66.60%	<11	42.86%
Unknown <sup>17</sup>	<11	1.01%	<11	0.64%	21	1.98%	0	0.00%
<b>Total</b>	<b>493</b>	<b>100.00%</b>	<b>1,416</b>	<b>100.00%</b>	<b>1,060</b>	<b>100.00%</b>	<b>&lt;11</b>	<b>100.00%</b>
<b>Race</b>								
African American	26	5.27%	83	5.86%	82	7.74%	0	0.00%
American Indian or Alaska Native	<11	0.20%	<11	0.21%	0	0.00%	0	0.00%
Asian	0	0.00%	<11	0.07%	<11	0.19%	0	0.00%
Declined <sup>18</sup>	<11	0.61%	11	0.78%	<11	0.28%	0	0.00%
Hispanic	20	4.06%	53	3.74%	42	3.96%	0	0.00%
Native Hawaiian or Other Pacific Islander	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Other <sup>19</sup>	<11	2.03%	24	1.69%	22	2.08%	0	0.00%
Unable to Obtain <sup>20</sup>	<11	0.81%	25	1.77%	42	3.96%	0	0.00%
White	447	87.02%	1220	85.88%	872	81.79%	<11	100.00%
<b>Total</b>	<b>493</b>	<b>100.00%</b>	<b>1,416</b>	<b>100.00%</b>	<b>1,060</b>	<b>100.00%</b>	<b>&lt;11</b>	<b>100.00%</b>

As illustrated in the table above, GSMC inpatient psychiatric Patient Panel differs from Steward Northeast's and GSMC's overall Patient Panel with some similarities. Unlike the Steward Northeast and GSMC's overall Patient Panel, the largest percentage of patients at GSMC inpatient psychiatric were in the 19-45 (compared to 46-64 age cohort) followed by 46-64 and 65+, respectively. Patients in the GSMC inpatient psychiatric patient panel are adult and geriatric so there were no patients in the 0-18 age cohort. Unlike the Steward Northeast and GSMC overall Patient Panels, the majority of GSMC psychiatric patients are male, with 60% of the patients identifying as male and 39% as female (compared to the converse for Steward Northeast and GSMC overall). GSMC's psychiatric Patient Panel is similar to GSMC's overall Patient Panel with respect to race and ethnicity. The predominant self-reported race of GSMC psychiatric inpatients was White, followed by African American and Hispanic, respectively, and had similar patterns as GSMC overall for the remaining races and ethnicities; however, there were no patients who self-reported as Native

<sup>15</sup> To ensure patient privacy, we have used the notation "<11" in any instance where the patient count for a demographic category included less than 11 individuals. The actual patient count has been included elsewhere so the total patient count remains accurate but patient privacy is maintained.

<sup>16</sup> Since February 25, 2022, approximately 10 months, the 16 psychiatric beds at GSMC have been offline due to staffing shortages.

<sup>17</sup> "Unknown" is defined as not recorded as male or female.

<sup>18</sup> "Declined" indicates the patient declined to provide.

<sup>19</sup> "Other" indicates not included in any of the categories mentioned in the table.

<sup>20</sup> "Unable to Obtain" indicates staff was unable to obtain from the patient due to trauma situations or patient was unconscious.

Hawaiian or Other Pacific Islander. Between FY19 (Q4) and FY21<sup>21</sup> there was on average 1,482 unique GSMC psychiatric inpatients.<sup>22</sup>

**F1.a.ii      Need by Patient Panel:**

**Provide supporting data to demonstrate the need for the Proposed Project. Such data should demonstrate the disease burden, behavioral risk factors, acuity mix, health disparities, or other objective Patient Panel measures as noted in your response to Question F1.a.i that demonstrates the need that the Proposed Project is attempting to address. If an inequity or disparity is not identified as relating to the Proposed Project, provide information justifying the need. In your description of Need, consider the principles underlying Public Health Value (see instructions) and ensure that Need is addressed in that context as well.**

The Applicant proposes to construct a new facility on the campus of GSMC that will provide both inpatient and outpatient behavioral health services. The facility will also provide outpatient psychiatric services including electroconvulsive therapy, among other services. Importantly, the Proposed Project will provide needed capacity for inpatient psychiatric services in the Commonwealth as discussed below.

The Proposed Project includes the replacement of 61 inpatient psychiatric beds that were licensed at Norwood Hospital prior to its closure. On June 28, 2020, an unprecedented, catastrophic flooding and storm caused damage to Norwood Hospital, forcing it to evacuate patients and close services at the main campus. Prior to the closure, Norwood Hospital provided emergency care, and inpatient and outpatient services at its main campus, including 61 psychiatric inpatient care beds (39 adult and 22 geriatric). Subsequently, the Department approved an emergency DoN to rebuild Norwood Hospital in the same location. In the DoN Program's memorandum, it noted a critical need to replace the inpatient psychiatric beds and imposed a condition to replace the 61 inpatient psychiatric beds at another Steward hospital facility or campus in Massachusetts to ensure the Patient Panel need for inpatient psychiatric beds continues to be met. Steward evaluated its options for re-opening the 61 psychiatric beds and determined that GSMC has available, sufficient land on its campus to accommodate an inpatient psychiatric facility.

In addition to fulfilling the need to replace Norwood Hospital's closed beds, the Proposed Project will meet the increasing needs of the Applicant's patient panel for access to inpatient psychiatric beds. As discussed further in Factor F1.b.i, research demonstrates that since 2020, the incidence of mental health conditions has increased substantially nationwide and in Massachusetts, and the number of individuals seeking treatment for mental health conditions has also increased. Many individuals with mental illness do not receive treatment and report unmet mental health needs. Unmet need refers to a person who has a perceived or recommended need for mental health treatment or counseling however they do not receive care.<sup>23</sup> From 2018-2019, 6.3% (343,000) of Massachusetts adults reported an unmet need for mental health treatment. During this same period, adults in Massachusetts did not receive treatment: 55.1% (352,000) of adults with mild mental illness; 35.6% (89,000) of adults with moderate mental illness, and 29.6% (85,000) with serious mental illness. Many individuals who do seek treatment face barriers to accessing care such lack of inpatient psychiatric bed capacity and long wait times for appointments. Unmet needs for mental health services is expected to continue due to the impact of the COVID-19 pandemic on access to care and the resulting exacerbation of mental health conditions.<sup>24</sup>

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<sup>21</sup> FY22 (Q1-Q3) was not used in data comparison due to IP psychiatric beds going offline as a result of staffing shortages. This would skew the data.

<sup>22</sup> Number of unique patients were likely lower due to patient avoidance of hospitals during the COVID-19 Pandemic.

<sup>23</sup> See *Mental Health in Massachusetts*, KFF (<https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/massachusetts/#:~:text=As%20shown%20in%20the%20figure,of%20adults%20in%20the%20U.S>) (last visited Dec. 23, 2022).

<sup>24</sup> *Id.*

This lack of access to care is evident based on ED boarding statistics. Boarding of patients awaiting admission to a psychiatric bed is often due inadequate capacity. A patient requiring admission to a psychiatric bed is defined as a boarder when the patient spends 12 or more hours in the ED from their time of arrival to their time of departure. Patients who present to the ED in need of inpatient psychiatric care wait nearly four times longer for an inpatient bed and more than five times longer for transfer to another facility relative to medical and surgical patients. Moreover, psychiatric patient boarders represent the majority of all boarders. High boarding rates and hours have historically been an issue in Massachusetts; however, the continuing effects of the COVID-19 pandemic have led to increased numbers of patients boarding for longer periods of time. Long boarding times result in delays in access to appropriate treatment and can worsen a patient's condition. In addition, EDs cannot accommodate additional patients seeking emergent care due to the high number of boarders occupying ED bays, leading to delays in care for all patients seeking ED services and straining staff.

According to a joint survey completed by the Massachusetts Health and Hospital Association ("MHA") and Massachusetts Association of Behavioral Health Systems ("MABHS"), there are routinely between 500-700 patients boarding in acute care hospitals each day as they await inpatient behavioral health placement. The number of patients aged 65 and over boarding in hospital EDs ranged from approximately 5-100 patients per day.<sup>25</sup> On average, Steward hospitals have 70-90 patients boarding across 8 emergency departments. Steward also has an average of 1,800 crisis evaluations per month in its EDs. GSMC has an average of 15 boarders awaiting admission to a psychiatric bed occupying its 43 ED bays. From January 1, 2022 through November 1, 2022, the GSMC ED evaluated 2,103 unique patients and the average boarding time was 34 hours (1 day and 10 hours) with a total of 71,782 boarder hours. Although new psychiatric beds have come online in recent years, the need for behavioral health services has dramatically increased further worsening ED boarding in the state.

Demand for inpatient psychiatric services will increase as the population increases. According to county-level population estimates released by the U.S. Census Bureau, Plymouth County, where GSMC is located, was one of three counties in Massachusetts to experience the greatest population increase in Massachusetts (net increase of 2,024 residents from July 1, 2020 to July 1, 2021), with a 0.4% increase in population from 2020 to 2021.<sup>26</sup> UMass Donahue Institute ("UMDI") projects that Southeastern Massachusetts will experience population increases in coming years.<sup>27</sup> With high rates of reported mental illness and the increase in Massachusetts residents seeking mental health treatment, it is expected the need for mental health services will continue to grow as the population grows. Further, GSMC has historically experienced high demand for its 16 inpatient geri-psychiatric beds. In FY20 the average length of stay was 25.45 days; in FY21 it was 25.3 days and FY22 it was 26.56.<sup>28</sup> Based on existing and projected demand, the Applicant projects that the occupancy rates at the new facility will steadily increase as follows: Year 1: 80%; Year 2: 82%; Year 3: 85%; Year 4: 87% and Year 5: 90%. Accordingly, Massachusetts, and more specifically southeastern Massachusetts require more inpatient psychiatric bed capacity to meet demand. The loss of 61 inpatient psychiatric beds at Norwood Hospital coupled with historic demand, population growth projection, and the state's high psychiatric boarding rates demonstrate the need for the Proposed Project to construct a facility at GSMC with 77 inpatient psychiatric beds.

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<sup>25</sup> See *Capturing a Crisis*, Massachusetts Behavioral Health Boarding Metrics available at ([https://mhalink.informz.net/mhalink/data/images/MHA%2020212022%20Trending%20Boarding%20Report\\_final.pdf](https://mhalink.informz.net/mhalink/data/images/MHA%2020212022%20Trending%20Boarding%20Report_final.pdf) [https://www.mhalink.org/MHA/IssuesAdvocacy/State/Behavioral\\_Health\\_Boarding/MHA/IssuesAndAdvocacy/Capturing\\_a\\_Crisis\\_MHAs\\_Weekly\\_Behavioral\\_Health\\_Boarding\\_Reports.aspx?hkey=40f7493a-e25b-4a28-9cda-d7de41e622d2](https://www.mhalink.org/MHA/IssuesAdvocacy/State/Behavioral_Health_Boarding/MHA/IssuesAndAdvocacy/Capturing_a_Crisis_MHAs_Weekly_Behavioral_Health_Boarding_Reports.aspx?hkey=40f7493a-e25b-4a28-9cda-d7de41e622d2)).

<sup>26</sup> UMass Donahue Institute, *Massachusetts Population Estimates by City and Town* (2021), available at ([https://donahue.umass.edu/data/pep/dashboards/2019\\_census\\_subcounty.html](https://donahue.umass.edu/data/pep/dashboards/2019_census_subcounty.html)). Data source is U.S. Census Bureau, Population Division.

<sup>27</sup> *Id.*

<sup>28</sup> Since February 25, 2022, approximately 10 months, the 16 psychiatric beds at GSMC have been offline due to staffing shortages.



**F1.a.iii****Competition:**

**Provide evidence that the Proposed Project will compete on the basis of price, total medical expenses, provider costs, and other recognized measures of health care spending. When responding to this question, please consider Factor 4, Financial Feasibility and Reasonableness of Costs.**

The replacement of psychiatric beds will not have an adverse impact on competition in the Massachusetts health care market based on price, total medical expenses ("TME"), provider costs or other recognized measures of health care spending. The Proposed Project seeks to meet the high demand for timely access to inpatient psychiatric services in Southeastern Massachusetts. The Proposed Project will lead to shorter boarding times and improved access to inpatient psychiatric treatment. It will also result in more efficient operation of the GSMC ED. Timely access to inpatient psychiatric services in the most appropriate setting may result in lower costs of care. Moreover, patients presenting to the ED in need of other care will also experience improved access to care, thereby improving outcomes and reducing costs driven by delays in diagnosis and treatment. Accordingly, the Proposed Project will meet the needs of the patient panel while reducing costs associated with delays in treatment and the provision of care in sub-optimal settings.

**F1.b.i****Public Health Value /Evidence-Based:**

**Provide information on the evidence-base for the Proposed Project. That is, how does the Proposed Project address the Need that Applicant has identified.**

The Proposed Project is supported by evidence-based literature. In the United States, nearly one in five adults lives with a mental illness.<sup>29</sup> According to a 2020 National Survey on Drug Use and Health (NSDUH) by the Substance Abuse and Mental Health Services Administration (SAMHSA), there was an estimated 52.9 million adults (aged 18 or older) with any mental illness ("AMI")<sup>30</sup>, which represented 21.0% of all U.S. adults. Among the 52.9 million adults with AMI in 2020, 24.3 million (46.2%) received mental health services in the past year. The NSDUH defines "mental health services" as having received inpatient treatment/counseling or outpatient treatment/counseling or having used prescription medication.<sup>31</sup> The percentage of adults aged 50 and older with AMI who received mental health services was 48.0% - highest among all adult age groups, with 42.1% of adults aged 18-25 and 46.6% of adults aged 26-49 receiving care.<sup>32</sup>

The COVID-19 pandemic exacerbated behavioral health conditions. According to the Centers for Disease Control and Prevention's National Center for Health Statistics, the percentage of adults who received any mental health treatment (defined as taking medication, received counseling or therapy or both) increased from 19.2% to 21.6% between 2020 and 2021.<sup>33</sup> Rates of depression and anxiety increased by more than 25% in the first year of the COVID-19 pandemic, adding to the nearly one billion people already living with a mental illness worldwide.<sup>34</sup> At the same time, access to mental health services has been severely disrupted and has caused a wide treatment gap.<sup>35</sup> In Massachusetts, one study reported that from January 2020 to March of 2021, more than 1 in 3 Massachusetts residents over the age of 19 reported needing

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<sup>29</sup> See *Mental Illness*, National Institute of Mental Health (<https://www.nimh.nih.gov/health/statistics/mental-illness>) (last visited Dec. 23, 2022).

<sup>30</sup> AMI was defined as a mental, behavioral, or emotional disorder. *Id.*

<sup>31</sup> See *supra* note 29.

<sup>32</sup> See *supra* note 29.

<sup>33</sup> Terlizzi EP, Schiller JS. *Mental health treatment among adults aged 18–44*: United States, 2019–2021. NCHS Data Brief, no. 444. Hyattsville, MD: National Center for Health Statistics. 2022 ([https://www.cdc.gov/nchs/products/databriefs/db444.htm#Suggested\\_citation](https://www.cdc.gov/nchs/products/databriefs/db444.htm#Suggested_citation)) (Sept. 2022).

<sup>34</sup> World mental health report: transforming mental health for all. Executive summary. Geneva: World Health Organization; 2022. License: CC BY-NC-SA 3.0 IGO. (<https://www.who.int/publications/i/item/9789240050860>) (June 16, 2022).

<sup>35</sup> See *id.*

behavioral health care for themselves or a close relative.<sup>36</sup> A 2021 Kaiser Family Foundation (KFF) analysis of U.S. Census Bureau, Household Pulse Survey found that among adults who reported experiencing symptoms of anxiety and or depressive disorder, 28.7% reported needing but did not receive any therapy or counseling in the past four weeks, as compared to the national average of 26.9% (a difference of 1.8%).<sup>37</sup>

The increased incidence of mental illness and the need for additional capacity has resulted in increased ED boarding rates. Described as a patient safety issue and worldwide public health problem, ED Boarding has been a longstanding issue in the Commonwealth and disproportionately affects patients requiring inpatient psychiatric treatment.<sup>38</sup> Between 2011 and 2015, the number of Massachusetts patients presenting to the ED with a mental health need increased 13% (22.9 visits per 1,000 residents in 2011 to 26.0 in 2015).<sup>39</sup> The Health Policy Commission (“HPC”) analyzed ED Boarding in the Commonwealth that included 2015 data and time trends in boarding from 2011 to 2015.<sup>40</sup> This research made the following, but not exclusive, findings: patients with a behavioral health diagnosis had significantly longer lengths of stays (“LOS”) in the ED than non-behavioral health patients (median LOS for patients with a primary behavioral health diagnosis was twice as long as for a patient without a behavioral health diagnosis – 5.4 hours versus 2.6 hours, respectively); patients with a behavioral health diagnosis comprised a disproportionate share of ED visits that boarded: while patients with a behavioral health diagnosis accounted for 14% of ED visits in 2015, they accounted for 71% of all ED visits that boarded; the number of patients boarding with a primary behavioral health diagnosis has increased over time; and patients with living in the Metro South and South Shore regions were the most likely to board (24% and 22%, respectively).<sup>41</sup> According to MHA’s last weekly boarding report (August 29, 2021), Region 5 (cities where GSMC’s Patient Panel primarily resides and where GSMC is located), had the largest number of boarders as compared to other Regions in Massachusetts, with a total of 139 boarders.<sup>42</sup> Further, often, psychiatric patients seek care in the ED because they have nowhere else to go.<sup>43</sup> Mental health boarding increases ED wait times for all patients, which can have a significant domino effect on hospital operations and patient outcomes.<sup>44</sup>

An adequate supply of inpatient mental health beds is an important way to combat ED and psychiatric boarding. Crowding can be caused by population growth, volume of patients waiting to be seen (referred to as input), delays in assessing and treating patients already in the ED (referred to as throughput), or any impediment to patients leaving the ED once they have been treated (referred to as output).<sup>45</sup> Input factors include volume, acuity and type of patient.<sup>46</sup> Older patients typically require a disproportionate amount of care as do patients with mental illness.<sup>47</sup> Increasing physical capacity (inpatient beds) is one solution to

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<sup>36</sup> See Deborah Becker, *The pandemic has led to a surge in mental health need in Mass., survey finds*, wbur (<https://www.wbur.org/news/2022/02/08/massachusetts-pandemic-mental-health>) (Feb. 8, 2022).

<sup>37</sup> See *supra* note 23.

<sup>38</sup> See Jesse M. Pines, Richard T. Griffee, *What we have learned from a decade of ED crowding research?* Acad. Emerg. Med. 2015;22(8):985–7. 10.1111/acem.12716 (July 20, 2015) (<https://onlinelibrary.wiley.com/doi/10.1111/acem.12716>).

<sup>39</sup> See *HPC Issues New Research on Behavioral Health-Related Emergency Department Boarding*, Massachusetts Health Policy Commission (Nov. 16, 2017) (<https://www.mass.gov/news/hpc-issues-new-research-on-behavioral-health-related-emergency-department-boarding>); *Behavioral Health-Related Emergency Department Boarding in Massachusetts*, Massachusetts Health Policy Commission (Nov. 2017) available at (<https://www.mass.gov/doc/behavioral-health-related-emergency-department-boarding>).

<sup>40</sup> See *id.*

<sup>41</sup> See *id.*

<sup>42</sup> See *supra* note 25.

<sup>43</sup> See *Quick Safety 19: ED boarding of psychiatric patients – a continuing problem*, The Joint Commission, (<https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety--issue-19-alleviating-ed-boarding-of-psychiatric-patients/alleviating-ed-boarding-of-psychiatric-patients/#.Y5NLM3ZOn-g>) (July 2021).

<sup>44</sup> See Martha Bebinger, *716 psych patients are struck in emergency rooms waiting for care, Mass. Report shows*, (Oct. 11, 2021) (<https://www.wbur.org/news/2021/10/11/massachusetts-mental-health-boarding-report>).

<sup>45</sup> Claire Morley, Maria Unwin, Peterson, Gregory M. Peterson, et al. *Emergency department crowding: A systematic review of causes, consequences and solutions*. PLoS One.;13(8):e0203316. doi: 10.1371/journal.pone.0203316.

<sup>46</sup> Adrian Boyle, Kathleen Beniuk, et al. *Emergency Department Crowding: Time for Interventions and Policy Evaluations*, Emergency Medicine International, vol. 2012, Article ID 838610 (Feb. 7, 2012) (<https://www.hindawi.com/journals/emi/2012/838610/>).

<sup>47</sup> *Id.*

addressing psychiatric boarding.<sup>48</sup> Access block refers to the situation where patients in the ED requiring inpatient care are unable to gain access to appropriate hospital beds within a reasonable time frame, resulting in ED overcrowding.<sup>49</sup> Studies have documented that the presence of inpatients in the ED is the primary reason for ED overcrowding.<sup>50</sup> Thus, increasing the availability of inpatient behavioral health acute care beds is recommended for improving patient flow and overall ED performance.<sup>51</sup>

**F.1.b.ii      Public Health Value /Outcome-Oriented:**

**Describe the impact of the Proposed Project and how the Applicant will assess such impact. Provide projections demonstrating how the Proposed Project will improve health outcomes, quality of life, or health equity. Only measures that can be tracked and reported over time should be utilized.**

The Proposed Project will provide public health value by improving access to inpatient psychiatric services, thereby improving patient satisfaction, access, and health outcomes. To assess the impact of the Proposed Project, the Applicant developed the following quality metrics, including projections. The baseline and projections for each measure will be established following the first full year of the Proposed Project's implementation and reported annually. All measures will be reported on an annual basis following the first year of the Proposed Project's implementation. The measures are discussed below:

1. **Patient Satisfaction Measure:** The Applicant will utilize the Press Ganey Performance monitoring to identify in-patient satisfaction scores.
2. **Access Measure – Length of Stay for patients in the ED:** The Applicant will measure the average ED boarder hours by dividing the total annual boarder hours for behavioral health patients by the total number of behavioral health patients admitted to an inpatient psychiatric bed at GSMC. GSMC anticipates that ED boarding hours will decline with the addition of the proposed beds.
3. **Outcome Measure – 30-Day Readmission Rate for GSMC psychiatric inpatients.** Hospital-Based In-Patient Psychiatric Services ("HBIPS") national core measures is a major national core measurement initiative that aims to improve and monitor the quality and safety of the psychiatric patient. There are 9 performance measures that are monitored and reviewed quarterly to ensure patient safety goals are being met. The Applicant will report the *30 Day All Cause Unplanned Readmission Following Hospitalization*. Given the scope of the Proposed Project, quality scores and re-admission rates will improve over time.

**F1.b.iii      Public Health Value /Health Equity-Focused:**

**For Proposed Projects addressing health inequities identified within the Applicant's description of the Proposed Project's needbase, please justify how the Proposed Project will reduce the health inequity, including the operational components (e.g. culturally competent staffing). For Proposed Projects not specifically addressing a health disparity or inequity, please provide information about specific actions the Applicant is and will take to ensure equal access to the health benefits created by the Proposed Project and how these actions will promote health equity.**

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<sup>48</sup> See *supra* note 25.

<sup>49</sup> See *supra* note 46; Access block causes emergency department overcrowding and ambulance diversion in Perth, Western Australia, 22 EMERGENCY MED. J. 351, 352-54 (2005), *available at* (<http://emj.bmj.com/content/emjmed/22/5/351.full.pdf>); Entry overload, emergency department overcrowding, and ambulance bypass, 20 EMERGENCY MED. J. 406, 408-09 (2003), *available at* (<http://emj.bmj.com/content/emjmed/20/5/406.full.pdf>); Psychiatric Emergencies, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (<http://newsroom.acep.org/index.php?s=20301&item=30093>) (last visited May 4, 2018).

<sup>50</sup> See *supra* notes 46, 49.

<sup>51</sup> See *supra* notes 46, 49.

To ensure health equity to all populations, including those deemed underserved, the Proposed Project will improve access to GSMC's services for all patients including economically disadvantaged, medically indigent, and/or MassHealth-eligible individuals. The Applicant and GSMC do not discriminate based on the payer source or an individual's ability to pay, and this practice will continue following implementation of the Proposed Project. As discussed throughout this narrative, the Proposed Project will increase access to high-quality and timely inpatient psychiatric care. These services are critical for underserved individuals and those facing barriers to care.

The provision of appropriate medical care largely depends on the ability to communicate. Steward and GSMC are dedicated to ensuring culturally and linguistically appropriate care. GSMC offers interpreter services that include in-person, telephonic, video, and ASL available to patients and families. GSMC has a team of qualified medical interpreters to provide effective communication to Limited English Proficiency ("LEP"), deaf and hard of hearing ("DHH") patients and has bilingual clinical staff. Staff interpreters are available days and evenings 7 days per week. If a staff interpreter is not immediately available, such as during high volume times, GSMC provides access to interpreters by phone (CyraCom) or video remote units (Stratus). GSMC's interpreters are assessed for their clinical fluency so they can provide direct care to patients in another language and are trained in terminology related to mental illness to ensure accurate and informed encounters. Interpreters on staff can speak the following languages, which represent the primary languages within GSMC's service area: Portuguese, Spanish, ASL, and Cape Verdean. GSMC also provides patient information that is translated and available in multiple languages, ensuring equal access to important patient information.

Hospital staff from all departments are informed of the existence and appropriate use of interpreter services through staff orientations, skills days, the Cultural Connection Newsletter, and staff meetings to ensure staff is aware of these services. With Steward's newly integrated EMR and dispatch system, GSMC has improved efficiencies, decreased redundancy, improved accuracy of appointments and improved identification of LEP and DHH patients.

**F1.b.iv            Provide additional information to demonstrate that the Proposed Project will result in improved health outcomes and quality of life of the Applicant's existing Patient Panel, while providing reasonable assurances of health equity.**

The proposed project seeks to expand access to inpatient psychiatric services at GSMC through the construction of a seventy-seven (77) bed facility that will accommodate sixteen (16) beds relocated from the existing GSMC campus and sixty-one (61) new inpatient psychiatric beds (formerly operated by Norwood Hospital). The Proposed Project will improve health outcomes and quality of life for GSMC's Patient Panel by providing timely access to inpatient psychiatric beds and reducing ED boarding. Timely access to inpatient psychiatric beds and decreased ED boarding will ultimately improve patient health outcomes and patient quality of life. GSMC remains committed to promoting health equity, ensuring patients can access the Hospital's services, effectively communicate with their providers, and ensure patients are linked to services outside of the Hospital. As a result, the Applicant anticipates that the Proposed Project will result in improved patient care and quality outcomes while promoting health equity.

**F1.c                Provide evidence that the Proposed Project will operate efficiently and effectively by furthering and improving continuity and coordination of care for the Applicant's Patient Panel, including, how the Proposed Project will create or ensure appropriate linkages to patients' primary care services.**

Providing patients with linkages to necessary post-hospitalization services can prevent readmission, ensure appropriate care management, reduce gaps in services during transitions and allow for patients to achieve smooth transitions to care locally. Prior to discharge, GSMC staff provides assistance to facilitate access to appropriate follow-up care. This may include referrals to outpatient services or providers. In addition, the

proposed facility will offer outpatient ECT, TMS, activity therapy and partial hospitalization services providing access to a continuum of care for patients. Discharge plans are shared with the patient's primary care provider, as well as a patient's psychiatrist or other mental health provider to ensure care coordination.

**F1.d Provide evidence of consultation, both prior to and after the Filing Date, with all Government Agencies with relevant licensure, certification, or other regulatory oversight of the Applicant or the Proposed Project.**

The Applicant consulted with numerous individuals at multiple regulatory agencies regarding the Proposed Project. The following individuals were consulted with regards to the Proposed Project:

- Dennis Renaud, Director of Determination of Need Program, Massachusetts Department of Public Health;
- Rebecca Rodman, Esq., Senior Deputy General Counsel, Massachusetts Department of Public Health;
- Jennica Allen, Manager of Community Engagement Practices, Massachusetts Department of Public Health;
- Lauren Peters, JD, Undersecretary for Health Policy at the Executive Office of Health and Human Services;
- Janet Ross, MS, RN, Assistant Commissioner for Clinical & Professional Services/ Director of Licensing, Massachusetts Department of Mental Health;
- The Centers for Medicare & Medicaid Services; and
- MassHealth

**F1.e.i Process for Determining Need/Evidence of Community Engagement: For assistance in responding to this portion of the Application, Applicant is encouraged to review *Community Engagement Standards for Community Health Planning Guideline*. With respect to the existing Patient Panel, please describe the process through which Applicant determined the need for the Proposed Project.**

The Department's Guideline for community engagement defines "community" as the Patient Panel, and requires that at minimum, the Applicant must consult with groups representative of the Applicant's Patient Panel. Regulations state that efforts in such consultation should consist of engaging "community coalitions statistically representative of the Patient Panel." In planning for the Proposed Project, GSMC held two meetings where it sought feedback from the community at large, including community groups such as Community Behavioral Health Centers (CBHC), the school committee, the town council, and the Hospital's Patient Family Advisory Council ("PFAC") which is comprised of patients and their family members, local residents, and members of local resident groups. GSMC also had initial discussions with the City of Brockton Mayor Robert F. Sullivan (and his planning team), Senator Michael D. Brady, and Representative Gerard Cassidy. The presentations reviewed the background and purpose of the Proposed Project, what it would mean for patients and the community, and provided a general overview of the Proposed Project's process. The Proposed Project will also be presented at the January 2023 session of the Brockton City Council, as well as at a community open forum.

**F1.e.ii** Please provide evidence of sound Community Engagement and consultation throughout the development of the Proposed Project. A successful Applicant will, at a minimum, describe the process whereby the "Public Health Value" of the Proposed Project was considered, and will describe the Community Engagement process as it occurred and is occurring currently in, at least, the following contexts: Identification of Patient Panel Need; Design/selection of DoN Project in response to "Patient Panel" need; and Linking the Proposed Project to "Public Health Value".

To ensure sound community engagement throughout the development of the Proposed Project, the Applicant took the following actions:

- Presentation to PFAC on December 14, 2022;
- Presentation at the January 2023 session of the Brockton City Council.
- Presentation at a Community open Forum on January 5, 2023.<sup>52</sup>

For detailed information on these activities, see Appendix 3.

## **Factor 2: Health Priorities**

**Addresses the impact of the Proposed Project on health more broadly (that is, beyond the Patient Panel) requiring that the Applicant demonstrate that the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation.**

**F2.a. Cost Containment:**  
Using objective data, please describe, for each new or expanded service, how the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment.

The Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment by providing patients with timely access to inpatient psychiatric treatment. Patients who receive appropriate, timely psychiatric care, especially patients suffering from depression, anxiety and schizophrenia are less likely to seek treatment through the ED upon discharge or need additional inpatient care.<sup>53</sup> The reduction in ED boarding and corresponding provision of care in the most appropriate setting will allow the Hospital to treat patients before their conditions worsen and become more costly to care for over time. Moreover, GSMC will provide a continuum of care including outpatient psychiatric services that may be accessed post-discharge. In addition, patients are provided with assistance in linking to staff to appropriate community resources to address the individual's social determinants of health ("SDoH") needs. Access to a continuum of care to address a patient's psychiatric needs and other issues that impact health can reduce costs by meeting the needs of patients before more costly ED and inpatient care is required. Lowering the total cost of care will contribute to the Commonwealth's cost containment goals.

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<sup>52</sup> The same presentation given to PFAC will be used at the community forum.

<sup>53</sup> Sunil Kripalani MD, MSc, Cecelia N. Theobald, MD, et al., *Reducing Hospital Readmission: Current Strategies and Future Directions*, 65 ANNUAL REVIEW MED. 4 71 (2014), available at (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4104507/>).

**F2.b.            Public Health Outcomes:  
Describe, as relevant, for each new or expanded service, how the Proposed Project will improve public health outcomes.**

As discussed in F.1.a.ii., the Applicant anticipates the prevalence of mental health illnesses will continue to increase. To ensure access to inpatient and outpatient psychiatric services for the portion of the patient panel who tend to have higher rates of mental illness (adults and older adults), it is necessary to have adequate capacity. The proposed 77 bed facility will improve public health outcomes by providing timely access to inpatient psychiatric care. Timely access to care will decrease delays that may lead to worsening of a patient's condition while boarding in the ED and can result in improved patient experience and outcomes, as well as reduced rates of readmission. The Proposed Project will also provide a continuum of care by expanding outpatient psychiatric services. Finally, with lower ED boarding, all patients presenting to the ED will have timely access to care, improving patient outcomes.

**F2.c.            Delivery System Transformation:  
Because the integration of social services and community-based expertise is central to goal of delivery system transformation, discuss how the needs of their patient panel have been assessed and linkages to social services organizations have been created and how the social determinants of health have been incorporated into care planning.**

As described throughout this Application, the Proposed Project will improve access to inpatient psychiatric services through expanded capacity. GSMC offers interdisciplinary services to its patients through its inpatient psychiatric service, ensuring appropriate medical and support services throughout their admission. Upon admission and prior to discharge, a care plan is developed for all patients to address their needs, including psycho-social supports that will increase likelihood of a successful recovery and continue care in an outpatient setting.

GSMC also conducts SDoH screening and links patients to community resources. Prior to discharge, GSMC staff provides assistance and written materials to patients to facilitate linkages to community resources to address the individual's medical, social, psychological, cultural, and ethnic needs. Individualized psychosocial assessments are also conducted on patients to assist in identifying community needs prior to discharge. To further ensure the quality and continuity of care after discharge, GSMC follows up with patients within 30 days to assess whether the patient requires additional assistance to address SDoH needs. The Hospital also offers numerous programs to address financial, spiritual, transportation, clothing, housing, and nutrition needs.

**Factor 5: Relative Merit**

**F5.a.i            Describe the process of analysis and the conclusion that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the existing Patient Panel needs as those have been identified by the Applicant pursuant to 105 CMR 100.210(A)(1). When conducting this evaluation and articulating the relative merit determination, Applicant shall take into account, at a minimum, the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternatives or substitutes, including alternative evidence-based strategies and public health interventions.**

**This Proposal:** The Proposed Project is to build a facility that will accommodate inpatient and outpatient psychiatric services.

**Quality:** Patients will have more timely access to appropriate care in the correct setting.

**Efficiency:** Increased inpatient capacity will result in the efficient transition of patients from the ED to an inpatient bed. This will create efficiencies in the ED as more patients will have timely access to emergent care and reduce strain on ED staff and resources as they will be able to focus on providing ED services.

**Capital Expense:** The total capital expenditure for construction of the 77-bed facility is \$76,865,511 million dollars.

**Alternative Proposal:** Do not build a facility on the GSMC campus to accommodate the beds previously operated by Norwood Hospital.

**Alternative Quality:** This alternative does not address the patient panel need for access to inpatient psychiatric services, both currently and as demand increases in the future. Limited inpatient psychiatric beds results in ED boarding and delays in the provision of inpatient psychiatric treatment which can adversely impact patient outcomes and quality of life.

**Alternative Efficiency:** If the 61 beds are not brought back online, the ED boarding crisis at GSMC and other Steward Hospitals will continue. This will adversely impact access for behavioral health and medical surgical patients and does not allow the ED to operate more efficiently.

**Alternative Capital Expenses:** There are no capital expenses under this alternative.

**Alternative Operating Costs:** There are no additional operating costs under this option.